Meeting Summary

Alaska Criminal Justice Commission
Presumptive Sentencing Workgroup

January 27, 2017, 3-5pm
Denali Commission Conference Room, 510 L Street, Suite 410, and teleconference

Commissioners: Quinlan Steiner, Alex Bryner, Brenda Stanfill, Trevor Stephens

Participants: Kaichen McRae, Kristy Becker, Rob Henderson, Josie Garton, Mike Schwaiger, Kathy Hansen

Staff: Susanne DiPietro, Barbara Dunham

GBMI/NGI

Drs. Kristy Becker and Kaichen McRae from API answered the group's questions about API's practices for those involved in the criminal justice system.

Dr. Becker introduced herself and explained that she was trained outside of Alaska and had used the M'Naughten test elsewhere; her practice is very different here where only one prong of the test is used – i.e. is the defendant able to form intent? (The second prong asks whether the defendant knew what they were doing was wrong.) Dr. Becker explained that API takes court-ordered evaluations from around the state—mostly the evaluations are for competency, but some are for culpability.

Neither Dr. Becker nor Dr. McRae had seen a GBMI evaluation, but their understanding is that the offender would be incarcerated indefinitely and would not be housed at API. Rob Henderson said that he thought they were supposed to be treated at API and then sent to DOC when stabilized. Josie Garton pointed out that the law just commits the offender to the custody of DOC. This was changed by executive order in the 1980s; previously it had been the custody of DHSS. Dr. Becker said she knows that DOC has two facilities for mentally ill offenders, Mike Mod in Anchorage and one in Hiland.

Rob asked whether API might have capacity to accept mentally ill offenders long-term. Dr. Becker said that historically API has accepted NGRI inmates, but there is no one at API with that status now. API has downsized from 100 beds to 80 and there is routinely a waitlist, including for the forensic unit which is capped at 10 beds. If there is no room in the forensic unit, inmates wait in DOC custody, with varying wait times—the maximum was 70 days, but it could be as little as one day.

Asked if it was better to treat individuals at API or DOC, Dr. Becker responded that the hospital is the more therapeutic environment. In an ideal world they could take in inmates to the forensic unit on a Monday or Tuesday on demand, which would give the inmate time to adjust to the unit with full staffing levels before the weekend.

Asked about civil commitment, Dr. McRae said that was a separate process. Patients are brought in for a 24-hour hold which can be extended for 72 hours. They can sign themselves in voluntarily; if they are not willing to be there the treatment team can decide to hold them if necessary. They can do a 30-day

commitment, and can get an order for a 90-180-day commitment. Most commitments are for 30 days; very few extend beyond 180 days.

Quinlan Steiner asked who files for civil commitment of a person after they are found not competent to stand trial. Dr. Becker said that the DAs will often file in felony cases, but not always for misdemeanor cases. They will see the same people cycle in and out of API on both the civil and criminal side. They will sometimes do evaluations for a joint filing under both standards. Incompetent defendants present a conundrum. As treatment providers, they are obligated to treat a person until they are made safe—their ethical obligation is to see their treatment through. But once a defendant is restored to competency, they are sent to trial whether treatment complete or not.

Josie remarked that a person who receives a verdict of GBMI or NGRI would necessarily have to be competent, but she imagined that someone who had that level of mental illness would need to be restored first. Dr. Becker confirmed this; she said that the Aurora shooter, for example, was restored to competency before being found guilty. If someone is not restorable, they'll never get to the culpability stage. In Alaska, if a defendant is restorable, there's not much point in doing a culpability analysis because the burden is so high—if they are competent to stand trial, they will almost always be culpable. People suffering from dementia or whose IQ is in the 30s or 40s can't be restored.

The only recent NGRI case she knew of concerned a defendant in an emergency state with pronounced confusion and disorientation—he didn't know who he was. He assaulted a nurse. There was no element of volition in his conduct. To be NGRI, the defendant has to have absolutely no intent or awareness of what they're doing. Most people do intend to engage in an act; the question is did they know that what they were doing was wrong.

Brenda Stanfill asked if there was any place for patients who are discharged from API to go to other than a shelter. Dr. McRae said that they always do discharge planning with patients. They will only go to a shelter if no assisted living facility (ALF) is available or the patient refuses to go to one. Josie asked if the assisted living facilities were private facilities. Dr. Becker said they were, for the most part. Juveniles and adults with developmental disabilities will get some money from the state. The chronically mentally ill often get blacklisted from the ALF or know they don't want to live there. There is no step-down facility from API that is locked or partly locked in Alaska. Brenda noted that if a patient has a mental health problem that is not a developmental disability, Medicaid doesn't cover the costs of an ALF.

Rob asked what API's process would be for treating someone who receives an NGRI verdict. Dr. Becker wasn't sure, because there has been no need to implement a protocol. Likely they would be treated at API, and if they completed treatment, would probably be given a stepdown program to follow, something like parole. Long-term hospitalization would be likely. Rob wondered what the process would be for low-level crimes. Dr. Becker said there weren't really any facilities for that in Alaska. Quinlan said there could theoretically be cases of a low-risk NGRI patient, who wouldn't necessarily need a facility.

Josie asked if the doctors knew how many NGRI patients there were before the law changed. Dr. Becker said her understanding was that there were about 15-20, and they were mostly charged with murder.

