Department of Mental Health & Substance Abuse Services

Forensic and Juvenile Court Services Annual Report for the Period July 1, 2024-June 30, 2025 (FY 25)

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Tennessee Code Annotated
Selected Forensic Evaluation and Treatment Statutes

T.C.A. § 33-7-301(a): pre-trial evaluation of a criminal defendant's competency to stand trial and/or mental capacity at the time of the offense; conducted first on an outpatient basis and may be referred for inpatient evaluation and treatment by the outpatient evaluator

T.C.A. § 33-7-301(b): indefinite commitment of pre-trial defendant following inpatient evaluation conducted under T.C.A. § 33-7-301(a); commitment standards are under **Title 33, Chapter 6, Part 5**

T.C.A. § 33-7-303(a): evaluation of a person found Not Guilty by Reason of Insanity (NGRI) to determine if the person meets commitment criteria under **Title 33, Chapter 6, Part 5;** evaluation conducted on an outpatient basis on cases after July 1, 2009

T.C.A. § 33-7-303(b): court-ordered Mandatory Outpatient Treatment for a defendant found NGRI who does not meet commitment criteria when evaluated under T.C.A. § 33-7-303(a) but whose condition resulting from mental illness is likely to deteriorate rapidly to the point that the person would pose a substantial likelihood of serious harm under **§ 33-6-501** unless treatment is continued

T.C.A. § 33-7-303(c): indefinite commitment of a person found NGRI following evaluation under T.C.A. § 33-7-303(a); commitment standards are under **Title 33, Chapter 6, Part 5**

T.C.A. § 33-6-602: defines criteria for Mandatory Outpatient Treatment for patients being discharged to the community after having been committed to an RMHI under Title 33, Chapter 6, Part 5

T.C.A. § 37-1-128(e): juvenile court-ordered evaluation on person alleged to be delinquent in juvenile court; evaluation conducted on an outpatient basis

Executive Summary Annual Forensic Report FY 25

- A post-pandemic increase in orders for forensic services continued in Fiscal Year 2025 (FY 25). The ten-year pre-pandemic average for outpatient orders per fiscal year (FY 11-FY 20) was 1,993. The average for the years FY 22-FY 25 is 2,493. There were 2,744 evaluations in FY 25.
- The total of 843 inpatient evaluations in FY 25 was the highest since data have been collected as facilities worked down referral lists and responded to increased demand.
- The frequency of outpatient misdemeanor evaluations increased from 21% in FY 24 to 26% in FY 25 while the frequency of inpatient misdemeanor evaluations for facilities other than MMHI increased from 12% (n=66) in FY 24 to 26% (n=168) in FY 25.
- The statutory requirement for an outpatient evaluation to recommend an inpatient evaluation before a defendant is admitted to a Regional Mental Health Institute resulted in 62% of that population being diverted from the need for an inpatient evaluation in FY 25. The rate of referral for inpatient evaluations crept up to 38%.
- Of the 843 inpatient evaluations, 20% resulted in recommendations for commitment for further inpatient evaluation and treatment. That is a rate of only 6% of the original pool of 2,744 total outpatient evaluations resulting in a recommendation for long-term commitment for inpatient evaluation and treatment.
- Even more dramatic was the increased demand for juvenile court-ordered evaluations under §37-1-128(e), due to the increase in cases of youth charged with Threatening Mass Destruction and concern about the risk of school shootings. There were 658 evaluations in FY 25, up from 540 evaluations in FY 24 and 397 in FY 23.
- Mandatory Outpatient Treatment (MOT) continues to be a suitable less drastic alternative to hospitalization. There were 271 patients on MOT at the close of FY 25, and only 7% were subject to non-compliance proceedings during FY 25 and 7% hospitalized at the end of the fiscal year for various reasons.
- The number of patients on census at the end of FY 25 who had been found not guilty by reason of insanity (86) was the largest number since FY 08.

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Overview of Forensic Services in the Department of Mental Health and Substance Abuse Services

The core of forensic mental health services in Tennessee, as in virtually all states, is based on providing evaluations to the courts on criminal defendants' competence to stand trial and the insanity defense. It was formally determined to be unconstitutional to try a mentally incompetent defendant by the United States Supreme Court in Yousey v. U.S. decision in 1899 (97 F. 937, 940-41). Therefore, in order to insure that incompetent defendants are not tried, and that convictions are not later overturned because an incompetent defendant was tried, courts traditionally look to the state mental health authority, such as the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), to provide competency evaluations and treatment and training for incompetent defendants. Tennessee also has a statutory provision for the insanity defense, so evaluation orders from the courts typically include both of these questions. The Office of Forensic and Juvenile Court Services in the TDMHSAS has adopted the "expert consultation" model, in which experts with specialized knowledge in the field of mental health and substance abuse provide consultation to courts on these issues to assist the courts in the legal process. TDMHSAS experts do not take a position on the ultimate legal question of guilt or innocence.

State law (T.C.A. § 33-7-301) requires that evaluations be conducted on an outpatient basis by an evaluator designated by the commissioner. Inpatient evaluations are conducted if and only if the outpatient evaluator recommends inpatient evaluation and treatment, so around two thirds to three quarters of all evaluations are conducted in the community without the need for an inpatient evaluation. Tennessee's forensic mental health system also includes providing comprehensive evaluations when ordered by juvenile courts on youth alleged to be delinquent or unruly.

The Office of Forensic and Juvenile Court Services has established standards for evaluation and treatment services intended to maximize the quality of services provided in a cost-effective manner. Services are reviewed on a case-by-case basis for reimbursement to be authorized, and an annual monitoring review is conducted on selected contracted agencies and all state hospitals.

Special projects currently underway in forensic services include a contract with the Board of Paroles to provide the Board with psychiatric evaluations and risk assessments for parole-eligible inmates, and a project to train youth service officers in juvenile courts to complete mental health and substance abuse screening, the Tennessee Integrated Court Screening and Referral Project. The

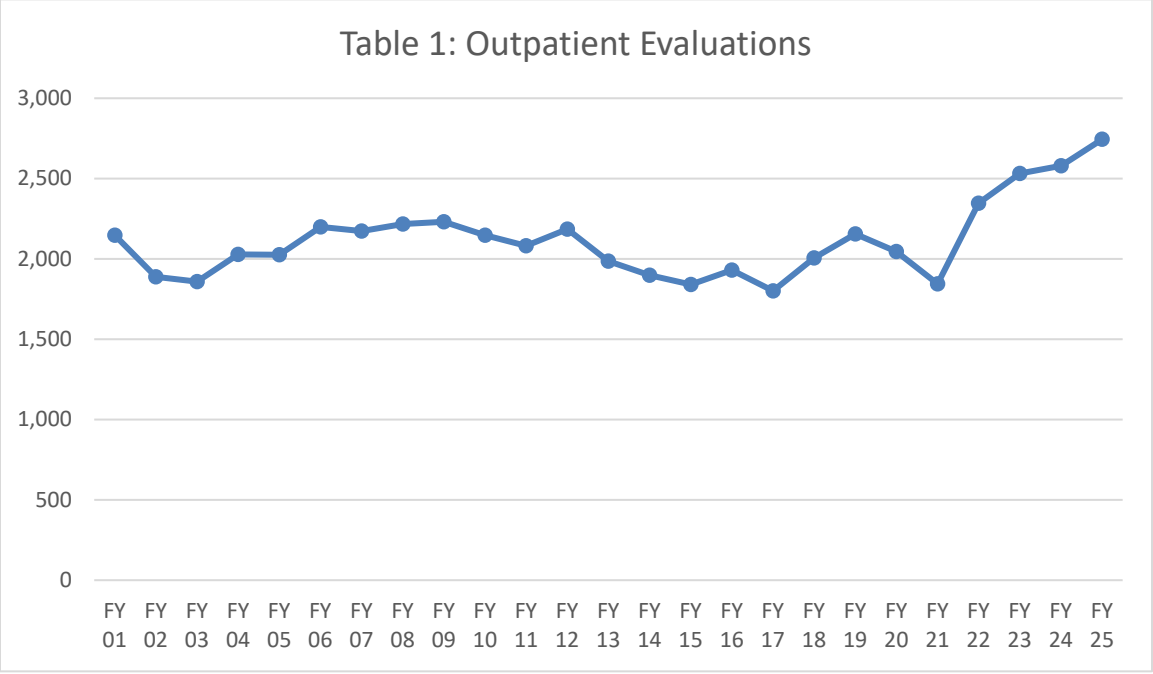
juvenile court screening project is a partnership with the Administrative Office of the Courts and a contract with the Vanderbilt University Center of Excellence for Children in State Custody.

Court-ordered forensic mental health evaluation and treatment are not considered medically necessary procedures which are paid for by public or private insurance like an intake assessment at a mental health clinic or doctor's office. Forensic services are funded directly by the state budget with few exceptions, such as payment for medically appropriate treatment services of persons found Not Guilty by Reason of Insanity who are released to the community, and for subsequent medically necessary hospitalizations. The expenditures for forensic services run between $15 and $30 million annually, including the *per diem* hospital reimbursement for forensic inpatients.

The TDMHSAS has adopted policies which promote the provision of forensic mental health services of the highest quality in the most cost-efficient manner. The emphasis is on using less costly and more clinically appropriate outpatient and lower security inpatient services and using inpatient services only when clinically necessary and maximum security only when necessary for security. To accomplish this, it is necessary to monitor the frequency and outcome of forensic mental health services provided by the TDMHSAS. This report summarizes the services provided in Fiscal Year 2025, from July 1, 2024, to June 30, 2025, along with the trends over previous years.

Outpatient Evaluations and Services for Pre-Trial Defendants

T.C.A. § 33-7-301(a) directs that court-ordered evaluation of a criminal defendant's competence to stand trial and/or mental capacity at the time of the offense be conducted by a community mental health agency or private practitioner designated by the Commissioner of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) on an outpatient basis, whether that's face-to-face in a jail, at the agency's office, or via videoconference. The TDMHSAS therefore has contracts with nine different providers across the state to cover all jurisdictions; each court has an assigned outpatient forensic mental health evaluation provider. The TDMHSAS Office of Forensic and Juvenile Court Services provides training, certification, and ongoing technical assistance to professionals designated at each provider to conduct forensic mental health evaluations and associated services. In Fiscal Year 2025 (July 1, 2024-June 30, 2025, hereafter FY 25), 2,744 outpatient evaluation cases were entered in the Grantee Billing database, above the average of 2,085 for the previous 23 years and the most in a single year. The table below shows an apparent post-pandemic increase.



The number of evaluations completed in FY 21 (1,844) was one of the lowest totals over the previous 20 years. In the 19-year period between July 1, 2000, and June 30, 2019 (FY01-FY19), the average was 2,042 evaluations per year. In the four-year post-pandemic period July 1, 2021-June 30, 2025 (FY22-FY25) the average was 2,550, an unprecedented 25% increase. The post-pandemic increased demand for health care services in general appears to be reflected in court-ordered forensic mental health evaluations.

As described above, TDMHSAS has contracts with community providers to cover all the courts for outpatient forensic services. There has been some re-distribution of counties among providers since April of 2020 when Centerstone declined to renew their contract for FY 21 upon the retirement of John Garrison, Psy.D., their long-serving forensic psychologist. Between April and September of 2020 evaluations from courts previously covered by Centerstone were conducted by staff at Western Mental Health Institute, Middle Tennessee Mental Health Institute, and Central Office on an *outpatient* basis (often via videoconference) in accordance with a provision in T.C.A. §33-7-301(a), which says "… if the evaluation cannot be made by the center or the private practitioner, (it shall be done) on an outpatient basis by the state hospital or the state-supported hospital designated by the commissioner to serve the court." Beginning July 1, 2020, Volunteer Behavioral Health Care Systems and Pathways, Inc. expanded their counties to take on some of Centerstone's counties. Then, beginning September 1, 2020, Moore Psychology Services, PLLC (Dr. Donna Moore) picked up the remaining counties. Table 2, below, shows how the counties formerly served by Centerstone were re-distributed.

Table 2: Re-Distribution of former Centerstone Counties

Agency	*Counties*
Volunteer Behavioral Health	Bedford, Coffee, Franklin, Giles, Lincoln, Marshall, Maury, & Moore
Pathways, Inc.	Houston, Humphreys, Perry, Stewart, & Wayne
Moore Psychology Services	Cheatham, Dickson, Hickman, Lawrence, Lewis, Montgomery, & Robertson

Table 3 shows the distribution of counties among providers during all of FY 25.

Table 3: County Distribution by Outpatient Forensic Services Provider

Agency	*Counties*
Frontier Health	Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington
Cherokee Health System	Blount, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Loudon, Monroe, Sevier, Union
McNabb	Knox
Ridgeview	Anderson, Campbell, Morgan, Roane, Scott
Volunteer Behavioral Health	Bedford, Bledsoe, Bradley, Cannon, Clay, Coffee, Cumberland, Dekalb, Fentress, Franklin, Giles, Grundy, Hamilton, Jackson, Lincoln, Macon, Marian, Marshall, Maury, McMinn, Meigs, Moore, Overton, Pickett, Polk, Putnam, Rhea, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, Wilson
Moore Psychology	Cheatham, Dickson, Hickman, Lawrence, Lewis, Montgomery, Robertson
Vanderbilt	Davidson
Pathways, Inc.	Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Houston, Humphreys, Lake, Lauderdale, Madison, McNairy, Obion, Perry, Stewart, Tipton, Wayne, Weakley
West TN Forensic Services	Shelby

Table 4, below, breaks out the total 2,744 adult outpatient evaluations into frequencies for each provider, displaying the same breakout for the previous 10 fiscal years for comparison. As noted above, the number of counties covered by Volunteer and Pathways expanded in FY 21.

Table 4: Frequency of Outpatient Evaluations by Provider

Provider	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
Centerstone	137	143	128	155	170	162	0	0	0	0	0
Cherokee	90	79	100	104	109	95	87	107	98	108	137
Frontier	111	142	124	130	137	123	114	128	133	165	160
McNabb	73	75	96	88	90	77	77	114	126	139	136
Moore Psych							36	53	50	59	59
Pathways	226	241	233	270	259	241	248	296	312	358	305
Ridgeview	41	50	68	64	66	81	68	71	80	75	81
Vanderbilt	137	155	164	217	267	308	315	449	454	448	468
Volunteer	346	358	314	328	329	314	346	435	516	464	587
WTFS/Midtown	680	687	574	649	729	644	545	694	762	763	811
RMHI-Outpt.	0	0	0	0	0	0	8	0	0	0	0
Total	1,841	1,930	1,801	2,005	2,156	2,045	1,844	2,347	2,531	2,579	2,744

Although the media and the general public often associate forensic evaluations with murder cases, these evaluations are ordered by courts on the full range of types of offense. At the beginning of FY 10 (July 1, 2009), T.C.A. § 33-7-304 took effect and the counties became responsible for the cost of misdemeanor forensic evaluation and treatment services ordered under Title 33, Chapter 7, Part 3 including both outpatient and inpatient services; that law has been subsequently repealed effective July 1, 2024. This change in the law which made counties responsible for the costs of evaluations for defendants charged only with a misdemeanor appears to have affected the frequency of those evaluations beginning in FY 10. For Table 5, "capital" refers to a defendant facing the death penalty for first degree murder, "violent felony" refers to a defendant charged with a

violent felony other than a sex offense, "sex offense" refers to a defendant charged with any felony sex offense, which is not duplicated in the "violent felony" category, and "misdemeanor" refers to a defendant charged *only* with misdemeanors. (Reminder: as noted, T.C.A. §33-7-304 was repealed effective July 1, 2024, so that going forward the counties are no longer responsible for the costs of forensic evaluation and treatment for misdemeanor-only case, and the state resumes responsibility for the costs regardless of the nature of the alleged offense.)

Table 5: Outpatient Evaluations by Type of Offense

	Capital	Violent Felony	Sex Offense	Non-Violent Felony	Misdemeanor
FY 09	0.3%	36%	9%	22%	32%
FY 10	0.6%	36%	9%	28%	27%
FY 11	0.6%	38%	8%	29%	23%
FY 12	0.5%	37%	9%	32%	20%
FY 13	0.3%	40%	8%	31%	19%
FY 14	0.2%	40%	7%	32%	18%
FY 15	0.1%	41%	8%	31%	17%
FY 16	0.1%	44%	8%	28%	19%
FY 17	<0%	44%	9%	29%	16%
FY 18	<0%	42%	10%	27%	20%
FY 19	<0%	43%	8%	30%	17%
FY 20	<1%	43%	8%	29%	17%
FY 21	<0%	46%	8%	29%	15%
FY 22	<0%	49%	8%	24%	18%
FY 23	<0%	47%	7%	28%	18%
FY 24	0%	42%	8%	30%	21%
FY 25	<1%	39%	7%	28%	26%

MISDEMEANOR SERVICES:

On June 26, 2009, **T.C.A.§ 33-7-304** (as described above) became law and was in effect until its repeal effective July 1, 2024, making counties responsible for the cost of forensic services ordered

under Part 3 of Title 33, Chapter 7 when the defendant was charged only with misdemeanors; this includes the outpatient forensic evaluations, the supplemental services used to help complete the evaluation on an outpatient basis so that the defendant is not referred for an inpatient evaluation (e.g., additional psychological testing, competency training sessions), inpatient evaluations and treatment, and inpatient commitments of pre-trial defendants and defendants found Not Guilty by Reason of Insanity. Counties were charged the same rate for outpatient services that outpatient evaluators are reimbursed by TDMHSAS (typically $800 per evaluation). Counties were charged an all-inclusive rate of $450 per day for inpatient services. As noted above, that statute (T.C.A.§ 33-7-304) was repealed as of July 1, 2024, and TDMHSAS resumed responsibility for the costs of all forensic evaluation and treatment services on an outpatient and inpatient basis regardless of the nature of the offense. As can be noted in Table 5, above, there was a decline in the proportion of evaluations in which the defendant is charged only with misdemeanors since FY 10. In the six years for which data on type of offense is available prior to the new law (FY 04-FY 09), misdemeanor evaluations were consistently 30%-33% of all evaluations. In five years prior to the repeal of T.C.A.§ 33-7-304, misdemeanor evaluations comprised 15%-21% of all outpatient evaluations. The frequency was 26% for FY 25.

Table 6: Outpatient Felony vs. Misdemeanor Trends

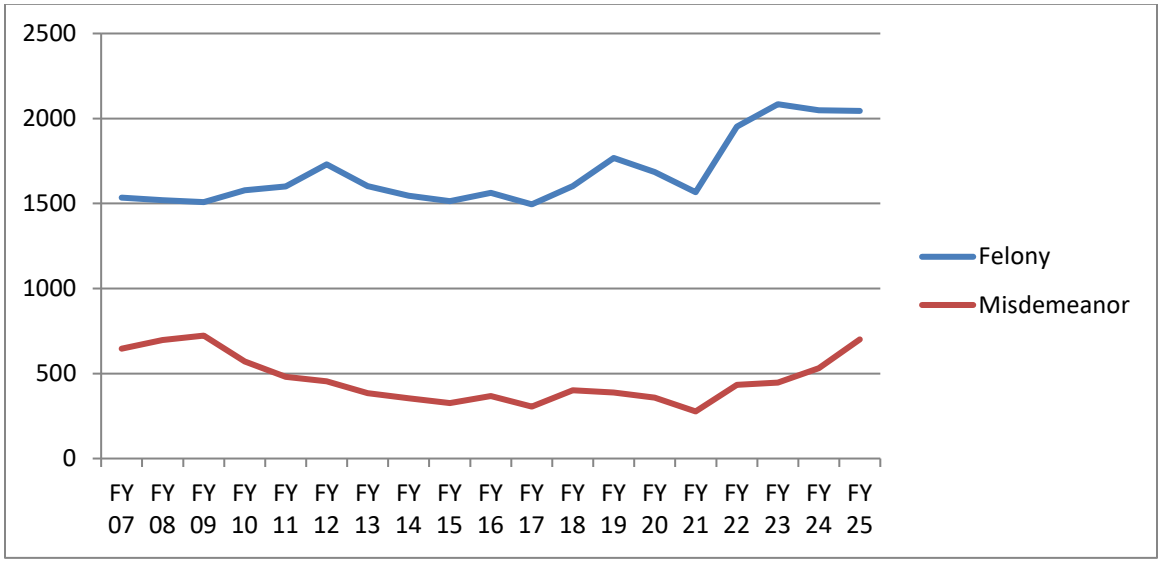


Table 6, above, shows that the frequency of misdemeanor evaluations declined when counties were being billed even when the frequency of other evaluations increased (e.g., FY 12, FY 18). Table 7, below, breaks out the percentage of misdemeanor evaluations for each provider as a proportion of all evaluations conducted by that provider, revealing some local differences in the frequency of misdemeanor evaluations. (Reminder: FY 10 is the first year of the new law.)

Table 7: Frequency of Misdemeanor Outpatient Evaluations

Provider	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17
Centerstone	32%	29%	22%	11%	11%	15%	8%	9%	11%
Cherokee	28%	29%	16%	16%	22%	9%	12%	3%	5%
Frontier	23%	20%	21%	15%	28%	23%	29%	21%	20%
McNabb	33%	36%	34%	27%	3%	20%	31%	26%	31%
Pathways	27%	8%	9%	5%	3%	2%	3%	2%	2%
Ridgeview	41%	25%	30%	22%	16%	17%	14%	20%	14%
Vanderbilt	34%	14%	4%	6%	2%	2%	8%	10%	25%
Volunteer	34%	25%	19%	16%	12%	16%	17%	14%	11%
WTFS	35%	34%	31%	30%	29%	27%	23%	31%	23%
TOTAL	32%	27%	23%	20%	19%	18%	18%	19%	19%

Provider	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
Centerstone	19%	7%	7%	-	-	-	-	-
Cherokee	4%	6%	12%	2%	13%	8%	13%	24%
Frontier	22%	29%	26%	18%	30%	24%	29%	31%
McNabb	22%	26%	18%	33%	27%	25%	27%	23%
Moore	-	-	-	6%	1%	14%	8%	15%
Pathways	3%	<1%	2%	2%	1%	4%	7%	25%
Ridgeview	10%	10%	8%	8%	16%	13%	9%	22%
Vanderbilt	33%	37%	33%	18%	25%	28%	32%	31%
Volunteer	9%	5%	10%	6%	8%	11%	15%	25%
WTFS	30%	24%	21%	25%	24%	21%	24%	24%
TOTAL	20%	17%	17%	15%	18%	18%	21%	26%

OUTCOMES:

Melton, Petrila, Poythress and Slobogin[1] reported that studies on the rates of competency to stand trial have found that defendants receiving a mental health evaluation were considered competent to stand trial an average of 70% of the time which is consistent with the rate of recommendations of trial competence for agencies contracted by the TDMHSAS. Murrie, Gardner, & Torres (2020) studied over 3,600 evaluations conducted in Virginia from 2016-2018 and found a competency rate closer to 60%.[2] These authors noted even lower rates of defendants being found competent in other states (e.g., 45% in Colorado and Alaska). Occasionally, a defendant is clearly incompetent to stand trial and would not benefit from inpatient psychiatric services at an RMHI (e.g., head injury, neurological disease), so the outpatient evaluator formally recommends a defendant be considered incompetent to stand trial without referring the defendant for inpatient evaluation and treatment. Table 8 shows the rates of recommendations from outpatient evaluations on competence to stand trial and the insanity defense.

