Hawai‘i Mental Health Core Steering Committee

A Joint Report

January 9, 2020

The Judiciary and Department of Health
State of Hawai‘i

I. INTRODUCTION

One need go no further than our street corners to see, firsthand, the behavioral health challenges our community faces today.

The current involvement of people living with mental illness in the criminal justice system is indicative of an absolutely inadequate societal response to mental and behavioral health issues. Our street corners depict the direct consequence of applying a criminal justice model to an illness, then compounding the damage through underfunded treatment and services. Those in Hawai‘i suffering from mental illness too often languish in our community jails, as jails have replaced mental health facilities as the primary institutions for housing the mentally ill and our courts have become a revolving door, with the same "familiar faces" cycling through the system repeatedly, at great cost and with little or no treatment. This pointless cycle has gone on for far too long.

Fortunately, the tide of community concern has risen and the broad mandate for reform is clear. We must re-examine our system to achieve better, longer-lasting and humane outcomes for those living with mental illness and increase public safety by focusing scarce public resources where they will have the greatest impact. The three branches of government must unite to coordinate this response by focusing on early diversion and treatment beyond the criminal justice system. It is in this spirit of hope and change that we offer the following proposals.

II. BACKGROUND OF THE COMMITTEE

From May 22-24, 2019, the Conference of Chief Justices ("CCJ") and Conference of State Court Administrators ("COSCA) held its annual Western Region Summit in Sun Valley, Idaho. A multidisciplinary delegation from Hawai‘i, led by Chief Justice Mark Recktenwald, attended the summit entitled "Improving the Court and Community Response to those with Mental Illness."

At the summit, we were reminded that those with mental illness first interact with law enforcement on our streets. With nowhere else to go, courts often become the next stop, with jail the temporary placeholder in between. Many across our country are caught in this seemingly endless cycle of arrest and detention. If there is any bright spot to the commonality in various jurisdictions, it is that a large variety of approaches have been tried and a large amount of research, resources, and effort have been focused on possible workable paths forward. The summit sought to coalesce the best ideas from the cutting edge innovators across the country.

The Hawai‘i delegation left the CCJ/COSCA Summit invigorated with a clear commitment to reform and convene the constituency necessary to implement meaningful solutions. In furtherance of one goal – to improve the justice system's response to mental illness – the delegation set forth the following Action Plan:

- Create an interagency steering committee by June 2019
- Hold a statewide mental health summit in the fall of 2019
- Assess resources and gaps
- Review, improve and strengthen diversion opportunities
- Assess data collection needs
- Engage the broader community in the conversation

Thus, in partnership between the Judiciary and the Department of Health, our Mental Health Core Steering Committee (the "Committee") was born. The members of the Committee are:

Mark E. Recktenwald
Judiciary, Chief Justice

Rodney A. Maile
Judiciary, Administrative Director of the Courts

R. Mark Browning
Judiciary, Chief Judge of the First Circuit

Brandon M. Kimura
Judiciary, Deputy Administrative Director of the Courts

Shirley M. Kawamura
Judiciary, Deputy Chief Judge of the First Circuit, Criminal Division

Kenneth J. Shimozono
Judiciary, District Family Judge of the First Circuit

Michelle D. Acosta
Judiciary, Special Assistant to the Administrative Director of the Courts

Dwight S. Sakai
Judiciary, Probation Administrator

Edward Mersereau
Dept. of Health, Deputy Director, Behavioral Health Administration

Amy B. Curtis
Dept. of Health, Administrator, Adult Mental Health Division

Michael Champion
Dept. of Health, Medical Director, Adult Mental Health Division

Renee R. Sonobe Hong
Dept. of Public Safety, Deputy Director, Law Enforcement

The Committee met monthly, and at times weekly, with the initial goal of holding a statewide mental health summit, to share the approaches set forth by the powerful speakers at the Western Region Summit with stakeholders back home. The Committee requested, and was graciously granted, technical assistance through the State Justice Institute and provided by the National Center for State Courts (NCSC) not only to invite these premier speakers, but to compile a wealth of pre-summit work up. NCSC representatives assisted the Committee by gathering research regarding the latest national trends and state legislation in mental health reform. The NCSC representatives visited our courtrooms and mental health facilities, met and questioned our mental health stakeholders from the Judiciary, Department of Health and police department, and methodically helped us to identify, step by step, the strengths and several gaps in our system. The objective insight proved invaluable in moving us forward.

On November 6, 2019, the Committee sponsored and held its Mental Health Summit. There were over 100 attendees representing the Judiciary, the Department of Health, the Office of the Attorney General, the Department of Public Safety, the Federal Courts, the police departments from each county, Federal Probation, each county prosecutors offices, the Office of the Public Defender, the Hawai‘i Association of Criminal Defense Lawyers, local hospitals and health service providers, the Office of Hawaiian Affairs, and members of the Hawai‘i State Legislature.

Opening remarks were provided by Governor Ige and Chief Justice Recktenwald. The Governor remarked that the "summit is a significant step toward improving not only the well-being of the individuals who are suffering from mental illness but the broader community who see it on our streets every day – and for the first responders, courts personnel and community providers who struggle day by day to make a difference." Chief Justice Recktenwald also welcomed and thanked the participants. He added that improving the governmental response to community mental illness is a critical issue for the Judiciary, and the time is ripe for increased attention and collaboration among all those in attendance.

Judge Steven Leifman of the 11th Judicial Circuit in Miami-Dade County, Florida has for over 20 years advocated for and implemented ways to steer defendants with a mental illness away from jails and into treatment. According to Judge Leifman, Miami-Dade County has the largest percentage of residents with serious mental illness in the country, with many continuously cycling from arrest to jail. Judge Leifman emphasized that individuals experiencing mental illness are 19 times more likely to find a bed in a correctional facility than in a psychiatric facility, and more likely to be victims of violent crimes. In acknowledging the number of agencies and organizations represented at the summit, Judge Leifman stated that this specific population accesses all the entities in the room, but not one agency or sector owns this problem. He went on to say, that this was a national problem that *can* be fixed.

Judge Leifman was joined by Mr. Travis Parker, Dr. Marjorie Balfour, and Los Angeles District Attorney (D.A.), Jackie Lacey. Each discussed national trends and shared their experience and lessons learned in responding to issues in the justice system related to mental illness within their own communities.

Mr. Travis Parker is a Senior Project Associate with Policy Research Associates, providing training and technical assistance to counties and communities for Intercept 1 diversion initiatives. Mr. Parker suggested three key takeaways from his presentation: 1) that there must be a universal presumption that every single person that comes into contact with law enforcement has a significant history of trauma; 2) that we must persistently pursue and provide help that is at the ready, no matter how many times it is offered and declined; and 3) that we must divert from jail and create a crisis care continuum that provides service from pre-crisis, crisis, emergency to stabilization.

Dr. Margie Balfour is a national leader in quality improvement and behavioral health crisis services. She is the Chief of Quality and Clinical Innovation at Connections Health Solutions which operates two facilities in Arizona: The Urgent Psychiatric Center in Phoenix and the Crisis Response Center in Tucson. Both facilities provide 24/7 access to mental health and substance use care. Dr. Balfour suggested that these outpatient facilities serve as an effective model in answering the question of "divert to what and where". No matter what model is chosen for a community, Dr. Balfour emphasized that a systemic approach is needed. This approach involves accountability and governance, collaboration with broad inclusion and alignment with the culture of the community and problem solving. Lastly, data must be gathered to measure whether desired outcomes are being achieved.

D.A. Jackie Lacey is the 42nd district attorney for Los Angeles County in California. D.A. Lacey chairs the Criminal Justice Mental Health Project for Los Angeles County which is devoted to diverting people who are mentally ill out of the criminal justice system. Her office provides training to first responders on how to safely de-escalate incidents involving people in a mental health crisis. In describing the initial steps taken to implement the diversion program in her county, D.A. Lacey noted that the law enforcement community found that diversion for those experiencing mental illness would greatly reduce officer-involved shootings and decrease the pre-trial jail population. Her committee held a summit with stakeholders including, among others, law enforcement, community stakeholders, and parents with children experiencing mental health issues. In doing so, they discovered that everyone in the group was in some way touched

by the mental health crisis. This led to a change in attitude and a willingness to work towards a better community response. With the assistance of the Policy Research Associates, the summit resulted in a blueprint for change that identified opportunities for intercepts zero to two.

Finally, the Hawai‘i summit included facilitated discussions regarding gaps, opportunities and potential solutions for pre-arrest diversion to treatment and alternatives to fitness/competency for lower level offenses. Participants shared local experiences and reactions to the models presented during the Summit. Judge Leifman concluded the Summit by stating that we have come full circle in our treatment of those who suffer from mental illness. We have progressed away from criminalization toward healing, yet we have circled back to using jails to house those with mental disorders. More beds in jails are not the solution. Instead we need to build a comprehensive system of care.

III. NATIONAL TRENDS

The Committee has researched the history of the criminal treatment of mental illness in America, previous movements for nation-wide reform, and recent shifting trends away from adjudicative competency restoration toward diversion and treatment.

