# TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

# REGIONAL MENTAL HEALTH INSTITUTE FORENSIC SERVICES MANUAL

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# Tennessee Department of Mental Health and Substance Abuse Services
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# SECTION I – OVERVIEW OF FORENSIC MENTAL HEALTH EVALUATION AND TREATMENT SERVICES IN THE REGIONAL MENTAL HEALTH INSTITUTES

# Description of Forensic Mental Health Services at Regional Mental Health Institutes

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) defines forensic services at the RMHIs to include:

- T.C.A.§ 33-7-301(a) pre-trial evaluation of an adult defendant for competency to stand trial and/or for mental capacity at the time of the alleged crime, conducted on an inpatient basis following referral by an outpatient evaluator after an outpatient evaluation under this statute;
- T.C.A.§ 33-7-301(b) treatment of pre-trial defendants found to meet involuntary commitment criteria under Title 33, Chapter 6, Part 5 following the inpatient evaluation under T.C.A. § 3-7-301(a);
- T.C.A.§ 33-7-303(c) treatment of persons found committable under the standards of Title 33, Chapter 6, Part 5 to an inpatient facility after having been found not guilty by reason of insanity and evaluated on an outpatient basis under T.C.A. § 33-7-303(a);
- Patients re-admitted to an RMHI under the Mandatory Outpatient Treatment (MOT) non-compliance procedures of Title 33, Chapter 6, Part 6 when the patient was under a forensic legal status (i.e. committed under T.C.A.§ 33-7-301(b) or T.C.A. § 33-7-303(c)) at the time of discharge on MOT.

**NOTE: See Standards for All Inpatient Forensic Work in Appendix G, p. 83**

## Office of Forensic and Juvenile Court Services

Forensic mental health services, including inpatient and outpatient services, are coordinated by the Office of Forensic and Juvenile Court Services in the Division of Planning, Research and Forensics. Forensic staff include the Director, three Forensic Specialists, the Mandatory Outpatient Treatment (MOT) coordinator and administrative support. Each Forensic Specialist is assigned to be the primary point of contact with the forensic coordinators of specific outpatient agencies and Regional Mental Health Institutes (RMHIs). The forensic staff collect information from forensic coordinators, maintain a database of forensic services, review and verify billing, facilitate

reimbursement, and monitor forensic services for fidelity to forensic standards. Forensic staff provide individual case consultation to forensic service providers in the community and in the RMHIs.

## Forensic Services Program

The Forensic Services Program (FSP), located on the grounds of Middle Tennessee Mental Health Institute (MTMHI), is the TDMHSAS secure facility. Although this unit is part of the MTMHI campus, it is a free-standing unit that provides services to the entire state. Placement in FSP's maximum security unit or in an RMHI is based on the defendant's behavior and treatment needs. The most common reasons for placement at FSP are risk of escape and level of threat to others posed by the patient. Patients who do not require maximum security are referred to an RMHI. Defendants requiring maximum security, regardless of their charges, are referred to FSP. FSP is able to house female defendants when necessary. It is the responsibility of the referring community mental health center to recommend the level of security needed by those they evaluate under T.C.A. § 33-7-301(a) in their letter to the court with the results of the evaluation.

There are only three methods by which individuals may be admitted to FSP. These include: court orders from courts with criminal jurisdiction as defined in Title 33, Chapter 7, authorization by the Commissioner of TDMHSAS for transfers from RMHIs (see Section V), or transfers from the Tennessee Department of Correction (TDOC) authorized through the proper procedures as defined by law.

## Regional Mental Health Institutes

Each RMHI provides pre-trial forensic services for the courts and patients in the same counties as they provide non-forensic ("civil") services, unless the patient requires the secure setting of the Forensic Services Program (FSP). Patients committed under T.C.A. § 33-7-301(b) to either Moccasin Bend Mental Health Institute (MBMHI) or MTMHI who are in the hospital longer than 90 days may be transferred to Western Mental Health Institute (WMHI) if there is no discharge plan in the foreseeable future. All patients committed under T.C.A. § 33-7-303(c) are admitted to WMHI unless they require the secure setting of FSP. Counties served by each RMHI are indicated in Table 1.

## Table 1: RMHI Forensic Services Counties Served

| *RMHI* | *Counties* |
|---|---|
| Moccasin Bend Mental Health Institute | Anderson, Bedford, Coffee, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Clay, Cocke, Cumberland, Dekalb, Fentress, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jackson, Jefferson, Johnson, Lincoln, Loudon, Knox, Macon, Marion, McMinn, Meigs, Monroe, Moore, Morgan, Overton, Pickett, Polk, Putnam, Rhea, Roane, Scott, Sequatchie, Sevier, Smith, Sullivan, Unicoi, Union, Van Buren, Warren, Washington, White |
| Middle Tennessee Mental Health Institute | Cannon, Cheatham, Davidson, Dickson, Giles, Hickman, Houston, Humphreys, Marshall, Maury, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, Wilson |
| Western Mental Health Institute | Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Lawrence, Lewis, Madison, McNairy, Obion, Perry, Tipton, Wayne, Weakley, and Shelby County patients committed under T.C.A.§ 33-7-301(b), T.C.A.§ 33-7-303(c), or patients re-admitted under MOT non-compliance procedures of Title 33, Chapter 6, Part 6; all patients found NGRI and committed under T.C.A. § 33-7-303(c) |
| Memphis Mental Health Institute | Shelby (T.C.A.§ 33-7-301(a) only) |

**RMHI Forensic Coordinator**

Each Regional Mental Health Institute (RMHI) has a designated staff person identified as the forensic coordinator who is the point of contact for court, outpatient forensic services providers, and the Office of Forensic and Juvenile Court services in the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). Duties include, but are not limited to, maintaining a waiting list of forensic cases to be admitted to the RMHI, coordinating forensic admissions and discharges, maintaining a discharge readiness list of forensic patients, providing information to the Office of Forensic and Juvenile Court Services, verifying the Avatar legal status code for forensic

patients, and tracking forensic cases in the RMHI to assure that forensic services meet all statutory requirements and standards of the Office of Forensic and Juvenile Court Services. The designation of the forensic coordinator and assignment of the duties associated with providing forensic services are at the discretion of the chief executive officer (CEO) of each RMHI.

Forensic admissions to the RMHIs and the Forensic Services Program occur under a valid court order and are scheduled based on the availability of suitable accommodations. The forensic coordinator collects and reviews information related to forensic admissions and maintains a waiting list. The waiting list includes cases under each legal status described above with separate categories for cases referred but for which no court order has been received and cases for which court orders have been received and the admission is being scheduled. Waiting lists are submitted weekly to the Office of Forensic and Juvenile Court services.

The RMHI forensic coordinators maintain a discharge readiness list to track the progress of forensic patients toward return to the community. The discharge readiness list includes all patients found Not Guilty by Reason of Insanity and committed to the hospital under T.C.A.§ 33-7-303(c), and forensic patients re-admitted under the MOT non-compliance procedures under Title 33, Chapter 6 Part 6. Other forensic patients may be included on the discharge readiness list, such as pre-trial defendants admitted under T.C.A. § 33-7-301(b) who were in the community on bond and will be returning to the community.

Each acquittee receives a discharge readiness ranking, from 1 to 10 with 1 being the least ready for discharge and 10 being the most. The discharge readiness ranking includes consideration of the severity of the acquittee's symptoms related to posing a likelihood of serious harm as defined in T.C.A. § 33-6-501 and the circumstances of potential less drastic alternatives to hospitalization. An acquittee who is clinically stable may have no community alternatives and therefore would not receive a maximum discharge readiness ranking. The discharge readiness list also includes a comment section for the identification of discharge barriers, such as clinical instability, lack of housing, or unavailability of a willing provider for an acquittee who meets criteria for Mandatory Outpatient Treatment (MOT). All barriers are listed so that all available resources may be marshalled to eliminate barriers to discharge, such as a second opinion when clinical instability persists, the use of Targeted Transitional Funds for financial barriers, or consultation from the TDMHSAS MOT coordinator when there are questions on whether an acquittee meets MOT criteria or the availability of a willing community provider of services under MOT. Discharge readiness lists are updated and submitted to the Office of Forensic and Juvenile Court Services monthly.

**Expert Witness Testimony**

RMHI staff with forensic certification provide expert witness testimony only when subpoenaed or court-ordered to appear and after consultation with the attorney in the RMHI Office of Legal Counsel. Upon receiving a subpoena or court order, the staff member must submit it to the attorney in the RMHI Office of Legal Counsel for review. The RMHI attorney will provide advice on how to proceed. If the attorney determines that the staff member has a legal obligation to appear, either the attorney or the staff member should contact whomever the subpoena or court order was issued on behalf of to determine what issues the party intends to cover and clarify for the party what the staff member can and cannot testify on. For instance, a defense attorney wanting to have testimony on whether the defendant was competent to waive Miranda rights when questioned by police should inform the attorney that this issue is outside the scope of the evaluation that was conducted and the staff member would not be able to offer any testimony on the issue. This consultation can also help clarify that testimony which the staff member could provide may not be necessary, as when a prosecutor intends to stipulate to the opinion that the defendant has support for the insanity defense (that is, offer no argument against the opinion that the defendant has support for the insanity defense).

When it is determined that an RMHI staff member with forensic certification has a legal obligation to appear and provide testimony on issues relevant to the evaluation and treatment services provided under a valid court order, the staff member should appear in court promptly, allow time for security procedures at the courthouse, and dress professionally. The staff member should bring three copies of a summary curriculum vita (one for the defense, one for the prosecution and one for the court) and be prepared to answer questions about his/her professional background and the forensic certification process as part of being seated by the court as an expert witness.

The staff member should be aware that any materials he/she brings to the court may be entered as evidence and reviewed by the judge and the attorneys. It is recommended that the staff does not bring the defendant's entire medical record but only the material necessary for testimony on the forensic issues, such as the most recent Staff Conference Process Note, or forensic evaluation.

# SECTION II – PRETRIAL AND POST-CONVICTION FORENSIC EVALUATIONS

# Pretrial Forensic Evaluation and Treatment

**T.C.A. § 33-7-301(a)**

**NOTE: See Standards specific to T.C.A. § 33-7-301(a) in Appendix G, p. 84 for comprehensive documentation requirements.**

**Materials needed to complete evaluations under T.C.A. § 33-7-301(a):**

- Court order signed by judge of general sessions, circuit or criminal court identifying issues to be evaluated (e.g. competency to stand trial, mental capacity at the time of the crime)
- Outpatient evaluation under T.C.A. § 33-7-301(a)
- Collateral account of alleged offense (e.g. police report, victim/witness statements)
- Criminal history
- Clinical background information (e.g. treatment records)

**Documentation to be submitted by RMHI to the Office of Forensic and Juvenile Court Services for admissions under T.C.A. § 33-7-301(a):**

| | |
|---|---|
| Day 1 | Patient admitted |
| Day 2 | The RMHI will submit the following to the Office of Forensic and Juvenile Court Services within 24 working hours:<br>1. The Court Order (Please note that the effective date for the purpose of reimbursement is the date of admission/or the date the order was received)<br>2. The Referral for Inpatient Forensic Evaluation (MH5253) completed by the outpatient evaluator,<br>3. The Forensic Intake Report (MH5281), and<br>4. The Psychiatric Evaluation. |
| Day 2 | The Office of Forensic and Juvenile Court Services Staff will review the information and certify 15 days, if the information is complete, or request more information prior to certification. |
| Day 15 | The RMHI will send an interim staff conference report/ progress note (MH5280) to the Office of Forensic and Juvenile Court Services that includes:<br>1. the status of competency,<br>2. committability (the behavioral indicators of committability),<br>3. mental condition at the time of the crime (if ordered by the court),<br>4. problem identification (any missing information, discharge plans, etc.) and<br>5. the discharge plan. |
| Day 15 | The Office of Forensic and Juvenile Court Services staff will review the information and certify up to 15 more days, if information is complete. If information is lacking, there must be clarification before the continued days are approved. Forensic Services staff may certify fewer days in order to track the progress of a case more closely. |

Physician documentation regarding forensic issues is required two days a week with no more than 4 days between notes.

Discharge — The RMHI submits to the Office of Forensic and Juvenile Court Services:

1. the completed data report form (MH5284),
2. the letter to the court, and
3. the final staff conference report (MH5280), and
4. the forensic discharge summary (MH5283).

Note: The discharge information must be received within 48 working hours of discharge in order for payment to be approved for the inpatient stay.

A progress report is expected each time a change in status, furlough or medical leave is taken.

**Documentation to be submitted to court:**

Upon completion of the evaluation under T.C.A. § 33-7-301(a), the RMHI sends a letter to the judge issuing the order for evaluation with the results of the evaluation with copies to the defense attorney, the district attorney on the case and the outpatient evaluation provider (unless otherwise indicated in the court order for the evaluation). The letter should include:

- competency to stand trial (if ordered);
- mental condition at the time of the crime (if ordered),
- diminished capacity (if ordered),
- committability under T.C.A. § 33-7-301(b) or Title 33, Chapter 6, Part 5, Tenn. Code Ann., and, if committable, the need for maximum security;
- the need for follow-up services from the appropriate outpatient mental health provider;
- the need for intellectual disability services (if indicated), including competency training and,
- the need for competency training for defendants who are incompetent and not committable.

**Documentation to be submitted to the outpatient provider (submit to provider of aftercare services, e.g. jail mental health staff):**

- a copy of the letter to the court
- the forensic discharge summary (MH5283)
- the discharge/aftercare plan (MH5486)
- the physician's discharge order (including medication list)

- any additional information to support aftercare or requested by aftercare provider for purposes of providing aftercare

**Documentation to be submitted to outpatient evaluation provider:**

- copy of the letter to the court
- copy of the final Staff Conference Progress Note (MH5280)
- copy of final forensic evaluation (if different than Staff Conference Progress Note)

Criminal defendants may be ordered to receive inpatient evaluation and treatment under T.C.A. § 33-7-301(a) by a general sessions, circuit or criminal court. The court must first order that the defendant be evaluated on an outpatient basis: "If, and only if, the outpatient evaluator concludes that further evaluation and treatment are needed, the court may order the defendant hospitalized, and if in a department facility, in the custody of the commissioner for not more than thirty (30) days for further evaluation and treatment for competence to stand trial subject to the availability of suitable accommodations (T.C.A. § 33-7-301[a])."

Referrals for inpatient evaluations under T.C.A. § 33-7-301(a) are received from outpatient evaluation providers which are contracted with and designated by the TDMHSAS to provide outpatient forensic evaluations. When an outpatient provider makes a recommendation to a court for an inpatient evaluation, the outpatient provider sends referral information to the RMHI forensic coordinator at the same time as the letter is sent to the court. **Inpatient evaluations can only be ordered upon the recommendation of the designated outpatient providers. RMHIs do not admit defendants unless the designated outpatient provider has conducted an outpatient evaluation and recommended an inpatient evaluation to the court, except in rare circumstances in which the TDMHSAS has agreed to an alternate provider.** Outpatient providers are assigned to cover all the courts in designated counties. Table 2 shows the providers and the counties they cover.

