House Bill – 1057 – Governor's Task Force

Senate Judiciary Committee

Senate Traynor, Chairman

February 28, 2005

Chairman Traynor and members of the Senate Judiciary Committee, I am Rosalie Etherington, the Clinical Director of the North Dakota State Hospital of the Department of Human Services. I am a member of the Governor's Task Force and have been a part of the various initiatives that come before you today. I will speak specifically to the civil commitment procedures and ask that you consider including provision for outpatient commitment within the already existing civil commitment for sexually dangerous individuals.

There is a small but dangerous group of sexual predators that pose a high risk for repeat acts of sexually predatory conduct. These recidivists do not respond to the traditional means of punishment and deterrence with the amelioration of behaviors. These recidivists do not initially respond to the treatment provided them within the community or the prisons. It is for these individuals the Civil Commitment procedures exist.

The current law allows for the commitment of an individual when two experts agree that there is a mental disease or defect present and that this makes the individual likely to engage in further sexually predatory conduct. We, the experts, have thus far narrowly defined the amount of risk necessary to recommend civil commitment. In doing so we have recommended for commitment only those individuals posing the highest risk for re-offense.

Adding the provision of outpatient commitment allows for commitment of individuals falling within the categories of high risk but provide an option for individuals that, in spite of risk, could live at-large under specific safety provisions. This does not, in any way, alter the already existing inpatient treatment services or change the threshold of risk identified for individuals requiring confinement.

The very best science uses two different ways of assessing an individual for whether he is high risk and therefore likely to engage. In the first way, we look at the individual as a unique person. We diagnose if he has a sexual disorder, a personality disorder, or another mental disorder that makes him likely to engage in additional acts of sexually predatory conduct. Then we calculate how much risk. To do this we use actuarial tables just like insurance companies. The measures used include the Minnesota Sex Offender Screening Tool, the Rapid Risk Assessment for Sex Offense Recidivism, and the Static-99. We incorporate identified factors into the instruments and the scores allow us to estimate on average the likelihood an individual will re-offend based on that individual's identified factors.

For those individuals at high risk, but yet not of the highest risk, and for whom a Risk Management Plan is reasonable, a course of outpatient commitment would be recommended. This commitment would include intensive group therapy and multiple other provisions to encourage stability within the community and continued safety against any further offending. These safety measures may include the requirement of full-time employment, stable residence, a list of persons with whom the individual may or may not be allowed to contact, submission to at least an annual polygraph and to electronic monitoring. Community supervision provided

by the Sex Offender Specialists within the Department of Probation and Parole ensures compliance of the plan and a point of contact for community concern. The Risk Management Plan becomes a living document that specifies the particular needs of the individual offender and provides a guide to all individuals assisting the offender, including family, friends, and community.

Treatment is difficult. Treatment needs of this population are very long term and the treatment modalities are very different than the treatment modalities generally provided. The various disorders that drive sexual offenses all distort an individual's deepest beliefs and attitudes about himself, about other people, about the universe, and, of course, about sex. Beliefs and attitudes do change. They change in a crucible fired by insight and tempered by kindness. Harsh methods only succeed in driving the warped thinking deeper into the unconscious mind. Overly supportive therapy achieves no change. There must be a balance and a tension between insight and kindness.

The treatment itself proceeds in five stages. Look unflinchingly at the problem. Identify the weaknesses that bring about sexual offense. Fix them. Test the fix. Prevent relapse for the rest of your life. This works if the individual works the program. Some patients get the basic idea that they need to change a lot faster than others. For individuals at highest risk this process usually moves the slowest. Nevertheless, the research clearly indicates that treatment works to reduce the risk for re-offense.

The addition of a provision for outpatient commitment allows for the identification, treatment, and management of a group of sexual offenders that may not otherwise receive treatment and are not otherwise under any

supervision. The Risk Management Plan would safeguard society from the risk that particular individuals pose but in a way that would not require their confinement.

In summary, I ask that you pass this initiative, in addition to all other initiatives proposed through the Governor's Task Force. Thank you and I will answer any questions.