A. History of Mental Health and the Criminal Justice System

1. Deinstitutionalization

From colonial days up to the early nineteenth century, those suffering from a mental illness were routinely incarcerated if deemed violent.[1] The combined efforts of Reverend Louis Dwight and Dorothea Dix shed light on the poor and inhumane conditions in which the mentally ill were kept. Dorothea Dix advocated that mentally ill persons needed treatment, and jails and prisons were not equipped to provide such treatment.[2] Dix’s lobbying of state legislatures led to the establishment of psychiatric hospitals nationwide which took in previously incarcerated mentally ill. The success of mental hospitals in reducing the number of mentally ill in jails and

prisons was reflected in the 1880 federal census. In that census, 397 "insane persons" were accounted for in prisons and jails, out of 58,609 other prisoners.[3]

In 1930, the American Medical Association commissioned Dr. John Maurice Grimes to investigate the state of mentally ill persons institutionalized in mental hospitals in the United States. At the conclusion of his two-year investigation, Dr. Grimes reported that mental patients languished in overcrowded mental hospitals with little or no actual treatment.[4] Dr. Grimes advocated for the deinstitutionalization of large mental institutions, reasoning that mentally ill persons would be better served within the community. He suggested that patients who were deemed not dangerous to the community be paroled along with the provision of aftercare support and supervision by social workers.

By 1955, there were approximately 559,000 resident patients in state and county mental hospitals.[5] This was an increase of 139,000 patients from 1940. This amounted to approximately .03% of the overall population of the United States, which was 164 million at that time.[6] Concerns over poor, dilapidated, and overcrowded conditions in mental hospitals and the high cost of hospitalization for mental health treatment prompted Congress to pass the Community Mental Health Act (CMHA) of 1963.[7] The CMHA became the primary vehicle for the deinstitutionalization movement. The CMHA made grants available to states to build community-based outpatient treatment and community health centers while also creating financial incentives to close down mental hospitals, although no centers were fully funded. The advent of antipsychotic drugs and federal subsidies further supported outpatient treatment.

A string of lawsuits also served to protect the rights of mentally ill persons which resulted in recognizing a constitutional "right to treatment", with the landmark case being *Wyatt v. Stickney*. In *Wyatt*, the U.S. District Court in the State of Alabama articulated three fundamental conditions for adequate and effective treatment programming in public mental institutions: 1) a humane psychological and physical environment; 2) qualified staff in numbers sufficient to administer adequate treatment; and 3) individualized treatment plans.[8]

Deinstitutionalization was intended to improve treatment and quality of life for the mentally ill, allow for inclusion within the community, and safeguard civil liberties. However, some observers argued that the savings recouped from closing mental hospitals were not effectively allocated to community health centers, thereby leaving outpatient care severely underfunded.[9] By the 1980s, several studies linked deinstitutionalization to the increasing number of mentally ill in jails and prisons.

Marc Abramson, a psychiatrist in San Mateo, California published data in 1972 which demonstrated that the number of people living with mental illness entering the criminal justice system had doubled since deinstituationalization. Abramson commented, "If the mental health system is forced to release mentally disordered persons into the community prematurely, there will be an increase in pressure for use of the criminal justice system to reinstitutionalize them. Those who castigate institutional psychiatry for its present and past deficiencies may be quite ignorant of what occurs when mentally disordered patients are forced into the criminal justice system."[10]

In the 1970s, an eight years study was conducted in California's Napa State Hospital after state laws had made it more difficult to involuntarily hospitalize the mentally ill. The study showed a five-fold increase in the arrests of individuals suffering from a mental disorder.[11] Dr. Linda Teplin conducted a study in Chicago's Cook County Jail in 1983-1984 which examined 728 new jail admissions. Teplin concluded that 6.4% of those admitted had a serious mental illness.[12] By 2004-2005, there were three times more individuals with serious mental illnesses in jails and prisons than in hospitals.[13]

2. Competence to Stand Trial

The legal doctrine of competence to stand trial has roots stemming back to English common law. In seventeenth century England, defendants could not be tried unless they entered a plea. If the defendant stood mute, the court would investigate whether the defendant was "mute by malice" or "mute by visitation of God." If the defendant was found "mute by malice"

extensive measures were used to force a plea. Those who were found "mute by visitation of God" were deemed to be deaf, mute or insane and spared trial proceedings.[14]

The competency to stand trial doctrine is intended to ensure criminal trials are fair and allows for the postponement of a proceeding if the defendant is deemed unable to participate in his defense due to a mental disorder or intellectual disability. The U.S. constitutional standard defining competence to stand trial was established in *Dusky v. United States*, 362 U.S. 402 (1960). In *Dusky*, the Court held that "the test must be whether the defendant has sufficient present ability to consult with his attorney to a reasonable degree of rational understanding and a rational as well as factual understanding of proceedings against him." In 1975, the Court expanded the *Dusky* "test" to include a defendant's capacity to make important decisions throughout the criminal proceedings.[15] These decisions, such as a waiver of the constitutional rights to a trial by jury, to testify on one's own behalf, or to be present at one's trial, must be made knowingly, intelligently and voluntarily.

In 1966, the U.S. Supreme Court ruled that the Fourteenth Amendment Due Process Clause requires trial courts to hold suitable hearings on competence to stand trial whenever there is a bona fide doubt as to the defendant's competency. [16] The Court further made clear that bona fide doubt is raised when "evidence of a defendant's irrational behavior, his demeanor at trial, and any prior medical opinion on competence to stand trial are all relevant in determining whether further inquiry is required, but that even one of these facts standing alone may, in some circumstances, be sufficient."[17]

The competency to stand trial doctrine is designed to ensure fairness to the defendant and to preserve the dignity of the criminal process. A defendant who is found incompetent to stand trial may be committed until competency is restored. In the years following *Dusky*, concern over the length of time an incompetent defendant was held raised challenges to the notion of fairness. In *Jackson v. Indiana*, the Supreme Court held that a defendant may only be hospitalized if competency may be achieved within the foreseeable future. *Jackson* placed limits on the length of time an incompetent defendant could be held, and, if competency could not be restored, then the defendant had to be either civilly committed or released.[18]

In 2016, across the United Sates, an estimated 90,000 mentally ill defendants were arrested and jailed but deemed incompetent to stand trial.[19] Depending in which state these individuals were held, competency evaluations were conducted in jails or within the community. Due to a shortage of beds at state mental health hospitals, pretrial detainees who suffer from a mental illness have extended waiting periods in jails for beds to become available.[20] A large number of these mentally ill defendants are on pre-trial holds for low-level offenses. A significant critique of the competency restoration process is that it does not provide long-term wellness or successful re-entry into the community.[21]

B. American Bar Association Criminal Justice Standards on Mental Health

In 1984, the American Bar Association's (ABA) House of Delegates promulgated 96 black letter Criminal Justice Mental Health Standards. The standards addressed, among other issues, the interaction between police and people with mental health disorders; competence to participate in the legal process; and the commitment, sentencing, and jailing of individuals with mental health disorders. Since the adoption of the Standards, the ABA has periodically revised them to reflect current law and best practices. The ABA House of Delegates adopted the most recent revised Standards in August 2016. [22]

The current Standards emphasize the need to balance public safety and respect for civil liberties when designing strategies to address mental health disorders within the criminal justice system. The standards also emphasize the need for collaboration among community justice officials and mental health treatment providers in developing intervention and diversion strategies. The ABA Standards also make clear the importance of training among all those involved in providing criminal justice diversion and community based services for people living with a mental illness.[23]

C. National Reform and Trends

1. Sequential Intercept Model

The Sequential Intercept Model (SIM) is a concept that helps both states and communities understand the interaction between the criminal justice and mental health systems.[24] The model considers diversion programs that aim to provide community based services to mentally ill individuals and keeps mentally ill individuals out of the criminal justice system. In addition, the SIM provides a framework to develop strategies and enhance the effectiveness of diversion initiatives.

There are six identified intercept points: Intercept 0 – involves crisis response and law enforcement strategies aimed at directing individuals to services prior to entry into the justice system, Intercept 1 – pertains to diversion at the point of law enforcement contact, Intercept 2 – addresses diversion options during post-arrest and initial court hearing, Intercept 3 – focuses on diversion after incarceration, Intercept 4 – addresses re-entry, and Intercept 5 – addresses support options at parole and probation.[25]

The SIM is supported by the Conference of State Court Administrators (COSCA), the National Conference of State Legislatures, and the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

2. Jail Diversion

Jail diversion is based on the premise that those who suffer from a mental disorder and commit an offense do so as a manifestation of their mental illness. As such, the appropriate response is treatment and not incarceration. Diversion is also an effort to reduce the number of mentally ill persons in jail and prison systems where adequate treatment is not always available. Various diversion models have been implemented throughout the United States that include both pre-booking and post-booking.

Pre-booking initiatives involve law enforcement decision-making to either arrest, divert the individual to mental health services, or do nothing at all. Nationally, arrests tend to be based on the lack of available psychiatric beds and the officer's assessment of consequences of doing

nothing at all.[26] Currently, there are several pre-booking diversion models in use. One example is a police-based specialized response program. Here, trained police officers are able to recognize mental illness and direct individuals to mental hospitals or crisis centers.[27] This specialized training known as Crisis Intervention Training (CIT) originated in the state of Tennessee. CIT has been effective in reducing violent incidents involving police and people living with mental illness.[28]

Oakland County, Michigan began CIT training of officers in 2015, in partnership with its community mental health agency. Since then, approximately 300 people per year have been diverted to treatment. Further, between 2014 and 2016, eight Michigan counties with CIT programs saw an overall reduction of 25% in the number of inmates with serious mental illness.[29] Miami-Dade County, Florida also saw success in its pre-booking jail diversion program. Within a seven-year span, 16,000 diversions to crisis units were conducted out of 71,628 mental health crisis calls. Of that number, only 138 arrests were made. The success of the pre-booking diversion program in Miami-Dade resulted in the closing of an entire jail facility.[30]

Another pre-booking diversion model involves a response from joint police and mental health teams. The mental health crisis worker conducts an assessment, and in certain situations, steers the individual towards community care services in lieu of arrest for low-level criminal offenses. In Seattle, Washington this model has been used to create a diversion program called Law Enforcement Assisted Diversion (LEAD). In that program, the individual with a mental disorder encountered by the LEAD team undergoes a preliminary assessment with a case manager upon the initial encounter with law enforcement. These individuals could have already committed an offense, or not. If the individual is deemed eligible, he or she is released from the encounter and undergoes a voluntary follow-up assessment. If the individual failed to follow through, an arrest could ensue. A study of the LEAD program showed that the recidivism rate was 22% lower than those who entered the traditional criminal process.[31]

Post-booking diversion models include jail-based diversion, court-based diversion and specialized mental health courts. In jail-based diversion programs, specialized pretrial services

staff identify and conduct assessments on detainees for mental health issues.[32] With consent from the judge, prosecutor and defense attorney, the individual can be released subject to undergoing mental health treatment within the community.

