

REVIEW OF ALASKA MENTAL HEALTH STATUTES

Sara Gordon, J.D., Project Lead
UNLV/William S. Boyd School of Law

Melissa Piasecki, M.D.
University of Nevada School of Medicine

Gil Kahn, Student
UNLV/William S. Boyd School of Law
(J.D. Candidate 2016)

Dawn Nielsen, Student
UNLV/William S. Boyd School of Law
(J.D. Candidate 2016)

For additional information, contact:

Sara Gordon, J.D.
UNLV/William S. Boyd School of Law
sara.gordon@unlv.edu

UNLV | **WILLIAM S. BOYD**
SCHOOL OF LAW



University of Nevada
School of Medicine

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Richard K. Allen, Office of Public Advocacy
Dunnington Babb, Public Defender Agency
Linda R. Beecher, Public Defender Agency
John A. Bernitz, Public Defender Agency
John K. Bodick, Department of Law
Laura M. Brooks, Department of Corrections
Karen Forrest, Department of Health and Social Services
Kathryn M. Monfreda, Department of Public Safety
Lannette R. Nickens, Department of Law
Tony Piper, Department of Health and Social Services
Honorable Stephanie Rhoades
Dr. Melissa E. Ring, Alaska Psychiatric Institute
Elizabeth M. Russo, Office of Public Advocacy
Adam L. Rutherford, Department of Corrections
Quinlan G. Steiner, Public Defender Agency
Katherine T. Sumey, Anchorage Mental Health Court
Richard Svobodny, Department of Law
Albert E. Wall, Department of Health and Social Services
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Rob Wood, Department of Health and Social Services

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INTRODUCTION

SCOPE OF WORK

At the request of the Criminal Justice Working Group–Title 12 Legal Competency Subcommittee (the Competency Subcommittee), this report was funded by the Alaska Mental Health Trust Authority (the Trust) and developed in partnership with the Competency Subcommittee.¹ In 2011, the Competency Subcommittee recommended that the Criminal Justice Working Group “secure consultant services for review of the existing AS § 12.47 statute,” including a comparison of Alaska statutes to other state statutes, a review of the connections between AS § 12.47 and Alaska’s civil commitment statutes, and a recommendation for changes to the existing statutes. Following Request for Proposal 14-067M, the UNLV Research Team (the UNLV Team) submitted a proposal to the Competency Subcommittee. The Trust awarded the contract to the UNLV Team to conduct a comprehensive study of AS § 12.47.010–AS § 12.47.130 (Insanity and Competency to Stand Trial) and AS § 47.30.700–AS § 47.30.915 (Involuntary Admission for Treatment). In addition, the Competency Subcommittee asked the UNLV Team to review statutes related to mental competence evaluation and restoration for juvenile and misdemeanor offenders.

The report identifies key statutory provisions that we recommend be amended, a description of our findings based on interviews with stakeholders, legislative history of the Alaska statutes, reviews of national best practices and, where applicable, information about emerging areas in national mental health law for Alaska to consider in creating new law. Our recommendations are based in large part on significant advances in law and medicine in the understanding and treatment of mental illness that have occurred in the years since Alaska last made significant and substantive reforms to its criminal and civil mental health statutes. It is important to note that proper implementation of many of the suggested reforms will require significant allocation of resources and development of infrastructure throughout the state and within local communities.

We have attempted to fully represent the views of the Competency Subcommittee members. Each member was given the opportunity to review and provide input on this report, but the members that reviewed the drafts of this document do not necessarily endorse all of the recommendations made by the authors. The authors are solely responsible for the content of this report and the report does not represent the opinions of the Competency Subcommittee members or funding agency.

METHODOLOGY

In August 2014, the UNLV Team traveled to Anchorage to interview Competency Subcommittee members and other key governmental and community stakeholders, to gain insight and perspective into the current mental health system, and to visit relevant offices and facilities. These stakeholders included representatives from the Alaska Court System, the Department of Administration–Public Defender Agency and Office of Public Advocacy, the Department of Health and Social Services, the Department of Law, the Department of Corrections (DOC) and the Alaska Psychiatric Institute (API). The UNLV Team also worked

¹ See Memo from Steve Williams, Alaska Mental Health Trust Authority, to Chief Justice Carpeneti and Attorney General Burns, Criminal Justice Working Group, Summary and Recommendations from the AS 12.47 – Competency subcommittee (Feb. 11, 2011), on file with authors.

closely with an ad hoc Juvenile Subcommittee (Juvenile Subcommittee) to develop specific recommendations for juvenile competency and restoration statutes.

Following the August 2014 interviews, the UNLV Team conducted extensive research of Alaska case law and legislative history, national trends and best practices in all relevant areas, and studies in peer reviewed literature. The UNLV Team drafted initial reports that summarized those findings and provided analysis of laws and legislation relating to mental health in Alaska. These reports were presented to the Competency Subcommittee and Juvenile Subcommittee, which provided significant input and insights gathered from each individual's personal experience with the Alaska mental health law system. This feedback allowed the UNLV Team to better tailor the final report to Alaska's specific and unique legal and mental health needs.

STRUCTURE OF THE REPORT

The body of this report addresses five categories of statutes: forensic evaluators and the use of telebehavioral health; civil mental health law; criminal mental health law; misdemeanor statutes; and juvenile statutes. Each category summarizes existing Alaska law, details findings based on interviews with stakeholders and outside research, recommends specific statutory amendments, and summarizes the Competency Subcommittee's response to those recommendations. The report then includes appendices with new statutory language relating to outpatient commitment (Appendix 1), misdemeanor defendants (Appendix 2), and juvenile competency and restoration (Appendix 3). Finally, the report concludes with the original and revised versions of Title 12 and Title 47, which implement the recommended revisions.

EXECUTIVE SUMMARY

FORENSIC EXAMINERS & TELEBEHAVIORAL HEALTH: Qualified and neutral evaluators should conduct all forensic evaluations (for purposes of insanity or negated mental state, competence to stand trial, and civil commitment). Qualified evaluators should have additional training and education in forensic evaluations, which should be coordinated by the Division of Behavioral Health. Neutral evaluators should not otherwise be involved in the defendant's clinical or restorative treatment. Alaska should adopt the use of telebehavioral health and reduce the number of required neutral and qualified evaluators in order to reduce staffing burdens.

AGENT RESPONSIBLE FOR IMPLEMENTING STATUTORY REQUIREMENTS: Responsible agents should be designated throughout the statutes to assume responsibility for implementing statutory obligations.

FINDING OF INCOMPETENCE TO STAND TRIAL AND COMMENCEMENT OF CIVIL COMMITMENT PROCEEDINGS: A finding of incompetence to stand trial should require that defendants charged with felonies and misdemeanors be evaluated for civil commitment and treatment upon dismissal of charges.

INVOLUNTARY OUTPATIENT COMMITMENT: Alaska's outpatient commitment laws should be amended to include enforcement mechanisms, consequence for non-compliance, and responsible agents. Suggested statutory language is attached in Appendix 1.

INVOLUNTARY INPATIENT COMMITMENT: Title 47 should be amended throughout to clarify the standard for commitment, and to reflect that the respondents condition is required to "be improved by the course of treatment" only in civil commitment based on grave disability. Grave disability should be defined according to the Alaska Supreme Court's definition in *Wetherhorn v. API*. The definitions of "likely to cause serious harm" and "grave disability" should be defined to include timeframes in which the relevant behavior must have occurred or is likely to occur. The procedures for the initiation of civil commitment proceedings should be revised and clarified.

NOT GUILTY BY REASON OF INSANITY (NGRI) STATUTES: Alaska should re-institute a functional insanity affirmative defense, with both the cognitive and moral incapacity prongs of the full M'Naghten test. If Alaska chooses to re-institute a full M'Naghten test for legal insanity, it should consider deleting the guilty but mentally ill verdicts from the statute.

GUILTY BUT MENTALLY ILL (GBMI) STATUTES: If Alaska retains the GBMI verdict, it should consider limiting it for acquittal under AS § 12.47.020(c) and post-conviction GBMI determination under AS § 12.47.060.

INTELLECTUAL AND DEVELOPMENTAL DISABILITY DEFINITIONS: Alaska should include more explicit and current definitions of intellectual disability and developmental disability within the text of its incompetence to stand trial statute.

COMPETENCY AND INVOLUNTARY MEDICATION: Alaska's incompetence to stand trial statute should be amended to include a provision allowing the use of medication to restore competency. This amendment could include references to the United States Supreme Court's decision in *Sell v. United States* and *Washington v. Harper*.

MISDEMEANOR STATUTES: Alaska should consider allocating more resources to creating sentencing alternatives for mentally ill low-level misdemeanants and implementing a statute that allows for diversion of incompetent misdemeanor defendants. Alaska should amend various statutes to implement competency evaluation and restoration guidelines that reduce the total amount of time defendants charged with misdemeanors spend in jail while awaiting trial. AS § 12.47.110 should be amended to allow for varying time periods for competency restoration, depending on the seriousness of the charged offense. Suggested statutory language allowing for diversion of incompetent misdemeanor defendants is attached in Appendix 2.

JUVENILE STATUTES: Alaska should implement a new statutory section within AS § 47.12, Delinquent Minors, which includes detailed standards related to juvenile competency and restoration and alternative approaches for juvenile delinquency adjudication. Suggested statutory language is attached in Appendix 3.

GUARDIANSHIP: Although guardianship issues are outside of the scope of work of this project, numerous stakeholders suggested that Alaska should revisit its guardianship statutes and examine ways to give more authority to guardians and further maximize the benefits of the guardianship system.

A. FORENSIC EXAMINERS

1. Use of Forensic Examiners

Current law: Two Alaska statutes address forensic examination in the context of criminal trials, and they contradict one another to some extent. First, AS § 12.47.070 addresses psychiatric examination generally and encompasses situations where a defendant claims an insanity defense, claims a mental disease that negates a culpable mental state, or where there is reason to doubt the defendant's fitness to proceed. AS § 12.47.070 then provides that "the court shall appoint at least two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology to examine and report upon the mental condition of the defendant."

AS § 12.47.100 more specifically governs incompetency to proceed, where a defendant who "as a result of mental disease or defect, is incompetent because the defendant is unable to understand the proceedings against the defendant or to assist in the defendant's own defense." Although the requirements for forensic examiners are addressed in 12.47.070, 12.47.100 has different requirements for forensic examiners, providing that "the court shall have the defendant examined by at least one qualified psychiatrist or psychologist, who shall report to the court concerning the competency of the defendant." Stakeholders report that this discrepancy has caused courts to require two evaluations in cases involving criminal responsibility, and one evaluation in cases involving competency. Moreover, as it relates to psychiatrists and psychologists, the term "qualified" is not defined in either statute.

AS § 47.30.730 governs forensic assessment in the context of civil commitment. AS § 47.30.730 requires that a petition for commitment to a treatment facility must be "signed by two mental health professionals who have examined the respondent, one of whom is a physician." "Mental health professional" is defined by AS § 47.30.915 as:

A psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; and a person who (A) has a master's degree in the field of mental health; (B) has at least 12 months of post-masters working experience in the field of mental illness; and (C) is working under the supervision of a type of licensee listed in this paragraph.

Finally, Alaska Statutes Title 8 governs the licensing and qualifications of professions in the state. AS § 08.64 (Medicine) governs the practice of psychiatrists, while AS § 08.86 (Psychologists and Psychological Associates) governs the practice of psychologists. Psychiatrists are medical doctors licensed by the State Medical Board; psychologists are licensed by the Alaska Board of Psychologist and Psychological Associate Examiners. In order to be licensed as a Psychologist or Psychological Associate, the individual must have

earned a doctorate degree (Psychologist) or master's degree (Psychological Associate) from an academic institution in clinical psychology, counseling psychology, or an equivalent field; must have one year (Psychologist) or two years (Psychological Associate) of post doctoral supervised experience; and must take and pass the objective examination developed or approved by the Alaska Board of Psychologist and Psychological Associate Examiners.²

Findings: Based on interviews with stakeholders, we learned that forensic assessment is primarily done by API. API is responsible for the assessment of a defendant's mental state at the time of a crime (for purposes of insanity or negated mental state), the assessment of competency to stand trial, and the assessment of whether a respondent meets the state statutory criteria for civil commitment. Because API is also responsible for competency restoration, several stakeholders expressed concern at the conflict of interest created by using the same psychiatrists or psychologists who function in both evaluative and clinical treatment roles with the same patient. We also learned that the requirements of AS § 12.47.070, specifically that the examination be conducted by two qualified psychiatrists or two board certified forensic psychologists, have been difficult to implement due to mental health workforce shortages in the state.

Although most states require only that competency and civil commitment evaluations be conducted by a psychiatrist or psychologist, a few states do require that the evaluation be done by a "qualified" psychologist or psychiatrist.³ During our interviews, stakeholders expressed confusion about the necessary qualifications of evaluators in both the civil and criminal settings, and repeatedly noted that the term "qualified" should be defined in the criminal statutes. Furthermore, the discrepancy between the use of "qualified psychiatrists and psychologists" in the criminal statutes and "mental health professionals" in the civil statutes seems to be adding to this confusion.

It is best practice that all forensic evaluators be a licensed psychologist or psychiatrist with forensic training and/or certification in performing competency, criminal responsibility or civil commitment evaluations, including continuing education in forensic evaluations. Psychiatrists should have education and training that includes a four-year residency in general psychiatry and either board certification in forensic psychiatry or evidence of post-residency education and training specific to forensic psychiatry. Psychologists should have a doctorate in clinical or counseling psychology from an accredited university, a license to practice in the jurisdiction where the evaluation is performed, and evidence of specialized education or training in performing forensic evaluations.⁴

² Other statutes govern nurses (AS § 08.68), marital and family therapists (AS § 08.63), professional counselors (AS § 08.29), and clinical social workers (AS § 08.95); because our recommendation below is that all forensic evaluations be conducted according to best practices, by a qualified psychiatrist or psychologist, this report does not outline those qualifications. All are available for review at <http://www.legis.state.ak.us/basis/statutes.asp#08>.

³ Douglas Mossman et al., *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, 35 J. AM. ACAD. PSYCHIATRY & L. S3, S59–67 tbl (2007).

⁴ NAT'L JUDICIAL COLL., MENTAL COMPETENCY: BEST PRACTICES MODEL (2012), available at <http://www.mentalcompetency.org/model/model-sec-I.html>. As this best practices guide notes:

Regardless of the clinical skills of the mental health professional, it is a best practice for the mental health professional who performs the competency evaluation to be forensically trained in performing competency evaluations. It is a best practice for such education and training to include, for psychiatrists, a four-year residency in general psychiatry and either a one-year fellowship in forensic psychiatry or board certification by the American Board of Psychiatry and Neurology in the sub-specialty of forensic psychiatry. For psychologists, it is a best practice for such education and training to include a doctorate in clinical or counseling psychology from an accredited university; a license to practice in the jurisdiction; and evidence

While the majority of Competency Subcommittee members generally felt that evaluations should be conducted by neutral and qualified evaluators, API expressed concern about the availability of neutral and qualified evaluators due to workforce shortages throughout the state and suggested that civil commitment evaluations need not be conducted by a neutral evaluator, as long as that evaluator was unbiased. Similarly, the Department of Law, Civil Division, objected to the proposed recommendations for “qualified evaluators” throughout the statutes.

RECOMMENDATIONS:

1. AS § 12.47.070 should be amended to remove references to a “defendant’s fitness to proceed,” or “reason to believe a mental disease or defect of the defendant will otherwise become an issue in the case.” Instead, the statute should simply refer to “a defendant’s competence to proceed under AS § 12.47.100.”
2. Title 12 and Title 47 should be amended to require that all forensic evaluations be conducted by neutral evaluators, and these terms should be defined in AS § 12.47.130 and AS § 47.30.915. Neutral evaluators should not be otherwise involved in either the individual’s clinical treatment, or any subsequent restorative treatment. If a neutral evaluator later becomes involved in the individual’s clinical treatment or restorative treatment, the statutes should require that subsequent evaluations be conducted by an additional, neutral evaluator.
3. Title 12 should be amended to require that forensic evaluations be performed by a qualified evaluator and this term should be defined in AS § 12.47.130. Similarly, Title 47 should be amended to require that evaluations for 30-day, 90-day and 180-day commitments be performed by a qualified evaluator and this term should be defined in AS § 47.30.915. A qualified evaluator includes psychiatrists and psychologists. A psychiatrist is a person who is licensed by the State Medical Board to practice in this state or is employed by the federal government, who has received additional training or certification in forensic psychiatry, and who is either board certified by the American Board of Psychiatry and Neurology in the subspecialty of forensic psychiatry or has received post-residency education and training specific to forensic psychiatry. A psychologist is a person who is licensed by the state Board of Psychologist and Psychological Associate Examiners. Moreover, AS § 12.47.130 and AS § 47.30.915 should require that any individual qualified to conduct a forensic examination under these statutes have forensic training and/or certification in performing competency or civil commitment evaluations, including continuing education in forensic evaluations.
4. Title 12 and Title 47 should be amended to require forensic assessments be performed by only one qualified evaluator. The requirement of more than one

of specialized education in the area of forensic psychology during an internship or post-doctoral fellowship and/or board certification in forensic psychology by the American Board of Professional Psychology. It is a best practice for the forensic training for both psychiatrists and psychologists to specifically include training on how to perform forensic evaluations, including competency evaluations. It is a best practice that such continuing educational requirements include, at a minimum, six hours of training within the 24 months preceding the order appointing the mental health professional to perform the evaluation.

Id. at 8.

evaluator has created a staffing burden and the state may not have sufficient resources to conduct two evaluations. Additionally, the statutes should allow for parties to hire a private expert, or to request that a second evaluator be appointed at that party's cost, in the event that the party is not satisfied with the report of the court-appointed evaluator.

5. The Division of Behavioral Health should be designated by statute to coordinate continuing education in forensic evaluations that would be available to psychiatrists and psychologists located in the state of Alaska. Continuing education in forensic training should include, when possible, in-person supervision of the examiner's evaluation practices and reports.
6. Title 12 and Title 47 should be amended to require the Department of Health and Social Services or its designee to assume responsibility for designating qualified and neutral evaluators under the statutes.

2. Use of Telebehavioral Health

Current Law: Alaska does not currently have statutory provisions permitting the use of telemedicine, telehealth, or telebehavioral health. AS § 08.01.062 does provide for courtesy licenses to non-residents who enter the state “so that on a temporary basis, they may practice the occupation regulated by the board or the department.” The Alaska Department of Commerce, Community and Economic Development, Division of Corporations, Business and Professional Licensing creates regulations that apply to both physicians and psychologists. Regulations relating to Psychiatrists, who are medical doctors licensed by the State Medical Board, are located in Alaska Administrative Code Chapter 40 (AAC 40), and regulations relating to psychologists, who are licensed by the Alaska Board of Psychologist and Psychological Associate Examiners, are located in Alaska Administrative Code Chapter 60 (AAC 60). Because two different administrative code chapters govern psychiatrists and psychologists, the ability of out-of-state mental health professionals to receive a courtesy license to practice in Alaska varies depending on whether the professional is a psychiatrist or psychologist.

AAC 60.035 applies to psychologists and provides for a courtesy license that allows the licensee to practice psychology in Alaska for no more than 30 days in a 12-month period, and prohibits an applicant from receiving more than one courtesy license in that person’s lifetime. The individual must provide verification of a current license to practice psychology in another jurisdiction for the scope of practice specified in the application, and provide verification of having passed the EPPP examination.

AAC 40.045 applies to psychiatrists and has stricter requirements for physicians not licensed in Alaska who wish to temporarily practice medicine in the state. AAC 40.045 only allows for a courtesy license for the licensee to conduct a specialty clinic, accompany an out-of-state sports team to a sporting event, provide emergency health or mental health services in response to a disaster, work in a supervised fellowship, or accompany a patient who is also the physician’s employer. Unlike AS § 60.035, there is no general provision allowing medical doctors to receive a courtesy license to practice medicine, absent one of the above conditions.

Findings: We learned that staffing burdens at API and mental health professional shortages throughout the state often impact the availability of evaluators, as well as the time in which evaluations are performed. Telemedicine and telebehavioral health is a developing field, but the American Psychiatric Association has endorsed telemedicine as a way to provide mental health care in underserved areas, especially those with provider shortages.⁵ Research has found that “psychiatric consultation and short-term follow up provided by telepsychiatry can produce clinical outcomes that are equivalent to those achievable when patients are seen face to face.”⁶ Furthermore, recent studies suggest that the use of telepsychiatry is an appropriate option in forensic and correctional settings.⁷

⁵ AMERICAN PSYCHIATRIC ASS’N, *Telepsychiatry*, (last visited May 22, 2015), <http://www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry>.

⁶ Richard O’Reilly et al., *Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results From a Randomized Controlled Equivalence Trial*, 58 PSYCHIATRIC SERVICES 836, 842 (2007).

⁷ Diana J. Antonacci et al., *Empirical Evidence on the Use and Effectiveness of Telepsychiatry via Videoconferencing: Implications for Forensic and Correctional Psychiatry*, 26 BEHAV. SCI. & L. 253, 265–66 (2008).

Most states with telebehavioral health statutes define telebehavioral health within the text of a more comprehensive “telehealth” statute and rely on other statutes allowing for temporary or guest practices—courtesy licenses—to permit for the use of telemedicine by mental health professionals located outside of the state.⁸ A few states without comprehensive telehealth statutes simply allow for courtesy licenses for mental health professionals licensed out of state and define “psychological services” to include the provision of all psychological services by those professionals, regardless of whether the professional is temporarily located in the state or is providing services by electronic or telephonic means from the state where the professional is licensed.⁹ States vary in their approach to licensing requirements for professionals licensed out-of-state, but all require such practitioners to be licensed to practice in their own state, in any state, or in any state where the state requirements exceed those of the state in which they are providing services.

As a way to increase all medical services to Alaskans throughout the state and particularly those in remote areas with physician shortages, Alaska should consider adopting statutes that allow for the broad use of telehealth. If it were to do that, the state could define “telehealth” or “telemedicine” as “the practice, by a licensed physician or other health care provider acting within the scope of such provider’s practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient.”¹⁰ If this definition were adopted, the state could further define “telebehavioral health” or simply include psychologists and psychiatrists under the definition of “health care providers” who may practice telemedicine in the state. Because Alaska does not yet have a telehealth statute, however, these recommendations will focus solely on “telebehavioral health” as it relates to the remote practice of forensic evaluations.

The implementation of telebehavioral health for psychologists would require amendments to the statutes to allow for telebehavioral health generally, but AAC 60.035 would seem to permit, in its current form, forensic evaluation services performed by psychologists who are located out of state if they first obtain a courtesy license. Because the availability of courtesy licenses is more limited for psychiatrists under AAC 40.045, the use of telebehavioral health by psychiatrists would require more significant changes to the courtesy license requirements related to medicine. The state could include a provision allowing courtesy licenses to conduct forensic examinations under Title 12 or 47 or it could expand the definition of “specialty clinic” to allow psychiatrists to receive a courtesy license to conduct “forensic evaluation clinics.” Either of these changes would permit psychiatrists to perform forensic evaluations within the state after receiving a courtesy license.

RECOMMENDATIONS:

1. Alaska should allow for the use of telebehavioral health and evaluation via videoconferencing in AS § 12.47.070 and AS § 12.47.100, and throughout Title 47. Each of these statutes should be amended to allow for the use of forensic evaluations via telebehavioral health.

⁸ See AM. PSYCHIATRIC ASS’N, 50-STATE TELEPSYCHOLOGY REVIEW, *available at* <http://www.apapracticecentral.org/advocacy/state/telehealth-slides.pdf>.

⁹ See, e.g., Wis. Stat. § 455.03; Wis. Adm. Code Psy 2.14(1).

¹⁰ Ga. Code Ann. § 33-24-56.4.

2. Alaska should define “telebehavioral health” as “including “the performance of forensic evaluations by secure electronic transmission using electronic communication technology, including two-way, interactive, simultaneous audio and video.” The statute should require that the providers of these evaluations must otherwise meet the qualifications for forensic examiners outlined above, and that the evaluations must meet the same legal and ethical standards as psychological services provided in person. Finally, the statute should require the maintenance of confidentiality of patient information, including electronic data.
3. Alaska Administrative Code 60.035 should be amended to allow an individual to receive a courtesy license to practice psychology in Alaska for no more than 30 days each calendar year without applying for a license to practice psychology in Alaska. The Regulation should also be amended to remove the provision that allows for only one courtesy license in that person’s lifetime. Changes to this regulation would allow psychologists who are licensed in other states to practice psychology via telebehavioral health in Alaska.
4. Alaska Administrative Code 40.045 should be amended to define “specialty clinic” to include the practice of forensic psychiatry as a “specialty evaluation clinic.” This amendment should specify that “specialty evaluation clinics” are to be conducted solely for purposes of forensic evaluation, not for treatment or the prescription of medication. Alternatively, the regulation could be amended to allow for a courtesy license for purposes of forensic examinations under Title 12 and Title 47. Either of these changes would allow psychiatrists to practice psychiatry via telebehavioral health within the state after receiving a courtesy license.

B. CIVIL MENTAL HEALTH LAW

1. Amendments to AS § 12.47.110(e) – Incompetence to Stand Trial and Civil Commitment

Current law: AS § 12.47.110(e) provides that:

A defendant charged with a felony and found to be incompetent to proceed under this section is rebuttably presumed to be mentally ill and to present a likelihood of serious harm to self or others in proceedings under AS § 47.30.700–47.30.915. In evaluating whether a defendant is likely to cause serious harm, the court may consider as recent behavior the conduct with which the defendant was originally charged.

Findings: The Alaska legislature amended AS § 12.47.110 to add subsection (e) in 2008. The legislative history of the statute,¹¹ as well as our interviews with various stakeholders, suggest that this amendment was intended to automatically initiate civil commitment proceedings upon a finding that a criminal defendant is incompetent to stand trial and non-restorable. While the legislative intent as reflected in the House Finance Committee Minutes seems clear, that intent is not reflected in the current statutory language and stakeholders report that subsection (e) is infrequently used.

Other states have adopted similar approaches to divert incompetent defendants to civil commitment. For example, Georgia requires the court, upon a finding that the defendant is incompetent to stand trial and that there is not a substantial probability that the defendant will attain competency in the foreseeable future, to direct the Department of Behavioral Health to petition for civil commitment of the defendant.¹² Similarly, Washington requires that courts, upon a finding that a defendant charged with a felony or misdemeanor is incompetent and is not likely to regain competency, dismiss the proceedings without prejudice and refer the defendant for a civil commitment evaluation.¹³

¹¹ The legislative history of Senate Bill 265, which amended AS § 12.47.110 in 2008, reflects comments from senators suggesting that a finding of incompetence will automatically trigger a commitment hearing. For example, Senator McGuire noted that the bill would

[H]elp avoid potentially dangerous situations where a person is charged with a crime, but found incompetent to be tried for it, and then is released back into a community without adequate consideration of the danger the individual may present and without notice of release to the prosecution. It would require a person charged with a felony and found incompetent to be evaluated for commitment and treatment. The bill adopts a rebuttable presumption that a person charged with a felony but found incompetent to proceed is mentally ill and likely to present a danger to themselves or others. It allows the court to consider the conduct with which the person has been charged in making that determination.

Similarly, Ms. Carpeneti explained that:

[T]hose sections address a problem that has arisen in how to deal with people that are not competent to be tried. The language requires that the persons charged with the felony to be referred for an evaluation by a mental health professional. It would then adopt the presumption that is rebuttable that the person sent for evaluation presumption that person is mentally ill and is likely to commit serious harm to them self or another individual. Later sections of the bill require that before a release of a person found to be incompetent, a professional must notify the prosecution before the release, allowing time to notify the law enforcement.

¹² Ga. Code Ann. § 17-7-130 (2014).

¹³ Wash. Rev. Code § 10.77.084 (2014).

However, neither of these states provide that a finding of incompetence to stand trial creates a rebuttable presumption that a defendant meets civil commitment criteria. The statutory criteria for a finding of incompetence to stand trial and a finding that the individual meets the statutory criteria for civil commitment are distinct and a rebuttable presumption is inappropriate. Should Alaska choose to keep subsection (e), it should provide that when a defendant's criminal case is dismissed due to a finding that he is incompetent to stand trial, a separate civil commitment proceeding should be initiated. The initiation of civil commitment proceedings upon a finding of incompetence to stand trial should occur in both misdemeanor and felony cases when those criminal charges are dismissed. If after an evaluation for civil commitment under AS § 47.30.730, the court finds that the defendant does not meet the criteria for civil commitment, the defendant should be released. Finally, the statutes should allow the court to designate the Department of Health and Social Services or its designee to initiate civil commitment proceedings upon a finding of incompetence in a criminal case.

The members of the Competency Subcommittee had varying responses to possible changes to this section. Members disagreed with how often subsection (e) was used in practice, and whether it should be removed entirely. Some members felt that subsection (e) should be removed from the statute altogether because a finding of incompetence to stand trial does not reflect the same mental state as the civil commitment statutes require. Other members felt this discrepancy in the two standards could be addressed by removing the language requiring that a finding of incompetence to stand trial creates a "rebuttable presumption" that the defendant meets the criteria for civil commitment. The Department of Law, Criminal Division, felt the rebuttable presumption could be kept for felonies, but not be applied to misdemeanors, should those be added to subsection (e). Several members of the Competency Subcommittee felt that the rebuttable presumption should be removed and that the statute should encompass defendants found incompetent to stand trial on misdemeanor charges. Should subsection (e) be kept, the Competency Subcommittee generally agreed that a responsible agent should be designated by statute to initiate proceedings

RECOMMENDATIONS:

1. AS § 12.47.110(e) should be amended to provide that when an individual is found to be incompetent and unrestorable in misdemeanor or felony cases, the individual should be evaluated for inpatient or outpatient civil commitment and treatment if charges are dismissed due to incompetency. The statute should not state that a finding of incompetence to stand trial creates a rebuttable presumption that the individual meets the statutory criteria for civil commitment and should instead trigger a civil commitment hearing under AS § 47.30.700.
2. The Department of Health and Social Services or its designee should be designated by statute to assume responsibility for initiating inpatient or outpatient civil commitment proceedings, if indicated, upon a finding that a criminal defendant is incompetent to stand trial and unrestorable in both felony and misdemeanor proceedings. The statute should require that the court provide a notice of intent to dismiss the charges against the defendant and that the Department of Health and Social Services or its designee shall have 24 hours to initiate inpatient or outpatient civil commitment proceedings, if indicated, or to create a discharge plan for the individual.

2. Amendments to AS § 47.30.700 – AS § 47.30.715 – Procedures for Initiating Civil Commitment

Current Law: AS § 47.30.700, AS § 47.30.705, AS § 47.30.710, and AS § 47.30.715 govern the timing and procedures surrounding the initiation of evaluation for civil commitment. AS § 47.30.700 governs “Initial Involuntary Commitment Procedures” and requires judges, upon the petition of any adult, to conduct a screening evaluation of a person alleged to meet civil commitment criteria. If the judge finds there is probable cause to believe the individual is mentally ill and, as a result, is a danger to himself or others, or is gravely disabled, the court may issue an ex parte order for the individual’s emergency examination and treatment. Specifically, AS § 47.30.700 provides the following:

(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS § 47.30.520–47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent’s clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

AS § 47.30.705 further regulates “Emergency Detention for Evaluation,” under which peace officers, psychiatrists, physicians, and clinical psychologists “may cause the person to be taken into custody and delivered to the nearest evaluation facility.” This section is distinguished from AS § 47.30.700 by its requirement that there be probable cause that the individual is mentally ill and, as a result, is a danger to himself or others, or is gravely disabled, and that the harm or grave disability is of “such immediate nature that considerations of safety” preclude the use of AS § 47.30.700. Specifically, AS § 47.30.705(a) provides that:

A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS § 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility. However, emergency protective custody under this section may not include placement of a minor in a jail or secure facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.

AS § 47.30.710's coverage is somewhat unclear as drafted, but in conjunction with AS § 47.30.715, it appears to govern the 72-hour examination of individuals delivered to evaluation facilities under AS § 47.30.700 and AS § 47.30.705:

(a) A respondent who is delivered under AS § 47.30.700–47.30.705 to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS § 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation.

Finally, AS § 47.30.715 governs “Procedure After Order,” and further outlines the requirements of the 72-hour hold and the scheduling of a 30-day commitment hearing:

When a facility receives a proper order for evaluation, it shall accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time, and place for a 30-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent.

Findings: Stakeholders noted various issues with AS § 47.30.700 through AS § 47.30.715. Stakeholders expressed confusion and concern about the stages of the commitment process, as well as the required locations and timeframes of the detention, evaluation, and hospitalization of individuals.

A. Lack of Clarity in the Commitment Process: The statutes seem to contemplate two stages of detention and evaluation, though this process is not clearly articulated.

First, an initial evaluation occurs under AS § 47.30.700. This evaluation is triggered in one of two ways. First, if an individual is not already in custody, any adult can petition the court to initiate civil commitment proceedings. When an individual petitions for commitment under AS § 47.30.700, the statute requires that the judge conduct a screening investigation or direct a local mental health professional to conduct a screening investigation. Upon completion of the screening investigation, the judge may issue an ex parte order within 48 hours. This order authorizes the 72-hour hold for hospitalization and evaluation under AS § 47.30.710 and AS § 47.30.715.

Although screening investigation is defined in AS § 47.30.915,¹⁴ the statute does not otherwise specify the procedures for implementing such an investigation.¹⁵ Stakeholders report that screening investigators are typically used when a family member initiates a petition under AS § 47.30.700. Because family members often do not allege sufficient facts to allow a judge to make a finding about whether there is probable cause to allow for a 72-hour hold, the screening investigation allows a mental health professional designated by the court to compile that information. In contrast, when a person is held for emergency detention under AS § 47.30.705 and the petition is filed by a mental health professional at the facility where the individual is detained, screening investigators are not typically used and the judge often relies solely on information contained in the petition in deciding whether to issue an ex parte order. Stakeholders expressed concern that the statute directs judges to conduct these investigations and noted that judges do not typically have the mental health expertise to adequately conduct such an investigation.

Second, under AS § 47.30.705, if safety considerations require the individual's immediate detention, an individual may be detained by a peace officer, psychiatrist, physician, or clinical psychologist and taken into custody. The person is often held at a local jail, community behavioral health center, or local hospital while the decision about whether to file a petition under AS § 47.30.700 is made. Sometimes, however, the person may already be at an evaluation facility, or at a designated evaluation and treatment (DET) facility. Regardless of the person's location, an ex parte petition must still be filed under AS § 47.30.700 in order to authorize a 72-hour hold under AS § 47.30.710 and AS § 47.30.715. The placement of this requirement, in AS § 47.30.710, can also lead to confusion, because AS § 47.30.710 applies to petitions originating under both AS § 47.30.700 and AS § 47.30.705.

¹⁴ "Screening investigation" means the investigation and review of facts that have been alleged to warrant emergency examination or treatment, including interviews with the persons making the allegations, any other significant witnesses who can readily be contacted for interviews, and, if possible, the respondent, and an investigation and evaluation of the reliability and credibility of persons providing information or making allegations.

¹⁵ Stakeholders reported that the court system has contracts in place with "screening investigators" who sometimes conduct screening investigations, but that the system and procedures are not consistent.

The second stage of evaluation—the 72-hour evaluation—occurs under AS § 47.30.710 and AS § 47.30.715. If a judge issues an ex parte order under AS § 47.30.700, or if an individual is taken into custody under AS § 47.30.705 and an ex parte petition is later filed under AS § 47.30.700, the individual is then transferred to a DET facility where AS § 47.30.710 requires that they must be evaluated within 24 hours after their arrival at the facility. Although the Alaska Supreme Court in *In re Daniel G.* described AS § 47.30.710 as requiring an “initial evaluation” to determine if further evaluation is necessary,¹⁶ stakeholders report that the statute has not been interpreted in this manner. Instead, AS § 47.30.710 has been interpreted only to require that the individual is seen by a mental health professional and a physician within 24 hours after arrival at the facility. In practice, stakeholders report that AS § 47.30.710 simply allows for the 72-hour hold, not an additional interim stage or evaluation as described by the Alaska Supreme Court.

Finally, the interplay between AS § 47.30.710 and AS § 47.30.715 is somewhat unclear and is non-chronological. Irrespective of whether an individual’s commitment proceedings are initiated under AS § 47.30.700 or AS § 47.30.705, the process should coalesce at the point that the individual is hospitalized for the 72-hour hold under AS § 47.30.710 and AS § 47.30.715; therefore, AS § 47.30.710’s requirement that an ex parte order be obtained for individuals detained under AS § 47.30.705 is somewhat confusing. Moreover, because AS § 47.30.715 is titled “Procedure After Order,” it seems to generally apply to the ex parte order that would be issued in response to a petition under AS § 47.30.700, or an ex parte order issued following detention under AS § 47.30.705. However, both AS § 47.30.710 and AS § 47.30.715 have some relation to the 72-hour hold. AS § 47.30.710 describes the civil commitment standard and requires that the mental health professional has reason to believe the person being held meets that standard. AS § 47.30.710 does not, however, refer to a 72-hour period, which is the likely source of confusion in *In re Daniel G.* In contrast, AS § 47.30.715 refers to the 72-hour hold, but does not describe the commitment standard, and its location in the code after AS § 47.30.710 suggests that there is some intermediate evaluation that occurs in AS § 47.30.710, while our interviews with stakeholders suggests this is not the case.

B. Location and Timeframes for Detention, Hospitalization, and Evaluation

The location where detention, evaluation, and hospitalization are meant to occur under each statute is unclear because of the inconsistent use of terms, including “evaluation facility,” “treatment facility,” and “designated treatment facility.” Numerous stakeholders noted that when an individual is detained under AS § 47.30.705 and an ex parte order for hospitalization and evaluation is issued, individuals are often held in local jails, community behavioral health centers, or community hospitals, where they are not receiving a mental health evaluation.¹⁷ Moreover, although the statutes do not specify where hospitalization for the 72-hour evaluation must occur, stakeholders report that they almost always occur in a

¹⁶ *In re Daniel G.*, 320 P.3d 262, 270 (Alaska 2014) (“The result of this statutory framework is that a person in Daniel’s position is given an initial evaluation within 24 hours. If the mental health professional determines that further evaluation is necessary, the statutory structure then ensures that a judicial officer will review the probable cause justifying the initial emergency detention as well as the justification for additional emergency hospitalization and evaluation. This second evaluation must be completed within 72 hours and followed by the release of the respondent or a 30-day commitment hearing with extensive procedural protections.”).

¹⁷ An ex parte order issued under AS § 47.30.700 requires that notice be given every 24 hours to the magistrate or judge who issued the order as to the time of the respondent’s actual arrival at a DET facility; this is a rolling requirement that continues until the respondent arrives at the facility for the formal evaluation.

DET location, of which there are three in Alaska: API DET in Anchorage, Bartlett Regional in Juneau, and Fairbanks Memorial in Fairbanks. There are also two facilities—Ketchikan PeaceHealth Medical Center in Ketchikan and Yukon-Kuskokwim Delta Regional Hospital in Bethel, which sometimes have the available staff to perform 72-hour evaluations, but stakeholders report that this coverage is not consistent. Stakeholders report that the majority of 72-hour evaluations are performed at API in Anchorage. Finally, stakeholders report that although most evaluations do occur at DET facilities, there are other evaluation facilities throughout the state that are equipped to perform evaluations for civil commitment, and in some cases these other facilities may be much closer to the individual's home or community. If evaluations at these facilities were permitted under the statutes, this would reduce some of the delay and expense associated with transporting individuals to DET facilities for the 72-hour evaluation.

Moreover, the statutes generally lack specific timeframes in which the various stages contemplated by the statutes must occur. If an ex parte order is ultimately issued following a petition under AS § 47.30.700, the statute does not require that the individual be taken into custody within a certain period of time. Stakeholders report that there is often a delay between when the order is issued and when the individual is taken into custody for delivery to a DET facility, during which time the individual's mental status can change. Similarly, AS § 47.30.705 is also silent about how long the person may be held before a petition for an ex parte order is filed, but stakeholders report that this typically occurs fairly quickly, and usually within 24 hours.

