Meeting Summary

Alaska Criminal Justice Commission
Sentencing Workgroup

March 24, 2017, 2-4pm
Denali Commission Conference Room, 510 L Street, Suite 410 and Teleconference

Commissioners present: Quinlan Steiner, Alex Bryner, Trevor Stephens

Participants: Josie Garton, Mike Schwaiger, Kathy Hansen, Rob Henderson, Adam Rutherford

Staff: Susanne DiPietro, Barbara Dunham

Revisions to law surrounding GBMI/NGI

Adam Rutherford from DOC gave an overview of the Department's Behavioral Health and GBMI processes. He explained that DOC is the largest behavioral health provider in the state. It is an imperfect system but he is proud of the program given its limited staff. DOC has two full-time psychiatrists and one ANP for the whole program. Like API, DOC also provides acute care, with 28 acute care beds for men and 18 for women. They also have 280 subacute beds.

On a snapshot day, 65% of inmates are Trust beneficiaries. 22% of inmates have a severe and persistent mental illness. Trust beneficiaries are more likely to be felons, more likely to serve longer sentences, and more likely to recidivate. The system is imperfect in terms of tracking; DOC welcomes any information on an inmate's mental health from family members or attorneys. They do get calls. Law enforcement personnel say they bring people to DOC custody because they know they can get services that way.

Mental health contacts by DOC personnel have increased by 61% over the past 9 years. There has not been a corresponding increase in staff or prison population. The increase might be attributable to increased drug use, and they seem to be seeing more mentally ill offenders entering custody. They are seeing an increase in comorbidity of substance abuse and mental illness in offenders. Adam has worked in the same field in other states and has noticed that a greater percentage of offenders enter custody with an untreated mental illness in Alaska than elsewhere. He suspected this was due to a lack of community resources.

The Institutional Discharge Project Plus (IDP+) program has a caseload of 90 felony offenders with severe and persistent mental illness. The program has two clinicians who help transition offenders to the community. The program also tracks recidivism and quality of life for program participants. The Assess Plan Identify Coordinate (APIC) program is also for offenders with severe and persistent mental illness. It brings treatment providers into DOC facilities to meet with offenders 90 days prior to release. DOC is getting the same program in place for offenders with substance abuse disorders through the reentry coalitions.

For treatment in prison, DOC focuses on evidence-based programs, including cognitive-behavioral therapy. Since they have only two psychiatrists, they don't have the ability to provide one-on-one therapy so they do more group work. Offenders diagnosed with FASD are typically housed in one of their subacute

units. They don't have a specific treatment plan for FASD clients but DOC intends to work with the Trust on that. They are starting to see more offenders with confirmed diagnoses.

DOC's GBMI policy is still under development. The GBMI population is just starting to be eligible for parole or furlough. They struggle to identify which offenders are GBMI—this information is not always relayed to Adam's team. They're developing a field for this in ACOMS. There are 12 total inmates who are GBMI in the system right now. They are in the middle of processing the first GBMI offender who is eligible for furlough.

The proposed hearing process for GBMI offenders right now is to hold a hearing of the GBMI Mental Health Review Committee (MHRC) 180 days before the offender is eligible for furlough or parole. The offender will be given 30 days' notice and may seek legal counsel. At the hearing DOC mental health staff will present evidence regarding whether continued treatment is required. The offender/legal counsel may also present evidence and question the mental health staff. The MHRC chair will forward the MHRC's decision to the Commissioner, who will then issue the final written decision.

Adam was not sure whether continued usage of medication was "continued treatment" for purposes of the GBMI parole/furlough determination. He was also not sure what the process would be if a GBMI offender were deemed ineligible for furlough/parole. The offender will be able to appeal the decision to the Commissioner.

There is no specialized treatment for GBMI inmates; as with all inmates with mental illness, DOC's primary goal is to stabilize them. Their housing will depend on their functioning but will likely be in one of the subacute beds. They may be released on the IDP+ program but may not, depending on the need.

There are plenty of non-GBMI inmates whose mental illness is as severe as GBMI inmates. Adam has noticed that the standards for when GBMI is used are not universal. Recently there was a case in Nome where a defendant was found GBMI for sleeping in other people's cars. He was sentenced to time served.

Adam also briefly touched on competency. They have worked out an agreement with API – about 90% of competency evaluations are done in the Anchorage Jail. Any restoration is done at API. DOC is in a bind with the pretrial population because they can't intervene with unsentenced inmates. Sometimes the misdemeanor offenders will stay in DOC custody awaiting an evaluation/being restored for longer than the sentence imposed.

Flow chart on competency, NGRI, and GBMI

Josie led the group through a PowerPoint explaining competency, insanity, and GBMI. Competency refers to the defendant's capacity to stand trial. If a defendant is found incompetent, the court may order that they be committed to see if they can be restored (the court must order this in felony cases). Typically the restoration period is 90 days; in some cases it will be extended to 6 months. Restoration can mean medication but it can also mean coaching as to procedure and the names of the judge, attorneys, etc.

Rob was curious to know the percentage of those initially found incompetent who were restored. Susanne suggested looking at motions but the group thought looking at orders would be better as not all motions for competency evaluations are granted. API might also have this data. Barbara will look into this.

The group discussed various problems with the GBMI statutes. The statute states that an inmate who is GBMI may not be released from DOC custody, meaning they can be held indefinitely, if the inmate is

receiving treatment. It is not clear what the statute means by receiving treatment—for example, an inmate could be taking medication and be stabilized, but the medication may count as "receiving treatment" and bar that inmate's release. This section of the statute has not been litigated; since (until recently) no GBMI inmates were yet eligible for release, the Court of Appeals has held that the issue was not yet ripe.

Another problem, as Adam had indicated, was that DOC did not have a mechanism to identify GBMI inmates. If an institutional PO comes across an inmate with a GBMI designation who would be eligible for release, they may just tell the inmate that he or she is ineligible and the inmate may just accept that. Josie knows of one case of a GBMI inmate whose mandatory parole date passed two years ago without any hearing.

Defense attorneys are also disincentivized from revealing a client's mental illness, even after trial, because they want to avoid the harsh consequences of a GBMI determination. Justice Bryner asked why this was the case if the jury had already found the defendant guilty. Josie explained that the case could be retried after an appeal, and that the attorney is usually also worried about any future case where this might come up. Essentially if a defendant's mental health has ever come up at trial, the defendant runs the risk of a GBMI finding at that trial or in future trials.

The group discussed options for reforming the statutes. One option was to amend the GBMI statute so that GBMI defendants are not treated more harshly than other inmates. Another option was to amend the NGI statute to bring it more in line with national standards so that it did not exclude virtually every defendant.

1. **Three-judge panel**
2. **Post-offense, pre-sentencing treatment mitigator First-time DUIs**
3. **Juvenile Waiver**
4. **Mandatory Minimums for Murder 2/Vehicular Homicide.**
5. **Public comment**
6. **Next meeting**