In some states, public defender offices have employed social workers to assist in the screening and case management for defendants with mental health needs. [33] This enables the public defender to effectively recommend and advocate for pretrial diversion.[34] Some courts have also either employed or contracted mental health clinicians who are based within the courthouse.[35] These clinicians screen and assess individuals at arraignment. Treatment plans are presented to the prosecutor, defense and judge to secure a bail release of the mentally ill defendant. Similar to the specialized pretrial service staff, the clinician links the defendant to community mental health and other needed social services immediately after assessment. Pretrial service staff and mental health clinicians must coordinate carefully with the courts, treatment providers, prosecutors, defense teams and one another to eliminate duplication and ensure program efficiency.[36]

Judges and court staff are also key to identifying individuals who are exhibiting mental health and/or substance abuse issues. Jurisdictions are investing time and effort to train judges and court staff to develop skills in recognizing behavioral needs and responding appropriately within the court setting.[37] Mental health courts have been established in several states with a goal of providing pre-adjudication diversion. Here, the court utilizes its power to bring together pretrial services, probation, defense attorneys, prosecutors and social workers to screen and assess individuals and to coordinate placement, treatment plans, and support services.[38]

D. Survey of State Statutes

1. Addressing Diversion

State agencies and local officials recognize the important intersect between the criminal justice system and health policies in addressing the needs of individuals with mental health problems. According to the National Conference of State Legislatures, at least 27 states and the

District of Columbia have enacted laws requiring officers to be trained to identify and respond to mental health and substance abuse crisis situations.[39]

In 2017, over 1,500 bills were introduced nationwide by states to improve police-community relations. Several of these measures aimed to reduce the frequency of arrests, especially for those individuals for whom the criminal justice system would be the least effective response.[40] Legislation enabling police to divert those suffering from mental illness or substance abuse in lieu of arrest went into effect in Washington State, Kentucky and New Jersey.[41] According to the National Conference of State Legislatures, at least eight states have enacted pre-booking diversion programs as of 2017.[42]

States have also recognized the specific treatment needs of individuals suffering from a mental disorder and/or co-occurring substance abuse and who become entangled in the criminal justice system due to their illness. In addressing this, 18 states have statutorily authorized specialty courts, and four states have enacted laws creating pretrial diversion programs.[43] Washington State and Indiana enacted legislation authorizing both specialty courts and diversion programs that are specific to mental health and substance abuse.[44]

2. Addressing Competency or Fitness to Proceed

The Committee was able to find very few states that have adopted a comprehensive and consistent process of de-linking the competency determination process from the adjudication of misdemeanors that involve people with serious mental illness. However, the following states offer distinct statutory schemes that do address competency.

In New York, a traditional competency determination process still occurs. However, for misdemeanors, if the defendant is found incompetent to proceed, the charges must be dismissed. Judges are required to enter an "Order of Observation" upon a finding of incompetence, and then the defendant is transported to either a civil (as opposed to forensic) state hospital or to an acute care hospital for assessment under the civil commitment standard. This "observation" (assessment) has to occur within 72 hours, at which point they are civilly committed, converted to voluntary status, or released and referred to community services.[45]

California recently enacted a statute that allows for pre-plea diversion agreement for misdemeanors (and most felonies) if:

- An assessment indicates a DSM-V diagnosis
- The court is satisfied that the defendant's mental disorder played a significant role in the commission of the charged offense
- In the opinion of a qualified mental health expert, the defendant's symptoms motivating the criminal behavior would respond to mental health treatment
- The defendant agrees to comply with treatment as a condition of diversion
- The court is satisfied that the defendant will not pose an unreasonable risk of danger to public safety.

Successful completion of the diversion agreement "shall" result in dismissal of the charges.[46] The statute also creates a diversion option for defendants found to be incompetent, with the same prerequisites.[47] The same 2018 legislation also created a fund to which counties could apply in order to pay for the community based treatment services for diverted defendants.[48]

In Miami-Dade County, Florida, Judge Leifman's misdemeanor diversion program rarely involves orders for competency evaluations for misdemeanants. Instead, eligible individuals are diverted to a crisis stabilization unit. If the individual stabilizes and agrees to enter the program, they are not re-booked into jail and are provided services focused on their recovery – case management, housing, medication and treatment. The court then oversees the treatment plan and in most cases, upon successful completion, the charges are dismissed. The program has substantially reduced recidivism and saved the county millions of dollars in competency evaluations.

The Miami-Dade County program begins with risk/need screening in the jail, by program staff, using the Texas Christian University (TCU) and the Ohio Risk Assessment System (ORAS) assessment tools. They target high-risk high-need participants, and to some extent low-risk high-need. If the screening recommends an assessment, the assessment is accomplished. If it suggests a serious mental illness and there are no public safety concerns, then the individual is placed in the diversion track and treatment begins. The criminal case stays open, but it is stayed indefinitely. If a case proceeds through the court system and if a misdemeanant is found incompetent by the court, the court has no further jurisdiction or ability to require anything further, including treatment. In addition, primarily for felonies, there is also a forensic hospital diversion that follows after an incompetency determination.

All of these programs in Miami-Dade are part of a much broader effort to bring treatment and evidence based practices to defendants with mental illness. Forensic evaluation and restoration resource use is maximized, and overall treatment costs and recidivism are reduced. There is no specific statute that dictates the terms of these programs, but are based on a memorandum of agreement between stakeholders.

Texas follows a traditional competency evaluation process. However, upon a determination of incompetency, misdemeanor defendants who are ordered to competency restoration and who are not dangerous are released to complete an outpatient restoration program.[49] Further, a recently enacted statute in Texas requires misdemeanants with mental illness to be assessed and a report issued within 96 hours of the defendant being taken into custody.[50] Texas also requires law enforcement agencies to make a "good faith effort" to divert misdemeanants to treatment.[51]

Indiana authorizes "pre-conviction forensic diversion" based simply on a behavioral health diagnosis and non-violent misdemeanor status.[52] Similarly, Connecticut statutes create a supervised pretrial diversion program for misdemeanants with "psychiatric disabilities." This is made available to defendants if an assessment determines "amenability" and for so long as treatment is available. Successful completion results in dismissal of the charges.[53]

Ohio recently introduced Senate Bill 58 that "prohibits a court from ordering a criminal defendant to undergo inpatient competency evaluations at certain facilities operated or certified by the state, unless the defendant is charged with a felony or offense of violence or unless the court determines that the defendant is in need of immediate hospitalization."[54] The evaluation ordered by a court for other charges that do not meet the felony or violence criteria must be conducted through community resources. If an affidavit is filed for civil commitment by the court or prosecutor in probate court, the court may enter an interim order of civil commitment for the defendant, pending a hearing with the probate court. The court may also appoint a limited guardian for the purpose of making mental health treatment decisions. In addition, the bill appropriates $250,000 to pay costs associated with the appointment of guardians.

The myriad of systems available across the nation provide a wide range of reform alternatives Hawai‘i could pursue.

IV. HAWAI‘I’S CURRENT LANDSCAPE

A. Recent Diversion Efforts

Several diversion initiatives have been put in place and continue to be implemented along the criminal justice spectrum throughout the State. These initiatives have been led by various governmental agencies and in partnership with local service providers.

1. Pre-Booking

One pre-booking diversion tool that has been implemented in Honolulu and Maui counties and is currently launching statewide, is the Mental Health Emergency Worker program. Funded through the Department of Health, the program provides mental health consultation to county and state law enforcement officers who encounter individuals in the community experiencing a crisis. The Mental Health Emergency Worker (MHEW), a qualified mental health professional trained in crisis stabilization, assists officers by determining if an individual is experiencing a crisis related to a mental health issue, is imminently dangerous, and would benefit from an emergency examination in a healthcare setting. This consultation and collaboration generates an opportunity to divert an individual experiencing a crisis related to mental illness away from the criminal justice system and into clinical assessment and treatment services. MHEWs are available 24/7 to take calls from law enforcement officers. Over 4,000 calls for consultation were received by MHEWs in Oahu in FY 2019. The statewide MHEW program started on Dec 30, 2019 and over 5,000 consultations statewide are anticipated in 2020.

Three specific diversion tools aimed at preventing individuals from entering the criminal justice system have been implemented in the City and County of Honolulu: the Health Efficiency and Long-term Partnerships (H.E.L.P.), the Law Enforcement Assisted Diversion (LEAD) and the Crisis Intervention Teams (CIT). These tools allow law enforcement who are often the first to engage with individuals suffering from mental illness to offer immediate social service assistance to those at risk for citation or low-level offenses. These initiatives are made possible through a partnership with local service providers, the Honolulu Police Department and

government agencies. A one year evaluation of the LEAD pilot project indicates promising outcomes.[55] For example, over the course of a nine-month period, a 47% decrease in the need for continued case management was observed. For that same period, there was also an 18% decrease in the need for mental health services. However, there was a much more modest decrease of 9% in the need for permanent housing at the nine-month mark. The LEAD program also saw 55% fewer cited encounters with law enforcement among those who were previously referred to the program.