## Table 2: 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 |
| H. R. McNabb | Knox |
| Ridgeview | Anderson, Campbell, Morgan, Roane, Scott |
| Volunteer Behavioral Health | Bledsoe, Bradley, Cannon, Clay, Cumberland, Dekalb, Fentress, Grundy, Hamilton, Jackson, Macon, Marian, McMinn, Meigs, Overton, Pickett, Polk, Putnam, Rhea, Rutherford, Sequatchie, Smith, Sumner, Trousdale, Van Buren, Warren, White, Williamson, Wilson |
| Centerstone, Inc. | Bedford, Cheatham, Coffee, Dickson, Franklin, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Montgomery, Perry, Robertson, Stewart, Wayne |
| Vanderbilt University | Davidson |
| Pathways, Inc. | Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Tipton, Weakley |
| West Tenn. Forensic Services | Shelby |

If an RMHI receives a court order for an admission under T.C.A. § 33-7-301(a) without having received a referral from the designated outpatient evaluation provider, the RMHI forensic coordinator should contact the provider assigned to that county to determine if an outpatient evaluation was conducted and request information. If no outpatient evaluation was conducted, or an outpatient evaluation was conducted by someone other than the designated agency, the RMHI forensic coordinator should contact the court to inform them of the need for an outpatient evaluation by the designated agency, and provide contact information to the court.

The requirement for an outpatient evaluation and referral by the outpatient evaluator for an inpatient evaluation also applies to defendants who may have been admitted to the RMHI under another legal status, such as emergency admission from the jail through the mobile crisis team. Defendants may be evaluated by the outpatient evaluator while the defendant is receiving treatment

at the RMHI, depending on the ability of both the RMHI and the outpatient evaluation to make the necessary logistical arrangements. Defendants may also be seen by the outpatient evaluator once they have been discharged from the emergency admission, at which point the defendant's condition may show the benefits of the inpatient treatment.

RMHI forensic coordinators keep waiting lists of patients to be admitted under the various forensic legal statuses, with categories for referrals received with no court order and for referrals when the court order has been received and is awaiting admission. Forensic cases are admitted in accordance with suitable available accommodations policies. Admission of cases under T.C.A. § 33-7-301(a) are scheduled once the collateral information necessary to complete the evaluation has been collected and when there is a suitable bed available. Defendants are typically admitted within 60 days of receipt of the court order, but may be admitted sooner if the information has been collected and there is a suitable bed available. In rare cases, an admission may be delayed to finish collecting information. An important consideration is when the defendant's next hearing is scheduled. It may be possible to delay scheduling an admission for a significant period of time but still have the evaluation completed and submitted to the court in time for the next hearing, or it may be important to schedule sooner because of tight turn-around time for the next hearing. **In no case should the quality of the evaluation be jeopardized by scheduling issues.**

Occasionally a patient who is on the waiting list for admission for an evaluation under T.C.A. § 33-7-301(a) will be admitted under the emergency involuntary commitment statutes, raising the question of whether the evaluation must be conducted then, or if the patient can be treated under the emergency statutes, discharged and then re-admitted for the evaluation at a later date. This decision should be made on a case-by-case basis. The recommended default position is to treat and discharge the patient and re-admit later for the forensic evaluation to prevent one case from "jumping the line" ahead of other cases waiting for admission for forensic evaluation. Emergency admissions commonly have a length of stay between three and five days, while forensic evaluation cases under T.C.A. § 33-7-301(a) have an average length of stay of 21 days. However, if the RMHI has received a valid court order for evaluation and treatment under T.C.A. § 33-7-301(a) when a patient is admitted under the emergency statutes, the RMHI may choose to change the patient's legal status to T.C.A. § 33-7-301(a) and complete the evaluation at that time. It may be that the patient was already scheduled in the very near future and doing this evaluation at this point would not affect other cases on the waiting list. It may be that the patient's condition is such that an extended admission will be necessary for treatment regardless of the legal status, and a readmission could be avoided by completing the evaluation when the patient is admitted for emergency treatment. Whenever the

determination is made to change a patient's legal status to T.C.A. § 33-7-301(a) and conduct the evaluation, the change should **not** be made retroactively to the date of the emergency admission. Defendants may be held under T.C.A. § 33-7-301(a) for a maximum of 30 days by statute. That 30 days, and the billing of the patient's stay to Forensic Billing, begins on the day the legal status is changed in Avatar at the RMHI. If the determination is made to complete a court-ordered evaluation under T.C.A. § 33-7-301(a) after a patient has been admitted to the RMHI under another legal status (such as emergency admission), the patient's legal status must be changed to T.C.A. § 33-7-301(a) at some point during the admission.

Defendants who were referred to FSP by the outpatient evaluator but admitted to an RMHI for emergency treatment will typically be discharged once no longer meeting emergency commitment criteria to be re-admitted to FSP under the T.C.A. § 33-7-301(a) order. A security assessment may be conducted during the emergency admission to determine whether a defendant referred to FSP could in fact be safely evaluated and treated at the RMHI or that a defendant referred to the RMHI actually requires the security of FSP for evaluation and treatment under T.C.A. § 33-7-301(a). In either case the defendant may be discharged after receiving emergency treatment and an amended order requested from the court.

It is important to note that T.C.A. § 33-7-301(a) refers to defendants being hospitalized (upon recommendation by the designated outpatient evaluator) for "evaluation *and treatment* of competence to stand trial (emphasis added)," indicating that treatment planning should be initiated for defendants admitted under T.C.A. § 33-7-301(a) like any other newly admitted patient, including the appointment of a Treatment Review Committee (T.C.A. § 33-6-107) for defendants who lack capacity to make treatment decisions under T.C.A. § 33-3-218. The most common reason reported by certified outpatient evaluation providers for referring defendants to the RMHIs is that the defendant is showing psychotic symptoms and cannot be effectively treated in the jail setting. Aggressive treatment of defendants admitted under T.C.A. § 33-7-301(a) shortens the length of stay in the hospital and returns a competent defendant to the legal process sooner.

**Defendants with Intellectual Disability**

Intellectually disabled defendants with no co-occurring mental illness should not be referred for inpatient evaluation and treatment under T.C.A. § 33-7-301(a) by the outpatient forensic evaluator. Training for incompetent intellectually disabled defendants or commitment to the Harold Jordan Center for intellectually disabled defendants can be obtained with the assistance of the Department of Intellectual and Developmental Disabilities (DIDD) in the community through a

process called ID Assist (see below). However, defendants with both an intellectual disability and a mental illness may require treatment of the mental illness before the actual level of intellectual functioning can be determined. Those cases may be referred for inpatient evaluation and treatment at an RMHI under T.C.A. § 33-7-301(a).

If, during the course of inpatient treatment and evaluation under T.C.A. § 33-7-301(a), the defendant's mental illness is stabilized and it is determined that a defendant may be intellectually disabled but is competent to stand trial, this may be reported to the court by the RMHI with the results of the evaluation with no ID Assist requested from DIDD. If it is determined that a defendant is intellectually disabled, is incompetent to stand trial and unlikely to become competent to stand trial even with training and habilitation, this may also be reported to the court with the results of the evaluation with no ID Assist needed from the DIDD.

If, during the course of inpatient treatment and evaluation under T.C.A. § 33-7-301(a), it is determined that a defendant may be intellectually disabled, is incompetent to stand trial, does not meet commitment criteria either due to mental illness or intellectual disability, and may become competent to stand trial with training or habilitation, this should be reported to the court with the recommendation that the court order mandatory community based services to be provided by DIDD under Title 33, Chapter 5, Part 5. An ID Assist request should be submitted to the Office of Forensic and Juvenile Court Services at the same time with the name and location of the defendant. The Office of Forensic and Juvenile Court Services will communicate with the DIDD to identify the service provider and the RMHI forensic coordinator will be asked to provide additional information about the defendant to the service provider.

If, during the course of inpatient treatment and evaluation under T.C.A. § 33-7-301(a), it is determined that a defendant may be intellectually disabled, is incompetent to stand trial, and may meet commitment criteria to a facility for the intellectually disabled (the Harold Jordan Center) under T.C.A. § 33-5-403, an ID Assist request must immediately be submitted to the Office of Forensic and Juvenile Court Services. The Office of Forensic and Juvenile Court Services will communicate with DIDD to identify the service provider that will evaluate the defendant and determine if the defendant meets commitment criteria under T.C.A. § 33-5-403. If the DIDD expert agrees the defendant meets commitment criteria, he/she will complete a certificate of need in accordance with T.C.A. § 33-5-404 and a second certificate should be completed by a licensed physician or licensed psychologist with health service provider designation at the RMHI who has examined the defendant.

T.C.A. § 33-5-404 requires two certificates of need be completed by licensed physicians or licensed psychologists with health service provider designation and that the two professionals be designated by the Commissioner of DIDD. Therefore it is necessary for the DIDD expert to be of the opinion that the defendant meets commitment criteria under T.C.A. § 33-5-403 for the commitment to proceed, regardless of the opinion of RMHI staff. If the DIDD expert does opine that commitment criteria are met, DIDD will accept a second certificate of need from any properly licensed RMHI physician or psychologist as having been completed by a professional designated by DIDD to complete the second certification. DIDD could provide both certificates of need, but typically one will be provided by DIDD and one by an RMHI psychologist. Please also note that for commitment under this statute, both certificates of need may be completed by licensed psychologists with health service provider designation. Unlike commitment under the mental health statutes in Title 33, Chapter 6, Part 5, it is not necessary for one of the certificates of need to be completed by a licensed physician.

**Legal Status Codes and Billing**

RMHI forensic coordinators do not have a direct role in the billing for services for forensic patients. Nevertheless, completion of billing for forensic services depends on the RMHI forensic coordinators submitting the required information to the Office of Forensic and Juvenile Court staff so that inpatient days are correctly certified in the Forensic Billing system. It is also important for RMHI forensic coordinators to work with other RMHI staff to insure that forensic patients have the correct legal status code in Avatar. Fiscal services staff at the RMHIs bill the TDMHSAS Office of Fiscal Services on a *per diem* basis for forensic patients who are charged with at least one felony. Bills are generated by the Avatar system based on the patients' legal status codes and submitted to the Office of Forensic and Juvenile Court Services for verification that the days billed match the days certified by forensic staff. Central office forensic staff then submit an invoice to the Office of Fiscal Services.

As of July 1, 2009 the counties became 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 misdemeanors (T.C.A. § 33-7-304). Inpatient services are billed to the counties directly by the RMHIs based upon the estimate of the actual per diem cost for that unit at that RMHI, which ranges from just over $700 a day to over $1,000 a day. The cost can be reduced if the county enters a contract with the TDMHSAS to set the *per diem* rate at $450. All counties who have actually used inpatient services have signed a contract. By the time an outpatient evaluation has

been conducted and referred for an inpatient evaluation, a determination should have been made as to misdemeanor or felony class of the defendant's charges, but this must be reviewed at the point of admission so that the proper Avatar legal status can be selected which determines whether the RMHI fiscal services will bill the county.

**Completion of Evaluation and Treatment under T.C.A. § 33-7-301(a)**

At the conclusion of any evaluation conducted under T.C.A. § 33-7-301(a), a letter should be submitted to the court stating the results of the evaluation. Results include opinions on all questions identified in the court order, and only those questions included in the court order, plus whether the defendant meets criteria for involuntary commitment. Opinions are not provided on issues not ordered by the court. Some court orders will include language requesting an opinion on whether the defendant may have had diminished capacity at the time of the crime, which is defined in T.C.A. § 39-11-302 (please refer to the Forensic Evaluator Training Manual for detail on the standards to be evaluated). *The forensic coordinator and each certified forensic clinician working on a case should read each court order carefully to determine what is being requested by the court.*

Defendants who have been admitted to FSP or an RMHI for evaluation under T.C.A. § 33-7-301(a) and meet the commitment standards under Title 33, Chapter 6, Part 5 at the conclusion of that evaluation may be committed for inpatient treatment and evaluation under subsection (b) of T.C.A. § 33-7-301. Commitment under T.C.A. § 33-7-301(b) may be recommended whether the defendant is considered competent to stand trial or not. In almost all cases, the defendant is considered incompetent to stand trial. However, in either case, *the requirements for commitment under Title 33, Chapter 6, Part 5 must be met for the defendant to be committed under T.C.A. § 33-7-301(b).*

This recommendation to the court for commitment should be made in the letter to the court reporting results of the evaluation under T.C.A. § 33-7-301(a). Two certificates of need for hospitalization completed in accordance with T.C.A. § 33-6-503 should be included with the letter recommending commitment, either by two licensed physicians or by one licensed physician and one licensed psychologist with designation as a health service provider by the board of healing arts.

Defendants cannot be held beyond 30 days under T.C.A. § 33-7-301(a), and so even with the recommendation for commitment under T.C.A. § 33-7-301(b), the defendant must be released, (typically back to the jail) to await commitment proceedings. The RMHI forensic coordinator should be sure that the mental health service provider for the jail is aware of the situation if the provider is a different agency than the outpatient forensic evaluation provider, who is routinely

notified of such recommendations. The crisis team should also be made aware to facilitate intervention if necessary prior to the hearing for commitment under T.C.A. § 33-7-301(b).

In rare cases, even this level of support is not considered adequate to maintain the safety of the defendant while in jail awaiting commitment under T.C.A. § 33-7-301(b). A defendant may be held in the hospital awaiting commitment but *only if a petition for commitment has been filed by the district attorney general or attorney for the defendant in a court with proper jurisdiction.* In such cases the legal status code is changed to 53 pending the outcome of the commitment hearing.

One of the reasons for delay between completion of an evaluation under T.C.A. § 33-7-301(a) recommending commitment under T.C.A. § 33-7-301(b) and the commitment hearing is that the petition must be filed in the "criminal court in which the case is pending or that would hear the case if the defendant were bound over to the grand jury to conduct proceedings for judicial hospitalization under chapter 6, part 5, of this title (T.C.A. § 33-7-301(b)(1)(B)(ii))," that is, in a criminal or circuit court. Letters to a general sessions court with the findings of an evaluation conducted under T.C.A. § 33-7-301(a) which recommend commitment under T.C.A. § 33-7-301(b) should make the court aware that the petition must be filed in criminal or circuit court for the commitment proceedings.

If a defendant is not competent at the conclusion of the T.C.A. § 33-7-301(a) evaluation and does not meet commitment criteria, the RMHI staff should consider a recommendation for outpatient treatment to help the defendant become competent. If the defendant is charged with a felony, the court may order mandatory community based services under Title 33, Chapter 7, Part 4. The defendant must also be at risk for becoming committable, and the court may order the defendant to participate in services for up to two years. If the defendant is charged with misdemeanors only, there is no statutory provision for the court to order mandatory community based services, but TDMHSAS contracts with outpatient forensic evaluation and service providers includes reimbursement for competency training regardless if the defendant is charged with a felony or only misdemeanors. The RMHI forensic coordinator should contact the outpatient provider to notify the provider of the recommendation for outpatient restoration services and provide additional clinical information as requested by the outpatient provider.

