HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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House Bill 1811

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House Judiciary Committee Task Force
on Civil Commitments

Federal Courthouse
601 Market Street
Philadelphia, Pennsylvania

Monday, August 17, 1998 - 10:15 a.m.

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BEFORE:

Honorable Al Masland, Majority Chairperson
Honorable Dennis O'Brien
Honorable Kathy Manderino

IN ATTENDANCE:

Honorable Jane Orie
Honorable Thomas Caltagirone
Honorable Peter Daley

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1998-100

1 ALSO PRESENT:

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Brian Preski, Esquire
3 Majority Chief Counsel

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David L. Krantz
5 Minority Executive Director

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John Ryan, Esquire
7 Minority Chief Counsel

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C O N T E N T S

WITNESSES	PAGE
Honorable Jane Orie	7
Michael Fisher Attorney General of Pennsylvania	9
Karl Baker, Esquire Defender Association of Philadelphia	22
Mary Ellen Rehrman, Director of Policy Alliance for the Mentally Ill of PA	60
Robert Wettstein, M.D. PA Psychiatric Association	65
Sue Walther, Policy Coordinator Mental Health Assn. of Southeastern PA	75
Randy Undercofler Criminal Justice Policy Specialist Governor's Office	89
Charles F. Curie, Deputy Secretary Mental Health & Substance Abuse Department of Public Welfare	92
Allen Castor, Board Member PA Board of Probation and Parole	100
Diane Dombach, Executive Director Sexual Offender Assessment Board	101
Robert Donatoni, Esq., President-Elect PA Criminal Defense Attorneys	123
Michael Chambers, Executive Director Mental Health/Mental Retardation. Program Administrators Ass'n of PA	143
Michael Engle, Project Director Violent Sex Offender Study Villanova University	155

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

CONTENTS (CONT'D)

Forensic Advocacy Coalition
William Faust, Vice President 176
Ernest Peebles, Board Member 179
Jeffrey Allen, Ph.D. 184

1 CHAIRPERSON MASLAND: Good morning.
2 I'd like to call this hearing to order. We are
3 meeting as a Task Force on Civil Commitment as
4 part of the House Judiciary Committee. We are
5 going to be focusing primarily on House Bill
6 1811, which is prime sponsored by
7 Representative Jane Orie. Before we start with
8 any opening remarks, I'd like the members of
9 the committee to introduce themselves starting
10 with Representative Orie.
11 REPRESENTATIVE ORIE: I'm State
12 Representative Jane Orie from the 28th District
13 out in Allegheny County.
14 MR. RYAN: John Ryan, counsel to the
15 Minority Chairman.
16 REPRESENTATIVE CALTAGIRONE: Tom
17 Caltagirone, Representative from Berks County,
18 City of Reading.
19 REPRESENTATIVE O'BRIEN: Dennis
20 O'Brien, representing the northeast section of
21 Philadelphia.
22 CHAIRPERSON MASLAND: We will also be
23 joined by Brian Preski, Counsel to the
24 Judiciary Committee. I am Al Masland. I'm the
25 representative from Cumberland and York

1 Counties.

2 We have a number of things to
3 consider today. As I mentioned earlier, we'd
4 like to focus on some of the weightier issues
5 because we do have to weigh and balance a
6 number of different factors when considering
7 how to deal with the issue of sexually violent
8 predators. We have to consider first and
9 foremost the safety to the public, but we also
10 have to consider and balance that against the
11 rights of individuals and also the rights of
12 mentally-ill individuals who are in
13 institutions where some of these sexually
14 violent predators may be placed. That's a
15 significant concern, as well as the cost of
16 doing all this.

17 Those are some points that we need to
18 consider. I think those are issues we need to
19 consider with just about any bill. I look
20 forward to hearing the testimony.

21 I think the fact is, no matter how
22 you look at this, we have to address this issue
23 because, even if you look at what the experts
24 say with respect to the situation as sexually
25 violent predators, most experts, the vast

1 majority would say that some should not be
2 allowed out in public. Given that fact, I
3 think we have to try to figure out how we will
4 address the problem when they come to the end
5 of their prison term. Representative Orie's
6 bill, 1811, attempts to do that. I'll allow
7 her to make some opening remarks at this time.
8 REPRESENTATIVE ORIE: Thank you very
9 much, Representative Masland. First, I'd like
10 to thank all the individuals that are here to
11 testify today. Your comments will be extremely
12 helpful in regards to us weighing the
13 information as well as the merits of the
14 legislation. The main purpose of this bill is
15 aimed at stopping sexually violent predators
16 from walking our streets in Pennsylvania.
17 Today is the most crucial issue, getting your
18 input on this issue.
19 As a former prosecutor who
20 specializes in these types of cases, this
21 legislation cannot come soon enough. Too many
22 innocent people are falling prey to violent
23 criminals. The recidivism rate alone speaks
24 volumes and is probably the main impetus behind
25 this type of legislation. Now is the time for

1 us to act, as well as why we are here today. I
2 expect the testimony received today will be
3 valuable as we consider this in the House.
4 I'm sponsoring House Bill 1811 in an
5 effort to stop violent sexual predators in
6 Pennsylvania and keep them off our streets.
7 What is important to note to you is, with the
8 present challenges to Megan's Law, my
9 legislation is vital in protecting women and
10 children throughout the Commonwealth.
11 One of the most important aspects of
12 this legislation is that, this legislation has
13 been upheld by the United States Supreme Court
14 in regards to constitutional challenges. It's
15 a proven entity in regards to combatting
16 sexually violent predators, and it's withheld
17 all legal challenges to it. As I stated, and I
18 can't state it enough, it's a proven entity.
19 That's what's important.
20 Thank you very much for the
21 opportunity to address you, and I look forward
22 to discussing this issue with you much further.
23 CHAIRPERSON MASLAND: Thank you. I
24 see we have been joined by Representative Kathy
25 Manderino from the City and County of

1 Philadelphia. We welcome her to come up front.
2 At this time I'll ask Attorney
3 General Michael Fisher to come forward to
4 present testimony. It's a pleasure to have you
5 here, as always. It's always a pleasure to get
6 your insight.
7 ATTORNEY GENERAL FISHER: Thank you
8 very much, Chairman Masland, and members of the
9 House Judiciary Committee Task Force on Civil
10 Commitment. I want to thank you for providing
11 me this opportunity to provide comment on House
12 Bill 1811, the Sexually Violent Predators Act.
13 I firmly believe as Pennsylvania's Attorney
14 General that this legislation, which provides
15 for the civil commitment of the most dangerous
16 sexually violent predators after they have
17 completed their prison sentences, is a much
18 needed tool to protect the public, especially
19 our children.
20 This legislation offers us a solid
21 crime prevention tool that will make our
22 communities safer and will undoubtedly save
23 lives. This is common-sense legislation which
24 has been enacted by a number of states, I think
25 as of this time 12 other states, and is

1 currently being pursued by dozens more. More
2 significantly, this legislation has been
3 approved by the United States Supreme Court.
4 Consider the case of Leroy Hendricks
5 who was the focus of the United States Supreme
6 Court decision on a Kansas law, which is
7 similar to the legislation that you are
8 considering today. Hendricks had a nearly
9 40-year history of molesting young children.
10 Decade after decade, Hendricks was convicted,
11 imprisoned and released only to prey upon more
12 children, including his own stepdaughter and
13 stepson. Finally in 1994, after Kansas enacted
14 a law allowing for civil commitment of violent
15 sexual predators, the state petitioned to have
16 Hendricks civilly committed upon the expiration
17 of that prison sentence.
18 During Hendricks' trial, the jury
19 heard chilling testimony from Hendricks
20 himself, including how he repeatedly abused
21 children when he was not confined, and that he
22 could not control his urge to molest children.
23 Hendricks stated that the only sure way he
24 could keep from molesting children in the
25 future was to die. The jury unanimously found,

1 beyond a reasonable doubt, that Hendricks was a
2 sexually violent predator, and he was turned
3 over to the control of the State Secretary of
4 Social Rehabilitation Services in Kansas.
5 The Kansas State Supreme Court
6 overturned the jury's decision and the Attorney
7 General of Kansas appealed to the United States
8 Supreme Court, arguing that the law did not
9 violate Hendricks' constitutional rights. The
10 U.S. Supreme Court agreed and upheld the
11 statute finding that the liberty secured by the
12 Constitution of the United States to every
13 person within its jurisdiction does not import
14 an absolute right in each person to be at all
15 times and in all circumstances wholly free from
16 restraint. There are manifold restraints to
17 which every person is necessarily subject for
18 the common good. On any other basis organized
19 society could not exist with safety to all its
20 members.
21 Given that a statute similar to the
22 bill you are considering has been reviewed by
23 the nation's highest court in the Hendricks'
24 case, we know that we are on solid
25 constitutional ground. In fact, the procedures

1 for placing dangerous sexual predators in the
2 custody of the Department of Public Welfare
3 requires a multistep process, culminating in a
4 hearing before a judge and possibly a jury.
5 Let me explain.
6 First, the legislation establishes a
7 multidisciplinary team comprised of mental
8 health and criminal justice experts which will
9 be responsible for reviewing the records of
10 persons convicted of a sexually violent offense
11 prior to their release from prison, as well as
12 those who have been charged with a sexually
13 violent offense but have been found incompetent
14 to stand trial. If the team determines that
15 the person meets the definition of a sexually
16 violent predator, then the original prosecutor,
17 whether it be the Attorney General or the
18 District Attorney, must be notified.
19 The Attorney General or District
20 Attorney would then make a determination as to
21 whether to file a petition with the court
22 alleging that the person is a sexually violent
23 predator. If a petition is filed, the court
24 would hold an initial hearing, in which the
25 offender, with counsel, may appear and call

1 witnesses. The purpose of this hearing is to
2 determine whether there is probable cause to
3 believe that the person is a dangerous sexually
4 violent predator.
5 If the court finds probable cause,
6 the person must be transferred to an
7 appropriate secure facility for an evaluation
8 to be performed by a professionally qualified
9 expert. The purpose of this evaluation is to
10 determine whether a mental health professional
11 considers the person a sexually violent
12 predator.
13 A trial must then be held within 60
14 days of the probable cause hearing to determine
15 whether, beyond a reasonable doubt, that person
16 is a sexually violent predator. The person or
17 the Commonwealth has the right to ask for a
18 jury trial. Indigent persons have the right to
19 the appointment of counsel throughout all
20 stages of these proceedings.
21 For trial purposes a person has a
22 right to have a professionally qualified expert
23 in the field of sexual violence or abuse
24 perform an examination on their behalf.
25 Indigent persons may petition the court to have

1 an evaluation done on their behalf at no cost
2 to them.
3 If the person is determined to be a
4 sexually violent predator, the person must be
5 transferred to the custody of the Department of
6 Public Welfare for civil commitment. DPW must
7 keep the patient in a secure facility and the
8 patient must be segregated at all times from
9 other patients under DPW's control.
10 Additionally, individuals committed
11 under the act would be entitled to an annual
12 review of their mental status. This review
13 includes the right to have a professionally
14 qualified expert examine the committed person.
15 The expert's report must be provided to the
16 court, and the court must conduct a hearing on
17 the mental status of the convicted person.
18 If the court believes that the
19 individual is no longer a threat to the
20 community, the court must have a full hearing
21 to determine if the person should be released.
22 The prosecuting attorney has the burden of
23 showing again, beyond a reasonable doubt, that
24 the person remains a threat and is not safe to
25 be at large.

1 Finally, let me stress that this
2 legislation not only seeks to prevent
3 Pennsylvanians from becoming victims of
4 sexually violent predators, but it also is
5 sensitive to the needs of past victims and
6 their families. Before a person can be
7 released from civil commitment, the Department
8 of Public Welfare would be required to notify
9 the state's victim advocate of the upcoming
10 release. The victim advocate, in turn, must
11 notify the victim or victims in writing that
12 the perpetrator is scheduled to be released
13 from civil commitment.
14 In closing, I want to congratulate
15 Representative Orie for her leadership on this
16 measure and all the other members of the
17 committee and of the House who have been
18 involved in bringing this legislation to the
19 forefront. By enacting this important bill, we
20 can make Pennsylvania a safer place for all of
21 our citizens, but particularly for our
22 children.
23 Mr. Chairman, I'd be pleased to
24 answer any questions that you or members of the
25 task force may have.

1 CHAIRPERSON MASLAND: Thank you very
2 much for your testimony. Thank you for your
3 willingness to answer questions. Let me begin
4 by announcing that we have been joined by
5 Representative Peter Daley, and I'm not sure if
6 he has any questions.
7 REPRESENTATIVE DALEY: No, Mr.
8 Chairman, I don't.
9 CHAIRPERSON MASLAND: Representative
10 Manderino.
11 REPRESENTATIVE MANDERINO: No, I
12 don't.
13 CHAIRPERSON MASLAND: Representative
14 Orie.
15 REPRESENTATIVE ORIE: Yes, Mr.
16 Chairman. Good morning, General. I guess one
17 of the questions that I have, there's been a
18 misnomer with this type of legislation that
19 this would encompass hundreds and hundreds of
20 inmates or people that qualify under this
21 statute. I was wondering, because I know I had
22 worked with you as well as Senator Greenleaf in
23 regards to really determining a factor about,
24 approximately, how many individuals would
25 qualify under sexually violent predator and how

1 many individuals this would really affect in
2 regards to this legislation.
3 ATTORNEY GENERAL FISHER:
4 Representative Orie, I have had the chance to
5 review a report which was done by the State of
6 Washington. It surveyed not only their state,
7 but other states who have had similar
8 legislation in place. That legislation has
9 been in place in Washington's case since 1990,
10 and in the case of other states as recently as
11 1998, the State of Florida. I think also the
12 State of South Carolina.
13 Those states that have responded, for
14 instance, the number of people committed in the
15 State of Washington has been 31. The number of
16 people committed in the State of California
17 since 1986 was 83. So, it does vary,
18 obviously, on the size of the state. It varies
19 on the size of the population, on the prison
20 population.
21 Those are the best statistics on
22 relatively new statutes that have been in
23 place. Also, if you look at the number in
24 California, if you look at California's number,
25 that number committed was like 83 out of 539

1 who were up for release from jail. Maybe 15
2 percent of the California inmates who could
3 have possibly fallen in that category ended up
4 being committed under their civil commitment
5 procedure.
6 REPRESENTATIVE ORIE: One other
7 aspect that I would ask if you could elaborate
8 on as well is in regard to this legislation,
9 it's a civil commitment, but yet they are
10 held -- the prosecution is held to a criminal
11 standard, a much tougher burden in regards to
12 proving that an individual is a sexually
13 violent predator. If you could just briefly
14 allude to that, I would appreciate that.
15 ATTORNEY GENERAL FISHER: The
16 legislation does call for a civil commitment
17 type procedure. I think that's very
18 appropriate, but to provide an additional
19 protection for anyone who would be subject to
20 one of these petitions, the law does require at
21 all stages that the District Attorney or the
22 Attorney General would need to establish that
23 the person is a sexually violent predator
24 beyond a reasonable doubt.
25 It also requires that where the jury

1 is involved that it be a unanimous verdict.
2 Even though this will be a civil procedure, it
3 will be a unanimous verdict to be proven beyond
4 a reasonable doubt, the highest possible
5 standard.
6 REPRESENTATIVE ORIE: I appreciate
7 your comments. Thank you very much.
8 CHAIRPERSON MASLAND: Thank you. I
9 don't believe we have any further questions
10 unless someone has thought of one. Let me
11 thank you, General Fisher, for appearing before
12 us today. We again appreciate your insight.
13 ATTORNEY GENERAL FISHER: Thank you
14 very much, Chairman Masland. As I said, this
15 is a very important piece of legislation. If
16 there is any other assistance that my staff or
17 I can give to this committee or the individual
18 members on this legislation, I consider it a
19 very important one.
20 Obviously, the scope of the laws
21 available to the people of Pennsylvania are
22 much greater than they were years ago. We know
23 we have a Megan's Law. In fact, I will be
24 personally arguing on behalf of the
25 constitutionality of Megan's Law next month

1 before the Pennsylvania Supreme Court, as will
2 a number of different district attorneys across
3 the state.
4 I think we have come a long way in
5 Pennsylvania, but this is one additional step
6 that I believe we need. I hope this task force
7 and the committee will recommend this to your
8 colleagues.
9 CHAIRPERSON MASLAND: Actually, we do
10 have a question. While Brian thought of his
11 question, I thought of one. Maybe you can help
12 us. Some people will be confused as they
13 listen or read about this and think we are
14 talking about Megan's Law. That is something
15 distinctly criminal that happens prior to this
16 civil commitment. If you want to maybe
17 elaborate on that.
18 ATTORNEY GENERAL FISHER: It does.
19 Megan's Law is a law named after young Megan
20 Kanka from neighboring New Jersey, but it
21 provides for criminal penalties for people who
22 have been convicted of sexually violent
23 offenses. In Pennsylvania, the possible new
24 range of sentences could go all the way up to
25 life in prison. It's not a mandatory life

1 term, but it could go up to life imprisonment.
2 Megan's Law, and Pennsylvania law
3 currently, recognizes that at some point unless
4 a person is kept for life that a person would
5 be released, whether they serve their maximum
6 sentence or be released under parole. There
7 are some people, whether it be Mr. Hendricks or
8 others, who have been deemed by other states,
9 and I believe also could exist here in
10 Pennsylvania, who just are not safe to be
11 released to the community. That's why this
12 additional step, this civil commitment would
13 provide that extra level of protection for the
14 people of Pennsylvania.
15 CHAIRPERSON MASLAND: Thank you.
16 MR. PRESKI: I guess just a quick
17 question, General Fisher. As you talk with
18 your other attorney generals throughout the
19 country, you seem to allude to the fact that
20 you have had a few states, and as more and more
21 states have come on board to adopt this type of
22 legislation, do you know if any, or do you have
23 any statistics about the recidivism rates in
24 those states that have already adopted these
25 types of laws? Has sexual offenses gone down

1 there?

2 ATTORNEY GENERAL FISHER: Clearly

3 those people who were deemed to be a threat and

4 were kept in jail, kept in these mental

5 facilities, they are not a threat to those

6 communities. I think it's just too early. I

7 think it's just too early to make a

8 determination on recidivism.

9 Others have said and what you will

10 see is that, most states did not adopt this

11 civil procedure until after the Hendricks'

12 decision of the United States Supreme Court.

13 Many people were waiting for the court to rule.

14 Once they did rule, a number of states have

15 followed suit.

16 MR. PRESKI: Thank you.

17 CHAIRPERSON MASLAND: Thank you

18 again, General Fisher. Our next witness is

19 Karl Baker with the Defender Association of

20 Philadelphia. We have your testimony. As soon

21 as you are ready you may begin.

22 MR. BAKER: Good morning, Chairman

23 Masland, and members of the task force. My

24 name is Karl Baker. I'm on the Board of the

25 Directors of the American Civil Liberties Union

1 of Pennsylvania. I'm also employed at the
2 Defender Association of Philadelphia as the
3 Deputy Chief of their Appeals Division. I'll
4 be speaking this morning on behalf of the ACLU
5 of Pennsylvania and the Defender Association of
6 Philadelphia.
7 As the Deputy Chief of Appeals, I
8 handle appeals from several divisions of our
9 organization. In addition to criminal appeals,
10 our cases come from the Mental Health Unit of
11 our organization and the Child Advocacy
12 Division. Our concerns, therefore, are not
13 limited to protecting the rights of indigent
14 defendants. In our Child Advocacy Division we
15 are charged with representing indigent children
16 in family court in matters involving child
17 abuse, neglect, contested custody, adoption and
18 other matters. We are duty bound to protect
19 their best interests.
20 In our Civil Mental Health Division
21 we represent most respondents in involuntary
22 mental health commitment proceedings in
23 Philadelphia and handle their appeals from
24 administrative and trial rulings.
25 Similarly, the American Civil

1 Liberties Union is not concerned exclusively
2 with the rights of the criminally accused. Our
3 longest running and most complicated and
4 expensive case has involved an effort to
5 protect foster care children in Philadelphia
6 from the myriad forms of abuse that they have
7 suffered as a result of lax supervision by the
8 Philadelphia Department of Human Services.
9 I am pleased to announce that after
10 eight years of litigating the Baby Neal case,
11 the ACLU and the City of Philadelphia recently
12 reached a settlement that will benefit
13 thousands of children in Philadelphia.
14 From our perspective we are greatly
15 concerned that the enactment of House Bill
16 1811, despite its good intentions, would do
17 little to protect children and women from the
18 dangers of sexual assault, and that it would
19 needlessly, unfairly and arbitrarily deprive
20 thousands of individuals of their liberty, at
21 great expense to the state.
22 I am not here before you to argue the
23 constitutionality of the statute, although it
24 would be advisable to heed the warning of
25 Justice Kennedy in the Kansas v. Hendricks

1 case, where he stated that if, and I quote,
2 civil confinement were to become a mechanism
3 for retribution or general deterrence, or if it
4 were shown that mental abnormality is too
5 imprecise a category to offer a solid basis for
6 concluding that civil detention is justified,
7 our precedents would not suffice to validate
8 it.
9 Those cautionary words, which appear
10 in the crucial concurring opinion of that
11 five-to-four decision, suggest that years of
12 litigation lay ahead.
13 Instead, I am before you this
14 afternoon to advocate for the positions taken
15 by the American Bar Association, the New Jersey
16 Commission on the Habitual Sex Offender, and
17 the Task Panel on Legal and Ethical Issues of
18 the President's Commission on Mental Health.
19 Sexual psychopath statutes go back to
20 the 1930's. The first such statute was enacted
21 by the State of Michigan in 1937. Similar
22 statutes soon swept the nation. By the 1950's
23 they were on the books in 12 states and the
24 District of Columbia. In 1970 there was some
25 form of sexual psychopath statute in 33 states

1 and the District of Columbia.

2 In most instances, the enactments

3 followed pervasive publicity surrounding a

4 particularly heinous sexual offense. Starting

5 in the 1930's these sensational crimes became

6 the focus of a new phenomenon, mass media,

7 which of course continues today.

8 Soon after they began to appear,

9 however, these statutes came under sustained

10 criticism. Professor Andrew Horwitz recently

11 commented in the Pittsburgh Law Review that the

12 assumptions relied upon by the legislators who

13 enacted these statutes, and I quote, were

14 quickly assailed as either unproven or patently

15 false. The assumptions which he referred to

16 were that:

17 1, sex offenses were committed by an

18 identifiable class of sexual psychopaths who

19 share a common diagnosis; 2, that sexual

20 psychopaths reoffend at higher rates than other

21 criminals or ordinary sex offenders; 3, that

22 there's a special form of psychiatric treatment

23 that can render this class of persons harmless;

24 and 4, that professionals can predict their

25 future behavior.

