HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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House Bills 1717 and 1718

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House Judiciary Subcommittee
on Crime and Corrections

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Main Capitol Building
Room 140, Majority Caucus Room
Harrisburg, Pennsylvania

Wednesday, November 19, 1997 - 9:30 a.m.

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BEFORE:

Honorable Jerry Birmelin, Majority Chairperson
Honorable Al Masland
Honorable Harold James, Minority Chairperson
Honorable Kathy Manderino

IN ATTENDANCE:

Honorable Robert Reber, Jr.
Honorable Stanley Saylor
Honorable Thomas Caltagirone
Honorable Joseph Petrarca
Honorable Donald Walko

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ALSO PRESENT:

Judy Sedesse
Majority Administrative Assistant

James Mann
Majority Research Analyst

Rodney Oliver
Minority Research Analyst

C O N T E N T S

CHAIRPERSON BIRMELIN: We have a full morning for you. We have some interesting people to testify here. Our in-house video system is going to be working hopefully in a few minutes, and we are going to have a couple of sex offenders who are under treatment -- chemical treatment for the problem that they have been evidencing in their lives and have been a part of a program to deal with that deals with the issue that we are talking with at hand.

I am Representative Birmelin, the chairman of the Subcommittee on Crime and Corrections for the full House Judiciary Committee. And we are picking up this morning after testimony was received yesterday, that I thought it was quite instructive and helpful in understanding this whole issue.

We also have with us the prime sponsor of the two bills, House Bills 1717 and 1718. And I will be introducing him shortly, and perhaps he could make a few opening comments again today.

But I want to introduce all of the members of the panel first before we have our testifiers come forward. And I will start to my

far right with the gentleman who is my counterpart on the Democratic side of the aisle.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman. I'm Harold James from the County of South Philadelphia and Democratic chairman of the Subcommittee on Crime and Corrections. Thank you.

REPRESENTATIVE MASLAND: Representative Al Masland from Cumberland County and parts of Northern York County.

REPRESENTATIVE SAYLOR: Representative Saylor from York County, the 94th District, and sponsor of the bills.

MR. MANN: I'm James Mann with the House judiciary research staff.

REPRESENTATIVE MANDERINO: Kathy Manderino, Philadelphia County.

REPRESENTATIVE REBER: Bob Reber, Montgomery County.

CHAIRPERSON BIRMELIN: As new or additional members join us this morning, I will be sure to introduce them as best I am able to.

We have with us as our first testifiers this morning two gentlemen who are involved in the treatment of sex offenders, who

have brought with them, and we will be hearing from on closed-circuit T.V. in a system in which their identities will not be made known to the public, two men who are under chemical treatment for their sexual bent, if you will. And we are going to be introducing them in just a minute.

The first thing I would like to do, however, is to give the prime sponsor of these two bills an opportunity to just share briefly with the folks who are here this morning why he is introducing these bills and what they will do.

Representative Saylor.

REPRESENTATIVE SAYLOR: Again, as I stated yesterday, I think that it's important to realize that the legislation that I have introduced is a program of treatment for sex offenders and certain sex offenders who fit into the qualifications that would be set forth by psychiatrists and counselors as well as medical professionals. And then those individuals would enter into this treatment program and hopefully bring them back into society.

The intent of this legislation is to offer to the Commonwealth of Pennsylvania an opportunity for the first time to have a

different program, a treatment program for sex offenders, and bring technology to our corrections system.

And I am hopeful that as we go through this process -- and I thank Chairman Birmelin as well as Democratic Chairman Harold James for their giving me this opportunity to bring this information and these bills forward as we move forward through the legislative process.

Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: At this time, I'm going to ask Mr. Robert Gingrich, the clinical director, and Dr. James Arndt, the psychiatrist, both with T.W. Ponessa & Associates Counseling Services from Lancaster, Pennsylvania, if they would come forward and present the testimony that they have for us.

Gentlemen.

We would appreciate it if you would first introduce yourselves and then, if you would, begin your testimony. Thank you.

MR. GINGRICH: My name is Robert Gingrich.

CHAIRPERSON BIRMELIN: Is the switch on?

MR. GINGRICH: My name is Robert Gingrich. As mentioned, I'm the clinical director.

REPRESENTATIVE SAYLOR: Move it closer.

MR. GINGRICH: Medical director at T.W. Ponessa & Associates.

DR. ARNDT: My name is Jim Arndt, and I'm a psychiatrist. And I have worked with Mr. Gingrich and T.W. Ponessa & Associates for six or seven years primarily evaluating individuals for medication treatment. And I also am on the Megan's Board.

MR. GINGRICH: I would like to just maybe give you some -- can you hear me? -- give you some idea of the clinic. We are presently treating approximately 305 individuals all with sexual offending issues, exhibitionism, rape, pedophilia. And that is in Reading, Harrisburg, Lancaster, and York. We do this in group therapy process; and of that number of 305, we do have a small percentage of men who do need medication to try to keep themselves safe within a community.

Probably the highest number of offenders that we have medicated right now are

exhibitionists. We have approximately 30 percent of all of our exhibitionists medicated on the SSRI medication, Paxil, Prozac, Zoloft.

The pedophile/pedophilia group, we have probably under 10 percent of all our offenders on medication of this type. We feel it's essential to the safety of the community if we are going to try to keep these individuals in the community. I believe some of them can be kept in the community with the medication.

I think you've got to take into consideration one thing, that this medication is not going to work all by itself as some type of a pink pill solution. It's got to be coupled with probation/parole involvement. It's got to be coupled with therapeutic involvement as well and all of those pieces working together.

So at that point, I'm going to pass over to Jim; and he can talk more about the medication issues.

DR. ARNDT: I don't know what you folks know about the use of these kind of drugs. There are several types of drugs that are used that we use commonly in the treatment of sex offenders. Probably the ones that you have heard

most about are the antitestosterone drugs or drugs that lower serum testosterone levels.

There's a large body of research, both European and American, with these kind of agents, which show significant decreased relapse rates when these types of agents are used. The research initially stemmed, particularly in Europe, from work done with castration. And in essence, what these drugs do is chemically castrate individuals, if you want to put it in that -- in those words.

Particularly with exhibitionists and pedophiles, they are particularly effective. They work by lowering serum testosterone by a variety of mechanisms, and the two most commonly used at present are Depo-Provera -- and that's a drug which increases hepatic metabolism of testosterone and lowers testosterone levels that way.

And then more recently we have begun to use a longer acting drug called Lupron, leuprolide. And it's a drug that is used for the treatment of certain cancers and endometriosis, but it has also been found beneficial for the treatment of sex offenders. And it works by

depleting hypothalamus LH and FSH, which are drugs which are integral in the manufacture of testosterone.

Both drugs are given by injection, although Depo can be given by P.O. form; but most times we give it by injection. Provera is given once weekly. Lupron is given once a month. A normal male has a serum testosterone level of somewhere between 200 and 800. And we try to make sure that offenders have a level of somewhere around 100, which is the testosterone level normally seen in females.

One of the gentlemen you will talk to today just had a blood test last week, and he has a serum testosterone level now of 47. So you can see that it substantially lowers -- within a couple months substantially lowers serum testosterone.

And with the lowering of serum testosterone comes a lower libido and lower -- less frequent fantasies. And what people on these drugs will report is that they don't fantasize as much; they don't have as many aberrant fantasies; their overall sex drive is reduced dramatically, although some of them can

still copulate and have normal sexual relations. Sometimes not, but sometimes that's maintained.

And, of course, that's very helpful in treating someone who has obsessive aberrant fantasies of one nature or another.

The drugs, despite some side effects, are actually very safe. Most people gain some weight. High blood pressure is a problematic side effect, hot flashes; but in general, they are very well tolerated. And I can't remember anyone we have had to take off in the last couple of years, take off because of side effects.

I think the most -- the thing which prevents us from using a lot more of it is the difficulty in obtaining it for some of our men because of cost factors and those kinds of issues. I think we have a number of men that would do better on it if we could make it more available to them.

MR. GINGRICH: I think what Jim means when he says "more available" is that presently I think you are looking at around $200 a month with respect to the cost of Depo-Provera. And I think the other cost we had recently was

500 to 600 a month for Lupron. And if insurance is not going to cover that, that's quite a tab for a working individual, although our men seem to be committed to trying to make it even with respect to that cost.

CHAIRPERSON BIRMELIN: For the information of the panel, what we are going to do now is ask these gentlemen any questions that you may have. And then we will use the video services to talk with the two sex offenders who are in another room in the building today.

So to do that, I will first turn to Representative James and ask if he has any questions of these men.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman. And thank you, gentlemen.

I heard -- not Mr. Gingrich, the other gentleman, I heard that when you had said you said that -- in your testimony, you indicated that if you want to call it chemical castration, you were saying that that could be a term used.

Do you have another term, and what do you think about the term "hormonal treatment"?

DR. ARNDT: Well, in the literature, I think hormonal treatment is probably more

commonly used; but certainly, in essence, what you are doing is suppressing the body's ability to manufacture testosterone.

REPRESENTATIVE JAMES: So in your professional experience, hormonal treatment or chemical castration is the same to you, no different?

DR. ARNDT: With the same end with regard to sex offenders.

REPRESENTATIVE JAMES: You also said and you indicated about the costs.

Who basically -- in your program now, are most of the people in your program or all of the people in your program on probation or parole?

MR. GINGRICH: About 95 percent.

REPRESENTATIVE JAMES: And the other 5 percent?

MR. GINGRICH: Are self-referred, presentence, off parole and staying with the program.

REPRESENTATIVE JAMES: So now, the costs for these treatments have to be paid for -- for the people on probation or parole, how are they paid for?

MR. GINGRICH: Are we talking about the therapy, or are we talking about the medication?

REPRESENTATIVE JAMES: Well, the medication.

MR. GINGRICH: The medication, the individuals themselves are paying for the medication. We have had in the past some scholarships with Prozac where the pharmaceutical companies have helped for a while, but the men themselves are paying for the medication.

REPRESENTATIVE JAMES: So you do not have any indigent people on probation or parole that are not paying for it, except for the scholarships?

MR. GINGRICH: We have some indigent people who need the medication, and we have no way of getting it to them.

REPRESENTATIVE JAMES: And they stay in the program?

MR. GINGRICH: And they stay in the program, and we do the best we can. I would feel a lot safer if they would be on the medication, but there is no way we can come up with the finances to even help them get on the medication.

REPRESENTATIVE JAMES: And my final question, Mr. Chairman, is that as you indicated that if the people on medication -- in the program on medication that it takes more than the medication for them to be successful.

MR. GINGRICH: Absolutely.

REPRESENTATIVE JAMES: So now that you have people in the program that's not on medication --

MR. GINGRICH: So one part of the component is missing. So what we try to do is have tighter reins by probation/parole, maybe more frequent polygraph to make sure that they are not getting into any behavior that's setting up another victim.

REPRESENTATIVE JAMES: Excuse me. At this time, have there been any problems or failures in that regard with the people not on medication?

MR. GINGRICH: Well, we have had some close calls. We have had some close calls. I would feel much more comfortable if some of these high risk people I'm referring to would be medicated.

REPRESENTATIVE JAMES: Okay. Thank

you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative Reber.

REPRESENTATIVE REBER: Thank you, Mr. Chairman.

Mr. Gingrich, have you -- how long has this medication been available to the public for use in programs like yours?

MR. GINGRICH: I mean we have been using Depo -- I'm going back to the early '90s, '90, '91, we have been using Depo-Provera for pedophilia.

REPRESENTATIVE REBER: And to your knowledge, there hasn't been any side effects or any kind of case histories developed other than the minimal ones that have been expressed?

MR. GINGRICH: That's right.

REPRESENTATIVE REBER: Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative Masland.

REPRESENTATIVE MASLAND: Thank you, Mr. Chairman.

Obviously, it only works for a small percentage of people, as you have said. I guess

my question is, Those people that are on Depo-Provera, this type of hormone treatment, how long do they continue it after they are out of your center? And is this something that you wean them off of, or is it something you consider is a permanent solution, so to speak?

DR. ARNDT: Well, I think there are some individuals whom it should be a permanent part of their treatment. We wean people off of the drug, and some of them relapse and some of them don't in the time that we have to observe them in the time that they are in treatment. But there are certain high risk individuals for whom it probably should become a long-term treatment.

MR. GINGRICH: I agree.

REPRESENTATIVE MASLAND: But ultimately since they are paying for it, once they are out of the program, if they no longer want to pay for it, that's it.

DR. ARNDT: Absolutely.

MR. GINGRICH: So what we are saying is that there are certain individuals where there needs to be a lifetime parole or some type of legal leverage over these individuals. We have been successful with some of our guys where we

have been able to move -- resolve some of the issues of abuse from the past and trauma and they have been able to get into age-mate sex. That doesn't mean they couldn't slip back into a pattern.

When we get into pedophilia, we are talking about a primary sexual preference; and sexual preferences are hard to modify.

REPRESENTATIVE MASLAND: Thank you.

Just a couple of technical questions now. Some of these drugs are administered weekly, some you said monthly.

How often do you have to monitor the blood serum? Do you do that on a weekly basis, because obviously, if you give somebody a pill or a shot --

DR. ARNDT: We do baseline blood work, including testosterone levels. And then after they have been on the drug two to three months, we will get another one to make sure that it's being effective. Once we get that, then we are talking several times a year after that along with other routine laboratories.

So once you are past those first three months, every four or six months.

REPRESENTATIVE MASLAND: Then it's pretty consistent. It doesn't have peaks and valleys?

DR. ARNDT: No. Once it's down, once it's suppressed, it will stay suppressed; but once you stop the drug, within four to six weeks, it's right back up.

REPRESENTATIVE MASLAND: Right. And I guess the reason I was asking that is because -- to tie into what I asked before. Once somebody is out from the treatment center, if they are still taking the medication, they would not have to come back weekly or monthly to have their serum levels checked, because it should be maintaining a fairly consistent level.

DR. ARNDT: Yes. They should have routine medical follow-up, but it doesn't have to be checked frequently.

REPRESENTATIVE MASLAND: Thank you.

And just one comment. I would prefer -- we are talking about terminology, chemical castration, hormonal treatment. I think I would prefer subsidized as opposed to scholarships for Prozac. Somehow Prozac scholarships just doesn't sound right to me.

Thank you.

CHAIRPERSON BIRMELIN: We have been joined by a couple of other members of the committee, Representative Walko, who is here somewhere, and Representative Caltagirone, who is seated directly behind me. And we will get to those for questions later, if they need to ask any.

CHAIRPERSON BIRMELIN: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman.

Mr. Gingrich, your counseling services gets your clients from where?

MR. GINGRICH: From the criminal system, from probation, from parole. We have referrals from attorneys, physicians, self-referrals.

REPRESENTATIVE MANDERINO: So those that you are getting from probation and parole, obviously, there's some -- either -- as a condition of their parole, they are told to get into some sort of appropriate therapy. Is that how it happens?

MR. GINGRICH: Correct.