Table 8: Recommendations of Outpatient Evaluations

	Competence to Stand Trial				Insanity Defense		
Fiscal Year	Competent	Incomp.	Defer		Yes	No	Defer
FY 02	72%	0.2%	28%		0.2%	70%	30%
FY 03	72%	0.1%	27%		3%	71%	26%
FY 04	74%	2%	24%		3%	73%	24%
FY 05	76%	0.2%	22%		3%	75%	21%
FY 06	75%	2%	23%		3%	74%	23%
FY 07	75%	3%	22%		3%	75%	22%
FY 08	74%	3%	24%		3%	72%	25%
FY 09	72%	3%	23%		2%	70%	23%
FY 10	73%	4%	21%		2%	72%	21%
FY 11	72%	3%	24%		2%	73%	23%
FY 12	72%	3%	22%		2%	69%	22%
FY 13	72%	4%	22%		3%	66%	21%
FY 14	71%	4%	23%		3%	66%	23%
FY 15	71%	4%	23%		2%	67%	23%
FY 16	72%	4%	22%		2%	69%	22%

[1] Melton, G.B., Petrila, J., Poythress, N.G., Slobogin, C., Otto, R.K., Mossman, D., & Condie, L.O. (2018) Psychological Evaluations for the Courts, 4th Edition. Guilford Press, NY

[2] Murrie, D. C., Gardner, B.O., & Torres, A.N. (2020) Competency to stand trial evaluations: a statewide review of court-ordered reports. *Behavioral Sciences & the Law, 1-19.*

Fiscal Year	Competent	Incomp.	Defer		Yes	No	Defer
FY 17	68%	5%	25%		2%	65%	26%
FY 18	67%	7%	23%		2%	64%	25%
FY 19	68%	7%	23%		2%	64%	27%
FY 20	64%	9%	26%		2%	62%	29%
FY 21	63%	9%	26%		4%	60%	28%
FY 22	57%	9%	31%		3%	55%	31%
FY 23	58%	8%	33%		4%	55%	33%
FY 24	58%	11%	29%		4%	58%	31%
FY 25	56%	5%	38%		3%	54%	36%

A recommendation on competency to stand trial and/or the insanity defense is typically deferred to the inpatient evaluators when the defendant is referred for further evaluation on an inpatient basis without a formal opinion provided to the court by the outpatient evaluator. Table 8 shows 5% in the column labeled "incompetent" for FY 25, meaning that the outpatient provider specifically recommended to the court that the defendant be considered incompetent, which typically means that the defendant was considered to be incompetent due to intellectual disability, or unrestorably incompetent, due, for instance, to a head injury or dementia and was not referred for inpatient evaluation. (Percentages do not sum to 100% due to a few cases not resulted.) There appears to be a trend of outpatient evaluators deferring opinions and referring the defendant for an inpatient evaluation, consistent with trends noted in other states and suggesting an overall increase in people with active symptoms of mental illness in the pre-trial jail population.

When a defendant clearly appears to be competent to stand trial by the outpatient evaluator and the evidence supporting the insanity defense is also clear, the outpatient evaluator will recommend the defendant be considered competent with support for the insanity defense without referral for an inpatient evaluation (an outcome which does not happen frequently; 2%-4%).

Outpatient evaluators can attempt to divert a defendant from an inpatient referral by seeing the defendant for competency training and are reimbursed for additional sessions. (Providers not listed in Table 9 did not bill for any pre-hospitalization competency training sessions in FY 25.)

Table 9: Outpatient Competency Training

Provider	Total # of cases	# of cases receiving training	# diverted	% of cases receiving training diverted
Cherokee	137	8	6	75%
Frontier	160	22	17	77%
McNabb	136	7	6	86%
VUMC	468	5	5	100%
WTFS	811	116	96	83%
TOTAL FY 25	2,744	158 (6%)	130	82%
TOTAL FY 24	2,579	15 (<1%)	8	53%
TOTAL FY 23	2,531	199 (8%)	151	76%
TOTAL FY 22	2,187	170 (8%)	138	81%
TOTAL FY 21	1,844	99 (5%)	90	91%
TOTAL FY 20	2,045	70 (3%)	61	87%
TOTAL FY 19	2,156	41 (2%)	35	85%
TOTAL FY 18	2,005	54 (3%)	44	81%
TOTAL FY 17	1,801	40 (2%)	36	90%
TOTAL FY 16	1,930	29 (2%)	25	86%
TOTAL FY 15	1,841	49 (3%)	45	92%
TOTAL FY 14	1,899	40 (2%)	35	88%
TOTAL FY 13	1,987	64 (3%)	60	94%
TOTAL FY 12	2,186	83 (4%)	74	89%

T.C.A. § 33-7-301(a) indicates that an inpatient evaluation of competence to stand trial and/or mental capacity at the time of the offense may be ordered "if and only if" the outpatient evaluator recommends an inpatient evaluation. The average rate of referral for all providers from FY 01 through FY 24 was 24%. The average rate for FY 25 was 38%. The pre-pandemic (FY 01- FY19) referral rate = 23% while the rate for FY 22 – FY 25 = 34%.

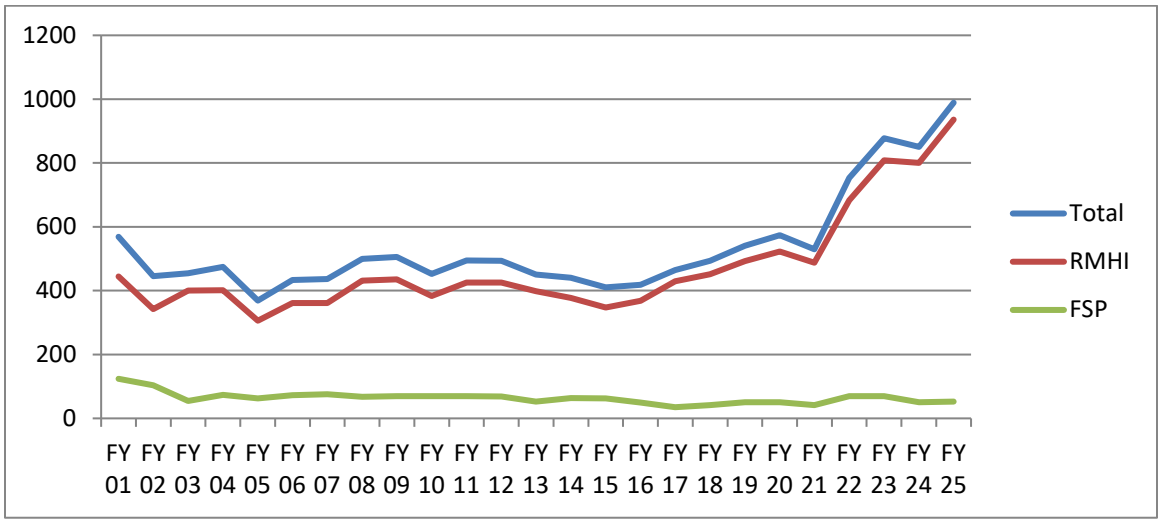
Table 10: Frequency of Inpatient Referral by Provider

(Note: MPsy = Moore Psychology Services; TN=statewide)

	Cent	Cher	Front	McNabb	MPsy	Path	Ridge	VU	Vol	WT	TN
FY 11	21%	13%	11%	22%	-	28%	18%	24%	22%	19%	20%
FY 12	31%	11%	11%	33%	-	21%	29%	33%	31%	17%	24%
FY 13	30%	13%	12%	21%	-	26%	27%	38%	29%	16%	22%
FY 14	32%	8%	8%	37%	-	27%	22%	41%	26%	18%	23%
FY 15	31%	14%	15%	28%	-	25%	19%	38%	22%	15%	21%
FY 16	23%	16%	8%	35%	-	25%	18%	33%	25%	15%	21%
FY 17	36%	12%	12%	45%	-	28%	23%	37%	32%	17%	24%
FY 18	41%	13%	13%	32%	-	16%	18%	28%	30%	20%	24%
FY 19	49%	16%	13%	26%	-	25%	15%	27%	27%	20%	24%
FY 20	39%	15%	17%	27%	-	38%	16%	27%	33%	22%	27%
FY 21	-	8%	10%	22%	44%	35%	34%	37%	30%	23%	27%
FY 22	-	14%	14%	40%	29%	33%	29%	29%	35%	32%	30%
FY 23	-	15%	10%	40%	19%	40%	30%	45%	36%	34%	35%
FY 24	-	14%	13%	36%	24%	35%	33%	45%	37%	30%	33%
FY 25	-	12%	16%	45%	52%	38%	41%	51%	47%	30%	38%

When an outpatient evaluator makes a recommendation for a referral for an inpatient evaluation, the evaluator also indicates when the referral should be to the maximum-security Forensic Services Program (FSP) or the Regional Mental Health Institute (RMHI) serving the area. FSP referrals are made when there is a risk of escape (the defendant has a history of attempted escape or faces such a long prison sentence if convicted that he might attempt to escape) or a risk of violence beyond what the RMHIs can safely manage (based primarily on the defendant's behavior in jail, particularly the use of property in jail as a weapon). The rate of referral has typically run approximately 90% to the RMHIs and 10% to FSP. In FY 25, the number and frequency of inpatient referrals increased, yet the proportion of referrals to FSP was down to 5%.

Table 11: Trends in Inpatient Referrals to RMHIs and FSP



Even as the number of referrals for inpatient evaluation has increased significantly post-pandemic, the statutory requirement that an outpatient evaluation be conducted prior to an inpatient evaluation, and the requirement that an inpatient evaluation can only be ordered when the outpatient evaluator recommends an inpatient evaluation is an effective means for preventing unnecessary forensic admissions and preserving scarce inpatient resources for persons most in need.

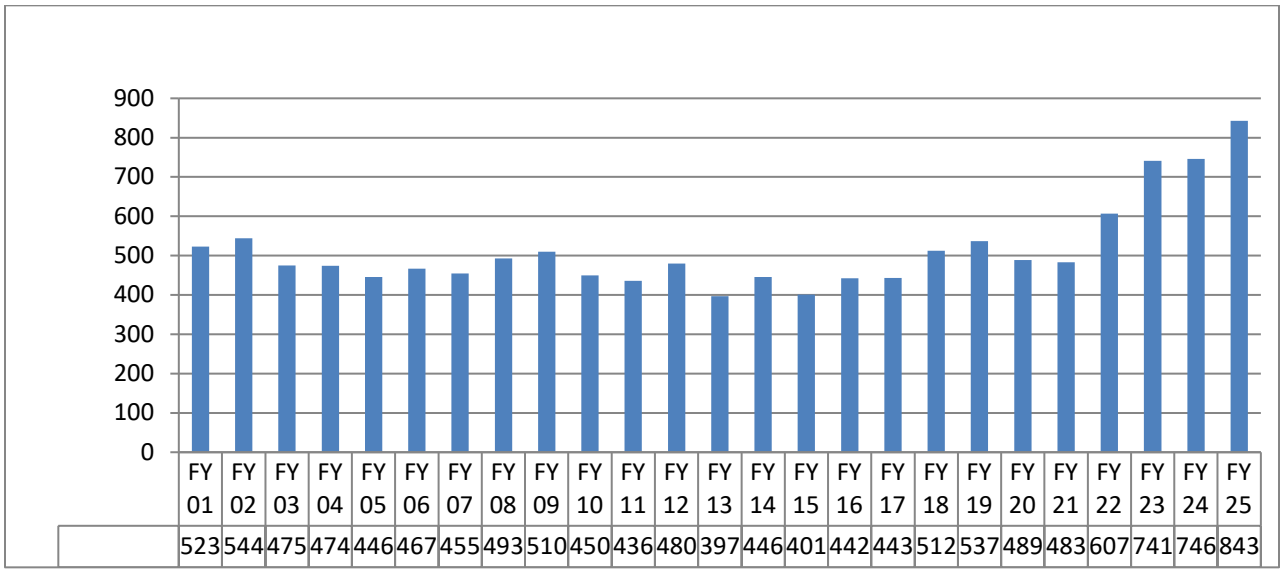
Inpatient Evaluations and Treatment Services for Pre-Trial Defendants

As previously noted, defendants may be referred for inpatient evaluation and treatment under T.C.A. § 33-7-301(a) by the outpatient evaluator to one of the Regional Mental Health Institutes (RMHIs) or the Forensic Services Program (FSP) for cases requiring maximum security. An informal poll of outpatient evaluators indicates that the primary reason for inpatient referral is the need for inpatient psychiatric treatment (i.e., the defendant is showing symptoms of psychosis rendering him incompetent to stand trial and can only be treated in an inpatient setting). The second most common reason for inpatient referral is that the outpatient evaluator suspects the

defendant may be malingering, that is, faking symptoms of mental illness or intellectual disability or exaggerating symptoms/impairments he has or has had in the past for the purpose of avoiding prosecution. Inpatient evaluations allow for the defendant to be observed by staff virtually around the clock in a variety of activities. Malingering defendants typically present quite differently during formal interviews for the evaluation as compared to interaction with staff and other patients outside the interview room. When an outpatient evaluator recommends an inpatient evaluation to the court, conclusions about the issues requested in the court order (competence to stand trial and/or mental capacity at the time of the offense) are deferred to the inpatient evaluators and the outpatient evaluator simply recommends "further evaluation and treatment on an inpatient basis," which is the language in the statute.

Not all referrals result in an inpatient admission. Charges may be dismissed or retired on some defendants. Defendants are admitted only if the court issues an order for inpatient admission based on the recommendations of the TDMHSAS designated outpatient evaluator. Defendants who are admitted for inpatient evaluation and treatment under T.C.A. § 33-7-301(a) may be hospitalized for a maximum of 30 days.

Table 12: Inpatient Admissions under T.C.A. § 33-7-301(a)

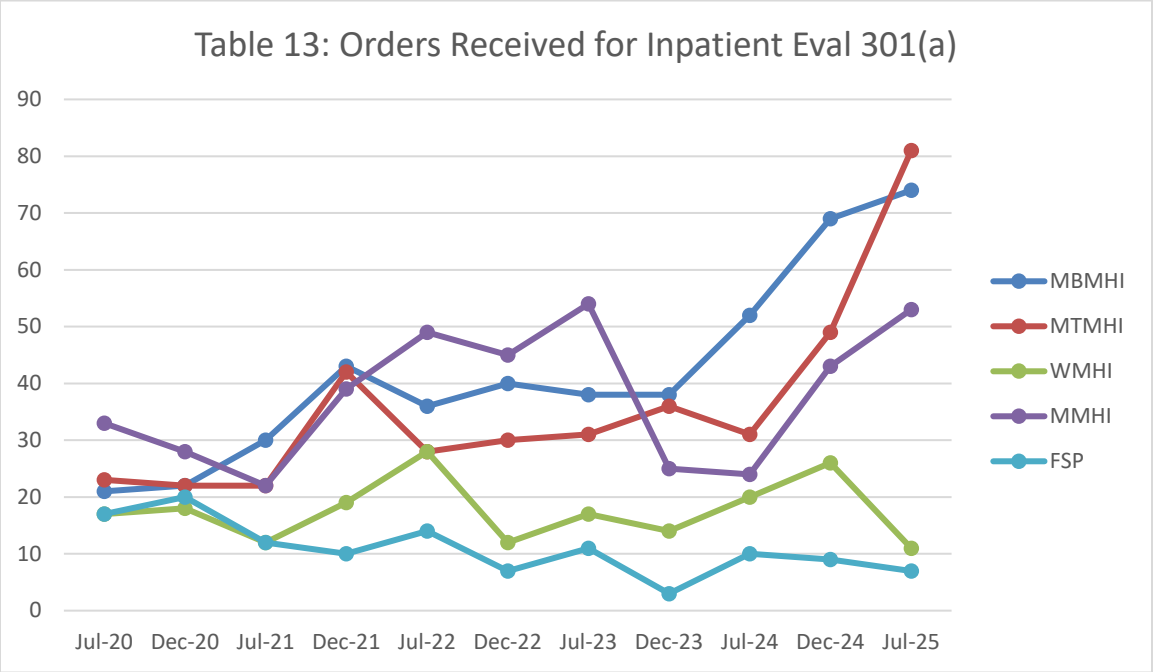


FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
523	544	475	474	446	467	455	493	510	450	436	480	397	446	401	442	443	512	537	489	483	607	741	746	843

Table 12, above, shows the total number of admissions for inpatient evaluation state-wide each fiscal year since FY 01. The inpatient evaluation totals for FY 23, 24, and 25 (average 777) are much higher than the average of 473 over the 21 years FY 01- FY 21, an increase of 45%. This is due

to a combination of reasons; the increase in the total number of outpatient evaluations from 1,844 in FY 21 to 2,744 in FY 25, and a higher rate of referrals from outpatient providers (from 27% in FY 20 and FY 21 to 38% in FY 25). The larger number of outpatient evaluations appears to be capturing a larger proportion of defendants with active symptoms of mental illness. The RMHIs have made specific efforts to increase the rate of admissions of forensic evaluations in order to reduce the referral lists, such as contracting with outside evaluators (certified by the Office of Forensic & Juvenile Court Services) to increase capacity. Even with these efforts it should be noted that there was still a ceiling to the number of forensic evaluations any RMHI could have on census at any one time, making the large total of evaluations completed even more remarkable.

The disruption in service delivery for mental health and medical services in general during the pandemic also affected the delivery of forensic evaluations. The decline of the pandemic resulted in a surge of new orders for forensic evaluations (see Table 1 on p. 3, above, for the jump in outpatient forensic evaluations in FY 22 - 25). Outpatient evaluators were able to resume working through pending orders but saw an increase in the frequency of cases requiring referral for inpatient evaluation over the past three years (Table 10, p. 13). Table 13, below, tracks the number of orders pending at the beginning of each December and July for each facility from July 2020, (the beginning of the pandemic in Tennessee), to July of 2025.



Facilities that typically had lower rates of orders for inpatient evaluations (WMHI and FSP) were able to work down referral lists more quickly than the facilities with larger volumes. The guideline for admission has been within 60 days of receipt of the court order (defendants may be admitted right away through the crisis team when in need of immediate inpatient treatment for safety). At the end of FY 25, only WMHI and FSP were admitting cases under the 60-day guideline.

Misdemeanor Services:

The distribution of inpatient evaluations by type of offense shown in Tables 14 and 15 on the following pages shows the proportion of misdemeanor-only inpatient cases jumped up to 29% in FY 25 after having been 10%-21% over the previous five years despite fluctuations in the total number of evaluations, inpatient and outpatient. In the last fiscal year prior to counties being billed for misdemeanors (FY 09), 34% of inpatient evaluation cases were misdemeanor cases. The cost of inpatient evaluations has a much greater impact on county budgets than outpatient evaluations. An outpatient evaluation for competency to stand trial and mental condition at the time of the crime cost $800 in FY 24, while an inpatient evaluation at $450 per day which would be $13,500 for the full 30 days, or $9,900 for the 22 days (the average length of stay in FY 24, the last year of billing counties for misdemeanors). As noted above, T.C.A. §33-7-304 was repealed effective July 1, 2024, so counties were not billed for misdemeanor services in FY 25. Shelby County never changed their practice and continued to order and pay for the same frequency of misdemeanor cases. The frequency of misdemeanor cases in facilities other than Memphis Mental Health Institute saw significant increases; MBMHI went from 11% in FY 24 to 25% in FY 25; MTMHI went from 19% in FY 24 to 29% in FY 25; WMHI went from 9% in FY 24 to 27% in FY 25.

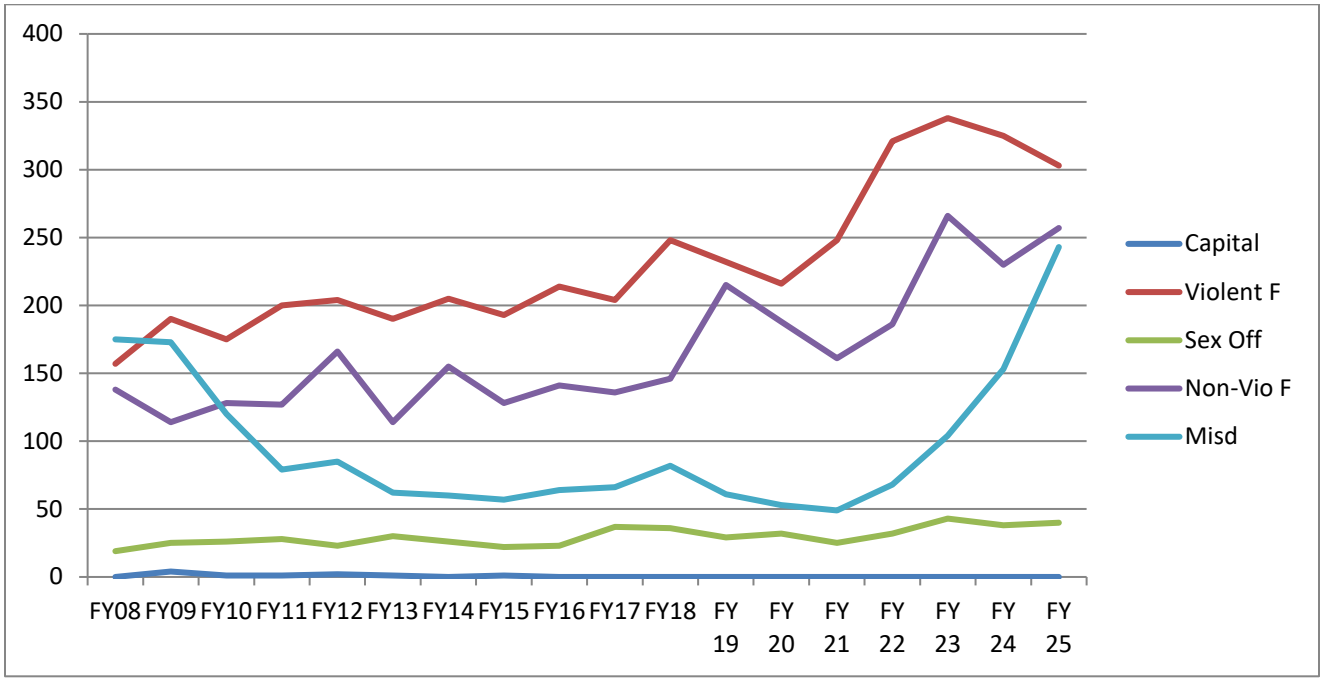
Table 14: Pre-Trial Inpatient Evaluations by Offense Type

	Capital	Violent Felony	Sex Offense	Non-Violent Felony	Misdemeanor
FY 09	0.8%	37%	5%	22%	34%
FY 10*	0.2%	39%	6%	28%	27%
FY 11	0.2%	45%	6%	29%	18%
FY 12	.004%	42%	4%	34%	17%
FY 13	.003%	47%	7%	28%	15%
FY 14	0	45%	5%	34%	13%
FY 15	0.2%	48%	5%	31%	14%
FY 16	0	48%	5%	31%	14%
FY 17	0	46%	8%	30%	14%
FY 18	0	48%	7%	28%	16%
FY 19	0	43%	5%	40%	11%
FY 20	0	44%	6%	38%	10%
FY 21	0	51%	5%	33%	10%
FY 22	0	52%	5%	30%	11%
FY 23	0	44%	6%	36%	14%
FY 24	0	44%	5%	31%	21%
FY 25**	0	36%	5%	30%	29%

*FY 10 was the first year that counties were billed for misdemeanor evaluations

**counties no longer billed for misdemeanor evaluations in FY 25

Table 15: Inpatient Felony vs. Misdemeanor Trends



A decline in misdemeanor evaluations is evident beginning in FY 10 after the law changed to make counties responsible for the cost of misdemeanor evaluation and treatment services. In FY 08, there were more inpatient evaluations on defendants charged only with misdemeanors (175) than on defendants with at least one violent felony charge (157). At the lowest point for misdemeanor evaluations in FY 21, there just over five times as many evaluations of violent felony evaluations (248) than misdemeanor evaluations (49). The number of misdemeanor evaluations began to rebound as part of the overall increase in forensic evaluations in FY 23-24 and then jumped by 59% between FY 24 and FY 25 when the counties were no longer being billed.