Most significantly, stakeholders stressed that the statutes should include timeframes by which an individual in custody and subject to an ex parte order must be transferred to a DET facility for the 72-hour evaluation and the scheduling of the 30-day commitment hearing, if needed. Stakeholders report that the transportation of individuals to a DET facility is often delayed for a variety of reasons including bed capacity, weather, limited availability of airline flights, and limited availability of secure transport escort staff. Notwithstanding these logistical considerations, stakeholders expressed great concern that individuals detained under AS § 47.30.705 are often held for several days after the issuance of the ex parte order and without receiving mental health care while awaiting transfer to a DET facility to undergo the 72-hour evaluation.¹⁸

Finally, stakeholders generally expressed a desire that a custodial agent be designated for individuals detained pursuant to the statutes. Most members agreed that the Department of Health and Social Services should be designated as the custodial agent.

The Department of Law, Civil Division, opposed several of these recommendations and provided extensive written feedback to the UNLV Team. Specifically, the Department of Law, Civil Division, objected to the following recommendations: (1) that an ex parte order issued under AS § 47.30.700 should expire if not executed within 72 hours; (2) that the Department of Health and Social Services or its designee be designated as the custodial agent of any individual detained under AS § 47.30.705; (3) that the Department of Health

¹⁸ Stakeholders report that there is ongoing litigation on this matter and The Disability Law Center recently filed an amended complaint against the State of Alaska on behalf of individuals detained “awaiting psychiatric evaluation pursuant to the state civil commitment statutes in jails or other locations unable to provide prompt evaluation and treatment in violation of constitutional due process and statutory protections.” Second Amended Complaint for Injunctive and Declaratory Relief, Disability Law Ctr., Inc., v. State of Alaska Dep’t of Health and Soc. Serv. et al., No. 3AN-11-07724CI (Mar. 6, 2015).

and Social Services or its designee should be required to petition for an ex parte order authorizing evaluation under AS § 47.30.710(a) within 24 hours of an individual's detention under AS § 47.30.705; and (4) that AS § 47.30.710 and AS § 47.30.715 be amended to clarify the stages of the 72-hour hold, the five-day tolling period following the issuance of the ex parte order, and the scheduling of the 30-day commitment hearing. Finally, the Department of Law, Civil Division, noted that the allowance of telebehavioral health for screening investigations was not necessary as such a practice is not currently prohibited.

RECOMMENDATIONS: We recommend extensive revisions to AS § 47.30.700 through AS § 47.30.715. These revisions are summarized here and the full text of the revisions is included in the revised statutes at the end of this report.

1. The titles of each section should be amended for further clarification about the purpose of each section. These titles should be AS § 47.30.700 Petition for Hospitalization and Evaluation for 72-hour Period; AS § 47.30.705 Emergency Protective Custody; § 47.30.710 Hospitalization and Evaluation for 72-hour Period; and § 47.30.715 Procedure after Notice of Hospitalization and Evaluation for 72-hour Period. These titles are also consistent with the Alaska Supreme Court's discussion in *In re Daniel G.*¹⁹
2. AS § 47.30.700 should be amended to allow the judge, when determining whether probable cause exists to issue an ex parte order, to either direct a local mental health professional to conduct a screening investigation, or to rely solely on the allegations stated in the petition. Because screening investigations typically only occur when petitions are made by family members, and because most other petitions are filed by mental health professionals who have had contact with individuals who are already detained, this amendment will better capture current practices and preserve limited mental health resources.
3. AS § 47.30.700 should include a timeframe in which ex parte orders issued against a person who is not already detained must be implemented and the person must be delivered to an appropriate evaluation facility for further evaluation under AS § 47.30.710. Because an individual's mental health status can change if the ex parte order is not enforced in a timely manner, these ex parte orders should expire if not implemented within 72 hours after issuance.
4. AS § 47.30.700 should explicitly authorize the use of telebehavioral health for screening investigations. This allowance would reduce the number of individuals who are transported out of their communities for evaluation.
5. AS § 47.30.705 should be amended to identify the Department of Health and Social Services or its designee as the custodial agent for individuals detained pursuant to the statute. The statute should require that the facility detaining a person pursuant to AS § 47.30.705 shall immediately notify the Department or its designee that the person is being detained. Finally, the statute should require that the Department or

¹⁹ 320 P.3d 262 (Alaska 2014) ("Because hospitalization for evaluation does not constitute an 'involuntary commitment,' the titles of the court system's MC-100 and MC-305 forms have been changed during the pendency of this appeal to accurately reflect the statutory language of AS § 47.30.710. Form MC-100 is now titled 'Petition for Hospitalization for Evaluation.' Form MC-305 is now titled 'Order Authorizing Hospitalization for Evaluation.'").

its designee petition for an ex parte order authorizing evaluation under AS § 47.30.710(a) within 24 hours. This will more clearly trigger the provisions of AS § 47.30.710 and begin to toll the 72-hour period contemplated by AS § 47.30.710 and AS § 47.30.715.

6. AS § 47.30.710 and AS § 47.30.715 should be amended to reflect that the 72-hour evaluation may occur in an appropriate evaluation facility and that evaluations need not occur only at DET facilities. Although we anticipate that the majority of 72-hour evaluations will continue to occur at DET facilities, when there is an appropriate evaluation facility that is closer to the individual's home or community, the statutes should allow for evaluations to occur in those evaluation facilities. If evaluations at these facilities were permitted under the statutes, this would reduce some of the delay and expense associated with transporting individuals to DET facilities for the 72-hour evaluation.
7. AS § 47.30.710 and AS § 47.30.715 should be amended to clarify the stages of the 72-hour hold and the scheduling of the 30-day commitment hearing, if needed. AS § 47.30.710, Hospitalization and Evaluation for 72-hour Period, should refer to the 72-hour hold and include a description of the civil commitment criteria. AS § 47.30.715, Procedure After Notice of Hospitalization and Evaluation for 72-hour Period, in contrast, should include timeframes in which the 72-hour evaluation must occur and the 30-day commitment hearing must be scheduled.
8. AS § 47.30.710 should be amended to clarify that the 72-hour evaluation period begins when the respondent meets with evaluation personnel at the evaluation facility, but that the total time of detention is not to exceed five days (120 total hours). This five-day period should begin tolling upon the issuance of the ex parte order under AS § 47.30.700 if the respondent is already detained under AS § 47.30.705, or upon the execution of the ex parte order under AS § 47.30.700 if the respondent is not already detained under AS § 47.30.705.
9. AS § 47.30.725(b) should be amended to remove references to the respondent's right to a hearing within 72 hours after admission to the designated treatment facility upon issuance of an ex parte order. This language is duplicative of the rights guaranteed to the respondent under the revised AS § 47.30.715.

3. Amendments to AS § 47.30.730 – Civil Commitment

We identified three main areas in need of revision in the involuntary inpatient commitment statutes. First, there is uncertainty in the text of the statutes as to whether the respondent, in addition to being mentally ill and likely to cause harm to self or others must also be in need of treatment. Second, there is ambiguity as to the timeframes of when past and future harm to self or others or grave disability must exist under the statutes. Finally, there is confusion as to the definition of grave disability and whether the statutory definition complies with existing case law.

A. Condition Improved by the Course of Treatment

Current law: AS § 47.30.730 provides the grounds for an initial 30-day involuntary commitment. AS § 47.30.730(a) requires that the petition for a 30-day involuntary treatment order must allege the following with regards to the respondent's mental state and the requirement that it would improve with treatment:

(1) allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled;...

(3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;

This statutory language therefore only requires a finding that the respondent's mental condition would be improved by treatment in the case of civil commitment based on grave disability. The same requirement is not included in (1) which applies to commitments based on danger to self or others. However, 47.30.710(b), which governs the initial evaluation, states the rule differently, and applies "in need of care or treatment" to respondents who are either gravely disabled or dangerous to self or others:

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis.

Finally, 47.30.655(6), which details the purposes of the revisions to Title 47, provides that "persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition." This seems to support an interpretation that a finding that treatment would improve the respondent's condition should be required for commitment on grounds of danger to self (but not to others).

Alaska's statutes, therefore, provide for two explicit grounds for adult civil commitment: substantial risk of harm to self or others, and gravely disabled. It seems clear that in committing a respondent due to grave disability, 47.30.730(a)(3) requires that the state must also show that the respondent's mental condition could be improved with treatment, and

Alaska Supreme Court decisions support this result.²⁰ Furthermore, while the text of AS § 47.30.730 does not require a finding that the respondent's mental condition would be improved by treatment in the case of civil commitment based danger to self or others, such a requirement does seem to be contemplated by 47.30.710(b), governing evaluation (treatment criteria in danger to self or others), as well as 47.30.655(6), which details the purposes of the revisions to Title 47 (treatment criteria in danger to self).

While the Alaska Supreme Court has not addressed the discrepancy in 47.30.710(b), it has addressed the discrepancy between the purposes listed in 47.30.655(6) and the “substantive statute,” AS § 47.30.730. In *E.P. v. Alaska Psychiatric Inst.*, the court noted that the statement of purpose in 47.30.655(6), conflicts with the substantive statute “and that the substantive statute controls.”²¹ In other words, the statutes that require a showing that treatment will lead to improvements only apply to respondents who are gravely disabled, and not to those who are dangerous to themselves or others. In emphasizing that the additional finding does not apply to either commitment based on harm to self or harm to others, the Court noted that “the legislature's specific requirement that the state allege that a gravely disabled person's condition will improve indicates that no such requirement exists in the case of mentally ill persons likely to harm themselves or others.”²²

RECOMMENDATIONS:

1. Title 47 should be clarified in various places to reflect the two grounds, in addition to the predicate finding of mental illness, upon which an individual may be civilly committed. Those include (a) a likelihood of serious harm to self or others, and (2) grave disability and there is reason to believe the respondent's condition could be improved by the course of treatment sought. This is not a substantive change, but will instead make the language consistent throughout the code.
2. 47.30.655(6), which states the purposes of the 1981 revisions, should be removed from the statute to reflect the Alaska Supreme Court's decision in *E.P. v. Alaska Psychiatric Inst.*, and to clarify that the state is only required to show that the respondent's condition could be improved by the course of treatment proposed in commitment based on grave disability.
3. 47.30.710(b), which governs the initial evaluation, should be amended to reflect that the state is only required to show that the respondent's condition could be improved by the course of treatment proposed in commitment based on grave disability.
4. 47.30.710(b)(2)'s language should be amended. The phrase “is in need of care or treatment” should be replaced with “there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought.” This change will make this section consistent with AS § 47.30.730(a)(3) and is consistent with the Alaska Supreme Court's language in various decisions.

²⁰ See, e.g., *E.P. v. Alaska Psychiatric Inst.*, 205 P.3d 1101, 1109 (Alaska 2009).

²¹ *Id.* at 1108–09 (Alaska 2009) (“We conclude that the statutory requirements of a showing that treatment will lead to improvement apply only to gravely disabled persons.”).

²² *Id.* at 1108.

B. Imminence & Grave Disability

AS § 47.30.730 does not define either “harm to self or others,” or “gravely disabled.” Both terms are defined in AS § 47.30.915, though there is a discrepancy between AS § 47.30.915 and 47.30.730. AS § 47.30.915(10) defines “likely to cause serious harm,” while 47.30.730 does not refer to “serious” harm. AS § 47.30.915 defines “likely to cause serious harm” as a person who:

- (a) poses a substantial risk of bodily harm to that person’s self, as manifested by recent behavior causing, attempting, or threatening that harm;
- (b) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or
- (c) manifests a current intent to carry out plans of serious harm to that person’s self or another.

Subsection (7) defines “gravely disabled” as “a condition in which a person as a result of mental illness”:

- (a) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
- (b) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person’s previous ability to function independently.

Finally, AS § 47.30.730(7) requires that a petition for civil commitment “list the facts and specific behavior of the respondent supporting the allegation” that respondent is likely to cause harm to self or others or is gravely disabled.

Our interviews with stakeholders suggested practitioners in the state are mainly applying the first ground of substantial risk of harm to self or others. Our interviews also suggested that practitioners are interpreting the statute to require imminent (and immediate) dangerousness to self or others in order to satisfy the commitment standards and many stakeholders expressed frustration about the statute’s lack of specificity in regards to the timing requirements of “recent” behavior and “current” intent. Finally, we learned that there was a lack of clarity over who held a duty to initiate civil commitment proceedings in the community.

In 2007, the Alaska Supreme Court addressed the addition of subsection (b) to the gravely disabled definition in *Wetherhorn v. API*, where it noted that the amendment was intended to broaden commitment standards and allow API to hold people who needed help but had not yet shown violent tendencies.²³ The Court noted that subsection (b) of the gravely

²³ *Wetherhorn v. Alaska Psychiatric Inst.*, 156 P.3d 371, 378 (Alaska 2007).

disabled provision was constitutional if interpreted to mean that the distress noted in the statute was of such intensity that the individual is unable to live safely outside of a controlled environment.”²⁴ This holding suggests that practitioners should interpret this ground more broadly, to allow for commitment when a person cannot live safely in the community, but is not yet imminently dangerous to himself or others.

Moreover, in analyzing the imminence required by the “passive nature of harm reflected” in gravely disabled grounds for commitment, the *Wetherhorn* Court noted that “the United States Supreme Court has not made imminence a requirement,” but that because the behavior at issue had occurred during the past three months, it was “drawn from the recent past” and would therefore be “sufficient to meet the evidentiary standards established by those states that have addressed the question of imminence.”²⁵ This decision does not address imminence in terms of the predictability of future behavior, nor does it discuss the concept of recent behavior or future imminence in the context of dangerousness grounds for commitment.

Other Alaska Supreme Court decisions have addressed recent and future behavior. For example, in *In re Tracy C.*, the Court noted in determining whether a patient is mentally ill and likely to harm herself or others or is gravely disabled, the court must consider the patient’s condition at the time of the hearing, but may also consider “the patient’s recent behavior and symptoms.”²⁶ The Court, in *In re Jeffrey E.*, restated this holding, and also added that “the statutory definition of gravely disabled is forward-looking—even if [the respondent] were not suffering from distress at the exact time of the hearing, he still could be gravely disabled at that time if he would suffer distress in the near future as a result of his mental illness.”²⁷ Again, this decision did not discuss imminence in the context of danger to self or others, though both decisions do more generally discuss the two commitment grounds in tandem.

Unlike the Court’s description in *Wetherhorn* of “recent behavior” as that which had occurred in the previous three months, there is no similar discussion in the case law of how to define “near future” in the context of harm or distress that is likely to occur due to mental illness. Most states do not define specific time limits in which behavior meeting civil commitment must have occurred in the past or must occur in the future. The majority of states continue to use terms like “recent past” and “near future.” However, a few states have included timeframes of 30 or 40 days in regards to past behavior²⁸ and one state—Nevada—allows for behavior that is “likely to occur within the next following 30 days.”²⁹ Stakeholders generally agreed that the statutes should include a specific timeframe of 30 days when defining recent behavior and likelihood of future behavior. The Department of Law, Civil Division, objected to this recommendation and felt the timeframe for recent behavior should be three months, as discussed in *Wetherhorn*.

²⁴ *Id.*

²⁵ *Id.* at 379.

²⁶ *In re Tracy C.*, 249 P.3d 1085, 1093 (Alaska 2011) (citing *Wetherhorn*).

²⁷ *In re Jeffrey E.*, 281 P.3d 84, 88 (Alaska 2012).

²⁸ Nevada (30 days); New Hampshire (40 days); Pennsylvania (30 days).

²⁹ Nev. Rev. Stat. § 433A.115(2)(a).

RECOMMENDATIONS:

1. AS § 47.30.730 should be amended to refer to “serious harm” in order to make it consistent with AS § 47.30.915.
2. The definition of grave disability in AS § 47.730.915(7)(b) should be amended to reflect the court’s interpretation of grave disability in *Wetherhorn v. API*. This definition should note that a person is gravely disabled if, as a result of a mental illness, the person “will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is of such intensity that the individual is unable to live safely outside of a controlled environment.”
3. The definitions of “likely to cause serious harm” and “gravely disabled” in AS § 47.30.915 should include timeframes, rather than vague descriptions like “current intent” and “recent behavior.” Although *Wetherhorn* allows for “recent behavior” to include behavior in the previous three months, no other court has allowed for such a broad interpretation of recent behavior. For this reason, we recommend that the statutes define “recent behavior” to provide for behavior that has occurred in the previous 30 days. Similarly, because the Court has not defined “near future,” the statutes should include a timeframe of 30 days; if any of the conditions noted in the statute is likely to arise in the next 30 days without treatment, commitment is appropriate.

4. Amendments to AS § 47.30.780 – Early Discharge from Civil Commitment

Current law: AS § 47.30.780 governs early discharge after involuntary inpatient commitment upon a finding by the professional person in charge that the respondent no longer meets civil commitment criteria. The statute provides that:

(a) Except as provided in (b) of this section, the professional person in charge shall at any time discharge a respondent on the ground that the respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness. A certificate to this effect shall be sent to the court, which shall enter an order officially terminating the involuntary commitment.

(b) The professional person in charge shall give the prosecuting authority 10 days' notice before discharging a respondent who was committed after having been found incompetent to proceed under AS § 12.47.110.

Findings: Stakeholders reported that this section has been confused with AS § 47.30.720, which allows for release before expiration of the 72-hour period of hospitalization under AS § 47.30.715 and AS § 47.30.720 pending a 30-day commitment hearing. More importantly, the inclusion of subsection (b) within this statute is contrary to the purpose of commitment under AS § 12.47.110. AS § 47.30.780 allows for a mental health professional to release an individual who no longer meets civil commitment criteria. A person who has been committed after being found incompetent to proceed under AS § 12.47.110 has been committed for restoration of competence, not because they independently meet civil commitment criteria. Moreover, because charges are pending against an individual who is committed under AS § 12.47.110, the release of the individual under AS § 47.30.780 would violate the procedural requirements of AS § 12.47.110, which direct both the commitment of the individual pending restoration, and the disposition of charges when a defendant is not restorable.

RECOMMENDATIONS:

1. The title of AS § 47.30.780 should be changed from “Early Discharge” to “Early Discharge from Civil Commitment.” This change will more clearly distinguish this section from AS § 47.30.720, which governs “Release Before Expiration of 72-hour Period.”
2. Subsection (b) should be removed from AS § 47.30.780. Because individuals committed under AS § 12.47.110 are committed for restorative treatment, and not because they independently meet civil commitment criteria, the inclusion of subsection (b) in the statute is inappropriate. Moreover, because criminal charges are pending against defendants committed under AS § 12.47.110, the defendant’s release by a mental health professional under this section would violate the requirements of AS § 12.47.110.

5. Involuntary Outpatient Commitment

Current law: AS § 47.30.735 governs civil commitment generally in the state of Alaska. Like almost every other state, Alaska does have statutory provisions that allow for involuntary outpatient commitment, or assisted outpatient treatment. 47.30.735(d) allows for outpatient treatment as a less restrictive alternative to inpatient commitment at the initial 30-day commitment hearing:

If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 30 days if the program accepts the respondent.

47.30.755(b) also seems to allow for outpatient commitment at the additional 90-day commitment hearing:

If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days.

Other Alaska statutes address involuntary outpatient commitment indirectly. AS § 47.30.795 allows for people involuntarily committed to inpatient treatment under 47.30.735 to be released to involuntary outpatient commitment if they do not pose a risk of harm to themselves or others and there is reason to believe they would benefit from outpatient commitment. Similarly, AS § 47.30.800 allows the court to convert an outpatient treatment order to an inpatient commitment order when the provider of outpatient care finds that:

(1) the respondent is mentally ill and is likely to cause serious harm to self or others or is still gravely disabled; (2) the respondent's behavior since the hearing resulting in court-ordered treatment indicates that the respondent now needs inpatient treatment to protect self or others; (3) there is reason to believe that the respondent's mental condition will improve as a result of inpatient treatment; and (4) there is an inpatient facility appropriate to the respondent's need that will accept the respondent as a patient. Treatment for these respondents shall be available at state-operated hospitals at all times.

Finally, AS § 47.30.915 defines "provider of outpatient care" as

a mental health professional or hospital, clinic, institution, center, or other health care facility designated by the department to accept for treatment patients who are ordered to undergo involuntary outpatient treatment by the court or who are released early from inpatient commitments on condition that they undergo outpatient treatment.

Findings: In various interviews with stakeholders, we learned that involuntary outpatient commitment is rarely used in the state of Alaska. Stakeholders report that outpatient community providers were typically not comfortable with perceived liability or risk. Others

expressed concern that this type of commitment was not “recovery oriented,” and is underused because the statute does not require it, but instead makes it elective. Furthermore, the unique geography of Alaska makes treatment in some communities difficult.

Furthermore, all of the existing statutes related to involuntary outpatient commitment seem to rely on the requirement that treatment take place in the least restrictive setting, so while they authorize outpatient treatment generally as a less restrictive alternative to inpatient commitment, the statutes do not provide specific criteria for outpatient commitment, nor do they include procedures to follow when outpatient commitment is ordered by the court.

A review of the literature, as well as results of New York’s successful outpatient commitment legislation—Kendra’s Law—suggests that properly implemented outpatient commitment laws are effective in improving compliance, reducing hospitalization and incarceration rates, and decreasing violent behavior among individuals with serious mental illness.³⁰ These laws are most effective when they are not reserved exclusively for patients who would otherwise meet inpatient commitment criteria, but are instead focused on individuals who are not currently dangerous to themselves or others or gravely disabled, but who are likely to relapse or deteriorate to the point that they will predictably become so. Furthermore, involuntary outpatient commitment is most effective when it requires and provides for intensive services for individuals subject to outpatient commitment. Should Alaska choose to adopt a more robust outpatient commitment scheme, it must assure that adequate resources are available to provide effective outpatient treatment. Finally, outpatient commitment orders are most successful when the mandated initial treatment period is at least 180 days; many states have initial treatment periods of 180 or 360 days, with extensions of 180 or 360 days.³¹

The Competency Subcommittee generally felt it was appropriate that the state create a more robust and detailed outpatient commitment scheme. While some stakeholders expressed concern about the extensive community resources that would be necessary to support this form of commitment, the Competency Subcommittee felt that overall, the outpatient commitment statutes should be overhauled and strengthened.

RECOMMENDATION: Alaska should adopt a more thorough and detailed outpatient commitment statute, one that includes enforcement mechanisms, consequences for non-compliance, and agents responsible for administration of community-based resources and programs related to outpatient commitment. A model involuntary outpatient commitment statutory scheme for the state of Alaska is attached in Appendix 1

³⁰ See, e.g., NEW YORK STATE OFFICE OF MENTAL HEALTH, KENDRA’S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT (2005), *available at* https://www.omh.ny.gov/omhweb/kendra_web/finalreport/.

³¹ THE COUNCIL ON PSYCHIATRY AND LAW, MANDATORY OUTPATIENT TREATMENT (1999), *available at* http://www.psychiatry.org/File%20Library/Learn/Archives/rd1999_MandatoryOutpatient.pdf.

C. CRIMINAL MENTAL HEALTH LAW

1. Amendments to Not Guilty by Reason of Insanity Statutes

Current law: Three statutes govern Alaska law related to verdicts based on “mental disease or defect.”

AS § 12.47.010 governs the “not guilty by reason of insanity” (NGRI) defense and provides that:

(a) In a prosecution for a crime, it is an affirmative defense that when the defendant engaged in the criminal conduct, the defendant was unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct.

Moreover, AS § 12.47.020 creates a diminished capacity defense, allowing for evidence of a mental disease or defect that negates the mental state required for the offense:

(a) Evidence that the defendant suffered from a mental disease or defect is admissible whenever it is relevant to prove that the defendant did or did not have a culpable mental state which is an element of the crime.

(b) When the trier of fact finds that all other elements of the crime have been proved but, as a result of mental disease or defect, there is a reasonable doubt as to the existence of a culpable mental state that is an element of the crime, it shall enter a verdict of not guilty by reason of insanity. A defendant acquitted under this subsection, and not found guilty of a lesser included offense, shall automatically be considered to have established the affirmative defense of insanity under AS § 12.47.010.

(c) If a verdict of not guilty by reason of insanity is reached under (b) of this section, the trier of fact shall also consider whether the defendant is guilty of any lesser included offense. If the defendant is convicted of a lesser included offense, the defendant shall be sentenced for that offense and shall automatically be considered guilty but mentally ill under AS § 12.47.030 and 12.47.050.

Finally, AS § 12.47.030 allows for a finding of “guilty but mentally ill” (GBMI) when:

(a) The defendant engaged in the criminal conduct, the defendant lacked, as a result of a mental disease or defect, the substantial capacity either to appreciate the wrongfulness of that conduct or to conform that conduct to the requirements of law. A defendant found guilty but mentally ill is not relieved of criminal responsibility for criminal conduct and is subject to the provisions of AS § 12.47.050.

Findings: Like the majority of United States jurisdictions, Alaska offers two avenues by which a defendant may introduce evidence of mental disease or defect: a M’Naghten-style affirmative defense and a diminished capacity defense. The traditional M’Naghten test includes two prongs. The first is cognitive incapacity and examines whether the defendant

knew “the nature and quality of the act.” In other words, the test asks whether a mental disease or defect left the defendant unable to understand what he was doing when he committed an unlawful action.³² M’Naghten’s second prong is moral incapacity. In this mental state, the defendant understands what he is doing at the time of the crime, but nonetheless has an “inability to understand that his action was wrong.”³³

Before 1982, Alaska used the Model Penal Code test for insanity. This test, which is commonly known as the “irresistible impulses test,” extended the traditional M’Naghten test to a defendant who understands what he is doing and that the law prohibits his actions, but nonetheless has a mental disease or illness that results in him “so lacking in volition . . . that he could not have controlled his actions.”³⁴ Additionally, the test also reduced M’Naghten’s requirement of complete incapacity to a lack of “substantial capacity.”

Following the *Meach* case and the resulting 1982 statutory reforms, Alaska changed its insanity defense from a Model Penal Code test to a modified M’Naghten test, with only a cognitive incapacity prong. AS § 12.47.010 therefore creates a M’Naghten-style affirmative defense whereby a defendant is not culpable for his criminal actions if he “was unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct” at the time of the crime. As an affirmative defense, the defendant has the burden of proving these elements by a preponderance of the evidence. Importantly, Alaska is the only state that limits its insanity defense to the cognitive incapacity prong.

Additionally, AS § 12.47.020 creates a separate, diminished capacity defense, whereby a defendant can introduce evidence of mental disease or defect to prove that at the time of the crime, he “did not have a culpable mental state which is an element of the crime.” However, unlike AS § 12.47.010, this statute is not an affirmative defense and relies on the prosecution’s inability to prove beyond a reasonable doubt all the elements of the crime, including “the existence of a culpable mental state.”

Despite the availability of both an insanity defense and a diminished capacity defense, Alaska’s narrow insanity defense—the cognitive incapacity prong of M’Naghten—merely duplicates the diminished capacity statute’s effect. If a defendant’s mental disease or defect is severe enough to satisfy M’Naghten’s cognitive incapacity prong, the defendant will necessarily be able to demonstrate diminished capacity. Because diminished capacity relies on the prosecution’s inability to establish the elements of the offense, the diminished capacity defense is less burdensome for defendants than the insanity defense. Thus, by making the insanity defense essentially duplicative of the diminished capacity defense, Alaska constructively abolished its insanity defense when it reformed the statutes in 1982.

Almost all stakeholders agreed that Alaska’s 1982 statutory reforms constructively eliminated the insanity affirmative defense. The fact that only two defendants post-reform have been acquitted as NGRI supports this conclusion. Additionally, our interviews revealed that this lack of a functional insanity defense has resulted in large numbers of mentally ill defendants continuously entering the criminal justice system and having charges deferred for competency restoration or being deemed “unrestorable.” Furthermore, stakeholders indicated that charges are not filed for approximately one-third of cases involving

³² Clark v. Arizona, 548 U.S. 735, 736 (2006).

³³ *Id.*

³⁴ *Id.* at 749.

defendants charged with misdemeanors who have been previously found incompetent to stand trial. Stakeholders also reported that the 1982 reforms have ultimately shifted many mentally ill offenders into the Department of Corrections, which provides a significantly less therapeutic environment than might be afforded if these individuals instead pled insanity and were held in a state psychiatric facility.

The Department of Law, Criminal Division, opposed these recommendations and provided extensive written feedback to the UNLV Team. The Office of Public Advocacy and the Public Defender Agency supported these recommendations and also provided written feedback to the UNLV Team.

RECOMMENDATIONS:

1. Alaska should re-institute a functional insanity affirmative defense, with both the cognitive and moral incapacity prongs of the full M’Naghten test. Alaska is the only state that limits its insanity defense to the cognitive incapacity prong of M’Naghten and this limitation deprives defendants of a true insanity affirmative defense.
2. If the state chooses to re-institute a full M’Naghten test for legal insanity, it should also consider removing the GBMI verdict from the statute.
3. If the state chooses to re-institute a full M’Naghten test for legal insanity, it should revisit and consider revisions to the procedures upon a verdict of not guilty by reason of insanity under AS § 12.47.090, and the procedures after raising a defense of insanity under AS § 12.47.090.

2. Amendments to Guilty But Mentally Ill Statutes

Current Law: AS § 12.47.030 governs GBMI verdicts in Alaska:

(a) A defendant is guilty but mentally ill if, when the defendant engaged in the criminal conduct, the defendant lacked, as a result of a mental disease or defect, the substantial capacity either to appreciate the wrongfulness of that conduct or to conform that conduct to the requirements of law. A defendant found guilty but mentally ill is not relieved of criminal responsibility for criminal conduct and is subject to the provisions of AS § 12.47.050.

(b) Evidence of a mental disease or defect that is manifested only by repeated criminal or antisocial conduct is not sufficient to establish that the defendant was guilty but mentally ill under (a) of this section.

Findings:

A. Guilty But Mental Ill Verdict

The GBMI verdict is a supplement to, and not a replacement for, a jurisdiction's insanity defense. States began adopting it out of concerns for public safety and a desire to mitigate the number of NGRI acquittees.³⁵ News stories of NGRI murderers, such as Charlie Meach in Alaska, resulted in a public perception that mentally ill offenders who received a NGRI verdict were quickly and easily granted release from mental hospitals, resulting in violent recidivism.

In Alaska, a defendant is deemed GBMI if he “lacked, as a result of a mental disease or defect, the substantial capacity either to appreciate the wrongfulness of that conduct or to conform that conduct to the requirements of law.”³⁶ Unlike the insanity or diminished capacity defenses, a GBMI verdict does not eliminate or mitigate criminal culpability. A defendant who is found GBMI will receive a sentence comparable to what he would have received under a standard guilty verdict. Unlike a normal guilty verdict, however, a GBMI verdict carries the expectation that the state will provide the mentally ill defendant with treatment, and AS § 12.47.050(c) requires the DOC to provide this treatment.

Published studies suggest that defendants who are found GBMI receive significantly longer prison sentences than defendants who pled NGRI and were found guilty.³⁷ Furthermore, the actual time spent in confinement for GBMI defendants convicted of violent crimes was significantly greater than defendants found guilty or NGRI for comparable crimes.³⁸ In Alaska, for example, our interviews with the DOC revealed that no GBMI inmate has ever

³⁵ Ira Mickenberg, *A Pleasant Surprise: The Guilty but Mentally Ill Verdict Has Both Succeeded in Its Own Right and Successfully Preserved the Traditional Role of the Insanity Defense*, 55 U. CIN. L. REV. 943, 972 (1987).

³⁶ This definition is the Model Penal Code's insanity test, which Alaska formerly used. It now serves as a defined mental state more cognitive than NGRI that still results in criminal culpability.

³⁷ STEADMAN ET AL., BEFORE AND AFTER HINCKLEY: EVALUATING INSANITY DEFENSE REFORM 119 (1993). For a recent critique of Alaska's GBMI verdict, see Lauren G. Johansen *Guilty But Mentally Ill: the Ethical Dilemma of Mental Illness as a Tool of the Prosecution*, 32 ALASKA L.R. 1, 1 (2015).

(noting that “Alaska has transformed the status into a prosecutorial tool to keep mentally ill defendants incarcerated for longer than their mentally sane counterparts through denial of “good time” credit”).

³⁸ *Id.* at 117–20.

received parole.³⁹ Stakeholders report that the automatic nature of AS § 12.47.030, coupled with the likelihood of a significantly longer confinement under a GBMI verdict, has deterred defendants from pleading insanity out of concern that they will instead be found GBMI.

Furthermore, the availability of the GBMI verdict does not appear to affect the treatment mentally ill prisoners receive in Alaska, and its deterrence effect may ultimately pose a risk public safety. AS § 12.47.055 enables the Alaska DOC to provide mental health treatment for both GBMI and non-GBMI inmates, and our interviews with DOC staff indicate that the Department treats all mentally ill inmates, notwithstanding the final disposition of their charges. Moreover, stakeholders report that the automatic nature of the GBMI verdict deters most defendants from pleading NGRI when they face less than a life sentence. In cases involving less than a life sentence, most mentally ill defendants will therefore choose to plead guilty and receive a standard sentence. Upon release, these mentally ill defendants will be released back into the community with far fewer procedural safeguards than would have been available under a NGRI acquittal.

Finally, though less significantly, a criticism in the research literature is that the GBMI verdict has a potential of increasing jury confusion.⁴⁰ Studies have found that juries comprehend only a minority of instructions and the insanity plea already poses jurors with the difficult tasks of determining a defendant's state of mind at the time of the crime and understanding the legal standard for insanity. Asking jurors to further distinguish between the mental states for NGRI and GBMI poses a risk of improper verdicts. Alaskan jurors must understand the highly nuanced difference between concepts such as “appreciate the nature and quality” of conduct for NGRI and to lack “substantial capacity either to appreciate the wrongfulness of that conduct” for GBMI. The resulting risk of improper verdicts only adds to the complications of maintaining a GBMI verdict.

B. Limiting the Guilty But Mentally Ill Verdict

The above discussion applies to GBMI verdicts rendered through 12.47.040(a)(4), which automatically raises the verdict when a defendant relies on the NGRI affirmative defense under AS § 12.47.010 or when evidence of diminished capacity is admissible under AS § 12.47.020. It is this tie between mental disease or defect evidence and the GBMI verdict that results in the deterrence effect and potential jury confusion. Two other uses of GBMI within AS § 12.47, however, do not suffer from these problems and might have continued value in limited circumstances.

The first such use is found in AS § 12.47.020(c). This subsection automatically applies the GBMI verdict to defendants convicted of a lesser offense after the diminished capacity defense results in acquittal under the more serious offense. Because the successful use of the defense would mitigate a defendant's sentence, this subsection would not likely deter him from introducing evidence of mental disease or defect. Furthermore, the verdict's automatic application in this subsection completely avoids the potential for jury confusion. Automatically deeming defendants GBMI is also likely warranted in this context, because

³⁹ AS § 12.47.050 prevents a GBMI defendant from being released on parole only during the course of treatment. The statute, however, does not prevent parole for such a defendant when he “no longer suffers from a mental disease or defect that causes the defendant to be dangerous to the public peace or safety.”

⁴⁰ See, e.g., John D. Melville & David Naimark, *Punishing the Insane: The Verdict of Guilty but Mentally Ill*, 30 J. AM. ACAD. PSYCHIATRY & L. 553, 553 (2002) (citing Alaska's GBMI statute as “an illustrative example of potential confusion”).

such defendants have demonstrated that they have a serious mental disease or defect and have committed a crime. Ensuring that these defendants receive mental health treatment while preventing them from gaining parole is therefore appropriate.

The second potentially beneficial use of GBMI is found in AS § 12.47.060. This subsection allows either party to seek a post-conviction determination of GBMI when the defendant did not raise the insanity affirmative defense or the diminished capacity defense. If neither defense is raised and the defendant is found guilty, then a separate hearing is held to determine whether the defendant is GBMI. Unlike 12.47.040(a)(4), this procedure does not deter defendants from pleading insanity or diminished capacity, because a party may only use the procedure if such evidence is not introduced. Furthermore, the statute creates a bifurcated hearing, first determining the defendant's guilt and then the issue of GBMI. Because the defendant is not raising the question of insanity and the fact finder is considering the GBMI standard independently from the question of culpability, this procedure eliminates the potential for jury confusion. Finally, because the prosecution is the party most likely to apply this procedure, it would give the state discretion to seek GBMI verdicts for defendants who should receive mental health treatment and be prevented from gaining parole.

The majority of Competency Subcommittee members were neutral or positive in their response to this recommendation. The Department of Law, Criminal Division, opposed these recommendations and provided extensive written feedback to the UNLV Team. The Office of Public Advocacy and the Public Defender Agency supported these recommendations and also provided written feedback to the UNLV Team.

RECOMMENDATIONS:

1. Alaska should abolish the GBMI verdict. This verdict is not needed to ensure that incarcerated mentally ill offenders receive appropriate mental health treatment and may compromise public safety by deterring mentally ill defendants from pleading NGRI.
2. If Alaska retains the GBMI verdict, it should limit it for acquittal under AS § 12.47.020(c) or post-conviction GBMI determination under AS § 12.47.060.

3. Diminished Capacity Statutes

Current Law: AS § 12.47.020 (a) allows for evidence of diminished capacity due to a mental disease or defect:

Evidence that the defendant suffered from a mental disease or defect is admissible whenever it is relevant to prove that the defendant did or did not have a culpable mental state which is an element of the crime.

Findings: While the majority of jurisdictions allow for evidence of diminished capacity due to mental disease or defect, Alaska is one of only a few jurisdictions that codify the defense. Under AS § 12.47.020, Alaska allows for evidence of diminished capacity and specifies two potential outcomes for defendants who offer such evidence. If the defendant is found guilty of a lesser offense, he is automatically deemed GBMI and at the end of his sentence and undergoes the same commitment proceedings as a defendant acquitted as NGRI.⁴¹ Similarly, a defendant who is acquitted under the diminished capacity defense and not found guilty of a lesser crime has the same legal status as a defendant acquitted under the insanity affirmative defense and undergoes the same commitment proceedings.

While some states that codify diminished capacity place the defense under the same statute as the insanity affirmative defense, Alaska statutes situate diminished capacity and the insanity defense in different sections. This approach helps distinguish between the important differences between an affirmative defense, which a defendant must prove, to a diminished capacity defense, which affects the prosecution's ability to meet its burden of proving each element of the offense beyond a reasonable doubt. Furthermore, this stratified approach enhances clarity when other statutes or court opinions discuss these different concepts.⁴²

Finally, while some states that permit a diminished capacity defense limit its scope to "specific intent" crimes, which require the offender to intend a specific outcome through his conduct, AS § 12.47.020(a) allows defendants to introduce diminished capacity evidence to negate any culpable mental state. Alaska's approach is appropriate because if a defendant's mental disease or defect is severe enough to eliminate the intentionality required for specific intent crimes, it may also eliminate mental states that require less than intent. Alaska's defense is well structured in this regard, as it requires fact finders to consider the spectrum of offenses the defendant may be guilty of based on his culpable mental state at the time of the offense.⁴³

RECOMMENDATIONS: We do not recommend any changes to AS § 12.47.020.

⁴¹ See AS § 12.47.020(c) and AS § 12.47.090.

⁴² See, e.g., Barrett v. State, 772 P.2d 559 (Alaska Ct. App. 1989) (contrasting the NGRI affirmative defense (12.47.010) with diminished capacity (12.47.020)).

⁴³ "If a verdict of not guilty by reason of insanity is reached under (b) of this section, the trier of fact shall also consider whether the defendant is guilty of any lesser included offense." AS § 12.47.020(c).

4. Amendments to AS § 12.47.130(5) – Intellectual and Developmental Disability Definitions

Current Law: For purposes of insanity and incompetency, AS § 12.47.130(5) defines “mental disease or defect” as:

A disorder of thought or mood that substantially impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life; “mental disease or defect” also includes intellectual and developmental disabilities that result in significantly below average general intellectual functioning that impairs a person’s ability to adapt to or cope with the ordinary demands of life.