The letter to the court should be copied to the defense attorney, the prosecutor, the outpatient evaluation provider, and the TDMHSAS Office of Forensic and Juvenile Court Services. The Forensic Discharge summary (form # MH5283) and all information necessary for aftercare should be submitted to the outpatient evaluation provider and to the jail mental health staff for defendants being discharged to jail.

Occasionally, a defendant's condition will worsen following discharge after an inpatient evaluation under T.C.A. § 33-7-301(a) has been completed, whether due to medication non-compliance or the stress of being detained in jail during criminal proceedings. These defendants cannot be re-admitted to the RMHI except through the emergency commitment procedures of Title 33, Chapter 6, Part 4, or if the outpatient forensic evaluator sees the defendant to monitor the defendant's condition and recommends that the court issue a new order for an additional period of hospitalization under T.C.A. § 33-7-301(a). The same procedures for admission, evaluation, treatment and discharge are followed for any subsequent hospitalization under T.C.A. § 33-7-301(a) as with the initial hospitalization.

# Post-Conviction Forensic Evaluation and Treatment

## T.C.A. § 33-7-301(a)(4)(A) - Competency to Participate in Post-Conviction Proceedings

Subsection (4)(A) of paragraph (a) of T.C.A. § 33-7-301 authorizes the court to order evaluation and treatment of a defendant thought to be "incompetent to assist counsel in preparation for, or otherwise participate in . . . post-conviction proceeding(s). . . ." The defendant may be "evaluated on either an outpatient or inpatient basis, as may be appropriate." While this subsection of the statute does not specifically require an outpatient evaluation prior to ordering an inpatient evaluation, most courts have been amenable when the TDMHSAS has requested the court to order evaluation on an outpatient rather than an inpatient basis. If an RMHI Forensic Coordinator receives an order for a post-conviction evaluation under this statute, the Coordinator should investigate the location and circumstances of the defendant. Post-conviction defendants held in a Tennessee Department of Corrections (TDOC) facility in Davidson County (e.g. DeBerry Special Needs Facility, Tennessee Prison for Women, Riverbend Correctional Institution) can often be evaluated on an outpatient basis by the designated outpatient evaluation providers for Davidson and surrounding counties (Vanderbilt University, Centerstone, Inc., or Volunteer Behavioral Healthcare). In some cases, it may be clear that the defendant's condition requires inpatient treatment, and so no attempt to conduct an outpatient evaluation is necessary. Post-conviction defendants being admitted for an inpatient evaluation from a TDOC facility will typically be admitted to FSP. Post-conviction defendants being held in local jails may be admitted to the RMHIs, although the risk of attempted escape should be considered given the defendant has been convicted and is facing sentencing. RMHI Forensic Coordinators should consult with the Office of Forensic and Juvenile Court Services on a case-by-case basis.

As with all forensic admissions, defendants are admitted under this subsection when there are available suitable accommodations. Defendants may be held in an RMHI a maximum of 30 days.

## T.C.A. § 33-7-301(a)(4)(B) - Post-Conviction Evaluations of Defendants Convicted of a Capital Offense

T.C.A. § 33-7-301(a)(4)(B) authorizes courts to order an evaluation of a post-conviction defendant's mental capacity at the time of the crime, but only if the defendant was convicted of a capital offense and no such evaluation was previously conducted. An evaluation may also be ordered to determine if a defendant convicted of a capital offense is intellectually disabled, and therefore ineligible for the death penalty. As with pre-trial evaluations, but unlike post-conviction evaluations of competency to proceed, an outpatient evaluation *must* be ordered first and an inpatient evaluation may be ordered "if and only if" the outpatient evaluator recommends inpatient evaluation.

## T.C.A. § 33-7-301(b)

**NOTE: See Standards specific to T.C.A. § 33-7-301(b) in Appendix G, p. 88 for comprehensive documentation requirements.**

**Materials needed to complete evaluation and treatment under T.C.A. § 33-7-301(b):**

- Commitment order and certificates of need
- Outpatient evaluation under T.C.A. § 33-7-301(a)
- Inpatient evaluation under T.C.A. § 33-7-301(a)
- Collateral account of alleged offense (e.g. police report, victim/witness statements)
- Criminal history
- Clinical background information (e.g. treatment records)

**Documentation to be submitted by RMHI to the Office of Forensic and Juvenile Court Services for admissions under T.C.A. § 33-7-301(b):**

| | |
|---|---|
| Day 1 | Patient Admitted |
| Day 2 | The RMHI will submit the following to the Office of Forensic and Juvenile Court Services within 24 working hours:<br>**1.** The Court Order and Certificates of Need (Please note that the date of receipt of the order for admission or change in legal status is the effective date for reimbursement)<br>**2.** The Forensic Intake Report (MH5281), and<br>**3.** The Psychiatric Evaluation |

| | |
|---|---|
| Day 2 | The Office of Forensic and Juvenile Court Services staff will certify for 30 days.<br><br>Physician documentation for T.C.A § 33-7-301(b) regarding forensic issues is required two (2) times a week for the first week, then weekly until discharge. |
| Day 30 | The RMHI will forward a progress report/staff conference report to the Office of Forensic and Juvenile Court Services that includes:<br>**1.** the status of competency,<br>**2.** committability (the behavioral indicators of committability)<br>**3.** mental condition if that opinion was deferred during the evaluation under T.C.A. § 33-7-301(a), and problem identification (any difficulty with courts, discharge plans, etc.)<br>**4.** The first Risk Assessment Checklist (RAC) will be completed, to be updated every 90 days. |
| Day 30 | The Office of Forensic and Juvenile Court Services staff review the information and certify up to 30 days more (if information is complete). |
| Day 60 | The RMHI will forward a progress report/ staff conference report to the Office of Forensic and Juvenile Court Services that includes:<br>**1.** The status of competency,<br>**2.** committability ( the behavioral indicators of committability)<br>**3.** mental condition if that opinion was deferred during the evaluation under T.C.A. § 33-7-301(a), and problem identification (any difficulty with courts, discharge plans, etc.)<br>**4.** The Violence Risk Appraisal Guide (VRAG) is due at the 60th day. |
| Day 90-180 | The same process will occur at 90 day intervals with a report to the committing court being due every six months.<br><br>At day 30 or prior to any discharge, leave or furlough, the Risk Assessment Checklist (RAC) is due and every 90 days until discharge. |
| Discharge | The RMHI submits to the Office of Forensic and Juvenile Court Services at discharge:<br>**1.** the completed data report form (MH5284),<br>**2.** the letter to the court, and<br>**3.** the final staff conference Report/Discharge Plan (MH5280)<br>**4.** the forensic discharge summary (MH5283) |
| Note | The discharge information must be received within 48 working hours of discharge in order for the inpatient stay to be approved.<br><br>A progress note is required each time there is a change in legal status, furlough or medical leave. |

**Documentation submitted to the court:**

A letter must be sent to the court at least every six months during the course of hospitalization, or whenever the RMHI is recommending release, or whenever the RMHI has is prepared to conclude that the defendant is unlikely to be restored to competence. The letter should be copied to the defense attorney, the district attorney on the case, the defendant's conservator (if any), the outpatient evaluation provider and the Office of Forensic and Juvenile Court Services. The letter should address:

- the defendant's current condition,
- the defendant's current competency status,
- any issues ordered in the T.C.A. § 33-7-301(a) evaluation which were deferred (e.g. mental capacity at the time of the crime),
- his/her likelihood of regaining competency,
- the required time frame required for relevant kinds of recovery,
- and the specific reasons for the need for continued commitment.

**Documentation to be submitted to the outpatient provider (submit to provider of aftercare services, e.g. jail mental health staff):**

- a copy of the letter to the court
- the forensic discharge summary (MH5283)
- the discharge/aftercare plan (MH5486)
- the physician's discharge order (including medication list)
- any additional information to support aftercare or requested by aftercare provider for purposes of providing aftercare

**Documentation to be submitted to outpatient evaluation provider:**

- copy of the letter to the court
- copy of the final Staff Conference Progress Note (MH5280)
- copy of final forensic evaluation (if different than Staff Conference Progress Note)

As noted above, defendants who have been admitted to FSP or an RMHI for evaluation under T.C.A. § 33-7-301(a) and meet the commitment standards under Title 33, Chapter 6, Part 5 at the conclusion of that evaluation may be committed for inpatient treatment and evaluation under subsection (b) of T.C.A. § 33-7-301. Commitment under T.C.A. § 33-7-301(b) may be recommended whether the defendant is considered competent to stand trial or not. In almost all

cases, the defendant is considered incompetent to stand trial. However, in either case, *the requirements for commitment under Title 33, Chapter 6, Part 5 must be met for the defendant to be committed under T.C.A. § 33-7-301(b).* Defendants who are committed under T.C.A. § 33-7-301(b) must be released when they no longer meet commitment criteria. Once the FSP or RMHI forensic coordinator receives a court order for commitment under T.C.A. § 33-7-301(b), the acquittee should be admitted in accordance with the available suitable accommodations procedures followed for emergency admissions.

Whether a defendant was considered competent or incompetent to stand trial when committed under T.C.A. § 33-7-301(b), subsection (c) requires the RMHI chief officer to report to the court every six months on the defendant's prospects for recovery, the defendant's present condition, the time required for relevant kinds of recovery, and whether there is substantial probability that the defendant will become competent to stand trial in the foreseeable future. This is done in a letter sent to the clerk (though addressed to the judge) of the court by whose order the defendant was confined and copied to the defendant, the defendant's attorney, the defendant's legal guardian or conservator, if any, and to the district attorney general. The chief officer shall also send a copy of the report to the defendant's parent, adult child, or spouse, whichever is appropriate, but at least one (1) of the three (3).

Please note that an updated report following those guidelines should be submitted at any point that a defendant originally considered to be incompetent is now considered competent (T.C.A. § 33-7-302), or if a defendant no longer meets commitment criteria and is being discharged, or if it is determined that an incompetent defendant will not become competent to stand trial in the foreseeable future.

If a defendant committed under T.C.A. § 33-7-301(b) was reported to the court to be incompetent to stand trial but then is considered to have become competent, the court should be notified whenever competency is attained. In rare cases, a defendant will be considered competent to stand trial but to still meet commitment criteria (e.g. the jail setting is not a suitable less drastic alternative to the hospital). The court should be notified that the defendant is considered to have become competent, but can remain committed to the custody of the Commissioner during criminal proceedings. The forensic coordinator should communicate directly with the attorney for the defense and the prosecution that the criminal case may proceed and discuss scheduling transportation with the sheriff for court appearances during the proceedings.

When notifying a court that in the experts' best judgment, an incompetent defendant will not become competent, the letter to the court should include some recommendation concerning

disposition, such as noting that if the defendant no longer faced criminal prosecution, he/she would remain committed under Title 33, Chapter 6, Part 5 until a suitable less drastic alternative community placement could be arranged. The RMHI should request written notification if the criminal charges are retired or dismissed.

If the order for commitment under T.C.A. § 33-7-301(b) includes a requirement for notification of the court prior to discharge under T.C.A. § 33-6-708, the chief officer should notify the committing court of the recommendation for discharge more than 15 days ahead of any planned date of discharge. The acquittee must be retained at the RMHI for 15 days after the court's receipt of the notification to allow the court to respond. If the court does not notify the chief officer within 15 days of receipt of the notification that a hearing shall be held to review the recommendation for discharge, the acquittee may be discharged with notice to the court.

If the court notifies the chief operating officer that a hearing shall be held to review the recommendation for discharge, T.C.A. § 33-6-708 specifies that the hearing shall be held within 21 days of the court's receipt of the chief officer's notification. The acquittee shall attend the hearing, unless his or her presence is waived by counsel. The chief officer's opinion that the person is eligible for discharge is presumed to be correct, and the district attorney may challenge that opinion.

If the court finds that the acquittee is not eligible for discharge by "clear, unequivocal and convincing evidence," the court shall order the acquittee's continued stay at the hospital under the original commitment. If the court finds that the acquittee is eligible for discharge, it shall order the service recipient's release from involuntary commitment in accordance with the recommendations of the chief officer.

Subsection (d) of T.C.A. § 33-7-301 indicates that misdemeanor charges against a defendant found incompetent to stand trial must be retired no less than 11 months and 29 days after the date of arrest if the defendant does not become competent to stand trial by that time. It is recommended that the RMHI notify the court when a defendant facing misdemeanor charges remains incompetent 11 months and 29 days after the date of arrest, and request the court issue written documentation retiring the misdemeanor charges. The requirement to report to the court every six months on the misdemeanor charges ceases for a defendant charged only with misdemeanors when the charges are retired under this subsection. A letter to the court reporting that a misdemeanor defendant has not become competent in that time frame should include notice that there will be no further reports to the court, in accordance with T.C.A. § 33-7-301(c).

As noted above, defendants committed under T.C.A. § 33-7-301(b) must be released when they no longer meet the commitment criteria under Title 33, Chapter 6, Part 5. This applies whether

the defendant is considered competent to stand trial or not. If a defendant is no longer committable, not yet competent, but may become competent with outpatient treatment, the treatment team should review the criteria for mandatory community based services under Title 33, Chapter 7, Part 4. If the defendant is charged with a felony, is not committable, but is at risk for becoming committable, then the court may order mandatory community based services for up to two years. If the defendant is charged with misdemeanors only, there is no statutory provision for the court to order services, yet the contracts with outpatient forensic evaluation providers includes reimbursement for competency training for misdemeanor defendants.

When an incompetent defendant is being released to a jail because he/she no longer meets commitment criteria, it is important to notify the criminal justice liaison serving that jail so that some aftercare may be arranged if the defendant is released from jail. The criminal justice liaison program operated by the Office of Criminal Justice Services in the Division of Substance Abuse Services is intended to reduce the risk of homelessness and re-arrest of individuals with mental health and substance abuse service needs returning to the community from jail. Competent defendants will proceed with their legal process while incompetent defendants who do not meet commitment criteria for admission to an RMHI have a much more uncertain course, so the criminal justice liaison can follow them and prepare for community release when needed.

If a defendant committed under T.C.A. § 33-7-301(b) is intellectually disabled in addition to being mentally ill, no longer meets commitment criteria as mentally ill because the mental illness has been stabilized, but may become competent with community based training or habilitation by an intellectual disability expert, or may meet commitment criteria to the Harold Jordan Center under the intellectual disability statutes in Title 33, Chapter 5, Part 4, then the RMHI forensic coordinator should follow the ID Assist procedures described above on pp 12-14.

Defendants committed under T.C.A. § 33-7-301(b) may be released with a Mandatory Outpatient Treatment (MOT) obligation to participate in treatment if the defendant meets the criteria under T.C.A. § 33-6-602. This is rarely done in practice because most defendants are returned to a highly structured setting in jail. Defendants on bond, however, return to their living situation and may be considered for MOT. A comprehensive review of the criteria and procedures for MOT can be found in the MOT Manual posted on the TDMHSAS website (http://www.tn.gov/assets/entities/behavioral-health/p-r-f/attachments/MOT_Manual.pdf). In summary, When considering a service recipient for MOT, the treatment team from the releasing facility, together with the proposed outpatient provider, must assess whether the service recipient meets the statutory criteria for MOT found in T.C.A. § 33-6-602:

- The person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission, and
- The person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm under T.C.A. § 33-6-501 (See Appendix B) unless treatment is continued, and
- The person is <u>likely to participate</u> in outpatient treatment <u>with</u> a legal obligation to do so, and
- The person is **not** likely to participate in outpatient treatment <u>unless legally obligated</u> to do so, and
- Mandatory outpatient treatment is a suitable, less drastic alternative to commitment.