Defendants ordered for inpatient evaluation under T.C.A. § 33-7-301(a) to a Regional Mental Health Institute (RMHI) are admitted to the RMHI that provides civil involuntary inpatient services to the county from which the order originates.

Table 16: RMHI Counties Served

RMHI	*Counties*
MBMHI	Anderson, Bedford, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Clay, Cocke, Coffee, Cumberland, DeKalb, Fentress, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jackson, Jefferson, Johnson, Knox, Lincoln, Loudon, Macon, Marion, McMinn, Meigs, Monroe, Moore, Morgan, Overton, Pickett, Polk, Putnam, Rhea, Roane, Scott, Sequatchie, Sevier, Smith, Sullivan, Unicoi, Union, Van Buren, Washington, Warren, White
MTMHI	Cannon, Cheatham, Davidson, Dickson, Giles, Hickman, Houston, Humphries, Marshall, Maury, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, Wilson
WMHI	Benton, Carroll, Chester, Crockett, Decatur, Dyer, Gibson, Fayette, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Lawrence, Lewis, Madison, McNairy, Obion, Perry, Tipton, Wayne, Weakley (+ felony commitments under T.C.A. §§ 33-7-301(b) & all commitments under -303(c) from Shelby County)
MMHI	Shelby
FSP	The maximum-security Forensic Services Program serves all 95 counties.

The distribution of admissions for evaluation and treatment by an RMHI was affected by the closure of Lakeshore Mental Health Institute (LMHI) at the end of FY 12 (June 2012). All forensic admissions normally routed to LMHI were diverted beginning April 1, 2012, the majority going to Moccasin Bend Mental Health Institute (MBMHI). LMHI served the upper east counties in Tennessee.

Table 17: Inpatient Evaluations by Facility

	LMHI	MBMHI	MTMHI	WMHI	MMHI	FSP	TOTAL
FY 08	67	64	56	56	170	80	493
FY 09	66	69	71	72	140	92	510
FY 10	70	39	70	55	128	88	450
FY 11	48	53	65	69	129	74	436
FY 12	45	67	84	53	146	85	480
FY 13	0	99	74	44	105	75	397
FY 14	0	108	89	68	109	72	446
FY 15	0	122	69	53	90	67	401
FY 16	0	132	98	56	89	67	442
FY 17	0	131	93	69	104	46	443
FY 18	0	156	132	50	118	56	512
FY 19	0	143	123	66	136	69	537
FY 20	0	134	130	78	100	47	489
FY 21	0	117	147	71	99	49	483
FY 22	0	161	165	80	134	67	607
FY 23	0	174	196	107	194	70	741
FY 24	0	172	198	106	216	54	746
FY 25	0	245	242	108	190	58	843
Avg.	-	141	117	69	191	67	501

The total for FY 25 shows a sustained increase in demand for forensic evaluations (reflected in outpatient numbers as well). WMHI's total was at their 17-year average and FSP below their average while the other facilities were all well above average. The state-wide average prior to FY 25 was 481, 75% below the total for FY 25.

As previously noted, a defendant admitted for an inpatient evaluation may only be held a maximum of 30 days under T.C.A. § 33-7-301(a). Most defendants respond to treatment initiated

upon admission in 2-3 weeks, so the average length of stay is actually shorter than the allotted 30 days. The average length of stay under T.C.A. § 33-7-301(a) statewide for the 22-year period FY 01-FY 24 was 21 days. The average length of stay statewide in FY 25 was 23 days.

Table 18: Average Length of Stay in Days for Inpatient Pre-Trial Evaluation

	LMHI	MBMHI	MTMHI	WMHI	MMHI	FSP	Statewide
FY 08	23	18	22	22	15	26	20
FY 09	20	21	24	23	16	26	20
FY 10	16	21	20	21	14	26	19
FY 11	20	21	22	19	19	26	21
FY 12	21	16	22	20	17	26	19
FY 13	-	21	27	21	18	26	22
FY 14	-	18	26	22	19	23	21
FY 15	-	21	27	24	24	20	22
FY 16	-	19	23	20	21	15	20
FY 17	-	22	20	23	20	15	20
FY 18	-	22	19	23	22	20	21
FY 19	-	22	23	25	20	20	22
FY 20	-	22	22	21	20	25	22
FY 21	-	23	24	22	22	25	23
FY 22	-	20	25	22	20	26	23
FY 23	-	21	24	21	20	25	22
FY 24	-	21	24	22	20	22	22
FY 25	-	24	25	20	20	25	23

OUTCOMES:

Outcomes for inpatient forensic evaluations include how frequently defendants were found to be competent to stand trial, whether there was support for the insanity defense, and whether defendants met criteria for judicial commitment.

Table 19: Recommendations That a Defendant is Competent to Stand Trial Following Inpatient Evaluation

	LMHI	MBMHI	MTMHI	WMHI	MMHI	FSP	State-wide
FY 08	70%	69%	53%	73%	83%	70%	73%
FY 09	69%	72%	40%	78%	69%	84%	69%
FY 10	67%	59%	57%	82%	77%	78%	72%
FY 11	79%	79%	76%	66%	69%	82%	74%
FY 12	66%	79%	67%	73%	74%	77%	73%
FY 13	-	64%	58%	84%	62%	72%	66%
FY 14	-	77%	66%	57%	76%	73%	71%
FY 15	-	72%	68%	66%	73%	74%	71%
FY 16	-	83%	84%	66%	53%	82%	75%
FY 17	-	70%	82%	69%	47%	71%	67%
FY 18	-	76%	81%	52%	50%	87%	70%
FY 19	-	77%	85%	62%	54%	75%	71%
FY 20	-	72%	71%	75%	55%	59%	67%
FY 21	-	70%	64%	69%	44%	44%	60%
FY 22	-	80%	66%	70%	48%	56%	65%
FY 23	-	72%	66%	86%	56%	51%	66%
FY 24	-	75%	57%	78%	57%	69%	65%
FY 25	-	75%	58%	92%	66%	59%	69%

Table 20 shows the frequency of inpatient evaluations which indicated support for the insanity defense (the number of cases is too small to break out by RMHI reliably).

Table 20: Support for the Insanity Defense in Inpatient Evaluations

FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
15%	14%	18%	16%	21%	14%	14%	14%	12%	10%	8%	10%	7%

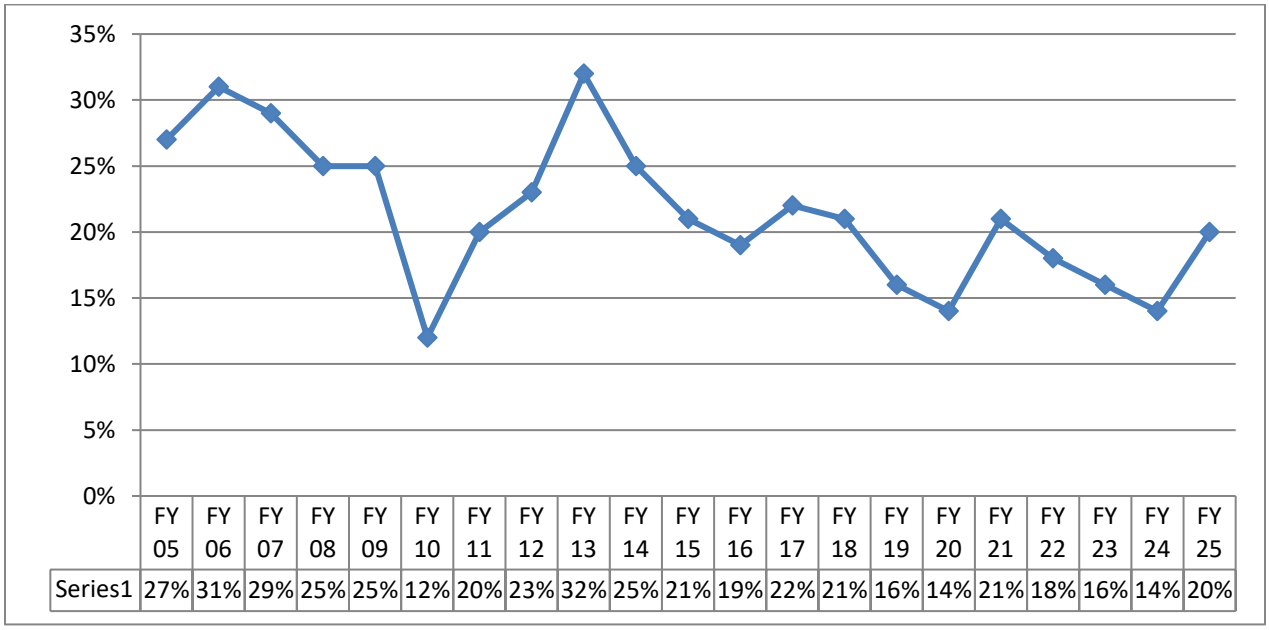
Inpatient evaluations conducted under T.C.A. § 33-7-301(a) also include a recommendation to the court on whether the defendant meets involuntary commitment criteria under Title 33, Chapter 6, Part 5, necessary for commitment for further evaluation and treatment under T.C.A. § 33-7-301(b), or if the defendant meets criteria for commitment to outpatient treatment including competency training under T.C.A. § 33-7-401. A small number of defendants are considered unrestorably incompetent to stand trial (e.g., due to brain injury or disease or significant intellectual impairment) and do not meet commitment standards for further inpatient treatment and are returned to court. In these cases, RMHI staff reach out to mental health providers for the jail and criminal justice liaisons to support the identification of community resources for defendants who cannot be prosecuted and are released from jail.

Defendants from Shelby County courts evaluated initially at MMHI and committed for further evaluation and treatment under T.C.A. § 33-7-301(b) are typically admitted to WMHI, though defendants may be admitted at any RMHI on a case-by-case basis. In the last half of FY 24, MMHI assumed responsibility for admitting Shelby County defendants charged only with misdemeanors who were committed under T.C.A. § 33-7-301(b), which continued through FY 25. Defendants evaluated initially at FSP may be committed to FSP under T.C.A. § 33-7-301(b) when maximum security is needed or may be committed to one of the other RMHIs if the defendant no longer requires maximum security.

On July 1, 2024 (and for the duration of FY 25), Jillian's Law took effect, named after Jillian Ludwig, a Belmont University student who was killed by a stray bullet allegedly fired by a person who had previously been found unrestorably incompetent on multiple charges of aggravated assault due to intellectual disability and not committable to an institute for the intellectually and/or developmentally disabled. The change in law shifted the burden of proof for commitment of defendants adjudicated incompetent to stand trial on any felony or class A misdemeanor. The statute for judicial commitment under Title 33, Chapter 6, Part 5 was amended to say that such defendants were presumed to meet commitment standards, and that this presumption could only

be rebutted by clear and convincing evidence that the defendant did not meet commitment standards. (Jillian's Law also amended the statute for emergency commitment under Title 33, Chapter 6, Part 4, but it is the judicial commitment standard that is relevant to defendants considered incompetent at the end of their inpatient evaluation under §33-7-301(a) for possible commitment under §33-7-301(b)). This made it easier to recommend commitment for defendants charged with a felony or class A misdemeanor who were considered incompetent at the end of their inpatient evaluation under §33-7-301(a). Tables 21 and 22 show the frequency of recommendations for commitment.

Table 21: Recommendations for Commitment under T.C.A. § 33-7-301(b) State-wide



	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
Series1	27%	31%	29%	25%	25%	12%	20%	23%	32%	25%	21%	19%	22%	21%	16%	14%	21%	18%	16%	14%	20%

Table 22: Recommendations for Commitment under T.C.A. § 33-7-301(b) by RMHI

	LMHI	MBMHI	MTMHI	WMHI	MMHI	FSP	State-wide
FY 08	27%	21%	49%	24%	12%	35%	25%
FY 09	15%	21%	44%	21%	27%	19%	25%
FY 10	0	21%	10%	13%	16%	15%	12%
FY 11	4%	20%	23%	24%	25%	20%	20%
FY 12	0	16%	34%	28%	26%	24%	23%
FY 13	-	29%	40%	15%	38%	32%	32%
FY 14	-	15%	32%	39%	16%	30%	25%
FY 15	-	15%	33%	32%	10%	25%	21%
FY 16	-	11%	15%	35%	33%	10%	19%
FY 17	-	18%	10%	39%	37%	26%	22%
FY 18	-	5%	14%	44%	45%	7%	21%
FY 19	-	4%	12%	33%	26%	13%	16%
FY 20	-	1%	8%	23%	37%	10%	14%
FY 21	-	4%	16%	29%	43%	22%	21%
FY 22	-	1%	12%	27%	41%	16%	18%
FY 23	-	3%	13%	13%	30%	17%	16%
FY 24	-	2%	15%	18%	23%	11%	14%
FY 25	-	4%	33%	8%	25%	33%	20%

The frequency of recommending commitment actually decreased at WMHI, showed little change at MBMHI or WMHI, but doubled at MTMHI and tripled at FSP. (As noted in Table 19, above, WMHI found 92% of defendants competent after their inpatient evaluation.) MTMHI and FSP are

located in Davidson County where the case leading to Jillian's Law occurred and which was covered extensively in the media.

Table 23 shows that the majority of orders for evaluation under T.C.A. § 33-7-301(a) were received from general sessions courts. An order received from a general sessions court typically indicates that an evaluation was ordered relatively early in the prosecution process of a criminal case. While the numbers of orders are larger this year, the pattern of percentiles shown in Table 23 is very consistent with previous years.

Table 23: Court of Origin for T.C.A. § 33-7-301(a) Orders

Court	Outpatient	Inpatient
General Sessions	69% *	73% **
Criminal Court	21% *	15% **
Circuit Court	7% *	8% **
Municipal	3% *	4% **

*% of total outpatient orders
**% of total inpatient orders

Defendant Characteristics

Below is a summary of the characteristics of defendants evaluated under T.C.A. § 33-7-301(a). These figures are very consistent with rates from previous years.

***Gender**:*

Outpatient: 76% male, 24% female

Inpatient: 76% male, 24% female

Age:

	Outpatient	Inpatient
0-18:	2%	<1%
19-30:	29%	26%
31-43:	37%	42%
44-64:	27%	27%
>64:	5%	5%

Race:

	Outpatient	Inpatient
Alaskan Native:	<1%	<1%
American Indian:	<1%	0
Asian	<1%	<1%
Black/African American:	47%	50%
White/Caucasian:	49%	47%
Unknown:	1%	<1%
Other:	2%	2%

Primary Diagnosis Outpatient Evaluations:

Psychotic D/O:	33%	Personality D/O:	3%
Affective D/O:	14%	Adjustment/Behavior:	1%
Deferred:	13%	Malingering:	2%
Substance Related:	16%	None:	2%
Anxiety:	5%	Borderline IQ:	1%
Intellectual Disability	3%	Medical:	1%
Neurological	2%	Other:	2%

Intellectual Disability in pre-trial Forensic Evaluations:

When a defendant who has been referred for a forensic evaluation appears to be incompetent due to intellectual disability (ID), the evaluator designated by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) may request assistance from evaluators in the Tennessee Department of Disability and Aging (hereafter, DDA), which was known as the Department of Intellectual and Developmental Disabilities (DIDD) prior to July 1, 2024. DDA forensic evaluators have completed the TDMHSAS forensic training for certified forensic evaluators. The consultation process is referred to as an "ID Assist" request. For many years, an ID Assist was requested whenever a forensic evaluator believed that a defendant was intellectually disabled, or there might be support for the insanity defense based on an intellectual disability, or the defendant might meet commitment criteria under Title 33, Chapter 5, Part 4 (the former commitment statutes for intellectually disabled defendants) to the Harold Jordan Center (HJC), the inpatient facility operated by DDA. The threshold for requesting an ID Assist changed in FY 14 due to (then) DIDD manpower limitations so that an ID Assist request was made only for 1) outpatient competency training which a court would have authority to order under T.C.A. § 33-5-501 (now §52-5-501) or 2) for commitment to HJC under Title 33, Chapter 5, Part 4 (now Title 52, Chapter 5, Part 4). These are the two circumstances under which courts are authorized to order services under the commissioner of DIDD/DDA. (NOTE: as of July 1, 2024, Chapter 5 of Title 33 was repealed and the Tennessee Code concerning intellectual disability was codified as a new Title, Title 52.)

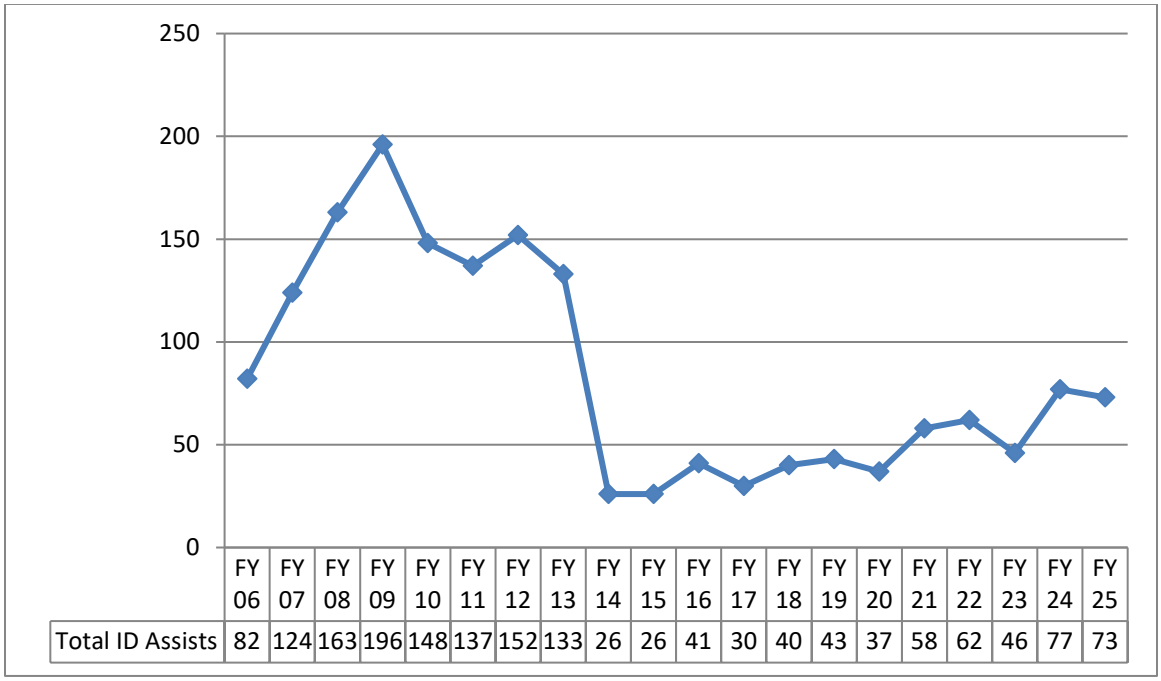
If a forensic evaluator believed that a defendant was incompetent to stand trial and committable to the HJC, the evaluator would request an ID Assist prior to communicating anything to the court. If the DDA expert found that the defendant did meet commitment criteria, he/she would complete one certificate of need and the TDMHSAS forensic evaluator (in these cases a licensed psychologist with Health Service Provider designation) would complete the other certificate of need and forward both to the court with a recommendation for commitment. If the DIDD/DDA expert did *not* find the defendant to be committable, the DDA expert would indicate whether training should be attempted on an outpatient basis and the recommendations would be submitted to the court. Jillian's Law, described above (see pp. 24-25), also shifted the burden of proof for

commitment standards for defendants adjudicated incompetent to stand trial due to intellectual disability if charged with any felony or a class A misdemeanor.

Alternatively, if a TDMHSAS forensic evaluator believed that a defendant charged with a felony was incompetent to stand trial due to intellectual disability, was not committable, but might be trained to competence on an outpatient basis by an expert in intellectual disability, the evaluator would recommend that the court order training and would simultaneously request an ID Assist. Once a court order was received (and *only* if a court order was received), the DIDD/DDA expert would then arrange for training sessions with the defendant. For defendants charged only with misdemeanors, the TDMHSAS evaluator would simply report to the court that the defendant was not competent to stand trial, and efforts would be made to arrange for services to address safety and habilitation needs depending on the location of the defendant.

Requests for an ID Assist could be made on an outpatient or inpatient basis. If a defendant suspected to be intellectually disabled also showed signs of psychosis (known as "dual diagnosis"), the defendant would be referred for inpatient evaluation at an RMHI for treatment to stabilize the mental illness before a final determination is made about the level of intellectual functioning and any impairment related to the forensic issues.

Table 24: Total ID Assist Request Trend



	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
Total ID Assists	82	124	163	196	148	137	152	133	26	26	41	30	40	43	37	58	62	46	77	73

The trend line shows the significant decrease in the total number of ID Assist requests in FY 14 when the threshold was changed for initiation of an ID Assist. It is notable that there was only a slight increase in FY 22 when there was 27% increase in the total number of outpatient evaluations ordered over FY 21. The increase in FY 24 was the most significant since FY 09.

Table 25: ID Assist Frequencies

	Outpatient Req. (% of outpt. evals)	Inpatient Req. (% of inpt. evals)	**Total ID Assists** (% of total evals)
FY 11	112 (5%)	25 (6%)	137 (5%)
FY 12	134 (6%)	18 (4%)	152 (6%)
FY 13	112 (6%)	11 (3%)	133(5%)
FY 14*	21 (1%)	5 (1%)	26 (1%)
FY 15	26 (1%)	0 (-)	26 (1%)
FY 16	37 (2%)	4 (1%)	41 (2%)
FY 17	26 (1%)	4 (1%)	30 (1%)
FY 18	38 (2%)	12 (2%)	40 (2%)
FY 19	32 (1%)	11 (2%)	43 (2%)
FY 20	28 (1%)	9 (2%)	37 (1%)
FY 21	52 (3%)	6 (1%)	58 (2%)
FY 22	54 (2%)	8 (1%)	62 (2%)
FY 23	37 (1%)	9 (1%)	46 (2%)
FY 24	64 (2%)	8 (1%)	72 (2%)
FY 25	57 (2%)	6 (1%)	73 (2%)

*****standard changed for when ID Assist is requested in FY 14

Forensic Specialist Dwan Grey, M.Ed., worked with DDA to collected outcome data and compiled the following summary:

Of the 73 total ID Assist requests in FY 25, 26 (36%) were to determine if the defendant met commitment criteria under Title 52, Chapter 5, Part 4 (consistent with 29 (40%) requests in FY 24, but a significant increase over FY 23), and 47 (64%) were for competency training.