Furthermore, in identifying factors a court should consider when evaluating a defendant’s competency to stand trial, 12.47.100(e) notes that:

In determining whether a person has sufficient intellectual functioning to adapt or cope with the ordinary demands of life, the court shall consider whether the person has obtained a driver’s license, is able to maintain employment, or is competent to testify as a witness under the Alaska Rules of Evidence.

Findings: Based on interviews with stakeholders, and a review of current psychiatric literature and best practices, we found that these statutes should be updated to reflect current terminology and understandings of intellectual and developmental disabilities.

RECOMMENDATIONS:

1. This definition should include more explicit and current definitions of intellectual disability and developmental disability. The state should consider including a reference in the statute to its existing definition of developmental disability found in AS § 47.80.900.
2. AS § 12.47.130(5) should be amended to remove references to the “ability to cope with the demands of everyday life.” This term is vague, and as defined in section 12.47.100 (e), is not indicative of either a person’s competency to stand trial or mental state at the time of a charged crime.
3. AS § 12.47.100(e) should be removed from the statute. The ability to obtain a driver’s license or testify as a witness is not indicative of a person’s competency to stand trial.

5. Competency Restoration and Involuntary Medication

Current Law: The Alaska statutes do not currently include provisions regarding the use of psychotropic medications to restore competency in criminal proceedings.

Findings: Until recently most courts held that the government could forcibly medicate a mentally ill defendant if the purpose was to restore the individual to competency. In 2003, however, the United States Supreme Court addressed this issue in *Sell v. United States*, where it restricted the use of involuntary medication to restore competency. Specifically, the Court identified four requirements that must be met before psychotropic medications may be used to restore competency in a criminal case:

- (1) administering involuntary medication to render the defendant competent must serve an important governmental interest in the case;
- (2) involuntary medication must significantly further that important governmental interest;
- (3) involuntary medication must be necessary to further that interest; and
- (4) involuntary medication must be medically appropriate for the particular defendant.

As the Court itself noted in *Sell*, however, courts do not need to consider the *Sell* factors if “forced medication is warranted for a *different* purpose, such as the purposes set out in *Harper* related to the individual’s dangerousness”⁴⁴ *Washington v. Harper* held that the “Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.”⁴⁵ *Harper* grounds for forced medication should therefore precede *Sell* grounds; if a defendant is dangerous to himself or others and the treatment is in the inmate’s medical interest, then the issue of forced medication should be considered under the less stringent *Harper* criteria.

Alaska statutes do not include this framework, nor do they include explicit provisions related to *Sell* or *Harper*. Only one state—California—includes an explicit reference to *Sell* in its statutes.⁴⁶ The vast majority of states, including Alaska, seem to have simply relied on United States Supreme Court precedent in *Sell* and *Harper* to guide decision-making in this area.⁴⁷ Some states simply allow an order upon a finding of incompetence to include the administration of medication to restore competency.⁴⁸

⁴⁴ 539 U.S. 166, 181–82 (2003) (emphasis in original).

⁴⁵ 494 U.S. 210, 227 (1990).

⁴⁶ Cal. Penal Code § 1369.1(b) (“This section does not abrogate or limit any law enacted to ensure the due process rights set forth in *Sell v. United States* (2003) 539 U.S. 166.”). Cal. Penal Code § 1370(B)(i)(III) also lists the *Sell* factors in another provision of the statute allowing for the use of medication to restore competency in criminal defendants.

⁴⁷ See, e.g., STEPHANIE RHOADES & COLLEEN RAY, ALASKA COURT SYSTEM, JUDGE’S GUIDE TO HANDLING CASES INVOLVING PERSONS WITH MENTAL DISORDERS (Mary Greene ed., 2008).

⁴⁸ See, e.g., Nev. Rev. Stat § 178.425 (allowing the court order on a finding of incompetence to “include the involuntary administration of medication if appropriate for treatment to competency”).

RECOMMENDATIONS:

1. AS § 12.47.110 should be amended to allow for the court order on a finding of incompetency to include the involuntary administration of medication, if appropriate, for treatment to competency.
2. AS § 12.47.110 could also be amended to include a reference to the United States Supreme Court's decision in *Sell*, as well as the fact that courts should first use the *Harper* factors when an incompetent defendant is dangerous to himself or others and the treatment is in his medical interest. Alternatively, the statute could simply allow for the involuntary administration of medication to restore competency and rely on the United States Supreme Court's decisions in *Sell* and *Harper* to guide the courts' analysis.

D. MISDEMEANOR STATUTES

1. Diversion Programs

Current Law: Although Alaska has not *statutorily* established diversion programs for misdemeanants suffering from mental illness, it was one of the first states in the country to implement a mental health court.⁴⁹ Anchorage's mental health court, the Coordinated Research Project (CRP), serves to "divert people with mental disabilities charged with criminal offenses from incarceration and into community treatment and services and to prevent further contacts with the criminal justice system."⁵⁰ Apart from AS § 12.47.110(e), which in its current form only applies to felonies, Alaska does not have a law that diverts misdemeanor criminal cases to civil commitment upon a finding of incompetence to stand trial.

Findings: Nineteen states statutorily authorize mental health courts or diversion programs for individuals with mental illnesses relating to their criminal offenses.⁵¹ Although there is no specific "best practices" model for states dealing with misdemeanants suffering from mental illness, mental health diversion practices, such as crisis intervention team (CIT) training and policing and specialized mental health courts, are routinely being utilized to treat, rather than incarcerate, individuals. Stakeholders expressed the need for more CITs, as a way to provide treatment and intervention to individuals before they are charged with a crime. Stakeholders also expressed concern about the current priority for community mental health treatment. Typically, individuals who are charged with misdemeanors and found incompetent to stand trial are released into the community without community-based treatment plans or a referral to a community mental health treatment facility.

Stakeholders expressed a concern that mental illness has been criminalized in the state of Alaska. Many individuals charged with misdemeanor offenses are suffering from mental illness and competency assessments for misdemeanants constitute approximately one-third of all competency assessments. Stakeholders further reported that many defendants with mental health issues who are charged with misdemeanors cycle in and out of the criminal justice system. Because misdemeanor charges are often dismissed when competency evaluation and restoration would take longer to accomplish than the potential sentence for a misdemeanor offense, defendants are released into the community where they often continue to commit misdemeanor offenses and do not receive mental health treatment. While many of these defendants might meet civil standards for commitment, there is no formal mechanism in the statutes to divert misdemeanor defendants into civil commitment. Stakeholders expressed a desire for such a diversion process.

The State of Washington recently introduced a bill that would allow for the diversion of misdemeanor defendants into inpatient or outpatient commitment when the issue of competence to stand trial is raised. If any party raises the issue of competence to stand trial,

⁴⁹ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., *SAMHSA's GAINS Center for Behavioral Health and Justice Transformation* (last visited May 21, 2015), http://gainscenter.samhsa.gov/grant_programs/adultmhc.asp.

⁵⁰ ALASKA COURT SYS., *Anchorage Mental Health Court* (last visited May 22, 2015), <http://courts.alaska.gov/therapeutic/mhct.htm>.

⁵¹ NAT'L CONFERENCE OF STATE LEGISLATURES, *Pretrial Diversion* (Jun. 10, 2013), <http://www.ncsl.org/research/civil-and-criminal-justice/pretrial-diversion.aspx>. The first mental health court was established in Florida in 1997. Anchorage's mental court was established in 1998.

the prosecutor may “continue with the competency process or dismiss the charges without prejudice and refer the defendant to an outpatient intensive treatment, residential treatment, or supportive housing program.”⁵² Alaska could create a similar statute, one that allows for a shorter screening exam for competency whenever the issue of competency is raised in a misdemeanor case. Based on that screening evaluation, if the evaluator felt the individual was likely not competent to stand trial and was likely to meet the criteria for a full examination under AS § 47.30.710, the case could be diverted to civil commitment; the mental health professional would petition for 72-hour hold under 47.30.700 and the full evaluation would then be conducted by a qualified evaluator.

Under this statutory scheme, if the criminal judge were informed that the individual met the standards for civil commitment, the criminal case would be dismissed. The prosecutor would not be permitted to re-file charges unless the defendant were charged with a new crime within one year or the prosecutor had reason to believe the defendant would be competent to stand trial within one year. If the defendant were not found to meet the criteria for civil commitment under AS § 47.30.710, they would be released and would be given priority to receive community mental health treatment. Alternatively, if, after the screening exam, the evaluator felt the individual was likely competent to stand trial, a full examination under AS § 12.47.070 would be performed by a qualified evaluator to determine whether the defendant was competent to stand trial.

Mental health professionals could be used to conduct these shorter screening exams; they would not need to be “qualified evaluators” as required by the proposed changes to other forensic evaluation requirements. This would allow for greater flexibility and efficiency in conducting the screening exams. The mental health professionals could use a screening tool to conduct this initial evaluation. The major challenge to this undertaking is finding a valid and reliable screening tool that could be administered by mental health professionals. Furthermore, mental health professionals would require adequate training in the administration of the screening exam. Should Alaska adopt this approach, these screening evaluations should not be used in place of a comprehensive competency evaluation, but only to make a rapid assessment of the defendant’s likely competence in order to decide whether the defendant should be diverted to civil commitment, or referred to a qualified evaluator to conduct a full competency evaluation of the defendant’s ability to stand trial under AS § 12.47.070.⁵³

RECOMMENDATION: Alaska should consider adopting a new statute that allows for a screening investigation and diversion of misdemeanor defendants who are likely to be incompetent to stand trial. This approach should only be adopted if the state is satisfied there is a valid and reliable screening tool available. Furthermore, this diversion should only

⁵² S. 5925, 2015 Leg., Reg. Sess. (Wash. 2015).

⁵³ See generally Mossman et al., *supra* note 2, at S42. One example of a screening assessment tool is the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA). This is a twenty-two item test that takes thirty to forty-five minutes to administer. It has three sections: the first section assesses the defendant’s understanding of the role of the defense attorney, elements of the offense, and the effect of a guilty plea; the second section assesses the defendant’s reasoning, including his understanding of concepts like self-defense and provocation; and the third section assesses the defendant’s appreciation of his personal circumstances, including his belief about the likelihood he will be treated fairly and his rationale for those beliefs. Research on the validity of this test suggests it “compares favorably with other measures of competence to stand trial with regard to validity, reliability and ease of administration.” The test is not intended to be a stand-alone assessment of competency to stand trial, but could be used as an initial screening examination conducted by mental health professionals trained in its use. *Id.*

trigger the provisions of AS § 47.30.710, at which time a complete evaluation for 30-day civil commitment should be performed by a qualified evaluator. If the defendant meets the criteria for civil commitment under AS § 47.30.710, the criminal charges should be dismissed without prejudice. We have included proposed statutory language, attached as Appendix 2.

2. Competency Evaluations in Misdemeanor Cases

Current Law: AS § 12.47.070 allows for psychiatric examinations used to determine competency to employ any method “which is accepted by the medical profession for the examination of those alleged to be suffering from mental disease or defect.” AS § 12.47.070(c) notes that the report must include a description of the nature of the examination, a diagnosis of the mental condition of the defendant, and an opinion as to the defendant’s capacity to understand the proceedings against him and to assist in his defense.

Findings: Stakeholders reported that the evaluation period alone can take several weeks and the first restoration commitment period is 90 days, with follow-up periods potentially totaling up to one year. While AS § 12.47.110(a) creates a commitment period of “not more than 90 days,” our interviews revealed that Alaska judges commonly set the follow-up hearing date for 90 days. In comparison, misdemeanors never result in more than a one-year imprisonment, and Class B misdemeanors in Alaska have a 90-day limit.⁵⁴ This potential imbalance infringes on the defendant’s liberty interest and drains public resources. Finally, it is our understanding that API performs the same level of competency evaluation for all defendants, irrespective of the charged offense (felony or misdemeanor) and the availability of previous, recent competency evaluations of the same defendant.

The Competency Subcommittee generally agreed that the timeframes for misdemeanor competency evaluations should be shortened. Some members expressed concern that a 15-day time period for misdemeanor competency evaluations would be challenging due to provider shortages, but acknowledged that if the use of telebehavioral health were permitted in performing evaluations, this burden would be eased. Some members expressed concern about recommendations about the use of limited competency evaluations in the case of misdemeanor defendants and, in particular, a concern that the statutes dictate professional practice for psychologists and psychiatrists.

RECOMMENDATIONS:

1. AS § 12.47.070 should be amended to require that competency evaluations for misdemeanor charges be performed within 15 calendar days of the court order for evaluation and this requirement should be included in the statutes. A 15-day extension of this time period should be permitted when the defendant appears to be under the influence of alcohol or drugs at the time of the order for the competency evaluation, in order to allow the defendant to withdraw or recover from the acute effects of any substance.
2. In order to better accommodate misdemeanor competency evaluations within 15 days of the court order for evaluation, Alaska could consider a more limited competency evaluation procedure for misdemeanants. Because competency to stand trial is related to the complexity of the charged offense, this more limited evaluation could be appropriate for misdemeanor defendants. The state could also consider creating a brief form for evaluators to complete for competency assessments in misdemeanor cases to help streamline the process. This form could incorporate the requirements included in AS § 12.47.070(c). This recommendation is not necessarily appropriate for a statutory amendment, as the content and form of competency evaluations are a

⁵⁴ See AS § 12.55.135.

matter of professional judgment; this recommendation may be better implemented outside of a statutory requirement.

3. In misdemeanor cases where a defendant has received a full competency evaluation in the previous 12 months, the statute could allow for a more limited, follow-up competency evaluation, which would better accommodate the 15-day requirement for competency evaluations in misdemeanor cases. This recommendation is not necessarily appropriate for a statutory amendment, as the content and form of competency evaluations are a matter of professional judgment; this recommendation may be better implemented outside of a statutory requirement.
4. AS § 12.47.070 should be amended to require that the court advance the date for the hearing on the defendant's competence to the day after the competency report is filed. Alaska should include this requirement in the statutes as it would prevent the defendant from decompensating while awaiting the hearing and reduce the length of time the misdemeanor defendant spends in jail or the hospital while awaiting the hearing.
5. AS § 12.47.070 should be amended to require that the court advance the date for the plea hearing or trial to the earliest possible date if a defendant is found competent to proceed on a misdemeanor charge. This will minimize the amount of time the defendant must be detained awaiting trial or a plea and avoid possible decompensation before the trial or plea hearing may begin.

3. Competency Restoration in Misdemeanor Cases

Current Law: 12.47.110 governs commitment upon a finding that the defendant is incompetent to stand trial. If a defendant charged with felony is found incompetent to stand trial, the statute requires him to be committed for 90 days; if a defendant is charged with any other crime, the statute permits him to be committed for 90 days. At the end of 90 days, if the defendant remains incompetent, the court may commit him for another 90 days. If the defendant is still incompetent the end of the second 90-day period, the court may extend the commitment another six months if the charged crime involves force against another person, the defendant poses a substantial danger to others, and there is a substantial probability he will regain competency. At the end of that six-month period, if the defendant is still incompetent, the statute requires that charges be dismissed without prejudice.

Findings: Apart from 12.47.110(a), which provides that the court “may commit a defendant charged with any other crime,” the statute does not provide guidelines or procedures for courts to follow with respect to competency restoration for misdemeanor crimes. Stakeholders reported that the restoration of competency in mentally ill defendants charged with misdemeanors poses unique challenges to Alaska’s criminal justice system. In many of these circumstances, the time such a defendant spends confined during the competency restoration process often outweighs the amount of time the defendant would have spent criminally incarcerated had he been found guilty. Despite these issues, a defendant’s constitutional rights related to trial competency limit a jurisdiction’s ability to alter this situation. While a defendant may spend less time confined without the restoration process, a jurisdiction cannot prosecute a mentally incompetent individual. Similarly, an incompetent defendant cannot plead guilty, which eliminates a mental health court’s ability to use the mental health care plan plea bargains.⁵⁵ Due to these constraints in Alaska, stakeholders reported that the Anchorage Prosecutor’s office dismisses as many as a third of all misdemeanor charges.

Nationally, the vast majority of states have done little to mitigate the amount of spent attempting to restore a defendant’s competency to stand trial. In *Jackson v. Indiana*, the United States Supreme Court held that states may not indefinitely confine criminal defendants solely on the basis of incompetence to stand trial. The court held that when states commit defendants solely because they are incompetent to stand trial, that period of time cannot “be more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.”⁵⁶ *Jackson* does not, however, define “reasonable period of time.” Moreover, the opinion does not require that the timeframe for restoration be explicitly linked to the legal exposure for the charged offense, or that the time period for restoration must not exceed the time the defendant would be incarcerated for the charged offense. Notwithstanding *Jackson*, many states still allow for indefinite commitment in felony cases.⁵⁷ A few states do have

⁵⁵ See *Godinez v. Moran*, 509 U.S. 389 (1993); see also MACARTHUR FOUNDATION, MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY 19 (2009), available at https://www.bja.gov/Publications/CSG_MHC_Research.pdf.

⁵⁶ *Jackson v. Indiana*, 406 U.S. 715, 738–39 (1972).

⁵⁷ Andrew Kaufman et al., *Forty Years After Jackson v. Indiana: States’ Compliance With “Reasonable Period of Time” Ruling*, 40 J. AM. ACAD. PSYCHIATRY & L. 261, 261 (2012) (“Yet, as of 2007, 30 percent of states allowed for indefinite commitment for the purpose of restoration for felony defendants, in direct violation of *Jackson*. Further, about 40 percent of the other states imposed a lengthy treatment period (1–10 years) or linked the duration of commitment to the potential criminal sentence, which can vary from 1 year to life.”).

statutes that distinguish between misdemeanors and felonies in the time permitted for competency restoration.⁵⁸ Nevertheless, because misdemeanor defendants often require significantly more time to retain competency than their potential legal exposure, this issue should be addressed statutorily.

RECOMMENDATIONS:

1. Alaska should consider amending AS § 12.47.110 to allow for varying time periods for competency restoration, depending on the seriousness of the charged offense. The statutes should also specify that the time a defendant is held for restoration may not exceed a period of time that is necessary to determine whether there is a substantial probability that the defendant will resume competency, and in any event, the time period may not exceed the time listed for each category of offense. A finding that there is a substantial probability that the defendant will resume competency before the total period of time allowed under the section should be required at each commitment hearing. The state could consider structuring the time periods according to the classification of offenses under AS Chapter 55, Sentencing and Probation.
 - A. The state should keep its existing timeframe for felonies involving the use of force against a person (90 days, 90 days, and six months) and felonies not involving the use of force against a person (90 days, 90 days). The statute should require that the time permitted for competency restoration should not be longer than is necessary to determine whether there is a substantial probability that the defendant will regain competency, and in any event, not longer than six months or one year. The statute should also provide that at each commitment hearing, the state cannot continue to hold the defendant unless there is a substantial probability he will regain competency in the time remaining.
 - B. For class A misdemeanors, which carry a sentence of imprisonment of not more than one year,⁵⁹ the statute should require that the time permitted for competency restoration should not be longer than is necessary to determine whether there is a substantial probability that the defendant will regain competency, and in any event, not longer than 60 days. The statute should also provide that at the 30-day commitment hearing, the state cannot continue to hold the defendant unless there is a substantial probability he will regain competency in the remaining 30 days.
 - C. For class B misdemeanors, which carry a sentence of imprisonment of not more than 90 days unless otherwise specified in the provision of law defining the offense,⁶⁰ the statute should require that the time permitted for competency restoration should not be longer than is necessary to determine whether there is a substantial probability that the defendant will regain competency, and in any event, not longer than 30 days.

⁵⁸ See, e.g., Ohio Rev. Code § 2945.38 (allowing for competency restoration periods not to exceed one year for Class A felonies; six months for Class B felonies; sixty days for first and second degree misdemeanors; thirty days for other misdemeanors).

⁵⁹ AS § 12.55.135.

⁶⁰ *Id.*

2. At any point during competency restoration, if there is not a substantial probability that the defendant will become competent with treatment within the remaining time allowed by each section, or if the defendant is still found incompetent to stand trial at the expiration of the timeframe listed in each section, the statute should require that the court dismiss the charges against the defendant without prejudice and the provisions of AS § 12.47.110(e) should require the Department of Health and Social Services to initiate inpatient or outpatient civil commitment proceedings or create a discharge plan for the defendant.
3. The statutes should be amended to require mental health professionals to notify the court as soon as they believe the defendant to be competent, even if that period is less than the total amount of time allowed for restoration. Alaska should consider including this requirement in the statutes as it would prevent the defendant from decompensating while awaiting trial and reduce the length of time misdemeanor defendants spend in jail while awaiting trial.

E. JUVENILE STATUTES

1. Civil Commitment of Juveniles and Placement in a Psychiatric Facility

Current law: AS § 47.12 governs juvenile delinquency in the state of Alaska. AS § 47.12.255 allows for the placement of minors who are already in the custody of the state by virtue of a criminal judgment or court order, and requires notice to the minor's parents or guardian, and the minor's guardian ad litem when a juvenile is placed in a facility. Furthermore, AS § 47.30.690 governs commitment of minors who are not already in the custody of the state. AS § 47.30.690(b) requires that a guardian ad litem for a minor admitted under this section be appointed as soon as possible after the minor's admission. Moreover, the state recently published a document entitled "Alaska Court System's Uniform Administrative Order Establishing Procedures for Mental Commitment Cases."⁶¹ Paragraphs 5 and 6 of this Order automatically close a case upon the court's receipt of a Notice of Voluntary Admission (MC-415) for a minor.

Findings: According to stakeholders, the procedures in the Uniform Order work for the majority of civil cases involving adults. Paragraphs 5 and 6 of the Uniform Order, however, do not distinguish between procedures for minors and adults. Once the case is closed, the appointment of counsel for the minor ends and a guardian ad litem ("GAL") is supposed to be appointed under AS § 47.30.690(b). Because there are no court rules and the Uniform Order does not address this issue, it remains unresolved. Furthermore, while the Attorney General's office has filed motions to re-open minors' cases and appoint GALs after a Notice of Voluntary Admission, stakeholders report that these appointments are not being made and the Office of Public Advocacy has declined the appointments as outside of its authority.

Furthermore, AS § 47.30.690 is silent about what should happen after 30 days of treatment. If a minor is not ready for discharge or an appropriate less restrictive placement is not available or acceptable to the parent or legal guardian at the end of 30 days, the appointment of a GAL is particularly important to protect the best interests of the minor and address discharge planning.

RECOMMENDATION: AS § 47.30.690 should be amended to require the court to appoint a Guardian Ad Litem for all juveniles subject to treatment in a secure psychiatric facility, and this appointment should continue until the minor is discharged and reintegrated into the community.

⁶¹ Alaska Uniform Administrative Order Establishing Procedures for Mental Commitment Cases (2012), available at <http://courts.alaska.gov/judorders.htm>.

2. Competency to Stand Trial in Juvenile Delinquency Proceedings

Current Law: Apart from the above provisions governing the commitment and placement of juveniles in secure psychiatric facilities, Alaska statutes are otherwise silent as to the treatment of minors with mental health issues within Alaska in juvenile delinquency proceedings. Alaska's definition of competency in adult criminal cases refers to two broad capacities: the defendant's ability to assist her attorney in a defense, and the ability to understand and appreciate the nature of the proceedings. Specifically, AS § 12.47.100 (a) provides that:

A defendant who, as a result of mental disease or defect, is incompetent because the defendant is unable to understand the proceedings against the defendant or to assist in the defendant's own defense may not be tried, convicted, or sentenced for the commission of a crime so long as the incompetency exists

Furthermore, in identifying factors a court should consider when evaluating a defendant's competency to stand trial, 12.47.100 (f)–(g) outlines additional specific functional abilities:

(f) In determining if the defendant is unable to understand the proceedings against the defendant, the court shall consider, among other factors considered relevant by the court, whether the defendant understands that the defendant has been charged with a criminal offense and that penalties can be imposed; whether the defendant understands what criminal conduct is being alleged; whether the defendant understands the roles of the judge, jury, prosecutor, and defense counsel; whether the defendant understands that the defendant will be expected to tell defense counsel the circumstances, to the best of the defendant's ability, surrounding the defendant's activities at the time of the alleged criminal conduct; and whether the defendant can distinguish between a guilty and not guilty plea.

(g) In determining if the defendant is unable to assist in the defendant's own defense, the court shall consider, among other factors considered relevant by the court, whether the defendant's mental disease or defect affects the defendant's ability to recall and relate facts pertaining to the defendant's actions at times relevant to the charges and whether the defendant can respond coherently to counsel's questions. A defendant is able to assist in the defense even though the defendant's memory may be impaired, the defendant refuses to accept a course of action that counsel or the court believes is in the defendant's best interest, or the defendant is unable to suggest a particular strategy or to choose among alternative defenses.

Unlike the adult competency statutes, however, the Alaska juvenile delinquency statutes do not contain any such additional guidance for courts. If a juvenile defendant is tried in adult criminal court, he will receive all of the due process protections provided to adult defendants and be evaluated under the same competence standard as adult defendants. If however, a juvenile is tried under juvenile delinquency standards, Alaska statutes do not address competency. Specifically, Alaska's juvenile delinquency statutes do not address whether juvenile defendants should be required to be as competent as adults, or if there is a lesser degree of ability required for a finding of competency in juvenile trials.

Competency to stand trial and restoration in juvenile delinquency cases raises special challenges not found in the adult system because juvenile defendants have a less developed capacity for decisionmaking and are more likely to have impaired legal capacities than older adolescents and adults.⁶² Notwithstanding this difference between juvenile and adult defendants, many states do not have statutes that specifically address juvenile competency.⁶³ Recognizing a need to help states draft legislation to address juvenile competency, the National Youth Screening & Assessment Project prepared *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers*.⁶⁴ We have used this report to develop specific recommendations for statutory provisions Alaska might adopt in the area of juvenile competency and restoration.

Findings: Stakeholders expressed concern and frustration that the Alaska statutes provide little direction to courts, lawyers, or mental health professionals as to how juveniles should be treated, and that stakeholders are being forced to resort to application of adult standards to juveniles. Specifically, AS § 47.12 does not provide guidelines or directions to courts as to how to determine competency for juveniles in delinquency proceedings. Although AS § 47.30.775 directs courts to apply adult standards to juveniles in the context of civil commitment proceedings, and AS § 47.12.255 and 47.30.690 govern civil commitment of minors, AS § 47.12 lacks similar guidance as to which standards should be applied to juveniles in criminal cases, specifically with regards to competency and restoration.

Beginning with *In re Gault*,⁶⁵ the United States Supreme Court recognized that juvenile courts often serve a punitive function and has required that minors in juvenile delinquency proceedings receive due process protection. While the Court has never explicitly required that juveniles must be competent to be adjudicated in juvenile courts, most state courts require that juveniles be competent to proceed in delinquency proceedings and most apply the *Dusky* standard to juvenile competence.⁶⁶ Some require that the juvenile's incompetence originate in a mental illness or intellectual disability, and not from developmental immaturity.

As of 2011, no state statute has addressed whether or if there is a lesser degree of ability required for a finding of competency in juvenile trials. Furthermore, there are difficulties in diagnosing mental illness in minors because symptoms of mental illness can vary with the age of the individual. For example, behavior that might not be considered normal for an adult may be considered normal for a child, such as temper tantrums or mood swings. For this reason, juvenile civil commitment evaluations should be performed by examiners with training and experience in child psychology or psychiatry.

Finally, high rates of fetal alcohol spectrum disorder (FASD) in Alaska pose special

⁶² Jodi L. Viljoen & Ronald Roesch, *Competency to Waive Interrogation Rights and Adjudicative Competence in Adolescent Defendants: Cognitive Development, Attorney Contact, and Psychological Symptoms*, 29 LAW & HUM. BEHAV. 723, 736 (2005).

⁶³ KIMBERLY A. LARSON & THOMAS GRISSO, NAT'L YOUTH SCREENING & ASSESSMENT PROJECT, *DEVELOPING STATUTES FOR COMPETENCE TO STAND TRIAL IN JUVENILE DELINQUENCY PROCEEDINGS: A GUIDE FOR LAWMAKERS 1* (2011), available at <http://www.modelsforchange.net/publications/330> (noting that, as of 2011, thirty-three states did not have juvenile specific statutes on competency to stand trial).

⁶⁴ *Id.* at 2.

⁶⁵ 387 U.S. 1 (1967).

⁶⁶ Richard E. Redding & Lynda E. Frost, *Adjudicative Competence in the Modern Juvenile Court*, 9 VA. J. SOC. POL'Y & L. 353, 354-55 (2001); see also *Dusky v. United States*, 362 U.S. 402 (1960).

challenges to juvenile competency evaluations. One study of children born between 1995 and 1997 found that “[FASD] rates in Alaska, Arizona, Colorado, and New York ranged from 0.3 to 1.5 per 1,000 live-born infants and were highest for black and American Indian/Alaska Native populations.”⁶⁷ Alaska’s Division of Public Health estimates that the rate of FASD in Alaska is 1.5 per 1,000 live births, “or that approximately 15 children are born with [FASD] every year in Alaska.”⁶⁸ Children with FASD “experience a range of physical, cognitive, and behavioral deficits thought to interfere with their ability to competently navigate the arrest, interrogation, and trial process.”⁶⁹ For this reason, Alaska juvenile delinquency statutes should include guidelines for courts and evaluators to follow in juvenile defendants diagnosed with FASD.

RECOMMENDATIONS:

1. Developmental immaturity should be included as a cause of a defendant’s incompetence to stand trial in juvenile court. Even in the absence of an intellectual disability or mental illness, some juveniles still do not meet *Dusky*’s competency requirements due to developmentally related deficits. However, incapacities in understanding and reasoning due to developmental immaturity are no less significant than those due to mental illness. Furthermore, Alaska should consider developing a multi-tiered system, distinguishing levels of protection for juveniles in competency hearings based on age and developmental status.
2. The juvenile delinquency statutes should be amended to include cognitive concepts like a juvenile defendant’s ability to understand the proceedings and assist counsel. The statutes should not include additional specific functional abilities, which have the potential to become outdated as the law’s understanding of juvenile intellectual development evolves.
3. In terms of whether the juvenile delinquency statutes should address the degree of ability required for competence, and whether this degree of ability should be the same or different than for adult defendants, we recommend that the statutes avoid specifying a degree of competence. The level of competence required is a matter best left to judges, and the new statutory scheme will allow judges to consider the defendant’s developmental immaturity in assessing the totality of the circumstances. Furthermore, judges who work with juveniles on a daily basis are best able to determine what level of competence in an individual juvenile defendant will ensure fairness. Finally, a lack of specificity about the degree of ability required for juvenile competence will give judges more flexibility in individual cases, which is consistent with the ideals of the juvenile court.
5. Alaska should consider providing a separate definition for childhood mental illness, which specifically notes what is included and excluded from the definition of mental illness.

⁶⁷ CENTER FOR DISEASE CONTROL, *Fetal Alcohol Syndrome—Alaska, Arizona, Colorado, and New York, 1995–1997* (May 24, 2002), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5120a2.htm>.

⁶⁸ ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF PUBLIC HEALTH, *Alaska Fetal Alcohol Syndrome (FAS) Surveillance Project*, <http://dhss.alaska.gov/dph/wcfh/Pages/mchebi/fas/default.aspx>.

⁶⁹ Kaitlyn McLachlan et al., *Evaluating the Psycholegal Abilities of Young Offenders with Fetal Alcohol Spectrum Disorder*, 38 LAW & HUM. BEHAV. 10, 10 (2014).

6. The statutes should include a requirement that competency evaluations for juveniles be performed within 30 calendar days of the court order for evaluation.
7. Juvenile competency evaluations should be performed by qualified and neutral evaluators with training and experience in child psychology or psychiatry.

Based on these recommendations and the Competency Subcommittee's feedback, we have drafted a model juvenile competency statutory scheme for the state of Alaska, which is attached as Appendix 3.

3. Restoration of Incompetent Juvenile Defendants

Current law: AS § 47.12 governs juvenile delinquency in the state of Alaska. This code does not include provisions related to competency restoration for juveniles.

Findings: Competency restoration in juvenile delinquency proceedings requires consideration of several factors unique to juvenile intellectual development. Specifically, some juvenile defendants may be incompetent due to developmental immaturity, and not due to a mental illness. While adult competency restoration statutes can provide guidance in the case of juveniles who are incompetent due to mental illness, they are less helpful when a juvenile defendant is incompetent due to developmental immaturity. Furthermore, there is a lack of empirical evidence regarding whether juveniles require longer or shorter periods of remediation than adults.

RECOMMENDATIONS:

1. Alaska should consider amending its juvenile delinquency statutes to provide for placements and services that will accomplish competency restoration in juveniles and should work with the Department of Juvenile Justice to identify and implement these placements. These services will necessarily differ depending on why the juvenile has been found incompetent. If a juvenile is incompetent due to mental illness, hospitalization is appropriate.
2. Statutes regarding competence restoration for juveniles should provide for appropriate periodic review and designate different amounts of time for inpatient versus outpatient restoration.
3. In cases where a juvenile is incompetent due to developmental immaturity or intellectual disability and restoration is inappropriate, Alaska could consider a compromise position, where cases involving less serious offenses are dismissed with prejudice; cases involving more serious offenses could be dismissed without prejudice.
4. In cases where a juvenile is incompetent due to developmental immaturity or intellectual disability and restoration is inappropriate, Alaska statutes should give juvenile courts the discretion to direct the juvenile into the appropriate social and clinical services to provide for follow-up care.

Based on these recommendations and the Juvenile Subcommittee's feedback, we have drafted a model juvenile competency statutory scheme for the state of Alaska, which is attached as Appendix 3.

CONCLUSION

Alaska's mental health statutes, like most states, contain some inconsistencies, gaps and areas in need of revision to better reflect evolving case law and emerging trends. The language and provisions for competency, commitments, and insanity are intertwined with the state's unique culture and history. The UNLV Team recognizes these important considerations and frames our recommendations with this awareness. In areas where research has pointed the way for best practices, we have summarized the research findings and incorporated them in the recommendations. Although our recommendations are limited to the text of the statutes themselves, it is important to note that proper implementation of many of the suggested reforms will require significant allocation of resources and development of infrastructures throughout the state and within local communities.

Throughout the research, site visit, and development of this report, we have been struck by the tremendous commitment of all stakeholders to the well-being of Alaskans and the needs of the mentally ill. This was particularly evident in the creative approaches to using limited resources when facing great needs. We hope that the recommendations in this report support the interests of mentally ill Alaskans, their families, and their communities. We also hope that some of the suggestions, such as telemedicine for forensic evaluations and changes to the evaluations for defendants with lower level charges, will reflect our awareness of Alaska's needs and resources.

APPENDIX 1
Proposed Involuntary Outpatient Commitment Statute

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SECTION A: PETITION FOR OUTPATIENT COMMITMENT

In the course of the 72-hour evaluation period, a petition for an outpatient commitment order may be filed in court. The petition must be signed by a neutral and qualified evaluator who has examined the respondent. A copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day outpatient commitment hearing.

SECTION B: CONTENTS OF PETITION

1. The petition must allege the respondent meets the following criteria:
 - a. The respondent is over the age of 18; and
 - b. The respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled; and
 - c. In view of the respondent's treatment history, the respondent now needs treatment to prevent a relapse or severe deterioration that would predictably result in the respondent causing harm to himself or others or becoming gravely disabled; and
 - d. As a result of the respondent's mental illness, he or she is unlikely to comply with the needed treatment unless the court enters an order for mandatory outpatient treatment; and
 - e. There is a reasonable prospect that the respondent's mental illness will respond to the treatment proposed in the treatment plan if the respondent complies with the treatment requirements specified in the court's order; and
 - f. The respondent has a history of lack of compliance with treatment for mental illness that has within the last 24 months prior to the filing of the petition:
 - i. Required inpatient hospitalization for treatment of a mental illness; or
 - ii. Been a significant factor in necessitating the receipt of services in a forensic or other mental health unit of a correctional facility; or
 - iii. Resulted in one or more acts, threats, or attempts of serious violent behavior towards self or others.

2. The petition must include a detailed treatment plan that includes specific conditions with which the respondent is expected to comply, together with a detailed plan for reviewing the respondent's medical status and for monitoring his or her compliance with the required conditions of treatment.
3. The petition must designate that the physician or treatment facility, which is to be responsible for the respondent's treatment under the commitment order, has agreed to accept the respondent and has endorsed the treatment plan.

SECTION C: DETAILED TREATMENT PLAN

The detailed treatment plan must include provisions for intensive case management, assertive community treatment, or a program for assertive community treatment. The order may also require that the Department of Health and Social Services or its designee supply any or all of the following categories of services to the individual:

1. Medication;
2. Periodic blood tests or urinalysis to determine compliance with treatment;
3. Individual or group therapy;
4. Day or partial day programming activities;
5. Educational and vocational training or activities;
6. Alcohol or substance abuse treatment and counseling, and periodic tests for the presence of alcohol or illegal drugs for persons with a history of alcohol or substance abuse;
7. Supervision of living arrangements; and
8. Any other services prescribed to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration.

SECTION D: DISPOSITION

1. If after hearing all relevant evidence, the court does not find by clear and convincing evidence that the respondent meets the criteria for involuntary outpatient commitment, the court shall dismiss the petition.
2. If after hearing all relevant evidence, the court finds by clear and convincing evidence that the respondent meets the criteria for involuntary outpatient commitment, and there is no appropriate and feasible less restrictive alternative, the court may order involuntary outpatient treatment for an initial period not to exceed 180 days. In fashioning the order, the court shall specifically make findings by clear and convincing evidence that the proposed treatment is the least restrictive treatment appropriate and feasible for the respondent. The order shall include a detailed treatment plan, pursuant to Section C.
3. If after hearing all relevant evidence, the court finds by clear and convincing evidence that the respondent meets the criteria for involuntary outpatient commitment, and the court has yet to be provided with a detailed treatment plan pursuant to Section C, the court shall order the Department of Health and Social Services or its designee to provide the court with such plan and testimony no later than the third day, excluding Saturdays, Sundays, and holidays, immediately following the date of such order. Upon

receiving the detailed treatment plan, the court may order involuntary outpatient commitment as provided in paragraph b of this subdivision.

4. A court may order the respondent to self-administer psychotropic drugs or accept the administration of such drugs by authorized personnel as part of an involuntary outpatient commitment program pursuant to AS § 47.30.772. Such order may specify the type and dosage range of such psychotropic drugs and such order shall be effective for the duration of such involuntary outpatient commitment.
5. The court order shall designate the Department of Health and Social Services or its designee to provide for or coordinate all services included in the detailed treatment plan throughout the period of the order.
6. The Department of Health and Social Services or its designee shall cause a copy of any court order issued pursuant to this section to be served personally, or by mail, facsimile or electronic means, upon the respondent, anyone acting on the respondent's behalf, the original petitioner, and identified service providers.

SECTION E: ENFORCEMENT OF INVOLUNTARY OUTPATIENT COMMITMENT ORDER

An involuntary outpatient commitment order's requirement to maintain treatment can be enforced for non-compliance. On the signature of a supervising psychiatrist, the order may be enforced either at the respondent's residence or a treatment center designated by the department of mental health or its designee, whichever the respondent chooses. Respondents who physically resist or fail to select a treatment location shall be treated at a designated treatment center.

SECTION F: FAILURE TO COMPLY WITH INVOLUNTARY OUTPATIENT COMMITMENT ORDER

If the respondent (a) fails or refuses to comply with the outpatient commitment; and (b) efforts were made to solicit compliance, the Department of Health and Social Services or its designee may petition the court to convert the outpatient commitment order to an inpatient commitment order under AS § 47.30.800, if the respondent otherwise meets all of the criteria of that statute. Additionally, if the respondent refuses to take medications as required by the court order, or if the respondent refuses to take, or fails a blood test, urinalysis, or alcohol or drug test as required by the court order, this refusal or failure may be taken into account when determining whether the respondent's outpatient commitment order should be converted to an inpatient commitment order under AS § 47.30.800.

SECTION G: RENEWAL OF OUTPATIENT COMMITMENT ORDER

The process for renewing an outpatient commitment order is the same as for the petition for an original outpatient commitment order. The first renewal for an outpatient commitment order period may last up to 180 days and subsequent renewals up to 360 days thereafter.