The success of the Oahu LEAD program resulted in the enactment of Act 209 which enabled funding for LEAD pilot programs on the islands of Kauai, Maui and Hawai‘i. In November 2019, LEAD was launched in West Hawai‘i, Kona. The Kona pilot project is expected to expand island wide. The LEAD project for Kauai also launched recently, with Maui launching its LEAD pilot project in May 2019.

2. Post-Booking

Post-booking and pre-arraignment jail diversion is supported by the State Department of Public Safety (DPS) and the State Department of Health (DOH). Assessment for jail diversion takes place when an individual is committed to the custody of the DPS. The initial intake is conducted by the Intake Services Center (ISC) of DPS at the Community Correctional Centers located on Oahu, Maui, Hawai‘i and Kauai. ISC utilizes the Ohio Risk Assessment-Pretrial Assessment Tool (ORAS-PAT) to determine the risk of a defendant being arrested for a new crime or failing to appear at a future court date.

When mental health issues are identified, ISC works directly with the DOH Jail Diversion Program administered by the Adult Mental Health Division (AMHD) for further assessment. AMHD provides a supportive case management system for non-dangerous arrestees who have mental illness and who are eligible for jail diversion. The statewide service coordinates therapeutic support and access to basic needs including food, housing, transportation and assistance in applying for benefits and entitlements.

B. Hawai‘i Revised Statutes, Chapter 704

Chapter 704 of the Hawai‘i Revised Statutes (HRS) provides the framework for mental examinations in the State of Hawai‘i. Currently, when individuals are arrested for a criminal offense, they are transported to the police station where they are processed, booked, and placed in confinement if they are not able to post bail or deemed not eligible for pre-arraignment diversion. On Oahu, at the District Court level, clinical assessments and referral services are provided by a Court-Based Clinician. The Court-Based Clinician works under the AMHD and provides consultation services to the courts and criminal justice agencies regarding the defendant's risk level, mental illness, and eligibility for mental health programs, including jail diversion.

Pursuant to Hawai‘i Rules of Penal Procedure (HRPP) Rule 5, persons held in custody must be brought before the Court within forty-eight hours of their arrest for their initial appearance. At the initial appearance, if there is reason to doubt the defendant's fitness to proceed, the Court may immediately suspend all further proceedings in the prosecution.[56]

Upon suspension of further proceedings, the court will appoint a qualified examiner in non-felony cases. Forensic services are provided by the Court Ordered Forensic Evaluation Services (Court Evaluation Branch) of the AMHD. The Court Evaluation Branch maintains a list of qualified examiners for the Judiciary in accordance with the HRS.[57]

The appointed examiner will perform court ordered evaluations for fitness to proceed as well as a risk assessment to assist in the court's decision to release on conditions or to commit to the custody of the DOH.[58] In addition, if there is reason to believe that the physical or mental disease, disorder, or defect of the defendant will or has become an issue in the case, the court may also order an examination as to the defendant's physical or mental disease, disorder, or defect at the time of the conduct alleged (penal responsibility issue).[59]

With regard to fitness to proceed, the examination may be conducted while the defendant is in custody or in the community. The court may, at its discretion, and when necessary, order the defendant to be committed to a hospital or other suitable facility for the purpose of the examination. The period of confinement must not exceed thirty days, unless the court

determines a longer period is necessary for the purpose of examination.[60] When a defendant requests a mental examination on the issue of fitness to proceed, the Court often considers ordering a penal responsibility examination and evaluation at the same time. For non-felony cases, the return date for the receipt of the examiner's report is 30 days for in-custody defendants and six to eight weeks for defendants who are out of custody. However, due to time needed to obtain necessary documents (many of which are hard copies) and staffing, reports are frequently not prepared by the 20 day deadline, and defendants are routinely held in custody for an additional 15-30 days.

The Court will make a determination on whether the defendant is fit to proceed pursuant to HRS § 704-405.[61] If neither the prosecuting attorney nor defense counsel contest the finding of the report(s) filed pursuant to HRS § 704-404, the Court will make the determination based on the report. If the finding in the report is contested, the Court will hold a hearing on the issue of fitness. If the Court determines that the defendant is not fit to proceed, the Court may commit the defendant to the custody of the DOH or may release the defendant on conditions. [62] If the Court commits the defendant to the custody of the DOH, the commitment shall be limited in certain cases as follows:

> (a) When the defendant is charged with a petty misdemeanor not involving violence or attempted violence, the commitment shall be limited to no longer than sixty days from the date the court determines the defendant lacks fitness to proceed; and
>
> (b) When the defendant is charged with a misdemeanor not involving violence or attempted violence, the commitment shall be limited to no longer than one hundred twenty days from the date the court determines the defendant lacks fitness to proceed.

For non-felony cases, a return date that falls within the statutory maximums (60 days or 120 days) is set by the Court to review the likelihood of defendant becoming fit to proceed in the future. If a defendant committed to the custody of the DOH for a limited period pursuant to HRS § 704-406 subsection (1) is not found fit to proceed prior to the expiration of the commitment, the charge for which the defendant was committed for a limited period will be dismissed. Thus, in many cases where a defendant is found unfit, they are held in custody at the Hawaii State Hospital for an additional 60-120 days. Upon dismissal of the charge, the defendant will be released from custody unless the defendant is subject to prosecution for other charges or subject

to section 334-60.2 regarding involuntary hospitalization criteria, in which case the Court would order the defendant's civil commitment to the custody of the DOH to be placed in an appropriate institution for detention, care, and treatment.[63]

If the Court does not commit the defendant to the custody of the DOH upon a determination of unfitness, the Court shall release the defendant on conditions that shall include participation in a community-based fitness restoration program. Specifically, the HRS provide that "if the court is satisfied that the defendant may be released on conditions without danger to the defendant or to another or risk of substantial danger to property of others, the court shall order the defendant's release, which shall continue at the discretion of the court, on conditions the court determines necessary; provided that the release on conditions of a defendant charged with a petty misdemeanor not involving violence or attempted violence shall continue for no longer than sixty days, and the release on conditions of a defendant charged with a misdemeanor not involving violence or attempted violence shall continue for no longer than one hundred twenty days."[64] However, "[i]f a defendant released on conditions for a limited period pursuant to HRS § 704-406 subsection (1) is not found fit to proceed prior to the expiration of the release on conditions order, the charge for which the defendant was released on conditions for a limited period will be dismissed. Upon dismissal of the charge, the Court will discharge defendant from the release on conditions unless the defendant is subject to prosecution for other charges or subject to section 334-60.2 regarding involuntary hospitalization criteria, in which case the court shall order the defendant's commitment to the custody of the director of health to be placed in an appropriate institution for detention, care, and treatment."[65]

If the defendant is released on conditions after a finding of unfitness to proceed, the DOH must establish and monitor a fitness restoration program consistent with conditions set by the court order of release, and must inform the prosecuting attorney of the county that charged the defendant of the program and report the defendant's compliance therewith.[66]

Thereafter, if the Court, or upon the application of the director of health, the prosecuting attorney, or the defendant, has reason to believe that the defendant has regained fitness to proceed, in non-felony cases the Court will appoint an examiner to determine if defendant has regained fitness to proceed.[67] In Class C or B felony cases, the Court may appoint one or three examiners to report on the defendant's fitness to proceed. In Class A felony cases, or murder or

attempted murder cases, the Court must appoint three examiners. After a hearing on the issue, or upon stipulation to the examiner's report, and upon the court's determination that the defendant has regained fitness to proceed, the penal proceeding shall be resumed and the defendant shall no longer be committed to the custody of the DOH. However, under certain offenses and upon a showing of good cause, the Court may order that the defendant remain in the custody of the director of health, but subject to bail.[68]

If the Court determines that the defendant is fit to proceed, and there is an issue regarding penal responsibility, it will be determined pursuant to HRS § 704-407.5[69] and HRS § 704-408.[70] If the Court determines, after hearing or based on the uncontested reports made pursuant to HRS § 704-404 and § 704-407.5, that defendant was, at the time of the alleged conduct, affected by a physical or mental disease, disorder, or defect that substantially impaired the defendant's capacity to appreciate the wrongfulness of the defendant's conduct or to conform the defendant's conduct to the requirements of law, the Court may enter a judgment of acquittal pursuant to HRS § 704-411. The Court may then: (1) commit the defendant to the custody of the DOH; (2) order the defendant released under terms and conditions of conditional release; or (3) discharge the defendant.[71]

V. SOCIAL AND ECONOMIC COSTS OF MENTAL ILLNESS

One in five adults in the United States suffer from mental illness, and one in 25 adults experience serious mental illness. Only 43.3% of adults in the United States received treatment for their mental disorder in 2018. Untreated mental health disorders come at high personal and public costs. According to the National Alliance of Mental Illness, an estimated $193.2 billion in lost earnings result from severe mental illness. Another 20.1% of people experiencing homelessness in the United States have a serious mental health condition.

Across the nation, individuals experiencing a psychotic episode are taken to emergency departments by law enforcement. The National Alliance of Mental Illness estimates that one out of eight hospital emergency adult visits involve mental illness or substance abuse disorders. Emergency departments are challenged with finding beds at a mental health facility or a psychiatric unit in a hospital. Quite often, with limited number of beds, patients may remain in

the emergency departments for several days. This practice is referred to as psychiatric boarding, where patients receive limited psychiatric treatment during their interim stay. A report published by the National Association of State Mental Health Program directors estimated an emergency department cost of $1,200 to $2,264 per day.[72] According to that report, 96% of individuals referred to crisis providers do not require an emergency department visit.