1 None of these assumptions has held up
2 over time. Indeed, with regard to future
3 prediction, Professor Horwitz's notes, and I
4 quote, the psychiatric community generally
5 accepted the propositions that psychiatric
6 predictions of long-term future dangerousness
7 are accurate in no more than one in three cases
8 and that the average psychiatrist was not
9 better at predicting future criminality than
10 the average layperson.
11 As a result of continuing criticism
12 and the ineffectiveness of the statutes, states
13 began repealing the statutes in the 1970's.
14 The coalitions which called for the repeal of
15 these statutes were very broad. In Wisconsin
16 not a single witness spoke in favor of the
17 statute during 1979 hearings, and the repeal
18 was adopted by a unanimous vote. By 1990, only
19 11 states and the District of Columbia had
20 sexual psychopath statutes on their books.
21 Although Pennsylvania had such a statute, it
22 had been previously declared unconstitutional
23 by the Pennsylvania Superior Court in 1967.
24 It was in this context that the
25 President's Commission on Mental Health and the

1 American Bar Association considered the
2 question of whether sexual psychopath statutes
3 should receive their support.
4 In 1977 the President's Commission
5 established an interdisciplinary task force of
6 14 members, consisting of doctors, lawyers,
7 administrators, professors, and one patient.
8 The recommendation of that task panel was as
9 follows, and I'll read part of it:
10 Laws authorizing the involuntary
11 commitment of sexual psychopaths and other
12 special offenders, such as defective
13 delinquents, should be repealed.
14 The recommendation goes on further.
15 I have it reproduced in my testimony. I'm
16 providing a copy of that recommendation and the
17 commentary that goes with it as part of the
18 appendix that I supplied to you.
19 In 1983 the American Bar Association
20 established a similar task force headed by the
21 district attorney of Denver, Colorado. That
22 task force contained persons representing the
23 American Orthopsychiatric Association, the
24 American Psychological Association, the
25 American Correctional Association, the American

1 Psychiatric Association, the President's
2 Committee on Mental Retardation, the A.B.A.
3 Section on Criminal Justice.
4 Also participating was the former
5 Deputy Assistant Director of the Inmate Program
6 Services of the Federal Bureau of Prisons. A
7 Pennsylvania member was Doctor Loren H. Roth,
8 Director of the Law and Psychiatry Program of
9 the University of Pittsburgh School of
10 Medicine. I understand we have a doctor from
11 that school who is here today to testify.
12 The recommendation of the task force,
13 which was approved by the House of Delegates of
14 the American Bar Association, as part of the
15 criminal justice mental health standards, is
16 concise and straightforward. The standard
17 declares, it's titled, Repeal of Psychopath
18 Statutes, and I quote: Statutes which provide
19 for special sentencing and treatment of sexual
20 psychopaths or defective delinquents should be
21 repealed.
22 The commentary traces the history of
23 these statutes. After listing the legislative
24 assumptions upon which these statutes rest, the
25 task force notes that these statutes were

1 passed despite the fact that there were, and I
2 quote, few extant data to support these
3 assumptions. It compares the statutes to the
4 eugenicist statutes passed by a majority of the
5 states in the early part of this century;
6 statutes that permitted sterilization of the
7 mentally ill, retarded, criminals and the poor.
8 As with the eugenicist statutes, the
9 sexual psychopath statutes have long been the
10 focus of professional criticism. The
11 commentary lists several of these criticisms
12 citing, for example, the exhaustive study
13 prepared by the Group for the Advancement of
14 Psychiatry, known as GAP. The earlier GAP
15 study asserted:
16 1, that such laws lack clinical
17 validity; 2, that sexual psychopathy is the,
18 quote, meaningless grouping from a diagnostic
19 and treatment standpoint; 3, that treatment
20 offered under the laws has been lacking,
21 inappropriate or ineffective; and 4, that
22 clinicians cannot, and I quote, predict future
23 criminality on the part of released offenders.
24 To these criticisms must be added an
25 earlier and continuing criticism of the

1 legislative assumption that sex offenders
2 present a high rate of recidivism. The most
3 intriguing early example of this criticism is
4 the report of a commission set up by the State
5 of New Jersey; the state from which the latest
6 wave of sexual psychopath statutes has
7 originated.
8 That report contradicts assumptions
9 that were echoed during the legislative debates
10 that accompanied the passage of Pennsylvania's
11 current Megan's Law statute, when members of
12 the legislature assumed that the recidivism
13 rates of sex offenders were between 70 and 90
14 percent.
15 The New Jersey report, however, long
16 ago rejected the assumption that there are
17 overwhelmingly rates of recidivism for
18 assaultive sexual crimes that demonstrate that
19 sex offenders as a group have a compulsive
20 desire to reoffend.
21 In 1950, the report of the State of
22 New Jersey, Commission on the Habitual Sex
23 Offender, drew the following conclusion, and I
24 quote about three or four few sentences:
25 Sex offenders have one of the lowest

1 rates as repeaters of all types of crime.
2 Among serious crimes homicide alone has a lower
3 rate of recidivism. Careful studies of large
4 samples of sex offenders show that most of them
5 get in trouble only once. Of those who do
6 repeat, a majority commit some crime other than
7 sex. Only seven percent of those convicted of
8 serious crimes are arrested again for a sex
9 crime. Those who recidivate are
10 characteristically minor offenders, such as
11 peepers, exhibitionists, homosexuals, which of
12 course was illegal back then, rather than
13 criminals of serious menace.
14 An article in 1955 by a member of the
15 commission, Paul W. Tappan, discussed many of
16 the myths that were prevalent at the time and
17 which remain prevalent today. I'm providing a
18 copy of that article in the appendix that I
19 provided.
20 Notably, recent government statistics
21 continue to bear out this same conclusion. A
22 report released by the Bureau of Justice
23 Statistics in 1989 declared that rapists
24 released from state prisons exhibited the
25 second lowest rate of rearrest for the same

1 offense of all criminals evaluated in that
2 major study, which covered approximately a
3 hundred fifty thousand people released from 11
4 state prisons in 11 different states. The rate
5 reported in the study was 7.7 percent. Only
6 released murderers had a lower rate of arrest
7 for the same crime, which was 6.6 percent. In
8 contrast, thieves had a rearrest rate of 35.5
9 percent for theft; burglars had a 31.9 percent
10 rearrest rate for burglary.
11 While it is true that released
12 rapists were more likely to recommit the crime
13 for which they were incarcerated, the same was
14 true of those released for larceny, fraud and
15 other crimes. Thus, the report stated that, I
16 quote: Released prisoners often rearrested for
17 the same type of crime for which they have
18 served time in prison. In contrast to thieves,
19 however, the rate at which former rapists were
20 rearrested for that crime occurred at a
21 remarkably lower rate.
22 Even more startling, however, were
23 findings of a subsequent Justice Department
24 study involving persons released on probation.
25 Since the prior record of persons released on

1 probation tends to be lower than those
2 sentenced to prison, it follows that their
3 subsequent rate of recidivism tends to be
4 lower. In this study, however, persons
5 released on probation for rape had the lowest
6 recidivism rate of all offenders, 2.9 percent.
7 In contrast, probationers released
8 for homicide, and that presumably homicide by
9 vehicle, had their rate of recidivism reported
10 at 4.9 percent. Once again, the highest rates
11 of recidivism were for burglary, at 17.2
12 percent, and robbery at 17.3 percent.
13 It's a fair question to ask whether
14 pedophiles present higher recidivism rates than
15 other rapists and sex offenders. The answer to
16 this question may be obtained from a major
17 retrospective study conducted by a team headed
18 by Doctor Fred Berlin, Director of the Johns
19 Hopkins Hospital Sexual Disorders Clinic in
20 Baltimore. That study is, quote, a Five-Year
21 Plus Follow-Up Survey of Criminal Recidivism
22 Within a Treated Cohort of 406 Pedophiles, 111
23 Exhibitionists and 109 Sexual Agressives:
24 Issues and Outcome. That's the title of the
25 report.

1 It focused on 626 male patients who
2 were assigned to the clinic during a 12-year
3 period, mostly while they were on parole or
4 probation. Many of them refused or failed to
5 complete the treatment program. Compliant and
6 noncompliant patients were separately analyzed.
7 The data analysis provided for statistical
8 consideration of a mean period at risk of 5.12
9 years. The report summarized the results as
10 follows:
11 Results: Sexual recidivism for the
12 group of 406 pedophiles was 7.4 percent.
13 Pedophiles discharged from the clinic as
14 treatment compliant had a 2.9 percent sexual
15 recidivism rate. The sexual recidivism rate
16 for the group of 111 exhibitionists was 23.4
17 percent; treatment compliant exhibitionists had
18 a 12.5 percent sexual recidivism rate.
19 Exhibitionists who did recidivate generally did
20 not commit more serious sexual offenses.
21 The sexual recidivism rate for the
22 group of 109 sexual aggressives, men who had
23 sexually assaulted women, was 4.6 percent;
24 treatment compliant aggressives had a 2.8
25 percent sexual recidivism rate. Those are

1 people who are treated while outside of a
2 commitment setting, outside of prison, outside
3 of a mental institution, while they were on the
4 street.
5 One remarkable conclusion of this
6 study is that, sexual aggressives and
7 pedophiles who completed the community-based
8 sexual offender program had almost identical
9 rates of recidivism; 2.8 percent and 2.9
10 percent. Commenting upon the beneficial effect
11 of treatment, the report concludes that,
12 recidivism rates following clinic discharge
13 could have been reduced even further for
14 noncompliant patients had their probationary
15 status been violated, with ensuing
16 incarceration, when the clinic reported lack of
17 cooperation to probation officers.
18 Unfortunately, the current
19 legislative and correctional response to this
20 problem is counterproductive. As a recipient
21 of hundreds of letters from state prisoners, I
22 know for a fact that the vast majority of sex
23 offenders are being held to, at or near their
24 maximum number on two to ten, five to 20-year
25 sentences.

1 Rather than place them in the
2 community under supervision and with treatment,
3 they are held at tremendous public expense, and
4 at the expense of their liberty. When they are
5 eventually released, these bitter individuals
6 will be under no supervision. That was the
7 case with Jessie Commendagaust (phonetic), who
8 was held until his maximum, released into the
9 community with no supervision where he lived
10 with two other sex offenders.
11 Those who have been declared sexually
12 violent predators under the current
13 Pennsylvania statute will be subject upon
14 release to a schizophrenic response by a
15 community that wants to drive them out of their
16 homes and places of employment, while demanding
17 that they receive treatment. How can a society
18 reintegrate an offender, while at the same time
19 forcing him or her to remain a pariah and to
20 wear a scarlet letter?
21 We urge this committee to reexamine
22 the assumptions that have led to the enactment
23 and repeal of this type of legislation in the
24 past. We are confident that a more appropriate
25 way to protect the safety of the community

1 would be to:

2 1, provide incarcerated offenders

3 with appropriate counseling early during their

4 confinement; 2, parole them in sufficient time

5 to provide a transitional period of community

6 supervision; and 3, provide sufficient

7 resources to assure that paroled offenders

8 receive appropriate counseling, where

9 necessary, and specialized parole supervision.

10 The proposed legislation would

11 initiate a system in our Commonwealth

12 strikingly similar to the network of asylums

13 that were used in the former Soviet Union to

14 incarcerate social misfits, persons perceived

15 to constitute a future danger.

16 By legislating psychiatric diagnoses

17 such as mental abnormality, authorizing the

18 imprisonment of the mentally abnormal, and

19 replacing wardens with doctors, this

20 legislation will surely transform the image of

21 our psychiatric profession into that of its

22 former Russian equivalent, to its great

23 discredit.

24 We urge you to reject the approach

25 taken by House Bill 1811. Thank you.

1 CHAIRPERSON MASLAND: Thank you, Mr.
2 Baker. Questions from members? To my left.
3 Representative Manderino.
4 REPRESENTATIVE MANDERINO: Thank you
5 for your testimony and for providing the
6 background material which I will read. One of
7 the things I guess perplexes me a little bit
8 about all of these numbers with regard to
9 recidivism is the following:
10 I'm correct in assuming that a
11 calculation of recidivism rate comes from when
12 we know the person has again violated the law;
13 when they have gotten caught.
14 Again, this may be one of those
15 assumptions that may or may not have any
16 validity to it, but I am wondering with regard
17 to everything that I hear about, particularly
18 about sexual predators, about how few are
19 caught and how underground the activity is.
20 Then I look at statistics that say,
21 well, the recidivism for sexual predators is at
22 six or seven percent and for a property crime
23 might be at 30 or 35 percent. My gut reaction
24 says to me, well, a property crime might mean I
25 lose my car, but it certainly is not as

1 violative and violent of the person as the
2 crime of a sexual predator.
3 Having known that, I guess I'm asking
4 questions about what's going into these
5 recidivism rates, and is that really a fair --
6 Either tell me why you think that's a fair way
7 for me to evaluate this if you do think it is
8 because, I'm not real sure if that's a good way
9 to evaluate and compare the effectiveness of
10 either treatment or for further mental care.
11 MR. BAKER: There's many studies that
12 have dealt with the question of recidivism.
13 This study, for example, which is a retrospect
14 study and a study by Doctor Fred Berlin takes
15 into account not only the persons that pass
16 through his clinic, but also reviews a variety
17 of various different other studies. Those
18 studies calculate recidivism rates in a number
19 of different ways. Certainly, some reports
20 calculate them on the basis of rearrest rates.
21 But, any number of other studies look to other
22 factors also, self-reporting, and other
23 indications of violation, simply rearrest.
24 It's sometimes difficult, and I'm not
25 going to represent that it's possible to put an

1 exact figure upon recidivism rates. All we can
2 try to do is get a fair sense by taking a look
3 at the statistics that have been prepared from
4 the various different studies, and there have
5 been many, and look at the factors that they
6 consider in determining recidivism.
7 But, it's true that you can't
8 determine all violations in any of these
9 crimes. And it is a problem that is true for
10 people who commit robbery, for the people who
11 commit theft, for the people who commit
12 aggravated assault, and also for people who
13 commit sex crimes. It's not always possible to
14 determine whether they'll commit the offense
15 again.
16 Many of these studies, and again
17 there have been hundreds of them, have tried to
18 take those into consideration in terms of
19 dealing with self-reporting and other methods
20 of determining recidivism rates. I'm not going
21 to represent that there is one set figure.
22 But, taking a look at all of these studies, the
23 pattern repeats over and over again and tends
24 to show that the recidivism rates of sex
25 offenders as a group tend to be amongst the

1 lowest.

2 The studies that were conducted by
3 the New Jersey Commission in the early 1950's,
4 it wasn't one study. It was a review of many
5 different studies that have taken place. That
6 pattern continues to today. In fact, there is
7 a stereotype within society that's been often
8 repeated that sex offenders have the highest
9 recidivism rate. In fact, it appears not to be
10 the case. This should be taken into
11 consideration. Not to say that there are
12 individuals who continually repeat their
13 crimes, both in this area and others.

14 Those people, from my point of view,
15 should be treated as habitual offenders.
16 Whether it's sex offenders or other offenders,
17 they should be treated as habitual offenders.
18 There are laws on the books in this state and
19 in most states across the country that deal
20 with habitual offenders and provide for far
21 more harsh treatment.

22 The problem with a case like
23 Hendricks is that, that person could have been
24 sentenced under an habitual offender statute.
25 Instead, the district attorney chose to enter

1 into a plea bargain and gave him a short
2 sentence. The result is clear.
3 Then they turn to a commitment,
4 quote, civil commitment proceeding to deal with
5 a problem that was created by the district
6 attorney's plea bargain. It creates a serious
7 situation when you are mixing civil commitment
8 and criminal proceedings, and that serious
9 problem is one that Justice Kennedy speaks to
10 in his very short concurring opinion. It
11 specifically refers to the problem that's
12 created by a district attorney who enters into
13 a short plea bargain for a short sentence in a
14 very serious case dealing with an habitual
15 offender, and then turns to the civil system to
16 fix what the district attorney broke.
17 REPRESENTATIVE MANDERINO: I share
18 your concern with regard to how the current
19 system works with offenders serving their
20 maximum penalties in prison so that there is no
21 transition into the community. I'm talking
22 broadly; not just with sexual predators, but
23 for any number of things.
24 Given that as background, that
25 reality or at least that that happens more

1 often than I guess we would hope that it would;
2 not necessarily the serving of the maximum, but
3 the return to community without any kind of
4 transition or reintegration, when the A.B.A.
5 House of Delegates Criminal Justice Task Force
6 made their recommendation for the repeal of
7 psychopath statutes, was there any more to it,
8 any other background, any other parts that
9 dealt with, if we are going to repeal, these
10 are the kinds of reintegration factors,
11 treatment factors, probationary status that we
12 should have? Can you address that issue?
13 MR. BAKER: Yes. When the task force
14 came up with its recommendation, it was part of
15 a larger effort that put out a set of standards
16 essentially an inch and a half thick dealing
17 with the mental health standards as a broad
18 area. This particular task force did not
19 suggest this as part of its recommendation,
20 alternative approaches. But, what it did do
21 was, it reviewed the history of these types of
22 statutes, the effectiveness or ineffectiveness
23 of them, various different constitutional
24 problems which have cropped up, the fact that
25 many of these statutes have been overturned and

1 the criticisms that have been raised. On the
2 basis of that they gave the recommendation.
3 If we take the look at the
4 President's Commission on Mental Health, that
5 task force, they did make some further
6 recommendations as to how this problem should
7 be handled. I didn't read that in my testimony
8 just to cut down the length of it. It is there
9 in the testimony, and it's a short commentary
10 there also.
11 REPRESENTATIVE MANDERINO: Thank you.
12 Thank you, Mr. Chairman.
13 CHAIRPERSON MASLAND: Thank you.
14 Representative Orie.
15 REPRESENTATIVE ORIE: I have a couple
16 questions. First of all, in regards to the
17 studies that you are quoting, your opposition
18 is that they lump all these sexual offenders
19 together and then they provide statistics about
20 recidivism; but yet, these task forces that you
21 are quoting have done the same thing, whether
22 it's exhibitionists or whomever. They are
23 being lumped together into determining
24 recidivism rate.
25 Is there any reason why you accept

1 those type of statistics versus the other ones,
2 how they lump them together in other
3 situations?
4 MR. BAKER: Actually, they did not
5 lump those together. In a report that was
6 chaired by Doctor Fred Berlin, they separated
7 those out so that they got a better sense of
8 what the recidivism rates were for the various
9 different types of persons; for pedophiles,
10 sexual aggressives, for exhibitionists, et
11 cetera. One reason that they did separate them
12 out was that there were different recidivism
13 rates. The exhibitionists, apparently, and the
14 peepers seemed to have far greater recidivism
15 rates than the others, than the persons who had
16 committed far more serious offenses. So, they
17 did separate those out.
18 With respect to the Bureau of Justice
19 Statistics' studies, they were dealing with
20 people who had committed felonies. They
21 weren't looking at exhibitionists or peepers.
22 They were dealing with people who went to state
23 prison or who were placed on probation and
24 parole for more serious offenses.
25 REPRESENTATIVE ORIE: Any type of

1 felony dealing with sexual offense; is that
2 correct?
3 MR. BAKER: Pretty much.
4 REPRESENTATIVE ORIE: My other
5 question is, as a prosecutor who had tried
6 these cases, sometimes you find these
7 individuals and they have histories, whether
8 it's an incestual relationship for generation
9 after generation after generation and probably
10 within one family maybe 10 to 15 victims.
11 In regards to the recidivism, this
12 isn't what's brought out in them. It's the one
13 offense that they're being prosecuted for; not
14 the history that comes along with these
15 individuals or even individuals that do not get
16 caught until a certain period of time after
17 they have gone. As a prosecutor I have had
18 those cases where they have had close to 60 to
19 70 victims. They are not included, but yet
20 that's recidivism. That's a victim, victim,
21 victim, victim.
22 How do you justify the number of
23 victims that are associated with the
24 individual? This is not accurate of that
25 either. Would you agree with me on that?

1 MR. BAKER: I would agree with you
2 that the majority of sex offenses against
3 children are not committed by strangers. But,
4 in fact, the majority of sex offenses against
5 children are committed by members of their
6 family or close relatives. This is something
7 that is borne out again by the Bureau of
8 Justice statistics. It's a separate report
9 that I have not placed in here that indicates
10 that perhaps as high as 75 percent of those
11 crimes are crimes that are committed within the
12 family. It does reflect the fact that,
13 perhaps, generation after generation there has
14 been abuse, and there has not been an
15 intervention within those families to halt that
16 process.
17 In the original statutes, and this
18 statute is very similar to the one in
19 Washington State, they tried to deal with
20 people who were not the classic family member
21 in terms of increasing their punishment or
22 placing them in commitment. That's why they
23 added the phrase predator, sexual violent
24 predator.
25 The definition for predator, which is

1 in the original Washington statute, was carried
2 over to the Kansas statute, is incorporated
3 into the Pennsylvania statute, specifically
4 talks about a relationship established with
5 someone for the primary purpose of sexual
6 exploitation. It was written by a committee
7 that wanted specifically to exclude family
8 members because they didn't want to deal with
9 the family through these sexual psychopath
10 statutes. They felt it was better to have
11 intervention into the family through a family
12 core and through counseling, rather than to use
13 these sexual psychopath statutes, which their
14 use would be to the detriment to the family.
15 What I suppose I'm saying, at least
16 in response to part of your question, is that,
17 there is a significant problem in terms of many
18 families in this country where there is a
19 history of abuse. That abuse is repeated
20 against a family member time after time. We
21 can refer to that as recidivism, or you can
22 refer to it as an incestual relationship. I
23 suppose that the recidivism statistics don't
24 pick up that incestuous relationship and say
25 that it's a recidivism rate of a hundred. They

1 view that as an incestual relationship.
2 Outside of this family situation,
3 many of the sexual offenses that occurred as
4 indicated by the New Jersey Commission were
5 committed by people who only commit the offense
6 once. Sometimes they have actually committed
7 it several times, but when they are arrested
8 and punished by the law, the effect in most
9 instances is to deter the person from
10 committing it again. That's the purpose of
11 criminal law, to deter.
12 The studies apparently show that in
13 these situations where an offense occurs
14 outside of the family, the recidivism rates are
15 far lower. Those apparently are the types of
16 crimes which these statutes of late have
17 attempted to focus on.
18 REPRESENTATIVE ORIE: I'll just
19 reemphasize my point that, the recidivism,
20 whether it's within the family or it's outside
21 of the family--I'm thinking pedophiles--it is
22 not the number of victims or the history that
23 led to that prosecution. Those are not
24 included in regards to recidivism. You
25 yourself indicated that within the family it's

1 called an incestual relationship from that
2 perspective versus on recidivism rates, which
3 to me is nonsensical.
4 My other point would be along the
5 lines, would you then on your stance in regards
6 to this type of situation, would it be accurate
7 for me to say that you also oppose the Megan's
8 Law version in Pennsylvania as well then?
9 MR. BAKER: The Megan's Law version
10 in Pennsylvania is a statute that is almost
11 identical to the one that was enacted in 1952
12 and which was struck down by the Third Circuit
13 Court of Appeals, the Superior Court in 1967, a
14 year after the United States Supreme Court had
15 struck down an identical statute out of
16 Colorado.
17 So, yes, I oppose that statute. I
18 think it's unconstitutional for a variety of
19 reasons. It's nearly identical to one that was
20 stuck down by three different courts, two in
21 this jurisdiction, the Third Circuit and the
22 Superior Court and the United States Supreme
23 Court.
24 REPRESENTATIVE ORIE: I just want to
25 make it clear for the record, your point of

1 view, at least in regards to your testimony,
2 that these individuals should be released
3 earlier from their parole and have a
4 transitional period within the community. In
5 essence, you are deferring to these individuals
6 who even --
7 I have a report from the American
8 Psychiatric Association, the task force report
9 where they themselves indicate--and this is
10 back on December 15th of 1996--that they don't
11 know enough themselves as an organization, or
12 as an association, that they haven't had the
13 time nor opportunity to review these
14 individuals. They don't know what treatments
15 are appropriate, what to do, but yet it's your
16 opinion that's the best route to take right
17 now.
18 MR. BAKER: What I'm referring to is
19 a situation where a judge has a case before him
20 or her. There's a conviction either by the
21 judge or a jury. The judge decides to impose a
22 sentence of, let's say, two to ten years or two
23 to 15 years. The judge's thinking is, this
24 person should spend two or three years in
25 prison, and there should be a period of

1 supervision. That's the judge's thinking.
2 Many of these sentences have been opposed.
3 At present the State Parole Board is
4 holding most of these people for an extended
5 period of time, either two or to near their
6 maximum. That's the reality of the situation.
7 Anybody will tell you that that's the
8 situation. I think that's wrong. That wasn't
9 the intention of the original judge. It
10 doesn't serve the interest of the state. It
11 doesn't serve the intention of the judge. It
12 does a disservice to the community to hold this
13 person for this long period of time when the
14 origin intention was two or three-year jail
15 sentence and then place them out on the street
16 without that supervision. The judge imposed
17 that period of extended supervision for the
18 purpose of allowing the person to make a
19 transition. If that's not utilized, then we're
20 missing an opportunity.
21 There are other individuals who
22 commit horrendous crimes who are given
23 extremely long prison terms that may never see
24 the light of day. The judge gave that sentence
25 because the judge felt that the person should

1 not be released, period.