If the treatment team determines that the acquittee does meet the criteria for MOT, the team must identify a willing provider of outpatient services under MOT. A complete MOT plan is then negotiated with the outpatient provider.

## <u>Summary: Evaluation And Treatment Of Pre-Trial Defendants</u>

- ❖ Adults are initially evaluated on an outpatient basis (by appointment if on bond, at the jail if detained, or in rare circumstances at a Department of Corrections facility when the defendant is there for safekeeping or is an inmate serving time for prior charges and facing trial on new charges)

- ❖ Persons seen for an outpatient evaluation who do not initially appear to be competent but could be rendered competent with some treatment or training on an outpatient basis should receive those services during the outpatient evaluation period, so that a recommendation of "competent" may be forwarded to the court.

- ❖ "If and only if the outpatient evaluator concludes that further evaluation and treatment are needed, the court may order the defendant hospitalized . . . for not more than thirty (30) days for further evaluation and treatment for competence to stand trial subject to the availability of suitable accommodations." T.C.A. § 33-7-301(a)

- ❖ Many defendants who received a recommendation of "incompetent" or "deferred" on an outpatient basis are treated and "restored" to competency during the inpatient evaluation and treatment under T.C.A. § 33-7-301(a).

- ❖ Individuals who are considered incompetent at the completion of the T.C.A. §33-7-301(a) period may be committed to the RMHI if they also meet commitment criteria pursuant to Tennessee Code Annotated Title 33, Chapter 6, Part 5 if mentally ill or Title 33, Chapter 5, Part 4 if intellectually disabled (failure to hospitalize would create a substantial likelihood of serious harm)

- ❖ Those found incompetent who are not committable or no longer committable may receive services on an outpatient basis for restoration to competency. The court may formally order

mandatory community based services if the defendant is charged with a felony and would be at risk for becoming committable if not treated (pursuant to T.C.A. Section 33-7-401 if mentally ill or T.C.A. Section 33-5-501 if intellectually disabled). They are subject to such a plan for no more than two years.

- Individuals who are committable may be hospitalized pursuant to T.C.A. § 33-7-301(b) and receive treatment and restoration services until they are no longer committable. A report is submitted to the court pursuant to T.C.A. § 33-7-301(c) six months later and at six-month intervals thereafter detailing the defendant's prospects for recovery, present condition, the time required for recovery, and the probability of the defendant becoming competent in the foreseeable future.

- If an individual becomes competent to stand trial but remains committable, the court is notified and the individual at the hospital and continues to receive treatment to render them no longer committable. Court proceedings can continue.

- If an individual's condition improves so that they are no longer committable but remain incompetent, the individual will be discharged.

# SECTION III: INSANITY ACQUITTEES

**T.C.A. § 33-7-303(c)**

**NOTE: See Standards specific to T.C.A. § 33-7-303(c) in Appendix G, p. 92 for comprehensive documentation requirements.**

**Materials needed for admissions under T.C.A. § 33-7-303(c):**

- Commitment order and certificates of need
- Evaluation under T.C.A. § 33-7-301(a) recommending support for the insanity defense (inpatient our outpatient, private or conducted by TDMHSAS certified evaluator)
- Collateral account of alleged offense (e.g. police report, victim/witness statements)
- Criminal history (to assist with risk assessment)
- Clinical background information (e.g. treatment records)

**Documentation to be submitted by RMHI to the Office of Forensic and Juvenile Court Services for admissions under T.C.A. § 33-7-303(c):**

| | |
|---|---|
| Day 1 | Patient Admitted |
| Day 2 | The RMHI will submit to the Office of Forensic and Juvenile Court Services within 24 working hours:<br>1. The Court Order and Certificates of Need (Please note that the date of receipt of the order for admission or change in legal status is the effective date for reimbursement)<br>2. The Forensic Intake Report (MH5281), and<br>3. The Psychiatric Evaluation<br>4. The patient should be added to the Discharge Readiness List and the Discharge Readiness Rating should be updated every 30 days |
| Day 2 | The Office of Forensic and Juvenile Court Services staff will certify for 30 days. |
| Day 30 | The RMHI will forward a progress report/staff conference report to the Office of Forensic and Juvenile Court Services that includes:<br>1. committability (the behavioral indicators of committability)<br>2. The first Risk Assessment Checklist (RAC) will be completed, to be updated every 90 days. |
| Day 30 | The Office of Forensic and Juvenile Court Services staff review the information and certify up to 30 days more (if information is complete). |
| Day 60 | The RMHI will forward a progress report/ staff conference report to the Office of Forensic and Juvenile Court Services that includes:<br>1. committability ( the behavioral indicators of committability)<br>2. The Violence Risk Appraisal Guide (VRAG) is due at the 60th day. |
| Day 90-180 | The same process will occur at 90 day intervals. |

| | |
|---|---|
| | At day 30 or prior to any discharge, leave or furlough, the Risk Assessment Checklist (RAC) is due and every 90 days until discharge. |
| Discharge | The RMHI will forward to the Office of Forensic and Juvenile Court Services at discharge:<br>1. the completed data report form (MH5284),<br>2. the letter to the court, and<br>3. the final staff conference Report/Discharge Plan (MH5280)<br>4. the forensic discharge summary (MH5283) |
| Note | The discharge information must be received within 48 working hours of discharge in order for the inpatient stay to be approved.<br><br>A progress note is required each time there is a change in legal status, furlough or medical leave. |

**Documentation to be submitted to the Risk Management Review Committee prior to furlough or discharge of insanity acquittees:**

- Summary of Request
- Commitment Order
- Initial Psychosocial Assessment
- VRAG, Initial RAC and most recent RAC
- Most recent Staff Conference Note
- Furlough/Discharge Plan
- MOT Plan (if recommended) or aftercare plan

When criminal defendants are found Not Guilty by Reason of Insanity (NGRI) in Tennessee, the court orders an outpatient evaluation under T.C.A. § 33-7-303(a) to determine whether the defendant (hereafter, the "insanity acquittee") meets commitment standards under Title 33, Chapter 6, Part 5. The outpatient evaluation is conducted by the same agency contracted to conduct the pre-trial evaluation under T.C.A. § 33-7-301(a) (see Table 2, p. 10). The evaluator may recommend that the acquittee be released and that no treatment is needed, may recommend release with treatment described in an outpatient treatment plan, may recommend release with outpatient treatment under Mandatory Outpatient Treatment as defined in T.C.A. § 33-7-303(b), or may recommend commitment to the RMHI under T.C.A. § 33-7-303(c).

Insanity acquittees may be committed to FSP if the court finds, based on the evaluator's opinion, that the acquittee is likely to harm him/herself or others unless treated in a forensic unit and treatment in a forensic unit is in the acquittee' s best interests. Effective April 1, 2014, all acquittees committed under T.C.A. § 33-7-303(c) who are not admitted to FSP are admitted to Western Mental

Health Institute (WMHI), regardless of their home county or court in which the NGRI offense was adjudicated. Acquittees committed prior to April 1, 2014 who were admitted to Middle Tennessee Mental Health Institute (MTMHI) or Moccasin Bend Mental Health Institute (MBMHI) and whose length of stay is longer than 90 days may be considered for transfer to WMHI depending on factors such as likelihood of discharge to the community in the foreseeable future, importance of local ties and other factors to be determined by the RMHI chief operating officer.

When the outpatient evaluator recommends commitment under T.C.A. § 33-7-303(c) to the court, he/she copies the RMHI forensic coordinator (FSP or WMHI after April 1, 2014) on the letter to the court which includes two certificates of need completed in accordance with T.C.A. § 33-6-503 and makes an inpatient referral. Once the FSP or RMHI forensic coordinator receives a court order for commitment under T.C.A. § 33-7-303(c), the acquittee should be admitted in accordance with the available suitable accommodations procedures followed for emergency admissions. Discharge planning begins when the acquittee is admitted.

All court orders must be carefully reviewed upon admission. The forensic coordinator should determine whether the order for commitment under T.C.A. § 33-7-303(c) also includes a requirement for notification of the court prior to discharge under T.C.A. § 33-6-708 (commonly known as "judicial review.") The acquittee's treatment team should be notified and any such requirement for notification should be noted in the discharge readiness listing for the acquittee.

As noted above, the basis for commitment under T.C.A. § 33-7-303(c) is the standard under Title 33, Chapter 6, Part 5; treatment and discharge planning for insanity acquittees overlaps a great deal with the services provided any service recipient in an RMHI under judicial commitment. Insanity acquittees should be afforded access to all the treatment options, privileges, community access and aftercare services as any RMHI patient, as warranted by their condition, need for security and treatment needs. The key feature of treatment specific to insanity acquittees is risk assessment to develop risk management strategies to reduce the likelihood of re-offense or aggressive behavior in the community.

## Risk Assessment

Risk assessment involves the careful review of a service recipient's history to assess the overall risk level associated with each insanity acquittee and for the identification of specific risk factors. The Dynamic Risk Assessment Checklist (RAC; Appendix A) should be completed by the 30$^{th}$ day of admission and updated every 90 days thereafter. The RAC is comprised of 24 dynamic and acute risk factors which are rated as either "present," "somewhat present," "absent," or unrated

due to a lack of information. The items reflect characteristics of the person (e.g. command hallucinations to harm others; clinically significant anger; poor motivation for treatment) or circumstances (e.g. inadequate aftercare plans; anti-social peers) which, if present, would increase the risk for aggression or re-offense, but which may change over time.

The RAC can identify some risk factors, but a thorough review of the acquittee's history is necessary for a comprehensive risk assessment. Research on recidivism of criminal offenders and insanity acquittees has identified a number of factors associated with increased risk for recidivism and aggression, including:

- substance abuse
- history of aggression
- previous failure on supervised release/MOT
- use of a weapon in the offense
- unemployment
- divorce or death of partner within past year
- criminal history (including history of juvenile detention)
- history of physical abuse (as victim)
- access to preferred victim or victim class (e.g. targeted person or class such as children/elderly)
- personality disorder

The Violence Risk Assessment Guide (VRAG; Appendix B) should be completed by the 60$^{th}$ day of admission. The VRAG is a 12-item actuarial instrument which provides an overall estimate of risk of aggression over as many as ten years following release to the community. One of the items is linked to the score of another instrument, the Psychopathy Checklist, which is a 40-item instrument rating the presence and strength of psychopathic personality traits. This VRAG item may be alternatively scored with an additional eight-item scale, the Childhood and Adolescent Taxon Scale, obviating the need to complete a Psychopathy Checklist. All of the VRAG items, including the Childhood and Adolescent Taxon Scale, are historical in nature for the exception of two items, one for whether the patient meets the diagnostic criteria for a personality disorder and one for whether the patient meets diagnostic criteria for schizophrenia. If a patient's diagnosis should change, the VRAG score could change. If new historical information is discovered, then the VRAG score could change. Otherwise, the VRAG score would not change during an admission, so the VRAG is only scored once unless new information requires an update. The unchanging nature of the VRAG score is one reason this score is such a reliable long-term estimate of risk.

The VRAG score supplies the overall estimate of risk: high, medium or low. The RAC supplies an indication of the current status of dynamic risk factors. Comparison of the first RAC with later updates can show improvement or regression. Additional risk assessment instruments may

be used according to the specifics of the case and the expertise of the evaluator. The HCR-20 V3, for example, provides an overall estimate of risk as accurately as the VRAG while also identifying specific risk factors suggesting management strategies. The STATIC-99R is the preferred instrument for sex offenders in estimating risk of sexual re-offense. The Spousal Assault Risk Assessment (SARA) guide may be useful when the acquittee's history of aggression includes domestic/intimate partner violence.

As noted above, the RAC can help identify specific risk factors, though a thorough review of the acquittee's history is required to identify all risk factors relevant to that particular acquittee. Risk management strategies are then developed for each risk factor. Below are examples of the sort of risk management strategy that would be suggested by certain risk factors. Risk management strategies, like treatment interventions, should be tailored to the individual needs of the service recipient. Some treatment interventions double as risk management strategies. Some risk management strategies will apply to more than one risk factor.

| **Risk Factor** | **Risk Management Strategy** |
|---|---|
| History of Substance Abuse | • Patient will not use alcohol or drugs not prescribed for treatment<br>• Drug and alcohol screens will be conducted (define frequency)<br>• Patient will participate in X drug and alcohol treatment |
| Prior aggression linked directly to psychiatric symptom (e.g. delusions) | • Patient's mental status will be evaluated (define frequency and who will conduct MSE)<br>• Patient will take medication as prescribed<br>• Staff will report non-compliance to MOT coordinator |
| Use of weapon in prior aggression | • Patient will not possess weapons |
| Pattern of aggression involves specific victim or victim class | • Patient will have no contact with (victim)<br>• Patient will have no unsupervised access to children (if preferred victims are children) |
| Personality disorder/psychopathy | • Include mechanism for independent monitoring of treatment participation and compliance with MOT requirements |
| Unemployed/not engaged in meaningful activity | • Patient will participate in daily activity of living outside the home (e.g. day treatment/vocational training/education) |
| Failure on previous community release | • Include mechanism for independent monitoring of treatment participation and compliance with MOT requirements |
| Family/psychosocial issues | • Patient will participate in family therapy as indicated<br>• OR patient will have no unsupervised contact with X |

| | |
|---|---|
| | family members |
| Arson | • Patient will not possess or have access to fire-starting materials (e.g. lighters, matches) |
| Suicide/Self-Injury | • Patient will participate in X mental health treatment<br>• Patient will develop safety plan with identified staff to contact with recurrence of suicidal thoughts<br>• Patient will participate in Dialectical Behavior Therapy provided by (agency/clinician) |

Please note that for a history of aggression, a risk assessment should determine the specific pattern of aggression, e.g. fighting with others while intoxicated or while psychotic, preemptory strike against imagined enemies when delusional, or spousal/partner abuse. For insanity acquittees, the evaluation of mental capacity at the time of the offense should be reviewed to determine exactly what feature of the person's mental illness was linked to the NGRI offense so that treatment can be developed to address the potential for re-offense.

The discharge readiness list includes all insanity acquittees at an RMHI (and may include other patients; see p. 3) and should be updated monthly. Each acquittee receives a discharge readiness ranking, from 1 to 10 with 1 being the least ready for discharge and 10 being the most. The discharge readiness ranking includes consideration of the severity of the acquittee's symptoms related to posing a likelihood of serious harm as defined in T.C.A. § 33-6-501 and the circumstances of potential less drastic alternatives to hospitalization. An acquittee who is clinically stable may have no community alternatives and therefore would not receive a maximum discharge readiness ranking. The discharge readiness list also includes a comment section for the identification of discharge barriers, such as clinical instability, lack of housing, or unavailability of a willing provider for an acquittee who meets criteria for Mandatory Outpatient Treatment (MOT). All barriers are listed so that all available resources may be marshalled to eliminate barriers to discharge, such as a second opinion when clinical instability persists, the use of Targeted Transitional Funds for financial barriers, or consultation from the TDMHSAS MOT coordinator when there are questions on whether an acquittee meets MOT criteria or the availability of a willing community provider of services under MOT.