An estimated 37% of adults incarcerated in state and federal prison systems have diagnosed mental illness. For calendar years 2017 and 2018, there were a little less than 150 individuals confined each year at a correctional facility for a misdemeanor or petty misdemeanor charge in Hawai‘i and who were subsequently transferred to the Hawai‘i State Hospital. Collectively, this averages out to approximately 12,000 jail days. At the average daily cost of incarceration per person of $182.00 this amounts to $2.18 million.

For those individuals with mental disorders, the cost to house them in jails is often double or triple the average cost to house other prisoners. These added costs come from the disproportionate rate of suicide among the population requiring frequent monitoring, the high tendency for prisoners suffering from a mental illness to become more symptomatic, and the high risk for untreated prisoners to pose harm to themselves, other prisoners or prison staff especially in overcrowded facilities.

The burden on public service like law enforcement, jails, health services, and the judicial system is substantial. The treatment under the current system is minimal, delayed and inefficient. The personal impact on families and the individual suffering from untreated mental illness is devastating.

VI. PROPOSED NEXT STEPS

A. Proposed Legislation for Fitness and Restoration

Nationally and locally in Hawai‘i, there have been significant increases in individuals who are living with mental illness that are arrested and remain in custody while awaiting a psychiatric evaluation of competency. Then, if determined to be legally unfit to proceed with their cases, these individuals continue to remain in custody for restoration of their legal fitness to proceed.

Currently in Hawai‘i, initial evaluations may take between 30 and 70 days, depending on the charge. Indeed, many determinations require an extension of time (continuance) due to the evaluators' inability to complete their report within the allotted timeframe. In many of these cases, and specifically in misdemeanor and petty misdemeanor cases, defendants living with mental illness remain in custody or at the Hawai‘i State Hospital while awaiting either a determination of fitness or restoration for months longer than the relevant statutory maximum period of incarceration for the crime with which they are charged.

In addition, these defendants are ultimately released—either with dismissal of the charge because they are unfit to proceed or with a sentence of credit for time served—*without* follow-up treatment services in the community. In too many instances these same defendants are arrested again for a petty misdemeanor or misdemeanor and the cycle restarts. The goals of crime prevention and rehabilitation are thwarted when services are not in place to facilitate appropriate reentry into the community.

The Department of Health and the Judiciary respectfully propose the following amendments to chapter 704 of the Hawai‘i Revised Statutes to: (1) ensure protection of the public, (2) better assist those living with mental illness obtain appropriate community-based assistance, and (3) alleviate the inefficient adjudication of defendants in the criminal justice system and healthcare system. By diverting nonviolent petty misdemeanants living with mental illness from the criminal justice system within days of their arrest, rather than months, the goal of crime prevention is furthered. By ensuring the diversion is to appropriate community treatment, the goal of rehabilitation is furthered. To these ends, the following proposed amendments authorize a condensed, on-site fitness determination, and multiple opportunities to divert individuals to the appropriate path to treatment (either through civil commitment or community based treatment).

Meaningful improvements in our treatment of those suffering from a mental illness can only be achieved with sufficient financial commitment from the State. The Department of Health and the Judiciary respectfully request that the Legislature give serious consideration to investing the necessary resources required to implement these much needed advancements.

Report Title:
Fitness to proceed; criminal justice diversion program

Description:
Diverts non-violent petty misdemeanants living with mental illness from the criminal justice system to appropriate community treatment.

THE THIRTIETH LEGISLATURE, 2020
STATE OF HAWAI‘I

__. B. NO.

A BILL FOR AN ACT

RELATING TO FITNESS TO PROCEED.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAI‘I:

SECTION 1. Chapter 704, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§704- Effect of finding of unfitness to proceed for defendants charged with a petty misdemeanor not involving violence or attempted violence; criminal justice diversion program.** (1) In cases where the defendant is charged with a petty misdemeanor not involving violence or attempted violence, if, at the hearing held pursuant to section 704-404(2)(a) or at a further hearing held after the appointment of an examiner pursuant to section 704-404(2)(b), the court determines that the defendant lacks fitness to proceed, the charges shall be dismissed with prejudice and the court shall order the defendant to be committed to custody of the director of health and placed in an appropriate facility for assessment, care, and treatment for up to seven days.

(2) If the defendant's treatment team determines that the defendant meets the criteria in section 334-60.2 for involuntary hospitalization, the director of health shall file a petition for involuntary hospitalization pursuant to section 334-60.3 in the family court. If the petition is granted, the defendant shall remain hospitalized for a time period as provided by section 334-60.6.

(3) If the defendant's treatment team determines that the defendant does not meet involuntary hospitalization criteria, or the family court denies the petition for involuntary hospitalization, or in the anticipation of discharge after involuntary hospitalization pursuant to section 334-60.3, the treatment team shall determine whether an assisted community treatment plan is appropriate pursuant to chapter 334, part VIII. If the treatment team so determines, the psychiatrist or advanced practice registered nurse from the treatment team shall prepare the certificate for assisted community treatment specified by section 334-123. The treatment team shall identify a community mental health outpatient program that agrees to provide mental health services to the defendant in the community as the designated mental health program under the assisted community treatment order. The defendant may be held at the

hospital or other suitable facility pending the family court hearing on the petition for assisted community treatment. If the petition is granted, the defendant shall be released for treatment with the designated mental health program once the assisted community treatment order is issued and the initial treatment consistent with the assisted community treatment plan is administered to the defendant.

(4) If the petition for assisted community treatment is not granted, or the treatment team determines that an assistant community treatment order is not appropriate, the defendant shall be referred to an appropriate outpatient mental health program for continued support, care, and treatment, and be discharged from the hospital or other suitable facility."

SECTION 2. Section 704-404, Hawaii Revised Statutes, is amended:

1. By amending subsections (1) and (2) to read as follows:

"(1) Whenever there is reason to doubt the defendant's fitness to proceed, the court may immediately suspend all further proceedings in the prosecution; provided that for any defendant not subject to an order of commitment to a hospital for the purpose of the examination, neither the right to bail nor proceedings pursuant to chapter 804 shall be suspended. If

a trial jury has been [~~empanelled,~~] empaneled, it shall be discharged or retained at the discretion of the court. The discharge of the trial jury shall not be a bar to further prosecution.

(2) Upon suspension of further proceedings in the prosecution[~~,~~]:

(a) In nonfelony cases, if a court-based certified examiner is available, the court shall appoint the court-based examiner to examine and provide an expedited report solely upon the issue of defendant's fitness to proceed. The court-based certified examiner shall file the examiner's report with the court within two days of the appointment of the examiner. A fitness determination hearing shall be held within two days of the filing of the report, or as soon thereafter as practicable;

(b) In nonfelony cases where a court-based certified examiner is not available, the court shall appoint [~~three qualified examiners in felony cases, and~~] one qualified examiner [~~in nonfelony cases,~~] to examine and report upon the defendant's fitness to proceed.

The court may appoint as the examiner either a psychiatrist or a licensed psychologist; and

(c) In felony cases, the court shall appoint three qualified examiners, to examine and report upon the defendant's fitness to proceed. The court shall appoint as examiners [~~at least one psychiatrist and at least one licensed psychologist. The third examiner may be a psychiatrist,~~] psychiatrists, licensed [~~psychologist,~~] psychologists, or qualified [~~physician.~~] physicians. One of the three examiners shall be a psychiatrist or licensed psychologist designated by the director of health from within the department of health. [~~In nonfelony cases, the court may appoint as examiners either a psychiatrist or a licensed psychologist.~~]

All examiners shall be appointed from a list of certified examiners as determined by the department of health. The court, in appropriate circumstances, may appoint an additional examiner or examiners. The examination may be conducted while the defendant is in custody or on release or, in the court's discretion, when necessary the court may order the defendant to be committed to a hospital or other suitable facility for the

purpose of the examination for a period not exceeding thirty days, or a longer period as the court determines to be necessary for the purpose. The court may direct that one or more qualified physicians or psychologists retained by the defendant be permitted to witness the examination. As used in this section, the term "licensed psychologist" includes psychologists exempted from licensure by section 465-3(a)(3) and "qualified physician" means a physician qualified by the court for the specific evaluation ordered."

2. By amending subsection (5) to read as follows:

"(5) [~~The~~] Except in the case of an examination pursuant to subsection (2)(a), the report of the examination for fitness to proceed shall include the following:

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

(b) A diagnosis of the physical or mental condition of the defendant;

[~~(b)~~] (c) An opinion as to the defendant's capacity to understand the proceedings against the defendant and to assist in the defendant's own defense;

[~~(c)~~] (d) An assessment of the risk of danger to the defendant or to the person or property of others for

consideration and determination of the defendant's release on conditions; and

[~~(d)~~] (e) Where more than one examiner is appointed, a statement that the opinion rendered was arrived at independently of any other examiner, unless there is a showing to the court of a clear need for communication between or among the examiners for clarification. A description of the communication shall be included in the report. After all reports are submitted to the court, examiners may confer without restriction."

3. By amending subsection (7) read as follows:

"(7) [~~Three copies~~] A copy of the report of the examination, including any supporting documents, 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~~]."