- Of the 26 evaluations for possible commitment, 5 were found committable by the expert from DDA, 12 were found not committable, 3 cases were still active at the end of FY 25, and 6 cases were not completed for various reasons such as charges being dismissed.
- Of 47 requests for competency training, 29 were completed or closed by the end of the fiscal year. There were 5 defendants trained to be competent to stand trial, 9 who could not be trained to become competent, 6 for whom the DDA evaluator could not confirm a diagnosis of intellectual disability, and 9 cases closed for various reasons such as having charges dismissed or determined to be misdemeanors. The remainder were still in progress at the end of FY 25.

Commitments for Evaluation and Treatment Under T.C.A § 33-7-301(b):

Most defendants who are evaluated on an inpatient basis under T.C.A. § 33-7-301(a) respond to treatment provided during the evaluation period and are competent to stand trial and do not meet commitment criteria at the end of the 30 days. Pre-trial defendants who meet the commitment criteria in Title 33, Chapter 6, Part 5 at the end of the evaluation under T.C.A. § 33-7-301(a) may be committed for further inpatient evaluation and treatment under subsection (b) of T.C.A. § 33-7-301; there were 166 new admissions under that part of the statute in FY 25, up from 130 in FY 24 and 113 in FY 23 (see Table 26, below). This is the largest number of new admissions during a fiscal year in the 19 years that reliable data are available, due primarily to the increase in the number of inpatient evaluations which expanded the pool of potential commitments under § 33-7-301(b). The jump between FY 22 and FY 25 reflects the increase in evaluations under T.C.A. § 33-7-301(a). The passage of Jillian's Law may also have made some evaluators more likely to recommend commitment of incompetent defendants rather than recommend outpatient competency training in the jail or community (see pages 24-25 and Table 21, above), adding to the increase, particularly at Middle Tennessee Mental Health Institute.

Virtually all defendants committed under T.C.A. § 33-7-301(b) are considered incompetent to stand trial, although a very few may be considered competent to stand trial but would pose a substantial likelihood of serious harm due to mental illness if discharged to the jail to await further court proceedings. That risk could include the defendant stopping their medication when discharged to jail, resulting in a relapse of symptoms and the defendant becoming incompetent to stand trial. Shelby County defendants are admitted to Memphis Mental Health Institute (MMHI) for evaluation under subsection (a) of T.C.A. § 33-7-301 for the initial evaluation and then were admitted to Western Mental Health Institute (WMHI) when commitment is necessary under subsection (b) for many years. Midway through FY 24, MMHI began admitting those Shelby County defendants charged only with misdemeanors and committed under T.C.A. § 33-7-301(b).

Davidson County defendants were 40% of all admissions under that statute state-wide. This is an unusual increase as Shelby County defendants are typically the greatest percentage (51% in FY 24 but only 27% in FY 25). Defendants admitted to the maximum-security Forensic Services Program (FSP) and evaluated under subsection -301(a) may be committed to FSP under subsection -301(b) or may be committed to a Regional Mental Health Institute if they no longer require maximum security.

WMHI lacked available suitable accommodations (ASA) for sub-acute cases such as incompetent defendants committed under T.C.A. § 33-7-301(b) in that cases were being referred faster than they could be treated and released. As noted above, in the second half of FY 24, MMHI began admitting Shelby County defendants who were charged only with misdemeanors. It is expected that MMHI will continue to admit and treat Shelby County misdemeanor cases.

Table 26: Admissions Under T.C.A. § 33-7-301(b)

	LMHI	MBMHI	MTMHI	WMHI	MMHI	FSP	Statewide
FY 07	12	11	28	37	0	10	98
FY 08	13	9	28	42	0	10	102
FY 09	9	6	35	38	1	8	97
FY 10	1	2	7	33	0	5	48
FY 11	1	8	16	39	0	10	74
FY 12	2	10	16	54	1	13	96
FY 13	-	19	32	51	0	11	113
FY 14	-	21	28	45	0	9	103
FY 15	-	16	27	27	0	12	82
FY 16	-	12	11	29	0	7	59
FY 17	-	15	20	65	1	7	108
FY 18	-	12	16	53	4	7	92
FY 19	-	1	14	64	0	9	88
FY 20	-	3	15	51	0	6	75
FY 21	-	5	19	47	2	8	81
FY 22	-	4	20	42	12	7	85
FY 23	-	19	31	52	7	4	113
FY 24	-	18	30	45	25	12	130
Avg. 07-24	-	13*	22	45	2	9	87
FY 25	-	19	84	43	13	7	166

*MBMHI average FY 13-FY 24 only, the years after LMHI closed

In order to assist WMHI with a lengthy referral list in FY 24, five of MBMHI's 18 admissions were Shelby County cases, two of MTMHI's 31 admissions (to the main building) were Shelby County cases, and all seven of MMHI's admissions would have been referred to WMHI.

There were 47 cases statewide coded as misdemeanors (28%), higher than previous years: FY 24 (22%), FY 23 (23%), FY 22 (14%), FY 21 (15%), FY 20 (16%), FY 19 (14%) and FY 17 (18%).

At any time that a defendant is considered to have been restored to competence, the court is notified so that the trial may proceed, whether or not the defendant stays in the hospital. Typically, defendants are discharged to jail when the court is notified that they are now considered competent to stand trial. Some defendants have their charges dismissed or retired, so they are no longer pre-trial criminal defendants, but if they remain committable, they remain in the hospital under Title 33, Chapter 6, Part 5 and are discharged to the community when a less drastic alternative to hospitalization is identified and outpatient treatment arranged. One of the changes in Jillian's Law is a requirement that defendants charged with any felony or a class A misdemeanor who cannot be restored to competence may only be released once the court with criminal jurisdiction approves a Mandatory Outpatient Treatment plan which accounts for the safety of the community (see pp. 67-74, below, for more on MOT). This population has always been considered good candidates for MOT, and release without MOT has been rare even before Jillian's Law. Table 27 shows the number of patients committed under T.C.A. § 33-7-301(b) whose legal status under that statute ended in each of the last 16 fiscal years, either by discharge from the hospital or by having their charges dismissed.

Table 27: T.C.A. § 33-7-301(b) Cases Closed

	LMHI	MBMHI	MTMHI	WMHI	MMHI	FSP	Statewide
FY 07	9	12	33	43	0	7	104
FY 08	7	16	24	45	0	9	101
FY 09	22	9	39	43	1	10	124
FY 10	2	1	11	36	0	5	55
FY 11	1	8	18	32	0	14	73
FY 12	3	7	15	51	1	11	87
FY 13	-	21	19	57	0	11	107
FY 14	-	23	30	40	0	10	103
FY 15	-	17	20	48	0	11	96
FY 16	-	10	12	27	0	7	56
FY 17	-	15	15	46	1	4	81
FY 18	-	15	15	53	4	10	97
FY 19	-	1	13	67	0	8	89
FY 20	-	3	18	60	0	4	85
FY 21	-	3	13	47	1	10	74
FY 22	-	5	24	40	13	6	88
FY 23	-	15	30	50	7	6	108
FY 24	-	18	28	47	25	12	130
FY 25	-	20	71	41	12	7	151

Of the 151 cases closed during FY 25, 60% (89 cases) were discharged while still pre-trial defendants and 40% (30 cases) had their charges retired and remained committed to the RMHI under Title 33, Chapter 6, Part 5. This rate is a little lower than the previous four years (FY 24 = 70%, FY 23 = 75%, FY 22 = 70%, and FY 21 = 70%) but higher than FY 15-20 when approximately half the cases were still pre-trial defendants (FY 15 and FY 16 = 52%; FY 17 = 51%; FY 18= 45%; FY 19 = 48%; FY 20=53%).

Table 28, below, shows defendants discharged from T.C.A. § 33-7-301(b) with charges still pending during FY 25 categorized by their length of stay. In FY 25, the most frequent length of stay

was between one and three months (49%) which is very consistent with previous years; 15% were discharged in less than 30 days for a total of 53% discharged in the first three months. Only 13% stayed longer than six months. There were four patients with a length of stay between one and two years, and no patients had been committed for longer than two years.

Table 28: Length of Stay
Discharges Under T.C.A. § 33-7-301(b) during FY 25

Facility	0 – 30 Days	31-90 Days	3-6 Mos.	6 Mo.- 1 Yr.	1-2 Yrs.	2-5 Yrs.	5 Yrs. +	Avg. LOS in days	Range in days
MTMHI	6	20	9	5	0	0	0	88	7-253
FSP	0	3	2	0	0	0	0	96	42-125
WMHI	5	17	6	1	3	0	0	119	14-650
MMHI	2	1	1	0	0	0	0	47	16-98
MBMHI	0	3	2	2	1	0	0	190	33-568
Totals	**13**	**44**	**20**	**8**	**4**	**0**	**0**	**107**	**7-650**

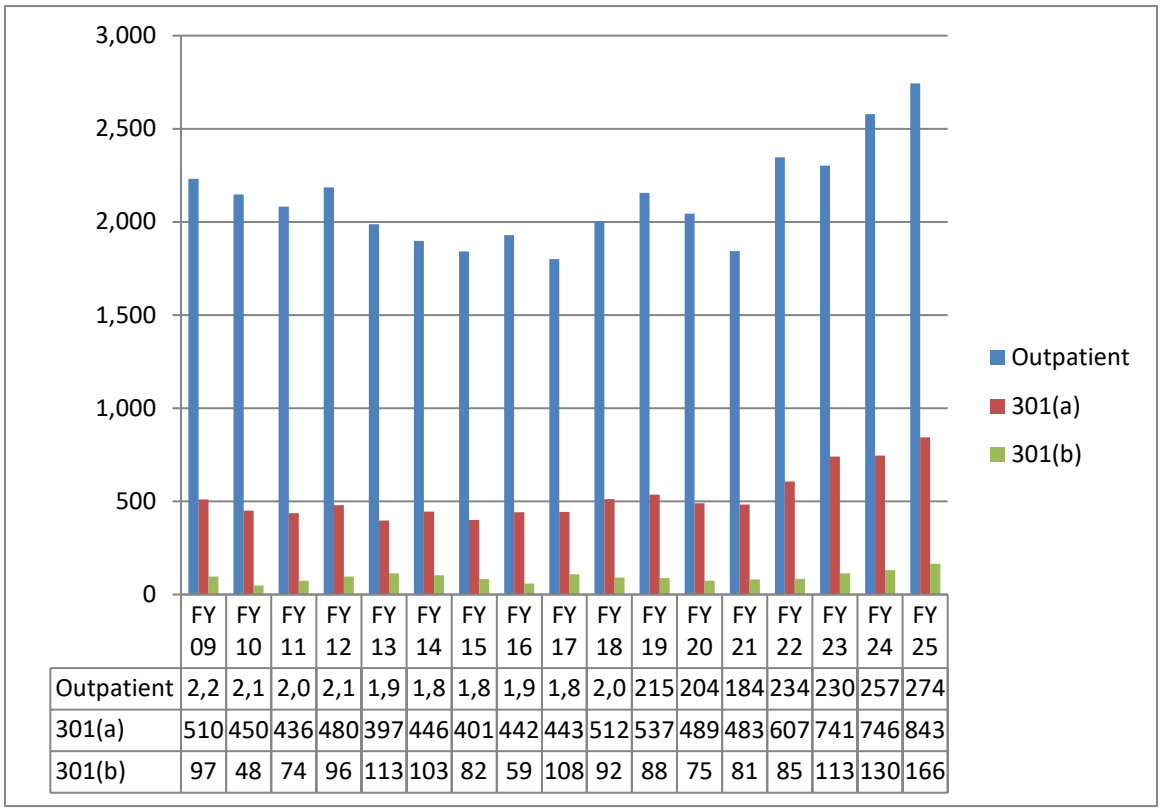
While Table 28 shows the length of stay for patients discharged during FY 25, Table 29 shows the lengths of stay for those patients still on census at the RMHIs at the end of each of the last ten fiscal years (June 30), providing a point-in-time view of the range in length of stay for patients committed under T.C.A. § 33-7-301(b). That number increased in FY 25 along with the overall increase in the number of commitments under that statute.

Table 29: Length of Stay for Patients On Census Under T.C.A. § 33-7-301(b) on June 30

	0-6 Months	6-12 Months	1-2 Years	2-3 Years	3 Years +	Total
# patients 6/30/2016	12	6	5	0	0	23
# patients 6/30/2017	26	9	3	2	0	40
# patients 6/30/2018	23	5	3	2	0	33
# patients 6/30/2019	22	2	2	1	2	29
# patients 6/30/2020	7	8	3	0	1	19
# patients 6/30/2021	23	2	1	0	1	27
# patients 6/30/2022	16	4	2	0	0	22
# patients 6/30/2023	20	3	4	1	0	28
# patients 6/30/2024	29	1	4	0	0	34
# patients 6/30/2025	35	9	2	0	0	46

Table 30 below combines tables 1, 12, and 26 to illustrate how the Tennessee forensic evaluation system established in law and carried out by TDMHSAS focuses on community-based services and minimizes demand on inpatient facilities.

Table 30: Forensic Evaluation Services



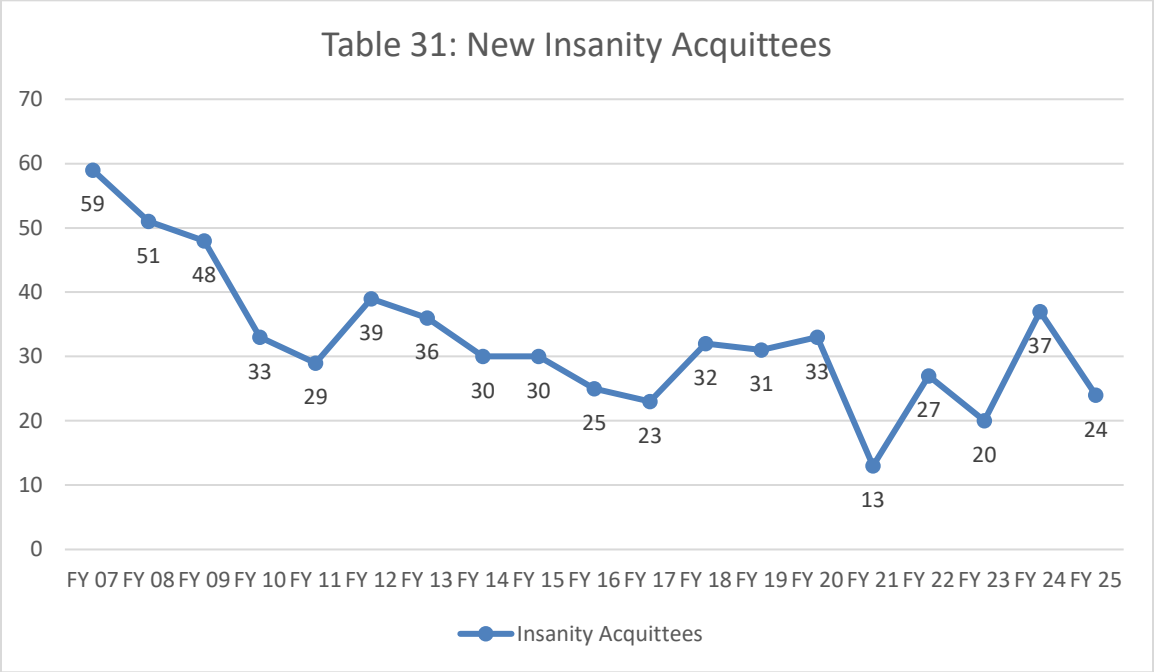
	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
Outpatient	2,2	2,1	2,0	2,1	1,9	1,8	1,8	1,9	1,8	2,0	215	204	184	234	230	257	274
301(a)	510	450	436	480	397	446	401	442	443	512	537	489	483	607	741	746	843
301(b)	97	48	74	96	113	103	82	59	108	92	88	75	81	85	113	130	166

Evaluation and Treatment of Defendants Found Not Guilty by Reason of Insanity

Evaluation of Insanity Acquittees Under T.C.A. § 33-7-303(a):

Defendants adjudicated Not Guilty by Reason of Insanity (NGRI) are required by law under T.C.A. § 33-7-303(a) to be evaluated to determine whether the acquittee meets the standards for indefinite commitment to an RMHI under Title 33, Chapter 6, Part 5, or should be released to the community. Legislation signed into law in June of 2009 amended T.C.A. § 33-7-303(a) so that all evaluations of defendants found NGRI are conducted on an outpatient basis when previously the statute required an inpatient evaluation. Evaluations conducted in FY 2010 (beginning July 1, 2009) and afterward have all been conducted on an outpatient basis, while evaluations conducted in FY 2009 (ending June 30, 2009) and prior years were conducted on an inpatient basis. The outpatient

evaluations are conducted by the same agencies which are contracted for outpatient pre-trial evaluations. There were 24 new NGRI acquittees in FY 25.



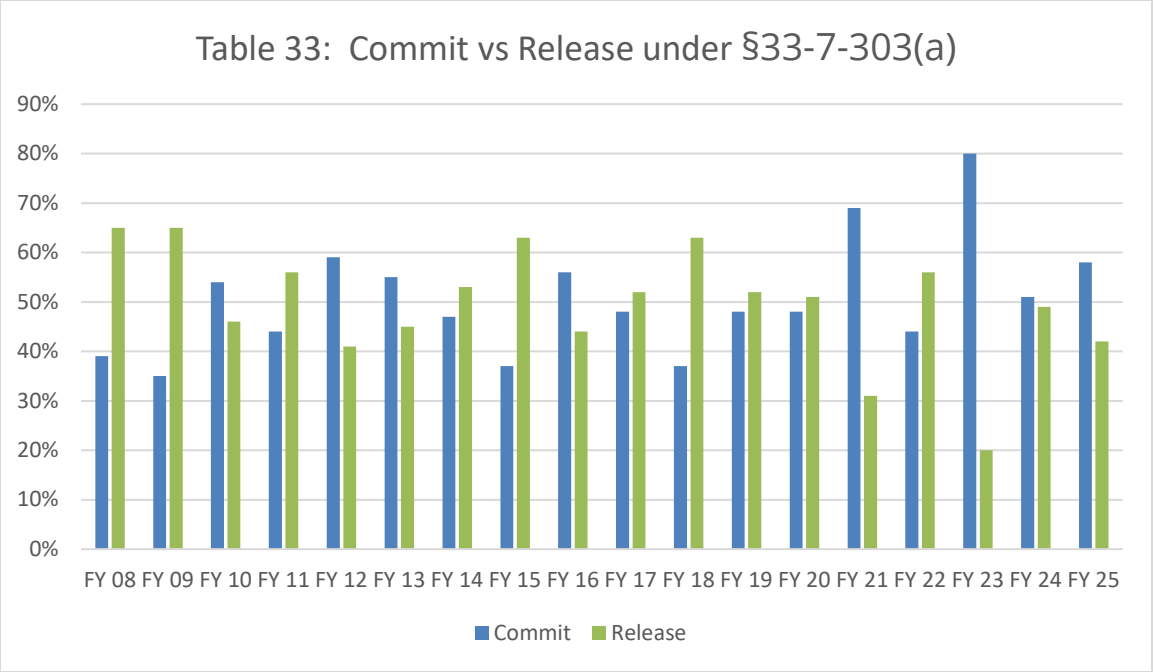
Of the 24 acquittees, 14 (58%) were acquitted on a violent felony offense (not sex offense) and 8 (33%) were acquitted on a non-violent felony (generally consistent with previous years).

Through the end of FY 25, there were four possible outcomes of an evaluation conducted under T.C.A. § 33-7-303(a): (1) commitment to an RMHI under T.C.A. § 33-7-303(c), (2) release to the community with an Mandatory Outpatient Treatment (MOT) plan under T.C.A. § 33-7-303(b) or (g), (3) release to the community with an outpatient treatment plan and no legal obligation under MOT, and (4) release to the community with no outpatient treatment plan when the defendant does not require outpatient treatment (see also p. 72, below, for the requirement for MOT for certain cases at any point of release to the community). Table 32, below, shows the outcomes with recommendations broken out by provider for FY 25 and shows the sum of outcomes statewide for the previous eight years.

Table 32: Recommendations following Evaluation Under T.C.A. § 33-7-303(a)

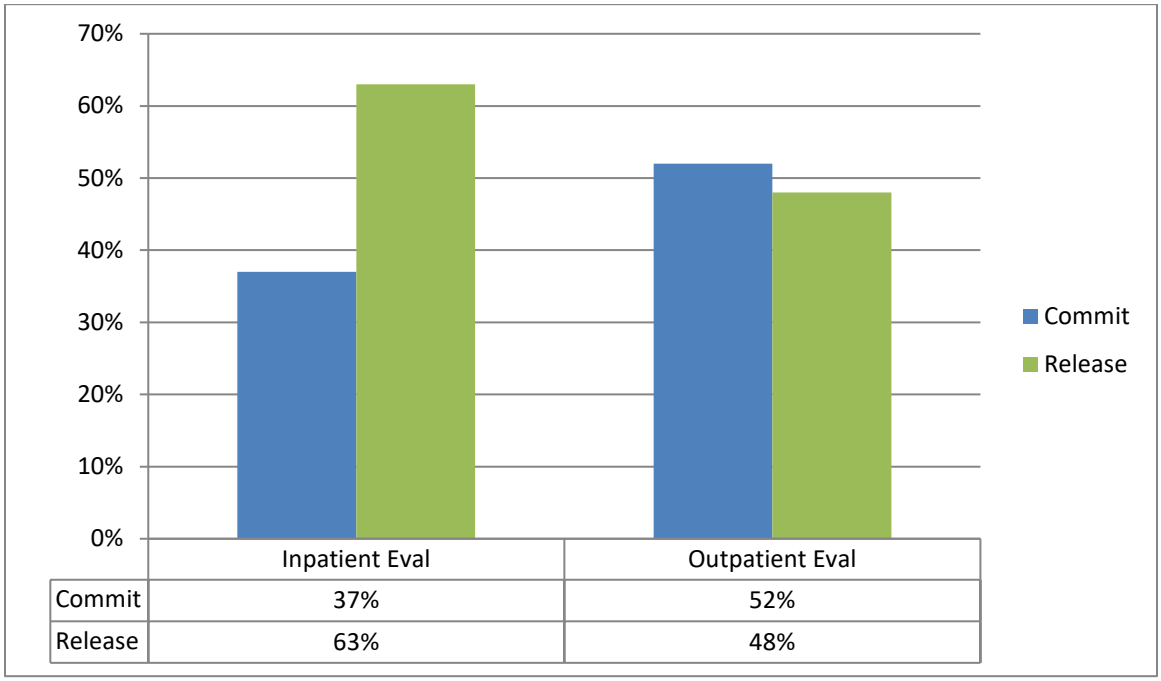
	Commit	MOT	release w/o MOT	release w/o tx
Cherokee	1	0	0	0
Frontier	2	0	4	0
McNabb	0	0	2	0
Pathways	2	1	3	0
Vanderbilt	3	0	0	0
Volunteer	5	0	0	0
WTFS	1	0	0	0
Total FY 25	14 (58%)	1 (4%)	9 (38%)	0
Total FY 24	19 (51%)	4 (11%)	14 (38%)	0
Total FY 23	16 (80%)	0	4 (20%)	0
Total FY 22	12 (44%)	7 (26%)	8 (30%)	0
Total FY 21	9 (69%)	1 (8%)	3 (23%)	0
Total FY 20	9 (48%)	2 (6%)	15 (45%)	0
Total FY 19	15 (48%)	4 (13%)	12 (39%)	0
Total FY 18	12 (37%)	6 (18%)	14 (43%)	0
Total FY 17	11 (48%)	3 (13%)	9 (39%)	0
9-yr total	**117 (50%)**	**28 (12%)**	**88 (38%)**	**-**

The relative frequency of recommendations for commitment vs. release has varied over the years, with some years showing a greater rate of commitment and some a greater rate of release. Table 33 shows the percentage of recommendations for commitment vs. release. The total number of evaluations per year (as shown in Table 31, above) ranges from a high of 51 in FY 08 to a low of 13 in FY 21. Evaluations in FY 08 and FY 09 were completed after a 60-day period of inpatient observation and evaluations conducted from FY 10 were conducted entirely on an outpatient basis.