2 Now, both of those types of

3 sentences are being treated the same way. It

4 simply doesn't make sense. If the original

5 judge thought the person should get 20 to 40

6 years, then that person has got to be in for a

7 long time. If the judge thought the person

8 should get two to 15 years, then the person

9 should be out on the street after several years

10 under a period of close supervision because it

11 will benefit the individual and society to

12 reintegrate that person into the community.

13 REPRESENTATIVE ORIE: Because of time

14 delay, I would welcome the opportunity to sit

15 down and discuss with you further, because even

16 on those points I would like to follow up.

17 I'll take that opportunity on my own. Thank

18 you.

19 MR. BAKER: Thank you.

20 CHAIRPERSON MASLAND: Thank you,

21 Representative Orie. We could probably -- Each

22 of you probably have much lengthier debate but

23 we have to save that for another time. I just

24 want to kind of clarify the last point that she

25 was making. Your recommendations don't really

1 get to the situation that she was saying of
2 those people that should not or cannot be
3 reintegrated into society.
4 I believe your position is, there
5 are some people, you would agree, that should
6 not be allowed back in society but that they
7 should be sentenced to the maximum or to a
8 life-type sentence to begin with. You are not
9 saying that there are not some people who
10 should not be reintegrated; is that correct?
11 MR. BAKER: There are some very bad
12 people out there. The laws that are on the
13 books provide the judiciary with the tools to
14 sentence them for very extensive periods of
15 time. As an attorney of the Defender
16 Association, we have seen some of those. We
17 have seen habitual offenders that we have
18 represented who were convicted, who were put
19 away -- one recently, for example, who received
20 a minimum sentence of 162 years. I'm not going
21 to say that was inappropriate in that
22 particular case. But, the tools were there to
23 impose that type of sentence.
24 But, where a judge imposes a
25 sentence, a short sentence of imprisonment and

1 a long tail for supervision, then that should
2 be respected. It's better not to dump the
3 person out on the street after that maximum
4 sentence has been completed.
5 CHAIRPERSON MASLAND: I know we could
6 talk about statistics a lot, and there's going
7 to be somebody testifying later, but I saw a
8 study that you may touch on that was done with
9 the Association for the Treatment of Sexual
10 Abusers where they basically asked experts what
11 they thought. When asked a question, one
12 statement was, it is not safe to release some
13 sexual offenders into the community after their
14 period of incarceration and treatment has been
15 completed. 88.3 percent agreed with that.
16 Thirty-eight percent agreed and 50.3 percent
17 agreed strongly. These are the people that are
18 trying to treat these individuals.
19 I guess my point is, pretty much
20 everybody agrees there are some people that
21 shouldn't be allowed back. We are tying to
22 deal with that situation because not all those
23 cases, I don't believe, are handled at the time
24 of sentencing. We have to have some other way
25 to handle some of those cases that weren't

1 appropriately handled then.

2 I know our counsel has some

3 questions. I don't what to get in long debates

4 on this. I'll turn it over to him.

5 MR. PRESKI: Just one question, Mr.

6 Baker. When you talk about the parole,

7 basically I guess what -- if I could paraphrase

8 it, what you have said is that, the parole

9 board is somehow absconding with the judge's

10 original intent by keeping people in even

11 though the judge has placed this long tail for

12 reintegration into society.

13 You would agree though that, one,

14 there's no absolute right for a defendant to

15 parole; two, I guess that the judge, if they

16 wanted to, could have sentenced to a lesser

17 sentence. I guess the third thing is, there is

18 other factors when someone is being considered

19 for parole or while they are incarcerated that

20 may keep them in there longer than what the

21 judge had originally envisioned.

22 MR. BAKER: Yes, I agree. The parole

23 board does have to have a certain degree of

24 discretion to take into consideration what they

25 have learned about the individual. A part of

1 that has to do with whether they have entered
2 the treatment programs and completed them
3 successfully.
4 What I'm speaking to, my experience
5 is that, there is now recognized -- I think
6 most people who are familiar with this will
7 agree that almost across the board sex
8 offenders are now being held close to or near
9 the maximum, whether or not they have completed
10 all of their counseling programs and have done
11 everything that they were supposed to do.
12 That's simply a reflection of the current
13 political climate.
14 It's not what the judge originally
15 intended. They intended that there be a short
16 prison term and that there be a longer period
17 of supervision; that the parole board exercise
18 some discretion, but not that they have this
19 policy that keeps these people in for extended
20 periods of time to near their maximum. Not
21 only is it depriving the individual of his or
22 her liberty contrary to the origin intention of
23 the judge, but it does a disservice to the
24 society to dump somebody on the street after
25 they have done their maximum and not allow them

1 that period of reintegration where they are
2 under a period of supervision.
3 MR. PRESKI: Mr. Baker, couldn't a
4 judge make sure his original intent in
5 sentencing was carried out to a sentence of
6 lesser time?
7 MR. BAKER: No. A judge could
8 certainly -- Under Pennsylvania law, a judge
9 can't impose a sentence of incarceration which
10 is more than half the maximum. In many
11 instances their intention is to have a period
12 of supervision. They cannot, however, impose a
13 flat sentence which will then force the parole
14 board to put someone on the street.
15 I'm not saying that that alternative
16 is a good alternative. I don't think it's a
17 good alternative. I think it's better that we
18 have a situation where there is a period of
19 incarceration followed by a period of parole.
20 MR. PRESKI: Thank you.
21 CHAIRPERSON MASLAND: Thank you, Mr.
22 Baker.
23 MR. BAKER: Thank you.
24 CHAIRPERSON MASLAND: We are going to
25 panelize a few people here so we can try to

1 proceed a little bit more speedily, although we
2 are not that far behind.
3 We will have next Mary Ellen Rehrman
4 from the Alliance for the Mentally Ill. She
5 will be joined by Doctor Robert Wettstein from
6 the Pennsylvania Psychiatric Association, and
7 Sue Walther of the Mental Health Association of
8 Southeastern Pennsylvania. If you would like
9 to all come up front at this time, what we'll
10 do is, we'll just go in that order, Ms.
11 Rehrman, Mr. Wettstein, and then Ms. Walther.
12 After that we will ask some questions.
13 As I mentioned earlier--some of you
14 may not have been here--if you can focus on
15 your most salient points, then we'll get to
16 questioning. That will help us keep things
17 moving. Thank you.
18 MS. REHRMAN: Thank you for this
19 opportunity to address your concerns. I did
20 submit written testimony. In my oral testimony
21 I'd like to focus a little differently and add
22 some additional recommendations for you to
23 consider. I want to focus on Section 7(d),
24 page 9, secure facilities. It's not what the
25 bill says; it's what the bill does not say.

1 You're committing sexual violent predators to
2 the Department of Public Welfare and you're
3 assigning the cost to the Department of Public
4 Welfare.
5 What remains in question is, which
6 office in the Department of Public Welfare for
7 the control, care and the treatment of sexually
8 violent predators? Will it be a new office or
9 will it be an existing office; the Office of
10 Children and Youth, the Office of Mental
11 Retardation, the Office of Mental Health and
12 Substance Abuse Services?
13 Which facilities are you going to
14 commit people to for the control, care and
15 treatment of sexually violent predators? Is it
16 going to be a new facility? Is it going to be
17 on the grounds of existing facilities? Is it
18 going to be placed at Norristown, Allentown
19 State Hospital, Clarks Summit State Hospital,
20 Danville State Hospital, Warren State Hospital,
21 Mayview State Hospital? Or, is it going to be
22 at South Mountain where we have mentally ill
23 nursing care? Are those people going to be
24 moved again? Are they doing to be placed
25 commingled with sexually violent predators? It

1 won't be Harrisburg because you need that for
2 state office workers.
3 CHAIRPERSON MASLAND: You've got to
4 watch how you phrase that. There's no
5 objection heard.
6 MS. REHRMAN: They're full of state
7 office workers. Or, will it be a vacant
8 facility? Will it be Byberry? Will it be
9 Philadelphia State Hospital in Northeast
10 Philadelphia? Will it be at Haverford State
11 Hospital, recently closed on the mainline?
12 Where are we going to put this?
13 The appropriation -- You know, in the
14 Senate hearings I heard the Deputy Secretary
15 for Mental Health, who I assume is going to be
16 the office that's going to be given this prize,
17 addressed the funding issues. Will there be
18 new funding? Are we going to use existing
19 funding? Are we going to shift around funding,
20 funding that we already have a population that
21 needs.
22 Both the Office of Mental Retardation
23 and the Office of Mental Health Substance Abuse
24 Services are continuing to implement plans,
25 plans that the families and consumers

1 themselves, the counties, the state, the
2 psychiatrist, we all agreed must happen; and
3 that is, to transfer people and the funding
4 from our institutions to the community, to care
5 for people with serious mental illness.
6 If we don't have that money
7 transferred with the people, we're going to be
8 likely to have more people such as Russell
9 Weston in an incident in Congress.
10 You've got to understand that 90
11 percent of the institutions' funding, well over
12 90 percent of the institutions' funding is for
13 staff, so you have to move the people in order
14 to get that money to go to the community to
15 help serve and care for that person and treat
16 them. If we put more people in there, if we
17 put a whole new population of sexual violent
18 predators, we can't get rid of that staff. The
19 staff remains. Therefore, there's no money
20 that can be transferred to care for people who
21 are more appropriately treated into the
22 community. It stops that whole process for
23 persons with brain disorders who are treatable,
24 but do need continuing community care and
25 oversight.

1 I'd like to recommend that you do
2 look at the sentencing guidelines, revisit
3 them, on certain language in Section 7(d) that
4 excludes the Office of Mental Health from
5 the --
6 THE COURT REPORTER: Section 70 or
7 7(d)?
8 MS. REHRMAN: 7(d). I don't see a
9 fiscal note, and I'd like to see an
10 appropriation and new money.
11 House Bill 1811 creates further
12 confusion in the public's mind by blurring the
13 distinction between sexually violent predators
14 and the seriously mentally ill. We have stigma
15 enough. There's enough confusion out there in
16 the community. If people think someone with
17 serious mental illness is really a sexually
18 violent predator moving next door, it's not
19 going to happen. It's just going to be very
20 damaging, and it also impacts on people's
21 recovery. I mean, to be seen in the same
22 light. Okay?
23 I doubt that families will encourage
24 people or people themselves will be encouraged
25 to get into treatment. They are going be

1 confused with these diagnoses. Civil
2 commitment of sexually violent predators may be
3 politically attractive, but in the long run,
4 and even in the short run, it's wrong. It's
5 going to be poor public policy. Our prisons
6 have made poor, poor mental hospitals. If this
7 bill goes as unamended, our state hospitals are
8 going to be poor prisons. Thank you.
9 CHAIRPERSON MASLAND: Thank you.
10 Doctor Wettstein.
11 DOCTOR WETTSTEIN: I thank you for
12 the opportunity to be here this morning. I'm
13 speaking on behalf of not only myself, a
14 psychiatrist, but also the Pennsylvania
15 Psychiatric Society which is a statewide
16 organization of 2,000 psychiatrists in
17 Pennsylvania.
18 I have personally 20 years of
19 experience in evaluating and treating sex
20 offenders. I have also been involved in the
21 scientific study of the prediction of dangerous
22 and mentally-ill individuals. I have provided
23 to you a copy of the law review article that I
24 wrote on the Washington statute, which I hope
25 you'll take a look at some point. It was cited

1 by the U.S. Supreme Court in the Hendricks'
2 case.
3 Obviously, there's a lot of material
4 in there that I'm not going to talk about this
5 morning. I would like to draw your attention
6 to some of the conceptual problems regarding
7 the predator statutes and also talk
8 specifically about the present bill.
9 The first conceptual problem here is
10 that, sexually violent predators cannot really
11 be widely distinguished from other types of sex
12 offenders. We talk about predators as if we
13 know that they exist. This is clearly just a
14 legislative term or a judicial term at this
15 point. It is not a clinical term; it is not a
16 scientific term. This is something that has
17 been derived outside of the scientific realm.
18 Sex offenders are a very
19 heterogeneous group of people. They are not
20 all the same. People talk about them as if
21 there is one kind of sex offender, but there is
22 more differences than similarities. There are
23 differences in their skills and their deficits,
24 their symptoms and their sexual arousement
25 pattern and their histories and in their

1 diagnoses.

2 It's also a mistake to use this
3 concept in the bill of a mental abnormality.
4 Again, that's not a clinical term. That does
5 not exist in the established psychiatric
6 criteria, which I'll refer to as the DSM
7 criteria, the Diagnostic and Statistical Manual
8 criteria. Mental abnormality again is a
9 legislative fiction. It's not a scientific
10 term. Mental abnormality is so broad, so vague
11 and so overinclusive that we no longer are
12 identifying a specific target, a population of
13 predators with a wide range of a group of
14 individuals.

15 When you have such a broad group,
16 broad criteria, there's going to be very little
17 agreement between different examiners or
18 different evaluators as to who really is a
19 predator. This is referred to as diagnostic
20 liability or inter-rater (phonetic) liability,
21 so that, instead of having a very high
22 liability like 70 or 80 percent agreement that
23 someone is or isn't a predator, you're going to
24 have very low liability because the target
25 population is so poorly defined.

1 There is, therefore, going to be a
2 great deal of inconsistency in the outcome of
3 these cases, and not only the judges but the
4 experts are going to have a great deal of
5 problem in coming to some concensus about who
6 really fits into this mold.
7 The terminology in the bill of
8 someone being a menace to the health and safety
9 of others, that too is very broad and very
10 vague. I don't know what that means.
11 Scientifically or clinically to say someone is
12 a menace, that's not a scientific or a clinical
13 or diagnostic term. That's my first point;
14 that we really can't reliably distinguish
15 predators from nonpredator sex offenders.
16 Even more than that, though, is the
17 problem with predicting long-term behavior in
18 individuals. No psychiatrist or psychologist
19 has a crystal ball. None of us can tell what's
20 going to happen in the future. We don't have
21 the ability to predict sexual violence, or even
22 nonsexual violence for that matter.
23 There's a great tendency to
24 overpredict behavior. That's been the result
25 of many scientific studies in the area of

1 prediction of violence. The tendency is to say
2 that someone is going to be a predator or is
3 going to sexually offend others but turns out
4 not, in fact, to do so. That's a very
5 important problem here because of the stakes.
6 Stakes here obviously relate to long term or
7 indefinite incarceration in a facility if
8 someone is adjudicated to be a predator. So,
9 the tendency to overpredict violence is a very
10 serious problem here for this bill.
11 We don't have what we call
12 statistical information or base rates or really
13 good recidivism data across all kinds of sex
14 offenders. This is important information to
15 have, to be able to make reliable predictions
16 of future behavior. Recidivism data is
17 scattered. It's many different populations.
18 We are talking about relatively small numbers
19 of studies. We are talking about using
20 different methods, and we have been discussing
21 that here this morning already.
22 So, scientifically we don't have a
23 take-home number that we can use to say what
24 the recidivism rate is for a given individual.
25 We only have a recidivism rate for groups of

1 individuals. That's a big difference. It's
2 one thing to talk about groups of individuals,
3 but it's something else to pull a number from
4 the group and say this is going to apply to the
5 individual before us in question.
6 Another problem with the area of
7 predicting violence is that, we need to know
8 something about the environment that the person
9 is going to live in. It's really a fallacy to
10 believe that behavior is the product only of an
11 individual. Rather, behavior is a product of
12 an interaction between the individual and the
13 environment in which that person lives. You
14 have to look at the individual's environment as
15 well as the individual to make some sort of
16 assessment of their future behavior.
17 Obviously, the environment changes for all of
18 us on a day-to-day basis, even within the day.
19 When we're asked to make predictions
20 of whether someone is going to reoffend in the
21 long-term future, we need to know a lot about
22 that person's environment. That information is
23 really not going to be available to the
24 evaluator.
25 Environmental information includes

1 drug or alcohol abuse, compliance with
2 treatment, employment, marital situations,
3 access to victims. It's a whole variety of
4 different variables that are important in
5 trying to assess future behavior. That
6 information is simply not going to be available
7 to us for a long-term period of time.
8 The statute also -- or the bill
9 actually, is very vague in terms of what it
10 means to be predicted as a sexually violent
11 person. It reads at present that the person is
12 likely to engage in acts of sexual violence.
13 What does that mean? Does it mean to say that
14 someone is likely to engage in acts of sexual
15 violence? How likely do you mean: very likely,
16 substantially likely, probably likely, more
17 likely to not, little bit likely or very much
18 likely? You can find your own qualifiers to
19 the idea here. The point is that, we simply
20 don't know how likely is.
21 A concept, or a problem really, for a
22 psychiatrist and for a psychologist generally
23 here is that, we think this predator statute,
24 this predator paradigm really represents a form
25 of social control. You are placing

1 psychiatrists and psychologists as social
2 control agents. Most mental health
3 professionals resent that kind of imposition.
4 Most of us went into clinical work and
5 professional training to be helpers; not
6 gatekeepers. Legislators and courts are
7 obviously placing social control functions on
8 us increasingly. This really conflicts with
9 our clinical roles.
10 We, therefore, believe that the
11 predator statutes misuse or constitute a misuse
12 of not only mental health professionals, but
13 also the mental health professions themselves.
14 We think that the statutes result in harm to
15 individuals. Let me give you one example.
16 Using such a statute is likely to
17 have an impact upon the people already in
18 prison in terms of their participation and
19 treatment. There's a provision in the bill
20 which cites that there will basically be no
21 confidentiality of treatment so that people who
22 are now in prison who would benefit from sex
23 offender treatment aren't likely to participate
24 in that sex offender treatment because they
25 know that that information could later be used

1 against them in a hearing regarding whether or
2 not they are a predator. So, there's likely to
3 be some real tangible adverse effects on
4 individuals.
5 Let me specifically address myself to
6 some portions of the bill, which I believe
7 should at least be amended. Generally, I turn
8 your attention to the California legislation.
9 I don't know if the task force has looked at
10 that legislation, but I'd strongly encourage
11 the task force to do so.
12 One thing that California has done is
13 restrict the definition of predator to
14 individuals who have offended or been convicted
15 on two or more occasions. As you know, House
16 Bill 1811 does not so restrict that.
17 California's approach narrows the net, so to
18 speak, cast the net less widely and probably
19 targets more specifically that particular
20 population that you are concerned about. I
21 would encourage the task force to consider
22 restricting the definition of predators to
23 those individuals who have at least two or more
24 previous convictions.
25 I would also suggest that the task

1 force take a look at California's approach
2 which added the conditional release concept to
3 the bill, and that was discussed earlier with
4 Mr. Baker. The idea that you cannot just
5 simply release individuals even from a predator
6 program, an institution, but it's important to
7 have a gradual transition carrier to allow the
8 individual to deal with the problems of
9 culmination into society.
10 California also has unlimited
11 commitments in their predator bill. They do
12 not have indefinite commitments as this present
13 bill here proposes. They have an initial
14 two-year period of commitment, after which time
15 the state bears the burden of recommitting the
16 predator to the facility. Again, that would
17 help to restrict the flow of individuals under
18 H.B. 1811 which I think will be rather
19 substantial.
20 They also limit evaluators to
21 individuals who have actual advanced degrees
22 like Ph.D.'s and M.D.'s; not simply people who
23 have Master's Degree individuals.
24 California has done other things.
25 There are ways to redefine predators without

1 using the word predator. There's no reason to
2 have this concept of mental abnormality which
3 makes no clinical sense. There's no reason
4 actually to use the word predator at all, in
5 fact.
6 We also would suggest that victims be
7 restricted to nonfamily members rather than
8 including family members. This was discussed
9 earlier as well.
10 What I have talked about are some
11 general conceptual problems with the approach
12 to managing sex offenders through a predator
13 type bill, but also some suggestions for
14 amending the present bill to more realistically
15 deal with some of these problems. Thank you.
16 CHAIRPERSON MASLAND: Thank you, sir.
17 Ms. Walther.
18 MS. WALTHER: I'm Sue Walther, and
19 I'm the Policy Coordinator with the Mental
20 Health Association of Southeastern
21 Pennsylvania. I have submitted written
22 comments. I don't have a lot to add.
23 I would just like to comment on,
24 earlier I heard the question to one of the
25 testifiers, would he agree that there are some

1 people who should not be reintegrated into the
2 society ever? If that's your intent, then I
3 would think that you need to find a way to do
4 that using the Department of Corrections and
5 the jail system.
6 If your intent is to provide
7 treatment to these folks, if you think
8 treatment can work and if treatment should be
9 offered, then I guess I would believe that it
10 would be better if these people are in need of
11 treatment, they are in need of treatment when
12 they first begin serving their sentences.
13 One way or another it's going to take
14 a commitment of resources and appropriation of
15 dollars to develop these programs because,
16 apparently, they're not currently at the level
17 they need to be in the prison system and they
18 certainly don't exist in state hospitals as we
19 know them today. One way or another I believe
20 you are going to have to invest a lot of
21 resources. It would make more sense to me to
22 invest them in the Department of Corrections so
23 that this person, when arrested, receives
24 treatment from the very beginning and also
25 needs to have treatment in the community.