REPRESENTATIVE MANDERINO: I noticed from the program material, which I didn't really get to read but I did glance at, that you also have a juvenile sex offenders program. Everything that we have talked about with regard to any kind of a drug therapy or chemical castration we have talked about with an adult population.

I am assuming, but don't want to assume, that that's the only place that it's considered appropriate?

DR. ARNDT: Yes. Thus far the only place we are using it is in the adult population, yes.

REPRESENTATIVE MANDERINO: Dr. Arndt, the people that we heard from so far yesterday and today, at least from the medical and technical end, have all been folks who have experience using this and think it is a good thing.

But if I can ask you to be a little bit objective for a moment, is there within the medical community any controversy about the effectiveness of chemical castration?

We heard a little bit about the fact

that sex offenders are motivated by both hormonal impulses -- I don't know if I'm using the right word -- as well as other psychological kinds of factors, meaning physiological and psychological. And for different people, it's different combinations, etc., etc.

Is there a stream within the learned medical community written literature that doesn't think that chemical therapy is appropriate at all?

DR. ARNDT: I'm not aware of a stream that would say it's not appropriate at all. I think, depending on the clinic and the type of people treated, you find people that relegate it to a much more minor role and some that use it much more extensively. And certainly, there's a controversy around whether it should be the mainstay of treatment or adjunctive in nature and whether these patients would -- how well would they do if they got no psychological sort of treatment or support. And I think that's a bona fide issue.

I don't think that -- I think that these patients would not do particularly well if treated solely with these type of agents without

any other sort of treatment. I mean their problems are so complex, psychological and family issues and historical issues that need to be dealt with. So I think that's the main controversy that you find.

I think the literature, as I said, has been quite extensive. And there's no doubt that it lowers recidivism in actively treated individuals. So I think that the controversy exists more about the totality of treatment.

REPRESENTATIVE MANDERINO: I guess my one last area of inquiry is everyone we heard from, yourselves included, has said, This doesn't work for everybody. And I think in your opening remarks, you talked about the small percentage of folks in your whole treatment program who are also using some sort of drug or chemical therapy.

As we move -- I guess my question is, How do you determine -- what are the kind of critical factors that determine whether somebody is appropriate and whether somebody isn't? And what I'm thinking of -- this might not be a good analogy, but it's the only one that I can think of.

I forgot what it's called, the

anti-hyperactivity drug that a lot of kids take.

CHAIRPERSON BIRMELIN: Ritalin.

REPRESENTATIVE MANDERINO: Ritalin, okay, as an example. In the medical community, everyone will tell you that it's certainly appropriate and there are children who that is an appropriate kind of therapy. But we've kind of -- once we started, we saw it as panacea; and there are way too many kids on it that don't belong on it. So there's always the potential for abuse of any kind of new drug therapy, etc.

And I guess putting that kind of thing into this setting, how do you know when you have the right -- how do you know -- how would we as a state -- say we said this was a good idea, what responsibilities would we have to monitor and how would we monitor to find out if we were appropriately using it or abusing it in terms of its application?

MR. GINGRICH: Maybe I could give you an example that would maybe clarify this. Recently we had an individual who served six, seven years of state time in another state. Clinically, he's classified as a pedophile. His sexual preference is eight- to ten-year-old

girls. We had some concerns about how safe he was in the community.

We ordered -- it was part of his treatment condition that he take therapeutic polygraph. We tested him on issues of was he setting up any behavior, was he fantasizing, was he masturbating to fantasies of children. And he did not pass those issues. Okay.

We find out that he has been where he works lifting little children out of shopping carts for pregnant ladies and moms who are having difficulty taking children out of shopping carts. So he is not unsupervised with children. So he is not violating a condition there.

But what he has doing is he is -- he is plugging into his fantasies, the touch of a little child, the smell of a little child. He is getting very erotic thoughts, and he's soon going to reoffend. He is a missile out of control.

This type of individual needs to be on medication and maybe more structure within the community or he is going to reoffend. He is a perfect example of a guy who has to be on medication or we are going to have another offense take place.

REPRESENTATIVE MANDERINO: Unless you do that kind of -- now, let's take this thought to the context of this bill, which was as a condition of parole, the courts can require that somebody take this therapy.

Would that then not necessitate that prior to parole, that sometime when that inmate is being assessed and their paperwork is being put together for the parole board to consider that they will have already gone through this kind of precounseling or pretesting to see where their proclivities are or else you don't know if you are appropriately -- doing the appropriate treatment and follow-up? Is that an accurate --

DR. ARNDT: Yeah, I think so. I think a lot of the gentlemen that we treat, though, are people that only after seeing them for some time in group therapy or getting to know them do we understand the intensity of their -- an aberrancy of their fantasy lifestyle. I mean that's one issue.

I think as a broader issue, I think you could define a subpopulation that might be at very high risk for a relapse, which I guess is essentially what Megan's Board tries to do,

patients with repetitive histories, patients with violence in their histories, patients with strong pedophilic tendencies. I mean we could probably define a subpopulation that would be much more likely to benefit from these type of agents.

REPRESENTATIVE MANDERINO: Thank you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative Saylor.

REPRESENTATIVE SAYLOR: Thank you.

Two questions. The first is you were talking about the drugs, the question I have, I guess, for you, the first question is, What is your drug of choice? What have you found that has worked the best, if you had a choice? Forget cost and everything else. What drug is easiest to administer? What drug has had the best effect on patients you are treating with drug therapy?

DR. ARNDT: Although I haven't had much experience with it, the results I have had with Lupron have been fairly good. Four to six weeks between injection maintains low testosterone levels. The side effect profile seems to be fairly manageable. That would be --

that would probably be my drug of choice, although the literature is much more voluminous with regard to medroxyprogesterone acetate, Depo-Provera, of those testosterone lowering agents.

The ones that we haven't talked about that we do use with some frequency also is in the recent years, there has been an increase in the use of SSRIs, serotonin reuptake inhibitor types of drugs, in treatment of these disorders. These are drugs like Prozac and Paxil and Zoloft and Luvox are the main ones available now.

And that's been spurred by the thought that many of these individuals we treat, their sexual drive has a very compulsive repetitive nature to it and that they frequently have other obsessive symptoms outside of just the sexual issues. And so in recent years, there have been more and more case reports of treating these individuals with these types of drugs. And we have done that, and we have had some success doing that.

REPRESENTATIVE SAYLOR: The second question is, I guess as I was writing this legislation and some of the things that we have

talked about as parts to be included and looked at is, for instance, the issue of privacy, doctor-patient relationship.

If -- and I don't know -- and maybe you can tell me as you are dealing with probation and parole and things like that, I guess my concern would be, as I have talked in other cases, not just sex offenses, but other cases where people are being asked to go to doctors as part of their conditions for parole or judges are sentencing people to medical treatment, whatever it may be, do you see a problem with if a patient falls out of therapy, doesn't show up, or the effect that has been recommended, the drug treatment and psychological counseling isn't working, do you see an ethical problem with reporting that back and having the person report back to probation and parole or to the judge for sentencing or other corrective measures?

MR. GINGRICH: I would like to see that probation and parole are a very necessary part of the treatment approach and they need to be an integral part of that treatment. I think you need to get rid of all -- sign the confidentiality waivers and let it be known from

the get-go that the P.O., the parole agent, is going to be part of this team and that we are working together and we are going to communicate and share.

We are talking about an individual who had a history of very manipulative, conning behavior. And I think that this would be a real party for them having the therapist on the one end and the probation officer on the other end or the parole agent on the other end and they can't communicate.

I think we have an obligation to the community to be able to report that if we have problems, we are in constant contact with probation and parole. And that's the way I think -- if you have a treatment program that's going to be effective, I think that's critical.

DR. ARNDT: I think it doesn't work very well when you are in private practice seeing one or two of these patients in that setting. Then you run into the type of ethical issues that you are talking about: (1) why it doesn't work very well in that setting and (2) why it's necessary right from the start to make it clear to everyone what -- that these things will be

reported and that the parole officer will have open book to --

REPRESENTATIVE SAYLOR: That's what my biggest question has been, what the medical profession feels as far as their ethical ability to report. And you are saying you don't see a problem with ethics and you think it's important that everybody be involved in the whole treatment program.

MR. GINGRICH: Absolutely

REPRESENTATIVE SAYLOR: Thank you very much, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative Caltagirone.

REPRESENTATIVE CALTAGIRONE: Thank you, Mr. Chairman.

Two quick questions, the age range of people that you are treating, from what age to what age?

MR. GINGRICH: Presently we have an age range of 19 to 84.

REPRESENTATIVE CALTAGIRONE: The number of males and females -- you do treat females?

MR. GINGRICH: We do treat females.

REPRESENTATIVE CALTAGIRONE: How many --

MR. GINGRICH: Presently of the 305 people in our program, I think we have under 8 females.

REPRESENTATIVE CALTAGIRONE: Under eight?

MR. GINGRICH: Yeah. That's not to say that that's a clear -- an accurate number that is out there offending; but there are fewer reports. Females don't have as high a testosterone level as males; but we do have about eight out of that number, yeah.

REPRESENTATIVE CALTAGIRONE: The average time frame that you keep them in your care.

MR. GINGRICH: If we have a sex offender where we are dealing with a primary sexual preference, exhibitionism, pedophilia, I will keep that person as long as I have probation or parole leverage.

Statistically, there's research that proves that these individuals, when they are in treatment, there are accountability issues that are present that they are less likely to offend.

I just feel they are too high risk to let go of.

REPRESENTATIVE CALTAGIRONE: Well, how many people do you actually have on probation and parole that you have the hook on that are in your care?

MR. GINGRICH: Well, probation and parole, we are talking about maybe 208 people.

REPRESENTATIVE CALTAGIRONE: 208 out of the 305?

MR. GINGRICH: We are talking four counties.

REPRESENTATIVE CALTAGIRONE: No, no. The reason why I bring this up is -- and this is something that I think is going to have to be given tremendous consideration to because once -- and nobody stays on probation and parole forever. Correct?

Once these people leave your care -- and it's like many other situations that we have dealt with with this committee over the years. People that have psychiatric problems, once they think they are okay, they stop taking their medication. Then they become a threat to society all over again.

We are letting these predators loose

on society, and especially these pedophiles, with no control. If they stop taking their medication --

MR. GINGRICH: This has happened --

REPRESENTATIVE CALTAGIRONE: -- when they get out of the program, they are a threat to society all over again.

MR. GINGRICH: Correct. They will resurface. If people know who they are in a particular area, if we are a choir director or something like that in the western part of Pennsylvania, we can resurface down in Florida and start a whole new recruitment trip with nobody knowing who we are.

We get away from our hospital care. We get off our medication, and we are back in business. We can now go back to doing what we wanted to do all along. We played the game long enough. Now we are back, and we are free. And we are going to roll.

REPRESENTATIVE CALTAGIRONE: What do you suggest?

MR. GINGRICH: That they stay on parole. If we have somebody who has been that repetitive and compulsive in their behavior and

we are not -- and the particular individual that I'm talking about is elderly.

You say, Well, he's safe, he's in his 70s, or whatever. But, no, that's not the case. I think he needs to either be on parole for the rest of his life or be in jail for the rest of his life. But don't let that person loose, because it's very predictable, I feel, what's going to happen.

REPRESENTATIVE CALTAGIRONE: Would castration be the last resort?

MR. GINGRICH: Surgical?

REPRESENTATIVE CALTAGIRONE: Sur-gical, absolutely.

MR. GINGRICH: But then we are getting back to the issue again if we are trying to take a look at a chemical or a surgical procedure that's going to cure or guarantee us that this will not happen again, and I wouldn't be comfortable saying that.

I mean if you would couple it with treatment and probation and parole involvement where we have guidelines and boundaries set up for this individual, otherwise I think he could still reoffend.

DR. ARNDT: Clearly, some people on testosterone lowering agents reoffend and maintain strong fantasies. I guess the bottom line is statistically you would probably lower your odds. Certainly, it's not a guarantee.

REPRESENTATIVE CALTAGIRONE: You think it would lower the odds if it was total castration?

DR. ARNDT: Yeah. I think if you guarantee someone's testosterone level will not get above 50 for the rest of their lives, you would probably lower the odds of recidivism. I wouldn't guarantee it.

REPRESENTATIVE CALTAGIRONE: Thank you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative Masland has one quick follow-up question.

REPRESENTATIVE MASLAND: Thank you. Just a comment on the last one, possibly you need a lobotomy. I think the brain is the major sex organ in the body. So I don't think surgical castration will do it.

Quickly, you mentioned therapeutic polygraphy. And I have received some information

about what's been happening out in Washington and Oregon in particular with respect to programs. And I have a book that I haven't really looked through by a Dr. Stan Abrams.

Do you ever use any therapeutic polygraphs at your facility, or how familiar are you with their use?

MR. GINGRICH: We use therapeutic polygraphs.

REPRESENTATIVE MASLAND: Do you find it effective?

MR. GINGRICH: Yes, we find it effective. And we use it for two purposes.

If we have an individual who is in denial or partial denial, we can use it to move him on so we can get to the issues and start trying to defuse this bomb a little bit.

Or, secondly, if we have a high risk sex offender, a pedophile, who we are not sure if they are being honest, I want to test their honesty. I mean unless this guy is living in a controlled setting, how do we know what he is doing outside? So we use polygraph for that reason.

That's how we found out about our

gentleman who is doing the wonderful favor to pregnant ladies. We would have never found out had we not given polygraphs. So I think it's a very effective tool.

REPRESENTATIVE MASLAND: Thank you very much.

CHAIRPERSON BIRMELIN: We are going to ask the video setup to be taken care of at this point in time.

And, Tom Fine, if you can hear me, if you would take care of the set up on your end, we would appreciate it.

A VOICE: We are ready to go.

CHAIRPERSON BIRMELIN: Welcome to our committee meeting. Would you like to give us a name that we can call you?

BOB: Bob.

CHAIRPERSON BIRMELIN: Excuse me?

BOB: Bob

CHAIRPERSON BIRMELIN: Bob, B-o-b. Okay. Bob, we want to thank you for coming here and for your willingness to participate in this hearing. We are fairly certain that your identity is being protected by the fact that we can't really see your face. We can only see a

shadow outline of you.

And, Bob, what I'm going to do is ask you if you have an opening statement or some comments that you would like to make to the committee members. Do you?

BOB: Well, I do think the drug is effective, and I do think it should be taken.

CHAIRPERSON BIRMELIN: Could you tell us how long you have been taking the drug and which drug you are taking?

BOB: I'm taking Depo-Provera, and I have been taking it for two years. I took it before I was sentenced, and I'm on probation now. And I have been taking it now through probation for one year, but I took it about a year before. It would be a total of two years.

CHAIRPERSON BIRMELIN: And, Bob, what were you sentenced for? What was your crime?

BOB: Molesting a child, a boy.

CHAIRPERSON BIRMELIN: Had you molested other children other than the one you were convicted of?

BOB: Yes.