A comparison of outcomes between the sum of the last two years of inpatient evaluations under T.C.A. § 33-7-303(a) (FY 08 & 09; n= 99) and the last 16 years of outpatient evaluations (FY 10 - FY 25; n= 462) shows a higher rate of commitment following outpatient recommendations (see Table 34 on the following page). It should be noted that although there was a greater frequency of release after a 60-day inpatient evaluation prior to FY 10, none of those recommended for release following an outpatient evaluation were hospitalized at all for the evaluation under T.C.A. § 33-7-303(a).

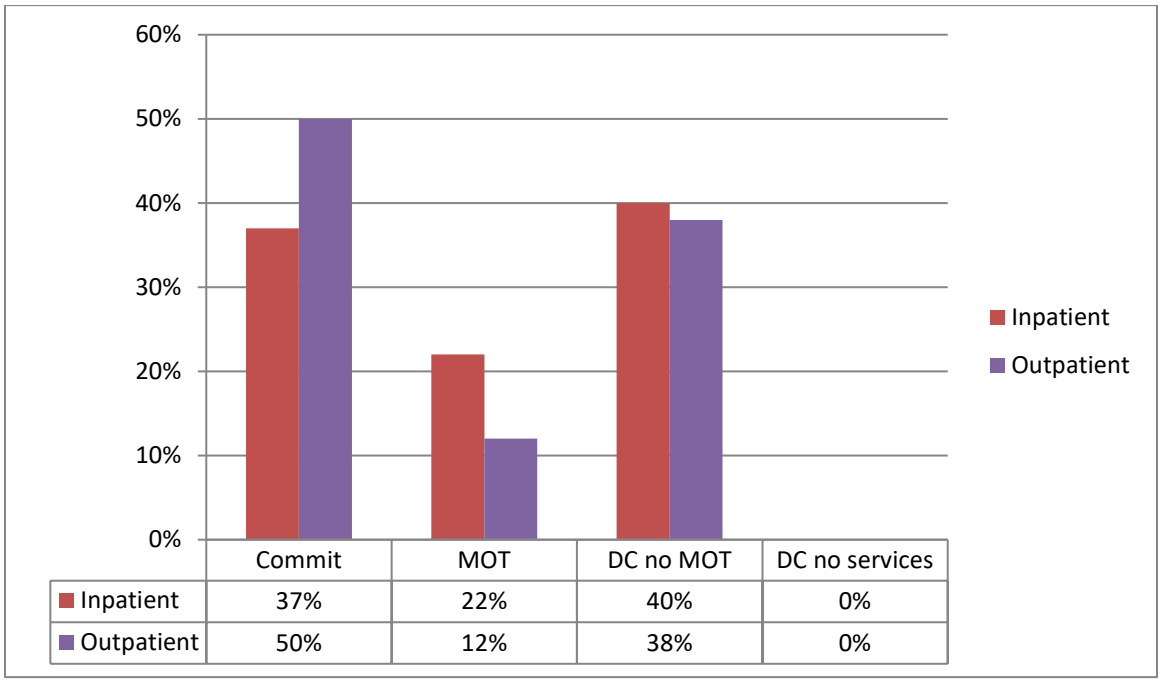
Table 34: Inpatient & Outpatient Evaluation Outcomes under T.C.A. § 33-7-303(a)



	Inpatient Eval	Outpatient Eval
Commit	37%	52%
Release	63%	48%

Breaking out the recommendations for release into those recommended for release with MOT vs. those recommended for release with no MOT requirement (Table 35, below; outpatient evaluation data FY 17-FY 25) shows that release without conditions (but with an aftercare plan) has consistently been more frequent than recommending release with MOT. Only one acquittee was recommended for MOT following the outpatient evaluation in FY 25. Comparing inpatient recommendations to outpatient recommendations, it appears possible that inpatient evaluators recommended release with MOT when outpatient evaluators have recommended commitment.

Table 35: Inpatient & Outpatient Evaluation Outcomes under T.C.A. § 33-7-303(a): Release with or without MOT



	Commit	MOT	DC no MOT	DC no services
Inpatient	37%	22%	40%	0%
Outpatient	50%	12%	38%	0%

COMMITMENT OF PATIENTS UNDER T.C.A. § 33-7-303(C):

Table 36 (below) shows the frequency of commitments of NGRI acquittees to the RMHIs under T.C.A. § 33-7-303(c). As noted above, the commitments prior to July 1, 2009 (the end of FY 09) occurred following an inpatient evaluation under T.C.A. § 33-7-303(a) and were based on recommendations from RMHI staff, while the commitments after July 1, 2009 (the beginning of FY 10) occurred after an outpatient evaluation based on recommendations from community agencies.

During FY 14, a determination was made that the shift of some forensic commitments from MTMHI and MBMHI to WMHI would increase the availability of suitable accommodations at MTMHI and MBMHI for emergency civil involuntary patients from those areas, and the increased concentration of forensic commitments at WMHI would allow for more focused treatment on relevant forensic issues for that population. As of April 1, 2014, new NGRI commitments under T.C.A. § 33-7-303(c) were admitted directly to WMHI regardless of the location of the committing court, with the exception of cases requiring the maximum security of FSP. In FY 16, 10 of the 17 commitments to WMHI were from courts outside the counties regularly served by WMHI (MTMHI = 9, MBMHI = 1).

This policy was reversed on October 1, 2016. All new commitments under T.C.A. § 33-7-303(c) were admitted directly to the RMHI which also accepted civil involuntary commitments from the same locality (see Table 16 on page 20 for breakout by county). Additionally, 12 NGRI patients who were not originally from WMHI's area were transferred to MTMHI on October 11th and 12th of 2016. Those transfers are **not** counted as new admissions to MTMHI in Table 35, below. The numbers in Table 35 are an unduplicated count of new NGRI admissions.

Table 36: T.C.A. 33-7-303(c) Commitment

FY 07-FY 09 Inpatient 303(a) evaluation; FY 10-FY 24 Outpatient 303(a) evaluation

	LMHI	MBMHI	MTMHI	WMHI	MMHI	FSP	TOTAL
FY 07	10	3	15	6	1	1	36
FY 08	10	1	9	5	0	0	25
FY 09	2	0	4	5	0	0	11
FY 10	4	1	7	7	0	1	20
FY 11	3	0	10	1	0	1	15
FY 12	3	2	20	4	0	2	31
FY 13	-	4	15	1	0	1	21
FY 14	-	0	6	5	0	3	14
FY 15	-	0	0	12	0	2	14
FY 16	-	0	0	17	0	0	17
FY 17	-	2	8	3	0	2	15
FY 18	-	3	5	9	0	0	17
FY 19	-	1	8	4	0	1	14
FY 20	-	2	11	5	0	1	19
FY 21	-	2	6	4	0	1	13
FY 22	-	2	6	6	0	0	14
FY 23	-	5	11	4	0	0	20
FY 24	-	7	7	6	0	0	20
FY 25	-	7	7	4	0	0	18
Avg.	-	2	9	6	0	1	19

When committed, NGRI acquittees begin a process of preparing for discharge. The number of patients discharged from the RMHIs who had been committed under T.C.A. § 33-7-303(c) is shown in Table 37.

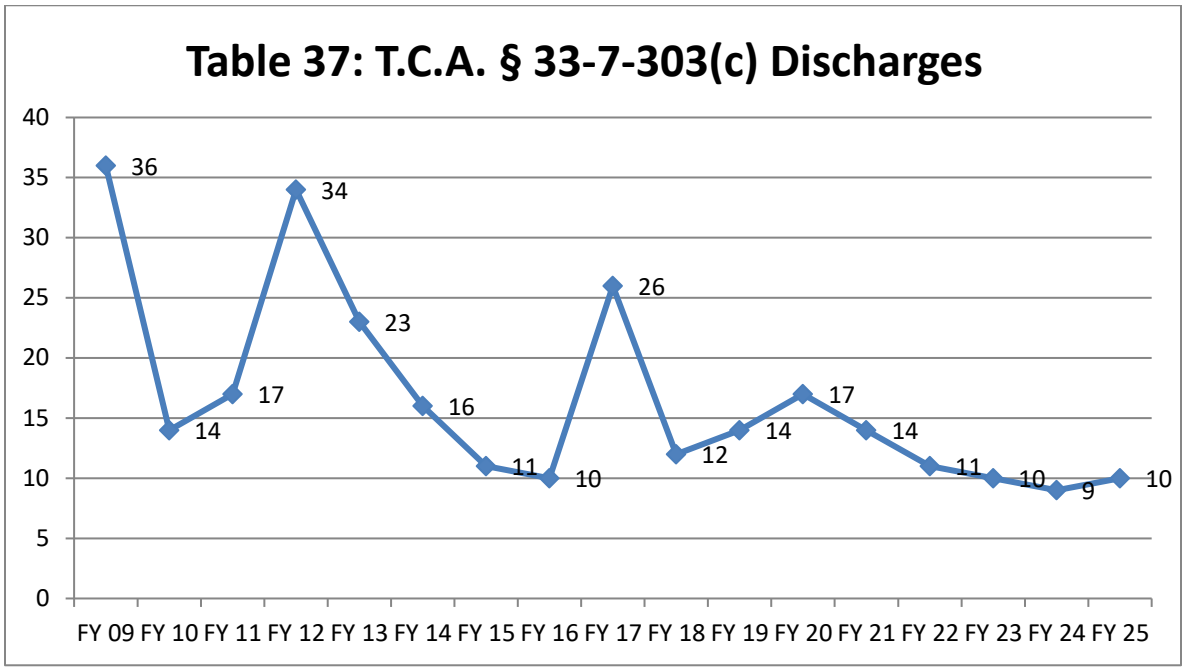


Table 38 summarizes the length of stay for all 10 patients discharged to the community during FY 25 who had been committed under T.C.A. § 33-7-303(c). This length of stay includes all days in all facilities for acquittees who have been transferred between FSP and an RMHI prior to discharge or transferred between RMHIs. This does not include any NGRI patients discharged who had been previously discharged on MOT and returned to the hospital for non-compliance with MOT.

Table 38: Length of Stay Under T.C.A. § 33-7-303(c)
Discharges during FY 25

Facility	0 – 30 Days	31-90 Days	3-6 Mos.	6 Mo.-1 Yr.	1-2 Yrs.	2-5 Yrs.	5 Yrs. +	Avg. LOS in days	Range in days
MBMHI					1	1	1	1,414	560-1,926
MTMHI		1			4		1	822	48-3,066
WMHI					1			484	484
Totals	**0**	**1**	**0**	**0**	**6**	**1**	**2**	**966**	**48-3,066**

The length of stay for insanity acquittees discharged in FY 25 was somewhat longer than in previous years. The shortest length of stay for NGRI patients discharged to the community in FY 24 was a month and a half (48 days) and the longest length of stay was almost eight and a half years. The average length of stay for all NGRI discharges in FY 24 was just under a year and a half.

In FY 25, the shortest length of stay was a month and a half, and the longest length of stay was just under eight and a half years. **The average length of stay for all NGRI discharges in FY 25 was two years and eight months.**

FY 24 was unusual in that there were no very-long-term patients discharged. Between FY 15 and FY 23, for the exception of FY 18 and FY 20, each year saw the discharge of a patient with a length of stay between seven and 25 years. In FY 25, there were two patients discharged with a length of stay between five and eight years.

Table 39 shows the lengths of stay for those patients still on census at the RMHIs at the end of the fiscal year (June 30), providing a point-in-time view of the range in length of stay for patients committed under T.C.A. § 33-7-303(c). The longest length of stay on June 30, 2025, was 16 years and eight months.

Table 39: Length of Stay for Patients On Census Under T.C.A. § 33-7-303(c) on June 30

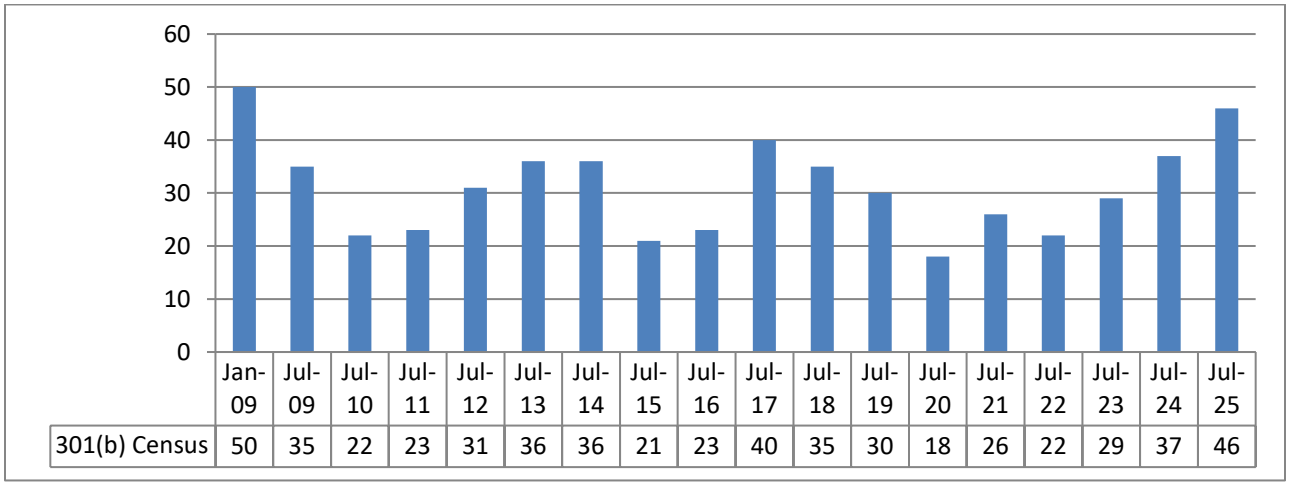
	0-6 Months	6-12 Months	1-2 Years	2-3 Years	3-5 Years	5-10 Years	10 + Years	Total
# patients 6/30/2020	7	9	5	5	9	6	4	45
# patients 6/30/2021	8	4	5	2	12	5	5	41
# patients 6/30/2022	8	1	9	6	5	10	6	45
# patients 6/30/2023	9	8	7	6	8	11	6	55
# patients 6/30/2024	10	8	13	4	11	14	6	66
# patients 6/30/2025	7	8	12	11	7	16	6	67

Forensic Census

The Office of Forensic and Juvenile Court Services monitors the forensic census in all the RMHIs closely to help insure that forensic patients are receiving evaluation and treatment in the most appropriate setting given the clinical and legal issues for each case. Commitments under T.C.A. §§ 33-7-301(b) and 33-7-303(c) are indefinite by statute and some patients will require an extended period of inpatient treatment which can significantly impact overall hospital census.

The tables below show the total number of patients in the facilities under T.C.A. § 33-7-301(b) (Table 40) and under T.C.A. § 33-7-303(c) (Table 41) who were on census on the first day of each month listed.

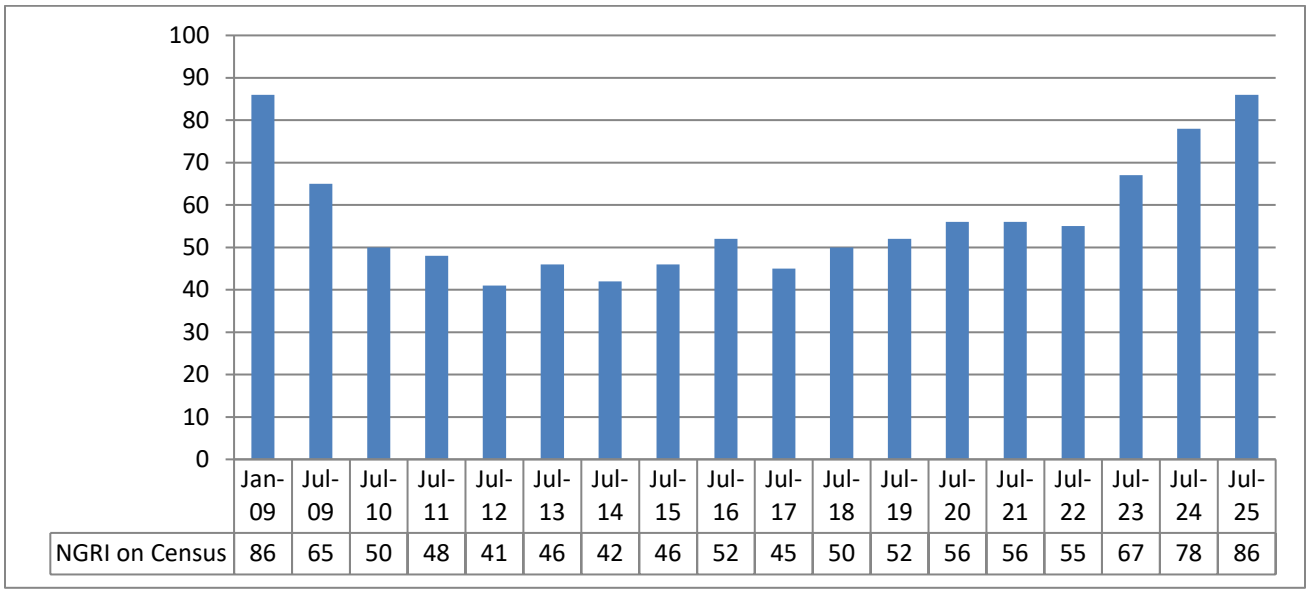
Table 40: T.C.A. 33-7-301(b) Cases on Census



	Jan-09	Jul-09	Jul-10	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17	Jul-18	Jul-19	Jul-20	Jul-21	Jul-22	Jul-23	Jul-24	Jul-25
301(b) Census	50	35	22	23	31	36	36	21	23	40	35	30	18	26	22	29	37	46

The number of patients on census under T.C.A. §33-7-301(b) on July 1, 2020, was clearly affected by the practice of slowing admissions in the last few months of FY 20 due to the pandemic. During FY 21 and FY 22, there was a push to bring all the cases that had been delayed, rebounding the census. FY 24 & 25 reflect the overall increase in demand for forensic evaluations.

Table 41: T.C.A. 33-7-303(c) Cases on Census

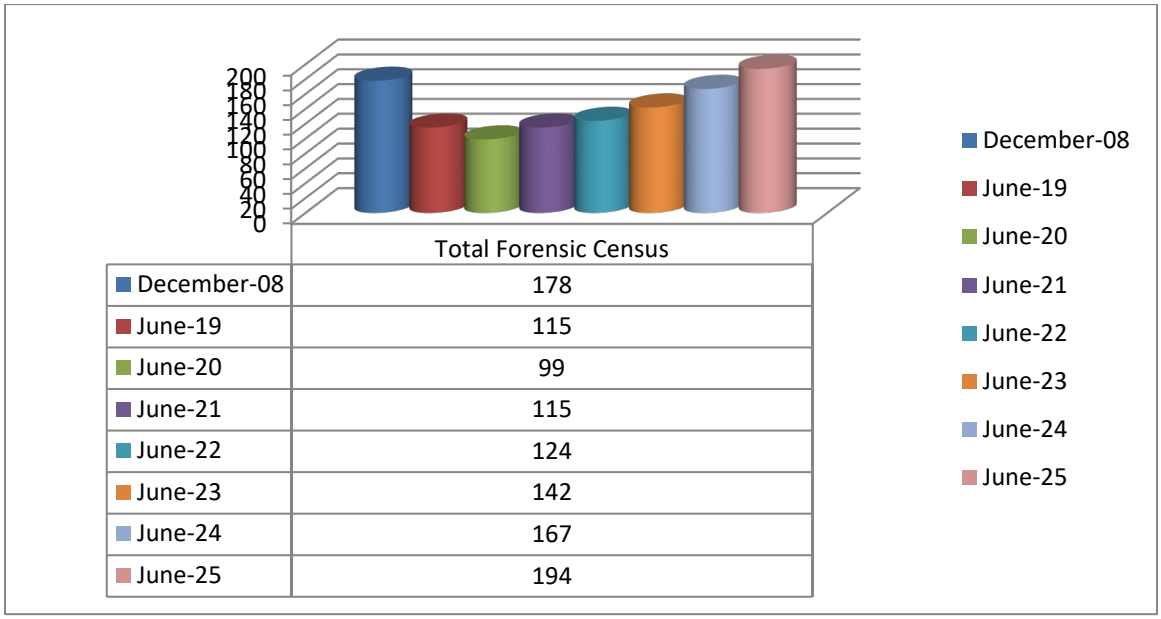


	Jan-09	Jul-09	Jul-10	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17	Jul-18	Jul-19	Jul-20	Jul-21	Jul-22	Jul-23	Jul-24	Jul-25
NGRI on Census	86	65	50	48	41	46	42	46	52	45	50	52	56	56	55	67	78	86

These totals include NGRI patients re-hospitalized following non-compliance with Mandatory Outpatient Treatment. The number on census ending FY 25 was the largest of any year since FY 09.