1 If people are going to be eventually
2 released to the community, I think it would be
3 incumbent upon the system to provide
4 community-based treatment; to allow them to do
5 a slow adjustment into the society as opposed
6 to just dropping them into society and hoping
7 that they will make it, and then being
8 surprised when they commit the crime again. I
9 think it only stands to reason that they are
10 going to if they haven't received the treatment
11 they need.
12 My only comment is that, I believe
13 the treatment needs to happen, but I think it
14 needs to happen under the Department of
15 Corrections and not in what I think is probably
16 at the state hospital setting. We have folks
17 in the state hospital setting that have mental
18 illness and deserve the same protection that
19 the general public deserves, I believe. I
20 don't have much more to add.
21 CHAIRPERSON MASLAND: Thank you very
22 much. We'll start to my left. Representative
23 Orie.
24 REPRESENTATIVE ORIE: Good morning,
25 Doctor Wettstein. In regards to your

1 statement, I find it peculiar that I have
2 before me the American Psychiatric Association
3 Task Force Report on Sexually Dangerous
4 Offenders. In that report it indicates some of
5 the recommendations are that, although
6 scientific understanding of the disorder has
7 improved in recent years, the societal
8 investment and research has not been
9 commensurate with the need for new knowledge
10 relating to the diagnosis and treatment of
11 persons with disorders. The Psychiatric
12 Association admits that they are not up in
13 regards to even addressing this within their
14 own profession; isn't that correct?
15 DOCTOR WETTSTEIN: You have that in
16 front of you. I thought that said that we
17 don't have a lot of information with regard to
18 managing and evaluating sex offenders and
19 nonsex offenders.
20 REPRESENTATIVE ORIE: I'm reading
21 specifically from it. It indicates that the
22 research by the Psychiatric Association has not
23 been commensurate with the need for new
24 knowledge relating to the diagnosis and
25 treatment.

1 DOCTOR WETTSTEIN: We need more
2 research.
3 REPRESENTATIVE ORIE: I guess when
4 one of the speakers had made the comment about
5 treatment and intervention, I think that's the
6 whole premise behind it--I'm the sponsor of
7 this legislation--is treatment. I think that
8 this provides for these individuals and as --
9 My impression, I come from a background of
10 being a prosecutor and have encountered
11 individuals that would fulfill sexually violent
12 predators with over 50 to 70 victims that this
13 would allow for the psychiatric community the
14 opportunity to observe these individuals,
15 intervene with them and, perhaps, get up to
16 date with what needs to be done.
17 We hear recommendations for chemical
18 castration, but they even say that's not a
19 cure-all. Maybe that will suppress the urge,
20 but not the mental capacity of them, which may
21 result in some violence or manifest itself in
22 another way.
23 My point to you is, and I know you
24 look to the correctional and say this should be
25 done within the correctional department itself.

1 There are some instances where you don't
2 encounter these individuals until after they
3 have had 70 victims, whether it be an incestual
4 situation or outside of their home where it's a
5 one time. You have a victim who, for whatever
6 reason, can't testify for psychological trauma.
7 You come before them with one victim, you plea
8 bargain, whatever happens, but you know there
9 is over 70 before that victim. Our hands are
10 tied too, but this will provide a -- each
11 multidisciplinary aspects of this, an
12 opportunity to observe, intervene, and get
13 help. Do you see that at all?
14 DOCTOR WETTSTEIN: Yes. I think that
15 there is good intention here. We all have seen
16 bad cases. I'm sure you do as a prosecutor,
17 and I have seen them too. The question is how
18 prevalent are those bad cases and how broadly
19 would this law reach into the cases that are
20 really not so bad at all, so to speak, and in
21 cases where there is one victim rather than 70
22 victims? You are going to pick up a lot of
23 those I'm afraid. That's my principal concern
24 here.
25 REPRESENTATIVE ORIE: I think in

1 regards to that, and I'd like to follow up with
2 you. In speaking--I'm from Allegheny
3 County--to some of the experts out there,
4 perhaps with the sexual violent predator making
5 it more specific as to the number of victims
6 and having a criteria so that if it doesn't
7 encounter or there's this misnomer that
8 virtually everybody would qualify under this
9 regarding -- making more criteria, working with
10 how many victims, what was the time frame, and
11 working along those lines, I would welcome the
12 opportunity to talk with you along those lines
13 for that type of -- developing something along
14 those lines because I do agree. I have
15 problems with the definition in and of itself.
16 DOCTOR WETTSTEIN: Thank you. I
17 agree with you.
18 REPRESENTATIVE ORIE: I guess my
19 other question to you is, even within this
20 psychiatric report it indicates that -- and
21 this just further emphasizes the need for some
22 type of intervention. Like one of the speakers
23 indicated, asked that this be separate and
24 distinct. I agree with you on the fiscal note
25 that I do not want to impair other individuals

1 that are not violent offenders or don't even
2 qualify for the treatment, the care, the money
3 that they are afforded.
4 One of the problems with these
5 individuals is, denial is a common trait with
6 these perpetrators. There are so many
7 dimensions to these predators that we need the
8 opportunity to -- when you have something like
9 the Hendricks' case or Kendricks' case where he
10 says if I get out of there, I'll do it again.
11 I have an urge. I can't control it. It's
12 history. The last thing you want to do is let
13 him out in the community.
14 My premise would be, give the
15 psychiatric association the opportunity to
16 observe, to see these individuals develop some
17 type of a system, and look what's the best and
18 you're getting the most ardent, affordable ones
19 to look at it, examine, and then from there we
20 can go from there. Right now there is no
21 catch-all for those people. That's really the
22 premise, at least in regards to my authoring
23 this legislation, is really to give you the
24 opportunity to get, to do and observe and
25 really develop something that we can protect

1 victims in Pennsylvania.
2 DOCTOR WETTSTEIN: I would welcome
3 any attention that you could offer to the
4 clinical needs of these individuals. Again, my
5 preference is to deal with them during the
6 course of their incarceration rather than after
7 the discharge from custody which may be 20
8 years later. I agree there are some very
9 disoriented individuals that are not safe to be
10 released. The question is whether we draw the
11 scope, the net so broadly we pick up some of
12 the other individuals that are really in
13 different categories. That's one of the major
14 concerns here.
15 REPRESENTATIVE ORIE: I appreciate
16 that. Again, I welcome the opportunity--I know
17 you are from the University of Pittsburgh--to
18 further discuss this with you, perhaps, really
19 hone in on the definition and create some type
20 of criteria for that. I thank you for your
21 comments.
22 CHAIRPERSON MASLAND: Thank you,
23 Representative Orie. For our panelist, I would
24 say to Ms. Rehrman that the next panel will
25 have a representative from DPW and maybe you'll

1 just shed some light on your concerns and I
2 think some valid questions in terms of which
3 office, where's the funding.
4 As Representative Orie said,
5 eventually this issue, whether it's the House
6 bill or the Senate bill dealing with it will be
7 reviewed by Appropriations Committee staff and
8 a fiscal note be placed on it. Then we will
9 have to make the policy decision as to how much
10 we want to fund a program like this and whether
11 we do that to the detriment or not to the
12 detriment of any existing programs.
13 In that context, I don't have a
14 crystal ball, I don't know how long this bill
15 will be reviewed, but I would like to mention
16 that this task force does intend to meet with
17 Representative O'Brien, who had to leave here,
18 but he is the Chairman of the House Health and
19 Human Services Committee. This is not an issue
20 that can solely be dealt with by the Judiciary
21 and the Judiciary staff. We will be meeting
22 with them and certainly with members of the
23 administration and Senate to try to work on
24 some of these issues.
25 At this time having stated that, let

1 me just announce that we have a letter from
2 Representative O'Brien dated October 20th,
3 1997, that I'd like to submit as part of the
4 record. This was to Senator Greenleaf who
5 chairs the Senate Judiciary Committee on this
6 specific issue. We'll make sure that that is
7 entered as part of the record.
8 Just one quick comment slash
9 question. I think we all agree from hearing
10 everybody that there are some people who really
11 can't be reintegrated into society; who can't
12 be integrated into society; who can't be
13 rehabilitated because maybe they were never
14 habilitated. The question is whether we deal
15 with them in the criminal justice system solely
16 or whether we deal with them in civil matters
17 too.
18 Your statement about putting more
19 money into the Department of Corrections, we
20 already have about a billion dollars in D.O.C.
21 I hesitate to put too much more in, although we
22 will eventually. Some day we will have,
23 instead of the Keystone State, we will be
24 Pennsylvania, a subsidiary of the Department of
25 Corrections. I hope it doesn't come to that.

1 We have this problem, Doctor
2 Wettstein, where we may not have the precise
3 clinical definition for some of these issues.
4 It may not be in precise terms, but as you
5 know, those clinical definitions change all the
6 time.
7 As a psychology major and I'm only
8 really qualified to graduate from college with
9 that, but I think I'm qualified to know that
10 there are some limits. Because there are those
11 limits and because things change, we are given
12 the job of melting those clinical problems with
13 the practical, and in reality, trying to come
14 up with something. I think that's what
15 Representative Orie has tried to do.
16 When you asked the question, what, as
17 far as likely to engage in acts of sexual
18 violence means as to how likely, some of us
19 might say a little bit likely is enough. Some
20 would say, well, it ought to be a lot likely.
21 That is difficult. That's something we'll have
22 to look at more closely. I see Ms. Rehrman has
23 a comment.
24 MS. REHRMAN: I want to come back to
25 your Department of Correction funding issue.

1 We do put a lot of money, and it's growing all
2 the time, into the Department of Corrections.
3 We have given up several state hospitals to the
4 Department of Corrections. We have juvenile
5 facilities on our state hospitals. We keep
6 giving up and giving up and giving up. Yet, at
7 the same time our budgets are not increasing.
8 We didn't get a two percent COLA for
9 our CHIPs, the most vulnerable people we have
10 in the Commonwealth, those who have been
11 transferred from state hospitals to the
12 community. There was no COLA put on them. I
13 see this whole downsizing of the funding and
14 the shifting of resources.
15 I also hear a lot of members of the
16 General Assembly say, oh, that Department of
17 Public Welfare is so big. We ought to cut it
18 down. Well, here we go again. We keep
19 shifting more and more people, more and more
20 different populations into it. I don't mind
21 the Department of Corrections being large.
22 Thank you.
23 CHAIRPERSON MASLAND: There is a
24 proposal to merge the Department of Health with
25 the Department of Welfare which would be pretty

1 big. That would be very big. I think Counsel
2 Preski has a question.
3 MR. PRESKI: Just one question for
4 you, Doctor Wettstein. When Mr. Baker was up
5 here, he had cited some studies from the '50's
6 and other studies that said that the recidivism
7 rate for sexual offenders was rather low or was
8 comparable to other offenses. During the
9 Megan's Law debate, during the special session
10 on crime, we had higher numbers.
11 Given your research on these topics,
12 is this the kind of situation where we can find
13 experts on both sides of the issue, or is there
14 60/40 experts or more on one side or the other?
15 Where are they, or is it that you can find an
16 expert for whatever you need?
17 DOCTOR WETTSTEIN: I think you can
18 find a paper for whatever you need. Really the
19 answer to the question is, take a look at the
20 literature yourselves. Don't take my word for
21 it or Mr. Baker's word for it. I can provide
22 you with the studies. You can read for
23 yourself that the study results are all over
24 the place. There are some studies with low
25 recidivism rates and other studies with higher

1 recidivism rates. Again, it depends on the
2 individuals that were studied and how they are
3 studied. It's not simply what people are
4 saying, but actually there are differences of
5 research results in this matter.
6 MR. PRESKI: Thank you.
7 CHAIRPERSON MASLAND: Thank you all,
8 panelists. We will now move on to our next
9 panel. I believe everyone is here. They may
10 sit in any position. We will start off with
11 Charles Currie, who is Deputy Secretary of
12 Mental -- or Secretary (sic) to Mental Health
13 in DPW. We have Allen Castor, who is a board
14 member of the Board of Probation and Parole;
15 Randy Undercofler, Criminal Justice Policy
16 Specialist for the Governor; Lee Ann Labecki,
17 Criminal Justice Policy Specialist for the
18 Governor; and Diane Dombach, Executive Director
19 of the Sexual Offender Assessment Board. We
20 have a full table. I understand that some of
21 you are not going to be testifying, but you
22 will be here for questions. I appreciate that.
23 MR. UNDERCOFLER: I'm here to provide
24 some introductory comments and to introduce the
25 panelists. My name is Randy Undercofler. I'm

1 Criminal Justice Policy Specialist working in
2 the Governor's Office. Let me begin by just
3 taking a moment to thank the task force and
4 committee for inviting us to testify here on
5 this important issue. We also thank you for
6 you flexibility in allowing us to present as a
7 panel.
8 As you know, House Bill 1811 would
9 have an impact on a number of the Executive
10 Branch departments and agencies. As it kind of
11 brings together mental health and criminal
12 justice issues, we thought it would be helpful
13 to present together and coherently.
14 Our remarks today are brief. The
15 Governor's Office supports the concept of civil
16 commitment of sexually violent predators.
17 Civil commitment represents another tool to
18 help protect Pennsylvanians from an extremely
19 dangerous class, perhaps the most dangerous
20 class of sex offenders.
21 We appreciate the commitment to
22 public safety that you are showing and it's
23 demonstrated by taking House Bill 1811 under
24 consideration. However, the current proposal
25 in House Bill 1811 raises a number of policy

1 and procedural questions that we believe
2 require additional examination and discussion.
3 Perhaps, one of the more critical being a
4 potential conflict between the civil process
5 proposed in this legislation and the criminal
6 justice criminal infrastructure created under
7 Megan's Law.
8 Representative Masland made a
9 distinction earlier between civil commitment
10 and Megan's Law. I think it's appropriate, but
11 I think as we have talked about this bill and
12 as you talk about civil commitment, you cannot
13 talk about it without also talking about
14 Megan's Law. Both of them provide a process
15 for an assessment as to an offender's status as
16 a sexually violent predator. One does it at
17 the front end in Megan's Law; the other who
18 would propose to do it at the back end.
19 As we continue with comments today,
20 especially with Diane Dombach who is here as
21 the Executive Director of the Sexual Offender
22 Assessment Board, we'll hear a little bit more
23 about the interface between Megan's Law and
24 this civil commitment process.
25 In addition, we have some concerns

1 about the availability of records and
2 information to make an initial predator
3 determination. Further, there are the legal
4 issues, constitutional due process issues. As
5 you know, the process of designing an entirely
6 new system is very involved. It takes time.
7 Megan's Law has gone through a number of
8 revisions. We are prepared to work with the
9 General Assembly to help develop a package or
10 develop a mechanism that will withstand
11 constitutional scrutiny.
12 Just briefly, it's our objective
13 today to identify for you and to discuss some
14 of the policy and practical questions and
15 difficulties that this legislation presents
16 given the existing mental health and criminal
17 justice infrastructure in Pennsylvania.
18 With that I'll turn it over to
19 Charlie Curie and the rest of the panel.
20 MR. CURIE: Thank you. Good morning,
21 Mr. Chairman, and members of the committee. My
22 name is Charles Curie. I'm the Deputy
23 Secretary for the Office of Mental Health and
24 Substance Abuse Services within the Department
25 of Public Welfare. I have been asked to offer

1 testimony on House Bill 1811 which establishes
2 a civil procedure for the involuntary
3 commitment of sexually violent predators.
4 As currently written, House Bill
5 1811 gives the responsibility for the care,
6 control, and treatment of these individuals to
7 the Department of Public Welfare. To that end,
8 I appreciate the opportunity to provide my
9 thoughts on the bill.
10 I would like to address four issues
11 related to this bill for your consideration.
12 First, let me say that with few exceptions,
13 sexually violent predators do not have mental
14 illness that would make them committable under
15 the Mental Health Procedures Act. The causes,
16 treatments and public safety issues presented
17 by sexually violent predators are very
18 different from those relating to persons with
19 serious mental illness.
20 Second, national trends and the
21 experience of other states can serve as a model
22 to Pennsylvania; and third, because of the
23 treatment, confinement, public safety issues
24 and prognosis for sexually violent predators,
25 placement within the state mental hospital

1 system will be problematic and difficult.

2 Fourth, data indicates that the

3 number of persons affected is significant,

4 costs for confinement and treatment are

5 considerable, and these costs can be expected

6 to increase over time.

7 In regard to House Bill 1811, first

8 let me address the issue of mental illness and

9 the sexually violent predator. As House Bill

10 1811 states, sex offenders very rarely suffer

11 from a mental illness that renders them

12 committable under the Mental Health Procedures

13 Act.

14 Consequently, treatment for violent

15 predators, and the philosophy behind that

16 treatment is outside the scope of that

17 traditionally administered by the state's

18 mental hospital system. The priority

19 population served by the state hospitals is

20 comprised of persons who are eligible for

21 involuntary commitment under the Mental Health

22 Procedures Act.

23 These persons generally suffer from

24 schizophrenia and major affective disorders,

25 which affect their ability to attend to or

1 complete the normal activities of daily living
2 without active treatment and support services.
3 These serious mental illnesses are generally
4 believed to be brain disorders which are
5 characterized by profound mood and thinking
6 disturbances, with symptoms which include
7 hallucinations, delusions, and disorganized
8 thought processes. These symptoms and these
9 illnesses do respond to medication and other
10 treatments.
11 In contrast, the diagnostic
12 categories which describe the behavior of
13 sexual offenders include antisocial personality
14 disorder and paraphillic disorders such as
15 pedophilia. Medications, therapies, and
16 supports successfully employed with persons
17 with serious mental illness are not appropriate
18 for treatment of the disorders characteristic
19 of the sexually violent predator.
20 Second, the National Association of
21 State Mental Health Program Directors shares
22 DPW's strong concern that this act will result
23 in the diversion of scarce resources allocated
24 for current mental health treatment services.
25 This will compromise our ability to provide

1 adequate quality of care, and the health and
2 safety of patients and staff may be
3 jeopardized. The drain on resources will also
4 impact on the community mental health program,
5 raising similar quality-of-care issues for the
6 250,000 children and adults with psychiatric
7 disorders covered by that program.
8 Ultimately, the drain on fiscal
9 resources will forestall any further movement
10 towards hospital rightsizing through placement
11 of the seriously mentally ill adults in more
12 appropriate, cost-effective community support
13 programs, and may adversely impact on our
14 ability to proceed with the Health Choices
15 Managed Care program.
16 Let me further note that there is a
17 lack of consensus among national experts about
18 the appropriate treatment for sex offenders.
19 Research in this area is inconclusive. For
20 example, a June 1996 sex offender treatment
21 report to the Congressional Committee on
22 Judiciary concluded that there is no consensus
23 about which treatments are most effective in
24 reducing sex offender recidivism. Conversely,
25 there are effective treatments available for

1 persons who have a mental illness and are
2 served by the state mental hospital system.
3 Third, regarding our recommendations
4 for the care, control and treatment of this
5 population, we find that it will be very
6 problematic to locate these facilities on state
7 mental hospital campuses. Committing sexually
8 violent persons to facilities on mental
9 hospital campuses undermines the mission and
10 integrity of the public mental health system,
11 and unjustly stigmatizes the nonoffending
12 persons who are committed to those hospitals
13 for treatment of their illness.
14 If this program were placed on the
15 campus of any state mental hospital, not only
16 would there likely be strong local opposition
17 by municipal and county governments and by
18 local residents because of its potential threat
19 to the safety of the community, but advocates
20 for persons with mental illness and their
21 families are likely to fight such a placement.
22 Finally, regarding the potential
23 numbers of individuals affected and the
24 projected costs of implementing this
25 legislation, staff at the Department of

1 Corrections have indicated that there are
2 approximately 4,200 offenders within their
3 custody that are serving time currently for a
4 sex offense listed in House Bill 1811.
5 In calendar year 1996, a total of
6 300 offenders incarcerated for one of these sex
7 offenses were released from D.O.C. custody.
8 D.O.C. has projected that between 1997 and the
9 Year 2005, the number of potential max-outs
10 involving offenders incarcerated for one of the
11 enumerated offenses will be approximately
12 2,000.
13 This averages out to roughly 250
14 offenders per year and represents the largest
15 pool of individuals from state facilities that
16 may be subject to possible commitment under
17 your proposal.
18 However, this pool of offenders could
19 significantly expand because of the number of
20 individuals serving time in county correctional
21 facilities for offenses designated in this
22 bill, which amounted to 428 individuals in
23 1994, according to D.O.C. data. Consequently,
24 yearly admissions to sexually violent predator
25 programs from state prisons and county jails

1 could significantly exceed 250 individuals per
2 year.
3 Based on current forensic state
4 mental hospital costs, a per diem of $450 for
5 each committed person could be expected in the
6 start-up year. For 250 beds, the annual
7 operating costs for a unit staffed by
8 Department of Public Welfare employees would be
9 $42 million. The number of sexually violent
10 predators in commitment status could exceed
11 1,000 in four years of operation, with an
12 annual operating cost of $165 million. This
13 does not include construction or building
14 renovation costs.
15 Of critical concern is that, DPW does
16 not have the physical capacity to house
17 offenders committed to its custody pursuant to
18 this act. All DPW secure mental health beds
19 are currently filled, and there is a waiting
20 list for admission. To house these offenders
21 and comply with the security and segregation
22 requirement of the bill, DPW will need, at a
23 minimum, to fully renovate existing vacant
24 state mental hospital buildings. To bring
25 these facilities up to standards and add

1 forensic security features will cost
2 approximately $22 million. The cost of
3 furniture and equipment, including security
4 devices, is an additional $7.5 million.
5 In conclusion, there are a number of
6 issues relating to the implementation of this
7 proposed legislation. As part of the Ridge
8 Administration, we at DPW look forward to
9 working with this committee to address areas of
10 concern regarding House Bill 1811.
11 Thank you for providing the
12 Department with the opportunity to present
13 comments to this committee today. I would be
14 glad to answer any questions you may have.
15 MR. CASTOR: Good morning, Mr.
16 Chairman, and members of the committee. I'm
17 Allen Castor, member of the Board of Probation
18 and Parole. I'll be making a brief comment
19 today. The board has met and discussed House
20 Bill 1811, and we are in substantial agreement
21 with the goals of this bill.
22 There are three areas of concern that
23 we'd like to offer to you. One, the section of
24 the bill that provides for the assessment of
25 the individuals being considered for release,

1 the board has considered the appropriateness of
2 having that information, that expert
3 information provided to us well in advance of
4 our interview so that that information can be
5 considered.
6 Additionally, we'd like you to
7 consider the fact that the prospect of
8 involuntary commitment, civil commitment may
9 serve as a disincentive for those individuals
10 within the Department of Corrections' sex
11 offender program, and that that would decrease
12 their participation and possible cooperation
13 while incarcerated.
14 Finally, we'd like to consider the
15 liability issues that may attend as we have the
16 assessments done by either the Sex Offender
17 Assessment Board or by the assessment board
18 that's noted in the bill.
19 I'm going to defer to Ms. Diane
20 Dombach, Executive Director of Megan's Law
21 Assessment Board to speak more in detail with
22 that. Those are three areas of concern we'd
23 like you to consider.
24 MS. DOMBACH: Good morning. I'm
25 Diane Dombach, the Executive Director of the

1 Sexual Offender Assessment Board. Thank you
2 for having me here today. Just a few brief
3 comments. I too, of course, support the
4 concept of this bill and efforts to further
5 enhance public safety.
6 I do have some concerns about the
7 bill in its present form. I'm concerned that
8 the bill, in effect, duplicates the structure
9 in place through our current Megan's Law and
10 creates a second investigative process and
11 expert opinion and a second investigative staff
12 and a second group of experts. I'm concerned
13 that we will have destructive competition for a
14 diminishing core of experts and the drain on
15 financial resources for our Megan's board.
16 To date the Sexual Offender
17 Assessment Board has evaluated over 540
18 offenders currently in the system. Megan's Law
19 does provide for reevaluation of those folks
20 designated as predators at various points in
21 their sentence. For instance, one year prior
22 to their minimum they can petition for
23 reconsideration to the court and then at
24 five-year intervals thereafter for
25 reconsideration of their classification from

1 predator to sexual offender.