SECTION 3. Section 704-406, Hawaii Revised Statutes, is amended by amending subsection (1) to read as follows:

"(1) If the court determines that the defendant lacks fitness to proceed, the proceeding against the defendant shall be suspended, except as provided in [~~section~~] sections 704-407[~~,~~] and 704- , and the court shall commit the defendant to

the custody of the director of health to be placed in an appropriate institution for detention, assessment, care, and treatment; provided that the commitment shall be limited in certain cases as follows:

(a) When the defendant is charged with a petty misdemeanor not involving violence or attempted violence, the [~~commitment shall be limited to no longer than sixty days from the date the court determines the defendant lacks fitness to proceed;~~] defendant shall be diverted from the criminal justice system pursuant to section 704- ; and

(b) When the defendant is charged with a misdemeanor not involving violence or attempted violence, the commitment shall be limited to no longer than one hundred twenty days from the date the court determines the defendant lacks fitness to proceed.

If the court is satisfied that the defendant may be released on conditions without danger to the defendant or to another or risk of substantial danger to property of others, the court shall order the defendant's release, which shall continue at the discretion of the court, on conditions the court determines necessary; provided that the release on conditions of a

defendant charged with a [~~petty misdemeanor not involving violence or attempted violence shall continue for no longer than sixty days, and the release on conditions of a defendant charged with a~~] misdemeanor not involving violence or attempted violence shall continue for no longer than one hundred twenty days. A copy of all reports filed pursuant to section 704-404 shall be attached to the order of commitment or order of release on conditions that is provided to the department of health. When the defendant is committed to the custody of the director of health for detention, care, and treatment, the county police departments shall provide to the director of health and the defendant copies of all police reports from cases filed against the defendant that have been adjudicated by the acceptance of a plea of guilty or nolo contendere, a finding of guilt, acquittal, acquittal pursuant to section 704-400, or by the entry of a plea of guilty or nolo contendere made pursuant to chapter 853; provided that the disclosure to the director of health and the defendant does not frustrate a legitimate function of the county police departments; provided further that expunged records, records of or pertaining to any adjudication or disposition rendered in the case of a juvenile, or records containing data from the United States National Crime

Information Center shall not be provided. The county police departments shall segregate or sanitize from the police reports information that would result in the likely or actual identification of individuals who furnished information in connection with the investigation or who were of investigatory interest. No further disclosure of records shall be made except as provided by law."

SECTION 4. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

INTRODUCED BY: _____

VII. CONCLUSION

The proposed legislation in this report seeks to achieve a more efficient and just response in the treatment of individuals with mental disorders within the criminal justice system.

The Mental Health Core Steering Committee is grateful for the collaboration of so many of the community stakeholders throughout the state. The Statewide Mental Health Summit could not have been a success without the assistance from the National Center for State Courts and the State Justice Institute. The Summit was a success and a springboard from which we know will continue productive discussions and collaborative problem solving.

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[2] *Id*. at 10.

[3] *Id*. at 11.

[4] Grimes, John Maurice. *Institutional Care of Mental Patients in the United States*, Grimes, John Maurice, 1934. Print.

[5] Ronald Manderscheid, The National Reporting Program for Mental Health Statistics: History and Findings, Public Health Reports. 1986 Sep-Oct 1996, Vol. 101, No. 5. 532-59. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1477772/ [https://perma.cc/4YGK-9QL9].

[6] Frontline, PBS, Deinstitutionalization: A Psychiatric "Titanic" (2005). https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html [https://perma.cc/Z7LL-LWKM]

[7] Milton L. Mack, Jr., L. 2016-2017 Policy Paper, *Decriminalization of Mental Illness: Fixing a Broken System*, Conference of State Court Administrators. https://cosca.ncsc.org/~/media/Microsites/Files/COSCA/Policy%20Papers/2016-2017-Decriminalization-of-Mental-Illness-Fixing-a-Broken-System.ashx **[**https://perma.cc/SD6H-PFRA].

[8] *Wyatt v. Stickney*, 334 F. Supp. 1341, 1343 (M.D.Ala. 1972). Landmark decision holding people who are involuntarily committed due to mental illness or developmental disabilities have a constitutional right to treatment that afford them a realistic opportunity to return to society. This led to sweeping reforms throughout the mental health systems in the U.S. to include the creation of minimum standards of care and rehabilitation for people with mental illness.

[9] Frances, Allen, Ruffalo, Mark, Psychiatric Times, Mental Illness, Civil Liberty, and Common Sense (2018). https://www.psychiatrictimes.com/couch-crisis/mental-illness-civil-liberty-and-common-sense

[10] Marc Abramson, *The Criminalization Of Mentally Disordered Behavior*, Journal of Hospital and Community Psychiatry (1972), 101-105.

[11] Torrey, Edwin, Steiber, Joan, Ezekiel, Johnathan, *Criminalizing the Seriously Mentally Ill: The Abuse of Jails As Mental Hospitals*, A joint report of the National Alliance for the Mentally Ill and Public Citizen's Health Research Group (1992), 40.

[12] Id. at 39.

[13] E. Fuller Torrey, Aaron D. Kennard, Don Eslinger et al., *More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States*, Treatment Advocacy Center (2010), 8.

[14] Barry W. Wall, Peter Ash, Emily Keram, Debra A. Pinals and Christopher R. Thompson, *AAPL Practice Resource for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, Journal of the American Academy of Psychiatry and the Law Online September 2018, 46 (3 Supplemental) S4-S79, DOI: https://doi.org/10.29158/JAPL.003781-18

[15] *Godinez v. Moran*, 509 U.S. 389 (1993).

[16] *Pate v. Robinson*, 383 U.S. 375 (1966).

[17] *Drop v. Missouri*, 420 U.S. 162, 181 (1975).

[18] *Jackson v. Indiana*, 406 U.S. 715 (1972).

[19] Doris A. Fuller, Elizabeth Sinclair, H. Richard Lamb, James D. Cayce, John Snook, Emptying the 'New Asylums', A Beds capacity Model to Reduce Mental Illness Behind Bars, A Report from the Office of Research & Public Affairs (2017), 1. https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf **[**https://perma.cc/9QWB-LP9F]

[20] Id.

[21] Id. at 3.

[22] American Bar Association, Criminal Justice Standards on Mental Health. https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf **[**https://perma.cc/2T29-KUSX]

[23] Standard 7-1.2. Responding to persons with mental disorders in the criminal justice system

> (a) Officials throughout the criminal justice system should recognize that people with mental disorders have special needs that must be reconciled with the goals of ensuring accountability for conduct, respect for civil liberties, and public safety.
>
> (b) Criminal justice officials should work with community mental health treatment providers and other experts to develop valid and reliable screening, assessment, diversion, and intervention strategies that identify and respond to the needs of individuals with mental disorder who come into contact with the justice system, whether the setting is traditional criminal court, problem-solving court, a diversion program, or post-adjudication supervision and monitoring.

Standard 7-1.7. Education and training

> (a) Interdisciplinary cooperation. Judicial, legal, and mental health professional associations, organizations, and institutions at national, state, and local levels should cooperate in promoting, designing, and offering basic and advanced education and training programs addressing the identification of and responses to individuals with mental disorders involved in or at risk of becoming involved in the criminal justice system. Such programs should include a focus on developing strategies to facilitate diversion from the criminal justice system to the community mental health treatment system before and after arrest, adjudication, and conviction. Such education and training programs should be offered to audiences working in both the criminal justice and mental health systems, including judges, attorneys, mental health professionals, and to students and trainees within these disciplines.

[24] Milton L. Mack, Jr., Decriminalization of Mental Illness: Fixing a Broken System, 2016-2017 Policy Paper, COSCA, 8.

[25] Id. at 8.

[26] Id. at 7-8.

[27] Id. at 14.

[28] Id. at 15.

[29] Id.

[30] Id. at 16.

[31] Pre-Arrest and Pre-Booking Diversion and Mental Health in Policing, Right on Crime, Texas Public Policy Research Foundation (2017), 2. http://rightoncrime.com/2017/04/pre-arrest-and-pre-booking-diversion-and-mental-health-in-policing/

[32] Hallie Fader-Towe, Fred C. Osher, Improving Responses to People with Mental Illnesses at the Pretrial Stage, Essential Elements, Justice Center, The Council for State Governments (2015), 11. https://csgjusticecenter.org/wp-content/uploads/2015/09/Improving_Responses_to_People_with_Mental_Illnesses_at_the_Pretrial_Stage_Essential_Elements.pdf

[33] Id. at 12.

[34] Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2015), 7.

[35] Id. Examples of Public Defender Offices employing social work staff: New York City, Shelby County Tennessee, and Travis County, Texas.

[36] Id. at 9.

[37] Id. at 7 and 16.

[38] Id. at 6. See Seattle Municipal Mental Health Court as an example.

[39] National Conference of State Legislatures, Law Enforcement Overview (2018). http://www.ncsl.org/research/civil-and-criminal-justice/law-enforcement.aspx **[**https://perma.cc/K4M4-4K9J].

[40] National Conference of State Legislatures, State Trends in Law Enforcement Legislation: 2014-2017 (2018) http://www.ncsl.org/research/civil-and-criminal-justice/state-trends-in-law-enforcement-legislation-2014-2017.aspx

[41] Id.

[42] National Conference of State Legislatures, Population Specific Diversion (2017) http://www.ncsl.org/documents/cj/pretrial/Population_Specific_Diversion_Chart.pdf [https://perma.cc/WJR6-WTNT].

[43] National Conference of State Legislatures, Pretrial Diversion (2017). States with statutorily authorized mental health specialty courts: Oregon, Idaho, Montana, Arizona, Nebraska, Oklahoma, Louisiana, Texas, Arkansas, Kentucky, Illinois, Michigan, Pennsylvania, South Carolina, Georgia, Florida, New Hampshire and Maine. States with statutorily created diversion programs for mentally ill: California, Nevada, Mississippi, and Connecticut. http://www.ncsl.org/research/civil-and-criminal-justice/pretrial-diversion.aspx **[**https://perma.cc/GMC9-HZZM]

[44] Id.