CHAIRPERSON BIRMELIN: How many?

BOB: Oh, about 15 or 16.

CHAIRPERSON BIRMELIN: Over what period of time? How long?

BOB: Over a period of maybe 15 or 20 years. It might even be more.

CHAIRPERSON BIRMELIN: Do you feel that the use of the chemical that you have been taking -- and you obviously are in favor of it.

Do you feel that that has -- is that primarily the reason why you now have this problem under control?

BOB: Yes.

CHAIRPERSON BIRMELIN: Bob, I'm going to ask the other members of our committee if they have any questions for you. And I'm going to begin with Representative Stan Saylor.

REPRESENTATIVE SAYLOR: Bob, in your treatment so far, have you been happy with the results?

BOB: Yes.

REPRESENTATIVE SAYLOR: And how long have you been in the treatment program?

BOB: How long have I what?

REPRESENTATIVE SAYLOR: How long have you been in the treatment program?

BOB: It was a year in January.

REPRESENTATIVE SAYLOR: In that time, you have felt a difference or been able to notice a difference in your attitude and your approach to life?

BOB: Yes.

REPRESENTATIVE SAYLOR: A positive approach?

BOB: Yes.

REPRESENTATIVE SAYLOR: In -- you are currently under drug treatment?

BOB: Yes.

REPRESENTATIVE SAYLOR: And how often do you seek counseling?

BOB: Every week.

REPRESENTATIVE SAYLOR: Every week.

In the process, have you found any negative -- if you were -- what negatives, if any, would you say are a part of this program currently that you are under?

BOB: The only thing is it makes you put on weight.

REPRESENTATIVE SAYLOR: What drug are you on right now?

BOB: Depo-Provera.

REPRESENTATIVE SAYLOR: Thank you very much.

CHAIRPERSON BIRMELIN: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you. Thank you, Bob, for being here.

REPRESENTATIVE MANDERINO: You mentioned that you are in counseling every week.

Is it your feeling that at some point in the future, you will be able to either finish with counseling, finish with the drug, or finish with both?

BOB: If I understood when I was sentenced by the judge, I have to take the drug for the rest of my life, if I understood him correctly. And I have probation for ten years, and it cannot be cut down.

REPRESENTATIVE MANDERINO: You said when you were sentenced by the judge. Was this a condition of probation, or had you been in jail and then this was a condition of parole?

BOB: I was not in jail. It's just probation.

REPRESENTATIVE MANDERINO: Prior to the judge making this a condition, what did he

make a condition of probation, that you just get into therapy?

BOB: That I go to Bob Gingrich for ten years and he cannot release me early. He has to let me there for ten years.

REPRESENTATIVE MANDERINO: How do you pay for the cost of the drug that you are on?

BOB: Out of my pocket. Part of it is paid by the medication -- by the insurance I have; but I had to fight for that. And I co-pay 15; but before that, I paid it all out of my pocket.

REPRESENTATIVE MANDERINO: Can you be just a little bit more specific? You have health insurance that --

BOB: I have health insurance that pays it now, but I had to fight for them to pay it.

REPRESENTATIVE MANDERINO: Okay. So originally, even though you had prescription coverage, they denied paying for it?

BOB: Yes. The insurance I had before this, they denied paying for it. And when I first took the drug, it was almost $50 a week plus $5 for the shot.

REPRESENTATIVE MANDERINO: And now you have the co-payment?

BOB: Yes, ma'am.

REPRESENTATIVE MANDERINO: You mentioned a side effect of weight gain.

BOB: Yes.

REPRESENTATIVE MANDERINO: Any other side effects that you have noticed?

BOB: No.

REPRESENTATIVE MANDERINO: When you were first suggested or approached by -- I assume when the judge gave you probation, he didn't necessarily make chemical therapy part of that probation. He just made going to this particular counseling service the probation. Correct?

BOB: No. He said -- that was part of the probation.

REPRESENTATIVE MANDERINO: Was chemical therapy?

BOB: Yes.

REPRESENTATIVE MANDERINO: Prior to his making that order, had anybody tested you or screened you or had you gone through any preliminary screening by medical or counseling

professionals to determine that drug therapy was the right choice for you.

BOB: I talked to Dr. Arndt before I was sentenced. I took it about six months before I was sentenced.

REPRESENTATIVE MANDERINO: So before you were sentenced, you had already started the therapy on your own?

BOB: Yes, ma'am.

REPRESENTATIVE MANDERINO: Of your voluntarily choice?

BOB: Yes.

REPRESENTATIVE MANDERINO: So what he was really saying is, I'm making you continue what you already started to do for the next ten years?

BOB: Yes. If I understood it right, it's for the rest of my life.

REPRESENTATIVE MANDERINO: Okay. Thank you, Bob. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative James.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman. And, Bob, thank you for testifying.

I guess you are testifying because you realize that there's a problem and that maybe by testifying, you can help others with your problem.

Bob, would you say -- are you over 50 or under 50?

BOB: I'm over 50.

REPRESENTATIVE JAMES: And you said that you have been helped because you have been taking the drug?

BOB: Yes.

REPRESENTATIVE JAMES: So when you haven't taken the drug, then you may have problems in terms of offending?

BOB: Yes.

REPRESENTATIVE JAMES: So that you said that you -- you agree that you would have to take the drug for the rest of your life in order for you to not offend?

BOB: Yes, according to what she said.

REPRESENTATIVE JAMES: Would you -- let me put it this way. Since you said that and you want to help other people, if, in fact, there was for someone that created sex offenses such as

you and if there was a law that said that that person had to be on parole for life, would you agree that would be an appropriate sentence in order to keep people with your condition from reoffending?

BOB: Yes.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman. And thank you, Bob.

CHAIRPERSON BIRMELIN: Representative Masland.

REPRESENTATIVE MASLAND: Thank you, Mr. Chairman.

Bob, I'm not really sure. Did you say you are an inpatient with Mr. Gingrich, or are you on an outpatient basis?

BOB: I go there once a week.

REPRESENTATIVE MASLAND: Okay. So you obviously are living in the community then.

BOB: Yes, I live in the community.

REPRESENTATIVE MASLAND: Now, have you found the drug that you are taking to be effective in reducing any of the mental fantasies that you used to have?

BOB: Yes. I do find out that it reduces your sex urges.

REPRESENTATIVE MASLAND: Can you give a few more details about that? Exactly how different do you feel on this drug, and what do you think it really is helping you control?

BOB: Well, it controls my thoughts. It controls your erections. It controls your mind, so to speak, that you don't think or even want to think of reoffending.

REPRESENTATIVE MASLAND: Just one other question. Have you ever taken a polygraph as part of your treatment?

BOB: No, sir, I have not.

REPRESENTATIVE MASLAND: That's all I have. Thank you.

CHAIRPERSON BIRMELIN: Representative Caltagirone.

REPRESENTATIVE CALTAGIRONE: Thank you, Mr. Chairman

Bob, let me ask you, if you were to stop taking this drug or you couldn't afford the expense of taking the drug, do you think there's a good chance that you would reoffend?

BOB: Yes.

REPRESENTATIVE CALTAGIRONE: Are there other people that you know that have had a

similar problem that you are dealing with in your lifetime that aren't being treated?

BOB: Yes.

REPRESENTATIVE CALTAGIRONE: You do know others?

BOB: Yes. Some of them in the group, they are not being treated. I guess I'm the only one, as far as I know.

REPRESENTATIVE CALTAGIRONE: If there was a program available -- and that's a big if. Of course, it's going to cost money, and people are going to have to put votes up to support such a program to provide the type of medication that would be needed, and that's biting the bullet then in situations like this.

But that aside, if that doesn't happen and people have to pay for it or fight with their insurance companies to get the needed help financially to provide the medication, if that doesn't happen, what do you think society's role should be and this legislature's should be as far as trying to curb this problem?

How far do you think this legislature or legislation and statutes should really go, Bob?

BOB: Well, I do think they should pay or help pay some of the bill. But for those who can't afford it that are like maybe out of work or something, I do think it should be paid altogether by the State.

REPRESENTATIVE CALTAGIRONE: Those that refuse to get treatment or continue in a program and reoffend, what do you think should be done with them and what would you suggest be done with them?

BOB: Well, I would think they should have the choice of taking the drug or going to prison, which would be more expensive for the State than to pay for the drug.

REPRESENTATIVE CALTAGIRONE: Do you think a choice of castration is a choice that could freely be made by a person faced with this problem?

BOB: I don't think castration would control the mind, because I had read once in a doctor's book where even if you are castrated, you can still get an erection.

REPRESENTATIVE CALTAGIRONE: I'm talking about total castration.

BOB: Well, I mean that. I read

that in the doctor's book, that with total castration, you can still perform and some can get an erection.

REPRESENTATIVE CALTAGIRONE: But I'm talking about taking it all off.

BOB: Well, maybe that way, but I don't think that would control the mind.

REPRESENTATIVE CALTAGIRONE: Well, the problem that I have is this. With people that are dealing with the problem -- and evidently, it's a lot more pervasive than I think most people realize in our society. And the government may be not willing or not wanting to put the money up to provide the medications that absolutely are necessary.

And then, of course, it's once you are off probation and/or parole, there's no telling whether or not you are going to be forced to take it or if you want to take it. There's some point in time where the leash ends is the point that I'm making.

BOB: Well, like with my case -- and Bob would have that on his record -- if I understood the judge right, I must take it for the rest of my life, according to the judge.

REPRESENTATIVE CALTAGIRONE: Do you know of people that have been mandated to take medication that stopped or that are not taking it --

BOB: No.

REPRESENTATIVE CALTAGIRONE: -- that are not in the program?

BOB: No.

REPRESENTATIVE CALTAGIRONE: Thank you, Mr. Chairman. Thank you, Bob.

CHAIRPERSON BIRMELIN: Bob, this is Representative Birmelin again. I have one last question.

If someone had told you before you started to abuse children that there was help for you in the form of a pill or an injection that you could take, at that point in time, would you have been willing to take that treatment?

BOB: Yes, I do believe I would, because I took it this time voluntarily before I was told I had to.

CHAIRPERSON BIRMELIN: And in your experience -- and I don't know how much you have contact with other people who have your sexual abusing situation -- do you feel most sexual

abusers would have preferred to have the treatment before they got into that practice, or was it only because they were forced into realizing that that was their only out?

BOB: That would depend on the individual. I think it would help if they would take it before they were told to take it, yes.

CHAIRPERSON BIRMELIN: How long did you realize that you had a desire to have sex with little children before you acted on that desire?

BOB: Well, first, when I started, you didn't think there was anything wrong because you never got caught. But now that I got caught, I do feel I should have had help long ago.

CHAIRPERSON BIRMELIN: I think you have just answered my first question, that you probably wouldn't have sought any help at first because you didn't think it was wrong.

BOB: Right.

CHAIRPERSON BIRMELIN: And after getting caught at it perhaps or having practiced that for a while, then you began to realize that what you were doing was wrong?

BOB: Yes.

CHAIRPERSON BIRMELIN: What made you reach the conclusion that what you were doing was wrong?

BOB: Well, I guess getting caught, because until you get caught, you don't think you are ever going to get caught and you don't think you are doing wrong.

CHAIRPERSON BIRMELIN: Well, you have given us some very interesting answers. We appreciate that. And, Bob, we want to thank you for your testimony.

We understand there is another gentleman there who is going to take your seat and has to be rewired with the microphone. So if you would change places with him now, I would appreciate that. Thank you.

We have one member of the committee who has joined us that I did not introduce. And that's Representative Petrarca who is sitting behind me and to my far right and is doing his best to cover up his real best identity with a beard, but we still know who he is.

Please don't leave your seats. It will only take about 30 seconds to transfer the microphone from one to another --

A VOICE: Representative Birmelin, we are ready to go with the second witness. I just wanted to let you know that they can see you as well thanks to PCN's camera.

CHAIRPERSON BIRMELIN: Another good reason for Representative Petrarca's beard, I guess.

Our second witness is seated. And could you tell us, sir, what name you would like us to call you?

ROBERT: Robert.

CHAIRPERSON BIRMELIN: Okay. Robert, we want to thank you for coming here and testifying before this subcommittee on this subject. We know it's not easy for you to do that. And I will assure you, as we did Bob, that there is no way that we know who you are, because you are simply a black shadow on the TV screen. And none of us can recognize you and neither will the public. But we do want to thank you for being here.

Could you tell us, sir, how old you are?

ROBERT: I am 37.

CHAIRPERSON BIRMELIN: Could you

tell us when you first began to experience what has been defined as aberrant behavior and pedophilia?

ROBERT: At age 35.

CHAIRPERSON BIRMELIN: So you have only been involved in this for two years?

ROBERT: Yes, sir.

CHAIRPERSON BIRMELIN: And who were your victims?

ROBERT: A 36-year-old woman and a 14-year-old child.

CHAIRPERSON BIRMELIN: Was the child male or female?

ROBERT: Female.

CHAIRPERSON BIRMELIN: I take it that you are either on probation or parole?

ROBERT: Yes, sir. My sentence was seven years intermediate punishment with the first six months house electronic monitoring and six years probationary tail. And I requested before sentencing to have this medication. It was not court ordered for me. I asked for it on my own.

CHAIRPERSON BIRMELIN: How did you find out about it?

ROBERT: I had heard about it, and I read pamphlets on it. I knew I had a problem. And I could have went to prison, but I would have got out with the same problem that I went in with plus with more anger and probably would have hurt somebody more worse than I did.

CHAIRPERSON BIRMELIN: What chemical treatment are you taking?

ROBERT: I'm taking Lupron.

CHAIRPERSON BIRMELIN: How often do you take it?

ROBERT: I take it once a month.

CHAIRPERSON BIRMELIN: Is that an injection?

ROBERT: Yes, sir.

CHAIRPERSON BIRMELIN: Robert, I'm going to turn the questioning now over to other members of the committee. And they will introduce them -- or I will introduce them so you will know who is asking you the questions.

I will begin with Representative James.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman.

Thank you, Robert, for agreeing to

testify. I hope you also testify, of course, you think that your testimony would help others that have a similar problem and will help us in order to develop policies that would help those people.

ROBERT: Right.

REPRESENTATIVE JAMES: Robert, before two years ago, did you realize you had a problem or were you involved in sexual -- these type of offenses?

ROBERT: No. If we take it back a little ways, I had been sexually abused as a child; but I don't really consider that a part of what I have done. But it had a little bit to do with it.

And when I went to the Dauphin County Prison the first time, I was in there for domestic relations. And then I had this indecent assault charge on me. Then when they brought the second one on me with the child, I then asked the judge, is there some way that I could get some help for it, because I realized then that I had a problem and it was going to get worse.

REPRESENTATIVE JAMES: So there were -- actually, in your view being abused as a child may have contributed some factors towards

your behavior and that you only had maybe two or three incidents just starting a couple years ago or some when you were much younger -- oh, the younger one was the domestic abuse?

ROBERT: Yes, sir. It happened to me.

REPRESENTATIVE JAMES: I see. And then you did the same thing?