2 We're concerned about the legal

3 issues surrounding subsequent assessment

4 should, for example, a person sentenced as a

5 sexual offender be assessed in a civil process

6 and be determined at that point to be a

7 predator. I'm also concerned that the civil

8 process as it exists now does not provide for

9 any form of supervision or conditional release.

10 It's our feeling that protection of the

11 community would be better served by sex

12 offender management in a combination of

13 specialized treatment and supervision.

14 If the committee has any questions

15 for me, I'll be happy to answer them.

16 CHAIRPERSON MASLAND: Thank you.

17 Starting down on the left, Representative

18 Manderino.

19 REPRESENTATIVE MANDERINO: Thank you.

20 Thank you all for coming. I guess I will

21 address my question to Mr. Undercofler since

22 he's the policy guy. I guess my question is a

23 policy question.

24 I'm truly confused by your opening

25 statement and the statement that was repeated

1 by both testifiers, which is, we support the
2 concept. We all love Representative Orie here.
3 I do too, and I know she's a good trooper for
4 the Governor, and I don't mean to make this
5 political. I'm really trying to understand
6 where we're coming from.
7 I guess I'm not sure which concept it
8 is that we support in concept. Do we support
9 in concept the idea that we should protect
10 society from sexual predators however we define
11 that? Do we support in concept the idea that
12 we should allow for an involuntary civil
13 commitment process? Do we support in concept
14 the putting a predator in DPW control as
15 compared to in D.O.C. control? What are we
16 supporting? Give me some guidelines because
17 I'm hearing --
18 MR. UNDERCOFLER: Supporting the
19 concept -- I didn't mean to cut you off.
20 Supporting the concept of creating a mechanism
21 to provide for the additional confinement of
22 these individuals who pose a serious threat to
23 the public safety; be it, you know, an
24 involuntary civil commitment process as
25 outlined in this or some other type of

1 mechanism to provide for that continued
2 treatment.
3 REPRESENTATIVE MANDERINO: So we are
4 not necessarily at this point sure that the way
5 to do it is through an involuntary civil
6 commitment or the way to do it is through
7 putting folks in DPW control as compared to
8 D.O.C. control?
9 MR. UNDERCOFLER: Correct.
10 REPRESENTATIVE MANDERINO: Okay.
11 That's very helpful.
12 MR. UNDERCOFLER: That's just
13 generally why, you know, we are here to raise
14 some of these procedural policy questions, just
15 to get you thinking to understand kind of the
16 universe's use -- no, that you know the
17 criminal justice infrastructure, you know the
18 mental health infrastructure and start to raise
19 some of these questions as to what is most
20 appropriate.
21 REPRESENTATIVE MANDERINO: Great.
22 That's very helpful. Mr. Castor, maybe you can
23 best answer this for me. In terms of the
24 current process and how it works, one of the
25 prior testifiers raised the concern about, in

1 any context, folks that max out, and sometimes
2 I don't think we realize as lawmakers, or at
3 least I'll speak for myself, I didn't realize
4 as lawmakers if somebody had a 10 to 20
5 sentence and they maxed out and spent all 20
6 years in prison, when they walk out on the
7 street the next day nobody is following them
8 around. They're not checking in with anybody.
9 They don't have a tail of probation where
10 somebody is making sure they are kind of a
11 straight arrow.
12 I see that sometimes when people walk
13 into my office looking for a job, and I try to
14 assess where their job skills are. Well, I
15 don't have any. Where have you then been the
16 last 20 years? I spent all 20 years in prison.
17 Just for somebody like that, there isn't even
18 a -- It's very hard to even find a program that
19 works with ex-offenders, helping them find a
20 job. Nobody is making sure this guy or gal
21 makes it in society.
22 Then you complicate it with folks
23 that we are really worried about here, people
24 who can do serious bodily harm to someone else.
25 I really see the problem. I guess my concern

1 is, what are we doing wrong -- not wrong
2 necessarily. What could we do better? What
3 might we be able to do in the current context
4 or with the current context, amended or changed
5 some way, with folks like this regardless of
6 which procedure we do that we make sure we have
7 a tail on the end, a string on the end that can
8 pull them back in? Do you have any thoughts
9 for us in that regard?
10 MR. CASTOR: Typically what happens
11 with -- and I'll be specific to those cases of
12 a sexual nature, sexual offense component,
13 typically those individuals do get out with
14 some period of supervision. We understand how
15 dilatory that can be to have individuals max
16 out without any type of follow-up, without any
17 type of supervision, and simply just disappear
18 into the society.
19 What does occur on occasion, and
20 there are several factors that create this.
21 What occurs on occasions, we have individuals
22 who are noncompliant with treatment inside the
23 D.O.C.; people are noncompliant with D.O.C
24 treatment; individuals who raise some very
25 significant concerns with individual board

1 members when we interview them; individuals
2 whose psyche reports raise some significant
3 concerns. Those individuals quite frequently
4 do max out. It's a concept that the board has
5 met and discussed and is here to support today
6 similar to House Bill 1811 which would provide
7 that additional supervision for individuals who
8 do max out and simply disappear into the
9 community.
10 REPRESENTATIVE MANDERINO: That
11 supervision is under -- Well, I don't know. I
12 guess it's not really under the Department of
13 Corrections. It's kind of under Probation and
14 Parole. But I think of those as criminal
15 justice arms as compared to DPW which I don't
16 see as a criminal justice line. Does it make
17 more sense when we are looking at how do we do
18 this, from your perspective, that we keep it
19 within the criminal justice arm if I can call
20 it that?
21 MR. CASTOR: Speculating on that
22 issue, and at this point I would be widely
23 speculating with you, it would probably be of
24 some use to have some type of legislation that
25 would have individuals continue under levels of

1 supervision, whether that be probation or
2 parole. I would defer to Mr. Undercofler and
3 the policy office there in terms of that.
4 MR. UNDERCOFLER: I'm sorry. I just
5 wanted you to repeat the question.
6 REPRESENTATIVE MANDERINO: A couple
7 of folks raised the concern, prior testifiers,
8 and I see the distinction that they are making
9 between -- whether or not something is a mental
10 illness, for example. Also, the kinds of
11 facilities and supervision, what we're trying
12 to accomplish in the various programs that DPW
13 would oversee from a social point of view, from
14 an illness point of view, mental illness or
15 things like that versus when we're looking at
16 this we're not sure -- I already heard today
17 that we're not sure that a sexual predator is a
18 policy definition, not a clinical definition;
19 that whether or not those folks are treatable
20 is still a question. As to whether or not they
21 have any kind of mental illness is in doubt.
22 So, therefore, whatever tail end that
23 we want to -- whatever we want to do to make
24 sure that we're protecting society, my question
25 was, does it make more sense or that thing,

1 whatever we decide that thing to be, whether
2 it's 1811 or something else, that thing to
3 belong in the entities of government that I
4 consider criminal justice, whether it's D.O.C.
5 or Probation and Parole, or whatever, as
6 compared to entities that I view as helping
7 people who haven't done anything criminal in
8 nature, but that need help from state
9 government in another way that are under DPW?
10 MR. UNDERCOFLER: I think that's an
11 issue that certainly needs to be explored
12 further. One of the concerns involving
13 criminal justice and the Department of
14 Corrections in this process is that, with the
15 Kansas statute or with the Supreme Court
16 upholding, it's this blending of a civil
17 process with these criminal justice entities
18 and --
19 REPRESENTATIVE MANDERINO: If I can
20 push --
21 MR. UNDERCOFLER: Is that going to
22 create problems or difficulties down the road
23 by blending, by mixing the two?
24 REPRESENTATIVE MANDERINO: If I can
25 push you just a little bit on that, from the

1 policy perspective of the Governor, do you have
2 a position yet? Have you come to a
3 determination as to where you would rather see
4 it?
5 MR. UNDERCOFLER: Not as of yet.
6 REPRESENTATIVE MANDERINO: Thank you.
7 Thank you, Mr. Chairman.
8 CHAIRPERSON MASLAND: Thank you.
9 Representative Orie.
10 REPRESENTATIVE ORIE: I would like to
11 address, Mr. Curie, some of the remarks you
12 made, specifically in regards to the monies
13 that would have to be allocated and perhaps
14 framed from others in need and whatever. I
15 think we had testimony to that extent. I
16 certainly would agreed that there should be a
17 fiscal note attached to this or monies
18 allocated for this specific program.
19 I guess one of my concerns, and this
20 keeps coming up, I think I have to emphasize
21 this. This is a civil commitment because these
22 individuals have maxed out and the only way we
23 can -- that's why it has to be civil and that's
24 why the Department of Welfare or Department of
25 Corrections, whomever, has to work together to

1 determine a place; or otherwise, these people
2 are released. That aspect is the most crucial
3 aspect to this legislation, or otherwise, these
4 individuals -- I'm talking about violate,
5 repeat, hard-core sex offenders will be
6 released out into society.
7 I think when you look at monies, and
8 it is going to be a lot of money, but I think
9 when you look at what this bill is
10 accomplishing, that money is certainly in my
11 opinion -- the lives of these victims, the
12 welfare of Pennsylvanians certainly outweighs
13 whatever money concerns that would be
14 associated with this.
15 Another thing, I have been in contact
16 with some of the other states that have been
17 utilizing this to see what type of stigma has
18 been involved or how they have been doing it.
19 It's ironic, most of the other states, whether
20 it be Arizona, California, Minnesota, New
21 Jersey, Washington, all utilize through the
22 Department of Welfare mental hospitals, but
23 these individuals are housed separately.
24 There's absolutely no intervention,
25 integration with the patients that are there.

1 They are totally separate and distinct. There
2 is never, whether it's lunch, break, whatever,
3 they are never combined together. I think I
4 welcome the opportunity to talk with the
5 Department of Corrections and Welfare in
6 regards to what the secured facility should be
7 comprised of.
8 I think my next comments would go to
9 Diane in regards to the Megan's Law. Doctor
10 Wettstein had just testified. I certainly
11 agree with him on this, and this has been my
12 concern, even after introducing this bill is:
13 I know Megan's Law defines a sexually violent
14 predator similar, identical to the way it's
15 defined under the Sexual Violent Predators Act.
16 I would have no problem utilizing the
17 same assessment, individuals with this bill,
18 but I would also like to have your input in
19 regards to the definition of sexually violent
20 predators, especially because these are the
21 hard-core sexual offenders. These are the
22 individuals who have numerous victims, have
23 committed these over several years, have a very
24 proven history of being violent predators.
25 Mind you, also indicate, if they are released

1 they will cause these problems again.
2 Perhaps, defining under this
3 legislation more criteria that would fit under
4 sexually violent predator; for example, the
5 nature of the crime, the history, the number of
6 victims, and maybe dealing in specific criteria
7 because, as Doctor Wettstein had alluded to,
8 this isn't an individual that has committed it
9 once or twice. Getting those individuals
10 community-based programs or within the
11 correction system itself, or whatever, really
12 looking into that aspect, especially with this
13 legislation, I'm just curious as to your input
14 on that.
15 MS. DOMBACH: Forgive me, would you
16 go back and tell me the question again.
17 REPRESENTATIVE ORIE: It's really
18 making specific criteria under the sexually
19 violent predator, including the definition
20 that's there, but also presenting criteria.
21 For example, how many victims were involved,
22 the history of this individual; just making,
23 perhaps, a more expansive list of factors that
24 should be considered in regards to these
25 individuals that are committing civil acts. I

1 was wondering what your input would be on that.
2 MS. DOMBACH: The criteria that I see
3 in this current bill is, perhaps, even more
4 vague than what was in our current Megan's Law
5 where we do have criteria delineated that our
6 experts consider toward that definition, mental
7 abnormality, personality disorder and predatory
8 behavior. I think toward the goal of
9 developing more specific criteria, you will
10 have perhaps a cleaner assessment process and a
11 cleaner outcome.
12 REPRESENTATIVE ORIE: That to me is
13 one of the weaknesses that has to be addressed
14 in regards to this, especially because of the
15 nature of civil recommitting an individual
16 based on significant history and threats to
17 society. I would say that in regards to some
18 of the comments that you made that this
19 certainly complements Megan's Law in the sense
20 that it's providing a mechanism just as the
21 Governor's Office had indicated for those
22 individuals that you can't get through Megan's
23 Law and the ones you just thrown out there.
24 I would welcome the opportunity to
25 sit with you as well to see what you are doing

1 along those lines with the assessment board. I
2 would certainly agree that with the number of
3 experts, there are very few experts in this
4 field, but combining both assessment boards
5 would make perfect sense in regards to this
6 legislation, especially because it isn't
7 competing. It's complementing. It's the same
8 goal in mind. I appreciate your comments.
9 MS. DOMBACH: I agree. I will be
10 happy to sit with you at anytime.
11 CHAIRPERSON MASLAND: Chairman
12 Caltagirone.
13 REPRESENTATIVE CALTAGIRONE: I have a
14 couple questions either for Mr. Undercofler or
15 Mr. Curie. Looking at the cost involved here,
16 are we looking from the Administration's point
17 of view of cost shifting or adding to budgets,
18 either D.O.C.'s, or the Mental Health budget?
19 MR. UNDERCOFLER: I don't believe we
20 have gotten that far with this yet. We have
21 raised these numbers and the cost issue just to
22 give you a sense of what this proposal
23 presents.
24 MR. CURIE: Yes. There are not any
25 specific recommendations beyond the fact that

1 we do have concerns about compromising current
2 programs that are effective in serving people
3 with serious mental illness. We want to raise
4 that, and also have a realistic assessment as
5 to what the greatest potential cost could be
6 based on the pool of individuals that fit the
7 category as defined under House Bill 1811.
8 REPRESENTATIVE CALTAGIRONE: In our
9 urban areas we are having tremendous problems.
10 Philadelphia is no different than the City of
11 Harrisburg or Reading or anywhere else in this
12 Commonwealth, where under the Thornburgh
13 Administration, and I'm sure some of you are
14 aware of this, phase down and phase out of many
15 of the institutions around the Commonwealth
16 with the concept of group home or group living
17 and blah, blah, blah sounded good on paper, but
18 in reality, we have had a tremendous problem in
19 many of our urban areas with the dumping of
20 people without serious follow-up or the proper
21 finances to make sure that those that are
22 integrated into society were receiving proper
23 care, after care, continuing care, medication
24 under vigilance of the appropriate people that
25 needed to take care of those people that were

1 being pushed into our mainstream society
2 without the proper dollars.
3 I was very cognizant of what was
4 going on at the time. It was cost savings.
5 Shut down as many of the institutions, get rid
6 of the staffs, and supposedly put some of that
7 money into the community for the proper after
8 care that was supposed to happen. It really
9 didn't happen. Ergo, you're seeing a lot of
10 problems on our streets in our urban areas,
11 particularly where that kind of phenomenon has
12 occurred. It hasn't been corrected. It's
13 gotten worse, and we're looking at a limited
14 number of dollars.
15 I listened very carefully to what you
16 were saying about, with start-up costs, 29 and
17 a half million dollars, $42 million financial
18 budget the first year, one sixty-five
19 potential; that's a tremendous commitment of
20 resources that would have to be made. Every
21 time we deal with any kind of legislation like
22 this, there's got to be a commitment of
23 dollars.
24 As was pointed out earlier--I forget
25 who mentioned it--over a billion dollars in the

1 cost of operating D.O.C. That's going to
2 continue to grow, by the way. That's not going
3 to shrink. With the legislation that this
4 committee particularly deals with, every time
5 we incarcerate more people rather than provide
6 them with the appropriate treatment, for
7 nonviolent offender or those that possibly, or
8 probably could do better in other types of
9 facilities rather than formal incarceration,
10 the tremendous fixed costs continue to grow.
11 I think you pointed it out very
12 adequately. I know my good friend Mr. Castor
13 from the Board of Probation and Parole that
14 their hands many times are tied because their
15 budgets are not what they should be in order to
16 provide the appropriate tail that need be
17 placed on a lot of the violent predators that
18 we are turning loose in society every day. You
19 can only keep people incarcerated for so long
20 and you have to release them.
21 MR. CURIE: I'd like to respond to
22 the example that you gave of the group home
23 situation and basically the community-based
24 infrastructure that needs to be in place when
25 people are discharged from the state mental

1 health hospitals, as well as we close beds. I
2 would agree that I think through the years we
3 have learned what's effective and what's not
4 effective in terms of maintaining people
5 outside of the state institutions and doing an
6 appropriate and adequate job and assuring that
7 people receive the supports they need.
8 The last few years I think you'll see
9 we have worked diligently to assure dollars do
10 come out of the state hospital system. It's
11 called CHIP, Community Hospital Integration
12 Program. As the beds closed down, the county
13 receives those dollars and develops the
14 services they need so that we don't fall back
15 into the pitfalls of the past, as well as begin
16 to develop a strong structure to help mitigate
17 those situations of the past that you
18 described. There's a strong commitment on our
19 part to do that, as well as counties and county
20 MH/MR programs to assure that there's a strong,
21 sufficient community-based structure.
22 I think that's one of the things we
23 want to make sure also is not at risk in this
24 process and why we pointed out the financial
25 situations because we do feel we're on the

1 right track. And with the tremendous progress
2 that's been made in new atypical psychotropic
3 medications that treat individuals with
4 schizophrenia and affective disorders, we want
5 to continue to maximize that so people can live
6 full lives in the community and not have this
7 issue and the population addressed in this bill
8 undercut or have an impact on the population of
9 people with serious mental illness.
10 MR. UNDERCOFLER: I guess the only
11 thing that I would add, again, just to
12 reiterate that the numbers we provided, they're
13 for your consideration, among the range of
14 issues that you will continue to discuss is
15 with respect to this very important health and
16 safety issue.
17 REPRESENTATIVE CALTAGIRONE: Thank
18 you.
19 CHAIRPERSON MASLAND: Just one brief
20 comment regarding mixing civil and criminal
21 issues. I think the Supreme Court was pretty
22 clear in Kansas versus Hendricks that it's okay
23 to have those criminal procedural safeguards in
24 a civil arena. I'm not sure addressing the
25 concern of Mr. Castor and Ms. Dombach that we

1 can somehow meld the two assessment processes.
2 I think we might have a constitutional problem
3 there.
4 This cannot in my mind be a totally
5 seamless situation from Megan's Law to whatever
6 you want to call this, because you are dealing
7 with the criminal arena and the civil arena.
8 There may be a problem constitutionally if we
9 start having the same team that does an
10 assessment in the Department of Corrections,
11 criminal justice purposes also doing the
12 assessment with respect to this circumstance.
13 That's something that's going to have to be
14 fleshed out and have to obviously look pretty
15 closely at that. Mr. Castor.
16 MR. CASTOR: One comment I would make
17 on this would be, it would be hopeful that the
18 two separate assessment boards would come to
19 the same conclusion, and that was the major
20 concern when we discussed that, at the minimum
21 the embarrassment that could occur if -- human
22 divergent conclusions. That's why we thought
23 that at least some unified process would be
24 useful.
25 CHAIRPERSON MASLAND: Coming to the

1 same conclusion on anything is difficult. This
2 does not involve economists or politicians. We
3 might be a little bit better off. It still
4 would be very difficult. I see Doctor
5 Wettstein smiling in the back. He knows how
6 difficult it can be as well. Any further
7 questions?
8 (No response)
9 CHAIRPERSON MASLAND: Thank you very
10 much.
11 (Short recess occurred)
12 CHAIRPERSON MASLAND: We're going do
13 reconvene the hearing now. Before our next
14 witness begins, I want to correct a
15 misstatement. The letter that I wanted to
16 submit as part of the record, October 20, 1997,
17 is from Dennis Walsh, who is the Governor's
18 Secretary for Legislative Affairs; not from
19 Representative Dennis O'Brien.
20 With that, our next person to testify
21 is Robert Donatoni, who is the President-Elect
22 of the Pennsylvania Association of Criminal
23 Defense Lawyers. Mr. Donatoni, you may begin.
24 MR. DONATONI: Thank you. I want to
25 thank you for the opportunity to speak. I'll