SECTION H: EFFECT OF DETERMINATION THAT A PERSON IS IN NEED OF INVOLUNTARY OUTPATIENT TREATMENT

The determination by a court that a person is in need of involuntary outpatient commitment shall not be construed as or deemed to be a determination that such person is incapacitated pursuant to AS § 13.26.150.

SECTION I: EDUCATION AND TRAINING

1. The Division of Behavioral Health shall prepare educational and training materials on the use of this section, which shall be made available to local governmental units, providers of services, judges, court personnel, law enforcement officials, and the general public.
2. The Division of Behavioral Health shall establish a mental health training program for supreme and county court judges and court personnel. Such training shall focus on the use of this section and generally address issues relating to mental illness and mental health treatment.

APPENDIX 2

Proposed Statute Regarding Disposition of Misdemeanor Charges

1. If the defendant is charged with a misdemeanor offense, and the issue of incompetence to stand trial is raised by the court or a party pursuant to AS § 12.47.100, the Commissioner of Health and Social Services shall designate a mental health professional as defined in AS § 47.30.915(13) or evaluation personnel as defined in AS § 47.30.915(8) who has also received training in how to perform competency screening evaluations for purposes of determining whether a full competency examination should be performed. The mental health professional or evaluation personnel do not need to be a qualified evaluator as defined in AS § 12.47.070, but shall be trained by the Division of Behavioral Health providing education and training to evaluators defined in AS § 12.47.070.
 - a. The mental health professional or evaluation personnel shall, within five days, examine the defendant and perform the screening using a competency screening instrument accepted in the field of forensic psychology and organized around the defendant's understanding of the nature of the proceedings, the possible consequences of the proceedings, and the ability to communicate with counsel and participate in a trial defense.
 - b. The mental health professional or evaluation personnel shall, as soon as is practicable, provide oral testimony or a brief written report to the court in the criminal case.
 - c. The oral or written screening report shall include the examiner's qualifications, training, and experience to conduct the screening examination; the circumstances of the examination; the defendant's willingness to understand and participate in the examination; the instrument employed, and a description of the defendant's current mental state and functional likelihood of understanding the criminal proceedings and assisting in their own defense.
 - d. The mental health professional is not required to produce a report meeting all the requirements of AS § 12.47.070 (c)(1)–(5) and (e).
2. If the court finds that there is reason to believe the defendant is not competent to stand trial pursuant to AS § 12.47.070(a), and the mental health professional or evaluation personnel believes there is a substantial probability that the defendant meets the criteria for outpatient civil commitment pursuant to AS § 47.[---], or hospitalization for evaluation pursuant to AS § 47.30.700, the mental health professional or evaluation personnel shall file a petition for involuntary outpatient commitment pursuant to AS § 47.[---], or hospitalization for evaluation pursuant to AS § 47.30.700. The rights of the respondent in that case shall be governed by AS § 47.30.725.
3. If an order issues, pursuant to AS § 47.30.700 authorizing hospitalization, or pursuant to AS § 47.[---] authorizing outpatient civil commitment, the court shall be notified of the arrival of the defendant at the evaluation facility or outpatient commitment placement, and the court shall, upon such notification, dismiss the charges without prejudice. The prosecutor may not re-file charges unless the defendant is charged with any new crime within one year of the date of the offense or the prosecutor has reason to

believe that the defendant is competent to stand trial within one year of the date of the offense.

4. If the court finds that there is reason to believe the defendant is competent to stand trial pursuant to AS § 12.47.070(a), the court shall order a full competency evaluation to be performed by a qualified evaluator. This evaluation and subsequent report shall contain all of the requirements of AS § 12.47.070 (c)(1)–(5) and (e).
5. This section shall not apply to defendants with a current misdemeanor charge involving substantial bodily harm against a person, use of a firearm or a sex offense or if the defendant has a prior conviction for a violent felony or sex offense.

APPENDIX 3

Proposed Juvenile Competency and Restoration Statutes

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SECTION A. DEFINITIONS

Childhood mental illness: Childhood mental illness means a current substantial disturbance of thought, mood, perception, or orientation, which differs from that which is typical of juveniles of a similar developmental stage, and which significantly impairs judgment, behavior, or capacity to recognize reality when also compared with juveniles of a similar developmental state. Childhood mental illness does not include a seizure disorder; a developmental disability, including fetal alcohol spectrum disorders; organic brain syndrome; or a physical or sensory handicap. A brief period or periods of intoxication caused by alcohol or other substances is not sufficient by itself to meet the criteria for childhood mental illness.

Developmental disability: Developmental disability means a severe chronic disability of a juvenile that: (1) Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments; (2) Is likely to continue indefinitely; (3) Results in an inability to live independently without external support or continuing and regular assistance; and (4) Reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services that are individually planned and coordinated for the juvenile.

Intellectual disability: Intellectual disability means a developmental disability that is evidenced by intellectual functioning that is significantly below average and impairment in the adaptive behavior of a juvenile.

Developmental immaturity: Developmental immaturity means the developing cognitive and social characteristics of juveniles that might impair abilities associated with the standard for competence, including juveniles’ understanding or decision-making.

Qualified and Neutral Evaluator:

(a) “Qualified evaluator” includes psychiatrists and psychologists. A qualified psychiatrist is a person who is licensed by the State Medical Board to practice in this state or is employed by the federal government, and who is either board certified by the American Board of Psychiatry and Neurology in the subspecialty of child and adolescent psychiatry or has received post-residency education and training specific to child and adolescent psychiatry. A qualified psychologist is a person who is licensed by the state Board of Psychologist and Psychological Associate Examiners. Psychologists should have training and/or certification in juvenile development.

(b) A neutral evaluator is a qualified psychiatrist or qualified psychologist who is not otherwise involved in the juvenile’s clinical treatment, or any subsequent restorative treatment. If a neutral evaluator later becomes involved in the juvenile’s clinical or restorative treatment, any subsequent evaluation shall be conducted by an additional, neutral evaluator.

Telebehavioral health: “Telebehavioral health” means the performance of forensic evaluations by electronic transmission using electronic communication technology; or two-way, interactive, simultaneous audio and video. When evaluations are conducted using telebehavioral health, all patient information, including electronic data, must be confidentially maintained.

SECTION B. SUSPENSION OF JUVENILE DELINQUENCY PROCEEDINGS

1. If, at any time following the filing of a delinquency petition, the court, defense counsel, department personnel, or the Department of Law has probable cause to believe that the juvenile has committed the delinquent act and the juvenile may be incompetent to proceed, the court shall suspend all delinquency proceedings and order that the question of the juvenile’s competence be determined at a hearing.
2. Upon suspension of proceedings, the court shall order the Department to appoint a neutral and qualified evaluator to assess whether the juvenile suffers from a childhood mental illness, developmental disability, developmental immaturity, or other condition and, if so, whether the condition or conditions impair the juvenile’s competency.
3. Evaluations under this section shall be performed within 30 calendar days of the court order for evaluation. If the juvenile is found competent to proceed under this section, the court shall advance the date for the delinquency proceeding to the earliest possible date, not to exceed three calendar days after the evaluation is complete.
4. Location of the Evaluation. If the court orders a competency evaluation, the court shall order that the competency evaluation be conducted in the least restrictive environment. The evaluation may be conducted in a secure hospital or juvenile detention facility if detention is necessary to protect the juvenile or the community or ensure the juvenile’s attendance at subsequent court hearings.

SECTION C. FACTORS AND CONTENTS OF EXAMINATION AND REPORT

1. A qualified and neutral evaluator shall examine the juvenile and prepare a report stating whether, in the evaluator's opinion, the juvenile is incompetent to proceed.
2. The juvenile may, at any reasonable time before the competency hearing, request that the court appoint an additional qualified and neutral evaluator, at the juvenile's cost. If an additional evaluation is ordered under this section, that evaluation shall be performed within 30 calendar days of the court order for the additional evaluation.
3. In conducting the examination, the qualified evaluator shall review all available medical, educational, and court records concerning the juvenile and the juvenile's case and consult with family members, guardians, or other persons who have extensive personal knowledge of the juvenile. Any records concerning the juvenile that are used under this section shall be served on the juvenile's counsel within three business days.
4. In determining whether the juvenile is incompetent to proceed, the qualified evaluator shall consider the following factors:
 - a. The juvenile's age, maturity level, developmental stage, current mental state, and decision-making abilities;
 - b. The capacity of the juvenile to:
 - i. Appreciate the allegations against the juvenile;
 - ii. Appreciate the range and nature of allowable dispositions that may be imposed in the proceedings against the juvenile;
 - iii. Understand the roles of all of the participants and the adversarial nature of the legal process;
 - iv. Disclose to counsel facts pertinent to the allegations;
 - v. Maintain appropriate courtroom behavior; and
 - vi. Testify relevantly and provide a coherent, logical account of facts, especially as they relate to the alleged offense; and
 - c. Any other factors that the qualified evaluator deems to be relevant in evaluating the juvenile's ability to understand the proceedings against the juvenile and to assist in the juvenile's own defense.
5. The written report submitted by the qualified evaluator shall:
 - a. Identify the specific matters referred for evaluation;
 - b. Describe the procedures, techniques, and tests used in the examination and the purposes of each;
 - c. Describe the history and current status of any psychiatric symptoms and, if relevant, the youth's psychiatric diagnosis;
 - d. Describe the history and current status of any intellectual incapacities or intellectual disabilities;
 - e. Describe the cognitive abilities of the youth associated with the youth's history and current level of development;
 - f. Describe the youth's development of psychosocial characteristics that might be relevant for competence to stand trial;
 - g. State the qualified evaluator's clinical observations, findings, and opinions on each factor specified in paragraph (3) of this section, and identify those factors, if any, on which the qualified evaluator could not give an opinion; and

- h. Identify the sources of information used by the qualified evaluator and present the factual basis for the qualified evaluator's clinical findings and opinions.
6. Counsel for the juvenile may be present at an examination under this section.
7. **Protections Against Self-Incrimination.** Any statements of the juvenile related to the alleged offense and included in the report under this section shall not be used against the juvenile in court proceedings on the offense, in any adjudicatory hearing on a petition alleging delinquency, or in any civil proceeding.
8. An examination under this section may be conducted by a neutral and qualified evaluator using telebehavioral health.

SECTION D. FINDING THAT JUVENILE IS INCOMPETENT TO PROCEED

1. If the qualified evaluator believes that the juvenile is incompetent to proceed, the report shall describe the treatment, if any, that the qualified evaluator believes is necessary for the juvenile to attain competency to proceed.
2. In determining the treatment that is necessary for the juvenile to attain competency to proceed, the qualified evaluator shall consider and report on the following:
 - a. The childhood mental illness, intellectual disability, developmental immaturity, or other developmental disability causing the juvenile to be incompetent to proceed;
 - b. The treatment or education appropriate for mental illness, intellectual disability, developmental immaturity, or other developmental disability of the juvenile, and an explanation of each of the possible treatment or education alternatives, in order of recommendation;
 - c. The likelihood of the juvenile attaining competency to proceed under the treatment or education recommended, an assessment of the probable duration of the treatment required to attain competency, and the probability that the juvenile will attain competency to proceed in the foreseeable future; and
 - d. Whether the juvenile meets the criteria for involuntary admission under AS § 47.30.775.

SECTION E. REPORTS FILED WITH COURT AND SERVED ON JUVENILE'S COUNSEL

1. All reports required under this section shall be filed with the court and served on the juvenile's counsel and the State's Attorney within 30 days after the court orders the examination. On good cause shown, the court may extend the time period specified in this section for an additional 15 days.
2. If a second evaluation is requested by the juvenile under Section C(2), the court may extend the time period specified in paragraph (1) of this section for an additional 30 days following the court's response to the juvenile's request for a second evaluation. On good cause shown, the court may extend the time period specified in this section for an additional 15 days.
3. Failure to file a complete report within the time periods specified in this section may not be, in and of itself, grounds for dismissal of the petition alleging delinquency.

SECTION F. COMPETENCY HEARING

1. Within three business days after receiving the report from the qualified examiner, the court shall hold a competency hearing.
2. In adjudicating competency in juvenile proceedings, the court shall apply the following presumptions:
 - a. For juveniles ages 10 and below: a non-rebuttable presumption of incompetence to stand trial.
 - b. For juveniles ages 11–13, a rebuttable presumption of incompetence. The party raising the issue of competency bears the burden of proving the juvenile is competent by a preponderance of the evidence. When the court raises the issue of competency, the burden of proving the juvenile is competent shall be on the party who elects to advocate for a finding of competency. The court shall then apply the preponderance of the evidence standard to determine whether the juvenile is competent.
 - c. For juveniles ages 14 and older, a rebuttable presumption of competence. The party raising the issue of competency bears the burden of proving the juvenile is incompetent by a preponderance of the evidence. When the court raises the issue of competency, the burden of proving the juvenile is incompetent shall be on the party who elects to advocate for a finding of incompetency. The court shall then apply the preponderance of the evidence standard to determine whether the juvenile is competent.
3. At a competency hearing, if the court determines that the juvenile is competent, the court shall enter an order to that effect, lift the stay imposed under Section B, and proceed with the delinquency petition.
4. Subject to the time periods for dismissal of the case specified in Section H, if the court determines that the juvenile remains incompetent to proceed, but may be able to attain competency in the foreseeable future, the court may order that services, if deemed necessary by the qualified and neutral evaluator, be continued in increments of not more than 90 days.
5. Within 90 days after the court orders additional services under paragraph 4 of this section, the qualified and neutral evaluator shall file a written report as described in Section C.
6. At the competency hearing, if the court determines that the juvenile remains incompetent to proceed and is unlikely to attain competency in the foreseeable future, the court shall proceed in accordance with Section G and Section H.

SECTION G. INCOMPETENT JUVENILES UNLIKELY TO ATTAIN COMPETENCY

1. At a competency hearing, if the court determines that the juvenile is incompetent to proceed; is unlikely to attain competency in the foreseeable future; is mentally ill, as defined in AS § 47.30.730, and as a result (a) is likely to cause serious harm to self or others, or (b) is gravely disabled and the juvenile's condition could be improved by the course of treatment sought, the court may order a petition for emergency evaluation under AS § 47.30.705.

2. At a competency hearing, if the court determines that the juvenile is incompetent to proceed and is unlikely to attain competency in the foreseeable future, and has a developmental disability or childhood mental illness, as defined in this section, the court may order the department to evaluate the juvenile within 30 days to determine the juvenile's eligibility for services and to provide these services.

SECTION H. DISMISSAL OF DELINQUENCY OR VIOLATION OF PROBATION PETITIONS.

At a competency hearing, if the court determines that the juvenile is incompetent to proceed and is unlikely to attain competency in the foreseeable future, the court:

1. May dismiss the delinquency petition; and
2. Shall dismiss the delinquency petition if the juvenile has not attained competency within one year after the date of the finding of incompetency.

SECTION I. INCOMPETENT JUVENILES LIKELY TO ATTAIN COMPETENCY AND ORDER FOR COMPETENCY ATTAINMENT SERVICES

1. At a competency hearing, if the court determines that the juvenile is incompetent to proceed, but that there is a substantial probability that the juvenile may be able to attain competency in the foreseeable future and that services are necessary to attain competency, the court may order competency attainment services for the juvenile for an initial period of not more than 90 days.
2. Competency attainment services shall be provided in the least restrictive environment.
3. The court may order a juvenile to be placed in a facility for juveniles if:
 - a. The juvenile is detained under Section B(4) at the time of the competency hearing; and
 - b. The court finds, after a hearing on the issue, that placement in a facility is necessary to protect the juvenile or the community or ensure the juvenile's attendance at subsequent court hearings; and
 - c. No less restrictive alternative placement is available that will protect the juvenile or the community or prevent the juvenile from leaving the jurisdiction of the court.

SECTION J. SUBSEQUENT COMPETENCY HEARINGS AND OPINIONS RELATING TO COMPETENCY OF JUVENILE AND LIKELIHOOD OF ATTAINING COMPETENCY

1. If the court orders competency attainment services under this section, the treating institution shall file a written report with the court, with notice to the juvenile's counsel of the submission of the report, within 90 days after the court order, stating whether, in the opinion of a qualified examiner as described in Section C, the juvenile:
 - a. Has attained competency;
 - b. Remains incompetent to proceed, but may be able to attain competency in the foreseeable future; or
 - c. Remains incompetent to proceed, and is unlikely to attain competency in the foreseeable future.

2. The court shall hold a subsequent competency hearing in accordance with Section F within three business days after the court receives the report described in this section.
3. For good cause shown, the hearing date may be continued for a reasonable period of time.
4. If at any time while receiving competency attainment services under this section, the treating institution determines that the juvenile has regained competency, it shall notify the court immediately, even if the time period permitted for competency attainment services has not expired.

EXISTING & REVISED STATUTES

TITLE 12

EXISTING AS § 12.47.010 Insanity as Affirmative Defense

- (a) In a prosecution for a crime, it is an affirmative defense that when the defendant engaged in the criminal conduct, the defendant was unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct.
- (b) The affirmative defense defined in (a) of this section may not be raised at trial unless the defendant, within 10 days of entering a plea or such later time as the court may for good cause permit, files a written notice of intent to rely on the defense.
- (c) Evidence of a mental disease or defect that is manifested only by repeated criminal or other antisocial conduct is not sufficient to establish the affirmative defense under (a) of this section.
- (d) The affirmative defense specified in (a) of this section is the affirmative defense of insanity. A defendant who successfully raises the affirmative defense of insanity shall be found not guilty by reason of insanity and the verdict shall so state.

REVISED AS § 12.47.010 Insanity as Affirmative Defense

[NO CHANGES]

EXISTING AS § 12.47.020
Mental Disease or Defect Negating Culpable Mental State

(a) Evidence that the defendant suffered from a mental disease or defect is admissible whenever it is relevant to prove that the defendant did or did not have a culpable mental state which is an element of the crime. However, evidence of mental disease or defect that tends to negate a culpable mental state is not admissible unless the defendant, within 10 days of entering a plea, or at such later time as the court may for good cause permit, files a written notice of intent to rely on that defense.

(b) When the trier of fact finds that all other elements of the crime have been proved but, as a result of mental disease or defect, there is a reasonable doubt as to the existence of a culpable mental state that is an element of the crime, it shall enter a verdict of not guilty by reason of insanity. A defendant acquitted under this subsection, and not found guilty of a lesser included offense, shall automatically be considered to have established the affirmative defense of insanity under AS § 12.47.010. The defendant is then subject to the provisions of AS § 12.47.090.

(c) If a verdict of not guilty by reason of insanity is reached under (b) of this section, the trier of fact shall also consider whether the defendant is guilty of any lesser included offense. If the defendant is convicted of a lesser included offense, the defendant shall be sentenced for that offense and shall automatically be considered guilty but mentally ill under AS § 12.47.030 and 12.47.050. Upon completion of a sentence for a lesser included offense, a hearing shall be held under AS § 12.47.090(c) to determine the necessity of further commitment of the defendant, based on the acquittal for the greater charge under (b) of this section. If the defendant is committed under AS § 12.47.090(c), the defendant is subject to the provisions of AS § 12.47.090(d)–(i) and (k).

REVISED AS § 12.47.020
Mental Disease or Defect Negating Culpable Mental State

[NO CHANGES]

EXISTING AS § 12.47.030
Guilty But Mentally Ill

(a) A defendant is guilty but mentally ill if, when the defendant engaged in the criminal conduct, the defendant lacked, as a result of a mental disease or defect, the substantial capacity either to appreciate the wrongfulness of that conduct or to conform that conduct to the requirements of law. A defendant found guilty but mentally ill is not relieved of criminal responsibility for criminal conduct and is subject to the provisions of AS § 12.47.050.

(b) Evidence of a mental disease or defect that is manifested only by repeated criminal or antisocial conduct is not sufficient to establish that the defendant was guilty but mentally ill under (a) of this section.

REVISED AS § 12.47.030
Guilty But Mentally Ill

[NO CHANGES]

EXISTING AS § 12.47.040
Form of Verdict in Certain Cases Involving Insanity or Mental Disease or Defect

(a) In a prosecution for a crime when the affirmative defense of insanity is raised under AS § 12.47.010, or when evidence of a mental disease or defect of the defendant is otherwise admissible at trial under AS § 12.47.020, the trier of fact shall find, and the verdict shall state, whether the defendant is

- (1) guilty;
- (2) not guilty;
- (3) not guilty by reason of insanity; or
- (4) guilty but mentally ill.

(b) To return a verdict under (a)(4) of this section, the fact finder must find beyond a reasonable doubt that the defendant committed the crime and that, when the defendant committed the crime, the defendant was guilty but mentally ill as defined in AS § 12.47.030.

(c) When the jury is instructed as to the verdicts under (a) of this section, it shall also be instructed on the dispositions available under AS § 12.47.050 and 12.47.090.

REVISED AS § 12.47.040
Form of Verdict in Certain Cases Involving Insanity or Mental Disease or Defect

[NO CHANGES]

EXISTING AS § 12.47.050
Disposition of Defendant Found Guilty But Mentally Ill

(a) If the trier of fact finds that a defendant is guilty but mentally ill, the court shall sentence the defendant as provided by law and shall enter the verdict of guilty but mentally ill as part of the judgment.

(b) The Department of Corrections shall provide mental health treatment to a defendant found guilty but mentally ill. The treatment must continue until the defendant no longer suffers from a mental disease or defect that causes the defendant to be dangerous to the public peace or safety. Subject to (c) and (d) of this section, the Department of Corrections shall determine the course of treatment.

(c) When treatment terminates under (b) of this section, the defendant shall be required to serve the remainder of the sentence imposed.

(d) Notwithstanding any contrary provision of law, a defendant receiving treatment under (b) of this section may not be released

(1) on furlough under AS § 33.30.101–33.30.131, except for treatment in a secure setting; or

(2) on parole.

(e) Not less than 30 days before the expiration of the sentence of a defendant found guilty but mentally ill, the commissioner of corrections shall file a petition under AS § 47.30.700 for a screening investigation to determine the need for further treatment of the defendant if

(1) the defendant is still receiving treatment under (b) of this section; and

(2) the commissioner has good cause to believe that the defendant is suffering from a mental illness that causes the defendant to be dangerous to the public peace or safety; in this paragraph, “mental illness” has the meaning given in AS § 47.30.915.

REVISED AS § 12.47.050
Disposition of Defendant Found Guilty But Mentally Ill

[NO CHANGES]

EXISTING AS § 12.47.055
Treatment for Other Defendants Not Limited

Nothing in AS § 12.47.050 limits the discretion of the court to recommend, or of the Department of Corrections to provide, psychiatrically indicated treatment for a defendant who is not adjudged guilty but mentally ill.

REVISED AS § 12.47.055
Treatment for Other Defendants Not Limited

[NO CHANGES]

EXISTING AS § 12.47.060
Post Conviction Determination of Mental Illness

(a) In a prosecution for a crime when the affirmative defense of insanity is not raised and when evidence of mental disease or defect of the defendant is not admitted at trial under AS § 12.47.020, the defendant or the prosecuting attorney may raise the issue of whether the defendant is guilty but mentally ill. A party that seeks a post-conviction determination of guilty but mentally ill must give notice 10 days before trial of intent to do so; however, this deadline is waived if the opposing party presents evidence or argument at trial tending to show that the defendant may be guilty but mentally ill. A hearing must be held on this issue before the same fact finder that returned the verdict of guilty under procedures set by the court. In cases decided by a jury, at the request of the defendant and with the concurrence of the prosecuting attorney, the court may decide the issue. A waiver of consideration by a jury must be in writing and in person before the court. At the hearing, the fact finder shall determine whether the defendant has been shown to be guilty but mentally ill beyond a reasonable doubt, considering evidence presented at the hearing and any evidence relevant to the issue that was presented at trial.

(b) If the fact finder finds that a defendant is guilty but mentally ill, the court shall sentence the defendant as provided by law and shall enter the finding of guilty but mentally ill as part of the judgment.

(c) A defendant determined to be guilty but mentally ill under this section is subject to the provisions of AS § 12.47.050.

(d) In this section, “guilty but mentally ill” has the meaning given in AS § 12.47.030.

REVISED AS § 12.47.060
Post Conviction Determination of Mental Illness

[NO CHANGES]

EXISTING AS § 12.47.070
Psychiatric Examination

(a) If a defendant has filed a notice of intention to rely on the affirmative defense of insanity under AS § 12.47.010 or has filed notice under AS § 12.47.020(a), or there is reason to doubt the defendant's fitness to proceed, or there is reason to believe that a mental disease or defect of the defendant will otherwise become an issue in the case, the court shall appoint at least two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology to examine and report upon the mental condition of the defendant. If the court appoints psychiatrists, the psychiatrists may select psychologists to provide assistance. If the defendant has filed notice under AS § 12.47.090(a), the report shall consider whether the defendant can still be committed under AS § 12.47.090(c). The court may order the defendant to be committed to a secure facility for the purpose of the examination for not more than 60 days or such longer period as the court determines to be necessary for the purpose and may direct that a qualified psychiatrist retained by the defendant be permitted to witness and participate in the examination.

(b) In an examination under (a) of this section, any method may be employed which is accepted by the medical profession for the examination of those alleged to be suffering from mental disease or defect.

(c) The report of an examination under (a) of this section shall include the following:

- (1) a description of the nature of the examination;
- (2) a diagnosis of the mental condition of the defendant;
- (3) if the defendant suffers from a mental disease or defect, an opinion as to the defendant's capacity to understand the proceedings against the defendant and to assist in the defendant's defense;
- (4) if a notice of intention to rely on the affirmative defense of insanity under AS § 12.47.010(b) has been filed, an opinion as to the extent, if any, to which the capacity of the defendant to appreciate the nature and quality of the defendant's conduct was impaired at the time of the crime charged; and
- (5) if notice has been filed under AS § 12.47.020(a), an opinion as to the capacity of the defendant to have a culpable mental state which is an element of the crime charged.

(d) If the examination under (a) of this section cannot be conducted by reason of the unwillingness of the defendant to participate in it, the report shall so state and shall include, if possible, an opinion as to whether the unwillingness of the defendant was the result of mental disease or defect.

(e) The report of the examination under (a) of this section shall be filed with the clerk of the court, who shall cause copies to be delivered to the prosecuting attorney and to counsel for the defendant.

REVISED AS § 12.47.070
Psychiatric Examination

(a) If a defendant has filed a notice of intention to rely on the affirmative defense of insanity under AS § 12.47.010 or has filed notice under AS § 12.47.020(a), or there is reason to doubt the defendant's competence to proceed under AS § 12.47.100, the court shall appoint a qualified and neutral

evaluator to examine and report upon the mental condition of the defendant. If the defendant has filed notice under AS § 12.47.090(a), the report shall consider whether the defendant can still be committed under AS § 12.47.090(c). The court may order the defendant to be committed to a secure facility for the purpose of the examination for not more than 60 days or such longer period as the court determines to be necessary for the purpose and may direct that a qualified and neutral evaluator retained by the defendant be permitted to witness and participate in the examination.

(b) In an examination under (a) of this section, any method may be employed which is accepted by the medical profession for the examination of those alleged to be suffering from mental disease or defect.

(ADDED) In an examination under (a) of this section of a defendant charged with a misdemeanor where there is reason to doubt the defendant's competence to proceed, the examination shall be performed within 15 calendar days of the court order for evaluation. A 15-day extension of this time period may be permitted when the defendant appears to be under the influence of intoxicating drugs or alcohol. The court shall advance the date of the hearing under AS § 12.47.100 for defendants charged with misdemeanors to the day after the competency report required by this section is filed. If the defendant is found competent to proceed on misdemeanor charges, the court shall advance the date for the plea hearing or trial to the earliest possible date.

(c) The report of an examination under (a) of this section shall include the following:

(1) a description of the nature of the examination;

(2) a diagnosis of the mental condition of the defendant;

(3) if the defendant suffers from a mental disease or defect, an opinion as to the defendant's capacity to understand the proceedings against the defendant and to assist in the defendant's defense;

(4) if a notice of intention to rely on the affirmative defense of insanity under AS § 12.47.010(b) has been filed, an opinion as to the extent, if any, to which the capacity of the defendant to appreciate the nature and quality of the defendant's conduct was impaired at the time of the crime charged; and

(5) if notice has been filed under AS § 12.47.020(a), an opinion as to the capacity of the defendant to have a culpable mental state which is an element of the crime charged.

(d) If the examination under (a) of this section cannot be conducted by reason of the unwillingness of the defendant to participate in it, the report shall so state and shall include, if possible, an opinion as to whether the unwillingness of the defendant was the result of mental disease or defect.

(e) The report of the examination under (a) of this section shall be filed with the clerk of the court, who shall cause copies to be delivered to the prosecuting attorney and to counsel for the defendant.

(f) Upon a request by the court, the Department of Health and Social Services, or its designee, shall designate a qualified and neutral evaluator as required under these statutes. The use of telebehavioral health is permitted under this statute. Examinations performed using telebehavioral health must meet the other requirements for examinations as provided by this statute.

EXISTING AS § 12.47.080
Procedure upon Verdict of Not Guilty

(a) If a defendant is found not guilty under AS § 12.47.040(a)(2), the prosecuting attorney shall, within 24 hours, file a petition under AS § 47.30.700 for a screening investigation to determine the need for treatment if the prosecuting attorney has good cause to believe that the defendant is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to self or others.

(b) In this section, “mental illness” has the meaning given in AS § 47.30.915.

REVISED AS § 12.47.080
Procedure upon Verdict of Not Guilty

[NO CHANGES]

EXISTING AS § 12.47.090
Procedure After Raising Defense of Insanity

(a) At the time the defendant files notice to raise the affirmative defense of insanity under AS § 12.47.010 or files notice under AS § 12.47.020(a), the defendant shall also file notice as to whether, if found not guilty by reason of insanity under AS § 12.47.010 or 12.47.020(b), the defendant will assert that the defendant is not presently suffering from any mental illness that causes the defendant to be dangerous to the public peace or safety.

(b) If the defendant is found not guilty by reason of insanity under AS § 12.47.010 or 12.47.020(b), and has not filed the notice required under (a) of this section, the court shall immediately commit the defendant to the custody of the commissioner of health and social services.

(c) If the defendant is found not guilty by reason of insanity under AS § 12.47.010 or 12.47.020(b), and has filed the notice required under (a) of this section, a hearing shall be held immediately after a verdict of not guilty by reason of insanity to determine the necessity of commitment. The hearing shall be held before the same trier of fact as heard the underlying charge. At the hearing, the defendant has the burden of proving by clear and convincing evidence that the defendant is not presently suffering from any mental illness that causes the defendant to be dangerous to the public. If the court or jury determines that the defendant has failed to meet the burden of proof, the court shall order the defendant committed to the custody of the commissioner of health and social services. If the hearing is before a jury, the verdict must be unanimous.

(d) A defendant committed under (b) or (c) of this section shall be held in custody for a period of time not to exceed the maximum term of imprisonment for the crime for which the defendant was acquitted under AS § 12.47.010 or 12.47.020(b) or until the mental illness is cured or corrected as determined at a hearing under (e) of this section.

(e) A defendant committed under (b) or (c) of this section may have the need for continuing commitment under this section reviewed by the court sitting without a jury under a petition filed in the superior court at intervals beginning no sooner than a year from the defendant's initial commitment, and yearly thereafter. The burden and standard of proof at a hearing under this subsection are the same as at a hearing under (c) of this section. A copy of all petitions for release shall be served on the attorney general at Juneau, Alaska. A copy shall also be served upon the attorney of record, if the attorney of record is not the attorney general, who represented the state or a municipality at the time the defendant was first committed.

(f) Continued commitment following expiration of the maximum term of imprisonment for the crime for which the defendant was acquitted under AS § 12.47.010 or 12.47.020(b) is governed by the standards pertaining to civil commitments as set out in AS § 47.30.735.

(g) A person committed under this section may not be released during the term of commitment except upon court order following a hearing in accordance with (e) of this section. On the grounds that the defendant has been cured of any mental illness that would cause the defendant to be dangerous to the public peace or safety, the state may at any time request the court to hold a hearing to decide if the defendant should be released.

(h) The commissioner of health and social services or the commissioner's authorized representative shall submit periodic written reports to the court on the mental condition of a person committed under this section.

(i) An order entered under (c) or (e) of this section may be reviewed by the court of appeals on appeal brought by either the defendant or the state within 40 days from the entry of the order.

(j) If the court finds that a defendant committed under (b) or (c) of this section can be adequately controlled and treated in the community with proper supervision, the court may order the defendant conditionally released from confinement under AS § 12.47.092 for a period of time not to exceed the maximum term of imprisonment for the crime for which the defendant was acquitted under AS § 12.47.010 or 12.47.020(b) or until the mental illness is cured or corrected, whichever first occurs, as determined at a hearing under (c) of this section.

(k) In this section,

(1) “dangerous” means a determination involving both the magnitude of the risk that the defendant will commit an act threatening the public peace or safety, as well as the magnitude of the harm that could be expected to result from this conduct; a finding that a defendant is “dangerous” may result from a great risk of relatively slight harm to persons or property, or may result from a relatively slight risk of substantial harm to persons or property;

(2) “mental illness” means any mental condition that increases the propensity of the defendant to be dangerous to the public peace or safety; however, it is not required that the mental illness be sufficient to exclude criminal responsibility under AS § 12.47.010, or that the mental illness presently suffered by the defendant be the same one the defendant suffered at the time of the criminal conduct.

REVISED AS § 12.47.090
Procedure After Raising Defense of Insanity

[NO CHANGES]

EXISTING AS § 12.47.092
Procedure for Conditional Release

- (a) A defendant committed to the custody of the commissioner of health and social services under AS § 12.47.090(b) or (c) may be conditionally released from confinement subject to the conditions and requirements for treatment that the court may impose, and placed under the supervision of the Department of Health and Social Services, a local government agency, a private agency, or an adult, who agrees to assume supervision of the defendant.
- (b) The commissioner of health and social services or the commissioner's authorized representative shall submit, at a minimum, quarterly written reports to the court describing the defendant's progress in treatment, compliance with conditions of release, and other information required by the court for defendants conditionally released under this section.
- (c) A person or agency responsible for supervision or treatment under an order for conditional release shall immediately notify the commissioner of health and social services upon the defendant's failure to appear for required medication or treatment, or for failure to comply with other conditions imposed by the court.
- (d) If the court, after petition or on its own motion, reasonably believes that a conditionally released defendant is failing to adhere to the terms and conditions of the conditional release, the court may order that the conditionally released defendant be apprehended and held until a hearing can be scheduled with the court to determine the facts and whether or not the defendant's conditional release should be revoked or modified. Nothing in this subsection is intended to limit procedures available for emergency situations, including emergency detention under AS § 47.30.705.
- (e) The commissioner of health and social services or the conditionally released defendant may petition the court for modification of an order of conditional release. A petition by the defendant for modification of conditional release may not be filed more often than once every six months.
- (f) A defendant conditionally released under AS § 12.47.090(j) may petition the court for discharge in accordance with AS § 12.47.090(e).

REVISED AS § 12.47.092
Procedure for Conditional Release

[NO CHANGES]

EXISTING AS § 12.47.095
Notice to Victims

(a) If an offender has been committed to the custody of the commissioner of health and social services under AS § 12.47.090, the victim of that crime is entitled to notice of a pending or actual change in the status of the offender. The commissioner of health and social services shall give notice as required by this section if

(1) the offender has been continued in commitment following expiration of the maximum term of imprisonment under AS § 12.47.090(f) and the commissioner gives notice of release of the offender;

(2) the court is to consider modification of an order of conditional release for the offender under AS § 12.47.092(e);

(3) a court is to consider conditional release of the offender under AS § 12.47.090(j) and 12.47.092(a);

(4) the offender petitions for discharge under AS § 12.47.092(f); or

(5) the offender escapes, is released from custody on conditional release, furlough or authorized absence, or is discharged or released from custody for any reason.

(b) If a victim desires notice under this section, the victim shall maintain a current, valid mailing address on file with the commissioner of health and social services. The commissioner shall send the notice required by this section to the victim's last known address. The victim's address may not be disclosed to the offender or offender's attorney.

(c) The commissioner of health and social services is required to give notice of a change in the status of an offender under this section to any victim who has requested notice.

(d) If more than one person who qualifies as a victim under AS § 12.55.185 desires notice, the commissioner of health and social services shall designate one person for purposes of receiving any notice required and exercising the rights granted by this section.

(e) A victim who has received notice under (a) of this section that a change in the status of the offender is pending before a court has the right to submit to the court a written statement, or to appear personally at a hearing to present a written statement, and to give sworn testimony or an unsworn oral presentation to the court.

(f) In this section,

(1) "offender" has the meaning given in AS § 12.61.020;

(2) "victim" has the meaning given in AS § 12.55.185.

REVISED AS § 12.47.095
Notice to Victims

[NO CHANGES]

EXISTING AS § 12.47.100
Incompetency to Proceed

(a) A defendant who, as a result of mental disease or defect, is incompetent because the defendant is unable to understand the proceedings against the defendant or to assist in the defendant's own defense may not be tried, convicted, or sentenced for the commission of a crime so long as the incompetency exists.

(b) If, before imposition of sentence, the prosecuting attorney or the attorney for the defendant has reasonable cause to believe that the defendant is presently suffering from a mental disease or defect that causes the defendant to be unable to understand the proceedings or to assist in the person's own defense, the attorney may file a motion for a judicial determination of the competency of the defendant. Upon that motion, or upon its own motion, the court shall have the defendant examined by at least one qualified psychiatrist or psychologist, who shall report to the court concerning the competency of the defendant. For the purpose of the examination, the court may order the defendant committed for a reasonable period to a suitable hospital or other facility designated by the court. If the report of the psychiatrist or psychologist indicates that the defendant is incompetent, the court shall hold a hearing, upon due notice, at which evidence as to the competency of the defendant may be submitted, including that of the reporting psychiatrist or psychologist, and make appropriate findings. Before the hearing, the court shall, upon request of the prosecuting attorney, order the defendant to submit to an additional evaluation by a psychiatrist or psychologist designated by the prosecuting attorney.

(c) A defendant is presumed to be competent. The party raising the issue of competency bears the burden of proving the defendant is incompetent by a preponderance of the evidence. When the court raises the issue of competency, the burden of proving the defendant is incompetent shall be on the party who elects to advocate for a finding of incompetency. The court shall then apply the preponderance of the evidence standard to determine whether the defendant is competent.

(d) A statement made by the defendant in the course of an examination into the person's competency under this section, whether the examination is with or without the consent of the defendant, may not be admitted in evidence against the defendant on the issue of guilt in a criminal proceeding unless the defendant later relies on a defense under AS § 12.47.010 or 12.47.020. A finding by the judge that the defendant is competent to stand trial in no way prejudices the defendant in a defense based on insanity; the finding may not be introduced in evidence on that issue or otherwise be brought to the notice of the jury.

(e) In determining whether a person has sufficient intellectual functioning to adapt or cope with the ordinary demands of life, the court shall consider whether the person has obtained a driver's license, is able to maintain employment, or is competent to testify as a witness under the Alaska Rules of Evidence.

(f) In determining if the defendant is unable to understand the proceedings against the defendant, the court shall consider, among other factors considered relevant by the court, whether the defendant understands that the defendant has been charged with a criminal offense and that penalties can be imposed; whether the defendant understands what criminal conduct is being alleged; whether the defendant understands the roles of the judge, jury, prosecutor, and defense counsel; whether the defendant understands that the defendant will be expected to tell defense counsel the circumstances, to the best of the defendant's ability, surrounding the defendant's activities at the time of the alleged criminal conduct; and whether the defendant can distinguish between a guilty and not guilty plea.

(g) In determining if the defendant is unable to assist in the defendant's own defense, the court shall

consider, among other factors considered relevant by the court, whether the defendant's mental disease or defect affects the defendant's ability to recall and relate facts pertaining to the defendant's actions at times relevant to the charges and whether the defendant can respond coherently to counsel's questions. A defendant is able to assist in the defense even though the defendant's memory may be impaired, the defendant refuses to accept a course of action that counsel or the court believes is in the defendant's best interest, or the defendant is unable to suggest a particular strategy or to choose among alternative defenses.