## Mandatory Outpatient Treatment under T.C.A. § 33-6-602

Insanity acquittees committed under T.C.A. § 33-7-303(c) may be eligible for release with Mandatory Outpatient Treatment (MOT) if the criteria defined in T.C.A. § 33-6-602 are met. A comprehensive review of the criteria and procedures for MOT can be found in the MOT Manual posted on the TDMHSAS website (http://www.tn.gov/assets/entities/behavioral-health/p-r-

f/attachments/MOT_Manual.pdf). In summary, When considering a service recipient for MOT, the treatment team from the releasing facility, together with the proposed outpatient provider, must assess whether the service recipient meets the statutory criteria for MOT found in T.C.A. § 33-6-602:

- The person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission, and
- The person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm under T.C.A. § 33-6-501 (See Appendix B) unless treatment is continued, and
- The person is likely to participate in outpatient treatment with a legal obligation to do so, and
- The person is **not** likely to participate in outpatient treatment unless legally obligated to do so, and
- Mandatory outpatient treatment is a suitable, less drastic alternative to commitment.

If the treatment team determines that the acquittee does meet the criteria for MOT, the team must identify a willing provider of outpatient services under MOT. A complete MOT plan is then negotiated with the outpatient provider.

**Discharge Procedures and the Risk Management Review Committee**

The assessment of discharge readiness of insanity acquittees is ongoing. When a treatment team is prepared to recommend discharge, the attending psychiatrist documents the assessment in the acquittee's medical record and requests a second opinion. A psychiatrist at the RMHI who is not currently treating the acquittee is designated by the chief operating officer to review the case and make an independent recommendation concerning discharge readiness. If the second opinion also supports discharge and the chief operating officer concurs, the chief operating officer or his/her designee must submit a request for review of the discharge to the Risk Management Review Committee (RMRC). Furloughs for insanity acquittees are also reviewed by the RMRC.

The RMRC is comprised of the Assistant Commissioner for Planning, Research and Forensics, the Assistant Commissioner of Hospital Services, the Assistant Commissioner for Clinical Services, and the Director of Forensic and Juvenile Court Services. Any member may designate an alternate participant when unavailable. The RMRC may seek consultation from outside the committee (e.g. Office of Legal Counsel, MOT Coordinator). The purpose of the RMRC is to

provide consultation to the RMHIs as needed in addition to independent review of discharge planning for insanity acquittees.

Requests for review by the RMRC shall include:

- Summary of Request
- Commitment Order
- Initial Psychosocial Assessment
- VRAG, Initial RAC and most recent RAC
- Most recent Staff Conference Note
- Furlough/Discharge Plan
- MOT Plan (if recommended) or aftercare plan

Risk management strategies should be included in the MOT/aftercare plan. If MOT is recommended, a description of how MOT criteria apply to that insanity acquittee must be included. Additional sources of information may be included in the RMHI's request, may be requested by the RMRC, or may be acquired and included in the review directly by the RMRC. The Director of Forensic and Juvenile Court Services is responsible for confirming that all relevant material has been collected for a case to be reviewed, for distributing the materials to the RMRC members, and shall be the point of contact for the RMHIs for communication to and from the RMRC.

**Discharging Insanity Acquittees**

Once review by the RMRC has been completed for the discharge of an insanity acquittee, the RMHI initiates discharge procedures. If the order for commitment under T.C.A. § 33-7-303(c) does not include a requirement for notification of the court of the acquittee's eligibility for discharge and the basis for that conclusion prior to discharge under T.C.A. § 33-6-708 (judicial review), then the acquittee may be discharged directly with referral for outpatient services and the committing court notified of the discharge (T.C.A. § 33-6-701). If the acquittee is being released on MOT and no judicial review is required, then the RMHI treatment team should at this point attempt to obtain the service recipient's consent to the MOT plan.

***The service recipient does not have to agree to the plan, but the service recipient should understand the obligation.***

The RMHI treatment team should inform the service recipient of his or her right to request court review of the MOT plan. The service recipient may request a judicial review of the MOT plan within forty-eight (48) hours after being advised of their eligibility for release under MOT (T.C.A.

§ 33-6-604). If the service recipient requests judicial review, the hospital has the responsibility to notify the court of the service recipient's request for judicial review of the MOT plan. The court shall hold a hearing within seven days of the notice from the hospital to determine whether the treatment plan is medically appropriate and legally permissible (See Form MH-5211). Following the hearing, the court shall either approve the plan or request that the releasing facility and the qualified mental health professional modify the plan to correct deficiencies found by the court (T.C.A. § 33-6-604; See Form MH-5212).

If the acquittee does not request a hearing the RMHI forensic coordinator should follow standard procedures of notifying the committing court of the discharge of a person involuntarily committed. The notice shall state that the discharge is subject to the obligation to participate in outpatient treatment (T.C.A. § 33-6-605). (Note: There is no requirement to send the committing court copies of the mandatory outpatient treatment plan. If this is desired, a release should be obtained from the service recipient; See Form MH-5210). The forensic coordinator should also notify the TDMHSAS MOT Coordinator of the discharge and provide the following information about the service recipient:

- Name
- Social security number
- Outpatient provider accepting the MOT
- Date of discharge
- Renewal/Expiration date for MOT
- Patient's legal status at the time of discharge
- Patient's place of residence at the time of discharge
- Committing court

Prior to discharge, the hospital must provide a clear written statement of what the service recipient must do to stay in compliance with the plan to the following persons:

- the service recipient;
- the service recipient's parents, legal custodian, or legal guardian if the service recipient is a child;
- the service recipient's spouse or other adult family member with whom the service recipient would live;
- the service recipient's conservator, if any.

If the order for commitment under T.C.A. § 33-7-303(c) does include a requirement for notification of the court prior to discharge under T.C.A. § 33-6-708, with or without MOT, the chief officer should notify the committing court of the recommendation for discharge more than 15 days ahead of any planned date of discharge. The acquittee must be retained at the RMHI for 15 days after the court's receipt of the notification to allow the court to respond. If the court does not notify the chief officer within 15 days of receipt of the notification that a hearing shall be held to review the recommendation for discharge, the acquittee may be discharged with notice to the court. If the acquittee is being released on MOT, then the procedures outlined on p. 29, above, must also be followed.

If the court notifies the chief operating officer that a hearing shall be held to review the recommendation for discharge, T.C.A. § 33-6-708 specifies that the hearing shall be held within 21 days of the court's receipt of the chief officer's notification. The acquittee shall attend the hearing, unless his or her presence is waived by counsel. The chief officer's opinion that the person is eligible for discharge is presumed to be correct, and the district attorney may challenge that opinion.

If the court finds that the acquittee is not eligible for discharge by "clear, unequivocal and convincing evidence," the court shall order the acquittee's continued stay at the hospital under the original commitment. If the court finds that the acquittee is eligible for discharge, it shall order the service recipient's release from involuntary commitment in accordance with the recommendations of the chief officer.

# SECTION IV: MOT REVOCATION

**T.C.A. § 33-6-610; Readmission for Non-Compliance with MOT**

When an insanity acquittee who was released on Mandatory Outpatient Treatment (MOT) as defined under T.C.A. § 33-6-602 is returned to the RMHI after having been found to be out of compliance with MOT without good cause and unlikely to be put into compliance voluntarily, the acquittee is considered to be a forensic patient and the procedures for admission, treatment, discharge planning and release under T.C.A. § 33-7-303(c) are followed. The acquittee is considered to have been re-admitted under the original commitment order (T.C.A. § 33-6-619). The legal status code 46F is used if the NGRI offense was a felony (or there was at least one felony among multiple charges) and 46M if the NGRI offense was a misdemeanor (or all misdemeanors among multiple felonies).

The following is a summary of MOT non-compliance procedures specifically relevant to the RMHIs. A complete description of all MOT procedures can be found in the MOT Manual posted on the TDMHSAS website (http://www.tn.gov/assets/entities/behavioral-health/p-r-f/attachments/MOT_Manual.pdf).

An acquittee may be returned to the discharging facility after a hearing in the community on non-compliance. Non-compliance procedures under Title 33, Chapter 6, Part 6 begin in the community when a parent, legal guardian, conservator, spouse, responsible relative, the person who initiated the commitment proceeding of the service recipient, the chief officer of the discharging facility or the qualified mental health professional managing the MOT plan files an affidavit of non-compliance with either the committing court or the court in the locality where the person is living in the community which has jurisdiction to conduct proceedings under Title 33, Chapter 6, Part 5. A hearing is scheduled under T.C.A. § 33-6-610 for the court to determine whether the person is out of compliance with MOT without good cause and whether the person could be put back into compliance voluntarily. If the person is found to be out of compliance without good cause and unlikely to be put back into compliance voluntarily, the person is ordered to be re-admitted to the discharging facility once it is determined that there are suitable available accommodations. If the person is found to be in compliance by the court, or out of compliance with good cause, or out of compliance without good cause but able to be put back into compliance, then the person is released and MOT is continued.

An acquittee may be returned to the discharging facility if the acquittee does not appear at the non-compliance hearing in the community. If the person does not appear for the hearing and the affidavit was filed by a qualified mental health professional, the court may issue an order for the sheriff to pick up the person and transport him/her to the discharging RMHI after determining that

there are available suitable accommodations (T.C.A. § 33-6-611). If the affidavit was filed by any of the other parties listed above, the court may issue an order for the sheriff to pick up the person and transport him/her to a qualified mental health professional for examination (T.C.A. § 33-6-612). If the person is found to be in compliance by the qualified mental health professional, or out of compliance with good cause, or out of compliance without good cause but able to be put back into compliance, then the person is released and MOT is continued (T.C.A. § 33-6-614). If the qualified mental health professional determines that the person is out of compliance with MOT without good cause and cannot be put back into compliance voluntarily, the person may then be transported to the discharging RMHI after determining that there are available suitable accommodations (T.C.A. § 33-6-615). In either of the latter two cases, the hearing under T.C.A. § 33-6-610 is conducted by the court where the hospital is located with the same jurisdiction as the committing court (T.C.A. § 33-6-616).

In some cases, the RMHI forensic coordinator or MOT coordinator may have been notified about problems the person was having being compliant with the MOT plan, and may even consult with the qualified mental health professional in the community about how to help the person get back in compliance. If the person is readmitted following the non-compliance procedures in Title 33, Chapter 6, Part 6, then, as noted above, the same procedures are followed as for newly admitted acquittees under T.C.A. § 33-7-303(c) with the exception of using the legal status code 46F or 46M instead of 19M/19F. The RMHI MOT coordinator should inform the TDMHSAS MOT coordinator in the Office of Forensic and Juvenile Courts Services of communications concerning persons on MOT.

Discharge planning for acquittees re-admitted for MOT non-compliance should include a review of whether the acquittee still meets MOT criteria. Persons who are unlikely to comply with outpatient treatment even with a legal obligation to do so do *not* meet MOT criteria under T.C.A. § 33-6-602.

Please note that insanity acquittees on MOT in the community may be subject to hospitalization via emergency involuntary commitment procedures under Title 33, Chapter 6, Part 4 even while in compliance with MOT. Hospitalization in and of itself does not constitute non-compliance with MOT. Under those circumstances, the acquittee is treated like any civil involuntary admission. The MOT is suspended while the person is hospitalized and resumes upon release.

# SECTION V: TRANSFERS TO/FROM THE FORENSIC SERVICES PROGRAM

**T.C.A. § 33-3-301: FSP Transfers**

The commissioner of the TDMHSAS may authorize the transfer of a patient from an RMHI to the maximum security unit at FSP and from FSP to an RMHI (as well as from one RMHI to another) regardless of the legal status of the patient. The commissioner must determine that the patient can be more properly cared for in the receiving facility and that the transfer is in the best interests of the patient. A transfer from an RMHI into FSP may only be authorized if the commissioner determines that the patient is substantially likely to injure him/herself or others if not treated in a secure facility. T.C.A. § 33-3-301 also requires that prior to any transfer, the patient shall be given a physical examination by a licensed physician and a "mental assessment and evaluation by a qualified professional." Written reports of these examinations must be submitted to the commissioner by the RMHI chief officer requesting the transfer.

The documentation required in the policies and procedures for transfers described in appendices C-E (Appendix C: emergency transfer to FSP from an RMHI; Appendix D: non-emergency transfer to FSP from an RMHI; Appendix E: transfer to an RMHI from FSP) is necessary to meet the statutory obligations of T.C.A. § 33-3-301. When making a determination of the need for transfer into FSP, it is important to note that the procedures for seclusion, restraint and emergency ("PRN") medication are the same at FSP as at the RMHIs.

Commitment to FSP may be recommended to a court when there is a significant risk of escape even without the threat of aggressive behavior within an RMHI. A request for transfer to FSP from an RMHI may be supported by evidence of a significant increase in the risk of escape due to changes in the patient's circumstances (e.g. being charged with a capital offense).

The rationale for requests for transfer into FSP from the RMHIs should include a description of efforts made at the RMHI to manage aggressive behavior which have not been successful, such as changes in medications, use of behavior analysis and behavioral planning, or moving the patient to a different unit. The staff of the Office of Forensic and Juvenile Court Services as well as the FSP staff are available for consultation on challenging cases and the standards for transfer into FSP.

Patients transferred to FSP return to the sending RMHI for discharge planning when clinically indicated and approved by the commissioner. Defendants admitted to FSP from jail for pre-trial evaluation and treatment under T.C.A. § 33-7-301(a) or T.C.A. § 33-7-301(b) are typically discharged back to jail. A defendant admitted to FSP for evaluation under T.C.A. § 33-7-301(a) may be recommended for commitment under T.C.A. § 33-7-301(b) at the RMHI if it is determined that a secure setting is not required. That defendant will be discharged to jail with the recommendation for commitment directly to the RMHI rather than transferred.

Similarly, it may be determined during an admission under T.C.A. § 33-7-301(a) at an RMHI that a defendant meets criteria for commitment under T.C.A. § 33-7-301(b) and requires the secure setting of FSP. That defendant may be discharged to the court with the recommendation for commitment directly to FSP. Any patient at FSP who would be discharged to the community should be transferred to the appropriate RMHI for discharge planning and release.

Defendants committed to FSP under T.C.A. § 33-7-301(b) may be transferred with the commissioner's approval to the appropriate RMHI during that commitment when it is determined that the secure setting is no longer necessary to assure the safety of the patient and/or others. Defendants committed to FSP under T.C.A. § 33-7-301(b) may remain in FSP if the charges are dismissed or retired as long as commitment criteria under Title 33, Chapter 6, Part 5 are met and the patient remains substantially likely to harm him/herself or others if not treated in the secure facility. The patient may be subsequently transferred to the appropriate RMHI when the secure setting is no longer necessary. In some cases, the dismissal/retirement of the charges will reduce the risk of escape to the point that there is no other safety concern requiring the security of FSP.