1 keep my remarks -- I prepared some testimony
2 that I've given to Brian, and I'm going to keep
3 my remarks beautifully, or at least brutally
4 brief and then answer whatever questions that
5 may be on the task force's mind and go from
6 there.
7 By way of background, let me
8 introduce myself and the organization for whom
9 I speak because we are not a politically
10 popular or politically strong constituency. I
11 will become in September the President of the
12 Pennsylvania Association of Criminal Defense
13 Lawyers.
14 Ten years ago six of us got together
15 and had a cookout. There was the birthplace of
16 an organization that has grown to 700 lawyers
17 across the state who practice primarily in the
18 area of criminal defense.
19 To our credit in the recent years,
20 somewhat against the tide, some of our members
21 have gone on the bench. I'm thinking of Judge
22 Warren Sanchez, from Chester County, my
23 hometown. I'm thinking of Scott Evans in
24 Dauphin County. I'm thinking of Lester
25 Rauhauser in Allegheny County. We're committed

1 to the process. We're not anti-government; we
2 are not anti-law enforcement; we are not
3 anti-police; we're not anti-anything. We are
4 folks who are pro, positive, and responsible
5 legislation and criminal law and criminal
6 procedure. That's where we come from as an
7 organization.
8 Personally, I'm not in favor of
9 crime. Crime generates a very good and
10 somewhat lucrative practice for me. But you
11 need to understand as I make these comments, at
12 home I have two beautiful creatures who are 10
13 years old. One is named Melinda and one whose
14 name is Lindsey. They are my daughters. I
15 call them my daughters, and they can call me
16 anything they want because I love them that
17 much. I'm aware of the concern that this task
18 force has, as I have as a lawyer, as a member
19 of the system. I believe in the system. My
20 association believes in the system, as a person
21 and as a father.
22 With that in mind, let me turn to
23 what I think are observations that I'd like to
24 make regarding the proposed legislation and
25 some flaws in it. I don't think -- As I was

1 taught as a prosecutor initially and then as a
2 public defender, and now as a private lawyer to
3 try cases, it takes -- you spend precious
4 little time emphasizing the good portions of
5 your cases. I think sometimes they obviously
6 speak for themselves. I wanted to highlight
7 what I foresee to be some problems.
8 They begin with I guess some
9 fundamental, I guess for sake of argument,
10 accepting the legislative findings. One being
11 that the prognosis for rehabilitating sexual
12 violent predators in the prison system is poor.
13 I'm going to accept that premise as valid for
14 purposes of argument, although I haven't heard
15 enough of today's testimony nor do I have
16 enough background in the area to know if that's
17 true. We turn then to the term sexually
18 violent offender, which is defined I think in
19 an overbroad and vague manner in the proposed
20 legislation.
21 The word violent obviously is a
22 visceral word that makes us all react in a
23 certain way; negatively for those persons who
24 may have that monogordum (phonetic) attached to
25 them. It's overbroad because, at least in a

1 couple of the crimes that are enumerated, the
2 qualifiers in this bill right now, violence
3 does not exist. Violence in the sense of harm
4 to a person does not exist.
5 Now, there may be some debate with
6 respect to the misdemeanor aggravated -- or
7 indecent assault where there has to be unlawful
8 touching, improper contact or sexual
9 gratification but there need not be violence.
10 I think that's an overbroad, ambiguous
11 qualifier.
12 I think the next rung up is where you
13 have penetration or something like that, where
14 you have involuntary -- or, I'm sorry,
15 aggravated indecent assault, vaginal
16 penetration which is more accurately termed
17 violent.
18 Secondly, although I don't condone or
19 I don't argue on further criminal ground would
20 be pornographic, obscene materials that are
21 enumerated in the bill and in Title 18 as
22 sexually violent. We've handled a number of
23 those types of defenses in my office, in my
24 county and around the state. They have
25 involved most recently a teacher, a private

1 school teacher that I had with 25 years at a
2 very, very, very prestigious, mainline private
3 school who had taught the classes there for 25
4 years and had a double life. He was involved
5 in pornographic material. He would qualify
6 under this bill as a sexually violent predator.
7 A scorched-earth investigation by his
8 school, which I won't name, and a
9 scorched-earth investigation by the liberal
10 prosecutorial authorities, and my own within my
11 office revealed that it was in fact a double
12 life. In fact, in 25 years he had taught
13 lawyers, bankers, teachers and judges, and the
14 investigator went back that many years to see
15 if there was ever an inappropriate suggestion,
16 let alone touching or violence by this man, and
17 there wasn't.
18 He paid his dues for the pornographic
19 material that he had, the obscene material
20 which was disgusting in and of itself. But
21 under the definition here, that man would
22 qualify. I think you need some tightening up.
23 I think you need to work on the definitional
24 section here as to the qualifiers.
25 I think, if I can, because I want to

1 keep my comments brief and answer any
2 questions, turn to what I believe to be the
3 fundamental flaw, and this again is an
4 overview, painting with a broad brush. Seems
5 to me in reading this bill, and I have no
6 history of the debates or any of the other
7 material, any of the other work that may have
8 gone into this. I'm sure it's substantial
9 prior to today.
10 But what we're saying here is, if
11 these people cannot be treated in the prison
12 system -- Well, it seems to me what some folks
13 are suggesting at least in terms of the
14 creation of the legislation is, let us at some
15 unknown but substantial cost create yet another
16 level of public or private bureaucracy to deal
17 with the treatment of people after they have
18 served a substantial prison sentence.
19 Now, the PACDL doesn't much care
20 about I guess taxes or money, but I think we do
21 to some extent, and I do as a citizen. By the
22 nontreatment now and delaying it for five, 10
23 or 15 years, I need to tell you folks, I don't
24 know if you have done any studies or have any
25 data with respect to the type of sentences that

1 are handed out for involuntary deviate sexual
2 intercourse or rape, but where I practice, the
3 judges are handing out some serious numbers.
4 Ten years is a negligible minimum, 10 to 20, 15
5 to 30, 20 to 40, 25 to 50. If what we're
6 talking about is not treating these people for
7 10 years, 12 years and keep in mind that the
8 parole people as of now, very few people are
9 getting their parole at their minimum.
10 In other words, as you know in
11 Pennsylvania you have to have a minimum and a
12 maximum. If you have a 10 to 20-year sentence,
13 you have to do your 10 before you are eligible
14 for parole. As I understand it, especially in
15 the sex area, sex case area they are not acting
16 or even giving hearings until well after the
17 minimum is served. Whether that's a function
18 of Probation and Parole policy, whether that's
19 a function of D.O.C. policy, whether that's a
20 function of Mudman Simon and all the other
21 things that we react to, that's a reality of
22 life.
23 But why not, if what we are trying to
24 do is ensure the safety, if what we are trying
25 to punish these people, and I agree that

1 punishment is a valid component of a sentencing
2 scheme in the criminal justice area; and it has
3 to be done, obviously in these type of cases,
4 you need to punish. You need to send a
5 message.
6 We're also saying that treatment is
7 necessary because sooner or later most of these
8 people need to be reintegrated into society. I
9 think it is fool-hearted. I think it's
10 ridiculous. I think it's almost inhumane to
11 wait until they have served 10 or 12 or 15
12 years.
13 I don't know how much time any of you
14 spent in the prison system, state and federal
15 prisons, but I have throughout the Commonwealth
16 and throughout the country because of the type
17 of cases I take, the type of cases that bring
18 me into other jurisdictions, there are
19 hierarchies in the prison system. The types of
20 people we are talking about, quite frankly, are
21 the bottom feeders and they are preyed upon.
22 Some people have told me, too bad. Miserably
23 sometimes I say, yeah, maybe that's too bad but
24 they are the victims and targets in the prison
25 system of individual inmates, prison gangs and,

1 yes, unfortunately, prison officials and
2 individual guards.
3 What we have are folks serving
4 substantial periods of time, victimized within
5 the prison system, bottom feeders, low end of
6 the totem pole, and then we expect to inject at
7 some unknown cost another layer of bureaucracy
8 with, perhaps, constitutional problems on many
9 levels. One was mentioned earlier with respect
10 to the blending of the disciplinary teams that
11 make the Megan Law assessment and the
12 assessment under this proposed legislation,
13 double jeopardy concerns which I can tell you
14 would be rattled around throughout the
15 Commonwealth by attorneys such as myself, and
16 then say, okay, now that you have done your 12
17 years, we are going to now involuntarily commit
18 you, which sounds to me a whole lot like jail
19 in a secured facility against your will for at
20 least a year and start to treat you now. It
21 seems to me, why can't we create a package
22 where the treatment is done at the same time as
23 the punishment?
24 I wasn't here and I wasn't privied to
25 some of the mental health experts and

1 psychologists and sociologists. Those that I
2 talked to informally over the years in handling
3 these types of cases tell me this: In order to
4 attempt to have the best shot available at
5 helping these people reintegrate, treatment is
6 necessary. In fact, we are obligated if we are
7 going to be anywhere near successful to inject
8 it, to introduce it sooner rather than later.
9 I have this concern then to sum up:
10 Why wait? Why can't we create a situation
11 where, if the prison system is the hangup to
12 treatment, well, when we're talking about 27
13 million, 42 million, 162 million, that's a lot
14 of money. I bet you that turns out to be
15 conservative because more of these cases are
16 coming into the system every day. Self-
17 fulfilling prophecy is not a slur or a jargon
18 to anyone. Bureaucracy eats upon itself, it
19 feeds itself and gets better. The money
20 commitment already is large and gets bigger.
21 Why not make the allocation now so
22 that we don't have to then have a bed 10 to 12
23 years down the road for 2,000 or more persons
24 for some unknown period of time. That, along
25 with the double jeopardy system, the concern

1 raised about the blending of the two assessment
2 teams is something that I did not address in my
3 written comments.
4 I do concur with some of the known
5 notion that -- One of the gentlemen said we
6 would hope there would be some uniformity. I'm
7 not sure that that could ever be the case, and
8 I'm not sure that it's good that would be the
9 case. I think the institutional structure of
10 having the same folks doing the same job
11 wearing two different hats creates a legal
12 problem. Double jeopardy may be yet another
13 problem even though we are putting the label of
14 civil commitment on it and we're giving,
15 purportedly, all kinds of criminal due process
16 rights, but not in all cases.
17 One other thought. How the heck can
18 we put on trial someone who is incompetent? I
19 know that there's a procedure in here, but
20 again, I'm thinking back to 19 years of
21 practice, some as a prosecutor, three years of
22 law school where the whole notion of
23 fundamental due process, that you do not try
24 those persons who are incompetent. To have
25 then some hearing to determine just how

1 incompetent they are, so that if they are
2 competent enough that their lawyer can put the
3 case together without the assistance of their
4 mind, folks, that's pure sophistry. It's
5 disingenuous. I don't mean to be impolite,
6 because I think what you are trying to do is
7 something worthwhile. But that's just
8 nonsense.
9 With that in mind, I thank you for
10 your time and your attention and any shots or
11 any questions you want to take at me, I'm a big
12 boy.
13 CHAIRPERSON MASLAND: Thank you, Mr.
14 Donatoni. Beginning down to the left,
15 Representative Manderino, any questions?
16 REPRESENTATIVE MANDERINO: No, thank
17 you.
18 CHAIRPERSON MASLAND: Representative
19 Orie.
20 REPRESENTATIVE ORIE: I guess the
21 first question I'd like to start with is, or
22 comment is, these individuals would not be
23 deemed incompetent under the statute. Instead,
24 under a mental abnormality they would be said
25 to be one that would commit this offense again

1 that's suffering under --

2 MR. DONATONI: No, no, I'm not

3 questioning that. There's a provision in here

4 that, generally, someone who is incompetent to

5 stand trial does not understand the nature of

6 the charges against them or cannot assist their

7 lawyers in terms of the charges. There's an

8 exception in here, in the second phase of the

9 civil commitment phase which sounds to me like

10 a criminal prosecution because you have the

11 right to counsel, proof beyond a reasonable

12 doubt. There's a provision in here to try

13 those people--I use that word try very

14 loosely--try those people even if incompetent.

15 That's what I was addressing. I hope I cleared

16 that up.

17 REPRESENTATIVE ORIE: I guess my

18 other question is, in regards to, if I could

19 offer you a situation; if, in fact, whether you

20 would be a defense attorney or a prosecutor

21 where you have an individual before you who has

22 a significant history involving numerous

23 victims and has numerous sexual offenses

24 attached to that and has been tried, but only

25 one of them comes forward with a plea or

1 whatever, and they have maxed out on whatever
2 sentence they have, but yet, these individuals
3 are within the prison system, whether or not
4 they are taking advantage of whatever is
5 offered within the system. But they indicate
6 based on their history and even based on any of
7 these sessions that they have, if they get out
8 they are going commit it again. They can't
9 control their urges.
10 What other alternative do you have,
11 then, to look at some type of civil commitment?
12 You can't keep them. You can't force some
13 treatment. In my opinion this is really
14 forcing treatment because there's nothing
15 really that exists right now providing the
16 psychiatric community the opportunity to take
17 the worse, most hard-core sex offender and
18 examine them, treat them, and really come up
19 with something. Really, we are at a lose right
20 now for --
21 MR. DONATONI: For that kind of
22 treatment. I can't answer it, but I can
23 understand your concerns and let me try to help
24 you out a little bit.
25 First of all, I think we need to give

1 some credit -- not some credit, some faith in
2 the trial judges and the prosecutors. I
3 understand someone may have a history that's
4 not reported or doesn't count as a prior --
5 doesn't enhance a prior record or those kind of
6 things.
7 But, I can tell you again, that most
8 of the judges in this Commonwealth or most of
9 the judges that I'm familiar with are going to
10 give that person, and whether I agree with it
11 or not as a defense lawyer, are going to give
12 that person as long a sentence as possible.
13 Although there may be only one
14 instance, there may be what we call crimes that
15 do not merge so they can get a sentence of five
16 to ten, which then may become, because of
17 multiconsecutive sentences, 15 to 30 years.
18 You are saying to me, what happens after 30
19 years? I don't think we should get to 30
20 years, because I think within that 15-year
21 period of time we should do what we're talking
22 about; give them some treatment within the
23 system.
24 If your question is, what do we do
25 with those people who have demonstrable -- that

1 there's nothing we can do with them no matter
2 what, my answer is, I don't have an answer. I
3 don't think anyone ever will have an answer.
4 REPRESENTATIVE ORIE: I guess I'm at
5 the point where you don't have an answer, the
6 worse thing you can do is release them into
7 society and jeopardize victims and citizens.
8 MR. DONATONI: It may be, Ms. Orie,
9 but it may be the only choice we have. It's
10 sort of like people say to me, you're not in
11 favor of the death penalty. No, I'm absolutely
12 opposed to the death penalty. What do you do
13 with someone who is serving a life sentence who
14 kills a prison guard if you are against the
15 death penalty? What do with that person?
16 That's the kind of case where I run out of
17 rationale.
18 I'll be honest with you. It's just
19 my religious, my philosophical, my ethical
20 aversion to the death penalty, but there are
21 cases -- don't let the aberrational case be the
22 tail that wags the dog. Use the mainstream
23 cases.
24 You raised a good point. The case
25 you are talking about, that example, is an

1 aberrational case. I don't want the
2 aberrational guy walking down the street next
3 to my two daughters. I guess what I've just
4 said is, I don't know how to help you on that,
5 other than trust the trial judges and get them
6 treatment early on.
7 There is one other thought, and then
8 I'll shut up for sure. There are ways to
9 construct sentences where you can receive many,
10 many years as minimal or maximum and attach a
11 probationary tail at the end as Representative
12 Manderino was talking about earlier so that
13 there is some type of supervision.
14 Again, you need some foresight, you
15 need some thought thinking, and you need some
16 action by the trial judges. But, I don't know
17 that you can legislate that aberrational -- I
18 don't think you should legislate anything based
19 upon an aberrational case. My concern is, you
20 work with that. I think it's absolutely great
21 if we could talk about it after break. I wish
22 I could be of more help.
23 REPRESENTATIVE ORIE: In regards to
24 that, you are going to have judges that have to
25 have psychological -- or much more information.

1 I think that's avert. I think you are going to
2 run into Catch 22 there as well.
3 MR. DONATONI: You may, but I think
4 it's pretty much routine now before any judge
5 that I know of or practice before sentences
6 somebody, in a Megan's Law situation or in one
7 of these big sex cases, they're going to court
8 order, if they don't have a defense party, a
9 psychological and psychiatric examination.
10 REPRESENTATIVE ORIE: Thank you.
11 CHAIRPERSON MASLAND: Thank you. You
12 present the dilemma of having a case that you
13 really don't know how to solve it. That's
14 difficult for a defense attorney.
15 Unfortunately, the public demands resolution or
16 some type of solution from folks up here. Our
17 only tool, it's the carpenter with the hammer
18 and everything looks like a nail. We're
19 legislators. Everything as well we have to
20 legislate.
21 MR. DONATONI: I understand that. I
22 sit in a much different situation from where
23 you sit. I want to make this comment. Don't
24 cast too broad of a net because you're going to
25 catch too much fish. You're under tremendous

1 public pressure to legislate, but don't let --
2 I can only just say, the straightened curves
3 that you have shown in the past, all of you
4 have shown in the past, not to be pushed around
5 by the notion that, well, Mudman Simon did this
6 and Arthur Bogart did that and, therefore,
7 we're going to legislate the hell out of a
8 problem that is a one percenter, two percenter
9 or five percenter. Too much regulation in
10 those types of areas are dangerous.
11 CHAIRPERSON MASLAND: It is a concern
12 and it reminds me when we were dealing with
13 Megan's Law issue that one of my colleagues
14 suggested, not seriously, but it would seem in
15 dealing with some of these people maybe the
16 most humane thing to do would be to use our old
17 aircraft carriers and just let them float
18 around in the Atlantic Ocean and the Pacific
19 Ocean, depending on which part of the country
20 you're coming, those that -- trying to
21 reintegrate them into society. It is --
22 MR. DONATONI: If you ever saw the
23 movie Papillion, the lepers were sent to a
24 colony in the 19th Century French prisons. It
25 might be a solution as ridiculous as that. I

1 don't have an answer. I'm honest to tell you
2 that.
3 CHAIRPERSON MASLAND: I appreciate
4 your candor. Thank you very much.
5 MR. DONATONI: Thank you, folks.
6 CHAIRPERSON MASLAND: I'll ask the
7 next three individuals to come forward and
8 testify. They are Michael Chambers with the
9 MH/MR Program Administrators Association,
10 Doctor Tim Foley of the Joseph J. Peters
11 Institute, and Michael Engle from Villanova
12 University. If you can testify in that order,
13 Mr. Chambers, Doctor Foley, and Mr. Engle. We
14 will then ask any questions that we have after
15 the three of you have all made your statements.
16 MR. CHAMBERS: Thank you. Good
17 afternoon, Mr. Chairman, members of the
18 committee: My name is Michael Chambers, and
19 I'm the Executive Director of the Mental
20 Health/Mental Retardation Program Adminstrators
21 Association of Pennsylvania. We are an
22 affiliate of the County Commissioners
23 Association of Pennsylvania. Thank you for
24 offering me the opportunity to testify on House
25 Bill 1811, known as the Sexually Violent

1 Predators Bill.

2 As I understand the bill, it's

3 designed to establish a class of involuntary

4 civil commitments to provide long-term care and

5 treatment to sexually violent predators who,

6 primarily, have served criminal sentences for

7 their acts, but who are at high risk of

8 repeating their offenses. While a number of

9 safeguards are built into the process to assure

10 fairness, the ultimate goal is to prevent these

11 criminals from presenting a danger to our

12 communities.

13 Rightfully, the bill recognizes that

14 these persons are generally not mentally ill.

15 Therefore, the bill establishes a

16 classification of mental abnormality which

17 would make civil commitment legally possible,

18 in the absence of mental illness. Despite a

19 few scattered successes, broad-scale treatment

20 cannot be expected to be successful, even in

21 the short term and certainly will not be

22 reliable over time. We cannot depend on any

23 treatment program for sexual predators to

24 protect our families from them.

25 My concerns stem from the stigma

1 applied to mental illness and the issues that
2 arise from that stigma. People with mental
3 illness are no more violent than the general
4 population. In fact, they are more vulnerable
5 to victimization of all sorts than the general
6 population. Still, when a person who has a
7 mental illness is charged with a violent crime,
8 the news media identify him or her as mentally
9 ill or a mental patient, and the public
10 develops an image of mental illness that is
11 distorted.
12 Discrimination against people with
13 mental illness has made it very difficult to
14 develop and maintain community-based services
15 and supports which help them to live
16 successfully in their communities.
17 Discrimination has made it possible for health
18 insuring organizations to deny or severely
19 limit treatment for mental illness. Decent
20 housing and employment are unavailable for many
21 people who have mental illness. Consumers of
22 mental health services and supports, their
23 families, advocacy organizations, service
24 providers and counties have fought stigma for
25 years, in a variety of ways.

1 Despite the definition that's in this
2 bill, most people will not differentiate
3 between mental abnormality and mental illness.
4 The confusion is exacerbated by the use of,
5 quote, mental health experts, unquote, in the
6 treatment team which initially assesses whether
7 or not a person is considered to be a sexually
8 violent predator. The bill would also require
9 that persons civilly committed as sexually
10 violent predators be confined in institutions
11 established by the Department of Public Welfare
12 compounds the issue.
13 DPW is the agency that is ultimately
14 responsible for services to Pennsylvanians who
15 have mental illness and is the entity
16 responsible for the management of state mental
17 hospitals. This clearly links the term mental
18 abnormality with mental illness.
19 At its core, House Bill 1811 is not
20 really intended to provide effective treatment
21 or rehabilitation, as much as it is expected to
22 confine sexually violent predators for the good
23 of society without violating their
24 constitutional rights and other rights under
25 criminal statutes. I believe that an

1 overwhelming majority of Pennsylvanians would
2 agree that they and their families deserve that
3 kind of protection.
4 On the other hand, I think that, if
5 these criminals are to be confined beyond the
6 terms of their criminal sentences, that
7 confinement should be provided as far away as
8 possible from Pennsylvania's mental health
9 service system.
10 If this bill, or a similar one must
11 be passed, I make the following
12 recommendations:
13 First, assign the responsibility to
14 some department of state government other than
15 the Department of Public Welfare. This will
16 help to separate mental illness from criminal
17 sexual behavior in the minds of the public. It
18 will also reduce competition for funding
19 between services for people with mental illness
20 and the confinement of criminals, which would
21 surely occur within the legislative
22 appropriations and within the department. The
23 desire to establish a new system of confinement
24 should not in any way be allowed to negatively
25 affect services and supports to Pennsylvanians

1 who have brain diseases.

2 The Department of Public Welfare

3 provides services and treatment through its

4 state mental hospitals and its mental

5 retardation centers. Because treatment is not

6 a serious consideration of this bill,

7 management of this type of institution is not

8 within the mission of DPW.

9 2. Provide a cost analysis and

10 economic impact statement with this bill,

11 considering both short and long-term

12 implications. The required institutions, as

13 well as the administrative and legal costs,

14 will be extreme. Last year, and again today,

15 Charles Curie, Deputy Secretary for Mental

16 Health and Substanse Abuse Services,

17 conservatively estimated that the annual

18 operational expense for one 250-bed unit would

19 be $42 million at a per diem cost of $450.00.