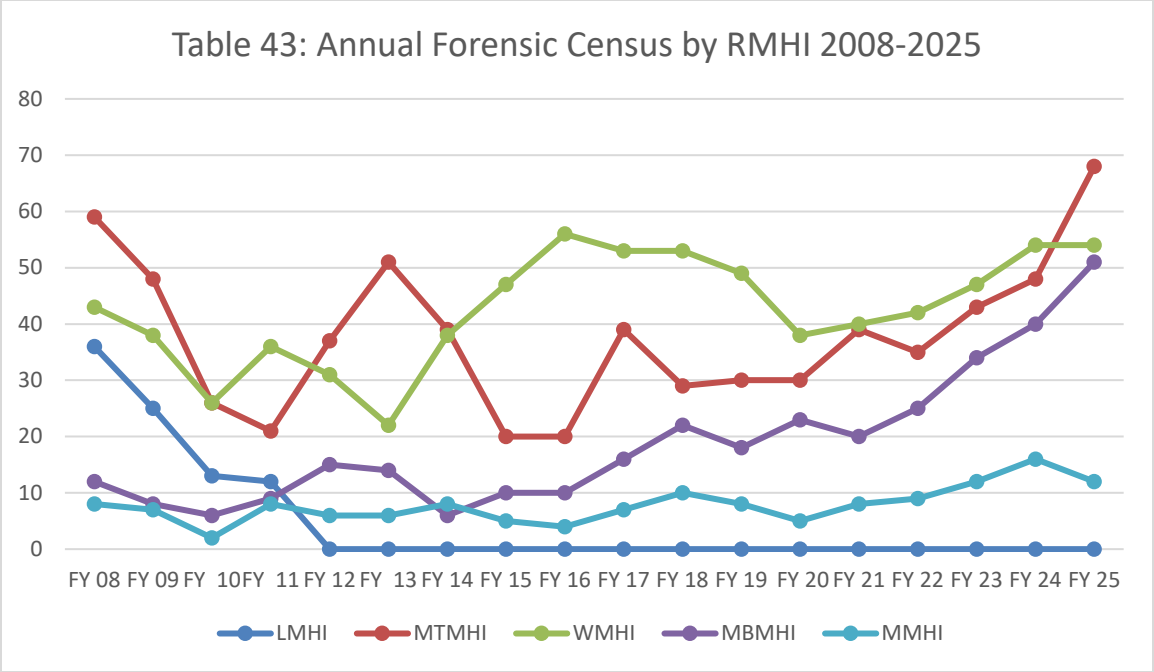
Table 42 shows the total forensic census for all facilities comparing December of 2008 (the formal beginning of census monitoring and management), with the last five fiscal years. FY 20 showed the effects of intentional efforts to reduce overall hospital census to facilitate isolation and general prevention of the spread of COVID-19. FY 21 shows some rebound, and FY 22 through FY 25 show the effects of increasing demand for forensic evaluations.

Table 42: Total Forensic Census State-Wide



	Total Forensic Census
December-08	178
June-19	115
June-20	99
June-21	115
June-22	124
June-23	142
June-24	167
June-25	194

Table 43 shows the RMHI forensic census since 2008, with one data point for each year (FSP census not included). All facilities increased forensic capacity beginning in FY 23 in order to work down referral lists for evaluations. Since 2009, the forensic census has comprised 25%-40% of the overall census.



As noted above (pp. 42-43) a determination was made to shift the commitment of all new NGRI admissions and incompetent defendants committed for longer than 90 days to WMHI from the other RMHIs beginning April 1, 2014. This policy continued until October of 2016 and the effects can be most clearly seen in Table 43, above. The census for WMHI increased while the census for MTMHI decreased and they actually crossed three months after implementation of the policy (July 2014).

The forensic census at MTMHI stayed low in 2015 while the forensic census at WMHI continued to grow until the policy was reversed in October 2016 and 15 forensic patients were moved from WMHI to MTMHI; note the increase at MTMHI between October 2016 and January 2017. This suggests that it was difficult for staff at WMHI to arrange aftercare and discharge for patients returning to the Middle Tennessee region, and that RMHIs are best able to arrange discharge and aftercare in those communities routinely served by that RMHI (county breakdown shown in Table 16, page 20, above).

Table 44 on the following page allows for an inspection of the census of each legal status within each facility and state-wide, comparing mid-December 2008 with the end of FY 25 (July 1, 2025). The change in law requiring that evaluations of new insanity acquittees under T.C.A. § 33-7-303(a) be conducted on an outpatient basis is reflected as that census goes to zero. Patients served at LMHI in 2008 were served at MBMHI in 2025. In the last half of FY 24, MMHI began to admit

incompetent defendants committed under T.C.A. §33-7-301(b) from Shelby County courts who were charged only with misdemeanors. The totals for 303(c) cases include NGRI patients who had been released on Mandatory Outpatient Treatment and then returned to the hospital for non-compliance with MOT as well as NGRI patients committed to the hospital yet to be released after their commitment.

Table 44: Forensic Census Comparison: December 2008 and July 2025

December 19, 2008

	LMHI	MTMHI	FSP	WMHI	MBMHI	MMHI	Total
301(a)	1	10	8	5	4	6	34
301(b)	16	11	8	12	4	0	51
303 (a)	2	2	0	2	0	0	6
303(c)	17	36	4	24	4	2	87
Total (% of total Census)	36 (24%)	59 (32%)	20 (95%)	43 (26%)	12 (10%)	8 (10.5%)	**178** (25%)

July 1, 2025

	LMHI	MTMHI	FSP	WMHI	MBMHI	MMHI	Total
301(a)	0	20	6	7	18	11	62
301(b)	0	18	2	17	8	1	46
303(c)	0	30	1	30	25	0	86
Total (% Census)	0	68 (36%)	9 (56%)	54 (38%)	51 (39%)	12 (32%)	**194 (38%)**

Risk Assessment Evaluations for the Board of Parole

Since Fiscal Year 2011 (July 1, 2010-June 30, 2011), the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) has had a Memorandum of Understanding with the Board of Parole (BOP) for TDMHSAS to provide risk assessment evaluations on certain parole eligible inmates in the Tennessee Department of Corrections (TDOC) as requested by the BOP. Statute requires a risk assessment of inmates convicted of certain sex offenses prior to consideration by the BOP (*see* T.C.A. § 40-28-116), but the majority of requests from the Board are for an assessment of propensity for violent re-offense on offenders sentenced for violent crimes. There have been 1,290 evaluations conducted FY 11-FY 25, 386 (30%) sex offender evaluations and 904 (70%) violent offender risk assessments. This total includes 41 female offenders (6 for sex offenses, 35 for violent offenses). There were fewer offenders requiring evaluation in FY 24 and FY 25 than in previous years, and fewer requests from the BOP for discretionary evaluations.

Evaluations are conducted by doctoral-level evaluators from the Department of Psychiatry at the Vanderbilt University Medical Center who have completed the TDMHSAS Forensic Evaluator certification and sex-offender-specific risk assessment training such as the Sex Offender Treatment Board provider training. Evaluations include the use of at least one actuarial risk assessment instrument for the male offenders (e.g., the Violence Risk Appraisal Guide[3] and/or the STATIC-99 revised scoring rules[4] with some measure of dynamic risk factors such as the SONAR[5]) as part of a comprehensive psychiatric evaluation and recommendations for treatment and risk reduction. Often, the institutional records will also contain the results of the Level of Service Inventory (LSI) and/or the STRONG-R completed by a TDOC forensic social worker. The LSI and STRONG-R are both measures intended to estimate the risk of general criminal recidivism, not limited to violent or sexual offenses. The results of the LSI and/or STRONG-R are in themselves useful in identifying the relevant amount of services necessary to reduce the risk of criminal re-offense and the specific

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[3] Quinsey, V. L., Harris, G. T., Rice, M. E. & Cormier, C. A. (2006) **Violent Offenders: Appraising and Managing Risk, 2nd Edition.** American Psychological Association; Washington, D.C.

[4] Phenix, A., Helmus, L., Hanson, R.K. (2012). Static-99R & Static-2002R Evaluators' Workbook. Ottawa, ON: Public Safety Canada.

[5] Hanson, R. K., & Harris, A. J. R. (2000). The Sex Offender Need Assessment Rating (SONAR): A method for measuring change in risk levels. (User Report 2000-01). Ottawa: Department of the Solicitor General of Canada.

issues to be addressed. Contrasting the results of the LSI and/or STRONG-R with other risk assessment instruments provides a useful view of the inmate's pattern of risk (e.g., an inmate may have a relatively low risk of a specific type of offense, such as violence or sexual offending, but a higher risk for criminal offending in general).

Prior to the pandemic, inmates were transported by the TDOC to a facility in Nashville for a face-to-face evaluation. TDOC discontinued transportation between facilities in March of 2020 and these evaluations transitioned to videoconference evaluations with the inmate in whichever TDOC they were located.

Table 45: Total Evaluations Conducted for the BOP

	Sex Offense	Non-Sex Offense	Total
FY 11	6	14	20
FY 12	20	38	58
FY 13	17	21	38
FY 14	22	30	52
FY 15	36	62	98
FY 16	20	94	114
FY 17	21	76	97
FY 18	41	98	139
FY 19	31	82	113
FY 20	28	80	108
FY 21	46	73	119
FY 22	37	66	103
FY 23	33	71	104
FY 24	14	61	75
FY 25	14	39	53
Total	**386**	**904**	**1,290**

Recommendations to the BOP are nuanced and case-specific, but for data collection purposes the Office of Forensic Services categorizes each evaluation as finding low, medium, or high

risk for re-offense of violent offenders. For offenders falling under one of the sex offense statutes, each evaluation is categorized as finding that the offender's risk for re-offense is either greater than or equal to the TDOC baseline for re-offense (TDOC Recidivism Study: Felon Releases 2001-2007) or less than the TDOC baseline for re-offense.

Table 46: Violent Offenders Risk Estimates

	High	Medium	Low
FY 11	8	2	4
FY 12	4	20	14
FY 13	3	8	10
FY 14	5	11	14
FY 15	12	25	25
FY 16	27	33	34
FY 17	13	39	24
FY 18	15	47	35
FY 19	7	48	27
FY 20	4	45	31
FY 21	10	35	28
FY 22	14	31	21
FY 23	10	33	28
FY 24	3	36	22
FY 25	4	14	21
Grand Total	**139 (15%)**	**427 (47%)**	**338 (37%)**

Table 47: Sex Offenders Risk Assessment

	Equal to or Greater Than Base rate for Re-Offense	Less Than Base rate for Re-Offense
FY 11	1	5
FY 12	4	16
FY 13	3	14
FY 14	3	19
FY 15	7	29
FY 16	6	14
FY 17	5	15
FY 18	10	32
FY 19	6	25
FY 20	2	26
FY 21	10	36
FY 22	7	30
FY 23	6	27
FY 24	4	10
FY 25	2	12
Grand Total	**76 (20%)**	**310 (80%)**

The smaller number of sex offender evaluations in FY 24 and FY 25 resulted in significant swings in the percentage of sex offenders whose risk for sexual re-offense upon release was estimated to be equal to or greater than that of the known base rate for TDOC-released sex offenders. In FY 24, 29% were rated as having a greater risk of re-offense than the known base rate while in FY 25 it was 14%. These results did not change the overall percentages for all years FY 11-FY 25 taken together (20%).

Juvenile Court-Ordered Evaluations

T.C.A. § 37-1-128(e) grants juvenile courts the authority to order mental health evaluations by an evaluator designated by the Commissioner of the TDMHSAS. While evaluations ordered for adult criminal defendants are limited strictly to competency to stand trial and/or mental capacity at the time of the offense, juvenile court-ordered evaluations are much broader in nature. These evaluations address:

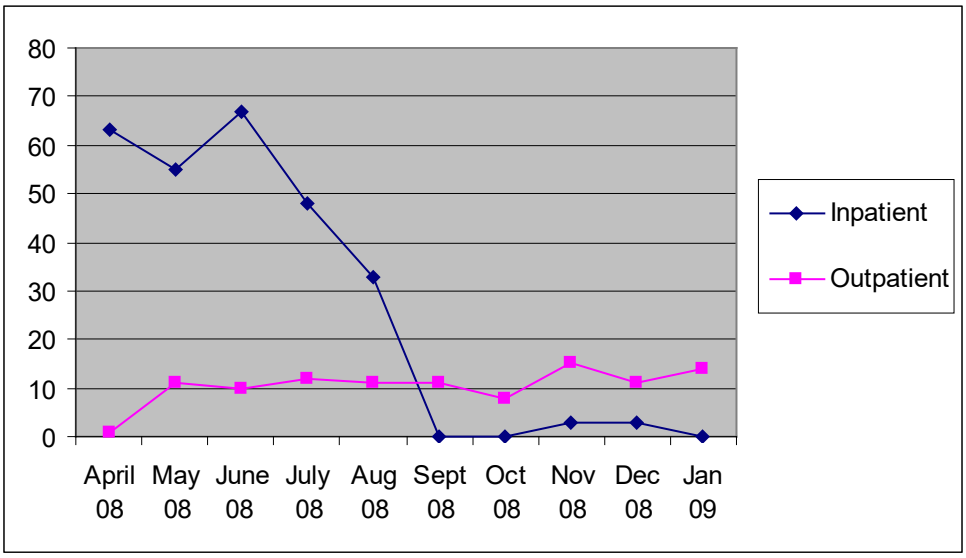
- whether the juvenile is mentally ill and/or developmentally disabled,
- what, if any, treatment is recommended,
- whether or not the juvenile meets commitment criteria, and
- legal questions such as competency to stand trial.

Prior to July of 2008, juvenile court judges made the determination of whether to order an evaluation to be conducted on an inpatient or outpatient basis. During FY 09, the Office of Forensic and Juvenile Court Services began to work with the Administrative Office of the Courts (AOC) on a project to transform the juvenile forensic evaluation service from a predominantly inpatient service to a more community-based service, a project which was supported by a Transfer Transformation Initiative (TTI) grant awarded by the Substance Abuse and Mental Health Service Administration and administered by the National Association of Mental Health Program Directors. On June 30, 2008, however, the Tennessee Court of Appeals released a decision in the case *In re: J.B.*[6] in which the Court found that the city or the county and not the state is responsible for the direct cost of evaluations ordered under this statute. State contracts with providers of inpatient juvenile court-ordered evaluations were terminated as of September 1, 2008, and the courts were notified that while juvenile court judges and "referees" (now "magistrates") retained the authority to order either inpatient or outpatient evaluations, inpatient evaluations ordered on or after that date would be billed to the county and outpatient evaluations would continue to be provided by the same local agencies and reimbursed by the TDMHSAS. This resulted in a dramatic change in the pattern of usage, demonstrated in Table 48, below, showing the monthly frequency of inpatient and outpatient juvenile court-ordered evaluations for the ten-month period around the Court of Appeals decision, April 2008-January 2009[7]. (The numbers on the vertical axis on the left should be multiplied by 10, so 60 = 600 and 10 = 100.)

[6] No. E2007-01467-COA-R3-JV; 2008WL 2579223 (TN. CT. App.); http://www.tsc.state.tn.us/OPINIONS/TCA/PDF/083/JBOPN.pdf

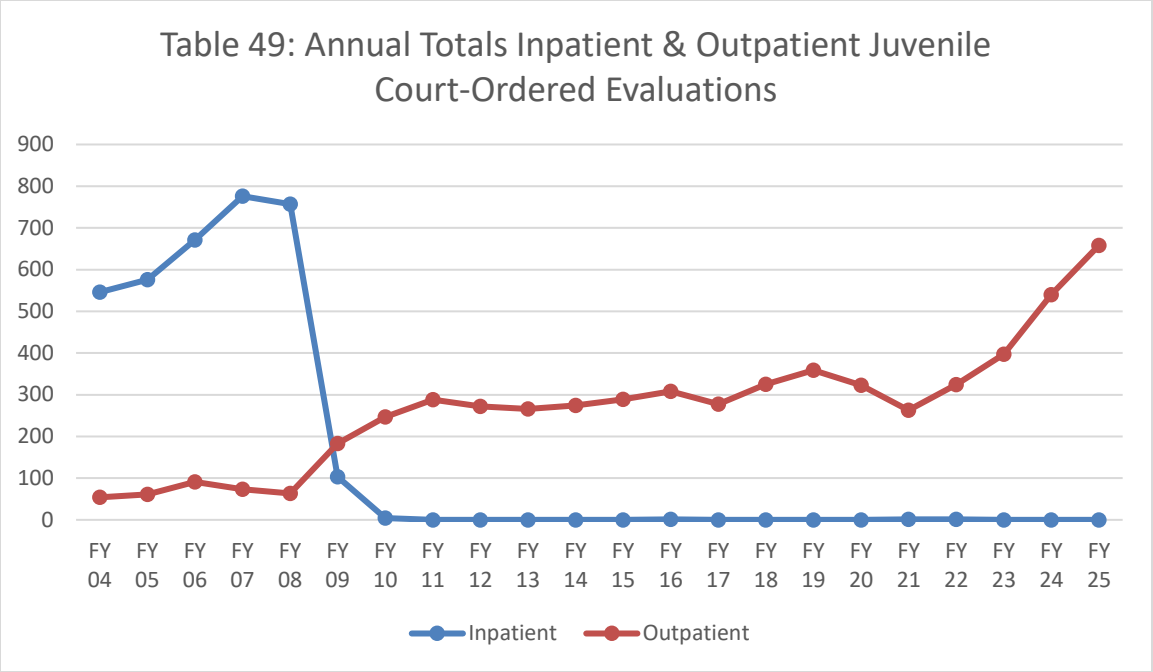
[7] See also Epstein, Feix, Arbogast, Beckjord & Bobo (2012) Changes to the financial responsibility for juvenile court ordered psychiatric evaluations *BMC Health Services Research* 12: 136

Table 48: Inpatient and Outpatient Juvenile Court-Ordered Evaluations



These changes were codified when the statutes governing the process for juvenile courts to order mental health evaluations and the responsibility for the cost of the evaluations were amended during FY 09. T.C.A. § 37-1-128(e) was amended to require that all evaluations be ordered on an outpatient basis first and only ordered inpatient if the outpatient evaluator recommended inpatient evaluation. T.C.A. § 37-1-150 was amended to clarify that the city or county would be responsible for the cost of inpatient evaluations. The decline in orders for inpatient evaluations resulted in the closing of child and adolescent units at the RMHIs. Juvenile courts have gradually increased the use of outpatient evaluations.

Table 49 shows an increase in demand similar to the increase in demand for "adult" forensic evaluations, but also likely shows an increased focus on youth making threats of "mass destruction" (school shooting threats) which law enforcement has noted increased over the past three years. Tennessee adopted a "no tolerance" policy for threats of school shootings, requiring anyone who makes such a threat to be charged, which results in a higher frequency of evaluations ordered on youth with those charges.



As noted above (see p. 4), Centerstone declined to renew their contract for FY 21 upon the retirement of John Garrison, Psy.D., their long-serving forensic psychologist. So that Dr. Garrison's retirement could become effective on June 30, 2020, Centerstone requested (and was approved) to stop accepting new orders as of April 1, 2020. At the beginning of FY 21, Volunteer Behavioral Health Care Systems and Pathways, Inc. expanded their counties to take on some of Centerstone's counties. Then, beginning September 1, 2020, Moore Psychology Services, PLLC (Dr. Donna Moore) picked up the remaining counties ("MPsy" in Table 50, below). (See Tables 4 and 5 on p. 6 for a key to which counties were re-assigned to which providers for FY 21 for outpatient forensic and juvenile court-ordered evaluations.)

Table 50: Frequency of Outpatient Juvenile Evaluations by Provider

	Cent	Cher	Front	McNabb	Path	Ridge	VU	Vol	WT	MPsy	TN
FY 08	5	11	5	0	5	4	9	15	9	-	63
FY 09	14	20	5	2	43	2	44	47	6	-	183
FY 10	23	24	9	1	79	2	41	68	0	-	247
FY 11	16	15	3	1	88	1	43	116	5	-	288
FY 12	23	20	11	1	70	3	40	102	2	-	272
FY 13	42	8	7	0	79	2	32	87	9	-	266
FY 14	43	10	9	0	77	6	33	82	14	-	274
FY 15	32	8	11	0	53	2	30	116	37	-	289
FY 16	46	10	8	0	75	3	19	96	51	-	308
FY 17	35	7	10	0	70	4	20	86	45	-	277
FY 18	23	14	8	1	93	2	41	109	34	-	325
FY 19	40	17	4	3	67	3	26	164	35	-	359
FY 20	40	9	6	0	59	4	17	147	41	-	323
FY 21	0	14	13	0	61	7	9	119	28	12	263
FY 22	0	10	12	0	81	4	23	141	32	21	324
FY 23	0	16	10	1	110	3	17	207	18	15	397
FY 24	0	15	16	0	151	7	17	269	49	16	540
FY 25	0	15	17	0	187	6	19	345	43	26	658

Juvenile court-ordered evaluations have been limited to youth alleged to have committed an offense that would be a felony for an adult until FY 23 (starting July 1, 2022) when funding was added to support conducting evaluations for youth charged with one specific misdemeanor; §39-16-315 threat of mass destruction for youth alleged to have threatened a school shooting (this offense became a felony as of July 1, 2024). The scope was then further expanded beginning July 1, 2024, to include *any* misdemeanor offense. Those evaluations are reflected in Table 51, below, which clearly shows the effect of the focus on school shooting threats resulting in juvenile court proceedings and orders for forensic evaluations.

Table 51: Type of Offenses Inpatient and Outpatient Juvenile Evaluations

	Violent Felony	Sex Offense	Non-Violent Felony	Misd.
FY 11	43%	39%	15%	-
FY 12	40%	43%	15%	-
FY 13	41%	44%	14%	-
FY 14	43%	44%	12%	-
FY 15	39%	42%	18%	-
FY 16	40%	43%	16%	-
FY 17	44%	40%	15%	-
FY 18	44%	33%	22%	-
FY 19	29%	47%	23%	-
FY 20	31%	41%	26%	-
FY 21	38%	50%	11%	-
FY 22	39%	46%	13%	-
FY 23	31%	32%	15%	22%
FY 24	26%	28%	13%	33%
FY 25	27%	19%	47%	7%

Table 52 indicates the frequency with which specific forensic issues were requested by juvenile courts in evaluation orders. Please note that a single evaluation may include multiple requests (e.g., psychosexual and competency to stand trial), so the percentages for a year will be greater than 100%.

Table 52: Rate of Specific Forensic Requests (Outpatient and Inpatient FY09- FY24)

	Competency	Insanity Defense	Psychosexual
FY 09	87%	61%	26%
FY 10	88%	40%	29%
FY 11	85%	33%	38%
FY 12	76%	38%	36%
FY 13	80%	38%	42%
FY 14	81%	42%	40%
FY 15	80%	43%	37%
FY 16	78%	39%	39%
FY 17	82%	42%	38%
FY 18	78%	40%	28%
FY 19	67%	37%	44%
FY 20	71%	37%	36%
FY 21	65%	35%	44%
FY 22	74%	37%	45%
FY 23	73%	39%	31%
FY 24	70%	38%	26%
FY 25	69%	40%	20%

Over half the evaluations were for youth ages 15-18 (52%). Almost one third (30%) of all juvenile court-ordered mental health evaluations were for youth ages 13-14, making 82% of evaluations for youth ages 13 and above (consistent with prior years).

Table 53: Age Range for Outpatient Juvenile Evaluations

	0-12	13-14	15 +
FY 11	14%	21%	63%
FY 12	13%	28%	58%
FY 13	12%	30%	57%
FY 14	14%	24%	60%
FY 15	12%	21%	65%
FY 16	8%	23%	67%
FY 17	10%	28%	61%
FY 18	8%	26%	64%
FY 19	11%	31%	57%
FY 20	10%	22%	67%
FY 21	13%	26%	60%
FY 22	9%	23%	66%
FY 23	12%	31%	58%
FY 24	14%	29%	57%
FY 25	18%	30%	52%

Tennessee Integrated Court Screening and Referral Project

In September 2009, the TDMHSAS and the Administrative Office of the Courts (AOC) were awarded a Criminal Justice/Mental Health Collaboration Grant by the Bureau of Justice Assistance to implement a process of conducting mental health and substance abuse screenings on youth referred to juvenile courts as unruly or delinquent. A two-and-a-half-year grant (October 1, 2009-March 31, 2012) in the amount of $196,750 was extended through March 31 of 2013. The project was intended to improve access to mental health and substance abuse services for youth in juvenile court, increasing the opportunities for diversion from the juvenile justice system and reducing recidivism. The project trains juvenile court staff, typically the courts' youth service officers (YSOs), to complete a juvenile justice screening version of the Child and Adolescent Needs and Strengths inventory (JJ-CANS) on youth at the point of intake into juvenile court for youth alleged to be unruly or delinquent (the first version was 33 items, reduced to 30 items in the revised JJ-CANS 2.0 version).