(h) In a hearing to determine competency under this section, the court may, at the court's discretion, allow a witness, including a psychiatrist or psychologist who examined the defendant, to testify concerning the competency of the defendant by contemporaneous two-way video conference if the witness is in a place from which people customarily travel by air to the court, and the procedure allows the parties a fair opportunity to examine the witness. The video conference technician shall be the only person in the presence of the witness unless the court, at the court's discretion, determines that another person may be present. Any person present with the witness must be identified on the record. In this subsection, "contemporaneous two-way video conference"

(1) means a conference among people at different places by means of transmitted audio and video signals;

(2) includes all communication technologies that allow people at two or more places to interact by two-way video and audio transmissions simultaneously.

REVISED AS § 12.47.100
Incompetency to Proceed

(a) A defendant who, as a result of mental disease or defect, is incompetent because the defendant is unable to understand the proceedings against the defendant or to assist in the defendant's own defense may not be tried, convicted, or sentenced for the commission of a crime so long as the incompetency exists.

(b) If, before imposition of sentence, the prosecuting attorney or the attorney for the defendant has reasonable cause to believe that the defendant is presently suffering from a mental disease or defect that causes the defendant to be unable to understand the proceedings or to assist in the person's own defense, the attorney may file a motion for a judicial determination of the competency of the defendant. Upon that motion, or upon its own motion, the court shall have the defendant examined by a qualified and neutral evaluator, who shall report to the court concerning the competency of the defendant. For the purpose of the examination, the court may order the defendant committed for a reasonable period to a suitable hospital or other facility designated by the court. If the report of the qualified and neutral evaluator indicates that the defendant is incompetent, the court shall hold a hearing, upon due notice, at which evidence as to the competency of the defendant may be submitted, including that of the qualified and neutral evaluator, and make appropriate findings.

(c) A defendant is presumed to be competent. The party raising the issue of competency bears the burden of proving the defendant is incompetent by a preponderance of the evidence. When the court raises the issue of competency, the burden of proving the defendant is incompetent shall be on the party who elects to advocate for a finding of incompetency. The court shall then apply the preponderance of the evidence standard to determine whether the defendant is competent.

(d) A statement made by the defendant in the course of an examination into the person's competency under this section, whether the examination is with or without the consent of the defendant, may not

be admitted in evidence against the defendant on the issue of guilt in a criminal proceeding unless the defendant later relies on a defense under AS § 12.47.010 or 12.47.020. A finding by the judge that the defendant is competent to stand trial in no way prejudices the defendant in a defense based on insanity; the finding may not be introduced in evidence on that issue or otherwise be brought to the notice of the jury.

(f) In determining if the defendant is unable to understand the proceedings against the defendant, the court shall consider, among other factors considered relevant by the court, whether the defendant understands that the defendant has been charged with a criminal offense and that penalties can be imposed; whether the defendant understands what criminal conduct is being alleged; whether the defendant understands the roles of the judge, jury, prosecutor, and defense counsel; whether the defendant understands that the defendant will be expected to tell defense counsel the circumstances, to the best of the defendant's ability, surrounding the defendant's activities at the time of the alleged criminal conduct; and whether the defendant can distinguish between a guilty and not guilty plea.

(g) In determining if the defendant is unable to assist in the defendant's own defense, the court shall consider, among other factors considered relevant by the court, whether the defendant's mental disease or defect affects the defendant's ability to recall and relate facts pertaining to the defendant's actions at times relevant to the charges and whether the defendant can respond coherently to counsel's questions. A defendant is able to assist in the defense even though the defendant's memory may be impaired, the defendant refuses to accept a course of action that counsel or the court believes is in the defendant's best interest, or the defendant is unable to suggest a particular strategy or to choose among alternative defenses.

(h) In a hearing to determine competency under this section, the court may, at the court's discretion, allow a witness, including the qualified and neutral evaluator who examined the defendant, to testify concerning the competency of the defendant by contemporaneous two-way video conference if the witness is in a place from which people customarily travel by air to the court, and the procedure allows the parties a fair opportunity to examine the witness. The video conference technician shall be the only person in the presence of the witness unless the court, at the court's discretion, determines that another person may be present. Any person present with the witness must be identified on the record. In this subsection, "contemporaneous two-way video conference"

(1) means a conference among people at different places by means of transmitted audio and video signals;

(2) includes all communication technologies that allow people at two or more places to interact by two-way video and audio transmissions simultaneously.

(i) Upon a request by the court, the Department of Health and Social Services, or its designee, shall designate a qualified and neutral evaluator as required under these statutes.

(j) The use of telebehavioral health is permitted under this statute. Examinations performed using telebehavioral health must meet the other requirements for examinations as provided by this statute.

EXISTING AS § 12.47.110
Commitment on Finding of Incompetency

(a) When the trial court determines by a preponderance of the evidence, in accordance with AS § 12.47.100, that a defendant is so incompetent that the defendant is unable to understand the proceedings against the defendant or to assist in the defendant's own defense, the court shall order the proceedings stayed, except as provided in (d) of this section, and shall commit a defendant charged with a felony, and may commit a defendant charged with any other crime, to the custody of the commissioner of health and social services or the commissioner's authorized representative for further evaluation and treatment until the defendant is mentally competent to stand trial, or until the pending charges against the defendant are disposed of according to law, but in no event longer than 90 days.

(b) On or before the expiration of the initial 90-day period of commitment, the court shall conduct a hearing to determine whether or not the defendant remains incompetent. If the court finds by a preponderance of the evidence that the defendant remains incompetent, the court may recommit the defendant for a second period of 90 days. The court shall determine at the expiration of the second 90-day period whether the defendant has become competent. If, at the expiration of the second 90-day period, the court determines that the defendant continues to be incompetent to stand trial, the charges against the defendant shall be dismissed without prejudice, and continued commitment of the defendant shall be governed by the provisions relating to civil commitments under AS § 47.30.700--47.30.915 unless the defendant is charged with a crime involving force against a person and the court finds that the defendant presents a substantial danger of physical injury to other persons and that there is a substantial probability that the defendant will regain competency within a reasonable period of time, in which case the court may extend the period of commitment for an additional six months. If the defendant remains incompetent at the expiration of the additional six-month period, the charges shall be dismissed without prejudice, and continued commitment proceedings shall be governed by the provisions relating to civil commitment under AS § 47.30.700--47.30.915. If the defendant remains incompetent for five years after the charges have been dismissed under this subsection, the defendant may not be charged again for an offense arising out of the facts alleged in the original charges, except if the original charge is a class A felony or unclassified felony.

(c) The defendant is not responsible for the expenses of hospitalization or transportation incurred as a result of the defendant's commitment under this section. Liability for payment under AS § 47.30.910 does not apply to commitments under this section.

(d) A defendant receiving medication for either a physical or a mental condition may not be prohibited from standing trial, if the medication either enables the defendant to understand the proceedings and to properly assist in the defendant's defense or does not disable the defendant from understanding the proceedings and assisting in the defendant's own defense.

(e) A defendant charged with a felony and found to be incompetent to proceed under this section is rebuttably presumed to be mentally ill and to present a likelihood of serious harm to self or others in proceedings under AS § 47.30.700--47.30.915. In evaluating whether a defendant is likely to cause serious harm, the court may consider as recent behavior the conduct with which the defendant was originally charged.

REVISED AS § 12.47.110
Commitment on Finding of Incompetency

(a) When the trial court determines by a preponderance of the evidence, in accordance with AS § 12.47.100, that a defendant is incompetent and unable to understand the proceedings against the

defendant or to assist in the defendant's own defense, the court shall order the proceedings stayed, except as provided in (d) of this section. The court shall commit a defendant charged with a felony, and may commit a defendant charged with any other crime, to the custody of the commissioner of health and social services or the commissioner's authorized representative for further evaluation and treatment, including the use of medication when appropriate. This commitment may continue until the defendant is mentally competent to stand trial, or until the pending charges against the defendant are disposed of according to law. This commitment shall not continue for a time period that is longer than necessary to determine whether there is a substantial probability that the defendant will regain competency, and in no event longer than the time period based on the classification of offense listed in this section:

(1) For felonies that involve the use of force against a person, defendants shall be committed for a time that is not longer than necessary to determine whether there is a substantial probability that the defendant will regain competency within 365 days, and not longer than an initial commitment of 90 days. On or before the expiration of the initial 90-day period of commitment, the court shall conduct a hearing to determine whether or not the defendant remains incompetent. If the court finds by a preponderance of the evidence that the defendant remains incompetent and that there is a substantial probability that the defendant will regain competency within the next 270 days, the court may recommit the defendant for a second period of 90 days. If, at the expiration of the second 90-day period, the court finds by a preponderance of the evidence that the defendant remains incompetent, and that there is a substantial probability that the defendant will regain competency within the next 180 days, and that the defendant presents a substantial danger of physical injury to other persons, the court may extend the period of commitment for an additional 180 days. If the defendant remains incompetent at the expiration of the additional 180-day period, the charges shall be dismissed without prejudice. If the defendant remains incompetent for five years after the charges have been dismissed under this subsection, the defendant may not be charged again for an offense arising out of the facts alleged in the original charges, except if the original charge is a class A felony or unclassified felony.

(2) For felonies that do not involve the use of force against a person, defendants shall be committed for a time that is not longer than necessary to determine whether there is a substantial probability that the defendant will regain competency within 180 days, and not longer than an initial commitment of 90 days. On or before the expiration of the initial 90-day period of commitment, the court shall conduct a hearing to determine whether or not the defendant remains incompetent. If the court finds by a preponderance of the evidence that the defendant remains incompetent and that there is a substantial probability that the defendant will regain competency within the next 90 days, the court may recommit the defendant for a second period of 90 days. If the defendant remains incompetent at the expiration of the additional 90-day period, the charges shall be dismissed without prejudice. If the defendant remains incompetent for five years after the charges have been dismissed under this subsection, the defendant may not be charged again for an offense arising out of the facts alleged in the original charges, except if the original charge is a class A felony or unclassified felony.

(3) For class A misdemeanors that carry a sentence of imprisonment of not more than one year, defendants may be committed for a time that is not longer than necessary to determine whether there is a substantial probability that the defendant will regain competency within 60 days, and not longer than an initial commitment of 30 days. On or before the expiration of the initial 30-day period of commitment, the court shall conduct a hearing to determine whether or not the defendant remains incompetent. If the court finds by a preponderance of the evidence that the defendant remains incompetent and that there is a substantial probability that the defendant will regain competency within the next 30 days, the court may recommit the defendant for a second period of 30 days. If the defendant remains incompetent at the expiration of the second 30-day period, the charges against the defendant shall be dismissed without prejudice.

- (4) For class B misdemeanors that carry a sentence of imprisonment of not more than 90 days, defendants may be committed for a time that is not longer than necessary to determine whether there is a substantial probability that the defendant will regain competency within 30 days, and not longer than 30 days of total commitment. On or before the expiration of the 30-day period of commitment, the court shall conduct a hearing to determine whether or not the defendant remains incompetent. If the defendant remains incompetent at the expiration of the 30-day period, the charges against the defendant shall be dismissed without prejudice.
- (b) If at any time during the commitment of any defendant under subsection (a) the qualified and neutral evaluator determines that the defendant has regained competency, the evaluator shall notify the court immediately, even if the time period permitted for commitment has not expired.
- (c) The defendant is not responsible for the expenses of hospitalization or transportation incurred as a result of the defendant's commitment under this section. Liability for payment under AS § 47.30.910 does not apply to commitments under this section.
- (d) A defendant receiving medication for either a physical or a mental condition may not be prohibited from standing trial, if the medication either enables the defendant to understand the proceedings and to properly assist in the defendant's defense or does not disable the defendant from understanding the proceedings and assisting in the defendant's own defense.
- (e) Before dismissing charges pursuant to subsection (a) against a defendant charged with a felony or misdemeanor, the court shall provide a notice of intent to dismiss the charge to the Department of Health and Social Services. Within 24 hours of receipt of that notice, the Department of Health and Social Services or its designee shall, if indicated, initiate inpatient civil commitment proceedings under AS § 47.30.700 or outpatient civil commitment proceedings under [---] or create a discharge plan for the defendant. In evaluating whether a defendant meets the criteria for inpatient or outpatient civil commitment, the court may consider as recent behavior the conduct with which the defendant was originally charged.

EXISTING AS § 12.47.120
§ 12.47.120. Determination of sanity after commitment

- (a) When, in the medical judgment of the custodian of an accused person committed under AS § 12.47.110, the accused is considered to be mentally competent to stand trial, the committing court shall hold a hearing, after due notice, as soon as conveniently possible. At the hearing, evidence as to the mental condition of the accused may be submitted including reports by the custodian to whom the accused was committed for care.
- (b) If at the hearing the court determines that the accused is presently mentally competent to understand the nature of the proceedings against the accused and to assist in the accused's own defense, appropriate criminal proceedings may be commenced against the accused.
- (c) If at the hearing the court determines that the accused is still presently mentally incompetent, the court shall recommit the accused in accordance with AS § 12.47.110.
- (d) A finding by the court that the accused is mentally competent to stand trial in no way prejudices the accused in a defense based on mental disease or defect excluding responsibility. This finding may not be introduced in evidence on that issue or otherwise brought to the notice of the jury.

REVISED AS § 12.47.120
Determination of Competence After Commitment

- (a) When, in the medical judgment of the qualified and neutral evaluator, the accused is considered to be mentally competent to stand trial, the committing court shall hold a hearing, after due notice, as soon as conveniently possible. At the hearing, evidence as to the mental condition of the accused may be submitted including reports by the custodian to whom the accused was committed for care.
- (b) If at the hearing the court determines that the accused is presently mentally competent to understand the nature of the proceedings against the accused and to assist in the accused's own defense, appropriate criminal proceedings may be commenced against the accused.
- (c) If at the hearing the court determines that the accused is still presently mentally incompetent, the court shall recommit the accused in accordance with AS § 12.47.110.
- (d) A finding by the court that the accused is mentally competent to stand trial in no way prejudices the accused in a defense based on mental disease or defect excluding responsibility. This finding may not be introduced in evidence on that issue or otherwise brought to the notice of the jury.

EXISTING AS § 12.47.130
Definitions

In this chapter,

- (1) “affirmative defense” has the meaning given in AS § 11.81.900(b);
- (2) “assist in the defendant’s own defense” means to consult with a lawyer while exercising a reasonable degree of rational functioning;
- (3) “culpable mental state” has the meaning given in AS § 11.81.900(b);
- (4) “incompetent” means a defendant is unable to understand the proceedings against the defendant or to assist in the defendant’s own defense;
- (5) “mental disease or defect” means a disorder of thought or mood that substantially impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life; “mental disease or defect” also includes intellectual and developmental disabilities that result in significantly below average general intellectual functioning that impairs a person’s ability to adapt to or cope with the ordinary demands of life;
- (6) “understand the proceedings against the defendant” means that the defendant’s elementary mental process is such that the defendant has a reasonably rational comprehension of the proceedings.

REVISED AS § 12.47.130
Definitions

In this chapter,

- (1) “affirmative defense” has the meaning given in AS § 11.81.900(b);
- (2) “assist in the defendant’s own defense” means to consult with a lawyer while exercising a reasonable degree of rational functioning;
- (3) “culpable mental state” has the meaning given in AS § 11.81.900(b);
- (ADDED) “developmental disability” has the meaning given in AS § 47.30.915 and AS § 47.80.900;
- (4) “incompetent” means a defendant is unable to understand the proceedings against the defendant or to assist in the defendant’s own defense;
- (ADDED) “intellectual disability” means a disability that is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. The condition is manifested prior to age eighteen (18). In this definition, “adaptive behavior” means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community.
- (5) “mental disease or defect” means a disorder of thought or mood that substantially impairs judgment, behavior, or capacity to recognize reality; “mental disease or defect” also includes intellectual and developmental disabilities that result in significantly below average general intellectual functioning;

(ADDED) “qualified and neutral evaluator”

(a) A qualified evaluator includes psychiatrists and psychologists. A qualified psychiatrist is a person who is licensed by the State Medical Board to practice in this state or is employed by the federal government, who has received additional training or certification in forensic psychiatry, and who is board certified by the American Board of Psychiatry and Neurology in the subspecialty of forensic psychiatry. A qualified psychologist is a person who is licensed by the state Board of Psychologist and Psychological Associate Examiners. Psychologists should have forensic training and/or certification in performing competency evaluations, including continuing education in forensic evaluations.

(b) A neutral evaluator is a qualified psychiatrist or qualified psychologist who is not otherwise involved in the defendant’s clinical treatment, or any subsequent restorative treatment. If a neutral evaluator later becomes involved in the individual’s clinical or restorative treatment, any subsequent evaluation shall be conducted by an additional, neutral evaluator.

(c) The Division of Behavioral Health shall coordinate continuing education in forensic evaluations that will be available to psychiatrists and psychologists located in the State of Alaska.

(ADDED) “telebehavioral health” includes “the performance of forensic evaluations by secure electronic transmission using electronic communication technology, including two-way, interactive, simultaneous audio and video.”

(6) “understand the proceedings against the defendant” means that the defendant’s elementary mental process is such that the defendant has a reasonably rational comprehension of the proceedings.

TITLE 47

EXISTING AS § 47.30.655 Purpose and Principles of Major Revision

The purpose of the 1981 major revision of Alaska civil commitment statutes (AS § 47.30.660 and 47.30.670 - 47.30.915) is to more adequately protect the legal rights of persons suffering from mental illness. The legislature has attempted to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings. In addition, the following principles of modern mental health care have guided this revision:

- (1) that persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system;
- (2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;
- (3) that treatment occur as promptly as possible and as close to the individual's home as possible;
- (4) that a system of mental health community facilities and supports be available;
- (5) that patients be informed of their rights and be informed of and allowed to participate in their treatment program as much as possible;
- (6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

REVISED AS § 47.30.655 Purpose and Principles of Major Revision

The purpose of the 1981 major revision of Alaska civil commitment statutes (AS §§ 47.30.660 and 47.30.670–47.30.915) is to more adequately protect the legal rights of persons suffering from mental illness. The legislature has attempted to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings. In addition, the following principles of modern mental health care have guided this revision:

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EXISTING AS § 47.30.690
Admission of minors under 18 years of age

(a) A minor under the age of 18 may be admitted for 30 days of evaluation, diagnosis, and treatment at a designated treatment facility if the minor's parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,

(1) the minor is gravely disabled or is suffering from mental illness and as a result is likely to cause serious harm to the minor or others;

(2) there is no less restrictive alternative available for the minor's treatment; and

(3) there is reason to believe that the minor's mental condition could be improved by the course of treatment or would deteriorate further if untreated.

(b) A guardian ad litem for a minor admitted under this section shall be appointed under AS 25.24.310 to monitor the best interests of the minor as soon as possible after the minor's admission. If the guardian ad litem finds that placement is not appropriate, the guardian ad litem may request that an attorney be appointed under AS 25.24.310 to represent the minor. The attorney may request a hearing on behalf of the minor during the 30-day admittance.

(c) The minor may be released by the treatment facility at any time if the professional person in charge or the minor's designated mental health professional determines the minor would no longer benefit from continued treatment and the minor is not dangerous. The minor's parents or guardian must be notified by the facility of the contemplated release.

REVISED AS § 47.30.690
Admission of minors under 18 years of age

(a) A minor under the age of 18 may be admitted for 30 days of evaluation, diagnosis, and treatment at a designated treatment facility if the minor's parent or guardian signs the admission papers and if, in the opinion of the professional person in charge, the minor is mentally ill, and as a result, is reasonably believed (1) to present a likelihood of serious harm to self or others, or (2) to be gravely disabled and that the minor's condition could be improved by treatment; and there is no less restrictive alternative available for the minor's treatment.

(b) As soon as possible after the minor's admission under this section, the court shall appoint a guardian ad litem to monitor the best interests of the minor. If the guardian ad litem finds that placement is not appropriate, the guardian ad litem may request that an attorney be appointed under AS § 25.24.310 to represent the minor. The attorney may request a hearing on behalf of the minor during the 30-day admittance.

(c) The minor may be released by the treatment facility at any time if the professional person in charge or the minor's designated mental health professional determines the minor (1) no longer presents a likelihood of serious harm to self or others or (2) is no longer gravely disabled and the minor's condition could be improved by treatment. The minor's parents or guardian must be notified by the facility of the contemplated release.

EXISTING AS § 47.30.700
§ 47.30.700. Initial Involuntary Commitment Procedures

(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520 - 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

REVISED AS § 47.30.700
Petition for Hospitalization and Evaluation for 72-hour Period

(a) Any adult may petition the court for the hospitalization and evaluation of an individual. The petition must allege that the individual is mentally ill, and as a result, is reasonably believed (1) to present a likelihood of serious harm to self or others, or (2) to be gravely disabled and that the individual's condition could be improved by treatment. The petition must specify the factual information on which that belief is based, including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

(b) Upon receipt of a petition, a judge may (1) issue a ruling based upon the allegations in the petition; (2) hold an ex parte hearing on the petition; or (3) order a mental health professional to conduct a screening investigation of the allegations contained in the petition. The judge shall rule upon the petition within 24 hours of filing, or if a screening investigation is ordered, within 48 hours of filing.

(c) A judge may grant an ex parte order for the hospitalization and evaluation of the respondent for a period not to exceed 72 hours upon finding that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent (1) to present a likelihood of serious harm to self or others, or (2) to be gravely disabled and that the respondent's condition could be improved with treatment. The court shall provide written findings on which the conclusion is based.

(d) If the judge grants an ex parte order for the involuntary hospitalization and evaluation of a respondent who is not already in custody or otherwise detained, the court may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate evaluation facility. If the judge grants an ex parte order for the involuntary hospitalization and evaluation of a respondent who is in custody or otherwise detained, but is not already at an

evaluation facility, the court shall direct that the Department of Health and Social Services or its designee deliver the respondent to the nearest appropriate evaluation facility for hospitalization and evaluation.

(e) When granting an ex parte order for involuntary hospitalization and evaluation, the judge shall appoint an attorney to represent the respondent and shall direct that the respondent be given written copies of all orders together with a notice of the rights contained in AS § 47.30.725.

(f) If, within 72 hours after the issuance of the ex parte order under this section, the respondent is not taken into custody and transferred to an evaluation facility for hospitalization and evaluation, the ex parte order shall expire. Nothing in this subsection prevents the petition for and issuance of an additional ex parte order for the individual's hospitalization and evaluation under AS § 47.30.700.

EXISTING AS § 47.30.705
§ 47.30.705. Emergency detention for evaluation

(a) A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS § 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility. However, emergency protective custody under this section may not include placement of a minor in a jail or secure facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.

(b) In this section, “minor” means an individual who is under 18 years of age.

REVISED AS § 47.30.705
Emergency Protective Custody

(a) A person who presents an immediate risk of serious harm to self or others such that considerations of safety do not provide time to obtain an ex parte involuntary hospitalization order under AS § 47.30.700 may be placed in emergency protective custody.

(b) A person may only be placed in emergency protective custody by a peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners.

(c) To place a person in emergency protective custody, there must be probable cause to believe that the detained person is mentally ill and, as a result of the mental illness is gravely disabled or is likely to cause serious injury to self or others if the person is not immediately detained.

(d) When a person is taken into emergency protective custody, the facility detaining the person shall immediately notify the Department of Health and Social Service or its designee, which shall be the custodial agent for the detained person. Within 24 hours of detention under this section, the Department of Health and Social Services or its designee shall file a petition for hospitalization and evaluation under AS § 47.30.700, or release the detained person.

(e) When a person is taken into emergency protective custody, the detained person must immediately be delivered to the nearest facility where the person can be examined by a mental health professional who will determine whether a petition for hospitalization and evaluation under AS § 47.30.700 is appropriate.

(f) Once a petition is filed, the person may be detained until the petition is adjudicated. If the petition is denied, the person shall immediately be released. If the petition is granted, the provisions of AS § 47.30.700(d) through (f) shall apply.

(g) A person taken into emergency protective custody may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to the evaluation facility ordered by the court.

(h) In no event may a minor in emergency protective custody under this section be placed in a jail or correctional facility. In this section, “minor” means an individual who is under 18 years of age.

EXISTING AS § 47.30.710

§ 47.30.710. Examination; hospitalization

(a) A respondent who is delivered under AS § 47.30.700-47.30.705 to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS § 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation.

REVISED AS § 47.30.710

Hospitalization and Evaluation for 72-hour period

(a) When an ex parte order for hospitalization and evaluation is issued pursuant to AS § 47.30.700, the respondent shall be delivered to an evaluation facility or designated treatment facility ordered by the court and the facility shall promptly notify the court of the date and time of the respondent's arrival. Evaluation personnel, when used pursuant to AS § 47.30.915(8), shall similarly notify the court of the date and time when they first met with the respondent.

(b) A respondent who is delivered under AS § 47.30.700 to an evaluation facility or designated treatment facility shall receive a physical examination by a physician no later than 24 hours after arrival at the facility.

(c) A respondent who is delivered under AS § 47.30.700 to an evaluation facility or designated treatment facility shall be evaluated by a mental health professional for the purpose of determining whether the respondent meets the criteria for a 30-day commitment under AS § 47.30.730 and whether it is necessary and appropriate to file a petition for 30-day commitment under AS § 47.30.730. An evaluation by a mental health professional under this section must occur no later than 24 hours after the respondent arrives at the facility.

(d) The respondent may be held at the evaluation facility or designated treatment facility for further evaluation as long as the respondent appears to meet the criteria for civil commitment under AS § 47.30.700(a), but in no event may the period of hospitalization and evaluation exceed 72 hours following the respondent's arrival at the facility, or upon meeting with evaluation personnel, when used. If the respondent agrees to voluntarily remain at the facility, the court shall immediately be notified and the ex parte order shall be dismissed.

(e) If at any time in the course of the 72-hour period the mental health professionals conducting the evaluation determine that the respondent does not meet the criteria for civil commitment specified in AS § 47.30.700(a), the respondent shall be discharged from the facility or the place of evaluation by evaluation personnel and a notice of release shall be filed with the court and the ex parte order shall be dismissed.

(f) The respondent has the right to refuse medication or other forms of treatment during the 72-hour period except as provided by AS § 47.30.725(e).

(g) If the respondent is already in custody or otherwise detained under AS § 47.30.705, the total period of detention for hospitalization and evaluation under this section shall not exceed five days (120 total hours) after the issuance of the ex parte order under AS § 47.30.700. If the respondent is not already in custody or otherwise detained, the total period of detention for hospitalization and evaluation under this section shall not exceed five days (120 total hours) after the execution of the ex parte order under AS § 47.30.700.

EXISTING AS § 47.30.715
§ 47.30.715. Procedure after order

When a facility receives a proper order for evaluation, it shall accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time, and place for a 30-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent.

REVISED AS § 47.30.715
Procedure after Notice of Hospitalization and Evaluation for 72-hour Period

- (a) When the court receives notice that a respondent has been delivered to an evaluation facility or designated treatment facility for hospitalization and evaluation under AS § 47.30.710, the court shall set a date, time, and place for a 30-day commitment hearing to be held, if needed, within 72 hours after the respondent's arrival at the facility or within 72 hours after the respondent meets with evaluation personnel, when used pursuant to AS § 47.30.915(8).
- (b) The court shall notify the evaluation facility or designated treatment facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements.

EXISTING AS § 47.30.720
Release Before Expiration of 72-Hour Period

If at any time in the course of the 72-hour period the mental health professionals conducting the evaluation determine that the respondent does not meet the standards for commitment specified in AS § 47.30.700, the respondent shall be discharged from the facility or the place of evaluation by evaluation personnel and the petitioner and the court so notified.

REVISED AS § 47.30.720
Release Before Expiration of 72-Hour Period

[NO CHANGES]

EXISTING AS § 47.30.725

Rights; notification

(a) When a respondent is detained for evaluation under AS § 47.30.660 - 47.30.915, the respondent shall be immediately notified orally and in writing of the rights under this section. Notification must be in a language understood by the respondent. The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

(b) Unless a respondent is released or voluntarily admitted for treatment within 72 hours of arrival at the facility or, if the respondent is evaluated by evaluation personnel, within 72 hours from the beginning of the respondent's meeting with evaluation personnel, the respondent is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause for detention after the 72 hours have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result presents a likelihood of serious harm to the respondent or others, or is gravely disabled. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS § 47.30.700 - 47.30.815.

(c) The respondent has a right to communicate immediately, at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice.

(d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing.

(e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 30-day commitment hearing; however, the facility or evaluation personnel may treat the respondent with medication under prescription by a licensed physician or by a less restrictive alternative of the respondent's preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to

(1) prevent bodily harm to the respondent or others;

(2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable the respondent to recover; or

(3) allow the respondent to prepare for and participate in the proceedings.

(f) A respondent, if represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 30-day commitment hearing and have the hearing set for a date no more than seven calendar days after arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver.

REVISED AS § 47.30.725

Rights and Notification Under this Title

(a) When a respondent is detained for evaluation under AS §§ 47.30.660–47.30.915, the respondent shall be immediately notified orally and in writing of the rights under this section. Notification must be in a language understood by the respondent. The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

- (b) If a respondent arrives at an evaluation facility or designated treatment facility pursuant to an ex parte order under AS § 47.30.700 and is then voluntarily admitted under AS § 47.30.803, the designated treatment facility shall give notice to the court of such admission.
- (c) The respondent has a right to communicate immediately, at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice.
- (d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing.
- (e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 30-day commitment hearing; however, the evaluation facility, designated treatment facility, or evaluation personnel may treat the respondent with medication under prescription by a licensed physician or by a less restrictive alternative of the respondent's preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to:
- (1) prevent bodily harm to the respondent or others;
 - (2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable the respondent to recover; or
 - (3) allow the respondent to prepare for and participate in the proceedings.
- (f) A respondent, if represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 30-day commitment hearing and have the hearing set for a date no more than seven calendar days after arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver.

EXISTING AS § 47.30.730
Petition for 30-day commitment

(a) In the course of the 72-hour evaluation period, a petition for commitment to a treatment facility may be filed in court. The petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. The petition must

- (1) allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled;
- (2) allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the respondent or others; or, if a less restrictive involuntary form of treatment is sought, specify the treatment and the basis for supporting it;
- (3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;
- (4) allege that a specified treatment facility or less restrictive alternative that is appropriate to the respondent's condition has agreed to accept the respondent;
- (5) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the specified treatment facility or less restrictive alternative for a period not to exceed 30 days;
- (6) list the prospective witnesses who will testify in support of commitment or involuntary treatment; and
- (7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(b) A copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day commitment hearing.

REVISED AS § 47.30.730
Petition for 30-day Inpatient Commitment

(a) In the course of the 72-hour hospitalization and evaluation period, a petition for commitment to a designated treatment facility may be filed in court. The petition must be signed by a qualified evaluator. The petition must:

- (1) allege that the respondent is mentally ill and as a result (a) is likely to cause serious harm to self or others, or (b) is gravely disabled and the respondent's condition could be improved by the course of treatment sought;
- (2) allege that the qualified evaluator has considered but has not found that outpatient commitment or another less restrictive alternative would adequately protect the respondent or others; or, if outpatient commitment or another less restrictive involuntary form of treatment is sought, specify the basis for supporting it;
- (3) allege that a designated treatment facility or less restrictive alternative that is appropriate to

- the respondent's condition has agreed to accept the respondent;
- (4) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the designated treatment facility or less restrictive alternative for a period not to exceed 30 days;
 - (5) list the prospective witnesses who will testify in support of commitment or involuntary treatment; and
 - (6) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.
- (b) A copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day commitment hearing.
- (c) Upon a request by the court, the Department of Health and Social Services or its designee shall designate a qualified evaluator.

EXISTING AS § 47.30.735
30-day commitment; hearing

- (a) Upon receipt of a proper petition for commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS § 47.30.715.
- (b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits. At the hearing, in addition to other rights specified in AS § 47.30.660 - 47.30.915, the respondent has the right
- (1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to the respondent's mental or physical health;
 - (2) to view and copy all petitions and reports in the court file of the respondent's case;
 - (3) to have the hearing open or closed to the public as the respondent elects;
 - (4) to have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence;
 - (5) to have an interpreter if the respondent does not understand English;
 - (6) to present evidence on the respondent's behalf;
 - (7) to cross-examine witnesses who testify against the respondent;
 - (8) to remain silent;
 - (9) to call experts and other witnesses to testify on the respondent's behalf.
- (c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 30 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled.
- (d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 30 days if the program accepts the respondent.
- (e) The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 30 days is to be sought, the respondent has the right to a full hearing or jury trial.

REVISED AS § 47.30.735
30-day Inpatient Commitment Hearing

- (a) Upon receipt of a proper petition for inpatient commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS § 47.30.715.

(b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits. At the hearing, in addition to other rights specified in AS §§ 47.30.660–47.30.915, the respondent has the right

(1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to the respondent's mental or physical health;

(2) to view and copy all petitions and reports in the court file of the respondent's case;

(3) to have the hearing open or closed to the public as the respondent elects;

(4) to have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence;

(5) to have an interpreter if the respondent does not understand English;

(6) to present evidence on the respondent's behalf;

(7) to cross-examine witnesses who testify against the respondent;

(8) to remain silent;

(9) to call experts and other witnesses to testify on the respondent's behalf.

(c) At the conclusion of the hearing the court may commit the respondent to a designated treatment facility for not more than 30 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result (a) is likely to cause serious harm to the respondent or others, or (b) is gravely disabled and the respondent's condition could be improved by the course of treatment sought.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 30 days if the program accepts the respondent.

(ADDED) If the court finds that the respondent meets the criteria for involuntary outpatient commitment, the court may order that commitment under AS § 47.30.---

(e) The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 30 days is to be sought, the respondent has the right to a full hearing or jury trial.

EXISTING AS § 47.30.740
Procedure for 90-day commitment following 30-day commitment

(a) At any time during the respondent's 30-day commitment, the professional person in charge, or that person's professional designee, may file with the court a petition for a 90-day commitment of that respondent. The petition must include all material required under AS § 47.30.730(a) except that references to "30 days" shall be read as "90 days"; and

(1) allege that the respondent has attempted to inflict or has inflicted serious bodily harm upon the respondent or another since the respondent's acceptance for evaluation, or that the respondent was committed initially as a result of conduct in which the respondent attempted or inflicted serious bodily harm upon the respondent or another, or that the respondent continues to be gravely disabled, or that the respondent demonstrates a current intent to carry out plans of serious harm to the respondent or another;

(2) allege that the respondent has received appropriate and adequate care and treatment during the respondent's 30-day commitment;

(3) be verified by the professional person in charge, or that person's professional designee, during the 30-day commitment.

(b) The court shall have copies of the petition for 90-day commitment served upon the respondent, the respondent's attorney, and the respondent's guardian, if any. The petition for 90-day commitment and proofs of service shall be filed with the clerk of the court, and a date for hearing shall be set, by the end of the next judicial day, for not later than five judicial days from the date of filing of the petition. The clerk shall notify the respondent, the respondent's attorney, and the petitioner of the hearing date at least three judicial days in advance of the hearing.

(c) Findings of fact relating to the respondent's behavior made at a 30-day commitment hearing under AS § 47.30.735 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.

REVISED AS § 47.30.740
Procedure for 90-day Inpatient Commitment Petition Following 30-day Inpatient Commitment

(a) At any time during the respondent's 30-day inpatient commitment, the professional person in charge, or that person's professional designee, may request that a qualified evaluator file with the court a petition for a 90-day inpatient commitment of that respondent. The 90-day petition must include all material required under AS § 47.30.730(a) except that references to "30 days" shall be read as "90 days"; and

(1) allege that the respondent has attempted to inflict or has inflicted serious bodily harm upon the respondent or another since the respondent's acceptance for evaluation, or that the respondent was committed initially as a result of conduct in which the respondent attempted or inflicted serious bodily harm upon the respondent or another, or that the respondent continues to be gravely disabled, or that the respondent demonstrates a current intent to carry out plans of serious harm to the respondent or another;

(2) allege that the respondent has received appropriate and adequate care and treatment during the respondent's 30-day commitment;

- (3) be verified by the professional person in charge, or that person's professional designee, during the 30-day commitment.
- (b) The court shall have copies of the 90-day commitment petition served upon the respondent, the respondent's attorney, and the respondent's guardian, if any. The 90-day commitment petition and proofs of service shall be filed with the clerk of the court, and a date for hearing shall be set, by the end of the next judicial day, for not later than five judicial days from the date of filing of the petition. The clerk shall notify the respondent, the respondent's attorney, and the petitioner of the hearing date at least three judicial days in advance of the hearing.
- (c) Findings of fact relating to the respondent's behavior made at a 30-day commitment hearing under AS § 47.30.735 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.
- (d) Upon a request by the court, the Department of Health and Social Services or its designee shall designate a qualified evaluator.

EXISTING AS § 47.30.745

§ 47.30.745. 90-day commitment hearing rights; continued commitment

(a) A respondent subject to a petition for 90-day commitment has, in addition to the rights specified elsewhere in this chapter, or otherwise applicable, the rights enumerated in this section. Written notice of these rights shall be served on the respondent and the respondent's attorney and guardian, if any, and may be served on an adult designated by the respondent at the time the petition for 90-day commitment is served. An attempt shall be made by oral explanation to ensure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language the respondent understands.

(b) Unless the respondent is released or is admitted voluntarily following the filing of a petition and before the hearing, the respondent is entitled to a judicial hearing within five judicial days of the filing of the petition as set out in AS § 47.30.740(b) to determine if the respondent is mentally ill and as a result is likely to cause harm to self or others, or if the respondent is gravely disabled. If the respondent is admitted voluntarily following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS § 47.30.740 or under AS § 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave, the professional person in charge may file with the court a petition for a 180-day commitment of the respondent under AS § 47.30.770. The 180-day commitment hearing shall be scheduled for a date not later than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be continued for no more than 10 calendar days. The jury shall consist of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10 calendar days.

(e) The respondent has a right to retain an independent licensed physician or other mental health professional to examine the respondent and to testify on the respondent's behalf. Upon request by an indigent respondent, the court shall appoint an independent licensed physician or other mental health professional to examine the respondent and testify on the respondent's behalf. The court shall consider an indigent respondent's request for a specific physician or mental health professional. A motion for the appointment may be filed in court at any reasonable time before the hearing and shall be acted upon promptly. Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shall in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS § 47.30.700 - 47.30.915, the rules of evidence and procedure in civil proceedings.

(g) Until the court issues a final decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If a decision has not been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, the respondent shall be released.

REVISED AS § 47.30.745
90-day Commitment Hearing Rights; Continued Commitment

- (a) A respondent subject to a 90-day commitment petition has, in addition to the rights specified elsewhere in this chapter, or otherwise applicable, the rights enumerated in this section. Written notice of these rights shall be served on the respondent and the respondent's attorney and guardian, if any, and may be served on an adult designated by the respondent at the time the 90-day commitment petition is served. An attempt shall be made by oral explanation to ensure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language the respondent understands.
- (b) Unless the respondent is released or is admitted voluntarily following the filing of a 90-day petition and before the hearing, the respondent is entitled to a judicial hearing within five judicial days of the filing of the 90-day petition as set out in AS § 47.30.740(b) to determine if the respondent is mentally ill and as a result (1) is likely to cause serious harm to the respondent or others, or (2) is gravely disabled and the respondent's condition could be improved by the course of treatment sought. If the respondent is admitted voluntarily following the filing of the 90-day petition, the voluntary admission constitutes a waiver of any hearing rights under AS § 47.30.740 or under AS § 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave, the professional person in charge may request that the qualified evaluator file with the court a petition for a 180-day commitment of the respondent under AS § 47.30.770. The 180-day commitment hearing shall be scheduled for a date not later than 90 days after the respondent's voluntary admission.
- (c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be continued for no more than 10 calendar days. The jury shall consist of six persons.
- (d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10 calendar days.
- (e) The respondent has a right to retain an additional qualified evaluator to examine the respondent and to testify on the respondent's behalf. A motion by the respondent for the appointment of an additional qualified evaluator, at respondent's cost, may be filed in court at any reasonable time before the hearing and shall be acted upon promptly.
- (f) The proceeding shall in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS §§ 47.30.700–47.30.915, the rules of evidence and procedure in civil proceedings.
- (g) Until the court issues a final decision, the respondent shall continue to be treated at the designated treatment facility unless the 90-day commitment petition is withdrawn. If a decision has not been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, the respondent shall be released.