ROBERT: Yes, sort of like acting out what happened to me with the anger that I was carrying all those years. I'm still not fully over it, but I'm dealing with it going to therapeutic.

REPRESENTATIVE JAMES: Now, do you think that if you stop taking the medicine that you would offend?

ROBERT: No, I don't believe so. I believe the medication works for those who want to be helped. You have to want to be helped in order for you to maintain.

REPRESENTATIVE JAMES: So you believe that if someone is taking the medicine and don't want the help, they probably would offend?

ROBERT: Yeah, I believe so.

REPRESENTATIVE JAMES: Do you think that those people that commit crimes such as this should be on parole for life in terms of helping them if they want to be helped?

ROBERT: Yes.

REPRESENTATIVE JAMES: Thank you. Thank you, Robert. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative Petrarca.

REPRESENTATIVE PETRARCA: Thank you, Mr. Chairman. Also, Robert, thank you for testifying.

A few quick questions. This drug, I believe you said it is called Lupron?

ROBERT: Yes, sir.

REPRESENTATIVE PETRARCA: Is that the only drug that you have been on?

ROBERT: Yes, sir.

REPRESENTATIVE PETRARCA: Do you have -- I don't know if you heard Bob's testimony before you; but have you had any side effects similar to his or different than what Bob experienced?

ROBERT: Just weight gain, getting fat, and little heat flashes here and there. But

other than that, the drug is -- it really works. And I would like to see it administered to a lot of sex offenders. Even ones that serve six or seven or eight years in prison, I still believe that they should get out and take this.

REPRESENTATIVE PETRARCA: Can you state how this drug seems to affect you mentally?

ROBERT: Well, I'm married. I could be walking with my wife somewhere before I was on this medication and take a look at a female or a young girl and fantasize within three or four seconds. Now I don't have those fantasies or desires. They are just gone.

And by me going to my meetings on Tuesdays with Dr. Gingrich, it really helps a lot, too.

REPRESENTATIVE PETRARCA: Thank you. That's all that I have. I appreciate it.

CHAIRPERSON BIRMELIN: Representative Masland.

REPRESENTATIVE MASLAND: Just one question to kind of follow up on Representative Petrarca's question or a comment you made.

You feel that people who are in prison and have been in prison for a lengthy time

ought to still be given the opportunity to take the drug when they get out.

Do you see any benefit for them to take the drug while they are still in prison?

ROBERT: Yes. If they can take it while they are in prison, it would help them when they come out into the world, into society. They would already be set to deal with it as long as they contribute in going to their classes, those meetings that they have, the sexual offenders meetings, because that's a major part in the medication. It helps.

REPRESENTATIVE MASLAND: During the term of intermediate punishment and electronic monitoring, were you attending counseling sessions then and had you already begun taking Lupron?

ROBERT: Yes, sir. And my electronic monitoring was in my first six months. I travel down to Lancaster once a month to receive my injection. And I'm currently paying $600 for it a month, and that's coming out of my pocket.

REPRESENTATIVE MASLAND: Thank you.

CHAIRPERSON BIRMELIN: Repre-

sentative Manderino.

REPRESENTATIVE MANDERINO: Thank you. Thank you, Robert.

I'm a little confused, because -- I think it's just because of the testimony that -- not about what you said, but the testimony that came before you. Most of the sex offender cases that we have talked about involved offenders who were pedophiles whose major target or fantasy were young children.

But you talked about two offenses with a 36-year-old woman and a 14-year-old woman. So I'm assuming that you are an offender of a different type. I don't know what to call that, but can you explain to me what exactly your offense was? I mean not the details per se, but just so that I can understand.

ROBERT: Repeat that again, ma'am.

REPRESENTATIVE MANDERINO: I'm sorry. I'm just trying to -- most of the testimony that we had heard to date with regard to folks who are on drug therapy was in relationship to offenders whose primary target of offense were young prepuberty girls.

ROBERT: Right.

REPRESENTATIVE MANDERINO: That's not your case.

ROBERT: Well, I would say the fantasies I had, it didn't really matter if they were older or younger. I had sexual fantasies. I had an inner deep problem.

REPRESENTATIVE MANDERINO: And when you say that it started just a couple years ago at age 35, is that when the desires started or is that when you first acted on the desires?

ROBERT: That's when I first acted on the desires.

REPRESENTATIVE MANDERINO: And when you got caught, that was the first time? I mean the first incident that happened was the first time that you were caught up in the criminal justice system?

ROBERT: Yes, ma'am.

Well, the 36-year-old woman, she reported me. And when I went and got probationary for -- I got probationary status for that, I then volunteered to let them know that I had done this to a 14-year-old child. That's when I wanted the help.

REPRESENTATIVE MANDERINO: You also

mentioned that you are married.

ROBERT: Yes.

REPRESENTATIVE MANDERINO: In testimony we heard yesterday about the effects of the different kind of drugs, I left with the impression that the Lupron, the one that you are on, diminished testosterone to such an extent that a person couldn't have normal conjugal relationships with their spouse.

I'm sorry to ask a personal question, but I'm really trying to understand the effects of the drugs. So is that true in your case? Or does it just deal with the fantasy and the other thing, but you can still have normal relations with your wife?

ROBERT: Well, your relations is not as strong as they would have been. My wife has been very supportive in that she, let's say, relaxes me any way that she possibly can. But the desire to go out beyond her is totally diminished.

REPRESENTATIVE MANDERINO: $600 a month is a hefty price tag.

ROBERT: Yes, ma'am.

REPRESENTATIVE MANDERINO: How are

you affording it, if you don't mind my asking; and how long do you think that you will have to continue paying that much for drug therapy?

ROBERT: Well, how I pay for it is I work and I also do odds-and-ends jobs. It makes me be more responsible about my money. I have to put it to the side. And for the seven years that I'm on -- the six years that I have left on my probationary period, I will have to get the medication.

REPRESENTATIVE MANDERINO: You don't have -- do you have health insurance?

ROBERT: Not at the present time.

REPRESENTATIVE MANDERINO: Did you ever have health insurance that you tried to get any of this paid for or no?

ROBERT: No, ma'am.

REPRESENTATIVE MANDERINO: And when you finish -- your reference to six years, that's the term that you are on probation?

ROBERT: Yes, ma'am.

REPRESENTATIVE MANDERINO: And for that whole length of time, you are to be with the Ponessa counseling services?

ROBERT: Yes.

REPRESENTATIVE MANDERINO: What is your expectation at the end of those six years both with regard to therapy -- counseling sessions and drug therapy?

ROBERT: Well, after my six years, I plan on staying with Dr. Gingrich to help me. If some of the sex offenders would have a sponsor like drug and alcohol do, we wouldn't have so many problems, you know, somebody we could talk to. You know, after you complete a status of medication or a probationary period, you need a sponsor.

Myself, I talk to my pastor, and I talk to Dr. Arndt when I go there. And I feel pretty good about that.

REPRESENTATIVE MANDERINO: I'm not clear whether or not at the end of the six years, you are thinking that you can get off of the drug and just through regular counseling be okay.

ROBERT: Well, I will leave that to Dr. Arndt and Dr. Gingrich when my six-year period ends. If my testosterone level is where it's supposed to be and they feel as though I'm qualified to be in society without the

medication, I will go with their word.

But myself, I continue to keep learning how to deal with what I have done and make sure that nobody else does this.

REPRESENTATIVE MANDERINO: You said that you volunteered to do this, that you had heard about it, meaning the drug therapy.

ROBERT: Yes, ma'am.

REPRESENTATIVE MANDERINO: Know-ing -- well, you couldn't know how it would work beforehand. If you hadn't volunteered, if someone had said your choice is probation and chemical castration and therapy or prison, what do you think your choice would have been?

ROBERT: Well, I think I would have went with probation and the chemical castration, because going to prison wouldn't have did nothing for me. I wouldn't have received the help.

I can get counseling inside prison, but it's not going to help me. When my prison term is up and I come right back out in society, I'm going to do the same thing again worse than I did the first time.

REPRESENTATIVE MANDERINO: Thank

you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Robert, we want to thank you and Bob for both coming to testify today. We thank you that you took the time to do that and answer some tough questions, I think, about yourself.

I guess from what I gather from what both of you have said, you appear to be both on the right track. But as we also know from those who also have sex offenses in their past, it's something you are going to have to deal with the rest of your life.

ROBERT: Yes, sir.

CHAIRPERSON BIRMELIN: I'm reminded of the analogy to the alcoholic who can never touch a drink again. You and Bob are going to have to be on guard against that behavior reoccurring for the rest of your life. But hopefully, you continue in the path that you have taken. And we wish you well.

ROBERT: Thank you, sir.

CHAIRPERSON BIRMELIN: Thank you very much for being here. Tom Fine, you can disconnect on your end if you would like.

And I want to thank Dr. Gingrich and

Dr. Arndt for their testimony and for bringing the two gentlemen who were here with you today. I think that was very instructive, and we appreciate all that you are folks are doing. Thank you for coming.

Our next testifier is Timothy Foley. Dr. Timothy Foley is director of clinic and forensic services at the Joseph J. Peters Institute, which is located in Philadelphia.

Mr. Peters -- or Mr. Foley, excuse me, if you would come forward.

I think we have cleared out the equipment that we need to clear out. Dr. Foley, welcome to the House Subcommittee on Crime and Corrections on this issue of be it chemical castration or hormonal treatment for sex offenders, whichever you prefer. And we encourage you to give your testimony at this time.

MR. FOLEY: I'm clinical director of Joseph J. Peters Institute in Philadelphia, one of the largest and oldest treatment facilities for sex offenders. We have been treating sex offenders since 1955.

We have an outpatient program of

juvenile sex offenders and adult sex offenders primarily referred to us by parole and probation, although there is a small number of voluntary referrals. We also run the prison program at Graterford and have 100 or so patients in our program there who are convicted sex offenders.

The current conventional wisdom about sex offenders is that nothing works and the thing that you are talking about today, are medications part of a treatment program. And just as the people who talked before me -- and I would pretty much concur with almost everything that they said -- it is a valuable assist particularly for some pedophiles.

No medication works for everyone all of the time. There's no medication, particularly alone, that is going to be always effective. Sexual behavior is a very complicated behavior, as is all human behavior. The drug mechanisms are not terribly well understood.

I would submit to you that the drug actions of the antihistamine that I'm taking right now for my cold are not well understood, nor the aspirin to reduce the throbbing headache I have had for the last couple days. But it

works, and I continue to take it. But I don't know why it works, and no one else really does either totally.

There's a recent article by my predecessor at JJPI, Robert Prentky, writing about antiandrogens and other kinds of medications to reduce sexual drive. They have been used over the last 40 years to reduce sexually aggressive behavior. Female sex hormones were used in the '40s. There were many side effects. There was a feminization effect, nausea, vomiting. And they were stopped.

The preferred mode in the '60s was neuroleptics, some of the same medications that are used for major thought disorders or schizophrenia. And primarily, it was a sledgehammer on a four-penny nail. It really would suppress many, many activities that weren't intended, also some very serious side effects, the least of which an irreversible tardive dyskinesia, which is a horrible sort of thing to endure.

Antiandrogens have been used -- began to be used as an alternative to neuroleptics primarily in the late 1960s at Johns

Hopkins. The most commonly used antiandrogen is Provera. The FDA allows Provera as an experimental drug for sex offenders. It's legal in 70 other countries, and the World Health Organization says it's okay.

In the United States, it's a little bit iffy. The FDA does not give its complete approval, because they say that there is evidence that it's a carcinogenic. I don't think that's strongly held.

Offenders that I have seen on Provera had many of the same sort of reactions as the two gentlemen that you just saw on the TV who are taking Provera and Lupron. Some will complain of hot flashes. Some will complain of other sorts of side effects, hypotension, some kidney failure, kidney disorders, reduced testicle size.

It's not a free drug. People for the most part, I think, enjoy the freedom when the reduced deviant thoughts are there. Also many times you will see a calming effect. It's almost as if when the offender does not have to contend with all the deviant thoughts and what to do with them, there is a calming effect.

Sometimes it's really quite startling, because you will see someone in therapy and they will be horribly confused and after Provera, they become very, very, very clear. You would almost think that they were taking some kind of another drug for a thought disorder.

Provera has a potent effect on sexual behavior. It does, as the gentlemen before me described, suppress the testosterone level. And primarily, the major thing that is reported is a decrease in the erotic imagery.

One of the things that we know in an article just published by Hanson, which is a medianalysis in looking at 26,000 sex offenders, is that deviant arousal to thoughts is the primary indicator and the primary sign of recidivism. With any of the kind of drugs, the first thing we want to do is reduce the entertaining of the thoughts.

The thoughts, if you will, is a rehearsal for the behavior. Where there is no rehearsal, the behavior is going to be very much -- the probability of the behavior is going to be decreased substantially.

The inhibitory effect of Provera has been attributed to the reduction of testosterone, but decreased sexual arousal is even noted when the testosterone is not decreased below, let's say, 100. At low to moderate doses, it also has been observed to have the calming effect, which I mentioned previously, as well as a reduction of the pedophilic urges, which the two men that you saw on T.V. discussed.

Provera, as you heard before, can be given by mouth or injection. In a noncompliant patient, injection certainly is preferable. Lupron is longer acting, which is less expensive in terms of visiting a clinic for the injection.

Primarily, what I think Provera does is it reduces aggression. In many sex offenders, aggression and oftentimes anger are the things that really need to be controlled. For many sex offenders, the goal is power and control over their victim rather than really it being a sexual sort of an act. As I'm sure you are probably aware, rape tends to be a behavior of anger rather than a sexual behavior.

SSRIs have become commonplace since the 1980s. We have all heard about Prozac. I'm

sure all of us know somebody who has taken Prozac or some sort of an antidepressant. One of the major advantages of this class of drugs over phenothiazines and the antiandrogens is relatively few side effects.

One of the major reasons that people in the general population who are taking it for depression stop taking it is because it reduces sexual drive, also retarded ejaculation in men. It also is given as a medication for men who have premature ejaculation. So then we came to use it with sex offenders.

And besides the side effect profile, which I'm discussing right now, it also seems to reduce the obsessional thoughts and oftentimes will have a differential in terms of its effectiveness. In other words, it will reduce pedophilic or repetitive pedophilic sorts of thoughts and, therefore, the behaviors as well as increasing conventional or appropriate sexual outlet.

The compulsive part -- the obsessive-compulsive part of the disorder, I think, is probably an essential part of many of repetitive sex offenders that we see.

Exhibitionists, I think, also probably really value -- really benefit from this medication.

The legal and ethical issues are, I think, very important to consider. It has been argued that someone incarcerated or on community supervision cannot give informed consent. Dr. Fred Berlin at Johns Hopkins, however, says that informed consent can be given. I think almost on a case-by-case basis, informed consent needs to be considered, particularly with the antiandrogens, not to say that SSRIs are free drugs. But the antiandrogens have, I think, a higher probability of untoward effects.