20 Because confinement would be long term, the

21 numbers would go up each year.

22 Mr. Curie added that DPW does not

23 have capacity for this service and would have

24 to spend at least $22 million to bring some

25 existing facilities to standard. I think that

1 his projections are as close to accurate as any
2 figures can be without a careful and prudent
3 evaluation. Additional costs to the judicial
4 system should also be considered. At any rate,
5 the potential cost of long-term confinement is
6 staggering and should be examined before any
7 bill of this type is passed into law.
8 Third, provide an appropriation when
9 passing the bill. Costs of this bill will be
10 so extensive that everyone involved should
11 clearly understand its potential impact.
12 Of course, the costs of county government,
13 which I represent related to this bill, should
14 be included. There should be no unfunded
15 mandates to divert funds from other areas of
16 public service to care for this criminal class.
17 Thank you.
18 CHAIRPERSON MASLAND: Thank you very
19 much, Mr. Chambers. Doctor Foley, you may
20 proceed.
21 DOCTOR FOLEY: I'd liked to thank the
22 committee for attempting to make Philadelphia
23 and Pennsylvania safer for my child. As well
24 as being a psychologist who studies, treats and
25 evaluates sex offenders every day, I'm a father

1 who is concerned about the well-being and
2 healthy development of his daughter.
3 I'm the Director of Clinical and
4 Forensic Services at the Joseph J. Peters
5 Institute which is located just down the street
6 in Center City. JJPI has been dedicated to the
7 evaluation and treatment of sexual offenders
8 and victims of sexual abuse for nearly 40
9 years. We currently have a large outpatient
10 program, as well as a prison program for
11 incarcerated sex offenders.
12 As I'm sure you are aware, sexual
13 psychopath or sexual predator laws are not new
14 to this country. The laws were quite popular
15 in the 1930's and some have remained on the
16 books in some of the states since that time.
17 Despite these well-intentioned efforts to
18 control sex offenders, research in the area
19 indicates that laws did not decrease the
20 reoffense rates of sex offending behaviors when
21 compared to states which did not have such
22 laws.
23 I want to talk about the treatment of
24 sex offenders. Conventional wisdom suggests
25 that sex offenders are not treatable and

1 interventions are ineffective in interrupting
2 the deviant cycles which are often implicated
3 in sex-offending crimes. The current research
4 on this matter, however, does not support this
5 conventional wisdom.
6 The first step in the treatment of
7 sex offenders involves a comprehensive
8 evaluation which helps to discriminate between
9 those who are likely to recidivate and those
10 who are not likely to recidivate. This goal is
11 achieved via actuarial risk assessments which
12 are already in place in some other states,
13 including New Jersey. Instruments to measure
14 the existence of sexual deviant fantasies,
15 which were not available in the 1930's, now
16 help us to accurately assign a risk category
17 and help with the development of an effective
18 treatment plan.
19 I'm talking about, here is a
20 comprehensive evaluation. Comprehensive
21 evaluation is in-depth, and really examines
22 many different aspects of sex offending
23 behaviors. The Sexual Assessment Board
24 evaluations which I reviewed are not
25 comprehensive. They do not go deeply enough.

1 They are, for the most part, cursory. It would
2 be very difficult, I think, to have much
3 confidence that there would be either -- not be
4 false positive or false negative findings in
5 those kinds of evaluations.
6 As you discussed here before, there
7 really is a paucity of people who are dedicated
8 to doing these kind of evaluations, which is
9 part of the problem in this regard. I know at
10 the Peters Institute we are constantly trying
11 to develop people who are dedicated to the
12 study and evaluation of sex offenders.
13 One of the difficulties of sex
14 offenders is that they are extremely
15 heterogeneous and very difficult to classify.
16 The behavior of sex offenders can be similar in
17 many ways, but the motivations for the crimes
18 vary widely across and within groups of sex
19 offenders. By understanding and studying the
20 motivations of the sex offender, treatment can
21 be designed which can interrupt the deviant
22 cycle of offending.
23 Most sex offenders are treatable.
24 Not all sex offenders are treatable. We know
25 that recidivism rate for sex offenders taken as

1 a whole is lower than for criminal code
2 violators, taken as a whole. We know that
3 completion of a sex offender specific treatment
4 program is the best predictor against future
5 offending.
6 We know that sex offender specific
7 behavioral treatments in combination with
8 intensive community supervision delivered by
9 dedicated parole and probation agents greatly
10 reduce the risk of reoffending behaviors.
11 While there is no cure per se, there are many
12 methods at our disposal which assist in
13 managing risk in decreasing the likelihood that
14 offenses will occur over the lifetime of the
15 offender.
16 We know that there are several
17 pharmacological treatments which are available
18 today which were not readily available in the
19 past. Antiandrogens, such as Provera and
20 Lupron, reduce the sexual drive of offenders
21 who are oriented toward a satisfaction of that
22 sexual aim. We know that less intrusive
23 medications, such as Prozac and its
24 derivatives, can be effective in decreasing
25 deviant sexual thoughts, and in combination

1 with behavioral treatments effectively reduce
2 the risk to reoffend.
3 We know that these treatments can
4 assist motivated, currently incarcerated
5 offenders who, without treatment, will spend
6 years entertaining deviant fantasies before a
7 likely release to the community. We must
8 recognize sexual offenders as patients, as well
9 as prisoners, rather than only as prisoners
10 until they have served their maximum sentences,
11 and then they are classified as patients who
12 should be civilly committed.
13 Sexual predator laws are directed
14 toward the small minority of convicted sex
15 offenders. The vast majority of sex offenders
16 target family members, not strangers. In
17 connection with the treatment suggestions
18 previously mentioned, we have an obligation to
19 educate the parents of our children about
20 sexually inappropriate behaviors and sex
21 offenders. For too long the burden was placed
22 on our children to discriminate between touches
23 which were bad and good. Community-based
24 programs such as Stop It Now can effectively
25 assist us in primary prevention programs which

1 curb the rate of sexual reoffending.
2 All of us have the same goal in mind,
3 which is to decrease the number of victims who
4 suffer child sexual abuse. Education and
5 primary prevention efforts can thwart some
6 sexual ause before it occurs. Treatment and
7 intensive community supervision is a
8 cost-effective alternative to civil commitment
9 for most sex offenders. Thank you.
10 CHAIRPERSON MASLAND: Thank you,
11 Doctor Foley. We'll proceed with Mr. Engle.
12 MR. ENGLE: I would like to thank
13 Chairman Gannon and the other members of the
14 House Judiciary Committee for inviting me here
15 today to testify. In October of 1997, I
16 testified before the Senate Judiciary Committee
17 and attempted to explain the significance of a
18 study conducted at Villanova University which
19 sought to ascertain the attitudes and opinions
20 of individuals who are involved in the
21 treatment of violent sexual offenders.
22 The Violent Sex Offender Study was
23 conducted by members of the Sociology
24 Department at Villanova, specifically Doctor
25 Bernard J. Gallagher, III, Doctor Joseph A.

1 McFalls, Jr. and myself. This study focused on
2 the attitudes and beliefs of members of an
3 organization know as ATSA, the Association for
4 the Treament of Sexual Abusers, and it explores
5 issues surrounding the treatment and release of
6 violent sex offenders.
7 Violent sexual offenders were defined
8 as those who have a predilection for committing
9 violence during an act of non-consensual sex,
10 where the violence involved goes above and
11 beyond the inherently violent nature of the sex
12 crime. The study sample included a thousand
13 forty members of ATSA from the United States,
14 of which 540, or 52 percent, responded to the
15 mail survey. The ATSA respondents included
16 individuals from many fields including,
17 psychiatry, psychology, social work,
18 corrections, parole and the like.
19 I must caution this committee that
20 the Violent Sex Offender Study was never
21 designed with the intent, or for the purpose of
22 investigating the specific issue which House
23 Bill Number 1811, the Sexually Violent Predator
24 Law, contemplates. The involuntary civil
25 commitment of sexual predators was not directly

1 examined by the study, nor can the data serve
2 as the basis for any legislative intent behind
3 the law such as the one being considered here
4 today. However, the results of the study can
5 provide some insight into aspects of this
6 legislation.
7 For example, the Sexually Violent
8 Predator Law is premised on the belief that
9 sexually violent predators have personality
10 features which are unamenable to existing
11 mental illness treatment modalities.
12 Nevertheless, the data suggest that this
13 assertion does not conform to the information
14 gathered from ATSA members.
15 In response to the statement, it is
16 not safe to release some sexual offenders into
17 the community after their period of
18 incarceration and treatment has been completed,
19 88.3 percent of those surveyed either agreed or
20 strongly agreed, while 5.4 percent were not
21 sure, and only 6.3 percent disagreed or
22 strongly disagreed. That data indicates that
23 some violent sex offenders are not safe to be
24 released while others can be. Therefore, some
25 sex offenders are amenable to current treatment

1 modalities.

2 The study further supports this
3 proposition, because the first item on the
4 questionnaire asked the respondent to evaluate
5 the effectiveness of various treatments from
6 completely ineffective to strongly effective.
7 All of the respondents indicated that some form
8 of treatment was, at the very least, effective.
9 This means that some of today's treatment
10 modalities work for certain categories of
11 sexual offenders. Violent sexual offenses
12 constitute a very broad category of behavior
13 engaged in by a very diverse group of
14 offenders, some of whom are amenable to
15 treatment, while others are not.

16 Unfortunately, this research did not,
17 and in many respects could not ascertain the
18 opinions of ATSA members with respect to which
19 types of sexual offenders are able to be
20 successfully treated. Nonetheless, this
21 legislation is overbroad because it will allow
22 for the involuntary commitment of people who
23 suffer from a mental illness that can be
24 treated when the law seeks to commit those sex
25 offenders who are unamenable to treatment.

1 Another significant limitation when
2 studying the field of violate sex offender
3 treatment involves the difficulty in generating
4 a definition for this broad category of
5 offenders. There are many types of sex
6 offenses and various kinds of sexual offenders
7 with a host of similarities and differences.
8 House Bill 1811 defines a sexually violent
9 offense in terms of statutory violations that
10 contemplate a wide variety of criminal
11 behavior, while it deems someone to be a
12 sexually violent predator if that person is
13 convicted of one of these crimes and also
14 suffers from a mental abnormality or
15 personality disorder.
16 A language barrier continues to exist
17 between law and psychiatry, whereby,
18 legislation identifies candidates for
19 commitment based on violations of criminal law,
20 while the people responsible for treating sex
21 offenders categorize based on a medical
22 diagnosis. These two separate and distinct
23 methods of classifying sex offenders do not fit
24 together well.
25 This legislation designates crimes

1 such as prostitution, kidnapping, and
2 misdemeanor indecent assault as sexually
3 violent offenses. However, none of these
4 crimes are necessarily committed because the
5 individual is a pedophile or suffers from
6 antisocial personality disorder. The existence
7 of a mental illness, in conjunction with a
8 conviction for prostitution, does not establish
9 that the crime was committed as a result of a
10 mental disorder or that the offender is
11 unamenable to treatment and, therefore, must be
12 involuntarily committed for the sake of
13 safeguarding society.
14 The results of the Violent Sex
15 Offender Study do indicate that many ATSA
16 members agree with the legislation's statement
17 that the prognosis for rehabilitating sexually
18 violent predators in a prison setting is poor.
19 In response to the statement, violent sexual
20 offenders would be better maintained within a
21 prison-like setting rather than in their own
22 treatment facilities, 48.7 percent strongly
23 disagreed or disagreed, 26.6 percent were not
24 sure, while 24.7 percent agreed or strongly
25 agreed.

1 If it is true that rehabilitation
2 does not occur while a sex offender is
3 incarcerated, then treatment cannot have any
4 chance of success until after the individual is
5 released from prison. However, if that person
6 is involuntarily committed without having been
7 treated in prison, and treatment is not
8 provided during the period of commitment, then
9 it will be impossible for anyone to provide the
10 evidence necessary to establish probable cause
11 to believe that the person is no longer a
12 danger to the community because their mental
13 abnormality or personality disorder has
14 changed. In essence, release will be virtually
15 impossible once someone is committed.
16 In conclusion, the data from the
17 Violent Sex Offender Study tells us that ATSA
18 members acknowledge the fact that some sex
19 offenders cannot be treated successfully and
20 that some offenders are not safe to be released
21 into the community. However, there are other
22 people who fall within the scope of this
23 legislation who are amenable to treatment.
24 The question is whether we, as a
25 society, choose to throw our hands in the air

1 and give up on the prospect of treatment and
2 rehabilitation in favor of mere incapacitation,
3 or will we advocate the continued study of
4 violent sex offenders with the hope of
5 constantly improving treatments.
6 From the written comments of the ATSA
7 members who responded to the study, it is
8 readily apparent the individuals who treat sex
9 offenders are not willing to simply give up,
10 but rather they need support in order to
11 continue their important work. I wish the data
12 collected thus far could provide definitive
13 answers to the questions surrounding the
14 utility of involuntary civil commitments of
15 sexually violent predators. Nevertheless, I
16 cannot proffer such information today. More
17 research must be conducted before any
18 conclusions can truly be made with regard to
19 the appropriateness of commitments contemplated
20 by House Bill 1811.
21 Thank you for your time and
22 attention. I hope that I can answer any
23 questions that you may have concerning the
24 study.
25 CHAIRPERSON MASLAND: Thank you very

1 much, Mr. Engle. We'll proceed to questions.
2 Representative Manderino.
3 REPRESENTATIVE MANDERINO: Thank you,
4 Mr. Chairman. I have two questions that I'd
5 kind of like each of you to, or whoever wants
6 to respond, if all three of you do want to
7 respond, to respond to. I'm very confused by
8 some of the testimony I have heard this morning
9 with regard to whether sexual offenders are
10 people with a mental health disorder, a mental
11 illness, a mental abnormality. I'm not quite
12 sure what any of those definitions mean.
13 I have heard folks say that sexual
14 predators are not the same as people with
15 mental illness. Then I see that, at least on
16 the letterhead of J. J. Peters that you treat
17 the mental health of sexual offenders, which
18 isn't the same as mental illness. Help me out
19 here. Who wants to volunteer some -- if you
20 can understand what my confusion is, maybe some
21 thoughts along that line.
22 DOCTOR FOLEY: I think your confusion
23 really reflects really what is happening and
24 what we have. Sexual offenders are extremely
25 heterogeneous, and they fit all the categories

1 that you just described. The only thing that
2 you can bet on with sex offenders is that they
3 are all different. They define and need
4 classification.
5 I have a sex offender waiting in my
6 office right now who fits many ATSA 1
7 disorders. He's developmentally delayed. He
8 probably has a full-scale IQ of less than 70.
9 I believe that he's probably schizophrenic, and
10 he's also violent and he's a sexual predator.
11 I think he probably does not really have
12 volitional control over his sexual urges. So,
13 this young man really sort of fits all the
14 criteria that you just described.
15 REPRESENTATIVE MANDERINO: Any other
16 different thoughts? (No response) Okay.
17 Here's my second line of
18 questioning. Towards the end of Mr. Engle's
19 testimony he said the fact, and others have
20 repeated this, the fact that some sex offenders
21 cannot be treated successfully and some are not
22 safe in society. However, there are other
23 people who fall within the scope of this
24 legislation who are amenable to treatment. We
25 heard that over and over again.

1 Mr. Foley from Peters Institute, you
2 say most sex offenders are treatable and we
3 know that the completion of the sex offender
4 treatment program is the best predictor against
5 future offending. Those two ideas, as well as
6 others I have heard repeated here, say to me,
7 when do we know whether somebody is more apt to
8 be able to be treated or more -- Do we know at
9 the time of sentencing when they're first
10 being -- Are we able to make that
11 determination? Some said let's leave the
12 decision to the judge, leave some discretion.
13 Do they know at the time when
14 somebody is just coming through the criminal
15 justice system and they're being sentenced for
16 the commission of this crime that they've just
17 been tried for whether or not this is a person
18 that's amenable to treatment, so therefore,
19 they have to fashion the sentence in such a
20 way? Or, did we not know that until we get
21 them in prison? If we are doing things right,
22 which sometimes we are and sometimes we aren't,
23 they are getting some treatment, and then after
24 they have been in prison and they have gone
25 through successfully or unsuccessfully a

1 treatment program, that then we know that we
2 have a little bit more of a predictive
3 capacity? Or, is it once they are out of the
4 prison setting and in the community and they go
5 through some program, then we know?
6 We may never know, I realize,
7 definitively. But when we talk about people
8 being treatable and successful completion of a
9 program being a good indicator of reoffense, I
10 guess I'm saying, at what stage does that
11 happen?
12 DOCTOR FOLEY: It can happen at any
13 stage. What you are requesting is that there
14 be an ongoing actuarial risk assessment at each
15 stage along the way, which is the best
16 predictor at our disposal right now. We know
17 that clinical prediction, this is sort of my
18 opinion, my gut feeling about an offender, is
19 very likely overpredicting percents.
20 Currently, the Pennsylvania Sex
21 Assessment Board uses clinical prediction which
22 is I think one of the dangers. In an actuarial
23 risk prediction model which is used in New
24 Jersey and used in a lot of other states, you
25 could do that at anytime. You could do ongoing

1 actuarial risk assessment or at specific times.
2 It's an in-depth assessment. It's not one that
3 can happen in an hour or two hours, and it's
4 one that is more expensive than evaluations
5 that are currently being used by the Sex
6 Assessment Board in Pennsylvania.
7 REPRESENTATIVE MANDERINO: Anyone
8 else with some other thoughts?
9 MR. CHAMBERS: I really don't think
10 there's any simple answer to that. I think
11 he's absolutely right. It requires ongoing
12 evaluation of each person. It becomes more
13 difficult to do that as the numbers become
14 larger. That's been my concern through this
15 process. We are talking about hundreds to
16 thousands of people. It's very hard to control
17 the kinds of process that they have gone
18 through and the risk then becomes greater in my
19 view.
20 MR. ENGLE: I can only address this
21 question in terms of what the study said.
22 Unfortunately, that was not something that the
23 study could determine. It wasn't something
24 that the respondents actually were questioned
25 about.

1 My answer would be, I don't have an
2 answer as far as that goes.
3 REPRESENTATIVE MANDERINO: Thank you.
4 Thank you, Mr. Chairman.
5 CHAIRPERSON MASLAND: Thank you.
6 Representative Orie.
7 REPRESENTATIVE ORIE: I guess my
8 first question would be in regards to the study
9 that you performed at Villanova University. We
10 had some of the testifiers indicate that there
11 isn't a problem of recidivism with these type
12 of individuals, that that's blown out of
13 proportion. It's actually in line with other
14 offenders. I see on your charts on page number
15 2 it says, and this is most disturbing to me,
16 Relapes After Completing Treatment.
17 And question 3 asks and it's entitled
18 Relapses After Completing Treatment, where
19 these individuals indicate that members
20 involved in treating sex offenders that they
21 strongly agree that these individuals are
22 relapsing. 64.5 percent say that they are
23 relapsing.
24 MR. ENGLE: 64.5 percent of those
25 members were saying that many violent sexual

1 offenders have relapses after completing
2 treatment programs. That, of course, doesn't
3 quantify the number for many.
4 REPRESENTATIVE ORIE: I guess that
5 that would lead into my question to Doctor
6 Foley, because you have indicated that you have
7 this treatment program in place. Yet, I have
8 before me the American Psychiatric
9 Association's Task Force Report on sexually
10 dangerous offenders where the task force
11 indicates specifically that there has to be an
12 increase investment in research on these
13 individuals, as well as clinical training of
14 psychiatrists and other mental health
15 professionals regarding assessment and
16 treatment of persons with those disorders.
17 It goes further to say that, although
18 the scientific understandings of this disorder
19 has improved in recent years, the societal
20 investment research is not being commensurate
21 with the need for new knowledge relating to the
22 diagnosis and treatment of persons with this
23 disorder and the effects. In essence, it
24 indicates that the training programs for
25 psychiatrists have been inadequate in regards

1 to teaching the assessment and treatments.

2 Taking that along with what the

3 psychiatric association indicates, we don't

4 know the value of these types of

5 community-based programs for sexually violent

6 predators because they are even questioning the

7 training as well as the assessment procedure.

8 Would you agree?

9 DOCTOR FOLEY: I would disagree with

10 that.

11 REPRESENTATIVE ORIE: You would

12 disagree?

13 DOCTOR FOLEY: Yes, I would disagree.

14 I'm a state representative for ATSA which Mr.

15 Engle refers to. I have questioned him

16 directly on his results. As far as that APA

17 Task Force, I'm certainly in agreement. We

18 certainly do need more study. We need more

19 depth into such a serious problem.

20 But, we know an awful lot right now.

21 We know an awful lot about recidivism rates.

22 We know an awful lot about sex offenders who

23 have been caught which is one of the limiters

24 with this. What we know about sex offenders is

25 about caught sex offenders.