Insanity acquittees committed under T.C.A. § 33-7-303(c) may be admitted directly to FSP if the court finds (based on the outpatient evaluator's recommendation in the evaluation under T.C.A. § 33-7-303(a)) that that the acquittee is substantially likely to injure him/herself or others if not treated in a forensic services unit. That acquittee will be recommended for transfer to the appropriate RMHI by the FSP chief officer when clinically appropriate, and community discharge planning will occur at the RMHI.

# Appendix A

## TDMHSAS Dynamic Risk Assessment Checklist

**(to be completed by day 30, then at 3-month reviews,**
**and whenever requesting a change of status, pass, transfer, furlough or discharge)**

| Legal status: | Compliance/Cooperation with Treatment: | Reason for Risk Assessment at this time: |
|---|---|---|
| _____T.C.A. § 33-7-301(b) | _____ Good (describe as needed) | _____ Continued Hospitalization |
| _____T.C.A. § 33-7-303(c) | _____ Fair _____ | _____ Pass |
| _____Other _____ | _____ Poor _____ | _____ Change of Status |
| | _____ None _____ | _____ Transfer |
| | | _____ Furlough or Discharge |

Service recipient's name: _____

Time period reviewed (since last Risk Assessment): From ____/____/____ to ____/____/____

Current Diagnosis _____

**Dynamic Risk Factors** *

| | + | ½ | - | N/I | |
|---|---|---|---|---|---|
| (1) | □ | □ | □ | □ | Active substance use or desire/threats to use substances (type): _____ _____ |
| (2) | □ | □ | □ | □ | Active symptoms of a major mental illness (list): |
| (3) | □ | □ | □ | □ | Command hallucinations to harm others (specify): |
| (4) | □ | □ | □ | □ | Clinically significant anger/agitation (specify): |
| (5) | □ | □ | □ | □ | Clinically significant impulsivity/disinhibition: |
| (6) | □ | □ | □ | □ | Threats or urges to harm others (specify): |
| (7) | □ | □ | □ | □ | Recent (past month) violent act(s) toward people or property (specify): |
| (8) | □ | □ | □ | □ | Absence of insight into mental illness and/or the need for treatment |
| (9) | □ | □ | □ | □ | Present non-compliance with recommended treatment |
| (10) | □ | □ | □ | □ | Poor motivation in current and future treatment |
| (11) | □ | □ | □ | □ | Poor response to current treatment (after adequate trial) |
| (12) | □ | □ | □ | □ | Does not demonstrate an understanding of the warning signs for relapse of mental illness and addiction |
| (13) | □ | □ | □ | □ | Cannot plan for dealing with warning signs of relapse of mental illness and addiction |
| (14) | □ | □ | □ | □ | Unrealistic, inadequate, after-care plan (regardless of cause) |
| (15) | □ | □ | □ | □ | Unemployment |
| (16) | □ | □ | □ | □ | Little or no stable income/financial support |
| (17) | □ | □ | □ | □ | Absence of healthy, supportive social/interpersonal relationship(s) |

*Please consult the manual for scoring directions and guidelines. A "+" means the factor is present beyond a reasonable doubt; "-" means that the factor is absent beyond a reasonable doubt; "1/2" means the factor is present based on a preponderance of evidence (more likely than not); "N/I" means there is insufficient information to score the factor.

| | + | ½ | - | N/I | |
|---|---|---|---|---|---|
| (18) | □ | □ | □ | □ | Criminal living partners/anti-social peer group/family |
| (19) | □ | □ | □ | □ | Criminal attitudes/thinking |
| (20) | □ | □ | □ | □ | Clinically significant psychosocial stressors (other than above stressors) |
| (21) | □ | □ | □ | □ | High risk of exposure to destabilizing influences specify): |
| (22) | □ | □ | □ | □ | Availability of and interest in weapons (specify): _____ |
| (23) | □ | □ | □ | □ | Accessibility of target victims (specify class(s)): _____ |
| (24) | □ | □ | □ | □ | Prior lifetime elopement(s) or attempt(s) to elope (specify):_____ |

_____

*Please consult the manual for scoring directions and guidelines. A "+" means the factor is present beyond a reasonable doubt; "-" means that the factor is absent beyond a reasonable doubt; "1/2" means the factor is present based on a preponderance of evidence (more likely than not); "N/I" means there is insufficient information to score the factor.

Other factors/comments:

_____
_____
_____

Violence Risk Appraisal Guide Findings (NOTE: Update VRAG score if additional information has been obtained):

_____
_____
_____

Recommendations:

_____ Continuation of hospitalization at
_____ Supervised pass to
_____ Unsupervised pass to
_____ Transfer to
_____ Furlough to
_____ Discharge to
_____ Other

Members participating in the evaluation:

| | | |
|---|---|---|
| _____ | -- Psychologist | _____ |
| Signature, Discipline/Title | | Date |
| _____ | -- Psychiatrist | _____ |
| Signature, Discipline/Title | | Date |
| _____ | _____ - | _____ |
| Signature, Discipline/Title | | |

# Appendix B

## Violence Risk Appraisal Guide (VRAG)
## Sex Offender Risk Appraisal Guide (SORAG)*

**(To be completed within 60 days of admission and updated if additional information is obtained.)**

Service Recipient's Name: _____
Date of Admission: _____ Legal Status _____
Charges: _____
Date of Assessment: _____ Location: _____
Assessor/s Name/s: _____
_____
_____

**Instructions*:**
Use the attached sheets to document the scores for each item in the VRAG/SORAG assessment for this service recipient. Please refer to the supplementary scoring guidelines for select items (elementary school maladjustment, index offense, separation from parents before age 16, and failure on conditional release). Be sure and include a brief description of the data source for each item in the area marked "Evidence" on the form. Also include a brief description of the adequacy of your data base used to score the VRAG/SORAG. Use the "Summary of Results" section to document the results of the VRAG/SORAG assessment. Do NOT separate these pages.

If the service recipient does not have a sexual offense history, do NOT score the SORAG. If there is a history of sexual offending or if the committing index offense is a sex offense, score BOTH the VRAG and the SORAG or score the VRAG and an alternative actuarial sex offense risk assessment instrument in place of the SORAG– (e.g., the Static-99 is recommended). In either event, the VRAG must be filled out as a measure of risk for general violent recidivism for all cases. Raters will also complete a sex offender risk assessment instrument for sex offenders.

If there are inconsistent data for one or more items, score the instrument using a range. Fill in the HIGHEST score in the Raw Score blank and the LOWEST score in parentheses.

*(Check the appropriate response)*
1. Does this service recipient have a sexual offense history or index sexual offense? ____ **Yes** ____ **No**

2. Did you interview this service recipient to gather data for this assessment? ____ **Yes** ____ **No**

**<u>Comments about completeness/accuracy of information used to score the VRAG/SORAG</u>:**
_____
_____
_____
_____

*NOTE: Please refer to "Violent Offenders. Appraising and Managing Risk" (1998) by Quinsey, Harris, Rice, and Cormier for additional information on the VRAG and SORAG.

***Source:** American Psychological Association; Quinsey, Harris, Rice and Cormier, 2nd Edition (2006); *Violent Offenders: Appraising and Managing Risk*; APA, Washington D.C.

# Summary of Results

| **VRAG Results** | | **SORAG Results** | |
|---|---|---|---|
| Raw Score (Lowest) | _____ | | _____ |
| Items Scored as "0" Due to Lack of Information | _____ | (fill in item numbers) | _____ |
| Items Scored as a Range | _____ | (fill in item numbers) | _____ |
| *Risk Category (Low, Medium, High) based on VRAG/SORAG scores alone | _____ | | _____ |

*DO NOT specify a risk category for females. Simply indicate N/A in the space provided. Research on the VRAG with women has not supported its predictive validity in this population [See Harris, Rice, & Cormier, 2002, Law and Human Behavior 26 (4)]

**Childhood & Adolescent Taxon Scale**

1. Elementary School Maladjustment
No Problems..... 0
Slight (Minor discipline or attendance)
or Moderate Problems .....0
Severe Problems (Frequent disruptive
behavior and/or attendance or behavior
resulting in expulsion or serious suspensions)
.....1
Evidence:

2. Teenage Alcohol Problem:
No.....0
Yes.....1
Evidence:

3. Childhood Aggression Rating:
No Evidence of Aggression .....0
Occasional Moderate Aggression.....0
Occasional or Frequent Extreme Aggression.1
Evidence:

4. More than 3 DSM Conduct Disorder
symptoms circled:
No..... 0
Yes..... 1

5. Ever suspended or expelled from school:
No ..... 0
Yes..... 1
Evidence:

6. Arrested under the age of 16:
No ..... 0
Yes..... 1
Evidence:

7. Parent alcoholism:
No ..... 0
Yes..... 1
Evidence:

8. Lived with both biological parents to age 16
(except for death of parents):
Yes..... 0
No .....1
Evidence:

**TOTAL CATS SCORE: (Sum of Circled Scores 1 - 8) _____**

---

**CONDUCT DISORDER SYMPTOMS**
*(Unless otherwise noted, circle any item that the person did before the age of 18):*

1. Often bullied, threatened or intimidated others

2. Often initiated physical fights

3. Used a weapon that could cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)

4. Was physically cruel to people

5. Was physically cruel to animals

6. Stolen while confronting a victim (e.g., mugging, purse snatching, extortion, robbery)

7. Forced someone into sexual activity

8. Deliberately engaged in fire setting with the intention of causing serious damage

9. Deliberately destroyed others' property (other than by fire setting)

10. Broken into someone else's house, car, or building

11. Often lied to obtain goods or favors or to avoid obligations (i.e., "cons" others)

12. Stolen items of nontrivial value without confronting a victim (like shoplifting, theft, or forgery)

13. **Before 13**, stayed out late at night, despite parental prohibitions

14. Ran away from home overnight (or longer) at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

15. **Before 13**, was often truant from school

**Violence Risk Appraisal Guide (VRAG) Items:**

1. Lived with both biological parents to age 16 (except for death of parent):
Yes ..... -2
No ..... +3
Evidence:

2. Elementary School Maladjustment:
No Problems..... -1
Slight (Minor discipline or attendance) or Moderate Problems..... +2
Severe Problems (Frequent disruptive behavior and/or attendance or behavior resulting in expulsion or serious suspensions) ..... +5
(Same as CATS Item)

3. History of alcohol problems *(Check if present):*
˜ Parental Alcoholism ˜ Teenage Alcohol Problem
˜ Adult Alcohol Problem ˜ Alcohol involved in prior offense
˜ Alcohol involved in index offense
No boxes checked..... -1
1 or 2 boxes checked ..... . 0
3 boxes checked ..... +1
4 or 5 boxes checked ..... +2
Evidence:

4. Marital status (at the time of or prior to index offense):
Ever married (or lived common law in the same home for at least six months) ..... -2
Never married..... +1
Evidence:

5. Criminal history score for nonviolent offenses prior to the index offense
Score 0 ..... -2
Score 1 or 2..... 0
Score 3 or above ..... +3
(from the Cormier-Lang system, see below)

6. Failure on prior conditional release (includes parole or probation violation or revocation, failure to comply, bail violation, and any new arrest while on conditional release):
No.....0
Yes ..... +3
Evidence:

7. Age at index offense
Enter Date of Index Offense: ___/___/_____
Enter Date of Birth: ___/___/_____
Subtract to get Age:
39 or over ..... -5
34 - 38 ..... -2
28 - 33 ..... -1
27 .....0
26 or less..... +2

8. Victim Injury (for index offense; the most serious is scored):
Death..... -2
Hospitalized.....0
Treated and released..... +1
None or slight (includes no victim)..... +2
Note: admission for the gathering of forensic evidence only is NOT considered as either treated or hospitalized; ratings should be made based on the degree of injury.
Evidence:

9. Any female victim (for index offense)
Yes ..... -1
No (includes no victim)..... +1
Evidence:

10. Meets DSM criteria for any personality disorder (must be made by appropriately licensed or certified professional)
No..... -2
Yes ..... +3
Evidence:

11. Meets DSM criteria for schizophrenia (must be made by appropriately licensed or certified professional)
Yes ..... -3
No ..... +1
Evidence:

12. a. Psychopathy Checklist score (if available, otherwise use item 12.b. CATS score).....
4 or under ..... -3
5 – 9..... -3
10-14 ..... -1
15-24 ..... 0
25-34 ..... +4
35 or higher ..... +12
Note: If there are two or more PCL scores, average the scores.
Evidence:

12. b. CATS score (from the CATS worksheet)
0 or 1 ..... -3
2 or 3 .....0
4 .....+2
5 or higher ..... +3

12. WEIGHT (Use the highest circled weight from 12 a. or 12 b.) ..... _____

**TOTAL VRAG SCORE (SUM CIRCLED SCORES FOR ITEMS 1 – 11 PLUS THE WEIGHT FOR ITEM 12): _____**

**CORMIER – LANG CRIMINAL HISTORY SCORES FOR NONVIOLENT OFFENSES[1]**

Instructions: Include ALL ARRESTS for ALL COUNTS for the following criminal offenses, including juvenile offenses. Write down the number of times the offender has been arrested (or the number of separate counts charged, whichever is highest) for each type of offense. Multiply that number by the weight in the column on the right and write that number in the blank. Total all of the resulting scores to obtain the total Cormier-Lang Criminal History Score.

| Offense | Arrests/Charges | Weight | Score |
|---|---|---|---|
| Robbery (bank, store) | _____ | X 7 = | _____ |
| Robbery (purse snatching) | _____ | X 3 = | _____ |
| Arson and fire setting (church, house, barn) | _____ | X 5 = | _____ |
| Arson and fire setting (garbage can) | _____ | X 1 = | _____ |
| Threatening with a weapon | _____ | X 3 = | _____ |
| Threatening (uttering threats) | _____ | X 2 = | _____ |
| Theft over * (includes car theft and possession stolen prop) | _____ | X 5 = | _____ |
| Mischief to public or private property over * | _____ | X 5 = | _____ |
| Break and enter and commit indictable offense (burglary) | _____ | X 2 = | _____ |
| Theft under *(includes possession stolen goods under) | _____ | X 1 = | _____ |
| Mischief to public or private property under * (also public) | _____ | X 1 = | _____ |
| Break and enter (includes break and enter with intent) | _____ | X 1 = | _____ |
| Fraud (extortion, embezzlement) | _____ | X 5 = | _____ |
| Fraud (forged check, impersonation) | _____ | X 1 = | _____ |
| Possession of a prohibited or restricted weapon | _____ | X 1 = | _____ |
| Procuring a person for, or living on the avails of prostitution | _____ | X 1 = | _____ |
| Trafficking in narcotics | _____ | X 1 = | _____ |
| Dangerous driving, impaired driving (including DWI) | _____ | X 1 = | _____ |
| Obstructing peace officer (including resisting arrest) | _____ | X 1 = | _____ |
| Causing a disturbance | _____ | X 1 = | _____ |
| Wearing a disguise with the intent to commit an offense | _____ | X 1 = | _____ |
| Indecent exposure | _____ | X2 = | _____ |

**TOTAL CORMIER – LANG NONVIOLENT SCORE** ..... _____

* Roughly equivalent to larceny versus grand larceny, based on the value of the stolen property. In 1997, the critical value was $1000.