I would also argue that not treating someone who is almost bedeviled by these thoughts and repetitive behaviors and impulses is cruel and unusual punishment.

Use of medications is really indicated for an awful lot of people, never alone, always in combination with psychotherapy.

One of the things that you also find with many drugs, let's say the Prozac kind of drugs for depression, is they really aren't indicated when psychotherapy doesn't go along with it, even for someone who is having a minor

major depression, if you will.

Antiandrogens are a powerful hormonal treatment that reduce sexual drive. The SSRIs appear to decrease some of the thoughts but also some of the libidinal urges that are frequently seen with pedophiles and also rapists.

The current criminal justice practice of long prison sentences with little chance of parole may not really be of assistance in decreasing recidivism among this group of people.

Pedophiles or even rapists who are incarcerated oftentimes will refuse treatment. There is no real motivation for treatment. They are not going to get parole. They are going to serve 85 percent of their sentence. And they will self-stimulate to deviant thoughts for maybe 10, maybe 15 years, and then they are released. No one stays in jail forever, although that may be appropriate for some people.

When they get out, they, for the most part, are probably going to act out a lot of their fantasies. And that's a lot of the recidivism that you see.

I think that beginning and offering

treatment while a person is in prison, not only the psychological counseling but also the medications that we have discussed today, is really very appropriate. Along with that is monitoring and measuring the deviant fantasies that someone is entertaining. I think it's also a much more economical approach and in many ways a more humane approach in treating these individuals.

So my recommendations would be, as far as this goes, medications would be made available to incarcerated sex offenders, as well as parolees, as part of a program dedicated to the treatment of their deviant behavioral patterns

Medication should not be administered without psychological treatment. And the use of medication should be voluntary. The process of informed consent should be carefully considered on a case-by-case basis.

I think compliance with the drug, motivation for the drug oftentimes is a large part of making the drug work. With any kind of medication, there's a large psychological component that facilitates the action of the

drug.

CHAIRPERSON BIRMELIN: Thank you, Dr. Foley.

And I'm going to ask the members of panel if they have any questions for you, and I will begin with Representative James.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman. And thank you, Doctor, for testifying.

In your professional experience, Doctor, do you see or is it chemical castration or hormonal treatment is the same or one is a better term than the other?

DR. FOLEY: Well, you know, what you are saying is that if you surgically castrate someone --

REPRESENTATIVE JAMES: No, I'm not talking about surgical castration. I'm talking about chemical --

DR. FOLEY: When you castrate someone, you remove their testes and they don't produce testosterone.

If someone takes the right amount of Lupron or Depo-Provera, they don't produce very much testosterone either. And that's how they

came -- just as sort of a backdrop, in German studies conducted beginning in the '50s where there was surgical castration, there was -- there was somewhat of a recidivism rate. Not all sex offenders are going to use their primary sex organs to reoffend, digital penetration and other things.

REPRESENTATIVE JAMES: I understand that. I'm not talking about surgical castration. I'm just saying chemical castration and hormonal treatment --

DR. FOLEY: It's the same thing.

REPRESENTATIVE JAMES: That was the answer I was -- I mean that wasn't the answer I was looking for; but that was the question that I had posed.

Do you agree or do you think that the medication is definitely helpful to those people who want to take it and that should they be on parole for life? Would you think that would be appropriate for sex offenders?

DR. FOLEY: For some, yeah.

REPRESENTATIVE JAMES: Particularly those that are violent pedophiles?

DR. FOLEY: Someone who is a true

pedophile. Not all child molesters are pedophiles, and not all pedophiles molest children.

REPRESENTATIVE JAMES: Okay. That's learning.

And you mentioned something about exhibitionists.

Do they progress in terms of that maybe they would grow from that, getting away from exhibitionism and then maybe start to commit assaults?

DR. FOLEY: That happens. I think most exhibitionists are pretty dedicated. That's a preferred form.

You can't really say that any sort of sexual offender is going to remain in his category. They will oftentimes visit other categories and progress. In other words, oftentimes a voyeur, someone looking through -- a peeping Tom and whatnot, will progress to other sorts of behaviors as well. Some people will be very, very faithful to their preference as we find them.

REPRESENTATIVE JAMES: All right. Thank you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative Masland.

REPRESENTATIVE MASLAND: Thank you, Mr. Chairman.

Dr. Foley, you were present when the two sexual offenders were testifying via the hookup we had. And you heard them state -- I think the first one said that he's had a problem for 15 to 20 years and he's over 50 and possibly there were 15 or so victims. The second one said, although not a pedophile, said that there were basically two victims of his sexual desires.

In your experience, is it likely that they were understating the number of victims and the length of their problem?

DR. FOLEY: I'm not sure about the first gentleman. The second gentleman, that was my feeling, that he may have been understating. And he might have very good reasons to understate; or he might have very good -- he might have a lot of beliefs that support his understatement at this point.

REPRESENTATIVE MASLAND: For the first gentleman, somebody who is over 50,

potentially over 60, who knows, is it likely that a problem like that would arise just in the 30s and not be present beforehand?

DR. FOLEY: It might only become manifested in the 30s.

One of the things that we find is that with a lot of pedophiles in particular or a lot of child molesters is that they present as dependent personalities, almost inadequate, withdrawn people who have a great deal of difficulty with any sort of social contact at all or with normal adult contact or socialization.

So, yeah. I recently examined a man, and his first acting out was in his mid 50s. And I have strong confidence that that was accurate.

REPRESENTATIVE MASLAND: Is it safe to say -- I mean by analogy, we have statistics that will say violent offenders are most likely to be violent between the ages of, say, 18 and 35. I may be off a little bit on those; but you can basically say that once somebody hits his 40s and 50s, he's a lot less likely to be violent.

Is there any way to say that with

respect to sexual offenders and pedophiles?

DR. FOLEY: Yes. That's one of the conclusions of Hanson's research that was just published, that age is a negative predictor of sex offending. In other words, somebody eventually will age-out of it, although as the gentleman before me discussed -- I mean I have one patient who is 80 years old. And I certainly have seen many patients in nursing homes who are continuing to sexually offend. So it's --

REPRESENTATIVE MASLAND: A case-by-case basis?

DR. FOLEY: Yeah. I mean it happens; but statistically, it's going to happen less. The occurrence is going to decrease.

REPRESENTATIVE MASLAND: Some people only age-out when they die, I guess.

DR. FOLEY: That tends to be true for a lot of different behaviors.

REPRESENTATIVE MASLAND: Just one quick question, because I know we have other people who want to ask things; but you might have heard the brief conversation I had with Mr. Gingrich about the use of polygraphs, therapeutic

polygraphy.

Are you familiar with that? Do you have any thoughts on that?

DR. FOLEY: I'm not a strong proponent of polygraphs, and that tends to be a preference. I think polygraphs can be beaten. I think people within the system -- a lot of it is very dependent on the skill of polygrapher. I have more confidence in measuring arousal. There are various methods to measure arousal.

REPRESENTATIVE MASLAND: The penile -- I forget the name of the --

DR. FOLEY: Also the Abel screen, which is visual reaction time, which is my primary -- is the primary thing that we use at JJPI. That's -- I have more confidence in that. It tells me more really.

REPRESENTATIVE MASLAND: But there are people, I guess, on both sides of the issue.

DR. FOLEY: Absolutely. And I don't think there's one right or wrong way of doing it.

REPRESENTATIVE MASLAND: Thank you very much, sir.

CHAIRPERSON BIRMELIN: Dr. Foley, in

your experience, have you ever treated anybody who hadn't been already caught in the act of being a sex molester? And under what circumstances do you see those types of people?

DR. FOLEY: They are almost always coerced sometimes by --

CHAIRPERSON BIRMELIN: Coerced by whom?

DR. FOLEY: A spouse, sometimes by even a neighbor. If you don't go get help, we are going to turn you in. If you don't go get help, I'm going to leave you.

CHAIRPERSON BIRMELIN: Well, they have been offending, though. They have been offending, just weren't adjudicated. They weren't caught up in the criminal system --

DR. FOLEY: They hadn't been adjudicated.

CHAIRPERSON BIRMELIN: -- but they had violated some little boy or little girl --

DR. FOLEY: Right.

CHAIRPERSON BIRMELIN: -- or somebody else.

But have you ever dealt with a person or treated a person who felt that they

were going to do that but hadn't acted on those --

DR. FOLEY: No.

CHAIRPERSON BIRMELIN: -- fantasies?

DR. FOLEY: No. No one says, you know, I'm going to call up and say I think I might today, can I come in for an appointment, no.

CHAIRPERSON BIRMELIN: Well, that's sort of like what Bob told us; but I asked him, When did you realize that it was wrong? He said, I realized it was wrong after I got caught.

DR. FOLEY: I think that's true. I think for the most part, they would -- one of the things that's difficult about treating sex offenders as opposed to treating the victims of sexual offense, is that you and me and everyone in this room, we have all been victimized at some time in our life. Someone has taken advantage of us. Someone has stolen from us. Someone has treated us poorly. So we can identify with victims.

We don't like to see ourselves as exploiters. We don't like to see ourselves as ever having taken advantage of somebody. And

when we have, we probably didn't think we were at the time. But anyone in this room who has an ex spouse, I'm sure that if he or she were here, would point a finger and say that he or she is an exploiter. And I'm sure that there would be a quite powerful argument that, no, I was not.

And I think that's part of it, and I think that might have been what Bob was really saying. I don't think he really thought that he was exploiting, and that's part of the cognitive distortions that go along with the ailment.

CHAIRPERSON BIRMELIN: Representative Manderino.

REPRESENTATIVE MANDERINO: You are the only person so far that even mentioned the fact that Provera or Depo-Provera has been suggested to have carcinogenic effects. I think you said that in the context of the FDA leaving it as an experimental drug.

To your knowledge of the medical literature, is that when used on males as a testosterone lowering agent or is that a potential effect of women using it as birth control, too?

DR. FOLEY: I think it would be

anybody. But that's what the FDA says. I don't know. That might have been a laboratory. They might have given 50 times the normal dose to rats and one of them got cancer. I don't know.

REPRESENTATIVE MANDERINO: So then why would -- I guess then I'm having -- I'm not asking you why would the FDA do something, because you can't tell me. But am I missing something from your understanding as to why -- that obviously then can't be the reason that it's still in experimental status because it's not in experimental status as birth control for women.

DR. FOLEY: And for sex offenders.

REPRESENTATIVE MANDERINO: I understand you are saying it's in experimental status for treatment of sex offenders.

DR. FOLEY: Right.

REPRESENTATIVE MANDERINO: But my question was, There has to be some other reason that it's in that status as compared -- and not the potential carcinogenic effect or else it would be in experimental status for everyone, wouldn't it?

DR. FOLEY: I'm not really sure. I thought -- one of the things that I wanted to

present to you today was the pros and cons of all of the medications. And that's why the FDA has it on experimental use for sex offenders. I'm not totally sure nor have I investigated all of the specifics of why the FDA treats Depo-Provera the way it does.

REPRESENTATIVE MANDERINO: Okay. Thank you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Representative James has one more question for you.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman.

In your professional opinion -- this hasn't come up much. Obviously in listening to one of the Bobs, Robert, talk about being abused as a child, do you think that if we can identify these kind of behaviors in juveniles, or juvenile sex offenders, should they be given medication or are the side effects too bad for them to start?

DR. FOLEY: No. We use medications for juvenile sex offenders at our clinic.

REPRESENTATIVE JAMES: So there's no difference in terms doses and stuff like that.

DR. FOLEY: No. We --

REPRESENTATIVE JAMES: It depends on

the offense.

DR. FOLEY: We would rarely use Provera, but we certainly use the SSRIs.

Oftentimes, they tend to be depressed. One of the best predictors of someone becoming a sex offender is being neglected as a child. Neglected people often become depressed. Aside from their sex offending, they often have many other kinds of problems as well as the specific behavior that brings them into our clinic.

I think that juvenile sex offenders -- and we have juvenile sex offenders as young as 11 -- are very, very appropriate for this kind of treatment.

By the way, there isn't a strong statistical link between being a juvenile sex offender and becoming an adult sex offender. That is not established so far. You would think it would be, but it's not.

REPRESENTATIVE JAMES: I would think it would be, also. Okay. Thank you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: I want to thank you, Dr. Foley, for your coming here and

talking with us. We appreciate your helping us out to understand this issue. Thank you for your testimony.

DR. FOLEY: Sure.

CHAIRPERSON BIRMELIN: Our next testifier is Dr. Fred Berlin. He is the director the National Institute for the Study, Prevention and Treatment of Sexual Trauma in Johns Hopkins Hospital in Baltimore, Maryland.

Dr. Berlin, we have been hearing a little bit about you in the last couple of days. Some people have been quoting you, accurately I hope. Of course, you weren't here to know that, and we haven't read all of your works to know that either. But you have been mentioned frequently as an expert on this subject, and we want to thank you for taking the time that you did to come up here and visit with us to give some testimony.

Our stenographer is going to change pads here for a second.

Are you ready?

COURT REPORTER: Yes.

CHAIRPERSON BIRMELIN: Dr. Berlin, you may share with us what you have to share; and

then, if you would, we may ask you some questions afterward.

DR. BERLIN: That's fine. And I appreciate the opportunity to be here.

Perhaps I can just give a brief overview of what I think are some of the important issues for people to understand. I will take 10 or 15 minutes, and then I will be glad to answer any questions that you folks may have.

Let me talk about the bigger picture so I can try to put the medications that are being discussed here into a proper perspective. Perhaps what I can do is, first off, talk about what I think is important in the evaluation of sexual offenders to determine which ones may or may not be candidates for this form of treatment, because I want to say up front that I certainly don't think that this is a panacea and it's not every sex offender who is going to profit from this. And so I want to talk a little bit about that.

Secondly, I would like to talk a bit about some of the disorders, the sexual disorders for which this is appropriate, what we do and

don't know about them, their cause, and so on.

And then, finally, I would like to say a little bit about the rationale for treatment and treatment. And I think the rationale is particularly important since we are in an area where certainly many people out in the public would assume we are just talking about bad people misbehaving. And certainly, there are bad people out there who do misbehave.

So I think if someone like myself who is a physician is going to use medical terms such as diagnosis and treatment and particularly talk about the medication treatment, I ought to try to present to you the rationale for that and why I think it makes some sense.

Having said that, let me talk a bit about how we would evaluate someone to see if they are an appropriate candidate for this form of treatment. There are many sex offenses that are committed by people who do not have a sexual disorder, where there is nothing abnormal about their sexual makeup.

A simple example might be a man who breaks into a home looking to steal some money or a television set and finds a woman home alone and

decides to rape her.

The problem there is certainly that he is not driven by abnormal sexual drives. The problem isn't going to be solved by giving him medicine that lowers his -- the intensity of his sexual makeup. This is someone who perhaps just lacks a sense of conscience and moral responsibility. And I don't know of any medicine or any pill that is going to be able to instill those values into somebody.

So the first point I want to make is simply that there are a number of sex offenders who don't have a sexual disorder and giving them medication to lower sex drive is not going to make any sense.