Regarding the UNLV report, Dr. Becker said she didn't agree with all of it but she did agree with the commentary on the NGRI statute. Also, the requirement of having two board-certified psychologists to do evaluations is impractical. Having a board certification in psychology is unusual; psychologists are licensed

but not board-certified. There are only 300 psychologists with board certification in the US and none in Alaska. Certification requires 5 years of practice. There are only 3 people who work for the state of Alaska who practice forensic psychiatry—Drs. Becker and McRae and one other. (There are more in private practice

Asked about average numbers of evaluations, Dr. Becker said that they will each typically do 2 or 3 competency evaluations each week, and their third psychologist does one every week or so. In total API does about 225 per year. They have done 9 or 10 culpability evaluations total.

The group next discussed how to proceed on this topic, and agreed to hear from someone at DOC and perhaps an administrator at API. The group discussed looking at the issue holistically, including competency—some thought it would be more palatable to the Commission/legislators if they were presented with a whole solution.

Brenda asked what the goal of any reform in this area would be. Quinlan suggested that returning NGRI to the M'Naughten standard and making the consequences less severe might be a good starting place—as well as getting at the more global question of why DOC is the state's biggest mental health provider. Josie suggested that simply eliminating the GBMI option would be a place to start as it wouldn't require expanding the capacity of API. Rob suggested removing the consequences for GBMI but keeping the designation so it would operate as a flag for mental illness. Brenda said the goal of any reform should be to get people to the right programming.

Kathy Hansen said that it was hard to talk to victims in cases where the defendant was declared not competent to stand trial, because of the potential that nothing would be done for that person to ensure they would not reoffend. Quinlan suggested looking into community-based services and the possibility of an outpatient civil commitment in the least restrictive setting.

Quinlan further suggested drafting a flow chart to outline the pressure points on DOC's capacity to handle mentally ill offenders and how they move through the system, along with the fiscal impact—the PDs will make this chart.

Josie will contact Adam Rutherford at DOC to see if he would be willing to speak to the group.

Presumptive sentencing

Justice Bryner had to leave the meeting at this point but said that he would like to revisit presumptive sentencing as a concept.

Three-judge panel

Mike Schwaiger led the group through the PDA's proposal for revising the three-judge panel statutes. He said it addressed an area of previous agreement—if the panel disagrees with the referral (i.e. disagrees that the case should have been sent to the panel), the parties can agree to having the panel impose a "regular" sentence at that hearing, rather than have the case return to the original judge for yet another sentencing hearing several months later.

Other parts of the proposal came from Mike's discussions with Judge Stephens. The proposed new mitigators are those that the three-judge panel has already indicated function as non-

statutory mitigators, and would allow parties to go around the requirement of going to the three-judge panel in cases where the mitigators apply. This would reduce the number of cases going to the panel. Judge Stephens noted that the proposals here would eliminate the need for AS 12. 55. 165(b) and .175(e).

(At this point Brenda had to leave but noted that she would take a look at these proposals with Taylor Winston/OVR.)

Mike explained that the proposal also removed language referring to aggravating factors and changed language to permit the victim to address the panel (rather than testify, the word used in the current version). Judge Stephens said that he had always treated that language as legislative oversight, and allowed victims to address the panel as they would in a normal sentencing hearing rather than make them provide sworn testimony subject to cross-examination. Kathy agreed that allowing the victim to simply address the panel rather than testify was better.

Mike explained that the proposal also inserts language into AS 12.55.175(b) about the panel's determination of whether it will take up the referral, and in .175(c) adds language to expand the panel's authority in imposing sentence.

Judge Stephens agreed that avoiding a third hearing was a good idea. By the time the panel has determined that it does not agree with the referral, the case has already had two hearings at the sentencing stage and all the available information has been presented. For the last two cases he referred, he told the parties that he will attend the hearing of the three-judge panel so that if the panel rejects the referral, he can sentence the defendant just afterward. Rob asked whether the sentencing should be done by the original judge in the case. Judge Stephens said that if the parties agree, there's no reason they should not be sentenced by the panel—but if the parties want to go back to the original sentencing judge, that's their prerogative.

Kathy said it would be better to have the victim address the court only one time. Victims hate the three-judge panel because it often involves three hearings and extensive delay.

The group agreed to take a look at the PDA's proposal and email Mike with any questions before the next meeting.

Post-offense, pre-sentencing treatment mitigator

The PDA had also submitted a proposal for a new motion to modify sentence, which would be the functional equivalent of the post-offense treatment mitigator the group had previously discussed. Quinlan said that he wanted to rethink this proposal and was going to redraft it. He welcomed the group to share their thoughts on this.

Rob said that he liked this proposal as a first cut. This is an issue that comes up a lot and the proposal was a creative way to think about it.

First-time DUIs

Barbara explained that at the Commission meeting earlier in the day, DOC Commissioner Williams had expressed consternation about the implementation of mandatory EM sentences for first-time DUI offenders. There are several problems with this: it is unclear what the appropriate sanction should be for someone who has violated the conditions of EM, it is difficult to monitor this population to know if they have complied with the EM requirement, and it is also difficult to monitor home confinement in areas where EM is unavailable. It also throws off their time accounting systems. The Commission agreed to refer this issue to the working group.

The group noted that it would have to think more about this but a few people offered first-take comments: Rob liked the idea of going back to a hard bed sentence; Susanne pointed out that 60% of first-time DUI offenders never reoffend and that DUI arrests have been going down; Quinlan said that some of the reduction in DUI arrests can be attributed to a shift in the culture—jail time was needed before to convince the public of the seriousness of the offense and to mount social pressure on people who drive drunk.

Public comment

There was no public comment.

Next meeting

The next meeting was set for March 24 at 2pm.