1 Please see attached scoring for additional information about the Cormier-Lang System.

## Sex Offender Risk Appraisal Guide (SORAG) Items:

1. Lived with both biological parents to age 16 (except for death of parent):
   Yes ..... -2
   No ..... +3
   (Same as VRAG)

2. Elementary School Maladjustment:
   No Problems..... -1
   Slight (Minor discipline or attendance) or Moderate Problems..... +2
   Severe Problems (Frequent disruptive behavior and/or attendance or behavior resulting in expulsion or serious suspensions) ..... +5
   (Same as CATS Item)

3. History of alcohol problems (Check if present):
˜ Parental Alcoholism ˜ Teenage Alcohol Problem
˜ Adult Alcohol Problem ˜ Alcohol involved in prior offense
˜ Alcohol involved in index offense
   No boxes checked..... -1
   1 or 2 boxes checked ..... 0
   3 boxes checked ..... +1
   4 or 5 boxes checked ..... +2
   (Same as VRAG)

4. Marital status (at the time of or prior to index offense):
   Ever married (or lived common law in the same home for at least six months) ..... -2
   Never married..... +1
   (Same as VRAG)

5. Criminal history score for nonviolent offenses (from Cormier-Lang system)
   Score 0 ..... -2
   Score 1 or 2..... 0
   Score 3 or above ..... +3
   (Same as VRAG)

6. Criminal history score for violent offenses
   Score 0 ..... -2
   Score 1 or 2..... 0
   Score 3 or above ..... +6
   (From the Cormier-Lang system, below)

7. Number of previous convictions for sexual offenses (pertains to convictions known from all available documentation to be sexual offenses prior to the index offense) Count any offense known to be sexual, including, for example, incest
   0 ..... -1
   1 or 2 ..... +1
   3 or more..... +5
   Evidence:

8. History of sex offenses only against girls under 14 (including index offenses; if offender was less than 5 years older than victim, always score +4)
   Yes .....0
   No..... +4
   Evidence:

9. Failure on prior conditional release (includes parole or probation violation or revocation, failure to comply, bail violation, and any new arrest while on conditional release):
   No.....0
   Yes ..... +3
   (Same as VRAG)

10. Age at index
Enter Date of Index Offense: ___/___/_____
Enter Date of Birth: ___/___/_____
Subtract to get Age:
   39 or over ..... -5
   34 - 38 ..... -2
   28 - 33 ..... -1
   27 .....0
   26 or less..... +2
   (Same as VRAG)

11. Meets DSM criteria for any personality disorder (must be made by appropriately licensed or certified professional)
   No..... -2
   Yes ..... +3
   (Same as VRAG)

12. Meets DSM criteria for schizophrenia (must be made by appropriately licensed or certified professional) .....
   Yes ..... -3
   No ..... +1
   (Same as VRAG)

13. Phallometric test results
   All indicate nondeviant preferences ..... -1
   No Phallometric test results available ..... 0
   Any test indicates deviant preferences ... +1
   Evidence:

14. a. Psychopathy Checklist score (if available, otherwise use item 12.b. CATS score)
   4 or under ..... -3
   5 – 9 ..... -3
   10-14 ..... -1
   15-24 .....0
   25-34 ..... +4
   35 or higher ..... +12
   Note: If there are two or more PCL scores, average the scores.
   (Same as VRAG)

14. b. CATS score (from the CATS worksheet)
   0 or 1 ..... -3
   2 or 3 .....0
   4 ..... +2
   5 or higher ..... +3

14. WEIGHT (Use the highest circled weight from 12 a. or 12 b.) ..... _____

TOTAL SORAG SCORE (SUM CIRCLED SCORES FOR ITEMS 1 – 13 PLUS THE WEIGHT FOR ITEM 14): _____

**CORMIER – LANG CRIMINAL HISTORY SCORES FOR VIOLENT OFFENSES[2]**

Instructions: Include ALL ARRESTS for ALL COUNTS for the following violent criminal offenses, including juvenile offenses. Write down the number of times the offender has been arrested (or the number of separate counts charged, whichever is highest) for each type of offense. With the exception of attempted murder, all attempted offenses are scored the same as the offense itself. Multiply that number by the weight in the column on the right and write that number in the blank. Total all of the resulting scores to obtain the total Cormier-Lang Violent Criminal History Score.

| Offense | Arrests/Charges | Weight | Score |
|---|---|---|---|
| Homicide (murder, manslaughter, criminal negligence w/death) .... | _____.... | X 28 = | _____ |
| Attempted murder, causing bodily harm with intent to wound ..... | _____..... | X 7 = | _____ |
| Kidnapping, abduction, and forcible confinement ..... | _____..... | X 6 = | _____ |
| Aggravated assault, choking, administering a noxious thing ..... | _____..... | X 6 = | _____ |
| Assault causing bodily harm..... | _____..... | X 5 = | _____ |
| Assault with a weapon..... | _____..... | X 3 = | _____ |
| Assault, assaulting a police officer ..... | _____..... | X 2 = | _____ |
| Aggravated sexual assault, sexual assault causing bodily harm .... | _____.... | X 15 = | _____ |
| Sexual assault with weapon ..... | _____.... | X 12 = | _____ |
| Sexual assault, gross indecency (vaginal, anal or oral penetration) | _____.... | X 10 = | _____ |
| Sexual assault (attempted rape, indecent assault) ..... | _____..... | X 6 = | _____ |
| Gross indecency (offender fellates or performs cunnilingus on victim) | _____ ..... | X 6 = | _____ |
| Sexual assault (sexual interference, invitation to sexual touching). | _____..... | X 2 = | _____ |
| Armed robbery (bank, store) ..... | _____..... | X 8 = | _____ |
| Robbery with violence ..... | _____..... | X 5 = | _____ |
| Armed robbery (not a bank or store) ..... | _____..... | X 4 = | _____ |

**TOTAL CORMIER – LANG VIOLENT SCORE**..... ..... …._____

2 Please see attached scoring guide for additional information about the Cormier-Lang System

## DETERMINING THE PROBABILITY OF VIOLENT AND SEXUAL RECIDIVISM

I. Violent Offender Recidivism

1.Use the VRAG total score from Page 4.

2. Using the VRAG table, go down the left column until you see the number of the VRAG score you wrote down in 1.

3. The VRAG Category of Risk tells you the risk category for this offender. The VRAG categories range from Low to High. If someone's score approximates a higher risk category, indicate such by citing a range (e.g., if someone's VRAG score is a –8, -9, or –10, categorize their risk as Low to Medium, rather than just Low). This indicates that the patient/defendant is at the high range of the Low scale.

---

II. Sexual Offender Recidivism

1. Use the SORAG total score from Page 6.

2. Using the SORAG table, go down the left column until you see the number of the SORAG score you wrote down in 1.

3. The SORAG Category of Risk tells you the SORAG category for this offender. The SORAG categories range from Low to High. If someone's score approximates a higher risk category, indicate such by citing a range (e.g., if someone's SORAG score is a 17, 18, or 19, categorize their risk as Medium to High, rather than just Medium). This indicates that they are at the high range of the Medium scale.

# VRAG

| VRAG Score | Category of Risk |
|---|---|
| | |
| -24 | Low |
| -23 | Low |
| -22 | Low |
| -20 | Low |
| -19 | Low |
| -18 | Low |
| -17 | Low |
| -16 | Low |
| -15 | Low |
| -14 | Low |
| -13 | Low |
| -12 | Low |
| -11 | Low |
| -10 | Low |
| -9 | Low |
| -8 | Low |
| -7 | Medium |
| -6 | Medium |
| -5 | Medium |
| -4 | Medium |
| -3 | Medium |
| -2 | Medium |
| -1 | Medium |
| 0 | Medium |
| 1 | Medium |
| 2 | Medium |
| 3 | Medium |
| 4 | Medium |
| 5 | Medium |
| 6 | Medium |
| 7 | Medium |
| 8 | Medium |
| 9 | Medium |
| 10 | Medium |
| 11 | Medium |
| 2 | Medium |
| 13 | Medium |
| 14 | High |
| 15 | High |
| 16 | High |
| 17 | High |
| 18 | High |
| 19 | High |
| 20 | High |
| 21 | High |
| 22 | High |
| 23 | High |
| 24 | High |
| 25 | High |
| 26 | High |
| 28 | High |
| 32 | High |

# SORAG

| SORAG Score | Category of Risk |
|---|---|
| | |
| -17 | Low |
| -16 | Low |
| -15 | Low |
| -14 | Low |
| -13 | Low |
| -12 | Low |
| -11 | Low |
| -10 | Low |
| -9 | Low |
| -8 | Low |
| -7 | Low |
| -6 | Low |
| -5 | Low |
| -4 | Low |
| -3 | Low |
| -2 | Low |
| -1 | Low |
| 0 | Low |
| 1 | Low |
| 2 | Low |
| 3 | Medium |
| 4 | Medium |
| 5 | Medium |
| 6 | Medium |
| 7 | Medium |
| 8 | Medium |
| 9 | Medium |
| 10 | Medium |
| 11 | Medium |
| 12 | Medium |
| 13 | Medium |
| 14 | Medium |
| 15 | Medium |
| 16 | Medium |
| 17 | Medium |
| 18 | Medium |
| 19 | Medium |
| 20 | High |
| 21 | High |
| 22 | High |
| 23 | High |
| 24 | High |
| 25 | High |
| 26 | High |
| 27 | High |
| 28 | High |
| 29 | High |
| 30 | High |
| 31 | High |
| 32 | High |
| 33 | High |
| 34 | High |

## Supplementary Scoring Guidelines

*(From http://www.mhcva.on.ca/Research/bookerr.htm)*

**Elementary School Maladjustment**

First, it's important to note that this refers to the eight grades (formal years) of schooling after kindergarten. Here are some criteria and examples for scoring this item:

**Minor or Moderate Problems:** (minor or moderate discipline or attendance problem; reports of nonassaultive, disruptive behavior or incidents of truancy on at least two occasions or one or two suspensions for nonassaultive or minor assaultive behavior) Some examples are: suspended for smoking on school property; told to report to the principal's office on at least two occasions for refusing to co-operate with assignments, or for interfering with other students' class participation, or for "talking back" to a teacher; parents notified because of incidents of pushing students down in the schoolyard; suspended twice for truancy; and told to report to the principal's office for threatening a teacher.

**Severe Problems:** (frequent disruptive behavior and/or attendance problems, or serious assaultive behavior, or any behavior resulting in expulsion) Some examples are: punching a teacher; expelled for selling drugs at school; suspended for beating up a student; several incidents of truancy either occurring all in one grade or over several grades.

**Index Offense**

In our research, the index offense was the criminal or antisocial activity that resulted in the offender becoming a subject in our research. In most cases, this was a criminal charge or conviction that directly resulted in his admission to Oak Ridge. Especially among sex offenders, however, the index offense sometimes involves judgment. For example, for a man sent to Oak Ridge for sexual assaulting his daughter many times over a decade, we defined the index offense date as the date on which the first assault occurred. As another example, for a man sent to Oak Ridge for rape who later was convicted for making obscene phone calls while incarcerated, the rape was the index offense. As yet another example, for a man sent to Oak Ridge for a sexual murder who revealed in therapy that he also committed rapes before being apprehended, the sexual murder was the index offense.

**Separation from Parents before age 16**

Any period greater than or equal to a month during which the offender lived completely apart from either biological parent counts. Separations could be due to divorce or marital separation, or institutionalization of parent or child but separation due entirely to death of a parent did not count. Also, voluntary (i.e., instigated by the family and not by the youth justice system) separations for vacation, summer camp, or boarding school did not count.

Did failure on Conditional Release count failures when under clinical supervision as an insanity acquittee or other psychiatric release?

No, only failures involving criminal justice services (bail, probation, parole, etc.) counted.

# Cormier-Lang System for Quantifying Criminal History

## GROUP 1

| | |
|---|---|
| Homicide (murder, manslaughter, criminal negligence causing death) | 28 |
| Attempted murder, causing bodily harm with intent to wound | 7 |
| Kidnapping, abduction, and forcible confinement | 6 |
| Aggravated assault, choking, administering a noxious thing | 6 |
| Assault causing bodily harm | 5 |
| Assault with a weapon | 3 |
| Assault, assaulting a peace officer | 2 |
| Aggravated sexual assault, sexual assault causing bodily harm | 15 |
| Sexual assault with weapon | 12 |
| Sexual assault, gross indecency (vaginal or anal penetration; victim Forced to fellate offender) | 10 |
| Sexual assault (attempted rape, indecent assault) | 6 |
| Gross indecency (offender fellates or performs cunnilingus on victim) | 6 |
| Sexual assault (sexual interference, invitation to sexual touching) | 2 |
| Armed robbery (bank, store) | 8 |
| Robbery with violence | 5 |
| Armed robbery (not a bank or store) | 4 |

## GROUP 2

| | |
|---|---|
| Robbery (bank, store) | 7 |
| Robbery (purse snatching) | 3 |
| Arson and fire setting (church, house, barn) | 5 |
| Arson and fire setting (garbage can) | 1 |
| Threatening with a weapon | 3 |
| Threatening (uttering threats) | 2 |
| Theft over* (includes car theft and possession of stolen property over) | 5 |
| Mischief to public or private property over* | 5 |
| Break and enter and commit an indictable offense (burglary) | 2 |
| Theft under* (includes possession of stolen goods under) | 1 |
| Mischief to public or private property under* (includes public mischief) | 1 |
| Break and enter (includes breaking and entering with intent to commit an offense) | 1 |
| Fraud (extortion, embezzlement) | 5 |
| Fraud (forged check, impersonation) | 1 |
| Possession of a prohibited or restricted weapon | 1 |
| Procuring a person for, or living on the avails or prostitution | 1 |
| Trafficking in narcotics | 1 |
| Dangerous driving, impaired driving (driving while intoxicated) | 1 |
| Obstructing peace officer (including resisting arrest) | 1 |
| Causing a disturbance | 1 |
| Wearing a disguise with the intent to commit an offense | 1 |
| Indecent exposure | 2 |

## NOTES AND INSTRUCTIONS*

This system is an adaptation of an adaptation of an earlier one by Akman and Normandeau (1967). It can be used to quantify an offender's history of criminal offenses, a current or index offense, or a particular subgroup of offenses (such as violent offenses or property offenses). For scoring the VRAG and SORAG, all arrests (including juvenile crimes) prior to the index offense are scored separately for violent and nonviolent criminal history. Add up each "count" of an offence to determine the seriousness within that type. For example, if there are two counts of breaking and entering (2 X 1 = 2) and three counts of theft under (3 x 1 = 3), then the resulting score would be 5. Scores can be cumulative or separated into desired categories (i.e., total of all offense types or separated into violent and nonviolent or sexual and nonsexual). Charges of "attempted" offense such as attempted armed robbery are scored the same as if the offense had been completed with the exception of attempted murder, which has a separate assigned value.