Now, what about that subgroup of people who do have a sexual disorder that seems to predispose them to act in a criminal fashion. We often assume that we are all the same sexually, but indeed we are not. And we differ in a couple of ways, and that relates to the so-called paraphilias or sexual disorders. And let me just talk about that very briefly.

Some people differ in their sexual makeup because they are attracted to a different

kind of partner than the norm. And I will expand on that in a moment. Other people differ because they crave a particular kind of sexual behavior in a way that is very different than what we tend to crave.

Let me start with the partner side of it first. Pedophilia is a clear example of how people differ in terms of their sexual makeup from the norm with respect to the kind of partner that they are attracted to. There are essentially two forms of pedophilia, the exclusive and the nonexclusive.

In the exclusive form of pedophilia, a person has no attraction whatsoever to adults, and yet they recurrently crave sex with children. And it's called the exclusive form because they are attracted exclusively to children and not too adults.

Now, any of us, even who aren't mental health experts, can recognize how high risk a person can be if they are walking around in society with no sense of wanting to be intimate with an adult and recurrently craving sex with children and that being the only way in which they can satisfy their sexual needs in

terms of a partnership would be with a child.

The second form of pedophilia, the nonexclusive form, involves people who do have attractions to adults but, in addition to that, experience strong cravings for children.

The important point to appreciate there is that even though they are capable of having adult sexual interactions, that doesn't erase the fact that they still have these other cravings and that these cravings can predispose them to be a danger in the community. So pedophilia is one of the conditions -- and I will get to treatment in just a few moments -- where using sex drive lowering medications might make some sense.

The other way in which I said people differ is in the kinds of behaviors that they are craving sexually. There are actually some people, just to pick one example, who are not aroused at all by consenting behavior. They can have the availability of a consenting partner and that kind of behavior isn't arousing to them, and yet they recurrently crave coercive or even sadistic sexual activity.

Now, again, I don't think one has to

be a mental health expert to know how dangerous a person can be if their sexual makeup is such that they are not aroused by consenting involvement and recurrently crave coercive involvement. These people can be adult -- rapists of adult women. And again, these people, where they seem to be driven by these abnormal sexual cravings, can be candidates for medicine that lower the intensity of sexual drive.

And I could give other examples. I will save that for questioning; but I did want you to understand the concept that some people are very different in their sexual makeup and that that's a basis for why we want to provide them with this kind of treatment.

Now, I said I wanted to say a little bit about the etiology of some of these disorders. And obviously, public safety is the first priority here; but I also think we want to understand and try, where we can without compromising public safety, to be just to people who do have psychiatric conditions. And so let me just comment briefly on what would or wouldn't be the cause of a disorder such as pedophilia.

The first point I want to make is

that people who have these disorders don't have them because of some sort of voluntary choice. None of us as little children ask ourselves, well, when I grow up, do I want to grow up to be attracted to men or to women or to boys or to girls? In growing up, we discover who we are attracted to.

As I grew up and discovered I'm attracted to women, that's a very lucky discovery to make. And I find that it's much easier for me to live in society.

But the person who is attracted, for example, to ten-year-old boys isn't that way because he was a bad boy who decided to be different. He discovers in growing up that he's afflicted with this kind of abnormal sexual orientation. And I would argue that it's one of the most tragic and even dangerous afflictions that one can have.

And so I did want to make the point as a physician that I do believe that these are mental disorders, mental afflictions. And that's the very reason why I think we have to have an interchange between the medical and scientific community and the criminal justice community in

dealing with these issues.

We cannot treat the pedophile the same way we treat the bank robber or the purse snatcher as though it's just a normal person misbehaving. We punish them and teach them a lesson. We cannot punish away pedophilia. There is nothing about being in prison that will enhance the capacity of these people to successfully resist acting on unacceptable sexual temptation.

Now, what I said these disorders aren't due to is choice. I heard some discussion earlier about what factors might be contributory, for example, environment. It is clear that the majority of people with sexual disorders were abused during childhood, which is not to say that the majority of abused kids become abusers.

It's like the relationship between cigarette smoking and lung cancer. Most smokers don't get lung cancer, but most people with lung cancer are smokers. It would be nice to know why some people are immune to the scarring effects of smoking in a way where they don't get lung cancer, but the fact that some are immune doesn't mean that others weren't scarred. That's the

relationship here.

Thank God most abused kids, particularly if they get help early, do not end up with conditions such as pedophilia or the other sexual disorders. The fact, however, that some of them were immune to being damaged in that way doesn't mean that others weren't scarred by the experience.

The other thing that we found as an etiological factor in some sexual disorders are various biological abnormalities. For sake of time, I won't go into that; but it's very clear that we are sexual in our makeup because of chromosomes, hormones, and so on. And some people may have abnormal sexual cravings because of pathology at that level.

Now, just to finish up with the rationale for treatment and treatment. I'm going to make the point that there shouldn't just be medication treatment. I suspect, since you have heard from many others, that that would be clear; but let me kind of describe the rationale for medication treatment first and then talk about how to put that into a larger perspective.

The law assumes when it comes to

behavior that everybody can control themselves just through will power alone. Obviously, we have to make that assumption, because if we didn't, I suppose the common thief could come into a courtroom and argue that he was just overpowered by incredible feelings of greed, some sort of a ludicrous argument, and say, you know, get me to the greed clinic, I don't deserve to be punished.

And we all know the cynicism that is out there that people want to beat the rap by pretending to have psychiatric disorders. On the other hand, psychiatric disorders exist, and human makeup exists. And we need to try to figure out how these things relates.

The point I want to make about these sexual disorders and the crimes that are committed by persons with sexual disorders is that they are the only crimes that are fueled by a powerful biological drive. And just to make the point of how difficult it can for people to control themselves when it comes to biological drives, we don't have to look at anything more complicated than overeating.

People, as you know, in this country

are spending a fortune to try to diet. And I can tell you as a physician the easiest thing in the world to do in theory should be to diet, because it's not complicated at all, just eat less. It's absolutely no more complicated than that. That's an absolute guarantee.

But what we find is that for many people, that's extremely difficult because of the power of that biological force that they are having to deal with. That's the issue that we are dealing with with conditions such as pedophilia and some of the other sexual disorders, that they are driven by a powerful biological force.

There's no other kind of criminal conduct that falls into that category. I think it helps us understand why in some cases these conditions seem to go on for so long or the drive diminishes somewhat as we get older, but it never disappears. And the sex drive recurrently craves satiation. God or nature put that drive into us for a very important reason. If I don't eat, I die. If I don't have sex, the human race dies.

So that drive is meant to recurrently be satisfied. And if it gets aimed,

if I can put it that way, in the wrong direction towards a child or towards coercive rather than consenting behavior, it still recurrently craves satiation. And that can indeed be a difficult state of events.

Now, having said that, where do these drugs fit in? And I hope I have laid a foundation that would make some sense to you.

If I'm hungering sexually for children, if I'm hungering sexually for coercive or even sadistic sexual activity, we don't yet know enough about the biology of sexual orientation to turn things around to replace the desire for children, for example, with a desire for adults. That would be a cure for pedophilia. And who knows, maybe some day we will get there; but we are nowhere near that point.

What we do know a lot about, though, is the intensity of sexual drive. Sex drive, in males at least, seems to be related to the levels of testosterone, a hormone produced by the human testes. And so, although I'm oversimplifying it a little bit, testosterone is the hormone that fuels the sexual drive.

And so if I'm hungering sexually for

children, hungering for coercive or sadistic sexual acts, if someone can at least reduce the intensity of that hunger, provide me with the equivalent of a sexual appetite suppressant, that's no guarantee, no panacea; but it should certainly, if I'm wanting to control myself, make it much easier for me to resist unacceptable sexual temptations and conform my behaviors to the appropriate standards.

Now, that's the concept that's also been looked at empirically because we need evidence. And hopefully, that makes sense. But what's the evidence that it works?

There's evidence in both humans and animals that lowering testosterone can have a profound effect on the frequency of sexually motivated behavior. Some people have used the term -- and I hope I can get everybody away from this -- "chemical castration" to describe what's being done here.

I have heard some people say castrating the sex offender is like cutting off the hand of the crook. That's wrong. Removing the penis would be like cutting off the hand of the crook, but that's not what we are talking

about here.

If you take an animal, male animal, leave the penis intact, but the testes -- I'm sorry. Let me put it the other way, because I think it's easier to understand.

You take a male animal. You leave the testes intact so he is still producing testosterone and remove the penis and put the male in with a female in heat, he still tries to perform sexually. He is still motivated sexually. He just can't do it genitally, because you removed the apparatus; but you've still got a sexually motivated animal.

On the other hand, this time you take the animal, and you leave the penis intact so he could have sex, if he wanted to, if I can put it that way. But you remove the testes, the source of testosterone production. Removing the testes is castration.

Now you put the male with the female in heat. He could have sex, if he wanted to. He simply doesn't try, indicating that lowering testosterone affects the motivation to engage in sexual activity, not simply interfering with the ability to perform genitally. And obviously, in

human beings, that's what we want to do is lower their motivation for sexual activity if the kind of activity they want is dangerous to themselves or to the community.

This has also been studied in human beings. Again, I'm not talking about the atrocities of Hitler's Germany, but in one large study in Scandinavia where testosterone was lowered by removing the testes.

Before we had the availability of medications, they looked at I think it was 900 men who had had testosterone lowered. There was a 30-year follow-up, over 4,000 follow-up examinations. The recidivism rate, the recurrence of sex offenses under those circumstances, was less than 3 percent, a very low recidivism rate. Studies have been replicated in other counties.

We now have medicines that can lower testosterone. We don't have to subject anybody to the trauma of surgery. The two more frequently used medicines here you have heard about, Depot Lupron and Depo-Provera.

You did hear some information earlier about these being experimental drugs.

That is not accurate. The FDA has three categories of drugs. One is to use a drug -- an approved drug for a labeled indication. So it's approved for human use, and it also says on the label to use it for this purpose. That's one category.

Another category is experimental. And you can only use it by getting an IND, an investigative new drug, number from the FDA and make it clear that you are using it for research.

And the third category, which is what these medicines fall into, is the use of an approved drug for a nonlabeled purpose. Depo-Provera is approved for human use as is Depot Lupron. They are very commonly used in men who have prostatic cancer, because those cancers grow more slowly if testosterone is down. They have a good track record in terms of safety. And using them for a nonlabeled indication is perfectly standard medical practice. It's not considered experimental.

In Maryland, the government Medical Assistance pays for this medication for people who take it. It's available in the prison systems in several states with states paying for

it. The idea that it's investigational, experimental may have been true 15 years ago. It certainly, in my judgment, is not true now.

As far as side effects, because I suppose there will be some questions, the side effects are pretty similar to the kinds of risks that a woman is taking when she uses hormones for the purpose of contraception.

Depo-Provera is used in 83 countries, including this one for that purpose. It's not without risks, and I can go into them with your questions. But it's certainly not very high on the scale of risks when it comes to looking at the different risks that various medications can have.

I did hear a question earlier -- and I will stop with this, but I happened to walk in when I heard it -- about carcinogenic effects. There had been many years ago concerns about Depo-Provera in particular causing cancer. It's actually not permitted in this country, except for people who have life-threatening illnesses, for the FDA to approve a drug for human use if it is carcinogenic.

The concerns came out of two

studies, one with female beagle dogs who get a lot of breast cancer. And at that point, there was worry whether they get more with Depo-Provera. The other was on monkeys where there was a worry about a risk of increased uterine cancer.

Both of those concerns that were present some 20 years ago have now been alleviated. There's a study on this both in JAMA, the Journal of the American Medical Association, as well as Science. It was because of that it wouldn't have passed five or six years, I think. Depo-Provera was approved by the FDA for human use in this country. It is not considered to be carcinogenic.

We actually, because we like to have informed consent with people that we provide this medication to, tell them about those earlier studies. We think they should still know; but we also tell them, which is accurate, that it's not been found to cause cancer so that the people we work with are fully informed.

As far as the bill itself is concerned, I do think it's important. As I said earlier, I think we need a collaboration between

the medical and scientific community and the criminal justice system to deal with the kinds of criminal behaviors that are related to mental and medical conditions. I don't think we can treat them like we treat all other conditions.

I don't want to overstate this case. This isn't going to be a cure-all for everything. But to the extent that some people are going to be safer in the community with it, I think it serves us all well. I do think that it's going to be important, if this is done, to establish up front some mechanism for tracking outcome.

We need to see whether or not it's working. If it is, you may want to do more of it. If it isn't, you want to find that out early on and not go down a path that is not successful. I think it will be, but the bill should stipulate some mechanism for tracking.

I think the other thing that has to be added to the bill, in my judgment, is that there should be a way of stopping this treatment, if you are going to give it, if it's no longer medically indicated. I wouldn't want to see a situation where someone is taking it and then perhaps they have taken it for several years and

it's no longer indicated medically and there's no way of stopping it. So I think that needs to get into it.

And I can answer more in questions. But I do think it will work best with people who are wanting to take it rather than with people who are being forced to take it.

So I would recommend -- and I think it's a very good bill -- that it start with people who are really willing to see what the track record is like. And then if it's good, you may want to expand it. But I think to force it on unwilling people prematurely and maybe not have some successes simply because they are resenting taking it and aren't making an effort to improve themselves might not be the best way to start.

But at any rate, I have covered a lot, and I hope it's been of some pertinence to you. And I have tried to give you the bigger picture. Why don't I stop at this point, and I will be glad to entertain any questions that you might have.

CHAIRPERSON BIRMELIN: Thank you, Dr. Berlin. You obviously know your subject

matter well to speak for so long and so authoritatively without notes.

DR. BERLIN: Thank you.

CHAIRPERSON BERLIN: And I do appreciate your using the illustration of the compulsion to eat. I can relate to that one.

DR. BERLIN: So can I.

CHAIRPERSON BERLIN: It brought it home for me.

We are going to ask the members of the panel if they have any questions for you. And I'm going to begin with Representative Saylor, who I understand knows you and has talked with you in the past about this. But I will give him the opportunity to ask you some questions.

Representative Saylor.

REPRESENTATIVE SAYLOR: Dr. Berlin, thank you for coming. You have made many trips here to the capitol to help me with this legislation and to educate me.

Would you reiterate or make clear again the fact that this is not a punishment, it is really a treatment? Am I correct?

DR. BERLIN: That's correct. As a physician, I would certainly not be in favor of

using medicines or surgery, for that matter, in a punitive way. This is meant to increase the ability of people to be in control of themselves.

There's often tremendous misunderstanding about psychiatric medicines. We hear them talk about mind control and things of that nature. I don't know of any medicine that ever made a Republican into a Democrat or vice-versa. We don't have any mind-controlling medicines. But there are people that seem to be out of control. We see that sometimes in alcoholism and drug addiction, even people who are having cravings to smoke.