EXISTING AS § 47.30.750
Conduct of hearing

The hearing under AS § 47.30.745 shall be conducted in the same manner, and with the same rights for the respondent, as set out in AS § 47.30.735(b).

REVISED AS § 47.30.750
90-day Inpatient Commitment Hearing

The hearing under AS § 47.30.745 shall be conducted in the same manner, and with the same rights for the respondent, as set out in AS § 47.30.735(b).

EXISTING AS § 47.30.755
Court order

- (a) After the hearing and within the time limit specified in AS § 47.30.745, the court may commit the respondent to a treatment facility for no more than 90 days if the court or jury finds by clear and convincing evidence that the respondent is mentally ill and as a result is likely to cause harm to self or others, or is gravely disabled.
- (b) If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days.

REVISED AS § 47.30.755
Court Order Following 90-day Inpatient Commitment Hearing

- (a) After the hearing and within the time limit specified in AS § 47.30.745, the court may commit the respondent to a designated treatment facility for no more than 90 days if the court or jury finds by clear and convincing evidence that the respondent is mentally ill and as a result (1) is likely to cause serious harm to the respondent or others, or (2) is gravely disabled and the respondent's condition could be improved by the course of treatment sought.
- (b) If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days.
- (c) If the court finds that the respondent meets the criteria for outpatient commitment under Section [---], the court may order outpatient commitment.

EXISTING AS § 47.30.760
Placement at Closest Facility

Treatment shall always be available at a state-operated hospital; however, if space is available and upon acceptance by another treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to the respondent's home unless the court finds that

- (1) another treatment facility in the state has a program more suited to the respondent's condition, and this interest outweighs the desirability of the respondent being closer to home;
- (2) another treatment facility in the state is closer to the respondent's friends or relatives who could benefit the respondent through their visits and communications; or
- (3) the respondent wants to be further removed from home, and the mental health professionals who sought the respondent's commitment concur in the desirability of removed placement.

REVISED AS § 47.30.760
Placement at Closest Facility

Treatment shall always be available at a state-operated hospital; however, if space is available and upon acceptance by another designated treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to the respondent's home unless the court finds that:

- (1) another designated treatment facility in the state has a program more suited to the respondent's condition, and this interest outweighs the desirability of the respondent being closer to home;
- (2) another designated treatment facility in the state is closer to the respondent's friends or relatives who could benefit the respondent through their visits and communications; or
- (3) the respondent wants to be further removed from home, and the qualified evaluator who testified in the respondent's commitment hearing agrees with the desirability of removed placement.

EXISTING AS § 47.30.765
Appeal

The respondent has the right to an appeal from an order of involuntary commitment. The court shall inform the respondent of this right.

REVISED AS § 47.30.765
Appeal

[NO CHANGES]

EXISTING AS § 47.30.770
Additional 180-day Commitment

- (a) The respondent shall be released from involuntary treatment at the expiration of 90 days unless the professional person in charge files a petition for a 180-day commitment conforming to the requirements of AS § 47.30.740(a) except that all references to “30-day commitment” shall be read as “the previous 90-day commitment” and all references to “90-day commitment” shall be read as “180-day commitment”.
- (b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS § 47.30.740 - 47.30.750. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS § 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 180 days from the date on which the first 90-day treatment period would have expired.
- (c) Successive 180-day commitments are permissible on the same ground and under the same procedures as the original 180-day commitment. An order of commitment may not exceed 180 days.
- (d) Findings of fact relating to the respondent’s behavior made at a 30-day commitment hearing under AS § 47.30.735, a 90-day commitment hearing under AS § 47.30.750, or a previous 180-day commitment hearing under this section shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.

REVISED AS § 47.30.770
Additional 180-day Commitment

- (a) The respondent shall be released from involuntary commitment at the expiration of 90 days unless the professional person in charge, or that person’s professional designee, requests that a qualified evaluator file a petition for a 180-day commitment conforming to the requirements of AS § 47.30.740(a) except that all references to “30-day commitment” shall be read as “the previous 90-day commitment” and all references to “90-day commitment” shall be read as “180-day commitment.”
- (b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS §§ 47.30.740–47.30.750. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS § 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 180 days from the date on which the first 90-day treatment period would have expired.
- (c) Successive 180-day commitments are permissible on the same ground and under the same procedures as the original 180-day commitment. An order of commitment may not exceed 180 days.
- (d) Findings of fact relating to the respondent’s behavior made at a 30-day commitment hearing under AS § 47.30.735, a 90-day commitment hearing under AS § 47.30.750, or a previous 180-day commitment hearing under this section shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.
- (e) Upon a request by the court, the Department of Health and Social Services, or its designee, shall designate a qualified evaluator.

EXISTING AS § 47.30.772
Medication and Treatment

An evaluation facility or designated treatment facility may administer medication or other treatment to an involuntarily committed patient only in a manner that is consistent with the provisions of AS 47.30.817–47.30.865.

REVISED AS § 47.30.772
Medication and Treatment

[NO CHANGES]

EXISTING AS § 47.30.775
Commitment of Minors

The provisions of AS 47.30.700–47.30.815 apply to minors. However, all notices required to be served on the respondent in AS 47.30.700–47.30.815 shall also be served on the parent or guardian of a respondent who is a minor, and parents or guardians of a minor respondent shall be notified that they may appear as parties in any commitment proceeding concerning the minor and that as parties they are entitled to retain their own attorney or have the office of public advocacy appointed for them by the court. A minor respondent has the same rights to waiver and informed consent as an adult respondent under AS 47.30.660–47.30.915; however, the minor shall be represented by counsel in waiver and consent proceedings.

REVISED AS § 47.30.775
Commitment of Minors

[NO CHANGES]

EXISTING AS § 47.30.780

Early discharge

(a) Except as provided in (b) of this section, the professional person in charge shall at any time discharge a respondent on the ground that the respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness. A certificate to this effect shall be sent to the court, which shall enter an order officially terminating the involuntary commitment.

(b) The professional person in charge shall give the prosecuting authority 10 days' notice before discharging a respondent who was committed after having been found incompetent to proceed under AS § 12.47.110.

REVISED AS § 47.30.780

Early Discharge Following Involuntary Inpatient Commitment

The professional person in charge shall at any time discharge a respondent on the ground that the respondent is no longer (1) likely to cause serious harm to the respondent or others, or (2) gravely disabled and the respondent's condition could be improved by the course of the treatment sought. A certificate to this effect shall be sent to the court, which shall enter an order officially terminating the involuntary inpatient commitment.

EXISTING AS § 47.30.785
Authorized Absences

A respondent undergoing involuntary treatment on an inpatient basis under AS § 47.30.700 - 47.30.815 may be authorized to be absent from the treatment facility during times specified by the professional person in charge, or that person's professional designee, when an authorization to be absent is in the best interests of the respondent and the respondent

REVISED AS § 47.30.785
Authorized Absences

A respondent undergoing involuntary inpatient commitment under AS §§ 47.30.700–47.30.815 may be authorized to be absent from the designated treatment facility during times specified by the professional person in charge, or that person's professional designee, when an authorization to be absent is in the best interests of the respondent and the respondent is not likely to cause serious harm to self or others.

EXISTING AS § 47.30.790
Unauthorized Absences: Return to Facility; Required Notice

When a respondent undergoing involuntary treatment on an inpatient basis is absent from the treatment facility without, or in excess of, authorization under AS § 47.30.785, the professional person in charge, or that person's professional designee, may contact the appropriate peace officers who shall take the respondent into custody and return the respondent to the treatment facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody. In addition, the family or guardian of the patient and any person known to have been threatened by the patient shall be notified of the patient's unauthorized absence immediately upon its discovery.

REVISED AS § 47.30.790
Unauthorized Absences: Return to Facility; Required Notice

When a respondent undergoing involuntary inpatient commitment is absent from the designated treatment facility without, or in excess of, authorization under AS § 47.30.785, the professional person in charge, or that person's professional designee, may contact the appropriate peace officers who shall take the respondent into custody and return the respondent to the designated treatment facility. If it is determined by the professional person in charge to be necessary, a member of the designated treatment facility staff shall accompany the peace officers when they take the respondent into custody. In addition, the family or guardian of the patient and any person known to have been threatened by the patient shall be notified of the patient's unauthorized absence immediately upon its discovery.

EXISTING AS § 47.30.795
Involuntary Outpatient Care for Committed Persons

(a) A respondent who was originally committed to involuntary inpatient care under AS 47.30.700–47.30.915 may be released before the expiration of the commitment period if a provider of outpatient care accepts the respondent for specified outpatient treatment for a period of time not to exceed the duration of the commitment, and if the professional person in charge, or that person’s professional designee, finds that

(1) it is not necessary to treat the respondent as an inpatient to prevent the respondent from harming self or others; and

(2) there is reason to believe that the respondent’s mental condition would improve as a result of the outpatient treatment.

(b) A copy of the conditions for early release shall be given to the respondent and the respondent’s attorney and guardian, if any, the provider of outpatient care, and the court.

(c) If during the commitment period the provider of outpatient care determines that the respondent can no longer be treated on an outpatient basis because the respondent is likely to cause harm to self or others or is gravely disabled, the provider shall give the respondent oral and written notice that the respondent must return to the treatment facility within 24 hours, with copies to the respondent’s attorney and guardian, if any, the court, and the inpatient treatment facility. If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge may contact the appropriate peace officers who shall take the respondent into custody and transport the respondent to the facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody.

(d) If the provider of outpatient care determines that the respondent will require continued outpatient care after the expiration of the commitment period, the provider may initiate further commitment proceedings as if the provider were the professional person in charge, and the provisions of AS 47.30.660–47.30.915 apply, except that provisions relating to inpatient treatment shall be read as applicable to outpatient treatment.

REVISED AS § 47.30.795
Involuntary Outpatient Care for Committed Persons

[NO CHANGES]

EXISTING AS § 47.30.800

Conversion of Involuntary Outpatient Treatment to Inpatient Commitment

(a) A respondent ordered by the court under the provisions of AS § 47.30.700 - 47.30.915 to receive involuntary outpatient treatment may be required to undergo inpatient treatment when the provider of outpatient care finds that (1) the respondent is mentally ill and is likely to cause serious harm to self or others or is still gravely disabled; (2) the respondent's behavior since the hearing resulting in court-ordered treatment indicates that the respondent now needs inpatient treatment to protect self or others; (3) there is reason to believe that the respondent's mental condition will improve as a result of inpatient treatment; and (4) there is an inpatient facility appropriate to the respondent's need that will accept the respondent as a patient. Treatment for these respondents shall be available at state-operated hospitals at all times.

(b) Upon making the findings specified in (a) of this section, the provisions of AS § 47.30.795(c) relating to notice and AS § 47.30.745 relating to hearings apply.

REVISED AS § 47.30.800

Conversion of Involuntary Outpatient Treatment to Inpatient Commitment

(a) A respondent ordered by the court under the provisions of AS §§ 47.30.700–47.30.915 to receive involuntary outpatient treatment may be required to undergo inpatient treatment when the provider of outpatient care finds that (1) the respondent is mentally ill and is likely to cause serious harm to self or others or is still gravely disabled; (2) the respondent's behavior since the hearing resulting in court-ordered treatment indicates that the respondent now needs inpatient treatment to prevent serious harm to the respondent or others; (3) there is reason to believe that the respondent's mental condition will improve as a result of inpatient treatment; and (4) there is an inpatient facility appropriate to the respondent's need that will accept the respondent as a patient. Treatment for these respondents shall be available at state-operated hospitals at all times.

(b) Upon making the findings specified in (a) of this section, the provisions of AS § 47.30.795(c) relating to notice and AS § 47.30.745 relating to hearings apply.

EXISTING AS § 47.30.803
Conversion from Involuntary to Voluntary Status

A patient subject to involuntary hospitalization under AS 47.30.705, 47.30.735, or AS 47.30.755 may at any time convert to voluntary status if the responsible physician agrees that

- (1) the patient is an appropriate patient for voluntary hospitalization; and
- (2) the conversion is made in good faith.

REVISED AS § 47.30.803
Conversion from Involuntary to Voluntary Status

A patient subject to involuntary hospitalization under AS § 47.30.700, AS § 47.30.705, AS § 47.30.735, or AS § 47.30.755 may at any time convert to voluntary status if the responsible physician agrees that

- (1) the patient is an appropriate patient for voluntary hospitalization; and
- (2) the conversion is made in good faith.

EXISTING AS § 47.30.805
Computation, Extension, and Expiration of Periods of Time

(a) Except as provided in (b) of this section,

(1) computations of a 72-hour evaluation period under AS 47.30.715 or a 48-hour detention period under AS 47.30.685 do not include Saturdays, Sundays, legal holidays, or any period of time necessary to transport the respondent to the treatment facility;

(2) a 30-day commitment period expires at the end of the 30th day after the 72 hours following initial acceptance;

(3) a 90-day commitment period expires at the end of the 90th day after the expiration of a 30-day period of treatment;

(4) a 180-day commitment period expires at the end of the 180th day, after the expiration of a 90-day period of treatment or previous 180-day period, whichever is applicable.

(b) When a respondent has failed to appear or been absent through the respondent's own actions contrary to any order properly made or entered under AS 47.30.660–47.30.915, the relevant commitment period shall be extended for a period of time equal to the respondent's absence if written notice of absence is promptly provided to the respondent's attorney and guardian, if there is one, and if, within 24 hours after the respondent has returned to the evaluation or treatment facility, written notice of the corresponding extension and the reason for it is given to the respondent and the respondent's attorney and guardian, if any, and to the court.

REVISED AS § 47.30.805
Computation, Extension, and Expiration of Periods of Time

[NO CHANGES]

EXISTING AS § 47.30.810
Habeas Corpus not Limited

Nothing in AS 47.30.660–47.30.915 may be construed as limiting a person’s right to a writ of habeas corpus.

REVISED AS § 47.30.810
Habeas Corpus not Limited

[NO CHANGES]

EXISTING AS § 47.30.815
Limitation of Liability; Bad Faith Application a Felony

(a) A person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person under AS § 47.30.700 - 47.30.915 is not subject to civil or criminal liability.

(b) The following persons may not be held civilly or criminally liable for detaining a person under AS § 47.30.700 - 47.30.915 or for releasing a person under AS § 47.30.700 - 47.30.915 at or before the end of the period for which the person was admitted or committed for evaluation or treatment if the persons have performed their duties in good faith and without gross negligence:

(1) an officer of a public or private agency;

(2) the superintendent, the professional person in charge, the professional designee of the professional person in charge, and the attending staff of a public or private agency;

(3) a public official performing functions necessary to the administration of AS § 47.30.700 - 47.30.915;

(4) a peace officer or mental health professional responsible for detaining or transporting a person under AS § 47.30.700 - 47.30.915.

(c) A person who willfully initiates an involuntary commitment procedure under AS § 47.30.700 without having good cause to believe that the other person is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to self or others, is guilty of a felony.

REVISED AS § 47.30.815
Limitation of Liability; Bad Faith Application a Felony

(a) A person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person under AS §§ 47.30.700–47.30.915 is not subject to civil or criminal liability.

(b) The following persons may not be held civilly or criminally liable for detaining a person under AS §§ 47.30.700–47.30.915 or for releasing a person under AS §§ 47.30.700–47.30.915 at or before the end of the period for which the person was admitted or committed for evaluation or treatment if the persons have performed their duties in good faith and without gross negligence:

(1) an officer of a public or private agency;

(2) the superintendent, the professional person in charge, the professional designee of the professional person in charge, and the attending staff of a public or private agency;

(3) a public official performing functions necessary to the administration of AS §§ 47.30.700–47.30.915;

(4) any individual responsible for detaining or transporting a person under AS §§ 47.30.700–47.30.915.

(c) A person who willfully initiates an involuntary commitment procedure under AS § 47.30.700 without having good cause to believe that the other person is suffering from a mental illness and as a result is likely to cause serious harm to self or others, or is gravely disabled, is guilty of a felony.

EXISTING AS § 47.30.915
Definitions

In AS § 47.30.660 - 47.30.915,

- (1) “adjudication of mental illness or mental incompetence” means a court order finding that a person is
 - (A) not guilty by reason of insanity or guilty but mentally ill under AS § 12.47.040;
 - (B) incompetent to stand trial for a criminal offense under AS § 12.47.100--12.47.120; or
 - (C) a danger to self or others, or is gravely disabled because of incapacity, incompetence, mental illness, dementia, or some other cause;
- (2) “commissioner” means the commissioner of health and social services;
- (3) “court” means a superior court of the state;
- (4) “department” means the Department of Health and Social Services;
- (5) “designated treatment facility” or “treatment facility” means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS § 47.30.670--47.30.915 but does not include correctional institutions;
- (6) “disability resulting from an involuntary commitment or an adjudication of mental illness or mental incompetence” means the prohibition against the possession of a firearm or ammunition under 18 U.S.C. 922(g)(4) that results from an involuntary commitment or adjudication of mental illness or mental incompetence.
- (7) “evaluation facility” means a health care facility that has been designated or is operated by the department to perform the evaluations described in AS § 47.30.660--47.30.915, or a medical facility licensed under AS § 47.32 or operated by the federal government;
- (8) “evaluation personnel” means mental health professionals designated by the department to conduct evaluations as prescribed in AS § 47.30.660 - 47.30.915 who conduct evaluations in places in which no staffed evaluation facility exists;
- (9) “gravely disabled” means a condition in which a person as a result of mental illness
 - (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
 - (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person’s previous ability to function independently;
- (10) “inpatient treatment” means care and treatment rendered inside or on the premises of a treatment facility, or a part or unit of a treatment facility, for a continual period of 24 hours or longer;

(11) “least restrictive alternative” means mental health treatment facilities and conditions of treatment that

(A) are no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and

(B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury;

(12) “likely to cause serious harm” means a person who

(A) poses a substantial risk of bodily harm to that person’s self, as manifested by recent behavior causing, attempting, or threatening that harm;

(B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or

(C) manifests a current intent to carry out plans of serious harm to that person’s self or another;

(13) “mental health professional” means a psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master’s degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; and a person who

(A) has a master’s degree in the field of mental health;

(B) has at least 12 months of post-masters working experience in the field of mental illness; and

(C) is working under the supervision of a type of licensee listed in this paragraph;

(14) “mental illness” means an organic, mental, or emotional impairment that has substantial adverse effects on an individual’s ability to exercise conscious control of the individual’s actions or ability to perceive reality or to reason or understand; intellectual disability, developmental disability, or both, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;

(15) “peace officer” includes a state police officer, municipal or other local police officer, state, municipal, or other local health officer, public health nurse, United States marshal or deputy United States marshal, or a person authorized by the court;

(16) “persons with mental disorders” has the meaning given in AS § 47.30.610;

(17) “professional person in charge” means the senior mental health professional at a facility or that person’s designee; in the absence of a mental health professional it means the chief of staff or a physician designated by the chief of staff;

(18) “provider of outpatient care” means a mental health professional or hospital, clinic, institution, center, or other health care facility designated by the department to accept for treatment patients who are ordered to undergo involuntary outpatient treatment by the court or who are released early from inpatient commitments on condition that they undergo outpatient treatment;

(19) “screening investigation” means the investigation and review of facts that have been alleged to warrant emergency examination or treatment, including interviews with the persons making the allegations, any other significant witnesses who can readily be contacted for interviews, and, if possible, the respondent, and an investigation and evaluation of the reliability and credibility of persons providing information or making allegations;

(20) “state” means a state of the United States, the District of Columbia, the territories and possessions of the United States, and the Commonwealth of Puerto Rico, and, with the approval of the United States Congress, Canada.

REVISED AS § 47.30.915
Definitions

In AS §§ 47.30.660–47.30.915,

(1) “adjudication of mental illness or mental incompetence” means a court order finding that a person is

(a) not guilty by reason of insanity or guilty but mentally ill under AS § 12.47.040;

(b) incompetent to stand trial for a criminal offense under AS §§ 12.47.100 – 12.47.120; or

(c) a danger to self or others, or is gravely disabled because of incapacity, incompetence, mental illness, dementia, or some other cause;

(2) “commissioner” means the commissioner of health and social services;

(3) “court” means a superior court of the state;

(4) “department” means the Department of Health and Social Services;

(5) “designated treatment facility” or “treatment facility” means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS §§ 47.30.670–47.30.915 but does not include correctional institutions;

(6) “disability resulting from an involuntary commitment or an adjudication of mental illness or mental incompetence” means the prohibition against the possession of a firearm or ammunition under 18 U.S.C. 922(g)(4) that results from an involuntary commitment or adjudication of mental illness or mental incompetence.

(ADDED) “developmental disability” means a severe, chronic disability that

(a) is attributable to a mental or physical impairment or combination of mental and physical impairments;

- (b) is manifested before the person attains age 22;
 - (c) is likely to continue indefinitely;
 - (d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
 - (e) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated;
- (7) “evaluation facility” means a health care facility that has been designated or is operated by the department to perform the evaluations described in AS §§ 47.30.660–47.30.915, or a medical facility licensed under AS § 47.32 or operated by the federal government;
- (8) “evaluation personnel” means a qualified evaluator designated by the department to conduct evaluations as prescribed in AS §§ 47.30.660–47.30.915 who conduct evaluations in places in which no staffed evaluation facility exists;
- (9) “gravely disabled” means a condition in which a person as a result of mental illness
- (a) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
 - (b) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is of such intensity that the individual is unable to life safely outside of a controlled environment;
- (10) “inpatient treatment” means care and treatment rendered inside or on the premises of a treatment facility, or a part or unit of a treatment facility, for a continual period of 24 hours or longer;
- (ADDED) “intellectual disability” means a disability that is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. The condition is manifested prior to age eighteen (18). In this definition, “adaptive behavior” means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community;
- (11) “least restrictive alternative” means mental health treatment facilities and conditions of treatment that
- (a) are no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and
 - (b) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury;
- (12) “likely to cause serious harm” means a person who

(a) poses a substantial risk of bodily harm to that person's self, as manifested by behavior in the previous 30 days where the person caused, attempted, or threatened that harm;

(b) poses a substantial risk of harm to others as manifested by behavior in the previous three months where the person caused, attempted, or threatened harm to another person, and is likely to cause physical injury, physical abuse, or substantial property damage to another person in the next 30 days; or

(c) manifests a current intent, as evidenced by present statements or behavior, or by statements or behavior in the previous 30 days, to carry out plans of serious harm to that person's self or another;

(13) "mental health professional" means a psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; or a person who

(a) has a master's degree in the field of mental health;

(b) has at least 12 months of post-masters working experience in the field of mental illness; and

(c) is working under the supervision of a type of licensee listed in this paragraph;

(14) "mental illness" means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand; intellectual disability, developmental disability, epilepsy, drug addiction, and alcoholism are not mental illnesses, although persons suffering from these conditions may also be suffering from mental illness;

(15) "peace officer" includes a state police officer, municipal or other local police officer, state, municipal, or other local health officer, public health nurse, United States marshal or deputy United States marshal, or a person authorized by the court;

(16) "persons with mental disorders" has the meaning given in AS § 47.30.610;

(17) "professional person in charge" means the senior mental health professional at a facility or that person's designee; in the absence of a mental health professional it means the chief of staff or a physician designated by the chief of staff;

(18) "provider of outpatient care" means a mental health professional or hospital, clinic, institution, center, or other health care facility designated by the department to accept for treatment patients who are ordered to undergo involuntary outpatient commitment by the court or who are released early from inpatient commitments on condition that they undergo outpatient commitment;

(ADDED) "qualified and neutral evaluator"

(a) A qualified evaluator includes psychiatrists and psychologists. A qualified psychiatrist is a person who is licensed by the State Medical Board to practice in this state or is employed by the federal government, who has received additional training or certification in forensic psychiatry, and who is board certified by the American Board of Psychiatry and Neurology in the

subspecialty of forensic psychiatry. A qualified psychologist is a person who is licensed by the state Board of Psychologist and Psychological Associate Examiners. Psychologists should have training and/or certification in performing civil commitment evaluations, including continuing education in civil commitment evaluations. The Division of Behavioral Health shall coordinate continuing education in civil commitment evaluations that will be available to psychiatrists and psychologists located in the State of Alaska.

(b) A neutral evaluator is a qualified psychiatrist or qualified psychologist who is not otherwise involved in the defendant's clinical treatment. If a neutral evaluator later becomes involved in the individual's clinical treatment, any subsequent evaluation shall be conducted by an additional, neutral evaluator.

(c) The Division of Behavioral Health shall coordinate continuing education in civil commitment evaluations that will be available to psychiatrists and psychologists located in the State of Alaska.

(19) "screening investigation" means the investigation and review of facts that have been alleged to warrant emergency examination or treatment, including interviews with the persons making the allegations, any other significant witnesses who can readily be contacted for interviews, and, if possible, the respondent, and an investigation and evaluation of the reliability and credibility of persons providing information or making allegations;

(20) "state" means a state of the United States, the District of Columbia, the territories and possessions of the United States, and the Commonwealth of Puerto Rico, and, with the approval of the United States Congress, Canada.

(ADDED) "telebehavioral health" means the performance of forensic evaluations by electronic transmission using electronic communication technology; or two-way, interactive, simultaneous audio and video. When evaluations are conducted using telebehavioral health, all patient information, including electronic data, must be confidentially maintained.

REVIEW OF ALASKA MENTAL HEALTH STATUTES

This document contains the written feedback the UNLV team received in response to the UNLV/UNSOM Report. The following written responses are attached:

1. James Fayette, Assistant Attorney General
Department of Law, Criminal Division
Memorandum: Comment regarding the UNLV Study & Recommendation for Title 12 amendment
2. Whitney Glover, Assistant Public Advocate
Office of Public Advocacy
Memorandum: The UNLV recommendations that the GBMI statute be repealed
3. Linda R. Beecher, Deputy Public Defender
Alaska Public Defender Agency, Civil Division
Memorandum: PDA Comments on Proposed Changes to Civil Commitment Statutes
4. Lanette Nickens, Assistant Attorney General
Department of Law, Civil Division, Human Services Section
Memorandum: Comment regarding UNLV Review of Alaska Mental Health Statutes

For additional information, contact:

Sara Gordon, J.D.
UNLV/William S. Boyd School of Law
sara.gordon@unlv.edu

UNLV | WILLIAM S. BOYD
SCHOOL OF LAW



University of Nevada
School of Medicine

MEMORANDUM

OFFICE OF SPECIAL PROSECUTIONS CRIMINAL DIVISION STATE OF ALASKA, DEPARTMENT OF LAW

From: James Fayette
Assistant Attorney General

To: Steve Williams
Chief Operating Officer
Alaska Mental Health Trust
Via email steve.williams@alaska.gov
On behalf of T12 Subcommittee

Date: April 15, 2015

Subject: Comment regarding the UNLV Study & Recommendations for Title 12 amendment

Department of Law (DOL) Criminal Division Director John Skidmore has asked me to respond on behalf of our division to the UNLV review of Alaska's mental health statutes and its recommendations.

Introduction

The Criminal Division agrees with and supports the recommended changes to civil commitment and misdemeanor competency restoration provisions, as outlined in the UNLV review. *Recommendations*, pages 7-10, 17-20. Specifically, the Criminal Division has no objection to the review's proposal to required designation of a responsible agent to initiate civil commitment upon a finding of incompetence. Nor does our division object to the proposal to expedite the evaluation procedures for misdemeanants. These are laudable suggestions.

But as this memorandum explains, the DOL respectfully, but pointedly opposes repeal of Alaska's GBMI special verdict. Nor does the Criminal Division endorse the corresponding expansion of the substantive insanity defense as

proposed by the UNLV Review. *Recommendations*, 1-3; pages 11-15, 30-36. Articulation of the reasons underlying that disagreement will be the primary focus of this memorandum.

Discussion

The UNLV review recommends that Alaska abolish the special verdict of “guilty but mentally ill (GBMI).” *UNLV review*, page 14. The study concludes that the verdict is “confusing” and infrequently used. *UNLV review*, 13, 34-35. This approach constitutes a rejection of the Alaska Legislature’s 1982 reform of AS 12.47.

As will be explained below, the GBMI verdict is not “confusing.” It was adopted for a legitimate purpose – to address offenders who recognize reality and understand the nature and quality of their actions – but who, due to mental disease, violate the law anyway – most commonly due to a sense of “false justification” or “obedience to a higher law” (false self-defense stemming from clinical paranoia; or due to supernatural command). These offenders are properly found GBMI under existing Alaska law. That statutory structure enacted by our legislature serves a vital public safety policy goal -- and should not be repealed.

I. The 1982 Alaska Legislature expressly rejected UNLV’s recommendation to adopt both the cognitive and the “unable to appreciate wrongfulness” prongs of the *M’Naghten* test.

A. The history of the tests for insanity in Alaska

Prior to 1972, Alaska applied the *M’Naghten* test for the insanity defense. The *M’Naghten* Rule, as announced in 1843, had provided:

[T]o establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.”
M’Naghten’s Case, 8 Eng.Rep. 718, 722 (H.L. 1843)

Chase v. State, 369 P.2d 997, 998 n. 2 (Alaska 1962). The defense included two independent bases for insanity, a “nature and quality of the act” prong and “not know the wrongfulness” prong.

Then in 1972, the Alaska legislature adopted the Model Penal Code test for the insanity defense in AS 12.45.083:

Sec. 12.45.083. Mental disease or defect excluding responsibility

(a) A person is not responsible for criminal conduct if at the time of the conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law.

One prong of the MPC test was a “wrongfulness” prong: “lacks substantial capacity to ... appreciate the wrongfulness of his conduct.”

In 1982, the Alaska legislature amended the statute to adopt a modified *M’Naghten* test for the insanity defense. The modification removed one of the two prongs of the *M’Naghten* Rule:

Sec. 12.47.010. Insanity as affirmative defense.

(a) In a prosecution for a crime, it is an affirmative defense that when the defendant engaged in the criminal conduct, the defendant was unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct.

This statute establishes the verdict of “not guilty but reason of insanity.” [NGI] The legislature left out the second prong “he did not know he was doing what was wrong” in the insanity statute, AS 12.47.010. However they placed this second prong in a different statute. The legislature enacted a new statute creating a “guilty but mentally ill” verdict [GBMI]:

Sec. 12.47.030. Guilty but mentally ill.

(a) A defendant is guilty but mentally ill if, when the defendant engaged in the criminal conduct, the defendant lacked, as a result of a mental disease or defect, the substantial capacity either to appreciate the wrongfulness of that conduct or to conform that conduct to the requirements of law. A defendant found guilty but mentally ill is not relieved of criminal responsibility for criminal conduct and is subject to the provisions of AS 12.47.050.

Thus the legislature included a comparable “not appreciate wrongfulness” provision in the GBMI statute. AS 12.47.030.

As will be explained below, this provision most frequently addresses an offender who recognizes reality and the nature and quality of his actions, but who kills or harms anyway – due to a belief that the conduct is “falsely justified” -- as in the case of a paranoid schizophrenic who unreasonably perceives that an innocent bystander is an aggressor, and harms him.

B. The UNLV recommendations

UNLV recommends putting the “not know the wrongfulness” prong back into AS 12.47.010, the insanity defense. If the wrongfulness prong is moved back into AS 12.47.010, UNLV recommends that AS 12.47.030, the GBMI statute, be repealed.

UNLV suggests, first, that the GBMI statute should be repealed, because it is rarely used. Second, it suggests that the statute should be repealed, because the GBMI statute requires the Department of Corrections to provide a defendant found guilty but mentally ill with psychiatric treatment, just like the Alaska Psychiatric Institute [DHSS] provides a defendant found not guilty by reason of insanity with psychiatric treatment, the GBMI verdict does not “have a meaningful impact on the mental health treatment the inmate receives.”

But these are unpersuasive arguments. It may be true that the GBMI verdict is rarely formally presented in court. But this is not because the special verdict is invalid or obsolete. It is because most criminal cases are settled by plea rather than by trial and because the defense bar often reaches a tactical decision to forego a formal insanity defense at trial. The *Washington* case, discussed below, is an example. Further, the fact that a GBMI offender receives treatment provided by DOC and not DHSS is no reason to repeal the verdict. As the cases discussed below will show, a GBMI offender – especially in the context of a homicide prosecution -- may well represent an extreme public safety risk. (e.g. *Duryea, Lord*). Therefore, protection of the public assumes a higher priority and is a more important sentencing consideration than the identity of the agency obliged to provide treatment.

C. The GBMI statute was a deliberate decision by the Alaska Legislature to take away the insanity defense from certain particularly-dangerous offenders: those who are capable of appreciating that they are killing a person, but lack the capacity to appreciate the wrongfulness of the conduct or conform their conduct to the requirements of the law.

The UNLV review proposes to move the State of Alaska backward in time by moving subjective appreciation of “wrongfulness” back into the insanity defense. This was the case for ten years -- between 1972 and 1982 -- when our state had adopted the Model Penal Code test for insanity. That ten-year experiment produced results that were unacceptable to the public. So the Alaska Legislature changed it in 1982. The Charles Meach case was the catalyst.

In 1973, Charles Meach beat and kicked to death 22-year-old Robert Johnson in Earthquake Park in Anchorage. Johnson, a mentally-challenged Alaska Native who worked as a grocery clerk, had met Meach in a topless bar. Meach was charged with murder, diagnosed as paranoid schizophrenic and found not guilty by reason of insanity, applying the Model Penal Code test with the “moral incapacity”

prong in effect at the time. He was sent to Atascadero State Hospital in California. In 1980 psychiatrists determined that his illness was in remission and he was returned to Alaska under the supervision of the Alaska Psychiatric Institute.

On May 3, 1982, Charles Meach was out on a pass from the Alaska Psychiatric Institute.¹ He was angry, because someone had stolen his favorite shirt, so he decided to steal something from someone else. He had bought a gun from a man on the street. He remembered seeing some cassette tapes in a tent in a camp site in Russian Jack Springs Park and went there. When one young man, age 19, showed up at the camp site – his camp site -- Meach shot him in the head, killing him. When a second nineteen-year-old went to see what had happened, Meach killed him with a shot to the head, too. When two sixteen-year-old girls showed up, he shot both of them to death. He plead not guilty by reason of insanity.

The collective common sense of the people of Alaska was offended that Meach could avoid criminal responsibility for murder on the grounds of insanity, get released and then kill again. Common sense said Meach should have been in jail, not a hospital. The consequence of the current UNLV proposal would be to send an offender like Meach to a hospital, not to jail – which was exactly the result the 1982 legislature sought to avoid.

The 1982 legislature's decision to include only the first prong of the two-prong *M'Naghten* Rule, ("nature and quality of the conduct") was deliberate. The legislature said:

By limiting the defense to case where the defendant is unable to appreciate the nature and quality of his conduct, this legislation enacts one branch of the *M'Naghten* test of insanity. That portion of the *M'Naghten* test which defines legal insanity as including situations where the defendant did not know the wrongfulness of his conduct is specifically rejected by this legislation and excluded from the definition of legal insanity. The fact that the defendant did not appreciate the wrongfulness of his conduct, nevertheless, may be relied upon to establish that the defendant was "guilty but mentally ill" under AS 12.47.030.

The commentary contained two examples of defendants who could establish that they were unable to appreciate the nature and quality of their acts under this standard: a defendant who is "unable to realize that he is shooting someone with a gun when he pulls the trigger on what he believes to be a water pistol, or a murder defendant who believes he is attacking the ghost of his mother rather than a living human being." According to the House Judiciary Committee report on the legislation,

¹ In a recent law review article, the author points out that API's releasing Meach on a pass, instead of releasing him unconditionally, was contrary to law. See *Insanity in Alaska*, 98 Georgetown L. J. 1481, 1496 (June 2010).

the defense of insanity would not apply “to a defendant who contends that he was instructed to kill by a hallucination, since the defendant would still realize the nature and quality of his act, even though he thought it might be justified by a supernatural being.” See 3 House Journal 2317–18 (1982) (voting to adopt commentary); 2 Senate Journal 1720 (1982) (voting to include reference to commentary in the journal).

The exclusion of the wrongfulness prong was intended take the insanity defense away from a class of offenders who, despite understanding that they were killing a real person, did not appreciate the wrongfulness of the murder. The most common example of this kind of offender is the paranoid schizophrenic who wounds or kills out a sense of “false justification.” Such an offender is often times very well aware of what human life is, and that by shooting an opponent with a gun or stabbing the opponent with a knife, they are injuring or killing a living human being. Yet, the offender does so anyway – due to a sense of “false justification.” In other words, they do not believe what they are doing is “wrongful” because they (unreasonably) believe it to be justified due to their paranoia. Or they believe it to be commanded by a “higher law.”

An offender in this category presents a serious danger to the public, because the mental disease underlying the conduct will often persist through life, is often difficult to treat, and may manifest itself in response to benign, everyday human interaction – with tragic consequences.

One such case is that of William Duryea. See *Duryea v. State*, 1999 WL 1260826 (Alaska App. Nov. 17, 1999). Duryea had a history of increasingly violent assaultive behavior and of failing to take his anti-psychotic medications when he was not incarcerated. In May, 1993, Duryea and some partners, the Tovson brothers, were in the course of setting up a bear viewing business on the west side of Cook Inlet near Iliamna. He had a falling out with the Tovson brothers and began to fear them. In May 1993, he flew to the site and discovered some of his equipment vandalized or missing. He believed this was the work of the Tovson brothers. On May 15, 1993, he arranged for an air taxi service to fly to the site to transport him to Anchorage. A pilot with whom he had flown back and forth to the site several times flew in to pick him up. Duryea was sleeping when the plane arrived and the engine noise awakened him from his sleep. Believing the pilot was one of the Tovson brothers returning to further damage the property, Duryea grabbed a bear rifle and fired a single shot at the pilot, striking him in the head and killing him. Duryea defended on the grounds that he was insane. He had a history of increasingly violent assaultive behavior and of failing to take his anti-psychotic medications when he was not incarcerated. A jury found him “guilty but mentally ill.”

Had the legislature not removed the wrongfulness prong of the *M’Naghten* test in 1982 from the statute, Duryea would have been found not guilty by reason of insanity. But his jury concluded that his mental illness caused him to believe, incorrectly, that he was being threatened when he was not. He caused the death of

a wholly innocent man. The legislature could, and did, properly conclude that, in a case like Duryea's, the prevention of a death of another innocent person is the primary public interest to be served by the law.

Another illustrative case is that of Michael Washington. See *Washington v. State*, 828 P.2d 172 (Alaska App. 1992). Washington, age 32, had previously been diagnosed as suffering from chronic paranoid schizophrenia and had occasionally received medication and treatment for this condition. While Washington had never previously been convicted of a felony, he had several misdemeanor convictions, as well as a history of violent and aggressive behavior toward law enforcement officers. Washington's assaultive conduct apparently occurred at times when he was off medication for his mental disorder. Although Washington appeared to pose no danger to public safety when taking appropriate medication, he had consistently resisted treatment and had regularly refused medication except under compulsion in an institutional setting. At the time of this offense, Washington was not taking his medication, even though his mental health counselors had urged him to do so.

On May 21, 1989, Washington purchased a .22 caliber semi-automatic rifle from a store in Anchorage. On his firearms application, Washington falsely claimed that he had never previously been committed to a mental institution. Sometime later, Washington removed the glass from one of his apartment windows, replacing it with a dark tent fly that could easily be moved aside. On the evening of June 5, 1989, Washington began firing his rifle out the window. He shot at an unoccupied car, a pole, and an electrical transformer, but made no effort to shoot at people who were in the vicinity.

The Anchorage Police Department received a call reporting that a gun was being discharged in the area of Washington's apartment. Officer Louis Mizelle was dispatched to the scene and stopped his patrol car near Washington's apartment building. Moments after Mizelle got out of his car, Washington began firing at the officer, striking him with at least six bullets. Officer Mizelle died of the bullet wounds later that night. Other officers captured and arrested Washington.

Several forensic evaluators examined Washington. One noted that Washington was experiencing auditory hallucinations, and that he believed he was ordered to kill the officer by the voices in his mind. 828 P.2d at 173 n.1. Three evaluators concluded that Washington understood the nature and quality of his actions – that the officer was a human, that a gun was capable of destruction. Washington pled no contest to murder in the first degree, in return for the prosecution's commitment that it would not seek a post-conviction finding of "guilty but mentally ill." Washington received a 99-year sentence for the murder of Officer Mizelle.