The JJ-CANS is an evidence-based screening practice on which each individual item identifies a need, and the screener rates the level of urgency on a four-point scale (0-3) for an action to address the need from "none" to "immediate." Items scored 2 or 3 are considered "actionable items"

when analyzing results. During the initial implementation of the project, youth who appeared to need mental health, substance abuse, or family services (including crisis services) were referred by the Department of Children's Services (DCS) court liaisons to locally available services. The original grant task force included DCS, the Vanderbilt University Center of Excellence for Children in State Custody (VUCOE), Tennessee Voices for Children, and the Tennessee Commission on Children and Youth along with the TDMHSAS and the AOC. These services were supported by a second and third round Transfer Transformation Initiative grant.

Project Expansion:

By the end of FY 17, YSOs from 33 juvenile courts[8] had completed training and certification for the JJ-CANS. During FY 18, the JJ-CANS was revised to include trauma related items that would provide an indication of the range of adverse childhood experiences in the youth's history. Items concerning the youth's juvenile justice history were added (e.g., number of previous referrals to juvenile court; age at first referral) which, along with selected JJ-CANS items (e.g., caregiver criminal activity, child substance abuse) produces a juvenile justice risk score. The revised JJ-CANS 2.0 also includes an estimated Commercial Sexual Exploitation Measure (CSEM) to aid in identifying potential victims of child sex trafficking.

The AOC's password-secure website for scoring the JJ-CANS 2.0 was modified so that after entering the demographic data and scoring the items, clicking a SCORE key produces a trauma score (the total number of nine trauma items scored "yes"), a juvenile justice risk score (high, medium, or low) and a CSEM score (high, medium, or low).

The algorithm for combining 11 items of information into a Community Risk Result score was derived from a sample of youth who had been scored on the CANS and rated for risk of re-offense using the Youth Level of Services Inventory (YLS[9]). The JJ-CANS 2.0 risk algorithm has face validity in that it contains the same 8-12 factors widely found to be associated with the risk of re-

[8] Benton, Blount, Bradley, Cocke, Coffee, Davidson, Decatur, Dickson, Dyer, Franklin, Grainger, Hamblen, Hawkins, Haywood, Jefferson, Johnson City, Knox, Lauderdale, Lawrence, Macon, Madison, Marion, McNairy, Meigs, Montgomery, Morgan, Obion, Putnam, Rhea, Sevier, Stewart, Sullivan, Washington

[9] Hoge, R.D. (2002) Standardized instrument for assessing risk and need in youthful offenders. *Criminal Justice and Behavior,* 2, 380-396.

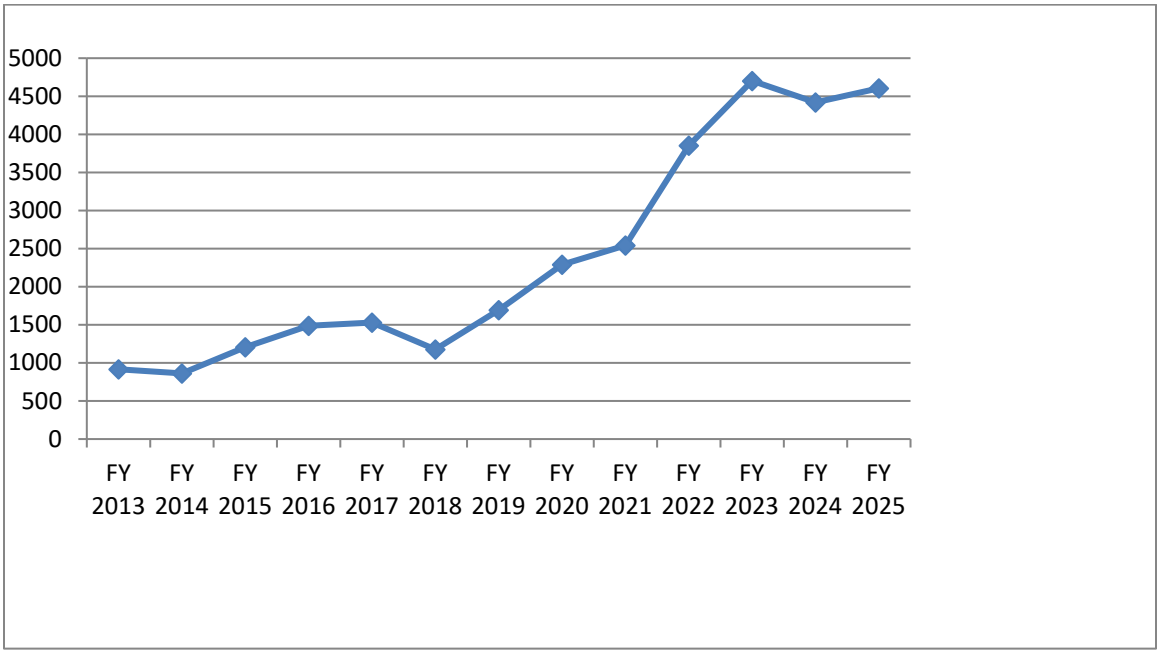
offense in youth[10] and concurrent validity in producing the same high-medium-low rating as the much longer YLS.

In the 2018 legislative session, the Tennessee General Assembly passed the Juvenile Justice Reform Act (Public Chapter 1052), a comprehensive package of reforms to the juvenile justice process with 58 sections, amending 22 existing statutes and creating six new ones. One such new statute, T.C.A. §37-1-164, requires that a validated risk and needs assessment shall be used in all delinquent cases post disposition in making decisions and recommendations concerning treatment and programming. Four other new statutes require that service plans for youth in juvenile court be "consistent with previously administered risk and needs assessment" (see T.C.A.§§37-1-129(a), -131(a)(2)(A), -137(f), and -173). The JJ-CANS 2.0 meets all the statutory requirements (see T.C.A. §37-1-102(b) for definition) for this process at no additional cost to the courts, so a significant expansion of TICSRP began in FY 19. The number of courts with at least one staff member certified in JJ-CANS scoring increased from 33 in FY 18 to 86 by the end of FY 20, with over 700 juvenile court staff certified on the JJ-CANS 2.0. During FY 25, 64 courts had entered JJ-CANS 2.0 screenings in the AOC portal (it has been 67 or 68 over the previous few years).

A de-identified data extract from the AOC was analyzed by Rameela Raman, Ph.D. and Alexis W. Fleming, M.S. of the Biostatistics team in the Vanderbilt University Center of Excellence, including data for Tables 54-57, below. The original version of the JJ-CANS was phased out starting in FY 19 so all screenings beginning in FY 22 were conducted using the JJ-CANS 2.0. There were **4,605 screenings (on 4,269 youth) conducted state-wide in FY 25**, compared to 4,420 screenings (on 4,095 youth) in FY 24, 4,703 screenings in FY 23, 3,852 screenings in FY 22, 2,542 in FY 21, 2,290 in FY 20 and 1,695 screenings in FY 19 (combined; 69 screenings with JJ-CANS 1.0 and 1,626 with JJ-CANS 2.0). The 4,605 screenings in FY 25 brings the grand total to **32,065** screenings conducted since October 2010. Table 54 shows the number of screenings conducted each fiscal year for which data is available separate from the running total.

[10] Baglivio, M. & Wolff, K. (2018) Serious and violent juvenile offenders and implications for juvenile justice systems. In Delisi & Conis (Eds.) *Violent Offenders: Theory, Research, Policy and Practice.* Jones & Bartlett Learning, Burlington MA.

Table 54: JJ-CANS Screenings per Fiscal Year (FY)



The demographic breakouts shown in Table 55, below, are very consistent with previous years.

Table 55: TICSRP JJ-CANS Demographics FY 25

Age Category	
19-21	0.1%
16 to 18	46%
13 to 15	42%
6 to 12	9%
Gender	
F	29%
M	71%
Race	
Black	37%
White	52%
Multiracial	5%
Other	6%
Offense Type	
Non-Violent	60%
Violent	40%

Table 56 shows the frequency of the automatically generated ratings of Community Risk (re-offense), the distribution of the number of trauma items coded "yes," and the Commercial Sexual Exploitation Measure scores. The frequencies are very consistent with previous years.

Table 56: TICSRP JJ-CANS Risk Ratings

Community Risk	
Low	88%
Medium	12%
High	0.4%
# Trauma Experiences	
None	21%
1 - 3	55%
4 - 6	19%
7 - 9	5%
Comm Sex Exploit Measure	
Low	91%
Medium	8%
High	1%

Notable outcomes:

50% of youth received an actionable score (2 or 3 on a scale of 0-3) on the item reflecting the need for mental health services. 21% received an actionable score on the item reflecting a need for substance abuse treatment. An actionable score would result in a referral to locally available resources.

43% of youth received an actionable score (2 or 3 on a scale of 0-3) on the item reflecting the Seriousness of the youth's alleged offenses, indicating some specifics steps should be taken to reduce the risk of recidivism.

23% of youth received an actionable score on School Achievement, and 20% received an actionable score on School Behavior.

Table 57 shows the frequency of the trauma items being scored as "yes." The order of frequency of the trauma items was the same each of the last three years.

Table 57: Trauma Items Scored Yes

	FY 23	FY 24	FY 25
Grief	48%	21%	21%
Community/School Violence	41%	18%	20%
Disruption in Caregiving	32%	12%	12%
Victim/Witness Criminal Activity	30%	11%	12%
Family Violence	28%	11%	10%
Emotional Abuse	23%	9%	9%
Neglect	19%	7%	6%
Physical Abuse	14%	6%	5%
Sexual Abuse	12%	4%	4%

Implementation of the Juvenile Justice Reform Act of 2018 was delayed due to the pandemic, but training and certification on the JJ-CANS 2.0 had been provided via Zoom meetings for months before the pandemic to provide access to YSOs across the state. Sessions have been held approximately every other month and include YSOs getting re-certified annually as well as first-time trainees, for a total of 50-70 participants at each training. The JJ-CANS 2.0 system provides an evidence-based, cost-free alternative screening for juvenile courts which is designed to fit into the regular practice of a youth service officer and can improve services planning and increase referral for mental health and substance abuse services when needed.

Mandatory Outpatient Treatment (MOT)

The annual report concerning Mandatory Outpatient Treatment (MOT) was prepared by Debbie Wynn, L.C.S.W., TDMHSAS MOT Coordinator. Her full report is posted elsewhere on the Forensics page of the TDMHSAS website (https://www.tn.gov/behavioral-health/mhsa-law/forensic-juvenile.html). This section provides a summary of that report.

Mandatory Outpatient Treatment (MOT) refers to a legal obligation for a person to participate in outpatient treatment. The purpose of MOT is to provide a less restrictive alternative to inpatient care for service recipients with a mental illness who require continued treatment to prevent deterioration in their mental condition and who will respond to a legal obligation to participate in outpatient treatment. There are three main types of MOT in Tennessee law, one in Title 33, Chapter 6, Part 6 (the requirements for which are defined in T.C.A. § 33-6-602), one in T.C.A. § 33-7-303(b), and one in T.C.A. § 33-7-303(g). Differences are summarized in Table 58, below:

Table 58: Three Types of MOT

T.C.A. § 33-6-602	T.C.A. § 33-7-303(b)	T.C.A. § 33-7-303(g)
Starts in the hospital for those committed under Title 33, Chapter 6, Part 5	Starts in the community for NGRI acquittees after evaluation under T.C.A. § 33-7-303(a)	Is required for service recipients found not guilty by reason of insanity of murder or a class A felony under Title 39, Chapter 13 whether released after evaluation under 33-7-303(a) or after commitment under 33-7-303(c).
Expires six months after release or previous renewal unless renewed	Does not expire	Need for continued treatment reviewed by court after an initial six month mandatory period, thereafter the court reviews annually
Can be modified or terminated by provider	Can only be terminated by the court	Can only be terminated by the court
A court finding of non-compliance can result in re-hospitalization	Does not allow for hospitalization, may result in civil or criminal contempt	Allows for hospitalization for those judicially committed, or may result in civil or criminal contempt

Table 59: Total MOTs
On June 30, 2025

Type of MOT	Active MOTs	Suspended MOTs Due to Hospitalization	Total MOTs
303b	66	5	71
303g	10	0	10
602	177	13	190
Both 303b and 602	3	0	3
Totals	253	18	271

Table 59, above, shows that on June 30, 2025, 7% of patients on MOT had their MOT suspended because they were hospitalized due to either non-compliance with their MOT contract or long-term emergency hospitalization despite being compliant with their MOT plan.

Non-forensic (i.e., civil) patients may be released on MOT. Non-forensic patients are judicially committed to a hospital for involuntary care under Title 33, Chapter 6, Part 5, Tenn. Code Annotated with no criminal charges. They may be placed on MOT when eligible for discharge if they meet the criteria for MOT under T.C.A. § 33-6-602. Forensic inpatients may also be placed on MOT under T.C.A. § 33-6-602 when released from the hospital if they have been committed subsequent to T.C.A. § 33-7-301(b), or 33-7-303(c) because those commitments are actually conducted under Title 33, Chapter 6, Part 5, Tenn. Code Annotated. Forensic cases may be placed on MOT under T.C.A. § 33-7-303(b) if the person is adjudicated not guilty by reason of insanity and does not meet commitment standards under Title 33, Chapter 6, Part 5, Tenn. Code Ann.

In FY 25 there were 99 forensic patients on MOT and 172 non-forensic patients on MOT. Many of the non-forensic patients released on MOT were originally forensic cases in the RMHIs under 33-7-301(b) but had their charges retired prior to discharge. That is about half the number of forensic patients on MOT compared to FY 23 and 34% more non-forensic patients on MOT.

New MOT Cases

In FY 2025, 27 new MOT cases were initiated. Of these cases, 25 were initiated under TCA § 33-6-602, two under TCA § 33-7-303(g), and none under TCA § 33-7-303b. This is an increase from FY 24 when 15 new MOT cases were initiated, FY 23 in which 10 new MOT cases were initiated, FY 22 in which 17 new MOT cases were initiated, and FY 21 in which 24 new MOT cases were initiated. It is a

decrease from FY 20 in which 36 new MOT cases were initiated and FY 19 in which 45 new MOT cases were initiated. The increase in new MOTs may partially be attributed to the regional mental health institutes recovering from the period of time in which they eliminated or reduced furloughs (and therefore discharges) during the pandemic during FYs 22 and 21 and the last three months of FY 20, or because the courts suspended hearings periodically during the same period. Some RMHIs continue to report having difficulty finding willing MOT providers for patients ready for discharge.

Table 60: FY 2025 Added MOTs by Month

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTALS
Added Total	1	2	3	5	2	3	0	1	3	2	2	3	27
303b	0	0	0	0	0	0	0	0	0	0	0	0	0
303g	0	0	0	0	0	1	0	0	0	1	0	0	2
602	1	2	3	5	2	2	0	1	3	1	2	3	25

TCA § 33-6-602 patients may have been in either forensic or non-forensic legal status, whereas all TCA § 33-7-303(b) and 303(g) MOTs are considered forensic patients having been found NGRI on a criminal offense. Six of the FY 25 new MOT cases had a non-forensic legal status and 21 had forensic legal statuses.

Thirteen of the 27 new MOT consumers had legal charges that originated in Davidson County. Five originated in Shelby County, and three in Hardeman County. The remaining six MOT consumers had legal charges that originated in Bedford, Campbell, Knox, Hamilton, Obion, and Unicoi counties.

Of the 25 new MOTs originating under T.C.A. § 33-6-602 and one originating in an RMHI under T.C.A. § 33-7-303(g), fourteen originated at Middle Tennessee Mental Health Institute, seven at Western Mental Health Institute, four at Moccasin Bend Mental Health Institute, and one at Memphis Mental Health Institute.

Terminations

In FY 2025, there were 18 MOT consumers whose MOT services were terminated, a reduced number from FY 24 when there were 27 MOT consumers whose MOT were terminated, 23 when

there were 48 MOT consumers whose MOT services were terminated and FY 22 when 47 MOT consumers had services terminated. In FY 21, 35 MOT consumers had services terminated.

Twelve of the FY 25 MOT consumers were terminated by their MOT agency and one consumer's MOT was allowed to lapse by their MOT agency. Two were terminated due to the death of the consumers. Two were terminated by court order. One consumer's MOT was terminated at the time of a hospital discharge by the regional mental health institute when their Treatment Team realized their legal status code was incorrect and the consumer did not require MOT.

There were thirteen consumers whose MOT was terminated or allowed to lapse by decision of the MOT agency's' Treatment Team. Of these 13 individuals, eight of them were complying with their MOT contracts and no longer needed MOT services to remain in compliance. The agencies lost contact with three individuals following a period of non-compliance. Two individuals suffered worsening physical health and needed to enter a long-term healthcare setting.

Of the 18 consumers whose MOT were terminated or lapsed, one received MOT services under the auspices of T.C.A. § 33-7-303(b), one under the auspices of T.C.A. § 33-7-303(g), and 16 received MOT services under the auspices of T.C.A. § 33-6-602.In FY 2024, there were 27 MOT consumers whose MOT services were terminated, a reduced number from FY 23 when there were 48 MOT consumers whose MOT services were terminated and also similar to FY 22 when 47 MOT consumers had services terminated. In FY 21, 35 MOT consumers had services terminated.

Table 61: FY 2025 MOTs Terminated or Lapsed By Type

T.C.A. § 33-7-303(g)	TCA § 33-7-303(b)	TCA § 33-6-602
1	1	16

The shortest length of MOT service of those 18 consumers whose MOT was terminated was less than one month (this individual died in the community). The next shortest length of MOT service was six months, when the consumer's MOT was terminated during a court hearing. The longest length of MOT service was for several consumers who had received MOT services for more than ten years.

Table 62: FY 2025 MOT Terminations
By Number of Years on MOT at Time of Termination

0 – 1 Year	1 – 2 Years	2 – 5 Years	5 – 10 Years	10 + Years
4	0	2	3	9

During FY 25, two consumers died while on active MOT. Both deceased consumers were receiving MOT services under TCA § 33-6-602. Of the remaining 16 consumers whose MOT was terminated, 14 received MOT services under TCA § 33-6-602, one under TCA § 33-7-303(b), and one under TCA § 33-7-303(g).

The most common reason for a MOT to be terminated was that the person had successfully adjusted to the community and no longer needed MOT. Twelve of the 18 individuals had their MOT terminated for this reason. Of these twelve, ten had become compliant and no longer needed MOT to maintain their mental health stability and two moved into long-term care settings due to poor physical health. The agencies lost contact with three individuals during a period of non-compliance and after searching for them with no result terminated their cases. As noted above, two individuals passed away while on MOT. And one individual's MOT was terminated at discharge by the RMHI after they learned that his legal status code was inaccurate and that he did not legally require an MOT.

Table 63: FY 2024 MOT Terminations

By Reason

Terminated by MOT agency	Deceased	MOT allowed to lapse by agency	Terminated by court order	Discharged from RMHI without MOT
12 (67%)	2 (11%)	1 (6%)	2 (11%)	1 (6%)

Affidavits of Non-Compliance

All MOT consumers sign a contract with a supervising agency at the time his or her MOT services were initiated. These MOT contracts are occasionally modified as needed to meet the consumer's changing treatment needs. When the recipient is not in compliance with their MOT contract the agency attempts to bring them into compliance. If they cannot be brought into satisfactory compliance the agency files an Affidavit of Non-Compliance to alert the court and/or the district attorney of the non-compliance.

A wide range of differing outcomes can result following the filing of an Affidavit of Non-Compliance. A previously non-compliant consumer may become compliant upon learning of the potential court hearing. If they meet commitment criteria, they may be admitted on an emergency basis to a private or a state hospital. If they are receiving MOT services under the auspices of T.C.A. § 33-6-602 or under the auspices of T.C.A. § 33-7-303(g) (and they had been discharged from a mental health hospital following a judicial commitment), then at the non-compliance court hearing they may be returned to the hospital from which they were released. If they are receiving MOT services under the auspices of T.C.A. 33-7-303(b) or were placed on MOT under the auspices of T.C.A. § 33-7-303(g) while in the community (without having been committed to a hospital) then the court may order civil or criminal contempt charges. Those cases may only be hospitalized through a new involuntary commitment procedure.

During FY 2025, a total of 18 new Affidavits of Non-Compliance were filed. Sixteen Affidavits of Non-Compliance were continued into FY 25 from previous fiscal years, but seven of these sixteen were resolved during FY 25. his constitutes a total of 34 non-compliant MOT consumers during FY 25. At the end of the year only 18 were still unresolved.

The 18 new Affidavits filed in FY 25 are a similar frequency as the 16 Affidavits of Non-Compliance filed in FY 24, 18 Affidavits of Non-Compliance filed in FY 23 and the 19 Affidavits of Non-Compliance filed in FY 22, but substantially fewer than the 27 Affidavits of Non-Compliance filed in FY 21 and a noticeable decrease from the 42 Affidavits of Non-Compliance filed in FY 2020.

At the end of FY 25 there were 271 individuals on MOT and 18 individuals with non-compliance affidavits still pending resolution, which is 7**%** of the total.

Table 64: FY 25 Outcome of Non-Compliance Affidavits

Status	Number
Consumer became compliant prior to court hearing	12
Location unknown to MOT agency.	6
Awaiting non-compliance hearing	5
Hospitalized for non-compliance or further treatment.	4
In jail awaiting hearing on unrelated charges or non-compliance	4
Insurance issues led to non-compliance	1
Difficulty with conservator compliance	1
Placed in nursing home	1
Total	34

Types of Original Legal Charges by Frequency

Table 65 shows the different types of criminal offenses that MOT consumers were charged with associated with the process that led to them being placed on MOT. As described above, patients committed to an RMHI under Title 33, Chapter 6, Part 5 may not have had any criminal charges associated with the hospitalization prior to their release on MOT under T.C.A. § 33-6-602. Those consumers are categorized as "none." That includes only patients who never had a criminal charge during this hospitalization. Patients who had their charges retired prior to release on MOT are counted in the category of the charge that was retired. Patients with multiple charges are only counted once under the most serious charge.

Table 65: FY 2025 Types of Original Legal Charges by Frequency

Charge(s)	Number of Occurrences
Aggravated Assault (felony)	82
Simple Assault (misdemeanor)	30
None	28
Murder	22
Vandalism/Trespassing/Nuisance	22
Sex Offense	21
Theft	20
Attempted Murder	16
Weapons Offenses	11
Arson	8
Robbery	5
Kidnapping/Attempted Kidnapping	3
Escape/Failure to Comply/Obstruction of Justice	3
Total	**271**

MOT for Persons Found NGRI of First-Degree Murder or Other Class A Felonies

Effective 7/01/2017 legislation took effect which requires persons found not guilty by reason of insanity (NGRI) of a charge of first-degree murder or a Class A felony under Title 39, Chapter 13, to participate in mandatory outpatient treatment (MOT) when discharged from the hospital or released by the court following the outpatient evaluation under T.C.A. § 33-7-303(a) who are not committable to a hospital. This legislation mandates that any person ordered by the trial court to participate in outpatient treatment must do so for an initial period of six months. The court may continue the MOT beyond the initial six-month period. After the initial six-month period the court shall review the person's need for continued MOT on an annual basis.