Here we are fortunate enough that we can have a medication that lowers the drive that may make it difficult for people to control themselves so that they can behave in a way that is responsive to the dictates of conscience and intellect rather than giving in to lust or passions or desires that they may not be able successfully to resist.

So this is absolutely treatment, and that's why I'm here supporting your efforts. If this were simply an attempt -- and I will put it bluntly -- to castrate the bastards, you should

find somebody else, because I'm not in favor of that.

REPRESENTATIVE SAYLOR: The other thing, when I crafted the bill and wrote the legislation, is that we didn't put a term in. We basically said medical treatment with psychological treatment to go along with that.

The first question has to do with that. And you would agree that the medication itself, by itself and only by itself, doesn't solve the problem. There must be counseling.

DR. BERLIN: That's right. First of all, there are people, as I mentioned, for whom the medicine isn't even appropriate. So that's one point. And then, secondly, for those who have it, there's still other things that need to go on.

I didn't get into it; but when people have strong cravings and satisfying them is pleasurable, they rationalize. They deceive themselves, and they are not looking at things objectively. So you need therapy to confront the kind of denial and rationalization that you see.

You need therapy to discuss changes in lifestyle that are going to make it easier for

people not to succumb to unacceptable temptations. You need to actually educate people about various strategies to resist and succeed and not relapsing. So that needs to be there.

I also want to make the point that there is a lot of cynicism out there. I think that mostly what has been shown is that bad or inadequate therapy doesn't work, not that adequate therapy fails.

And what I mean by that is people who are in prison ought to begin to receive treatment while they are in there. They ought to be able to have a continuity of treatment once they leave. There ought to be some feedback so that you know when they are out whether or not they are succeeding in therapy.

And when you have that big package, I think there is reason to feel that many, not all, but many people can be successfully rehabilitated. If you just have a lip service program in prison, no follow-up treatment when they come into the community, no mechanism for tracking how they do once they are out there, you might as well not do it.

So I guess my message is either do

it right or maybe you ought not do it at all.

REPRESENTATIVE SAYLOR: When I wrote the legislation, again, we didn't classify it as chemical castration or whatever.

Is there a term that we should be using that is recognized either worldwide or nationally, a term for this kind of a treatment, hormonal treatment, chemical treatment?

DR. BERLIN: Hormonal. I think an important thing is to avoid connotations that can be very misleading. I talk about sex drive lowering medication or aberrant sexual appetite suppressant medication, because that's a description of what it is that we are doing. And I tried to give you some sense of why that makes sense.

Castration has so many overtones tied to it. It brings up the specter of going back into the Dark Ages. The only thing that this has in common with castration is that it's another way of lowering testosterone. It doesn't involve surgery. It doesn't involve mutilation of the genital area. It doesn't prevent someone from fathering a child, because it doesn't completely eliminate sperm, as would be the case

with surgical castration.

I might add for those who might say, well, listen, public safety is first, let's just castrate them, because they can stop the medication and castration is irreversible, even that isn't true.

Castration is irreversible in that you can't put back the testes. But the only reason that surgical castration has an effect on state of mind and behavior is that it lowers testosterone. And an approved use of Depo-Testosterone is to increase sexual libido and sexual drive in people who aren't producing enough or in people who because of injuries have had the testes removed.

So surgical castration is no more or no less irreversible in terms of mental and behavioral effects than is what we are talking about here. And that's another misconception, I think, we need to help people get away from.

REPRESENTATIVE SAYLOR: Last question that I asked earlier of Dr. Gingrich, but your opinion of the privacy issues of doctor-patient relationship and how it works with probation and parole and working with judges, do

you see an ethical problem with the team working together where a patient who comes in and is in treatment and you realize that either he is not cooperating in the treatment or he or she is -- it's not working for them?

DR. BERLIN: This is a delicate issue, because we want people to tell us about problems before they get into trouble so that we can keep that trouble from developing in the first place. On the other hand, if they are concerned they will be deprived of their liberty or that bad things will happen to them, they are hesitant to talk up in the first place.

Someone asked earlier about people who come in voluntarily. And we had actually had an interesting -- and I hope this will address your point. In Maryland for many years, if a person came into a physician seeking help for something like pedophilia and told the doctor about that, that they have been involved, for example, with a child, we didn't have to report that.

So we had 70-some people over a ten-year period come in who weren't in any trouble with the law who said that they had a

problem, they realized that they needed to get help. And we gave them help and we believe, as a result of knowing that, safeguarded the community. I mean when an undetected pedophile is coming forward to get treatment, that was making them safer.

In Maryland several years ago, they changed the law. And so when we get that call now, we have to tell these people that according to the law, we will have to report you. And indeed we would if they gave us their name.

All that happens now is they say, I better talk to a lawyer. And it's usually a lawyer that calls and says, I'm not going to tell my client to self-incriminate. And so a law that was intended to protect children is actually deterring undetected people from coming forward to get the very help that might make children safer.

Now, it's a little bit like that here. So I can just tell you what we do. We report compliance and noncompliance regularly to the appropriate authorities. If someone is supposed to be taking medicine and they don't, we report it. If they are supposed to come to

treatment and they don't, we report it. If they are just sitting in the room and don't seem invested, we report it.

What we don't do is report the content of what they tell us in treatment, because if they thought we were going to do that, they aren't going to tell us in the first place. And so how are we any better off?

What I can assure you of, though, is that if they tell us something that leads us to believe they are dangerous, we don't just say thank you very much and leave it go. We will insist they get into the hospital. If they refuse, we will simply commit them if we think they are dangerous.

But we are trying to have a middle ground so that at least we hear the information that lets us intercede to protect the public rather than having people feel if we tell that doctor, we have to be crazy, because why should we tell them that in the first place.

Everyone is going to have to work that out; but to bury our heads in the sand and say, well, we just have them totally waive all privilege and to think that they are then going

to tell us the kinds of things that we would need to hear I think is rather naive.

CHAIRPERSON BIRMELIN: Doctor, I just have one area that I would like to ask you a couple of questions in, and that's the prison systems of Pennsylvania or other states. And I'm not sure how familiar you are with any of them.

But in your experience with convicted people who are serving in prisons and who are in sex offender programs, could you tell me what states you know of that do things that are helpful and if -- or what things could be done that would be more helpful in the prison systems today than is currently being done?

DR. BERLIN: Well, I think -- and I hope this doesn't sound condescending; but I don't think we have quite the kind of programs that we need anywhere. I think we have not really made up our mind as a society whether we really believe that these are people who are ill and deserve treatment. And so we kind of tiptoe into it, but I don't think we have really made a full effort.

As I mentioned earlier, the kind of programs that we need are ones that not only are

present in prison, but then provide adequate follow-up so that it's continued when people leave prison and then again have the feedback so that there is some data as to whether or not the treatment it proving successful.

And having said that, Vermont has a program that's been supported by the State. They have had some difficulties with it, not to hide that from you; but they have at least made an effort to try to establish specific treatment for people with sexual disorders.

Colorado -- and I don't know how -- is it Colorado or Arizona? I'm not sure, but one of them has lifetime parole and has parole agents who are trying to work with people. And they are certainly touting themselves as having something they think is going to be useful. I think the bottom line is one needs to ask for data.

We, for example, published a large study on over 600 men over a 5-year period to see how we are doing. I think if someone says that they have a program that works, ask them to see the data, how many people you have treated and what's your recidivism rates.

The Justice Department -- and this

may help you. Laurie Robinson, who is the assistant secretary of state at the Justice Department is looking at what they are calling the issue of safe management of sex offenders in the community, because they recognize that, you know, we are never going to just have enough jails and with all of the rhetoric, we are never going to lock these people all up forever. Sooner or later most of them still come out.

So they are looking at that, and they are establishing an attempt to set up to look at eight model programs around the country as ways of trying to look at the treatment of sex offenders. They are going to look at some prison based programs. So you might want to be in touch with them.

But I don't know of any state that I think is really doing it in the way that would stand a high probability of success for most of the men that they are working with.

CHAIRPERSON BIRMELIN: Thank you.

Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. You actually asked my question.

CHAIRPERSON BIRMELIN: Great minds run in the same channels, I guess.

We want to thank you, Dr. Berlin. It's really been an eye opener to have you here. And as I mentioned earlier, we have been receiving testimony -- yesterday we had several testifiers and today. And your name has been bandied about in a good way.

So we thank you not only for your coming and testifying today, but for the work you have done in this area. I know that Representative Saylor, who is the prime sponsor of this legislation, has depended to a great extent on your advice and will continue to work with you. And perhaps you will be part of some legislation in Pennsylvania some day.

DR. BERLIN: Well, I wanted to thank Senator -- Representative Saylor and all of you. I know some states have leaped into this without any attempt to look at it carefully, without any collaboration between the scientific and medical community and the legislature.

Senator Saylor -- or Representative Saylor -- excuse me -- from the beginning has attempted to research it and understand it. And

I appreciate all of you giving me an opportunity to come and talk today. It's a very complicated issue, and I personally have found this very helpful.

I'm also a Pennsylvanian myself. I grew up in Pittsburgh. So I have a special affinity for this state, and it has been a real privilege to be here.

CHAIRPERSON BIRMELIN: Well, we thank you. And your observation of Representative Saylor as being a thoughtful legislator is ours as well. Thank you.

DR. BERLIN: Thank you very much.

CHAIRPERSON BIRMELIN: Our next testifier and last for the morning is The Honorable Jeannine Turgeon. She is a Dauphin County Court of Common Pleas judge.

And, Your Honor, if you could. Choose either microphone. I guess they are both working as long as the switch is on. We have a copy of your testimony and you may share that with us now, if you will.

JUDGE TURGEON: Thank you. Good morning.

As you are well aware, sexual

assaults and sexual abuse of children is a horrific public health and criminal justice problem. Trial judges such as myself face the daunting task, sometimes on a daily basis, of sentencing these child molesters and other deviant sex offenders that appear before us.

My initial inclination, as well as most of the other judges on the bench, certainly is lengthy incarceration when you hear the facts of some of these cases. However, many of these offenders plead guilty to lesser offenses and thus receive relatively short sentences under our sentencing guidelines.

To stand aside from my written testimony, the reason for that is understandable. They want to avoid putting the children on the stand. Child witnesses typically are not believed by juries; and therefore, the prosecution and the DAs, I think, have a very good social reason for accepting negotiated guilty pleas to lesser offenses. And we should be grateful for that and thankful for that.

Nevertheless, they are then in our criminal justice system under something usually as simple as an indecent assault, which under

the sentencing guidelines, which we must follow, if we do not follow, we will be reversed, calls for very small, short jail sentences, if any at all.

According to multitudinous studies, many of which I have cited in my article and many of which I have not, I came to learn that drug therapy is a highly promising treatment which reduces recidivism for certain paraphiliacs, or what you would refer to as sex offenders, child molesters. Those persons -- and it's defined as those persons compelled to commit sex crimes in order to realize a specific deviant sexual fantasy. And certainly, sexual contact with a child is deviant.

There are all sorts of recognized paraphilias, pedophilia, a craving for children; exhibitionism; transvestitism; voyeurism; frotteurism, which is when you touch up against a child or a woman for sexual pleasure, deviant sexual pleasure; fetishism; sexual sadism, masochism; and other psychosexual disorders, including some types of rape.

This is nothing new. People seem to think that this is just something new that's come

up over the past year or two or decade. In fact, it's over a quarter of century ago numerous studies started demonstrating the effectiveness of pharmacological treatment for these paraphiliacs.

Most sex offender programs that exist today rely not only on the pharmacological aspect of this treatment, but also cognitive-behavioral conditioning, which is sometimes one or one. The effectiveness of group therapy for these guys, it takes one to know one, they are very effective with each other, sometimes more effective than a one-on-one counselor.

Many Pennsylvania psychologists have devoted their entire professional lives treating sex offenders. We certainly have lots of national psychologists and psychiatrists who have spent their life treating sex offenders. So I compliment you for getting some of those experts here today and encourage you to speak to others.

Bob Gingrich from Lancaster, Anthony Pedone, who is from the northeastern end of the state, believe that a sex offender treatment program that does not have a pharmacological

component should not be considered a viable or an effective program.

Bob Gingrich, who has treated these offenders for nearly 20 years, said to me that "the use of medication in reducing the risk factors in compulsively deviant sexual behavior is an essential component in the treatment of paraphiliacs. Unless the judicial system incorporates the medication factor at sentencing" -- and that's what we are talking about here with this legislation -- "physicians and therapists will be greatly handicapped in their effort to control this population. We should not expect a change in behavioral functioning from a schizophrenic or a person who suffers from bi-polar disorder without the use of medication. The same logic applies when we are talking about the treatment of the paraphiliac."

A growing number of courts across the country are imposing it. California adopted a lot mandating it.

I think we should consider the option of considering that the condition of these sex offenders being released from prison be that they receive long-term pharmacological treatment

in conjunction with the other appropriate sex therapy.

A sentence can be issued by a judge for the longest possible time that the law allows; but the mandatory sentencing that I'm talking about where we can only commit them for, say, three or four months, the standard range sentence, if you will, as you understand from the guidelines, is what that minimum term generally is.

You are, I'm sure, used to hearing a sentence of, say, 3 to 12 months or 3 to 60 months. It's that maximum long-term tail that we have to supervise them that I'm talking about would be the critical time to embrace this approach.

What the medication does, as I am told by the experts, is it reduces their compulsive deviant sexual urges by decreasing and affecting the metabolism of testosterone in some of these individuals. Some of the others address the level of serotonin in their system. Again, it depends on the individual. It depends what his illness -- diagnosed illness is.

If it indeed is the metabolism of

testosterone for that particular individual based on how they have been evaluated by the psychiatrist, that sort of medication reduces their sexual craving, and then it relieves this person of their compulsive and behavioral fantasies. And by decreasing that compulsion, they then become more amenable to the cognitive-behavioral therapy treatment.

And as an aside, I have heard typically men in my courtroom tell me, who have been on this, that it is just a great relief to them to get this compulsiveness, this compulsivity under control. They hate themselves -- many of them hate themselves for this.

There are a lot of categories of drugs that are available. Most today, as I understand it, as I have been advised, and the ones that I have used with my few defendants that we have been able to get on this program are simple serotonin reuptake inhibitors that are used with all sorts of obsessive-compulsive disorders from mainstream America, if you will, such as Prozac, Paxil, Luvox, and Zoloft.

Lots of people complain about the

side effects of Depo-Provera; but when we use these SRIs, the national experts that I have spoken to such as Drs. Abel and Balyk, they report very minimum side effects to this sort of drug.

While the medical and scientific community continues to debate which drugs are more -- are most effective, the fact remains that there are an abundant number of studies that establish that there is substantially increased success in dealing with these types of defendants in using pharmacological treatment when compared to psychotherapy alone.

Now, what's the benefit? Well, the reduction in recidivism, I think, is something that judges certainly look at and you must look at. And we've got a proven reduction in many studies, not for everybody, but we've got a proven reduction of certain sex offenders' recidivism following the pharmacological treatment in conjunction with traditional therapy. And that's its most appealing attribute, I am convinced.