[45] https://www.omh.ny.gov/omhweb/forensic/populations_served.htm

[46] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1810 at sec. 1001.36

[47] Id. at sec. 1370.01

[48] Id. at sec. 4361

[49] Code of Criminal Procedure. Art. 46B.0711. Release on Bail for Class B Misdemeanor. (a) This article applies only to a defendant who is subject to an initial restoration period based on Article 46B.071. (b) Subject to conditions reasonably related to ensuring public safety and the effectiveness of the defendant's treatment, if the court determines that a defendant charged with an offense punishable as a Class B misdemeanor and found incompetent to stand trial is not a danger to others and may be safely treated on an outpatient basis with the specific objective of attaining competency to stand trial, and an appropriate outpatient competency restoration program is available for the defendant, the court shall: (1) release the defendant on bail or continue the defendant's release on bail; and (2) order the defendant to participate in an outpatient competency restoration program for a period not to exceed 60 days.

[50] Code of Criminal Procedure. Art. 16.22. Early Identification of Defendant Suspected Of Having Mental Illness Or Intellectual Disability. (a)(1) Not later than 12 hours after the sheriff or municipal jailer having custody of a defendant for an offense punishable as a Class B misdemeanor or any higher category of offense receives credible information that may establish reasonable cause to believe that the defendant

has a mental illness or is a person with an intellectual disability, the sheriff or municipal jailer shall provide written or electronic notice to the magistrate. The notice must include any information related to the sheriff's or municipal jailer's determination, such as information regarding the defendant's behavior immediately before, during, and after the defendant's arrest and, if applicable, the results of any previous assessment of the defendant. On a determination that there is reasonable cause to believe that the defendant has a mental illness or is a person with an intellectual disability, the magistrate, except as provided by Subdivision (2), shall order the service provider that contracts with the jail to provide mental health or intellectual and developmental disability services, the local mental health authority, the local intellectual and developmental disability authority, or another qualified mental health or intellectual and developmental disability expert to: (A) interview the defendant if the defendant has not previously been interviewed by a qualified mental health or intellectual and developmental disability expert on or after the date the defendant was arrested for the offense for which the defendant is in custody and otherwise collect information regarding whether the defendant has a mental illness as defined by Section 571.003, Health CODE OF CRIMINAL PROCEDURE Statute text rendered on: 11/20/2019 - 207 - and Safety Code, or is a person with an intellectual disability as defined by Section 591.003, Health and Safety Code, including, if applicable, information obtained from any previous assessment of the defendant and information regarding any previously recommended treatment or service; and (B) provide to the magistrate a written report of an interview described by Paragraph (A) and the other information collected under that paragraph on the form approved by the Texas Correctional Office on Offenders with Medical or Mental Impairments under Section 614.0032(c), Health and Safety Code.

[51] Code of Criminal Procedure. Art. 16.23. Diversion Of Persons Suffering Mental Health Crisis Or Substance Abuse Issue. (a) Each law enforcement agency shall make a good faith effort to divert a person suffering a mental health crisis or suffering from the effects of substance abuse to a proper treatment center in the agency's jurisdiction if: (1) there is an available and appropriate treatment center in the agency's jurisdiction to which the agency may divert the person; (2) it is reasonable to divert the person; (3) the offense that the person is accused of is a misdemeanor, other than a misdemeanor involving violence; and (4) the mental health crisis or substance abuse issue is suspected to be the reason the person committed the alleged offense.

[52] *IC 11-12-3.7-11 Eligibility for pre-conviction forensic diversion; advisements; stay of entry of judgment; consequences of successful completion or failure*

Sec. 11. (a) A person is eligible to participate in a pre-conviction forensic diversion program only if the person meets the following criteria:

(1) The person has an intellectual disability, a developmental disability, an autism spectrum disorder, a mental illness, an addictive disorder, or a combination of those conditions.

(2) The person has been charged with an offense that is:

(A) not a violent offense; and

(B) a Class A, B, or C misdemeanor, or a Level 6 felony that may be reduced to a Class A misdemeanor in accordance with IC 35-50-2-7.

[53] https://www.cga.ct.gov/current/pub/chap_960.htm#sec_54-56l

[54] https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA133-SB-58

[55] Law Enforcement Assisted Diversion Honolulu 1-Year Program Evaluation Report, October 1, 2019. https://fc0ddd6f-b0d2-462d-bfa5-465a5095a9d6.filesusr.com/ugd/4dce6e_7be4ac03835f4026898d961645d7ba5f.pdf

[56] HRS § 704-404(1): Examination of defendant with respect to physical or mental disease, disorder, or defect excluding fitness to proceed. (1) Whenever there is reason to doubt the defendant's fitness to proceed, the court may immediately suspend all further proceedings in the prosecution; provided that for any defendant not subject to an order of commitment to a hospital for the purpose of the examination, neither the right to bail nor proceedings pursuant to chapter 804 shall be suspended. If a trial jury has been empaneled, it shall be discharged or retained at the discretion of the court. The discharge of the trial jury shall not be a bar to further prosecution.

[57] HRS § 704-404(2); § 704-407.5(2)

[58] HRS § 704-404(2)

[59] HRS § 704-407.5(1)

[60] HRS § 707-404(2)

[61] HRS § 704-405 Determination of fitness to proceed. When the defendant's fitness to proceed is drawn in question, the issue shall be determined by the court. If neither the prosecuting attorney nor counsel for the defendant contests the finding of the report filed pursuant to section 704-404, the court may make the determination on the basis of such report. If the finding is contested, the court shall hold a hearing on the issue. When the report is received in evidence upon such hearing, the party who contests the finding thereof shall have the right to summon and to cross-examine the persons who joined in the report or assisted in the examination and to offer evidence upon the issue.

[62] HRS § 704-406 Effect of finding of unfitness to proceed and regained fitness to proceed. (1) If the court determines that the defendant lacks fitness to proceed, the proceeding against the defendant shall be suspended, except as provided in section 704-407, and the court shall commit the defendant to the custody of the director of health to be placed in an appropriate institution for detention, care, and treatment; provided that the commitment shall be limited in certain cases as follows:

> (a) When the defendant is charged with a petty misdemeanor not involving violence or attempted violence, the commitment shall be limited to no longer than sixty days from the date the court determines the defendant lacks fitness to proceed; and
>
> (b) When the defendant is charged with a misdemeanor not involving violence or attempted violence, the commitment shall be limited to no longer than one hundred twenty days from the date the court determines the defendant lacks fitness to proceed.

If the court is satisfied that the defendant may be released on conditions without danger to the defendant or to another or risk of substantial danger to property of others, the court shall order the defendant's release, which shall continue at the discretion of the court, on conditions the court determines necessary; provided that the release on conditions of a defendant charged with a petty misdemeanor not involving violence or attempted violence shall continue for no longer than sixty days, and the release on conditions of a defendant charged with a misdemeanor not involving violence or attempted violence shall continue for no longer than one hundred twenty days.

[63] HRS § 704-407(7)

[64] HRS § 704-406(1)

[65] See HRS § 704-406(8)

[66] HRS § 704-406(2)

[67] HRS § 704-406(3): When the court, on its own motion or upon the application of the director of health, the prosecuting attorney, or the defendant, has reason to believe that the defendant has regained fitness to proceed, for a defendant charged with the offense of murder in the first or second degree, attempted murder in the first or second degree, or a class A felony, the court shall appoint three qualified examiners and may appoint in all other cases one qualified examiner, to examine and report upon the physical and mental condition of the defendant. In cases in which the defendant has been charged with murder in the first or second degree, attempted murder in the first or second degree, or a class A felony, the court shall appoint as examiners at least one psychiatrist and at least one licensed psychologist. The third examiner may be a psychiatrist, licensed psychologist, or qualified physician. One of the three examiners shall be a psychiatrist or licensed psychologist designated by the director of health from within the department of health. In all other cases, the one qualified examiner shall be a psychiatrist or licensed psychologist designated by the director of health from within the department of health. The court, in appropriate circumstances, may appoint an additional examiner or examiners. All examiners shall be appointed from a list of certified examiners as determined by the department of health. After a hearing, if a hearing is requested, if the court determines that the defendant has regained fitness to proceed, the penal proceeding shall be resumed and the defendant shall no longer be committed to the custody of the director of health. In cases where a defendant is charged with the offense of murder in the first or second degree, attempted murder in the first or second degree, or a class A felony, upon the request of the prosecuting attorney or the defendant, and in consideration of information provided by the defendant's clinical team, the court may order that the defendant remain in the custody of the director of health, for good cause shown, subject to bail or until a judgment on the verdict or a finding of guilt after a plea of guilty or nolo contendere. Thereafter, the court may consider a request from the director of health to rescind its order maintaining the defendant in the director's custody, for good cause shown. As used in this section, the term "qualified physician" means a physician qualified by the court for the specific evaluation ordered. If, however, the court is of the view that so much time has elapsed since the commitment or release on conditions of the defendant that it would be unjust to resume the proceeding, the court may dismiss the charge and:

(a) Order the defendant to be discharged;

(b) Subject to section 334-60.2 regarding involuntary hospitalization criteria, order the defendant to be committed to the custody of the director of health to be placed in an appropriate institution for detention, care, and treatment; or

(c) Subject to section 334-121 regarding assisted community treatment criteria, order the defendant to be released on conditions the court determines necessary.