In affirming his sentence, the court of appeals noted that Washington's case, "involve[d] precisely the type of conduct that led the Alaska legislature to amend our former insanity statute and to enact, instead, the provisions dealing with offenders

who are found guilty but mentally ill. *Id.* at 174-75 (Bryner, C.J.) But if the GBMI verdict were repealed or restricted as now suggested by the UNLV review, Washington would have been found NGI and sent to a hospital.

A third such case is that of Cynthia Lord. *Lord v. State*, 262 P.3d 855 (Alaska App. 2011). Cynthia Lord suffered from schizoaffective disorder, depressive type. This disorder is characterized by delusions, hallucinations, disordered thought process and disturbed emotional experience. Ms. Lord had been in and out of psychiatric hospitals since age 17, and had been receiving mental health services in Anchorage regularly since 1994. Her condition was not likely to improve, although medication might reduce her hallucinations. Since at least 2003, Ms. Lord had had delusions about a force she called "Evil," delusions about being watched by police and the CIA, and about Satanic labels on food. Although suffering from delusions part of the time, Ms. Lord had been able to secure employment in the past, attend school at Wayland Baptist University, take care of her children, and undertake daily life care responsibilities such as shopping, cooking, and housecleaning.

On March 16, 2004, the Anchorage Police Department received a 911 call from Ms. Lord reporting that she had "killed my three boys." APD was familiar with Lord, and the police were initially skeptical about her report. However, when officers entered her home, they found the bodies of Ms. Lord's three children: Joseph, age 16, Michael, age 18, and Christopher, age 19. Each boy had been killed by a single shot to the head.

Ms. Lord gave a voluntary statement to police that day. She told APD Detectives Mark Huelskoetter and Glen Klinkhart that she had purchased a gun in October 2003, when she made the decision to kill her sons. Ms. Lord said that on the day before she killed her sons, she mixed some of her medication with Crystal Light so that her boys would drink it and get sleepy. She set her alarm for early in the morning and woke at approximately 2:30 a.m. It took her about an hour to work up the courage to kill Michael, her eighteen-year-old, during which time she drank alcohol. She first worried that the gunshot would wake the other boys or her neighbors. She then covered Michael's body with a blanket and waited for her other sons to wake up.

Ms. Lord told police that when Joseph, the youngest, woke up she told him that Michael was sick and would not be going to school. Joseph then left to attend classes at East High. When Christopher woke up around 10:00 a.m., she waited until he was playing video games in front of the entertainment center. She then shot him in the head, pulled his body into another room, and covered it with clothes so that Joseph would not see it when he came home. Christopher had asked about Michael, but Ms. Lord told him that Michael was sick as she had told Joseph. She then locked the door so "that when Joey came home ... I would be ready with the gun." When Joseph returned from school at around 2:30 p.m. and walked in the door, Ms. Lord waited until Joseph's face was turned away from her and shot him in the back of the head. She then contemplated killing herself for a couple of hours and

eventually called the police around 4:30 p.m. Ms. Lord told detectives she expected punishment for what she did.²

Judge Volland found that Lord was guilty but mentally ill. He explained, Lord killed her children, “to save them from ‘Evil’ and to send them to heaven. She believed that she was doing the right thing and would do it over again...” *Lord, id.* at 860. Because Lord recognized that her children were living beings, and knew that, by killing them she was removing them from this earth and that she would never see them alive again, she was properly found GBMI. Once again, if the UNLV recommendation had been law, Lord would have been found NGI, and sent to a hospital.

One might argue that that some mental illnesses may be controlled by medication. Most of the mental illnesses of such offenders like Meach, Duryea, Washington and Lord are not curable, but some are subject to a measure of control if medicated. However, as occurred in several of the above cases offenders find reason to stop or never start taking their medications. Some offenders believe they do not need medication and will not take it. Some only take the medication if promoted by a nurse in a hospital or jail, but not independently once released. Some initially find the medication helpful and faithfully take it, but then conclude they do not need it any longer -- or that there are side effects they do not want to put up with -- and stop taking it. The GBMI statute is intended to protect society from the risk that such medical controls fail.³

² Other defendants convicted as guilty but mentally ill include John B. Monroe – *Monroe v. State*, 847 P.2d 84 (Alaska App. 1993)(killed his father by stabbing him 33 times); Kimberly Patterson – *State v. Patterson*, 740 P.2d 944 (Alaska 1987), *rev’g* 708 P.2d 712 (Alaska App. 1985)(tried to rob a man at gunpoint in the parking lot of Anchorage International Airport); and Dekeitric Lewis – *Lewis v. State*, 195 P.2d 622 (Alaska App. 2008) (assaulted his mother, pregnant sister and a police officer with a knife while medication non-compliant).

³ For a failure, see *Beaudoin v. State*, 57 P.3d 703, at 710 & n. 15 (Alaska App. 2003), discussing *Hansen v. State*, 582 P.2d 1041 (Alaska 1978). Robert Hansen, “Butcher Baker,” kidnapped, sexually assaulted and murdered at least 17 women in Alaska between 1971 and 1983. In 1976, he stole a chain saw from a department store in Anchorage and, because he had two prior felony convictions for arson and assault with a deadly weapon, the sentencing judge imposed five years in jail. At sentencing, however, a psychiatrist had testified 1) that Hansen had a bipolar affective disorder, but that Hansen had been stabilized on lithium, 2) that Hansen had a good rapport with him and meaningful therapy had begun, and 3) that the psychiatrist “wouldn’t anticipate any problems with [Hansen] continuing treatment now.” The Supreme Court, in an opinion dated August 11, 1978, reduced the sentence to the one year Hansen had already served and ordered that he be released as “expeditiously as possible.” Hansen killed his next victim three weeks after the release.

D. UNLV argues that the GBMI statute should be repealed because it is rarely used, but that confuses trial merits defense with sentencing issues.

If the GBMI statute is rarely used, it is rarely used because the defense bar often makes a tactical decision to forego a mental defense on the merits at trial. The *Washington* case, discussed above, is an example.

AS 12.47.050(d)(1) provides that an offender convicted as guilty but mentally ill is ineligible for parole. Asked why they choose not to use it, the defense bar frequently points to the “no parole” provision. That is, the defense bar frequently concludes that it is more advantageous to their clients to plead guilty to an offense – and then present psychological evidence at sentencing – rather than risking a GBMI verdict at trial on the merits.

But there is no suggestion in the UNLV review that psychological issues are not frequently -- and appropriately -- presented as sentencing issues. And, in practice, that is often the case. Alaska law has long recognized that psychological evidence is an important sentencing consideration, and that a judge may give appropriate weight to an offender’s amenability to psychological treatment where shown. *Gest v. State*, 619 P.2d 724, 726 n.8 (Alaska 1980) (where a crime stems from a psychological aberration as much as from general criminal propensity, the potential for rehabilitation is a “paramount consideration” in fashioning sentence).

E. UNLV argues that the GBMI statute should be repealed because there is no enhancement of public safety and to the difference between the medical treatment provided to an offender found not guilty by reason of insanity and an offender found guilty but mentally ill.

Even if one agrees that the obligation on the Department of Health and Social Services and API to provide mental health treatment to an offender found not guilty by reason of insanity is the same as the obligation on the part of the Department of Corrections to treat an offender found guilty but mentally ill, that is no reason to abolish the GBMI statute. It is wholly appropriate that the state provide mental health treatment regardless of whether a NGI or GBMI verdict is reached. The distinction is that the public is protected better when a mentally ill offender who has violated the law – and believes he is justified in doing so – remains in a secure corrections facility and not in a semi-secure hospital setting. The 1982 legislature concluded that treatment within a secure setting was consistent with public safety. The *Meach* case underscores the distinction.

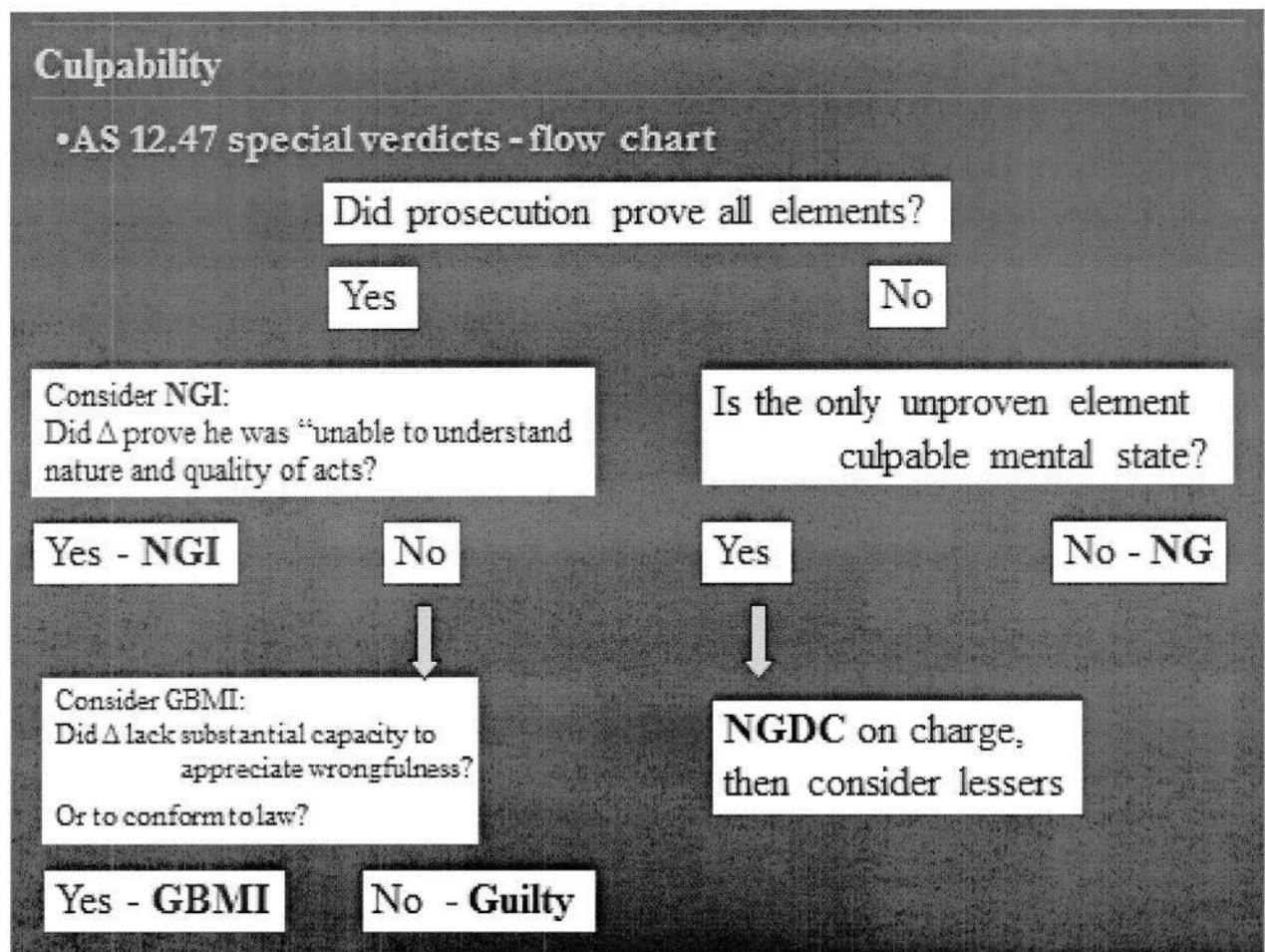
II. UNLV recommendation to amend the GBMI statute

A. *UNLV argues that the GBMI statute should be repealed because it confuses jurors.*

The UNLV review argues that the GBMI verdict should be repealed because it is confusing and that jurors “comprehend only a minority of instructions.” *UNLV review*, page 35. This criticism is startlingly dismissive and rests upon surprisingly superficial authority.

The argument ignores a fairly straightforward statutory premise: to prove an offender GBMI, the prosecution must first prove all the elements of the offense, and then prove an *additional* proposition – that the offender’s mental disease or defect caused the offender to lack substantial capacity to understand wrongfulness or conform to legal requirements. AS 12.47.030; *Lewis v. State*, 195 P.3d 622, 637 (Alaska App. 2008). Typical jury instructions on this point are attached in the appendix. They are written in plain, simple English.

Similarly, the same logical steps for the jury to take to decide an insanity case may be illustrated to a jury in a flow chart like this one:



It is certainly true that interplay of the three separate AS 12.47 special verdicts requires juror evaluation of many interlocked propositions of law and fact. Mental defense trial practice certainly demands thoughtful jury reflection and thorough explanation of the pertinent instructions by the trial attorneys and the trial judge.

But this is no less true and no different than the demands placed upon jurors in many criminal jury trial contexts. For example, the statutory scheme set forth in AS 12.47.010-030 is actually less complex than the Alaska's statutory scheme for traditional criminal self-defense litigation. See AS 11.81.330-335.

Consider that, self-defense cases – even those involving non-deadly force -- involve multiple, interlocking legal and factual propositions as well as the prosecutor's proof of an ultimate negative proposition (that the defendant did not act in self-defense) beyond a reasonable doubt. Self-defense jury work is challenging and difficult. This is doubly true if the case involves lesser-included offenses and other commonly-noticed special defenses such as heat-of-passion. Yet no credible commentator would seriously suggest that Alaska abolish its self-defense statutes simply because they are “confusing.”

Further, in the hands of trial attorneys who appreciate the distinction between NGI and GBMI standards, the difference between the two verdicts is really not that confusing at all. In past AS 12.47 trials, prosecutors have sought and secured a jury instruction based upon the 1982 Legislative Commentary discussed above –which provides helpful examples to a jury. The instruction attached to this packet correctly explains that an offender who does not understand that they were killing a human being might be found “not guilty by reason of insanity,” but an offender who knew they were killing a person, but believed it to be justified because it was commanded by a hallucination, might be found “guilty but mentally ill.”

The requirement that the jury make several factual findings to determine a verdict in a criminal case involving insanity, diminished capacity, and guilty but mentally ill is not so different from the often tedious process that a civil jury undertakes. For example, in a mundane civil contract dispute, a jury may have to determine whether any of several theories of liability apply. If liability is found, it will have to determine the dollar amount of the damage. If the jury reaches a dollar amount, it may have to apportion the damages from one form of substandard performance as opposed to another. If so, the jury must determine how much of the dollar amount can be attributed to each. A sample of such a civil verdict form is attached in the appendix.

These tasks are often tedious. They demand the Court's thorough written instructions and able arguments of counsel – which, as Alaska's pattern jury instructions acknowledge, are intended to be and usually are, helpful.

The UNLV review's criticism that a modern Alaska jury is somehow incapable of wading through AS 12.47 concepts is startlingly dismissive. "[Studies show] that juries comprehend only a minority of instructions...", UNLV review, pages 13, and 35) Yet, in almost every homicide case ever presented to an Alaska jury, the jury is confronted with "lesser included offenses" and is required to evaluate whether a defendant acted "intentionally," "knowingly," "recklessly," or "negligently" – implicating very fine degrees of distinction and culpability -- which are all the difference between first- and second-degree murder and lesser degrees of homicide. See *Panther v. State*, 780 P.2d 386 (Alaska App. 1989) (distinction between recklessness and criminal negligence was not unconstitutionally vague). Mental defense cases place similar, critical, but realistically manageable, demands upon the jury system.

At this point in its review, the UNLV review's contrary argument and methodology is unpersuasive. On this specific point, (jury confusion) the UNLV study cites a single, dated three-page journal article. (page 13, 35 citing *Melville & Naimark*; 30 J. Acad. Psychiatry Law 553, (2002)). This is startlingly scant authority upon which to reject the work of the 1982 legislature.

But further, a close reading of the brief Melville/Naimark article shows that the authors actually approvingly acknowledge one meritorious aspect of Alaska's GBMI statute, because, as the authors recognize, Alaska "is one of the few states" which have defined critical GBMI terms. *Id.*, at 553-54. The authors' criticism is directed primarily at other states with a less comprehensive statutory scheme.

Melville and Naimark's primary argument is a broader policy concern: that GBMI is an "intermediate" or "compromise" verdict which "deceives" and "hijacks" a jury. *Id.* Yet Melville and Naimark do not acknowledge that, as defined by Alaska's statute, the GBMI verdict is not an "intermediate" verdict at all. It addresses a different class of offender. It addresses the legitimate public safety concerns presented by an offender who is oriented to and recognizes reality – but kills or harms anyway – motivated by "false justification" "supernatural command," or "irresistible compulsion.

Nor do Melville or Naimark acknowledge that Alaska law – perhaps in contrast to sister states -- require the finder of fact to prove all the elements of an offense, and then to prove an additional proposition – that the offender's mental disease caused the offender to lack substantial capacity to appreciate wrongfulness of the conduct or to conform conduct to the requirements of the law. Nor do the authors acknowledge that in Alaska, the trial judge in an insanity defense case must instruct the jury about the effect of their verdict. This blunts any criticism that the GBMI statute "deceives" a jury. An illustrative Alaska "effect of your verdict" jury instruction is attached to this memorandum.

Seen in this light, the UNLV criticism of Alaska's insanity statutes is really reduced to a somewhat dismissive criticism of the jury system as an institution in general.

B. UNLV recommends limiting the GBMI verdict to diminished capacity verdicts under AS 12.47.020(c), but that would be unconstitutional.

In *Lord v. State*, 262 P.3d 855 (Alaska App. 2011), the defendant argued that the diminished capacity under AS 12.47.020 violated the U.S. and Alaska constitutions by imposing criminal responsibility in cases in which the defendant does not have the capacity to appreciate the wrongfulness of her conduct. The Alaska Court of Appeals held:

If the State proves beyond a reasonable doubt that the defendant possessed the *mens rea* required by a criminal statute, the United States Constitution does not require any further inquiry into the defendant's mental state to support a conviction. Lord argues that we should interpret the Alaska Constitution more broadly than the Supreme Court has interpreted the federal constitution. But we have previously rejected constitutional attacks on the Alaska statutes that set out the defense of not guilty by reason of insanity. In *Hart v. State*, the defendant argued that holding a person who lacked the capacity to conform her conduct to the requirements of the law criminally responsible for that conduct violated the due process, cruel and unusual punishment, and equal protection clauses of the United States and Alaska constitutions. In rejecting those constitutional challenges, we observed that the Alaska statutes required the State "to prove beyond a reasonable doubt that the defendant engaged in conscious voluntary acts ... and possessed the requisite *mens rea* for the offense." We ultimately concluded that "the State may constitutionally eliminate a separate insanity defense based on 'irresistible impulse' or inability to conform one's conduct to the requirements of the law." We stated that the "determination of the point at which a person's mental condition justifies exculpation is ... an ethical question for legislators and juries, not courts." We also upheld the statutes establishing the verdict of guilty but mentally ill against constitutional attack in *Barrett v. State*. We adhere to those decisions.

Thus, the U.S. and Alaska constitutions require that the defendant engaged in conscious voluntary acts and possessed the requisite *mens rea* for the offense. If a defendant is found not to have possessed the required culpable mental state, the defendant is not guilty. More specifically, in legal terms, the person is not guilty by reason of diminished capacity, not possessing the culpable mental state required by law; or, in the statutory language, the person is not guilty by reason of insanity. Whatever the language, a court cannot impose a sentence on the defendant as it can with a verdict of guilty but mentally ill.

C. UNLV recommends limiting the GBMI verdict to post-conviction determinations under AS 12.47.060.

UNLV recommends limiting the GBMI verdict to post-conviction determinations under AS 12.47.060. AS 12.47.060 provides that either the defense or the prosecution may seek a post-conviction determination of GBMI “where the affirmative defense of insanity is not raised and when evidence of mental disease or defect of the defendant is not admitted at trial under AS 12.47.020.” So, under the terms of the statute, both the defense and the prosecution can do that now. This means that UNLV’s proposal is that the defendant be permitted to raise insanity and/or present evidence of diminished capacity means without the jury being instructed on GBMI.

This proposal runs afoul not only of the current limitations on post-conviction determinations in AS 12.47.060, but also principles of law that existed before GBMI was enacted. That is, in 1973, the Alaska Supreme Court held that jurors must be instructed on the effects of their verdict. It was a rule intended to reduce the likelihood that misconceptions by jurors would lead to a “miscarriage of justice,” namely, a verdict returned to produce or avoid a particular post-trial consequence, instead of a verdict based on the law and the evidence. See *Schade v. State*, 512 P.2d 907, 917-18 (Alaska 1973); accord *Kinsman v. State*, 512 P.2d 901, 904 (Alaska 1973). That rule was adopted by the legislature in AS 12.47.010 when the GBMI verdict was authorized. AS 12.47.040 provides:

Sec. 12.47.040. Form of verdict in certain cases involving insanity or mental disease or defect.

(a) In a prosecution for a crime when the affirmative defense of insanity is raised under AS 12.47.010 , or when evidence of a mental disease or defect of the defendant is otherwise admissible at trial under AS 12.47.020 , the trier of fact shall find, and the verdict shall state, whether the defendant is

- (1) guilty;
- (2) not guilty;
- (3) not guilty by reason of insanity; or
- (4) guilty but mentally ill.

(b) To return a verdict under (a)(4) of this section, the fact finder must find beyond a reasonable doubt that the defendant committed the crime and that, when the defendant committed the crime, the defendant was guilty but mentally ill as defined in AS 12.47.030 .

(c) When the jury is instructed as to the verdicts under (a) of this section, it shall also be instructed on the dispositions available under AS 12.47.050 and 12.47.090.

Construing the UNLV proposal to permit the defendant to raise insanity or diminished capacity without telling the jury about the GBMI verdict means that, if the

jury's initial verdict is either not guilty or not guilty by reason of insanity, double jeopardy will prevent the jury from returning a verdict of guilty but mentally ill in the "post-conviction determination," because there was no "conviction." In the initial trial, the jury would never hear argument or get instructed on the distinctions between a mental disease or defect which "prevented the defendant from appreciating the nature and quality of his conduct" in comparison to or contrast with "the incapacity to appreciate the wrongfulness of the conduct or to conform the conduct to the requirements of the law." The jury would never understand the effect of its verdict, because one of the possible effects would be left out.

D. Practical problems raised by the UNLV proposal.

Furthermore there are practical problems with UNLV's proposed expansion of the insanity defense. An increase in mental status merits defense would implicate a greater demand for forensic evaluations and cause greater delay to obtain them. Alaska is a state with relatively few forensically-trained psychiatrists or psychologists. When the definition of insanity was broader between 1972 and 1982, whenever a crime involving a possible defense of insanity occurred, both the prosecution and the defense rushed to retain one of the few forensically-trained psychiatrists in Alaska for their side. This left opposing counsel searching the lower 48 states for a suitable expert. It also meant great expense, with experts charging their hourly rate for every hour they were away from their practices or every hour they sat in an airplane as they flew to and from Alaska. It also caused corresponding delay. These points are equally true today.

An equally formidable practical problem with the UNLV proposal is that it would tend to shift post-disposition responsibility for treatment away from the Department of Corrections to the Department of Health & Social Services. A reader must be cognizant of persistent shortage of secure bed capacity within DHSS. As things are now, the system struggles with secure bed space for short-term competency evaluations. Expanding the NGI verdict to encompass GBMI offenders and then committing them to long-term DHSS custody would exacerbate the existing bed space shortage. It is not apparent that the UNLV review has meaningfully considered this practical consequence of the repeal the review suggests.

CONCLUSION

The UNLV review includes many other suggestions, which merit further discussion. As mentioned briefly at the outset of this memorandum, the criminal division has no objection to the review's proposal to required designation of a responsible agent to initiate civil commitment upon a finding of incompetence. Nor does our division object to the proposal to expedite the evaluation procedures for misdemeanants.

But as this memorandum has explained, the DOL respectfully, but pointedly opposes repeal of Alaska's GBMI special verdict.

Thank you for the opportunity to provide this comment.

-JF
04152015

APPENDIX – JURY INSTRUCTIONS

IN THE DISTRICT COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

MICHAEL MANUEL and)
MARY MANUEL,)
Plaintiffs,)
vs.)
JAMIE BAKER and)
FREDRICK PEDRO,)
Defendant.)
_____) Case No. 3AN-09-5899 CI

Special Verdict Form

We, the jury in the above-entitled case, answer the questions submitted to us as follows:

Question No. 1: Did Defendant Jamie Baker d/b/a J & V Drywall breach the contract by failing to install the EFIS siding on the Manuel's residence in accordance with the standards of his profession or trade?

Answer "yes" or "no." Answer: _____

Question No. 2: Did Defendant Jamie Baker d/b/a J & V Drywall breach the implied warranty of fitness for a particular purpose by failing to provide a finished EFIS product that was reasonably fit for its intended use?

Answer "yes" or "no." Answer: _____

Question No. 3: Did defendant Jamie Baker d/b/a J & V Drywall breach the contract by failing to secure the five-year Synergy material warranty?

Answer "yes" or "no." Answer: _____

If your answer to one or more of Questions No. 1, Question No. 2 or Question No. 3 above was "yes," proceed to Question No. 4. If your answers to all of Question No. 1, Question No. 2, and Question No. 3 were "no," stop here.

Question No. 4: What is the total amount of Plaintiffs' damages for which Jamie Baker is liable?

Answer: \$_____

After you have filled in the total amount of damages, proceed to Question No. 5.

Question No. 5: In deciding the total amount of Plaintiffs' damages, were you able to separate the amount of damages attributable to cracking from the amount of damages attributable to surface irregularities, also referred to as "panelization"?

Answer "yes" or "no." Answer: _____

If your answer to Question No. 5 is "yes," proceed to Question No. 6. If the answer to Question No. 5 is "no," stop here.

Question No. 6: What was the amount of damages attributable to cracking and what was the amount attributable to "panelization"?

Answer: Cracking \$_____

"Panelization" \$_____

Sign and date this form.

Dated this _____ day of October, 2012.

Jury Foreperson

**COMBINED DEFENSES OF INSANITY AND
DIMINISHED CAPACITY**

1.42

**Added 1999
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**INSTRUCTION PACKET FOR COMBINED DEFENSES OF INSANITY AND
DIMINISHED CAPACITY**

When you decide whether or not the state has proved beyond a reasonable doubt that the defendant____ (insert requisite culpable mental state(s))_____, you must consider all of the evidence bearing on the defendant's state of mind, including any evidence that the defendant was suffering from a mental disease or defect at the time of the offense.

USE NOTE

AS 12.47.020; Barrett v. State, 772 P.2d 559, 565 (Alaska App. 1989).

This series of instructions (1.42A-H) must be given if the defendant has raised both the defense of diminished capacity and the affirmative defense of insanity. This instruction (1.42A) should immediately follow the instruction that defines the culpable mental state for the offense. See Patterson v. State, 708 P.2d 712, 714 (Alaska App. 1985).

Before using this instruction, trial judges must replace the parenthetical language – "(insert requisite culpable mental state(s))" – with specific language appropriate to each case. See Use Note to Pattern Instruction 1.42D.

DEFINITION OF MENTAL DISEASE OR DEFECT

1.42B

Added 1999

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"Mental disease or defect" means a disorder of thought or mood that substantially impairs a person's judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

"Mental disease or defect" also includes mental retardation. A person is mentally retarded when his or her level of intellectual functioning is significantly below average and this defect impairs his or her ability to cope with the ordinary demands of life.

Evidence of a mental condition that is manifested only by repeated criminal conduct or other antisocial conduct is not sufficient to establish that the defendant is "not guilty by reason of insanity" or "guilty but mentally ill." However, you must consider such evidence when you decide whether the defendant (insert requisite culpable mental state(s)) .

USE NOTE

Alaska Statute 12.47.130(5) (defining "mental disease or defect"); AS 12.47.010(c) (antisocial conduct alone not sufficient to establish affirmative defense of insanity); AS 12.47.030(b) (antisocial conduct alone not sufficient to establish that defendant was "guilty but mentally ill").

According to the Commentary to the 1982 legislation that adopted the current definition of "mental disease or defect," this term was only intended to cover major mental disorders:

DEFINITION OF MENTAL DISEASE OR DEFECT

1.42B

Added 1999

Page 2 of 35

The terms used to define "mental disease or defect" in AS 12.47.130, are taken from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (1980). The term is intended to include those major mental disorders such as schizophrenia, severe mood disorders, or profound organic mental disorders which substantially impair a person's ability to perceive reality or adapt to it.

There are many mental disorders defined in psychiatry, however, which, though they affect behavior, are not of the severity or magnitude necessary to qualify under this definition. Examples of these disorders would be drug addictions, posttraumatic stress disorders, conduct disorders, dissociative disorders, psychosexual disorders, and impulse control disorders. Voluntary intoxication or drug withdrawal states, regardless of their severity, would not qualify as a "mental disease or defect."

House Journal Supp. No. 64 at 8 (June 2, 1982).

Before using this instruction, trial judges must replace the parenthetical language – "(insert requisite culpable mental state(s))" – with specific language appropriate to each case. See Use Note to Pattern Instruction 1.42D.

**STANDARD OF PROOF FOR QUESTIONS RELATED TO
MENTAL DISEASE OR DEFECT**

1.42C

Added 1999

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As I have explained to you, the state must prove the elements of the offense "beyond a reasonable doubt." In Instruction No. _____, I explained to you what it means to prove something beyond a reasonable doubt.

But some of the questions in this case must be decided according to a different standard, which is known as the "preponderance of the evidence" standard. Something is proved by "a preponderance of the evidence" when the evidence persuades you that it is more likely true than not true. When I specifically instruct you to decide whether something "is more likely true than not true," you must apply this standard rather than the "reasonable doubt" standard.

USE NOTE

Alaska Statute 12.47.010(a) (insanity defense is an affirmative defense); AS 12.47.050(b) (creating "preponderance of the evidence" standard for verdict of "guilty but mentally ill"); AS 11.81.900(b)(1) (defining "affirmative defense").

If you find that the state has not proved beyond a reasonable doubt that the defendant (insert requisite culpable mental state(s)), but you find that the state has proved the other elements of the offense beyond a reasonable doubt, then you must decide whether the defendant is "not guilty by reason of diminished capacity" or is simply "not guilty."

For you to find that the defendant is "not guilty by reason of diminished capacity," you must find that the following statements are more likely true than not true:

- (1) when the defendant engaged in the prohibited conduct, the defendant was suffering from a mental disease or defect, and
- (2) this mental disease or defect was a substantial factor in preventing the defendant from (insert requisite culpable mental state(s)).

If you find that statements (1) and (2) are both more likely true than not true, then you must return a verdict of "not guilty by reason of diminished capacity" for the offense. You must then proceed to consider whether the defendant is guilty of any lesser included offense.

If you do not find that statements (1) and (2) are both more likely true than not true, then you must return a verdict of "not guilty" for this offense. You must then proceed to consider whether the defendant is guilty of any lesser included offense.

USE NOTE

Before using this instruction, trial judges must replace the parenthetical language – "(insert requisite culpable mental state(s))" – with specific language appropriate to each case. For example, in Barrett v. State, 772 P.2d 559, 567 n.8 (Alaska App. 1989), the jury was instructed to consider evidence of mental disease or defect when it decided whether the defendant "knowingly removed himself from a correctional facility."

In some cases, evidence of a mental disease or defect will be relevant to more than one element of the offense. For example, in a prosecution for sexual assault in the first degree under AS 11.41.410(a)(1), the state is required to prove both that the defendant knowingly engaged in sexual penetration with another person and that the defendant recklessly disregarded the person's lack of consent. See, Reynolds v. State, 664 P.2d 621 (Alaska App. 1983). In such cases, the trial judge may be required to insert language that indicates that the evidence of mental disease or defect is relevant to more than one element of the offense.

The relevant statute, AS 12.47.020(b), does not use the phrase "not guilty by reason of diminished capacity"; instead, the statute uses the phrase "not guilty by reason of insanity." These instructions use the phrase "not guilty by reason of diminished capacity" to avoid juror confusion in cases where the defendant has raised both the defense in AS 12.47.020(b) and the defense in AS 12.47.010. A verdict of "not guilty by reason of diminished capacity" is legally equivalent to a verdict of "not guilty by reason of insanity."

The committee does not intend, by using the phrase "not guilty by reason of diminished capacity," to imply that the statutory defense contained in AS 12.47.020(b) is equivalent to the common law defense of diminished capacity. The committee expresses no view on whether application of the statutory defense is governed by principles developed in connection with the common law defense. Compare Mill v. State, 585 P.2d 546, 550-51 (Alaska 1978) (common law defense of diminished capacity available only for specific intent crimes) with Barrett v. State, 772 P.2d 559, 567 (Alaska App. 1989) (jury instructed

on statutory defense where defendant charged with knowingly removing himself from correctional facility).

AS 12.47.020; Barrett v. State, 772 P.2d 565, 568 (Alaska App. 1989). See generally Johnson v. State, 511 P.2d 118, 124 (Alaska 1973). But see Barrett, 772 P.2d at 575 (Bryner, C.J., concurring). Chief Judge Bryner, in his concurrence, expressed "serious reservations" concerning the constitutionality of AS 12.47.020, the statute on which this instruction is based: "In my view, there is a substantial question whether the state may legitimately require the entry of any verdict other than the traditional verdict on not guilty in a case where the state is incapable – for whatever reason – of proving all of the elements of an offense."

For cases involving diminished capacity by intoxication, see Pattern Instruction 81.630 (#2).

If you conclude that the state has proved all of the elements of the offense beyond a reasonable doubt, then you must decide whether the defendant is "not guilty by reason of insanity."

For you to find that the defendant is "not guilty by reason of insanity," you must find that the defendant has proved that the following statements are more likely true than not true:

- (1) when the defendant engaged in the criminal conduct, [he][she] was suffering from a mental disease or defect, and
- (2) as a result of this mental disease or defect, the defendant was unable to understand the nature and quality of that conduct.

If you find that statements (1) and (2) are both more likely true than not true, then you must return a verdict of "not guilty by reason of insanity" for this offense.

If you do not find that statements (1) and (2) are both more likely true than not true, then you must next decide whether the defendant is "guilty but mentally ill" or is simply "guilty."

USE NOTE

AS 12.47.010; Patterson v. State, 708 P.2d 712, 714 (Alaska App. 1985) ("the jury should not have considered and decided the issue of insanity unless it was prepared to conclude that the state's proof was otherwise sufficient to convict").

If you find that the state has proved all of the elements of the offense beyond a reasonable doubt and you find that the defendant is not "not guilty by reason of insanity," then you must decide whether the defendant is "guilty but mentally ill."

For you to return a verdict of "guilty but mentally ill," you must find that the following two statements are more likely true than not true:

- (1) when the defendant engaged in the criminal conduct, [he][she] was suffering from a mental disease or defect, and
- (2) as a result of this mental disease or defect, the defendant either (a) lacked the substantial capacity to appreciate the wrongfulness of that conduct or (b) lacked the substantial capacity to conform that conduct to the requirements of the law.

If you find that statements (1) and (2) are both more likely true than not true, then you must stop deliberating and return a verdict of "guilty but mentally ill."

If you do not find that statements (1) and (2) are both more likely true than not true, then you must return a verdict of "guilty."

USE NOTE

Alaska Statute 12.47.050(b) (to return a verdict of guilty but mentally ill, "the jury must find beyond a reasonable doubt that the defendant committed the crime and find by a preponderance of the evidence that when the defendant committed the crime the defendant was guilty but mentally ill"); AS 12.47.030(a) (defining "guilty but mentally ill").

VERDICT FORM NO. _____

Charge: _____

We, the jury empaneled to try this case, find the defendant:

- ☐ 1 Not Guilty
- ☐ 2 Not Guilty by Reason of Diminished Capacity
- ☐ 3 Not Guilty by Reason of Insanity
- ☐ 4 Guilty
- ☐ 5 Guilty But Mentally Ill

of the charge of _____.

Note:

- (1) Only one of these boxes should be checked.
- (2) If you have found the defendant either "guilty" or "guilty but mentally ill," you should stop your deliberations and return to court for further instructions.
- (3) If you have found the defendant "not guilty by reason of diminished capacity," then you must proceed to consider whether the defendant is guilty of the lesser included offense of _____.
- (4) If you have found the defendant "not guilty by reason of insanity," you should stop your deliberations and return to court for further instructions.
- (5) If you have found the defendant "not guilty," then you must proceed to consider whether the defendant is guilty of the lesser included offense of _____.

INSTRUCTION NO. ____

I will now give you examples which you may find helpful. An example of a person who could be found “not guilty by reason of insanity” is someone who, as a result of a mental disease or defect is unable to realize that he is shooting someone with a gun when he pulls the trigger on what he believes to be a water pistol, or a defendant who believes he is attacking the ghost of his mother rather than a living human being. In such cases, the defendant could be found “not guilty by reason of insanity”.

On the other hand, this finding of “not guilty by reason of insanity” would not apply to a defendant who contends that he was instructed to kill by a hallucination, since this defendant would still realize the nature and quality of his acts, even though he thought it might be justified by a supernatural being. A defendant in this category may be found “guilty but mentally ill.”

Authority: *Commentary to AS 12.47.010*, House Journal Supp. No. 64, at 7-8 (June 2, 1982); *State v. Johnson*, 720 P.2d 37, 39 n.5 (Alaska 1986)(approving of Murder 2^o jury instruction incorporating Legislative examples); This instruction given by Judge Charles Cranston in *State v. Duryea*, 3KN-S93-682, September 1997.

INSTRUCTION NO. ____

The law requires me to tell you about the effect of the various verdicts which you may return in this case:

1. If you return a verdict of "guilty" for any offense, I will impose an appropriate sentence for that offense.

2. If you return a verdict of "guilty but mentally ill" for any offense, I will likewise impose an appropriate sentence for that offense. But the defendant also will receive mental health treatment from the Department of Corrections. If I impose a sentence of imprisonment, the defendant will be required to serve the entire sentence, even if the defendant's mental illness is cured before the end of his sentence.

3. If you find the defendant "not guilty by reason of insanity" or "not guilty by reason of diminished capacity," the defendant will be committed to the custody of the Department of Health and Social Services. The defendant's commitment will continue until he demonstrates that he no longer suffers from a mental illness that causes him to be dangerous to the public.

4. If you find the defendant "not guilty" of all charges, I will discharge the defendant.

This information is given to you so that you will understand the meaning of the various verdicts available to you. But you are to decide this case on the law as I have instructed you and on the evidence presented to you. You should not allow your view of the evidence to be affected by your feelings about what may be the proper sentence or disposition of this case.

Authority:

See AS 12.47.040(c) and Legislative *Commentary* thereto. (requiring court to instruct jury on dispositions available upon verdict of "guilty but mentally ill" or "not guilty by reason of insanity"). See also, *Kinsman v. State*, 512 P.2d 901, 904 (Alaska 1973) (the trial court should instruct the jury that a defendant who is found not guilty by reason of insanity will be institutionalized). This instruction is intended to fulfill the requirements of AS 12.47.040(c) and *Kinsman*.

The Alaska Supreme Court has held that an instruction on the effects of an insanity acquittal "should be given whenever it is requested by the defendant." *Schade v. State*, 512 P.2d 907, 917-18 (Alaska 1973). See also *Kinsman v. State*, 512 P.2d 901, 904 (Alaska 1973). More recently, the legislature has declared that the jury must be instructed as well on the effects of a verdict of "guilty but mentally ill." See AS 12.47.040; House Journal Supp. No. 64 at 10 (June 2, 1980).

The purpose of the required instruction is to reduce the likelihood that misconceptions by jurors will lead to "a miscarriage of justice." *Schade*, 512 P.2d 918. The "miscarriage" referred to is a verdict returned to produce or avoid a particular post-trial consequence, as opposed to a verdict determined by the law and the evidence. *Id.* The instruction must achieve this end solely by imparting to the jury an "accurate" understanding of the effects of various verdicts. *Id.*

This instruction given by Judge Charles Cranston in *State v. Duryea*, 3KN-S93-682, September 1997.