1 I think there's always going to be
2 room for us knowing a whole lot more. We know
3 an awful lot about recidivism rates, and we
4 know some things about predicting offending
5 behaviors.
6 REPRESENTATIVE ORIE: I guess this
7 task force goes further to say that, even
8 recent studies do not provide good measures of
9 treatment because whatever treatment is
10 provided within the prison system is not
11 continued in the community after release. Nor,
12 is there a cooperative effort with Parole and
13 Probation to ensure proper monitoring of these
14 things. I guess my question --
15 DOCTOR FOLEY: One of the things that
16 I really feel is very good about what we are
17 doing at Peters is the kind of cooperation that
18 we have established between the special sex
19 offender units at Parole and also Probation.
20 I'm aware of even in the past week intervening
21 in what I think would have been a sure offense.
22 I'm also aware of a failure that way too. That
23 was when, because of the administrative
24 difficulties in another unit we weren't able to
25 establish that kind of cooperation. That was

1 very upsetting. We're doing things to fix it
2 and refine it and to get better at what we do
3 every single day.
4 REPRESENTATIVE ORIE: Obviously, you
5 must be the exception to the rule. The
6 American Psychiatric Association is indicating
7 that this is not what's happening. That's my
8 biggest concern is, you know -- I'm certainly a
9 big proponent of treatment and intervention
10 with these individuals, but I also think
11 that -- I'm curious to see the effectiveness if
12 they themselves indicate that they are not even
13 up to par in regards to dealing with this
14 problem. That's where my concern is with these
15 very serious sexually violent offenders. That
16 really even holsters more why there should be
17 some other measure or mechanism there to ensure
18 the safety of the citizens of Pennsylvania.
19 DOCTOR FOLEY: We have a treatment
20 program integrated with prisons and frequently
21 coordinate an offender moving from treatment in
22 the prison to our outpatient clinic. Then
23 working very, very hard with a particular
24 parole agent in that case in making the
25 treatment continuous and constantly reassessing

1 that offender to make sure we know where the
2 risk rate is and communicating that kind of
3 information to the parole agent.
4 It may not be everywhere, but I don't
5 think that what we do is magic and it would be
6 easily replicated.
7 REPRESENTATIVE ORIE: I appreciate
8 your input, and I also would welcome the
9 opportunity to, perhaps, go out on site and see
10 exactly what you do out there. I thank you
11 very much.
12 CHAIRPERSON MASLAND: Thank you,
13 Representative Orie. Doctor Foley, you talked
14 about conventional wisdom as being -- as
15 holding that these people are not treatable. I
16 think of conventional wisdom frequently as I do
17 with the term common sense. Maybe it's
18 conventional but it's not necessarily wise.
19 Common sense is not necessarily common. Maybe
20 it makes sense.
21 I think the problem though is the
22 distinction between treatable and curable. I
23 would venture to say that most members of the
24 public don't think something is really being
25 treated unless it's been cured. Give me a

1 pill; make it go away. I take the pill and it
2 goes away. I have been treated; I have been
3 cured.
4 As I have come to understand with
5 this type of a situation, it's really not
6 curable. It may be treatable for some people.
7 I think we have an agreement based on all of
8 the testimony so far today that for some people
9 it's treatable; for some people it's not. The
10 difficulty we have is trying to decide who
11 falls into each of those camps. Any comments
12 on that?
13 DOCTOR FOLEY: That's one of my
14 struggles every single day. That's exactly
15 what I do on most days is try to make that
16 discrimination and to use all the scientific
17 tools I have, all psychological testing tools
18 that I have, all the reasonable risk
19 assessments that I can apply to make that kind
20 of a decision. The number of people who are
21 really going to be untreatable, the kind of
22 people that you see in the media that say, if
23 you release me, I'm going to go back and
24 reoffend are rare; extremely rare.
25 CHAIRPERSON MASLAND: I agree they

1 are rare, but we had one in the case of Kansas
2 versus Hendricks which is the United States
3 Supreme Court decision we're all dealing with.
4 Somebody was very honest and said I will offend
5 until the day I die. You are not always going
6 to have that in those type of hearings.
7 DOCTOR FOLEY: One of the regrettable
8 things about Mr. Hendricks' case is that, he
9 was considered a prisoner for all those years
10 in the Kansas Department of Corrections and
11 never offered any treatment. He was declared a
12 patient on the day of his release.
13 I would certainly contend it's hard
14 to have it both ways. I think we would be
15 better served, as the gentleman spoke before
16 us, if we begin treatment earlier on. Then
17 maybe Mr. Hendricks wouldn't have been in that
18 kind of situation.
19 CHAIRPERSON MASLAND: Thank you.
20 Thank you very much, gentlemen. Our last panel
21 consists of members of the Forensic Advocacy
22 Coalition, Mr. William Faust, Mr. Ernie Peebles
23 and Doctor Jeffrey Allen. If you three would
24 come forward.
25 I would say, I know you have been

1 sitting here all day listening to this as we
2 have. To the extent you can get to most
3 important issues, that will be appreciated.
4 Thank you.
5 MR. FAUST: You have the written
6 testimony of the coalition. I'm merely going
7 to talk a little bit about the issues. My name
8 is William Faust. I'm Vice President of the
9 Forensic Advocacy Coalition. As we have
10 addressed here, Ernest Peebles and Doctor
11 Jeffrey Allen, they will take their own as we
12 go along.
13 Listening to today's discussions has
14 left me with the point of wondering, we are all
15 between a rock and a hard place, if you will
16 allow me to use that vernacular. It has been
17 an experience to learn and hear the various
18 positions.
19 The position of our coalition which
20 is a true coalition of mental health consumers,
21 family members and professionals and all of us
22 being advocates, we are very concerned with the
23 criminal justice system and mental illness.
24 That is our expertise.
25 The focus of this entire testimony is

1 indicating that we do not wish to have mentally
2 ill people commingle with sexually violent
3 predators. We don't have a definition for what
4 that is, sexually violent predator. We just
5 don't want to see this group commingled in
6 state hospitals. We need to have them
7 separate, funded separately, and treated
8 separately.
9 I don't have any answers to all of
10 these thoughts, but I know that we got here
11 from one place--the Kansas versus Hendricks
12 decision of the Supreme Court.
13 I was present at that argument. That
14 was my first time in 71 years seeing a Supreme
15 Court argument. It may be the last time. I
16 don't know. But, I assure you that it has
17 developed an offspring of problems in our
18 society. Hendricks did, as you have all said,
19 say that he would go out and offend again. It
20 has caused a tremendous outpouring of problems,
21 financial. The Hendricks' case in our
22 discussion with -- By the way, we have talked
23 with Carla Stovall. She said for her first
24 group of beds that it cost a million dollars to
25 set up.

1 In the last recent discussion just a
2 short time ago, the average treatment costs per
3 year are $100,000 per person. So, it is a very
4 expensive operation to deal with.
5 From all of those problems that have
6 occurred, it seems that we all -- I don't know
7 how you would write legislation that will help
8 everything; that will help everything. I
9 really don't. I know as advocates that in our
10 struggle to keep mentally-ill people and the
11 stigma with mentally-ill people in the criminal
12 justice system, that we cannot allow this
13 entire stigma to overcome and say that they
14 have a mental illness. I don't know what you
15 say--mental abnormality, excessive libido, I
16 don't know. I truly don't.
17 I testified at the Senate hearing on
18 this bill, and it has just become more
19 difficult over this period of time with all of
20 the things that have occurred since then.
21 Just last week the New Jersey
22 Governor, Christie Whitman, signed a bill about
23 violent sex predators. You will see in our
24 exhibits various issues that have occurred that
25 help us to get the research that we've done.

1 But, from that standpoint, that doesn't answer
2 your problems. It truly doesn't.
3 There is an exhibit which shows her,
4 Christie Whitman's statement, press release;
5 plus, there is another issue relative to the
6 bill, just the cover part of the bill. From
7 that standpoint this entire problem continues
8 on.
9 I don't want to take anymore time
10 addressing the issues. You have the testimony
11 in front of you. It will be very easy to walk
12 through and show, and every exhibit is detailed
13 in this testimony.
14 Because of time constraints, I think
15 I would like to now turn it over to Ernie
16 Peebles to take care of what he wants to tell.
17 CHAIRPERSON MASLAND: Thank you, Mr.
18 Faust. You may proceed, Mr. Peebles.
19 MR. PEEBLES: Good afternoon, Mr.
20 Chairman, and members of the committee: I'd
21 like, with your permission, to digress from my
22 script as much as you have had a long day.
23 I am a board member of the Forensic
24 Advocacy Coalition and am employed by the
25 Mental Health Association of Southeastern

1 Pennsylvania as its adult psychiatric advocate.
2 Previously I was assigned to Philadelphia State
3 Hospital, also known as Byberry and presently
4 assigned to Norristown State Hospital, as well
5 as Philadelphia and surrounding counties.
6 I could only suggest that our
7 committee would like people treated, but within
8 state psychiatric institutions. I would
9 suggest to the committee members that that
10 treatment should be confined and consigned to
11 the chronically mentally ill.
12 Currently, there's roughly 600 or
13 more patients at Norristown State Hospital as a
14 result of Haverford State Hospital's closing.
15 It costs presently, perhaps, $100,000 to
16 $125,000 per patient per year to treat the
17 chronically mentally ill in state institutions.
18 On the campus of Norristown State
19 Hospital there are two independent treatment
20 facilities for sex offenders who are also
21 chronically mentally ill. The current
22 Executive Director of the Mental Health
23 Association, Joseph A. Rogers, as well as the
24 association as a result of the closing of
25 Philadelphia State Hospital were instrumental

1 in getting both those facilities on the campus
2 of Norristown State Hospital initially, for the
3 Byberry class patients, but now those
4 facilities, at least one to my knowledge, also
5 treats other than the Byberry class patient.
6 Having attended a few years ago some
7 annual meetings at one of those facilities, I
8 was amazed that with regard to the treatment of
9 sex offenders there were so many various
10 modalities, and among those clinicians and
11 scientists, at least in my lay opinion, there
12 was no agreement as to the most effective
13 treatment modalities for sex offenders. That
14 for me, as a layperson and as an advocate was a
15 concern, and I'm also a parent of a 12 year
16 old.
17 Subsequent to attending some of those
18 meetings, approximately a year ago as the panel
19 members and public are aware, an individual as
20 a patient at Norristown State Hospital left the
21 campus and verbalized some of his (pause)
22 sexual aberrants to some neighbors. One
23 neighbor happened to be I believe a cousin of
24 one of your colleagues within the state
25 legislature. As a result of that verbalization

1 and an attempted break-in to one of the
2 neighbor's homes, that led to a lock-down at
3 Norristown State Hospital, to which hundreds of
4 psychiatric patients had what little freedoms
5 that they previously enjoyed curtailed, and for
6 the most part still do.
7 I think as I speak now, there are
8 only, perhaps, 112 chronically mentally ill
9 individuals that have campus privileges at
10 Norristown State Hospital. Everybody else is
11 locked away; or, escorted, which, as a
12 layperson and advocate, I could suggest
13 exacerbates their individual mental illnesses.
14 It's a very serious question as to
15 how individuals are treated. But, there's a
16 broader question in my opinion. Do we move an
17 individual from incarceration to another form
18 of incarceration which is a state mental
19 facility, when that individual moving from a
20 penal system has no prior history of mental
21 illness, and when in surrounding counties there
22 are individuals who could benefit from moving
23 from acute hospitalization to chronic
24 hospitalization and have demonstrated a history
25 of mental illness?

1 I don't know which came first, the
2 chicken or the egg. I do know that the
3 individuals that are in the two facilities on
4 the campus of Norristown State Hospital that
5 are independent, and the three and a half to
6 four years that both these independent agencies
7 have operated, to my knowledge, and I could be
8 wrong, at least in one program there's only
9 been one individual that's been discharged in
10 three and a half to four years. This facility
11 deals primarily with mentally ill sex offenders
12 from the Byberry class.
13 So, I don't. I really don't know. I
14 can only suggest that many of the individuals
15 that I come in contact with, whether they have
16 a forensic mental health history or not are
17 crying out for their freedoms that have been
18 curtailed as a result, at one time, of a
19 scientific definition of dangerous to self or
20 others. In many cases the individuals are
21 exacerbated when their mental health illnesses
22 are being criminalized either by the
23 bureaucracy to which they're domiciled to or by
24 the ignorance or excitement of the public
25 and/or the press.

1 CHAIRPERSON MASLAND: Thank you. I
2 appreciate that. Doctor Allen will conclude
3 and then we'll begin questions.
4 DOCTOR ALLEN: Good afternoon, Mr.
5 Chairman, and members of the task force. I'm
6 Jeff Allen. I'm a licensed psychologist in
7 Pennsylvania and New Jersey. I'm in private
8 practice. I have about a 15-year background in
9 the treatment and evaluation of sexual abusers.
10 I was for four years the Director of Psychology
11 at New Jersey's facility for the treatment of
12 sentenced male sex offenders, the Adult
13 Diagnostic and Treatment Center down in New
14 Jersey.
15 I am now in private practice, and I
16 serve as a consultant to three state
17 departments in the State of New Jersey; the
18 Division for Developmental Disabilities, the
19 Division of Youth and Family Services, and the
20 Department of Corrections. In all three of
21 those capacities I treat and/or consult on
22 and/or evaluate sexual offenders. So, I have a
23 background in the area in which to speak to
24 you.
25 I know that you are all tired and

1 you're probably suffering from information
2 overload at this point, so I just have two
3 points to make. The first is that, treatment
4 of sexual offenders, if it's properly designed
5 and adequately funded, can be effective.
6 I have brought with me a study which
7 I'd like to describe for you. It was published
8 in 1995 by Nancy Steel, who is a nationally
9 recognized expert in the evaluation of sex
10 offender treatment programs. Doctor Steel went
11 to the literature and looked at the studies
12 that have been published on eight institutional
13 sex offender treatment programs.
14 These are programs that have been
15 housed, for the most part, in correctional
16 settings, state prisons that have been devoted
17 to the housing and treatment of sexual
18 offenders. Included in that study was Avenel,
19 the institution where I used to work.
20 The follow-up period for assessing
21 recidivism from these programs varied from one
22 to 15 years. In the field of sex offender
23 recidivism research, 15 years is a very long
24 time.
25 The percent of new sex offenses from

1 these programs varied from a low of 9.3 percent
2 to a high of 25.5 percent. I want to add that
3 the 25.5 percent comes from a program where the
4 individuals started treatment but did not
5 complete it. So, they were only partially
6 treated.
7 If we look at the reciprocal of these
8 numbers, this means that roughly 75 to 90
9 percent of those in these programs did not
10 commit a new sexual offense. That may run
11 counter to what we hear in the press and in the
12 other media. I think it should be clear from
13 the previous testimony by now, however, that
14 the people that we are talking about who
15 recidivate with sex offenses are a relatively
16 small number. I think that's an important
17 point to keep in mind in making a decision
18 about how to set up a commitment procedure for
19 sexual offenders.
20 We have additional, more specific
21 data from two other programs. These are
22 California's Atascadero Research Project and
23 Vermont's Sex Offender Treatment Program. I
24 mentioned these two particular programs because
25 they are probably the most comprehensive sex

1 offender treatment programs that have been
2 discussed in the literature to date. The
3 figures from Atascadero on recidivism are very
4 interesting.
5 The follow-up period was 38 months; a
6 little over three years. For rapists, 23
7 percent of those who were treated recidivated
8 within 38 months. There was a voluntary
9 control group of sex offenders who were matched
10 to the rapists but who did not receive
11 treatment. In that control group, almost half,
12 48 percent, recidivated within 38 months. The
13 recidivism rate for rapists in this program was
14 cut in half by treatment.
15 For child molesters, 7.8 percent of
16 the child molesters who received treatment
17 recidivated within 38 months; that's eight
18 percent. From the voluntary control group of
19 untreated child molesters, the recidivism rate
20 was 11 percent; still quite low. But,
21 obviously, there were some treatment benefit to
22 the child molesters.
23 In Vermont the picture is roughly the
24 same. I hasten to add that the treatment
25 period in Vermont was shorter than the

1 treatment period in California. The follow-up
2 period was one to eight years. For pedophiles,
3 seven percent of those released recidivated.
4 For incest offenders, three percent of those
5 recidivated, and for rapists, 19 percent of
6 those treated recidivated.
7 So, it is clear, at least to me, from
8 these numbers that properly designed and
9 adequately funded treatment programs can make a
10 difference, a significant difference.
11 Second point. How much does it cost
12 to have an adequately funded treatment program?
13 Well, thoughts on this vary. My experience at
14 at Avenel in New Jersey was of a program with a
15 million dollar treatment budget on top of the
16 usual correctional costs.
17 Avenel is a prison with a sex
18 offender treatment program. The cost of
19 treatment alone was a million dollars. We had
20 about 600 sentenced offenders at the time that
21 I was the Director of Psychology there. So
22 that works out roughly to about sixteen to
23 $17,000 a year per offender.
24 In my opinion, we were understaffed
25 and needed almost double the number of

1 treatment professionals that we had, which was
2 16 at the time. So, in all fairness I think
3 that an adequate program at that time could
4 have been run out of that institution at a cost
5 of about $33,000 per offender per year.
6 I know that Attorney General Stovall
7 from Kansas has indicated that their program
8 for sex predators would be funded at the figure
9 of a hundred thousand dollars per year per
10 offender. I think that's reasonable. I would
11 love to have had that much.
12 There are figures in the literature
13 to which you can compare these two figures.
14 I'll mention just one. Minnesota has a sex
15 offender treatment program that costs about
16 $2,400 a year per offender. In looking at
17 these figures, though, it's important to
18 determine whether or not we're setting up an
19 entirely new program where we have to do
20 everything and fund everything, or whether we
21 are simply installing a treatment program
22 within an already existing institution.
23 Obviously, the cost of the latter is much
24 cheaper.
25 The last point I want to mention is

1 really a philosophical point. It has to do
2 with locating programs for sex offenders within
3 existing institutions. My experience in New
4 Jersey is that, the philosophy of the staffs
5 regarding the likelihood that treatment will
6 work makes a big difference in what you are
7 able to do. If the staff believe that the only
8 thing that's effective and the only thing that
9 offenders deserve is the punishment, that is
10 not a treatment positive review. I will
11 suggest that your results would show it.
12 It's important that people who work
13 in these programs know what they are doing and
14 know what's possible. Thank you.
15 CHAIRPERSON MASLAND: Thank you.
16 Before we start with questions, Doctor Allen, I
17 just ask if you could get us copies of, I
18 believe it was Nancy Steel's 1995 study or
19 maybe a summary, and then the last study you
20 were looking at, some of those statistics would
21 be helpful too. If you can get them to
22 Attorney Preski of our staff.
23 DOCTOR ALLEN: Certainly.
24 CHAIRPERSON MASLAND: Questions?
25 Representative Manderino.

1 REPRESENTATIVE MANDERINO: Thank you,
2 Mr. Chairman. Mr. Faust, it's clear to me I
3 have to go back and read Hendricks, but help me
4 out a little bit. What was the nature of his
5 sexual offense?
6 MR. FAUST: I believe he was a
7 pedophile, I believe.
8 REPRESENTATIVE MANDERINO: One of the
9 prior panelist said but toward the end, kind of
10 an aside, it wasn't part of his testimony, that
11 when he was -- the whole time he was in prison,
12 and then, of course, I guess this issue arose
13 because when he was -- the end of his sentence
14 he was saying, I'm going to go out and
15 recommit, but they had said he never got any
16 treatment when in prison. Is that your
17 understanding of the fact pattern?
18 MR. FAUST: I'm not aware of that
19 part of it. I can't even get it in my head.
20 REPRESENTATIVE MANDERINO: Is anybody
21 aware of whether that is accurate?
22 DOCTOR ALLEN: That is correct.
23 REPRESENTATIVE MANDERINO: My
24 question then to Doctor Allen is, I'm just
25 wondering in cases like, let's assume that

1 Hendricks' sexual offense was pedophilia and if
2 somebody had not been in any kind of treatment
3 which I assume is teaching them how to
4 recognize, control, and whatever their urges or
5 whatever, is part of what they get in treatment
6 an understanding of it?
7 I'm just sitting here wondering, had
8 Hendricks had treatment before he came out of
9 prison if he would have even made those
10 statements or felt so desolate about whether he
11 would or wouldn't be able to -- whether he
12 would reoffend or not? I don't know. This is
13 all raising a lot of questions in my mind.
14 DOCTOR ALLEN: Well, I can't really
15 comment on Mr. Hendricks individually, but I
16 can share with you my experience of doing
17 treatment. Many offenders that I have treated
18 begin therapy extremely depressed because they
19 know they have a problem. They have been
20 keeping it a secret for a long time and doing
21 all kinds of things to avoid detection and to
22 avoid facing who they really are.
23 When a person learns to control his
24 behavior and discovers that there are
25 individuals who will support him in his efforts

1 and he sees some change, that often tends to
2 make him less depressed and more hopeful.
3 I suspect, although I don't know, if
4 Mr. Hendricks had had the opportunity to
5 participate in several years of good treatment,
6 that he might have been less pessimistic about
7 his future. I've seen that.
8 REPRESENTATIVE MANDERINO: So, you
9 can't predict it but you have seen it happen?
10 DOCTOR ALLEN: Yes.
11 REPRESENTATIVE MANDERINO: Thank you.
12 Thank you, Mr. Chairman.
13 CHAIRPERSON MASLAND: Thank you.
14 Representative Orie.
15 REPRESENTATIVE ORIE: I'm going to
16 make one comment in regards to what your last
17 statement was. I don't have it before me but I
18 know that 60 Minutes did a thing on this
19 sexually violent predator with Kansas City law
20 and took predators that were within the most
21 intensive programs that you could possibly have
22 for sexual offenders, and they still said that
23 they couldn't control the urge. They'd sit
24 there and they would see a child and in their
25 mind see themselves raping that child or

1 hurting that child.

2 I think you have been here as I have

3 been presenting, at least the American

4 Psychiatric Association has indicated that for

5 the association itself they have not come to

6 how to treat these individuals, what's the best

7 treatment. They can't even monitor the

8 treatment programs they have now because they

9 are behind the time.

10 I just hope that this intervention is

11 working, but I do think that there are

12 individuals that no matter how much treatment

13 you give them that they're not going to be

14 reformed, and they are a threat to the society.

15 Those are individuals we have to keep off the

16 street. I saw that point-blank. They had

17 about five different ones from all across the

18 nation indicating the same type of urges that

19 they couldn't control, but yet they had been

20 under intensive, I mean intensive, for two,

21 five, six years of therapy, and they were still

22 having the urges and admitting it.

23 DOCTOR ALLEN: I would agree with you

24 1000 percent. I would emphasize something that

25 Doctor Foley said earlier in his testimony.

1 This is a very heterogeneous different
2 population. Sex offending is a range. I treat
3 adolescents who have touched one child that
4 they were baby-sitting one time. I have also
5 treated Donald Chapman who was a rather
6 notorious case in New Jersey who I think
7 probably would meet your sex predator
8 definition in the statute that you are
9 discussing now.
10 That's a tremendous range. That's a
11 tremendous variability. This law I think makes
12 sense for the small, less than five percent of
13 caught sex offenders who have real difficulty
14 controlling their urges despite our best
15 efforts. That is not, however, a reason not to
16 try to treat them while we have them separated
17 from the rest of society.
18 REPRESENTATIVE ORIE: I agree. I
19 think my whole point behind the legislation is
20 to try that treatment intensively in a
21 controlled environment where psychiatrists can
22 really take a part of this study and see what
23 they can do with these individuals. I commend
24 you for what you have done. Thank you very
25 much.

1 CHAIRPERSON MASLAND: Thank you,
2 Representative Orie. Thank you, gentlemen. We
3 appreciate your testimony, sharing your
4 thoughts. I think it's safe to say that we've
5 raised a number of questions today. I don't
6 know that we have necessarily answered them as
7 Mr. Faust pointed out. I don't know if that's
8 a philosophical Faustian employee comment or
9 not.
10 With that I will conclude this
11 hearing. Thank you.
12 (At or about 2:30 p.m., the public
13 hearing concluded)
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1 C E R T I F I C A T E

2

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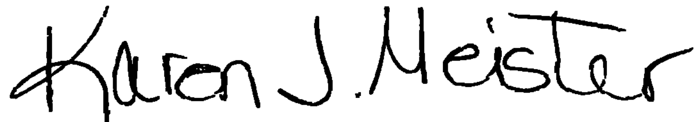
21 
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