The Legislature appropriated some funds for FY 25 to pay for MOT services for persons on MOT under the new law who do not have insurance or income to meet their treatment needs. During FY 25 two consumers were adjudicated under the new law, raising the total number of persons on MOT under the auspices of T.C.A. § 33-7-303(g) to 11. At the initial six-month court

review one of the new 303(g) consumer's MOT was terminated, lowering the total number of 303(g) MOTs to ten at the end of the fiscal year. At this point other resources have been available to meet the treatment and housing needs of these consumers.

Summary and Conclusion on MOT:

As noted in the introduction, the purpose of MOT is to provide a less restrictive alternative to inpatient care for service recipients with a mental illness who require continued treatment to prevent deterioration in their mental condition and who will respond to a legal obligation to participate in outpatient treatment. The data reported here support MOT in Tennessee as an effective mechanism to support the recovery of people living with mental illness who might otherwise have difficulty actively participating in treatment in the community. In FY 25 **new** affidavits of non-compliance were filed in only **7%** of all MOT cases. When those affidavits that were carried over from previous fiscal years are included that percentage rises to 13%. A person living with a severe and persistent mental illness may require hospitalization even if they are compliant with treatment. Even so, as a point-in-time measure, on June 30, 2025, only 7% of all patients with an MOT obligation were hospitalized. Finally, the most common reason by far for the termination of the MOT is that the person had recovered to the point they no longer required a legal obligation to participate in treatment, which is the ultimate goal of MOT in Tennessee.

Forensic Services Financial Report

Outpatient Services

Outpatient services are reimbursed on a fee-for-service basis. Table 66 (below) reflects the reimbursements for outpatient adult and juvenile evaluation and treatment services by provider. Reimbursement rates for evaluations were increased in FY 17 from $300 per evaluation of competency to stand trial and $300 per evaluation of mental capacity at the time of the crime (i.e., $600 for both issues) to $400 per each evaluation (i.e., $800 for both questions). In FY 24, reimbursement for cases with at least one felony charge were increased to $500 per competency and $500 per mental condition (i.e., $1,000 for both) while reimbursement for misdemeanor-only cases remained at $400 each ($800 total) to ease the impact on county budgets. In FY 25, counties were no longer billed for forensic evaluation and treatment services, and the reimbursement for misdemeanor cases was increased to match that of felony cases (since the same amount of work is done regardless of the nature of the offense) to $500 per competency and $500 per mental condition (i.e., $1,000 for both).

Reimbursement rates for juvenile court-ordered forensic evaluations remained unchanged in FY 25. Adult and juvenile outpatient services are counted together in the totals below. Each provider submits a monthly invoice with documentation on each case. The TDMHSAS forensic specialists check each case for proper documentation that the appropriate service was provided and authorizes payment on those cases with adequate documentation. Denial of payment for a case is rare. Please note that Moore Psychology Services PLLC was only contracted for nine months of FY 21 but all 12 months beginning in FY 22, and that Pathways and Volunteer expanded the number of counties they covered starting in FY 21.

Table 66: Outpatient Expenditures, Adult and Juvenile Services

	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17
Centerstone	$127,600	$132,100	$138,600	$131,300	$152,100	$149,650
Cherokee Health Systems	$91,300	$68,950	$70,950	$63,000	$60,500	$88,550
Frontier Health, Inc.	$104,950	$86,350	$91,050	$85,700	$100,250	$118,000
Helen Ross McNabb	$42,100	$35,550	$29,250	$42,050	$43,500	$71,800
Pathways	$183,100	$188,800	$182,700	$189,400	$208,300	$260,800
Ridgeview	$54,050	$33,150	$36,750	$24,800	$34,500	$63,250
Vanderbilt	$147,800	$119,150	$126,300	$117,550	$125,300	$184,450
Volunteer	$291,700	$303,850	$280,400	$325,600	$321,750	$338,850
WTFS	$531,350	$487,200	$471,400	$429,250	$449,650	$497,600
TOTAL	**$1,573,950**	**$1,455,100**	**$1,427,400**	**$1,408,650**	**$1,495,850**	**$1,772,950**

	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23
Centerstone	$156,750	$193,350	$177,850	0	0	0
Cherokee Health Systems	$98,600	$106,250	$88,550	$81,550	$89,500	$94,250
Frontier Health, Inc.	$113,850	$119,200	$113,300	$106,100	$117,400	$118,950
Helen Ross McNabb	$69,000	$72,950	$61,200	$56,000	$90,250	$90,850
Moore Psychology	0	0	0	$48,700	$82,400	$59,700
Pathways	$308,700	$280,800	$256,100	$260,950	$322,850	$344,450
Ridgeview	$64,755	$57,650	$69,750	$61,800	$62,300	$71,500
Vanderbilt	$253,450	$297,450	$318,800	$270,050	$387,350	$386,450
Volunteer	$366,700	$418,450	$387,350	$392,300	$477,450	$590,800
WTFS	$543,350	$609,350	$561,750	$443,150	$563,950	$596,550
TOTAL	**$1,966,700**	**$2,155,450**	**$2,034,650**	**$1,720,600**	**$2,193,450**	**$2,353,500**

	FY 24	FY 25	FY 26	FY 27	FY 28	FY 29
Cherokee Health Systems	$120,558	$152,625				
Frontier Health, Inc.	$215,416	$180,100				
Helen Ross McNabb	$127,300	$132,000				
Moore Psychology	$89,800	$119,550				
Pathways	$529,300	$523,650				
Ridgeview	$98,444	$90,300				
Vanderbilt	$464,820	$493,150				
Volunteer	$840,150	$992,100				
WTFS	$767,075	$812,300				
TOTAL	**$3,325,863**	**$3,495,775**				

Inpatient Services

The Regional Mental Health Institutes are reimbursed by the Office of Forensic Services for forensic services at the rate of $450 per day. Documentation is required from the facilities to allow the TDMHSAS forensic specialists to authorize payment. This helps insure that proper procedures are followed in forensic cases and that patients stay only as long as necessary. Documentation is submitted by the facilities on an ongoing basis for active cases, and the invoices are reconciled at the end of each month. A facility would not be reimbursed, for instance, for the days that a patient was on leave in the community and not actually at the facility. The decrease in FY 21 reflects the total forensic admissions being held down by the need for each facility to pause non-emergency admissions for weeks at a time for infection control during the pandemic.

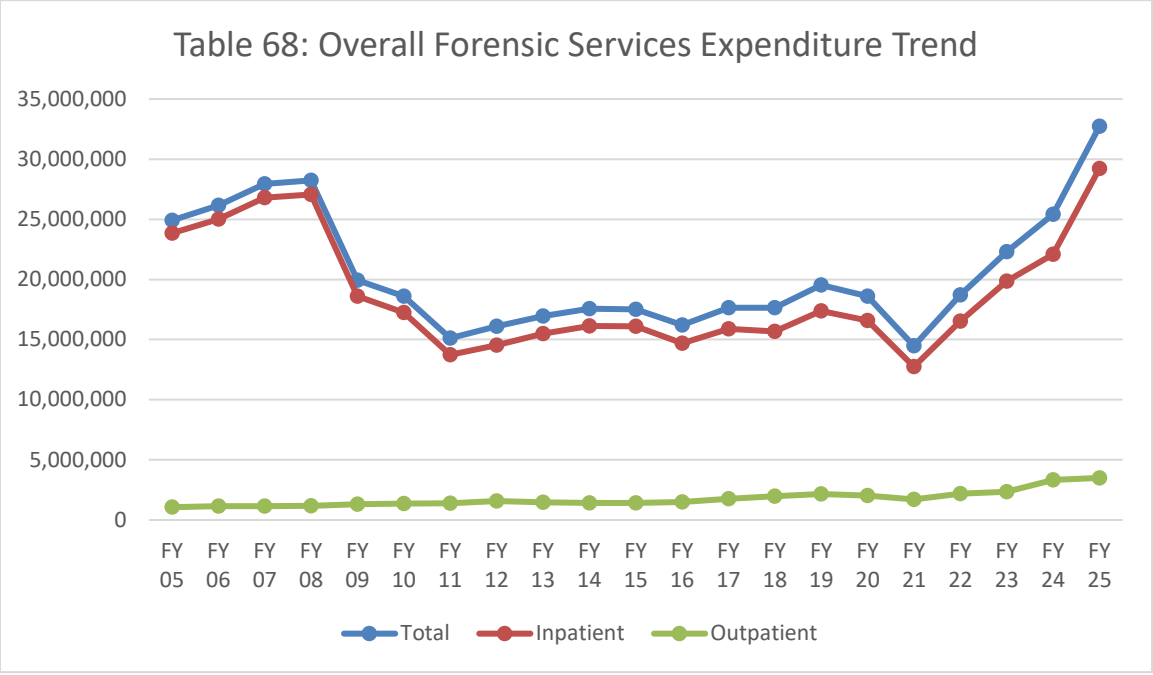
Table 67: Inpatient Forensic State Expenditures

	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
LMHI	$2,667,600	$2,302,650	$1,293,300	0.0	0.0	0.0
MBMHI	$872,100	$774,450	$864,900	$2,258,100	$2,150,100	$1,226,250
MMHI	$526,050	$666,000	$689,850	$539,100	$563,850	$564,750
MTMHI	$8,126,875	$5,657,850	$7,234,650	$8,771,400	$8,689,500	$7,380,450
WMHI	$5,047,200	$4,380,300	$4,454,100	$3,931,650	$4,725,900	$6,942,600
TOTAL	**$17,239,825**	**$13,731,250**	**$14,536,800**	**$15,500,250**	**$16,129,350**	**$16,114,050**

	FY 16	FY 17	FY 18	FY 19	FY 20
MBMHI	$1,174,500	$1,715,400	$2,525,850	$2,510,100	$2,356,200
MMHI	$558,900	$634,950	$666,450	$882,900	$634,500
MTMHI	$4,782,150	$5,944,050	$5,539,950	$5,819,400	$6,523,200
WMHI	$8,190,000	$7,587,000	$6,944,400	$8,169,300	$7,065,450
TOTAL	**$14,703,750**	**$15,881,400**	**$15,676,650**	**$17,381,700**	**$16,579,350**

	FY 21	FY 22	FY 23	FY 24	FY 25
MBMHI	$2,850,300	$3,413,250	$4,106,250	$5,069,250	$7,006,500
MMHI	$762,750	$1,030,050	$1,294,200	$1,341,000	$1,973,700
MTMHI	$7,351,200	$6,020,100	$7,493,400	$8,005,950	$11,947,050
WMHI	$6,225,300	$6,052,500	$6,972,300	$7,676,550	$8,298,900
TOTAL	**$12,746,750**	**$16,515,900**	**$19,866,150**	**$22,092,750**	**$29,226,050**

Table 68, below, combines total inpatient expenditures with outpatient expenditures. There was a significant decrease between FY 08 and FY 09 with the switch of juvenile court-ordered evaluations from predominantly inpatient evaluations to virtually all outpatient evaluations. Notable declines can be seen in FY 10 and FY 11 following the changes in billing for misdemeanor-only evaluations (see p. 14, above) and the change in evaluations of NGRIs under T.C.A. § 33-7-303(a) from inpatient to outpatient. The lowest point in expenditures was FY 21, reflecting the pauses in non-emergency admissions noted above during the pandemic. Increases in FY 25 reflect an increase in overall volume with a particular increase in misdemeanor inpatient evaluations once the counties were no longer being billed for misdemeanor services, and an increase in commitments of incompetent defendants influenced by Jillian's Law.



Misdemeanor Billing:

At the beginning of FY 10 (July 1, 2009; actually signed into law June 26, 2009) T.C.A. § 33-7-304 made counties responsible for the cost of forensic evaluation and treatment services ordered under Title 33, Chapter 7, Part 3 for cases in which the defendant was charged only with a

misdemeanor (or misdemeanors). This statute was subsequently repealed effective July 1, 2024. During the period July 1, 2009-June 30, 2024, TDMHSAS billed counties for outpatient services for misdemeanor cases the same amount that outpatient providers were reimbursed. Inpatient services were billed to the counties directly by the RMHIs at the *per diem* rate of $450 for all counties regardless of which RMHI provided the services. This rate was established by contract between TDMHSAS and each county. That rate was consistent with the typical reimbursement rates from most third-party payers when the law was enacted in 2009, it provided consistency for all counties across the state and was in fact a reduction of the "private pay" rate established under T.C.A. § 33-2-1101 which varies across facilities.

It should be noted that the billed amount in FY 17 reflects an increased cost per evaluation, typically $800 per evaluation after being $600 per evaluation previously.

Table 69: Outpatient Misdemeanor Billing July 1, 2009-June 30, 2024

	Billed
FY 10	$150,900
FY 11	$257,900
FY 12	$263,300
FY 13	$249,000
FY 14	$250,200
FY 15	$194,300
FY 16	$217,400
FY 17	$234,700*
FY 18	$322,000
FY 19	$307,000
FY 20	$333,600
FY 21	$214,600
FY 22	$331,700
FY 23	$340,900
FY 24	$404,000
Total	**$4,071,500**

*rate per evaluation increased from $600 to $800 in FY 17

The total for FY 21 was the lowest since the rates for outpatient evaluations increased from $600 per evaluation to $800 per evaluation in FY 17. This supports the hypothesis that fewer evaluations were ordered on misdemeanor cases during the pandemic since defendants charged

with misdemeanors were more likely to be released from jail in order to reduce the census for infection control. This is further supported by the return in FY 22 and 23 to pre-pandemic totals.

Shelby County billing ($137,800) accounted for 34% of the total in FY 24, the last year of billing the counties, which was fairly consistent with FY 23 (33%) and FY 22 (38%) and more notably lower than FY 21 (46%) and FY 19 (44%), but consistent with FY 20 (33%). Davidson County's billing of $114,500 was significantly higher in FY 24 than FY 23 ($84,800) and FY 22 ($88,400). A task force coordinated by the Metro Davidson County mayor's office and led by Davidson County General Sessions court staff identified a need for additional funding which was granted for FY 24, which resulted in increases for outpatient and inpatient misdemeanor evaluation orders.

Table 70 shows the amounts billed by the RMHIs and FSP for inpatient misdemeanor evaluation and treatment services. The total for FY 21 showed a general slowdown during the pandemic.

Table 70: Inpatient Misdemeanor Services Billing

	Billed
FY 10	$985,150
FY 11	$918,450
FY 12	$1,776,150
FY 13	$997,100
FY 14	$702,450
FY 15	$1,019,250
FY 16	$959,400
FY 17	$1,306,350
FY 18	$1,340,100
FY 19	$1,044,900
FY 20	$904,500
FY 21	$639,450
FY 22	$904,050
FY 23	$1,536,300
FY 24	$2,090,250
Total	**$7,950,350**

During FY 25, the first year after repeal of §33-7-304, there was an increase in the frequency of misdemeanor cases, both outpatient and inpatient. Outpatient misdemeanor evaluations increased from 21% (n=531) of all evaluations in FY 24 to 26% (n=700) in FY 25. Inpatient misdemeanor evaluations increased from 21% (n=152) to 29% (n=244) in FY 25. Shelby County did

not change their pattern when being billed for misdemeanor evaluations for either outpatient or inpatient evaluations, so the difference is even more pronounced for RMHIs other than MMHI: 12% (n=66) in FY 24 and 26% (n=168) in FY 25.

Forensic Targeted Transitional (TTS) Funds:

Forensic TTS funds are used primarily as "bridge" funding to help forensic patients in RMHIs be discharged to the community and to stay in the community longer. Disability benefits are typically discontinued for most forensic patients during the period after their arrest while they are incarcerated during the criminal justice process. For those eventually found not guilty by reason of insanity and committed to an RMHI, benefits may not start again until an administrative process to confirm eligibility is completed after their discharge to the community. Forensic TTS funds are used to pay for housing and treatment services until benefits are restored and are used primarily to support patients who had been found Not Guilty by Reason of Insanity and committed to an RMHI. Defendants found unrestorably incompetent to stand trial and have had their charged dismissed or retired are also eligible when they are ready to return to the community and a discharge plan that accounts for the safety of the individual and the community has been developed.

In FY 25, $244,922 was spent supporting 20 separate individuals. Housing accounted for 98% of the expenditures, with 1.6% for medical services and 1% for miscellaneous items such as new eyeglasses.

Conclusions and Recommendations

1. There has been a steady and significant increase in the demand for forensic evaluations since the pandemic. The ten-year pre-pandemic average for outpatient orders per fiscal year (FY 11-FY 20) was 1,993, which increased to an average of 2,493 in the period FY 22-FY 25, an increase of 25%. While other states have noted significant increases over the past several years, Tennessee did not see any change in demand until after the pandemic, the reasons for which remain unclear.

   The frequency of Forensic Evaluator Certification training sessions was increased from three to six per year in FY 25 and should be maintained to help insure an adequate workforce to meet the demand. The Office of Forensic & Juvenile Court Services will continue to provide technical support

to providers so that they can manage the new higher rate of evaluation orders. The Regional Mental Health Institutes (RMHIs) should deploy psychology services through either staff positions or contracts to manage an equal sustained increase in the demand for inpatient evaluations. Another increase in the rate of reimbursement should be considered for FY 27.

2. The increase in volume for outpatient evaluations translated into a sustained increase in the number of orders for inpatient evaluation. Regional Mental Health Institutes added forensic evaluator staff to increase the rate of admissions in order to keep up with demand. The volume may include a larger proportion of people detained in jail with active symptoms of psychosis as the rate of inpatient referral by outpatient providers has increased from 24% for the years FY 17-19 to 33%-38% for the years FY 23-FY 25. (Still lower than in most other states based on data collected by the University of Virginia's Institute for Law, Psychiatry, and Public Policy.)

   Recommendations:

   - *Jail referral lists will require close monitoring and frequent consultation with RMHI forensic coordinators to prevent long waiting times.*
   - *Outpatient evaluators should be supported with increased reimbursement rates so that they may devote more time to attempting to divert referrals from the RMHIs by working with criminal justice liaisons and jail mental health staff to get defendants into treatment.*
   - *Jails with larger populations (e.g., Davidson, Shelby, Knox, and Hamilton Counties) should be engaged to develop jail-based "restoration" programs for defendants being considered for referral to an RMHI*

3. There is some evidence that referrals of misdemeanor cases for inpatient evaluation which were diverted when counties were being billed for those services were instead being ordered by courts for inpatient evaluations during FY 25 when the state resumed financial responsibility. The rate of misdemeanor-only inpatient evaluations outside of Shelby County was 12% (n=66) in FY 24 and 26% (n=168) in FY 25.

   Misdemeanor cases are often seen as particularly good candidates for diversion projects such as those recommended above due to the low legal jeopardy they face despite their need for mental health services.

4. Even more dramatic was the continued increased demand for juvenile court-ordered evaluations under §37-1-128(e), driven primarily by the increase in cases of youth charged

with Threatening Mass Destruction and concern about the risk of school shootings. There were 658 juvenile court-ordered evaluations in FY 25, 540 evaluations in FY 24, and 397 in FY 23.

- *Full psychological evaluations under §37-1-128(e) are discretionary, so it is recommended that youth in juvenile courts receive risk and needs screening with some instrument to separately identify three categories of cases: 1) youth who have no real need for a full psychological, 2) youth who should be referred to a mental health clinic where they will do their own intake and 3) those youth for whom a forensic evaluation under §37-1-128(e) is important and indicated to resolve the youth's legal situation.*
- *Youth charged with threats of mass destruction should be subject to a threat assessment conducted by the local education authority with only those cases determined to be substantial risks referred for full forensic evaluations.*

5. The basic features of Tennessee's current forensic mental health system include using outpatient, community-based services whenever possible and using inpatient services only after outpatient services have been attempted. This approach has been in place since the underlying statutes became law in 1974. There have been some changes in law and in policy and procedure since then, but the foundation remains unchanged. The combination of the Tennessee mental health statutes, the TDMHSAS system for training and monitoring evaluators, and the expertise of the providers results in a highly effective screening and diversion of adult criminal defendants from RMHI bed usage while providing quality evaluations for the courts: for FY 25, 2,744 initial outpatient evaluations diverted 62% of that population from the need for an inpatient evaluation. There were 843 inpatient evaluations under T.C.A. § 33-7-301(a). This was the largest number of inpatient evaluations since data has been collected, even though the inpatient evaluations were limited by the availability of beds and evaluators to conduct the evaluations. Recommendations for commitment for further inpatient evaluation and treatment were made in 20% of those cases state-wide. That is a rate of 6% of the pool of 2,744 total outpatient evaluations resulting in a recommendation for long-term commitment for inpatient evaluation and treatment (see Table 30, p. 37). There were 24 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) with 14 recommendations for commitment to an RMHI under T.C.A. § 33-7-303(c)

(58%). The rate of recommendations for commitment for the 16-year period FY 10- FY 25 (all evaluations conducted on an outpatient basis) is 52%.

Recommendations: This pattern underscores the importance of maintaining the current outpatient provider network and of the training and monitoring of the performance of inpatient as well as outpatient certified forensic evaluators. Expertise should be maintained with updated training.

The efficiency of the current system is due in part to the technical support which the staff of the Office of Forensic and Juvenile Court Services provides to evaluators. This activity is as essential as the data entry and monitoring of billing.

6. The effects of Jillian's Law, which shifted the burden of proof for the commitment standard for defendants adjudicated incompetent to stand trial on a felony or class A misdemeanor to a presumption that the defendant meets commitment criteria (without changing the actual commitment standards), appears to have affected the rate of recommendations for commitment only in the middle Tennessee area. Those rates for MTMHI went from 15% in FY 24 to 33% in FY 25, and for FSP went from 11% to 33%. Those facilities are located in Davidson County where the Jillian's Law case occurred and was heavily covered in the media. The rates at MBMHI (2% to 4%) and MMHI (23% to 25%) were essentially unchanged, while the rates at WMHI decreased from 18% to 8%. The combination of the increased volume of inpatient evaluations and the increase rate of recommendations in middle Tennessee resulted in the largest number of commitments under §33-7-301(a) (166) during a fiscal year.
   Recommendations: MTMHI and FSP have initiated an independent, second-opinion review of cases being considered for commitment under §33-7-301(b) to insure that there are no alternatives for commitment on those cases. Cases that are committed should be tracked closely and returned to court as soon as they are considered competent to stand trial and no longer meet commitment criteria.
7. Mandatory Outpatient Treatment (MOT) appears to be a useful less drastic alternative to hospitalization that helps patients return to and stay in the community. The most common cause for termination of MOT is that the person no longer requires MOT to remain compliant with treatment and only 7% of all MOT clients had compliance problems significant enough for affidavits of non-compliance to be filed and not withdrawn after

attempts to bring the client back into compliance. A total of 7% were hospitalized on June 30, 2025, for various reasons, including non-compliance and relapse despite compliance.

The MOT Coordinator should continue to seek opportunities to provide MOT training and support to community agencies to facilitate the use of MOT when appropriate.