THE STATE
of ALASKA
GOVERNOR BILL WALKER

Department of Administration

OFFICE OF PUBLIC ADVOCACY
APPEALS & STATEWIDE DEFENSE

1016 West 6th Ave, Suite 100
Anchorage, Alaska 99501
Main: 907.269.6075
Fax: 907.269.0307
www.doa.alaska.gov/opa/

Memorandum

To: Rick Allen, Director of the Office of Public Advocacy
Steve Williams, Chief Operating Officer for Alaska Mental Health Trust

From: Whitney Glover, Assistant Public Advocate

Date: April 21, 2015

Subject: The UNLV recommendations that the GBMI statute be repealed

The Department of Law has submitted comments recommending that the GBMI statute not be repealed. The Department of Law's comments include discussion of the *Meach* case that was the impetus for the statutory change in 1982. The Department of Law also discusses several other cases including *Duryea v. State*¹ and *Lord v. State*.² The Department of Law's general view is that individuals like Lord and Duryea should be in prison instead of a hospital because their crimes were committed during psychoses that caused an inability to appreciate wrongfulness but not an inability to appreciate the nature and quality of their actions.

In response to the Department of Law's comments, the Office of Public Advocacy now submits one of the briefs filed in the post-conviction proceedings for Cynthia Lord. In that case, the Superior Court dismissed her petition. Her case is now on appeal.

This brief is submitted in response to the Department of Law's comments because it provides an overview of the history of the insanity defense, and discusses the constitutional problems with punishing GBMIs who are unable to appreciate wrongfulness.

¹ *Duryea v. State*, 1999 WL 1260826 (Alaska App. Nov. 17, 1999).

² *Lord v. State*, 262 P.3d 855 (Alaska App. 2011).

Lord's brief also discusses some of the recordings of the legislative hearings from 1982 that are replete with derogatory references to the mentally ill. At the very least, these recordings reflect animus and fear of a vulnerable group of disabled citizens that should be revisited today with greater understanding of the difficulties in treating these individuals in a prison setting.

Finally, the brief discusses the tremendous suffering of one GBMI inmate, Cynthia Lord, for whom the Department of Corrections cannot provide care that is either adequate or humane.

Three affidavits from Lord's post-conviction case are also provided to this group. The first affidavit is from Dr. David Sperbeck. Dr. Sperbeck was the State's chief witnesses in Lord's underlying trial. He provided an affidavit for the post-conviction proceedings in which he concluded that the Department of Corrections is replete with policies and procedures that exacerbate the symptoms of mentally ill offenders. He affied that there are vast differences between the care received in a hospital setting versus the care received in the Department of Corrections. He discussed the problem with exposure to predators to which vulnerable mentally ill offenders are frequently subjected in custody. He also commented on the lack of adequate training for corrections officers. He noted that he has advocated throughout his career that offenders like Cynthia Lord be placed in a separate forensic hospital in order to prevent the further deterioration that she has displayed during her incarceration.

In addition to Dr. Sperbeck's affidavit, the affidavits of Cynthia Lord and Shelly Wilson-Schoessler, Mental Health Clinician III with the Department of Corrections are also provided. Ms. Lord describes in her affidavit some of the difficulties that she experiences at Hiland Mountain Correctional. Ms. Wilson-Schoessler discusses the care that Lord receives at Department of Corrections, and she also acknowledges Lord's issues with predatory inmates and some of the policies that are detrimental to psychotics such as segregation and strip-searches.

The Department of Law has expressed the view that reincorporating the wrongfulness prong of the *M'Naughten* test into the NGI defense would be moving backwards. But the Department of Law fails to acknowledge that the 1982 decision to eliminate the wrongfulness prong from the NGI defense was a step backwards from progress that was reactionary and should be revisited given results like those demonstrated in the Lord case.

The Department of Law argues that the best way to protect the public from dangerous mentally ill offenders like Lord is to house them in prison. But DHSS is capable of housing this very small group of vulnerable GBMI inmates (currently only 6) in secured beds and provide care that actually improves their symptoms and reduces their dangerousness. The Department of Law also argues that shifting the burden to DHSS to care for GBMIs would have an impact on resources. But the national consensus clearly weighs in favor of greater protections than those afforded by the pre-*M'Naughten* "Wild Beast Test" that the Alaska Legislature returned to when it excluded the wrongfulness

prong from the NGI defense.³ We are the only state that has reverted to such a test. It should be repealed so that this very small and vulnerable population can be cared for in an appropriate setting.

³ See *Penry v. Lynaugh*, 492 U.S. 302, 332 (1989) (discussing the Wild Beast Test that was articulated in 1724 as “a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast, such a one is never the object of punishment”); see also *Clark v. Arizona*, 548 U.S. 735, 748 (2006) (conducting a nationwide survey of insanity defenses state by state and confirming that four states have abolished the insanity defense in its entirety and Alaska is the only state that utilizes the nature and quality prong of the *M’Naughten* test as its insanity defense).

North Star Behavioral Health System
2530 DeBarr Road
Anchorage, Alaska 99508
(907) 258-7575

December 27, 2013

AFFIDAVIT OF DAVID SPERBECK

In the matter of application for post-conviction relief of Cynthia Lord, applicant.

Superior Court Number: 3AN-09-4469-CI

1. I am a licensed clinical psychologist with 32 years of experience performing forensic psychological evaluations for the criminal and civil courts of the State of Alaska. I received my PhD from the University of Rochester in 1982 after completing doctoral Internships in clinical psychology and clinical neuropsychology. I am a Fellow of the National Academy of Neuropsychology and currently employed as the Director of Psychological Services for the North Star Behavioral Health Hospital.
2. I was asked to perform the competency evaluation and culpability evaluation of Ms. Cynthia Lord during tendency of her criminal case in 2004.
3. I concluded that Ms. Cynthia Lord was competent to stand trial but that she was unable to appreciate the wrongfulness of her actions at the time that she killed her three children. I concluded that Cynthia Lord was able to appreciate the nature and quality of her conduct at the time that she killed her three teenage sons pursuant to the fact that she clearly met the State of Alaska's definition for intentionally causing the death of her children. I testified as an expert called by the Department of Law during Ms. Lord's criminal trial.
4. I conducted an extensive evaluation of Ms. Cynthia Lord and concluded that she suffers from Schizoaffective Disorder with Mood-Congruent Psychotic Features. I testified at Ms. Lord's trial that she was gravely disabled by her mental illness and in fact was actually one of the most disabled mentally ill persons that I have ever examined. It should be noted that I have conducted over 3000 evaluations for the District and Superior Courts for the State of Alaska since 1982.

5. I have recently reviewed a fairly substantial stack of records including my original trial testimony, my original forensic psychological evaluations, Judge Phillip R. Vollard's Verdict After Court Trial, medication and mental health records detailing psychiatric services received by Ms. Cynthia Lord since her incarceration and commitment within the Alaska Department of Corrections, and a letter apparently written by Ms. Cynthia Lord and dated 05/08/2012. In this letter, Ms. Cynthia Lord attached a document which she labeled "a conspiracy theory" in which she details multiple manifestations of the same delusion that I noted in my original evaluations of Ms. Lord, and delusions which ultimately led to Ms. Lord's motives for murdering her three sons.
6. It is my opinion that Ms. Lord has obviously made essentially no progress therapeutically since her arrest and incarceration. It is further my opinion that there are numerous aspects to incarceration within a prison setting that actually exacerbate Ms. Lord's schizoaffective disorder. Patients who suffer from schizophrenia are prone to depressogenic withdrawal, social isolation, and rumination, all of which feed into the patient's tendency to focus upon their psychotic and delusional belief systems. This has obviously happened in Ms. Lord's case. Ms. Lord has also complained privately to her attorney that strip searches, which are mandatory for all visits, causes her to decline to attend any visitations that she may have with family members, attorneys, or friends. In this sense, the policies and procedures of a prison setting clearly are counter-therapeutic and can and have substantially contributed to social withdrawal and isolation of this particular inmate.
7. There are large differences between what occurs in a mental/psychiatric hospital versus what occurs in prisons. I am very familiar with these differences due to the fact that I practiced at both the Alaska Psychiatric Institute and the Alaska Department of Corrections from 1982 to 2005.
8. One aspect of incarceration that is particularly difficult for severely mentally ill prisoners are policies and procedures that require that the inmate box up their possessions, be subjected to cell shakedowns, and/or be subjected to routine strip searches after visitations and/or upon the transfer from a sub-acute unit to a so-called acute units. As I noted above, the impact of these routine and customary security procedures often exacerbates the mentally ill offender's mental condition worsening due to their defensiveness, general level of paranoia, cognitive and social rigidity, and general level of anxiety. Furthermore, patients who suffer from chronic paranoid delusions of persecution are prone to projecting malevolent intent often where none exists.

9. Psychiatric hospital settings generally are considered much more therapeutic than prison settings for chronically mentally ill persons, principally because there is a recognition among well trained medical staff that social and physical isolation is extremely destructive and counter-therapeutic for mental health patients. Most psychiatric hospitals severely limit the degree to which patients can be isolated or left alone. This is in stark difference to a correctional center, where the primary tool of discipline that is frequently utilized to manage the behavior of inmates is physical and social isolation. The use of isolation to manage inmates is particularly devastating to chronically mentally ill inmates because isolation, as I noted above, creates anxiety and promotes depressogenic rumination. Being alone is particularly devastating for individuals such as Cynthia Lord due to the fact that when they are alone, they are alone with their thoughts. When alone with their delusional thoughts, these thoughts are often cultivated, ultimately resulting in reality distortion and a magnification of the intensity of the thought disorder and its effect upon the mentally ill individual's emotional condition.
10. In a prison setting, inmates are frequently subject to predators (i.e., manipulative inmates who seek to exploit peers) within the inmate population itself. These so-called predators often will pressure chronically mentally ill individuals for privileges, services, and/or material items. As a consequence, chronically mentally ill individuals will often seek the very physical and social isolation that is a source of protection from predators, in spite of the fact that in the long run this is very harmful to them and can cause rapid decompensation in their emotional condition.
11. Psychiatric hospitals are governed by rigorous accreditation standards which is accompanied by annual audits to ensure that clinical procedures are performed competently and under the supervision of highly credentialed and trained physicians, psychiatrists, licensed nurses, and psychologists. This level of accreditation and professional medical oversight is not available within a correctional center. Furthermore, licensed and accredited psychiatric hospitals have up-to-date, comprehensive and modern formularies that provide psychiatric patients with the most up-to-date and effective medications available to medical practitioners. This is not the case within correctional systems in general and the Alaska Department of Corrections in particular.
12. The bulk of vigilant clinical observation and supervision within a prison setting falls upon correctional officers who essentially have little to no training at all dealing with severely mentally ill offenders. As a consequence, rates of

North Star Hospital

Page 4

Cynthia Lord

MR#: 000999

DOS: 12/27/2013

suicide are much higher in correctional facilities than in psychiatric hospitals, where staff-to-patient ratios are weighted substantially in favor of close patient observation and care, as opposed to the very minimal levels of staffing available in prison settings.

13. I have long been an advocate for the development of a secure forensic psychiatric hospital for mentally ill offenders in Alaska. I would strongly recommend that chronically mentally ill offenders who suffer from severe, complicated, and disabling chronic mental illnesses be treated within a psychiatric hospital setting in order to reduce the likelihood of ongoing therapeutic deterioration demonstrated by Cynthia Lord.

Sincerely,

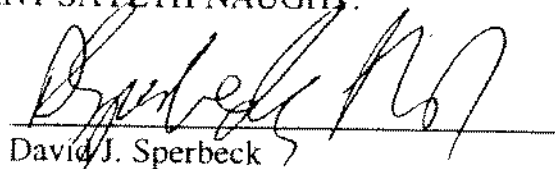


DAVID J. SPERBECK, PH.D.
Licensed Clinical Psychologist (#AA0233)
Fellow, National Academy of Neuropsychology

Clinical Professor of Psychiatry
University of Washington School of Medicine

DJS/ml DD: 12/27/13 DT: 12/27/13 Report #337765/337765

FURTHER YOUR AFFIANT SAYETH NAUGHT.

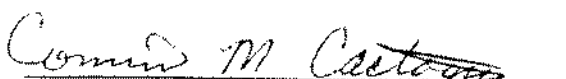


David J. Sperbeck

ADL 521 4321

SUBSCRIBED AND SWORN to before me on December 30, 2013 at
Anchorage




NOTARY PUBLIC FOR ALASKA
My Commission Expires: w/ office

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the)
Application for Post-conviction)
Relief of)

CYNTHIA LORD, Applicant)

Superior Court No. 3AN-09-4469 CI

AFFIDAVIT OF SHELLY WILSON-SCHOESSLER

STATE OF ALASKA)
) ss:
THIRD JUDICIAL DISTRICT)

Shelly Wilson-Schoessler, being first duly sworn upon her oath, deposes and says:

1. I am a Mental Health Clinician III with the Department of Corrections.
2. I have been employed with Alaska Department of Corrections since January 2009.
3. I have known Cynthia Lord since February 2010.
4. Ms. Lord has face to face visits with a DOC psychiatrist on a monthly to weekly basis depending on her current mental stability.
5. If Ms. Lord is on the acute unit, she has face to face visits with the psychiatrist at least one time per week. If Ms. Lord is on the sub-acute unit, she has face to face visits with the psychiatrist as needed.
6. Ms. Lord attends community group and gym every morning, along with Hope Wing groups and other activities.
7. Ms. Lord is in general population unless she requires more acute treatment and then she is admitted by the psychiatrist to the acute unit for stabilization.
8. There are forty beds at Hiland in the two sub-acute Hope wings where the needing more intense mental health services reside. Placing inmates on the Hope wings assists in deterring the opportunities for other inmates to take advantage of the mentally ill inmates.

9. Ms. Lord has had difficulty with being taken advantage of by other inmates.
10. DOC policy requires strip-searches after contact visitation and before an inmate is admitted to the acute mental health unit.
11. The primary form of discipline at DOC is segregation.
12. Ms. Lord was previously diagnosed with Schizophrenia, paranoid type and continues to exhibit symptoms of paranoia and depression.

FURTHER YOUR AFFIANT SAYETH NAUGHT.

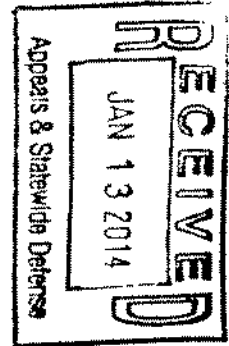
Shelly Wilson-Schoessler

SUBSCRIBED AND SWORN to before me on _____, 2013 at Anchorage, Alaska.

NOTARY PUBLIC FOR TEXAS
My Commission Expires: _____

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the)
Application for Post-conviction)
Relief of)
CYNTHIA LORD, Applicant)
Superior Court No. 3AN-09-4469 CI)



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AFFIDAVIT OF CYNTHIA LORD

STATE OF ALASKA)
) ss:
THIRD JUDICIAL DISTRICT)

Cynthia Lord, being first duly sworn upon her oath, deposes and says:

1. I am the petitioner in the above matter.
2. I have lived at Hiland Mountain Correctional Facility since I was arrested in 2004.
3. At Hiland, I have community group every morning. After community group, I spend the rest of each day in my room.
4. I believe that it is best for me to keep a low profile because I am afraid of other inmates.
5. If I am obviously out in the population, other inmates ask me to give them things. I am afraid not to do what they ask because they might be mean to me if I don't. So I always do what they ask. But I am not allowed to give them things and I can get in trouble for doing this. So it is easier to hide in my room.
6. I also have a hard time figuring out what I should do to keep myself busy.
7. I do not accept visitors because I do not want to get a strip-search. If I get a strip-search, the CO makes me take all of my clothes off, bend over, and cough while the CO is watching.
8. I also receive a strip-search before I can go onto the acute unit.

Att. F

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9. I received a strip-search last summer on July 3rd because the CO thought I looked suspicious. At the time, I was walking back to my housing unit after taking meds. There were cameras watching. I passed the security office. I did not take anything out of my mouth. Then I went back to my wing and the housing officer called me into the bathroom and strip-searched me. I did not do anything to provoke the strip-search.
10. I see the psychiatrist in person approximately one time per month or once every two months. I have gone as long as three months without seeing them before.
11. I do not talk to the psychiatrist about my beliefs and what I really think about from day to day because I am afraid that they will put me on the acute unit if I tell them what I really think.
12. I do not want to be on the acute unit because you are strip-searched and you are in a cement cell with a toilet. The toilet can only be flushed twice in twenty minutes. You have to use the bathroom in front of everyone including officers and other inmates. You are behind bars. You are on lock-down a lot of the time. When you are on lock-down, you are alone unless you have a roommate. Staff decide whether or not someone gets a roommate.
13. Box-up happens every Wednesday. It is overwhelming for me because I might have too much stuff from shopping at commissary on Saturdays. And we have to pack up and unpack everything. Sometime they don't show up to inspect. All your stuff has to stay packed and you can't lie down on the bed because everything is boxed up. Officers might find something wrong with my box. If they find something wrong, they will call me out in front of all of the other inmates.
14. Cell shake-down happens one time per month. I worry about the shake-down because I have a lot of stuff, mostly soda, and I might have too much property.

1 They might find something in my room that does not belong to me like tobacco or
2 drugs. A roommate might have these things and then I would have to go to the hole.
3 They unmake my bed. They go through all of my stuff. I am always afraid that I
4 will get into trouble because of someone else. And then I would have to go to the
5 hole. I am afraid to go to the hole because you are lock down for 23 hours a day. I
6 like to pace and there is no room to pace.
7

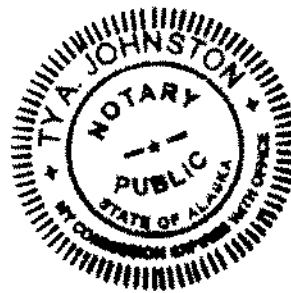
8 15. I wrote the letter to James Gottstein with the attached document titled "A
9 Conspiracy Theory." I agree fully with the letter that I wrote to Mr. Gottstein and
10 my attached document as well.

11 16. They read all of my mail. So you have to watch what you write. The letter that I
12 wrote to James Gottstein was taken to the doctor. The doctor increased my
13 medication and then said that I could send the letter.

14 FURTHER YOUR AFFIANT SAYETH NAUGHT.

15
16 Cynthia Lord
Cynthia Lord

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18
19 SUBSCRIBED AND SWORN to before me on JANUARY 8, 2013/14 at Anchorage, Alaska.



NOTARY PUBLIC FOR ALASKA
My Commission Expires: 12/31/14
Office




MEMORANDUM

ALASKA PUBLIC DEFENDER AGENCY
CIVIL DIVISION

Linda R. Beecher
900 W 5th Ave., Suite 200
Anchorage, AK 99501
Tel: (907) 334-4438
Fax: (907) 868-2588

TO: Sara Gordon
UNLV

RE: PDA Comments on Proposed Changes
to Civil Commitment Statutes

FROM: Linda R. Beecher 
Deputy Public Defender

DATE: April 16, 2015

I have prepared a response to the recommendations regarding the civil commitment statutes. Our director, Quinlan Steiner, may have additional comments when the final report is reviewed.

Recommendations Regarding Amendments to AS 47.30.730

A. Condition Improved by Course of Treatment

1. We agree that the grounds for commitment are danger to self or others, or grave disability.
2. Although in *E.P.*,¹ the Alaska Supreme Court held that the state does not need to show whether the respondent's condition could be improved by the course of treatment in cases of danger to self, this is a policy question that could be revisited.² We recommend incorporating the requirement that the state show that the confinement and treatment of the respondent could be expected to improve his or her condition in those cases where the respondent is alleged to pose a danger to him or herself. This would mean modifying AS 47.30.655(6) and AS 47.30.730(a)(3).
3. More broadly, there is a threshold policy decision with regard to whether individuals such as E.P. should be confined to an acute care psychiatric facility. The risk that E.P. posed to himself was a result of both brain injury and addictive behaviors.³ Although the Supreme Court elected to treat E.P.'s conditions as satisfying the definition of mental

¹ *E.P. v. Alaska Psychiatric Inst.*, 205 P.3d 1101 (Alaska 2009).

² See generally Proud Usahacharoenporn, Note, *E.P. v. Alaska Psychiatric Institute: The Evolution of Involuntary Civil Commitments from Treatment to Punishment*, 28 Alaska L. Rev. 189 (2011).

³ *E.P.*, 205 P.3d at 1109-1110 (respondent's organic brain damage established mental illness; exclusion of "drug addiction" from definition of mental illness in statute did not prevent finding that E.P. was mentally ill because his use of substances had impaired his ability to appreciate the dangers of addiction).

illness, this conclusion could be revisited by the legislature. The analysis in E.P. potentially broadens the population of individuals who can be confined at acute care psychiatric facilities. Definitions of mental illness have evolved, and the legislature should consider whether individuals with a primary issue of brain injury, dementia or addiction are appropriately confined at an acute care psychiatric facility.

4. The proposed change to AS 47.30.710(b)(2) makes sense to achieve uniformity in the statutes.

B. Imminence & Grave Disability

Comments track the numbers on page 17 of the draft report dated April 3, 2015.

1. We agree with the recommendation for amendments regarding “serious harm.”
2. We agree with the recommendation regarding the definition of grave disability.
3. We disagree that a three-month look-back is appropriate. The timeframe for “recent behavior” should be no more than 30 days.
4. No disagreement regarding the recommendation for identifying individuals with a professional duty to initiate civil commitment.

Recommendations Regarding Amendments to AS 47.30.715 and Related Statutes

We support having more timely evaluations to see if respondents meet criteria for commitment after they are detained and awaiting transport. However, a consequence of this choice could be an increase in formal petitions for commitment. The suggestion in paragraph 5 is a compromise in lieu of having formal commitment hearings within a 72 hour time period after issuance of an ex parte order authorizing hospitalization for evaluation.

1. Statutes should identify the Department of Health and Social Services as the custodial agent for anyone detained pursuant to civil commitment statutes.
2. Statutes should provide for a time frame by which a petitioner must file an ex parte petition for hospitalization pursuant to AS 47.30.700 after an emergency detention obtained under AS 47.30.715. Emergency detention should last no more than twenty four hours before the filing of an ex parte petition.
3. Statutes should specify that Department has the obligation of providing (generally through the grantees contracted to provide emergency services around the state) ongoing clinical assessment to determine if detention remains appropriate, if an ex parte petition should be sought, or if an ex parte order for evaluation should be vacated.
4. The term “evaluation” should be used consistently in statute. It may be helpful to use two different terms to draw the distinction between an emergency examination⁴ at the outset

⁴ See AS 47.30.710.

of the case, and the more specific evaluation made to determine whether an individual should be released or formal commitment sought. Statutes should specify a deadline for a clinical evaluation to determine if the respondent meets criteria for commitment whether or not the individual has been transported to an “evaluation facility” as currently defined by the Department. A seven day detention period without any evaluation or meaningful treatment is not reasonable.⁵ The current model does not contemplate the evaluation for commitment being made in outlying hospitals or communities. Delaying the evaluation to determine the necessity for commitment until after the respondent’s arrival at an “evaluation facility” can result in unreasonable detention periods without court review or a timely initiation of commitment.


5. If the respondent cannot be transported to an “evaluation facility” within the initial 72 hours of the issuance of the ex parte order, a court hearing should be scheduled with appointed counsel during that timeframe. This would afford due process protections for the respondent and consistent oversight by the court in the respondent’s community or region. The respondent and counsel should automatically receive discovery regarding the existing clinical assessment, as well as access to all of the evidence considered by the court in granting the ex parte petition.
6. Finally, the subcommittee may wish to discuss modifications to the time period during which the Department must either:
 - a. determine if the respondent should be released after issuance of the ex parte order; or,
 - b. schedule a court hearing on a petition for 30-day commitment.

This time period should be counted from the date of the issuance of the ex parte order regardless of whether the respondent has arrived at an “evaluation facility.” One option would be permitting a five calendar day detention period during which the Department must release the respondent or set a court hearing on a 30-day petition to commit. However, if the period of detention is expanded beyond the current 72 hours, the threshold findings to support issuance of the ex parte petition should be augmented and require that the judge have a clinical recommendation regarding the necessity for hospitalization. The statute should provide guidance about who is qualified to provide that recommendation and the nature of the recommendation. The provision in AS 47.30.700 allowing the judge to conduct his or her own “screening investigation” should be eliminated.

⁵ Cf. *D.W. v. Department of Social and Health Services*, 332 P.3d 423, 428 (Wash. 2014) (holding that state involuntary commitment statute does not authorize psychiatric boarding as a method to avoid overcrowding at certified evaluation and treatment facilities).

MEMORANDUM

HUMAN SERVICES SECTION
CIVIL DIVISION
STATE OF ALASKA, DEPARTMENT OF LAW

From: Lannette Nickens 
Assistant Attorney General

To: Steve Williams
Chief Operating Officer
Alaska Mental Health Trust
Via email steve.williams@alaska.gov
On behalf of T12 Subcommittee

Date: July 10, 2015

Subject: Comment regarding UNLV Review of Alaska Mental Health Statutes

The Department of Law, Civil Division, Human Services Section ("DOL-Civil") has been asked by Deputy Attorney General James Cantor to provide a written response to the UNLV review of Alaska's mental health statutes and its recommendations. This memorandum addresses only those recommendations regarding civil mental health law and is intended to supplement the memorandum submitted April 15, 2015 by AAG James Fayette on behalf of the Department of Law, Criminal Division. The attached table provides additional specific comments regarding the proposed revisions to Title 47 as presented in the Appendices to the June 18, 2015 UNLV Review of Alaska Mental Health Statutes.

Introduction

The DOL-Civil appreciates the extensive work of the UNLV team and the members of the T12 Subcommittee on this collaborative project. Several important recommendations promote clarity within the statutes and clarify procedures for the legal system and mental health providers. However, the DOL-Civil respectfully opposes recommendations designed to significantly change the nature of Alaska's integrated community-based mental health system.

Discussion

I. The proposed Amendments to AS 47.30.700 – AS 47.30.715 – Procedures for Initiating Civil Commitment

It is the position of DOL-Civil that the recommendations to revise AS 47.30.700 – AS 47.30.715 include several provisions that will markedly alter Alaska’s integrated community-based mental health system. Specifically, the recommendations currently numbered 1, 5, 7, and 8 in this section, propose amendments to the procedures for initiating civil commitment that appear not to recognize the dual purpose of AS 47.30.710. The provisions of this statute are invoked when patients are delivered under AS 47.30.705 emergency detention to an evaluation facility, or when patients are delivered to a facility designated by court order for a 72-hour evaluation period under AS 47.30.700.¹

Persons taken into emergency custody by authorized individuals and delivered to a hospital under AS 47.30.705 may be examined and released or referred to local mental health resources in their communities for additional follow-up without intervention or involvement by the court or DHSS. A common example is a patient delivered to a local community hospital by law enforcement officials for an examination. *In re: Daniel G.*, 320 P.3d 262, 270 (Alaska 2014) and AS 47.30.710(b) make clear that if, AFTER these initial emergency examinations, it is determined that further evaluation is necessary and a judicial order for evaluation under AS 47.30.700 has not been obtained, the mental health professional must apply for court-authorization of further detention.² This mental health professional is rarely employed by DHSS or acting as an agent of DHSS.

The UNLV’s recommendations propose to limit the time frame for which an ex parte order remains valid. The DOL-Civil recommends that any time period beyond 72 hours should be expressed in days, not hours, to align with the computation of time under the Alaska Civil Rules of Procedure. Furthermore, any revision should be made with consideration of the language in the Alaska Court System’s current MC-305 form order. Service of an ex parte order within seven days, as calculated under the Alaska

¹ See, definition of evaluation facility in AS 47.30.915(7). It should be noted that this statute does not expressly authorize the court to order these different types of facilities to provide housing for detention and care during the 72-hour evaluations or order providers at these facilities to file petitions, etc. The statute should be interpreted as permitting non-DET facilities to voluntarily conduct the evaluations. The court’s current MC-305 form order allows the judicial officer to designate ANY of the DET/DES facilities as well as any other facility described by the statute that is willing and capable of safely detaining an involuntary respondent for up to 72 hours.

² The UNLV report’s citations to the *Daniel G* should be corrected from “320 P.3d 265” to 320 P.3d 262.

Civil Rules of Procedure, is more appropriate to the various scenarios in which immediate service is not possible. Limiting the life of the order to only 72 hours is not always practical and may result in unnecessary use of judicial resources and service providers' time to repeatedly renew petitions. This is especially true when the ex parte order must be served in remote areas not accessible by the road system or when the respondent is not in protective custody.

The UNLV recommendations also address the use of telebehavioral health for screening investigations. The DOL-Civil questions the need for additional statutory language in this regard. It is extremely rare for a respondent to be transported for a screening investigation. It also is rare for a respondent to be available for voluntary interview when an order for a screening investigation is issued. Screening investigations frequently are conducted by telephone, this is partly due to time and the great geographic distances in Alaska. Since the purpose of a screening investigation is solely to provide the court enough information to make a determination of probable cause, the DOL-Civil is opposed to revisions that would suggest a screening investigation cannot be conducted by telephone or other "audio only" means. There currently is no prohibition to the use of videoconferencing or "telebehavioral health" to complete this investigation. Adding this unnecessary reference to the use of telebehavioral health for screening investigations invites confusion in what should be an expedited process.

II. Identification of the Department of Health and Social Services as "custodial agent"

The DOL-Civil opposes any amendment that identifies or suggests that the Department of Health and Social Services ("DHSS") is the "custodial agent" for individuals detained pursuant to AS 47.30.705 unless an actual employee of DHSS takes custody of the individual or the individual is housed in a facility owned or controlled by DHSS. This amendment would fundamentally change the character of Alaska's integrated community-based mental health system to a centralized, closed system operated by DHSS.

III. Current statutes permit 72-hour evaluations to be conducted at appropriate non-designated evaluation facilities.

The UNLV report suggests changes to AS 47.30.710 and AS 47.30.715 are required to "reflect that the 72-hour evaluation ...need not occur only at DET facilities." It is the position of DOL-Civil that this proposed amendment is unnecessary and places the court at risk of issuing orders for which it has no authority to enforce. The issuance of an invalid order in the midst of a mental health emergency only serves to delay the respondent's care and treatment. When this happens, the mental health system must stop and until motions to be filed and judicial officers to amend the orders.

As an example, an Alaska State Court has no authority to order a facility operated by the federal government to conduct mental health evaluations. On the other hand, AS 47.30.915(7) is permissive. If the operators of an appropriate facility, that meets the statute's definition of "evaluation facility," are willing to conduct a 72-hour evaluation pursuant to an order under AS 47.30.700, there presently is no legal barrier to such an evaluation. The court's MC-100 petition form requires healthcare professionals to advise the court as to which evaluation facilities are prepared to accept the respondent and conduct the evaluation. The apparent "goal" of this recommendation can be achieved through education of the court system and community providers.

IV. The stages of the 72-hour hold and scheduling of the 30-day commitment hearing

It is the position of DOL-Civil that the existing language of AS 47.30.710 sets out the evaluation facility's responsibilities for persons taken into emergency custody and delivered for examination under AS 47.30.705 in their local community. The principles behind this statutory language may be found in Alaska's Community Mental Health Services Act and are the reasons why these individuals may be released or referred to local mental health resources with no involvement by the court or DHSS.³ A common example is a patient delivered to a local community hospital by law enforcement officials for an examination.

The UNLV recommendations seem not to support community mental health intervention under AS 47.30.705 as it is currently implemented in Alaska. If the intent is to provide separate statutes for AS 47.30.705 examinations, there should be clear language to authorize the current "24-hour" detention for these initial examinations as described in *In re: Daniel G.*, 320 P.3d 262, 270 (Alaska 2014).⁴ Similarly, any revisions should be made with consideration of Alaska rules of civil procedure. The DOL-Civil opposes all language referencing "120 hours" in the proposed amendments as inconsistent with the provisions of AS 47.30.805 and incompatible with the Alaska Civil Rules for time computation.⁵ The "120 hours" appears to be arbitrary and not based on historical data. Finally, any new time period beyond "72 hours" should be expressed in numbers of days.

³ See, AS 47.30.520.

⁴ The report's citations to the *Daniel G* should be corrected from "320 P.3d 265" to 320 P.3d 262.

⁵ See, Alaska Civil Rule 6.

V. The “30-day” limitation on behavior considered as likely to cause serious harm

The DOL-Civil opposes the “30-day” limitation on behavior considered as likely to cause serious harm in UNLV’s proposed revision to AS 47.30.915(12). The UNLV report explains that the majority of states do not limit the court’s consideration of evidence of the respondent’s behavior by defining specific time periods. Alaska’s Supreme Court has already considered this question and determined that, “it would defy common sense to ignore (a respondent’s) treatment history, which supplied context for her symptoms on the day of the hearing.”⁶ Furthermore, the court has discussed and made clear that evidence of behavior from the three months prior to the hearing, “...were drawn from the recent past...(and)were sufficient to meet the evidentiary standards established by those states that have addressed the question of imminence.”⁷

IV. Conclusion

The UNLV Review of Alaska Mental Health Statutes represents an impressive collaborative effort by the UNLV team and the many professionals who practice in this area of the law. Any project by such a diverse group is bound to reflect diverse perspectives and agency missions. The DOL-Civil appreciates this opportunity to make its position known and to provide this comment.

⁶ *In re Tracy C.*, 249 P.3d 1085, 1093 (Alaska 2011).

⁷ *Wetherhorn v. Alaska Psychiatric Inst.*, 156 P.3d 371, 379 (Alaska 2007).

Proposed Revision	DOL-Civil Response
AS § 47.30.655 – Purpose and Principles of Major Revision	The suggested change should preserve the original stated purpose of the 1981 revisions by repealing the statute and replacing with the “purpose and principles” of future major revision
AS § 47.30.690 – Admission of Minors Under 18 Years of Age	no comment
AS § 47.30.700 – Petition for Hospitalization and Evaluation for 72-hour Period	(c) suggests “...court shall provide <i>written</i> findings...” (d) requests “...Department of Health and Social Services <i>or its designee</i> ” (f) NO – 72 hours should be 7 days as currently indicated on the court system’s MC-305 form order.
AS § 47.30.705 – Emergency Protective Custody	(a) strongly suggests revision should include grave disability (c) strongly suggests revision should include grave disability (d) NO – DHSS should not be the “custodial agent” of any person unless DHSS takes emergency custody of that person; the petitioner should be the person who initiated emergency custody, the evaluator or another person with knowledge of the underlying facts. DHSS should only petition if DHSS takes emergency protective custody or is otherwise directly involved in the situation leading to emergency custody. (f) see objections to AS § 47.30.700(f).
AS § 47.30.710 – Hospitalization for 72-hour Period	(a) opposes changes to the existing statute that eliminate its dual function for emergency examinations under existing AS 47.30.705 or 72-hour evaluations under AS 47.30.700. (b) suggests that elimination of the requirement for evaluation of physical condition is not best practice (c) suggests final sentence should be deleted to avoid confusion with AS 47.30.803. (d) NO – this contradicts the “probable cause standard” referenced in AS 47.30.720 – continued custody during the 72-hour evaluation period is based on probable cause that the respondent is mentally ill and as a result, gravely disabled or presents a

	<p>likelihood of serious harm to self or others. Commitment under AS 47.30.730 is based on clear and convincing evidence.</p> <p>(f) NO - this confuses the provisions of AS 47.30.805 and is unnecessary. The 72-hour evaluation period should be reserved solely for evaluation pursuant to an order issued under AS 47.30.700 and not merged with any other time period. Any limitations on emergency custody under AS 47.30.705 should be addressed within that statute.</p>
AS § 47.30.715 – Procedure after Notice of Hospitalization and Evaluation for 72-hour Period	suggests all references to “designated treatment facility” be replaced with “evaluation facility” to facilitate potential evaluations at non-designated treatment facilities. See AS 47.30.915(7).
AS § 47.30.720 – Release Before Expiration of 72-hour Period	no comment
AS § 47.30.725 – Rights and Notification Under This Title	(b) suggests all references to “designated treatment facility” be replaced with “evaluation facility” to facilitate potential evaluations at non-designated treatment facilities. See AS 47.30.915(7).
AS § 47.30.730 – Petition for 30-day Inpatient Commitment	<p>(a) DOL-Civil joins API’s objections to use of “qualified evaluator” for civil commitment proceedings.</p> <p>(a)(2) replace “qualified evaluator” with “petitioner”</p> <p>(c) NO, the provisions of AS 47.30.700 direct the court to determine “the nearest appropriate evaluation facility.” This facility may or may not be operated or controlled by DHSS; this department has no authority to direct operations in private or other non-DHSS facilities.</p>
AS § 47.30.735 – 30-day Inpatient Commitment Hearing	no comment
AS § 47.30.740 – Procedure for 90-day Inpatient Commitment Petition Following 30-day Inpatient Commitment	<p>(a) DOL-Civil joins API’s objections to use of “qualified evaluator” for civil commitment proceedings.</p> <p>(d) NO – in addition to the general objection to “qualified evaluators,” if the court desires to appoint an expert witness at this stage of the proceedings, it should be pursuant to Evidence Rule 706.</p>

AS § 47.30.745 – 90-day Commitment Hearing Rights; Continued Commitment	(b) DOL-Civil joins API's objections to use of "qualified evaluator" for civil commitment proceedings. (e) suggests that the respondent's existing right to retain an independent licensed physician or other mental health professional to examine and testify on the respondent's behalf not be compromised by this proposed revision.
AS § 47.30.750 – 90-day Inpatient Commitment Hearing	no comment
AS § 47.30.755 – Court Order Following 90-day Inpatient Commitment Hearing	no comment
AS § 47.30.760 – Placement at Closest Facility	(3) DOL-Civil joins API's objections to use of "qualified evaluator" for civil commitment proceedings and suggests that the existing statutory language appropriately makes placement a clinical decision.
AS § 47.30.765 – Appeal	no comment
AS § 47.30.770 – Additional 180-day Commitment	(a) DOL-Civil joins API's objections to use of "qualified evaluator" for civil commitment proceedings (e) NO – in addition to the general objection to "qualified evaluators," if the court desires to appoint an expert witness at this stage of the proceedings, it should be pursuant to Evidence Rule 706.
AS § 47.30.772 – Medication and Treatment	no comment
AS § 47.30.775 – Commitment of Minors	no comment
AS § 47.30.780 – Early Discharge Following Involuntary Inpatient Commitment	Existing section (b) from current statute refers to persons committed under AS 47.30 and should not be deleted. See, Review of Alaska Mental Health Statutes, UNLV William S. Boyd School of Law, June 18, 2015 version, footnote 11, for statement of legislative intent to provide this notice to prosecutors.

AS § 47.30.785 – Authorized Absences	no comment
AS § 47.30.790 – Unauthorized Absences: Return to Facility; Required Notice	no comment
AS § 47.30.795 – Involuntary Outpatient Care for Committed Persons	no comment
AS § 47.30.800 – Conversion of Involuntary Outpatient Treatment to Inpatient Commitment	no comment
AS § 47.30.803 – Conversion from Involuntary to Voluntary Status	suggests revision to include AS 47.30.700 in existing statutory language
AS § 47.30.805 – Computation, Extension, and Expiration of Periods of Time	no comment
AS § 47.30.810 – Habeas Corpus Not Limited	no comment
AS § 47.30.815 – Limitation of Liability; Bad Faith Application a Felony	no comment
AS § 47.30.915 - Definitions	<p>(8) DOL-Civil joins API's objections to use of "qualified evaluator" for civil commitment proceedings</p> <p>(12)(a) <u>NO</u>, this limitation of "30 days" is not supported by Alaska law. See, <i>Wetherhorn v. Alaska Psychiatric Inst.</i>, 156 P.3d 371, 379 (Alaska 2007); <i>In re Tracy C.</i>, 249 P.3d 1085, 1093 (Alaska 2011).</p> <p>(12)(b) <u>NO</u>, see comment for 12(a).</p> <p>(12)(c) <u>NO</u>, see comment for 12(a).</p> <p>(13) suggest inclusion of "physician's assistant, working under the supervision of a psychiatrist"</p> <p>(14) <u>NO</u>, the revision changes the legal meaning of the existing statute</p> <p>(ADDED) "qualified and neutral evaluator" : DOL-Civil joins API's objections to use of "qualified evaluator" for civil commitment proceedings</p>