[68] See HRS § 704-406(3)

[69] HRS § 704-407.5 Examination of defendant with respect to physical or mental disease, disorder, or defect excluding penal responsibility. (1) Whenever the defendant has filed a notice of intention to rely

on the defense of physical or mental disease, disorder, or defect excluding penal responsibility, or there is reason to believe that the physical or mental disease, disorder, or defect of the defendant will or has become an issue in the case, the court may order an examination as to the defendant's physical or mental disease, disorder, or defect at the time of the conduct alleged.

(2) The court shall appoint three qualified examiners in felony cases and one qualified examiner in nonfelony cases to examine and report upon the physical or mental disease, disorder, or defect of the defendant at the time of the conduct. In felony cases, the court shall appoint at least one psychiatrist and at least one licensed psychologist. The third examiner may be a psychiatrist, licensed psychologist, or qualified physician. One of the three examiners shall be a psychiatrist or licensed psychologist designated by the director of health from within the department of health. In nonfelony cases, the court may appoint as examiners either a psychiatrist or a licensed psychologist. All examiners shall be appointed from a list of certified examiners as determined by the department of health. The court, in appropriate circumstances, may appoint an additional examiner or examiners. The court may direct that one or more qualified physicians or psychologists retained by the defendant be permitted to witness the examination. As used in this section, the term "licensed psychologist" includes psychologists exempted from licensure by section 465-3(a)(3) and "qualified physician" means a physician qualified by the court for the specific evaluation ordered.

(3) An examination performed under this section may employ any method that is accepted by the professions of medicine or psychology for the examination of those alleged to be affected by a physical or mental disease, disorder, or defect; provided that each examiner shall form and render diagnoses and opinions upon the physical and mental condition of the defendant independently from the other examiners, and the examiners, upon approval of the court, may secure the services of clinical psychologists and other medical or paramedical specialists to assist in the examination and diagnosis.

(4) For defendants charged with felonies, the examinations for fitness to proceed under section 704-404 and penal responsibility under this section shall be conducted separately unless a combined examination has been ordered by the court upon a request by the defendant or upon a showing of good cause to combine the examinations. When the examinations are separate, the examination for penal responsibility under this section shall not be ordered more than thirty days after a finding of fitness to proceed. The report of the examination for fitness to proceed shall be separate from the report of the examination for penal responsibility unless a combined examination has been ordered. For defendants charged with offenses other than felonies, a combined examination is permissible when ordered by the court.

(5) The court may order the examination to occur no sooner than one hundred twenty days of a finding of unfit to proceed under section 704-404 upon a showing of good cause.

(6) The report of the examination for penal responsibility shall include the following:

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

(b) A diagnosis of the physical or mental condition of the defendant;

(c) An opinion as to the extent, if any, to which the capacity of the defendant to appreciate the wrongfulness of the defendant's conduct or to conform the defendant's conduct to the requirements of law was impaired at the time of the conduct alleged;

(d) When directed by the court, an opinion as to the capacity of the defendant to have a particular state of mind that is required to establish an element of the offense charged; and

(e) Where more than one examiner is appointed, a statement that the diagnosis and opinion rendered were arrived at independently of any other examiner, unless there is a showing to the court of a clear need for communication between or among the examiners for clarification. A description of the communication shall be included in the report. After all reports are submitted to the court, examiners may confer without restriction.

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

(8) Three copies of the report of the examination, including any supporting documents, 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.

(9) Any examiner shall be permitted to make a separate explanation reasonably serving to clarify the examiner's diagnosis or opinion.

(10) The court shall obtain all existing relevant medical, mental health, social, police, and juvenile records, including those expunged, and other pertinent records in the custody of public agencies, notwithstanding any other statute, and make the records available for inspection by the examiners in hard copy or digital format. The court may order that the records so obtained be made available to the prosecuting attorney and counsel for the defendant in either format, subject to conditions the court determines appropriate; provided that juvenile records shall not be made available unless constitutionally required. No further disclosure of records shall be made except as permitted by law.

(11) All public agencies in possession of relevant medical, mental health, social, police, and juvenile records, and any other pertinent records of a defendant ordered to be examined under this chapter, shall provide those records to the court, notwithstanding any other state statute.

(12) The compensation of persons making or assisting in the examination, other than those retained by a nonindigent defendant, who are not undertaking the examination upon designation by the director of health as part of their normal duties as employees of the State or a county, shall be paid by the State.

(13) The time during which completion of an examination pursuant to this section is pending shall be excluded in computing the time for trial commencement.

[70] HRS § 704-408 Determination of irresponsibility. If the report of the examiners filed pursuant to section 704-404, or the report of examiners of the defendant's choice under section 704-409, states that the defendant at the time of the conduct alleged was affected by a physical or mental disease, disorder, or defect that substantially impaired the defendant's capacity to appreciate the wrongfulness of the defendant's conduct or to conform the defendant's conduct to the requirements of law, the court shall submit the defense of physical or mental disease, disorder, or defect to the jury or the trier of fact at the trial of the charge against the defendant.

[71] HRS § 704-411 Legal effect of acquittal on the ground of physical or mental disease, disorder, or defect excluding responsibility; commitment; conditional release; discharge; procedure for separate post-acquittal hearing. (1) When a defendant is acquitted on the ground of physical or mental disease,

disorder, or defect excluding responsibility, the court, on the basis of the report made pursuant to section 704-404, if uncontested, or the medical or psychological evidence given at the trial or at a separate hearing, shall order that:

(a) The defendant shall be committed to the custody of the director of health to be placed in an appropriate institution for custody, care, and treatment if the court finds that the defendant:

(i) Is affected by a physical or mental disease, disorder, or defect;

(ii) Presents a risk of danger to self or others; and

(iii) Is not a proper subject for conditional release;

provided that the director of health shall place defendants charged with misdemeanors or felonies not involving violence or attempted violence in the least restrictive environment appropriate in light of the defendant's treatment needs and the need to prevent harm to the person confined and others. The county police departments shall provide to the director of health and the defendant copies of all police reports from cases filed against the defendant that have been adjudicated by the acceptance of a plea of guilty or nolo contendere, a finding of guilt, acquittal, acquittal pursuant to section 704-400, or by the entry of a plea of guilty or nolo contendere made pursuant to chapter 853; provided that the disclosure to the director of health and the defendant does not frustrate a legitimate function of the county police departments; provided further that expunged records, records of or pertaining to any adjudication or disposition rendered in the case of a juvenile, or records containing data from the United States National Crime Information Center shall not be provided. The county police departments shall segregate or sanitize from the police reports information that would result in the likelihood or actual identification of individuals who furnished information in connection with the investigation or who were of investigatory interest. Records shall not be re-disclosed except to the extent permitted by law;

(b) The defendant shall be granted conditional release with conditions as the court deems necessary if the court finds that the defendant is affected by physical or mental disease, disorder, or defect and that the defendant presents a danger to self or others, but that the defendant can be controlled adequately and given proper care, supervision, and treatment if the defendant is released on condition; or

(c) The defendant shall be discharged if the court finds that the defendant is no longer affected by physical or mental disease, disorder, or defect or, if so affected, that the defendant no longer presents a danger to self or others and is not in need of care, supervision, or treatment.

(2) The court, upon its own motion or on the motion of the prosecuting attorney or the defendant, shall order a separate post-acquittal hearing for the purpose of taking evidence on the issue of physical or mental disease, disorder, or defect and the risk of danger that the defendant presents to self or others.

(3) When ordering a hearing pursuant to subsection (2):

(a) In nonfelony cases, the court shall appoint a qualified examiner to examine and report upon the physical and mental condition of the defendant. The court may appoint either a

psychiatrist or a licensed psychologist. The examiner may be designated by the director of health from within the department of health. The examiner shall be appointed from a list of certified examiners as determined by the department of health. The court, in appropriate circumstances, may appoint an additional examiner or examiners; and

(b) In felony cases, the court shall appoint three qualified examiners to examine and report upon the physical and mental condition of the defendant. In each case, the court shall appoint at least one psychiatrist and at least one licensed psychologist. The third member may be a psychiatrist, a licensed psychologist, or a qualified physician. One of the three shall be a psychiatrist or licensed psychologist designated by the director of health from within the department of health. The three examiners shall be appointed from a list of certified examiners as determined by the department of health.

To facilitate the examination and the proceedings thereon, the court may cause the defendant, if not then confined, to be committed to a hospital or other suitable facility for the purpose of examination for a period not exceeding thirty days or a longer period as the court determines to be necessary for the purpose upon written findings for good cause shown. The court may direct that qualified physicians or psychologists retained by the defendant be permitted to witness the examination. The examination and report and the compensation of persons making or assisting in the examination shall be in accordance with section 704-404(3), (5)(a) and (b), (7), (8), (9), (10), and (11). As used in this section, the term "licensed psychologist" includes psychologists exempted from licensure by section 465-3(a)(3) and "qualified physician" means a physician qualified by the court for the specific evaluation ordered.

(4) Whether the court's order under subsection (1) is made on the basis of the medical or psychological evidence given at the trial, or on the basis of the report made pursuant to section 704-404, or the medical or psychological evidence given at a separate hearing, the burden shall be upon the State to prove, by a preponderance of the evidence, that the defendant is affected by a physical or mental disease, disorder, or defect and may not safely be discharged and that the defendant should be either committed or conditionally released as provided in subsection (1).

(5) In any proceeding governed by this section, the defendant's fitness shall not be an issue.

[72] https://www.nasmhpd.org/sites/default/files/TACPaper5_ComprehensiveCrisisSystem_508C.pdf