Dr. Fred Berlin, from whom you just received testimony, has compiled quite a large

body of data on this subject. In 1991, he reported that among 626 men on the antiandrogen Depo-Provera, fewer than 8 percent had committed a sex crime in the following five years.

Dr. Gene Abel in Atlanta had even better results. In various other studies which I have cited in my article, one group had 0 percent recidivism; one group, 28 percent; another group, 0 percent.

I think it's important to note that all of the studies that I reviewed and read and studied emphasize that the use of this drug is not a cure and it should only be used in conjunction with other therapy to help the offender adjust to a new lifestyle.

There are certainly critics of this approach. I'm sure you will hear from them, but there are no other effective options to protect the public and protect our children from these offenders.

They can't be incarcerated for life absent a crime such as murder. Castration, which is the only other effective way to decrease testosterone levels, which I oppose, is also uniformly, almost uniformly, opposed on

humanitarian and constitutional grounds. So that certainly is not an option that any of us can consider.

And I think part of the problem in adopting this approach indeed is the public perception that this treatment is castration, albeit chemical castration. This is not true. With the SRIs, it is not true. The purpose is to reduce the offender's compulsive sex drive, giving them better control of these deviant sexual interests.

And the studies have also shown that they can, while they are on this medication, continue normal sex lives with a normal socially acceptable sexual partner such as their girlfriend or their wife while on this medication. What we are doing is addressing the deviant compulsive sexual drive with children.

The legal implications of this, that a convicted sex offender, if they are sentenced as I propose in this article, who fails to obtain the pharmacological treatment, they would remain incarcerated for the balance of their sentence. Therefore, of course, imposing this condition would raise some -- does raise some complex

medical, ethical, and legal concerns.

While I did not address them at length in my article, they have been addressed by numerous Law Review articles across the country in depth by legal scholars. I would tell you, though, that I have reviewed many of them. And the consensus is that if the offender gives his -- and that he must give his informed consent to this treatment.

It is well established that county probation conditions can limit certain constitutional rights of convicted offenders. And probation conditions are generally considered by the courts legally acceptable if they are reasonably related to the rehabilitation of the offender, if they relate to protection of the public, or if they deter future criminal acts by this defendant.

Pharmacological treatment in conjunction with therapy meets all of these conditions. There probably is not adequate scientific evidence at this point to guarantee a high likelihood of success, however, when this treatment is imposed on an unwilling individual. So probably for that reason as well, it should be

imposed upon those who consent to it. And that is my recommendation.

The logistics of it are fairly simple for the court. Upon conviction or guilty plea when the defendant stands before us, upon the offender's request to undergo this treatment or upon the agreement to undergo this treatment following some colloquy in the courtroom, the judge merely would order a medical and psychological evaluation to determine whether or not he is appropriate -- an appropriate paraphiliac sex offender -- that's how they refer to it -- amenable to drug therapy.

And if so, you then condition his release on receiving the pharmacological drug treatment in conjunction with the traditional sex therapy.

Now, this is a separate assessment from the one that we are now doing under Megan's Law that you passed. In fact, the defendant I had before me several weeks ago was determined by your -- the state board you have established under Megan's Law not to be a violent sexual predator such is monitored under Megan's Law. Nevertheless, he was a predator on children and

had been his entire life.

If an evaluation and diagnosis can't be made prior to sentencing, we can just direct that one be made immediately upon his release. And I would encourage the state system to incorporate this in their plans.

Once the offender has been diagnosed and has undergone a complete medical evaluation to ensure there is no medical complications, the offender would merely enroll in a sex treatment therapy program which incorporates the pharmacological treatment. They can be administered by a physician or at any health clinic.

If the offender violates the plan, the program would merely notify the county or state parole or probation office and his parole or probation could be revoked.

Over the past several years in my courtroom, I have had over 30 such sex offenders who have agreed to this treatment, agreed to the evaluation, but they can't afford it. The two who are currently in this treatment under my jurisdiction who are on the medication and in the sex therapy have not reoffended.

The medication is expensive. So we need some sort of funding mechanism to assist these offenders in this approach to their rehabilitation. And the question, I guess, the legislature and the Senate and the Governor have to ask is, Is it worth $200 a month to save children in that community from being sexually violated.

In conclusion, I think we all agree deviant sex crimes are a public health as well as a criminal justice problem. The criminal justice system and the scientific and medical communities must work together in order to address this issue.

The traditional approach of just locking them up for their term and then releasing them cold turkey back into their community has not worked. Therefore, we must expand our paradigms and explore new solutions, which is what is occurring today with this committee.

In the case of certain sex offenders, a jail sentence followed by a long-term probation or parole conditioned on pharmacologic treatment in conjunction with

cognitive-behavioral therapy meets all of the goals of sentencing. And those traditional goals of sentencing are punishment to the defendant, deterrence, public safety, and rehabilitation.

The offender certainly benefits, because he gets out on probation probably quicker; but most importantly the children and the other victims in our community can be saved from these heinous sexual assaults.

And therefore, I respectfully suggest it's in the best interest of our children, the likely victims, as well as society as a whole that they would be well served by incorporating this latest biomedical treatment in our criminal justice system today.

I want to thank this committee for considering this proposal, and I look forward to seeing this legislation progress. Thank you.

CHAIRPERSON BIRMELIN: Thank you, Your Honor.

It says here that you had approximately 30 sex offenders who have agreed to the treatment but couldn't afford it.

How many sex offenders over the

years have agreed to it and could afford it?

JUDGE TURGEON: I have had two, and those two have not reoffended.

CHAIRPERSON BIRMELIN: Only two?

JUDGE TURGEON: Yes, sir.

CHAIRPERSON BIRMELIN: You have only had two who could afford it?

JUDGE TURGEON: Yes, sir.

Most people coming out of jail do not have jobs for corporations where they have health care benefits. Many of these men -- and I refer to men because the highest percentage of child molesters and sex offenders and paraphiliacs are men.

Most of the men who are released from prison are working hourly jobs that they are able to obtain which do not have the health care benefits. They might have a green card or something from DPW that helps them get emergency medical treatment or perhaps go to the dentist or the doctor for a broken leg or a broken arm. It does not, however, cover funding for the drugs which would help prevent them from molesting children.

CHAIRPERSON BIRMELIN: How many

years have you served on the bench?

JUDGE TURGEON: I was elected in 1991 and went and started on the bench January of '92.

CHAIRPERSON BIRMELIN: How many judges are there that sit in Dauphin County?

JUDGE TURGEON: Seven.

CHAIRPERSON BIRMELIN: Are you the judge who most often handles sex offender cases --

JUDGE TURGEON: No. They are equally --

CHAIRPERSON BIRMELIN: -- or are they just distributed at random?

JUDGE TURGEON: They are equally divided among all seven judges.

CHAIRPERSON BIRMELIN: Do you have any knowledge of how many sex offenders have stood before all of the judges in total in these years that you have been on the bench and whether or not this 30-to-2 ratio of those that cannot afford it to those who can is the same?

JUDGE TURGEON: I do not have those statistics. I have had hundreds of sex offenders before me during the past five years.

The 30 that I refer to -- and I'm just educating myself on this within the past few years. This is not something you get taught in law school. Only since I have done self-education on this and learned about this and did research on my own, nights in the law library, I just then started doing this in my sentencings within the past, I would say, three years.

So that 30 are just those sex offenders that I have gotten their consent or have consented to this sort of treatment. There are hundreds of child molesters that we see every year.

CHAIRPERSON BIRMELIN: But they have not agreed to the treatment, the others apart from these 32?

JUDGE TURGEON: Correct.

CHAIRPERSON BIRMELIN: You have never made it a condition of probation that they had to have this chemical treatment?

JUDGE TURGEON: Yes. In those 30, I have.

CHAIRPERSON BIRMELIN: Okay.

JUDGE TURGEON: But if they can't

afford the $200 a month for the medication, I think it would be inappropriate for me to put them back in jail unless they violate the law. And it is a system that cannot work without the support of the entire community. And we have to decide if protecting our children is worth paying for this medication.

CHAIRPERSON BIRMELIN: The only other question I have for you is, Dealing with the recidivism problems that you have, you have had hundreds of these sex offenders before you.

Do you have any idea of how many of them are recidivists before you or before the Dauphin County Courts?

JUDGE TURGEON: I do not know. I can only follow -- I can only tell you what the scientific community studies have shown, which is if you've got this obsessive-compulsive disorder with children, you will always have it. It is a mental illness.

CHAIRPERSON BIRMELIN: Are most of these sex offenders put into state prisons?

JUDGE TURGEON: No, few of them. If you are convicted of rape, that's a state sentence. Typically, it's a negotiated plea

agreement for an indecent assault.

CHAIRPERSON BIRMELIN: Thank you very much.

Representative Saylor.

REPRESENTATIVE SAYLOR: Judge Turgeon, thank you for coming. You have been kind of an innovator on the bench.

If the use of this, getting back a little bit to the rest of your bench in Dauphin County, have any of the other judges utilized your techniques or your sentencing on this --

JUDGE TURGEON: There are judges across the state who have utilized this approach. I prefer not to mention them by name certainly.

REPRESENTATIVE SAYLOR: That's okay.

JUDGE TURGEON: But, yes, there are other judges who are utilizing this approach. We are all looking for things that work.

REPRESENTATIVE SAYLOR: Have you -- what has been your biggest problems other than funding, because that seems to be a definite problem here we can outline?

What, if any, other problems have you found in trying to institute medical and

psychological counseling for -- and treatment for sex offenders?

JUDGE TURGEON: One problem does relate to the prisoners in the state system. It would -- I have no jurisdiction over defendants who are given a state sentence. Once I have given them their state sentence, they are totally under the supervision of the state probation and parole board.

And I know that I am advised that many of those sex offenders are being kept to their maximum date in prison and then left out cold turkey, so to speak, right back into the community where there is children. They haven't been with children for two or five years. They are then released with no supervision at all into a community with children. And I find that very frustrating.

My preference would be that we develop a system with especially the state supervised people that they start getting treatment in the prison program and then are segued into the community while continuing that therapy and medication.

I think all of your experts would

agree that that is certainly a better approach. It's certainly the approach we have taken with drug addiction. You have some fabulous programs in the county and state prisons across this Commonwealth to treat drug addiction.

And it starts in the prison setting itself, the county and state prisons have that. They start with -- it is cognitive-behavioral therapy. It's group therapy. It's whatever you call it. But they start giving these defendants the tools to deal with their illness, which is addiction. In this case, I'm just dealing with another illness with another name; but it's more destructive, in my opinion, to society.

REPRESENTATIVE SAYLOR: Are you as a judge -- and you will have to excuse my ignorance possibly since I am not an attorney.

As a judge when you sentence somebody to state prison for a sentence that you can make as part of that sentence the requirement that once they are released and have served their time or for parole as part of the sentence that they seek and must have treatment for the disorder?

JUDGE TURGEON: I can include that

in my order, but I have no way of enforcing it or monitoring it.

REPRESENTATIVE SAYLOR: Have you done that at this point? I mean I'm just curious as to whether it has been followed through.

JUDGE TURGEON: I have ordered it with a few state sentences, I believe; but I have no way --

REPRESENTATIVE SAYLOR: Of knowing whether it's being carried out?

JUDGE TURGEON: Correct.

I would assume it is not, because there is no funding available to pay for this treatment for them when released. We've got lots of funded programs for drug addictions, but we don't have programs for mental illness.

REPRESENTATIVE SAYLOR: Thank you, Judge.

CHAIRPERSON BIRMELIN: Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you. And thank you for your thorough treatment. I know the chairman will be glad to know that most of the questions that I had, as you spoke, you answered by the time you got to the end.

But one thing that I'm still having problems with is the difference between -- everyone says the person has to be willing. And you said that in your testimony. And I'm having problems with the idea of willing versus unwillingly when my option is willing, get out of jail, unwillingly, stay in jail.

And kind of related to that is the notion of -- you know, you talked about people agreeing -- that you've had 30 that agreed to the treatment. Of course, only two could take advantage of it, because of the physical costs. But the notion of agreeing to the treatment versus what I hear the medical experts talk about being appropriate for the treatment, are those one in the same?

Now, you are down on a practical level. Have you already had people evaluated for their appropriateness before you asked them whether they will agree to it?

JUDGE TURGEON: No. What my order says is based upon this defendant's agreement to undergo this treatment, if deemed appropriate following evaluation, they will.

REPRESENTATIVE MANDERINO: My only

other question is, you said there are critics of this and we have probably heard from them. We haven't heard from them.

From your review of the literature, etc., who are the critics, either by name or by kind of a general category of who are the critics of this approach and what are their criticisms?

JUDGE TURGEON: The criticisms that I have heard, one, of course, legally you've got the critics who say, You cannot order this. There have been criticisms to the California legislation because it mandates it in every defendant's case who is convicted of the crimes enumerated.

There may be validity in that criticism, because the scientists and the experts and the psychiatrists, based on what I have read, are saying not everybody is appropriate for this. There are some people that this would be inappropriate for: Psychiatrically, they are not a true paraphiliac, or maybe medically they've got liver or heart problems and should not be.

So those critics if we have legislation that says every defendant who commits this crime must undergo this treatment, that

addresses the one issue.

The second issue is many -- and I'm sure you are used to reactionaries to new ideas -- say, oh, no, this is chemical castration, and then react in a visceral way, which is why I was very careful to point out this is not physical castration. This is not chemical castration. This is pharmacological treatment for an obsessive-compulsive disorder.

So you will have reactionaries just reacting to the idea of this as it is twisted in the delivery of the idea to the public.

REPRESENTATIVE MANDERINO: From your review of the literature, have you run across any in the medical community who dispute the use of pharmacological therapy as a part of the approach?

JUDGE TURGEON: The disputes that I am familiar with are over which drug is more effective than the other.

REPRESENTATIVE MANDERINO: And not whether it should be used at all?

JUDGE TURGEON: Right.

REPRESENTATIVE MANDERINO: Thank you. Thank you, Mr. Chairman.

CHAIRPERSON BIRMELIN: Judge, we want to thank you very much for coming. We appreciate your testimony.

Since you are not too far away from the legislature here and as this legislation moves through the legislative process or if it does, you may want to follow it and have some suggestions in the future.

Many of our testimony presenters in the last two days have buttressed what you have said as well, that this can be a very effective tool with some sexual offenders. So it would appear that the legislation is headed in the right direction. It will need to be modified perhaps along the way, but we thank you for your experience and sharing with us the testimony that you gave today. Thank you very much.

JUDGE TURGEON: Thank you.

CHAIRPERSON BIRMELIN: This meeting is now adjourned.

(Hearing adjourned at 12:35 p.m.)

CERTIFICATE

I hereby certify that the proceedings are contained fully and accurately in the notes taken by me during the hearing of the foregoing cause and that this is a correct transcript of the same.

Denise L. Travis, Reporter

Notary Public in and for the Commonwealth of Pennsylvania

My commission expires
April 20, 1998