This system can be used when only official police "rap sheet" information is available (e.g., records from the Royal Canadian Mounted Police Fingerprint Service), but when possible, police reports from investigating officers and witnesses should also be used to clarify details. In cases where the exact type is unknown, use an "at least" method to score. For example, if an offense is known to be assault but there are no details as to whether it was assault causing bodily harm or aggravated assault, score the offense in the lowest category, as 2.

Many Criminal Codes and other systems to categorize criminal conduct distinguish between violent and nonviolent offenses. In Canada there is a distinction between offenses against the person and offenses against property. However, such official distinctions usually do not appropriately capture what is, at best, a somewhat arbitrary distinction. In Canada, for example, bigamy is listed as an offense against the person, whereas robbery is an offense against property. In scoring the VRAG and the SORAG, offenses listed in Group 1 are generally considered to be violent, and offenses listed in Group 2 are nonviolent, but exceptions are possible. Documents with details of offenses can (and should whenever possible) be used for scoring. In general, for example, armed robbery and robbery with violence are scored as violent offenses, but robbery is considered to be nonviolent. However, if investigating officers' reports indicated that a robbery arrest was associated with violent conduct (e.g., a victim was injured), the offense would be recorded as violent. As another example, an arrest for pointing a firearm or possession of a restricted weapon would be recorded as nonviolent without additional information. However, if police reports from witnesses indicated that the charges were associated with violent conduct (e.g., attempting to fire a weapon at someone), the offense would be recorded as violent. Similarly, a conviction for setting offense may be recorded as mischief (with a score of 1), but if details of the offense clearly indicated that the offense was actually setting fire to a home and causing substantial damage, then the score would be 5 for the most serious of the arson offenses.

Many criminal offenses do not appear here. There are a variety of reasons for this. First, some offenses (e.g., sedition, bestiality, bribery, counterfeiting, hijacking, pretending to discover stolen property by occult science) are so rare that we did not derive a score for them. In the case of such rare offenses, the listed offense closest to the rare one should be used: kidnapping for hijacking; and fraud for counterfeiting, for example.

Second, some offenses – prostitution, possession of narcotics, bookmaking and other so-called "victimless" crimes – were to minor to include. Third, some offenses – parole; mandatory supervision violations; breach of probation, recognizance or bail; failure to appear; and escape and

unlawfully at large – were addressed separately in other areas of the original research and are therefore not included here unless these crimes resulted in additional offenses (e.g., a murder by a prison escapee), which then would be scored.

This system (and the earlier one by Akman & Normandeau, 1967) is based on the Criminal Code of Canada, which itself is based on British Common Law, as are the criminal statutes throughout the English-speaking world. Thus, the Canadian Criminal Code is very similar to the statutes in individual states in the United States. To the extent that a particular state code is different, some amount of judgment is required to approximate as closely as possible the names of offenses in other jurisdictions. For example, an offense commonly listed in U.S. states is battery, which usually involves some physical injury. It would therefore be comparable to the assault causing bodily harm listed in this scoring method. Similarly, larceny does not appear in the Canadian Code but is usually equivalent to theft.

In addition, the Canadian Criminal Code entails two classes for some offenses (e.g., theft, mischief, possession of stolen property) against property-offenses resulting in a loss over a particular monetary value versus those involving a loss less than that value. This is similar to the grand larceny versus larceny distinction in some other jurisdictions. The scoring system presented here reflects that distinction assigning larger values to offenses exceeding that criterion (Over*) compared to those that do not (Under*). Because of inflation, the critical value has changed from time to time (from $50 to $200 to $1,000). Scoring is done according to whether the offense exceeded the cutoff value at the time. Problems with interjurisdictional comparability are more troublesome for research application of this system than application to individual cases. In an individual case, once it is clear an offender's score is zero or exceeds 2 (e.g., more than one violent offense and more than two nonviolent offenses automatically exceed a score of 2), scoring is straightforward Only in cases where a distinction is possible among scores of 0, 1, or 2 is any judgment required to determine how a particular arrest corresponds to the system here. Sometimes the sentence prescribed by the Criminal Code can be a guide to relative seriousness.

# Appendix C

## Emergency Transfer from an RMHI to FSP

1. **PURPOSE**:

To provide guidelines for the emergency transfer of a service recipient from a Regional Mental Health Institute (RMHI) to the Forensic Services Program (FSP) at Middle Tennessee Mental Health Institute.

2. **POLICY**:

The forensic staff in the Office of Forensic Services will ensure that the emergency transfer of a service recipient from an RMHI to FSP is expeditious, based on appropriate clinical judgment and in consideration of the welfare and safety of the service recipient, as well as other service recipients and staff.

The following criteria must be met in order for a transfer to be considered:

A. the individual requires emergency care and treatment that cannot be provided for by the transferring facility; and
B. the transfer is in the individual's best interest; and
C. the individual has a substantial likelihood of injuring himself/herself or others if not treated in a secure facility, and,
D. the individual is not under a voluntary commitment.

3. **SCOPE**:

This policy applies to TDMHSAS and to the RMHIs, including the Forensics Services Program (FSP).

4. **PROCEDURE**:

A. After determination by the treating clinicians that the service recipient meets the criteria for emergency transfer, the following procedures must be implemented: The Chief Officer/Designee of the referring RMHI will:
   (1) Place a telephone call to the designated Forensic Specialist in the Office of Forensic Services and the Forensic Coordinator at FSP. If a transfer is needed during non-working hours, please contact the Assistant Commissioner of the Division of Planning, Research and Forensics.
   (2) No later than 2 hours after verbal request, FAX the following to the Director of Forensic/Juvenile Court Services or to the designated forensic specialist:
      (a) Recommendation for transfer from the referring Chief Officer/Designee that includes the rationale for transfer and the interventions taken to treat the individual prior to the request. This recommendation must include, but is not limited to, the following: use of restraint/seclusion, changes in medication, use of PRN medications, and/or changes in unit assignment (Attachment A). An emergency transfer should not be requested until all appropriate interventions have been tried and have been documented and deemed unsuccessful.

(b) Documentation of the need for transfer from either a licensed physician with expertise in psychiatry or a licensed psychologist with health service provider designation (Attachment B).
(c) A written report of a physical examination completed by a licensed physician within the last six (6) months with an addendum within the last twenty-four hours that indicates that the service recipient is physically stable prior to transfer.
(d) A written report of a mental status assessment and evaluation completed by a physician or licensed psychologist within the last twenty-four (24) hours.
(e) The most recent risk assessment, if a forensic service recipient.
(f) The transfer request cannot be processed without all of the above information.

B. Upon receipt of the above information, the designated Forensic Specialist at the Office of Forensic Services will:
(1) Review the request and complete an emergency transfer check sheet. (Attachment #1)
(2) Make a recommendation to the Director of Forensic/Juvenile Court Services, the Assistant Commissioner of Planning, Research and Forensics, and the Commissioner.
(3) Attach items (2)(a) through (2)(e) (justification for the transfer, certification of need, the physical exam, and the mental status assessment and evaluation).

C. Upon review of the above information, the Director of Forensic/Juvenile Court Services, the Assistant Commissioner of Planning, Research and Forensics, and the Commissioner will verbally:
(1) Authorize transfer, via the Forensic Specialist, or,
(2) Request that further information be received before authorization, or,
(3) Deny the transfer.

D. If the emergency transfer request is denied, the Forensic Coordinator at the RMHI who requested the transfer and the designated Forensic Specialist at the Office of Forensic Services will develop an alternative safety plan (e.g., behavioral modification, change in medications, moving the service recipient to a different unit) and identify an appropriate period of time for review of this new safety plan.

E. If the emergency transfer request is approved, then the designated Forensic Specialist at the Office of Forensic Services will:
(1) Verbally convey the decision to the Chief Officer/Designee of the referring facility, the Chief Officer of MTMHI/Designee, and to the forensic coordinator of FSP.
(2) Prepare a letter from the Commissioner of TDMHSAS to the service recipient (Attachment C) with a copy faxed, followed by mail, to both the sending and receiving Chief Officers.

F. Upon receipt of the verbal authorization, the referring Chief Officer/Designee will:

(1) Assure that the service recipient receives a signed statement from the referring Chief Officer/Designee (Attachment D) notifying the service recipient of the authorized transfer.
(2) Obtain a signed receipt of the notice to the service recipient (Attachment E). Note: If the service recipient is unwilling or unable to sign this attachment, this must be documented and then witnessed by a second RMHI staff.
(3) Verbally contact the appropriate relative/conservator, followed by written notice of transfer (Attachment F).
(4) Set up a teleconference between the referring psychiatrist and the receiving psychiatrist to discuss diagnosis and medication decisions.
(5) File a complaint for commitment under Title 33, Chapter 6, Part 5, Tenn. Code Annotated, if necessary (if the service recipient has not already been judicially committed).

G. The service recipient may then be transferred, accompanied by a copy of the service recipient's clinical record. This should occur no later than twenty-four (24) hours from receipt of verbal approval of the transfer request.

H. The Chief Officer/Designee of the referring facility will then notify the committing court (Attachment G) of the emergency transfer.

I. The Chief Officer/Designee of the referring facility will prepare and send a transfer packet to the designated forensic specialist in the Office of Forensic Services that will include:
(1) A copy of the court commitment order (if available).
(2) A copy of court notification (Attachment G) of the transfer.
(3) A copy of the notification of the transfer to the service recipient (Attachment E) and to the appropriate relative/conservator (Attachment F).

J. The designated Forensic Specialist in the Office of Forensic Services will then prepare a letter to the service recipient (Attachment H) from the Commissioner indicating that the continued need for treatment in the secure facility will be determined within 72 hours.

K. Within 72 hours of the transfer to FSP, the treatment team at FSP will determine if there is need for continued care and treatment for up to 30 days.
(1) If continued treatment at FSP is recommended:
(a) The Chief Officer/Designee of MTMHI will send written notification to the service recipient (Attachment I), copied to the designated Forensic Specialist at the Office of Forensic Services.
(b) The Commissioner will send written notice to the service recipient of the authorization of the continued need for care and treatment in a secure facility (FSP) (Attachment J), copied to the referring and receiving Chief Officers.

(2) If continued treatment at FSP is not needed:
(a) The FSP Coordinator will notify the referring RMHI Chief Officer/Designee by telephone, followed by letter, and the service

recipient must be returned to the referring facility within twenty-four (24) hours of the decision, and,

(b) Notify the designated Forensic Specialist in the Office of Forensic Services by telephone, followed by a copy of the letter to the Chief Officer/Designee of the referring RMHI.

L. Within thirty (30) days of the transfer to FSP, the FSP treatment team will determine if continued care and treatment at FSP is required beyond thirty (30) days.

M. If continued treatment beyond thirty (30) days at FSP is recommended:
(1) The Chief Officer/Designee of MTMHI will notify the service recipient (Attachment K), and,
(2) Will request approval from the Commissioner of TDMHSAS, via the Forensic Coordinator of FSP. This must include the justification of the need for continued care and treatment in the secure facility (Attachment L).

N. Three (3) original copies of the authorization form (Attachment M) for continued care and treatment at FSP are then routed to the following for signature:
(1) Director of Forensic/Juvenile Court Services.
(2) Assistant Commissioner of Planning, Research and Forensics.
(3) Commissioner.

O. If the need for continued care and treatment is approved by the Commissioner, the Commissioner will:
(1) Notify the Chief Officer of the referring facility via authorization memo (Attachment M).
(2) Notify the Chief Officer of MTMHI via authorization memo (Attachment M).
(3) Notify the service recipient (Attachment N) and include a complaint form (Attachment O).
(4) Notify the appropriate relative/conservator (Attachment P) and include a complaint form (Attachment O).

P. If continued treatment at FSP is approved, the FSP Coordinator will notify the committing court of this approval of need for continued treatment (Attachment Q).

Q. If continued treatment at FSP is not recommended:
(1) The Chief Officer/Designee of MTMHI will notify the Chief Officer/Designee of the referring facility (copied to Forensic Specialist in the Office of Forensic Services), and,
(2) Return the service recipient to the referring facility within twenty-four (24) hours of the decision.
(3) Forensic coordinator of RMHI will notify the service recipient's family and the committing court of the service recipient's return to the RMHI.

R. The Forensic Coordinator of FSP will notify the designated Forensic Specialist in the Office of Forensic Services of the date of the service recipient's return to the referring facility.

# Appendix D

## Transfer <u>from</u> RMHI <u>to</u> FSP (Regular/Non-Emergency)

1. **<u>PURPOSE</u>**:

To provide guidelines to the forensic staff in the Office of Forensic Services to transfer a service recipient from a Regional Mental Health Institute (RMHI) to the Forensic Services Program (FSP) at Middle Tennessee Mental Health Institute (MTMHI).

2. **<u>POLICY</u>**:

THE COMMISSIONER OF THE TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (TDMHSAS) MAY AUTHORIZE A TRANSFER TO THE FSP AT MTMHI OF A SERVICE RECIPIENT WHO WAS ADMITTED, COMMITTED, OR HOSPITALIZED AT AN RMHI WHEN:

(a) the service recipient could more properly be cared for and treated in the Forensic Services Program at MTMHI, *and*,

(b) the transfer is in the service recipient's best interest*, and*,

(c) the Commissioner determines that the service recipient is substantially likely to injure himself/herself or others if not treated in a secure facility.

3. **<u>SCOPE</u>**:

This policy applies to TDMHSAS and to the RMHIs, including the Forensics Services Program (FSP).

4. **<u>PROCEDURE</u>**:

A. **Referring RMHI Chief Officer/Designee: Initiating Transfer Request**

Upon recommendation by the treatment team, the Chief Officer/designee of the referring facility shall prepare and send a transfer packet to the Commissioner via the designated Forensic Specialist in the Office of Forensic Services. This transfer packet shall also be sent to the Forensic Coordinator of FSP. The transfer packet must include:

(1) a cover letter from the Chief Officer/designee requesting the transfer with the rationale for the request (Attachment 1)

(2) certificate of need (Attachment A) from a licensed physician with expertise in psychiatry or a licensed psychologist with a health service provider designation that includes documentation related to the service recipient's behavior and attempted treatment interventions (including, but not limited; to the use of seclusion/restraint, a new unit assignment, PRN medications, and/or changes in routine medication),

**(3) a mental status assessment/evaluation completed within the last twenty-four hours prior to request,**

(4) a physical examination completed within the last six months prior to the request for transfer with an addendum verifying that a physical exam was *updated* within the past twenty-four (24) hours,

(5) a copy of the court commitment order,
(6) a copy of the most recent risk assessment, if forensic, and
(7) documentation that the service recipient (Attachment B) and his/her appropriate relative/conservator (Attachment C) have been notified of the transfer request by the Chief Officer/designee. Unless the relative/conservator is in agreement with the transfer, the transfer cannot occur for twenty-four hours from the time of request for approval.

B. Office of Forensic Services

Upon receipt of the transfer request, the designated forensic specialist in the Office of Forensic Services will review the request and make a recommendation to the Director of Forensic/Juvenile Court Services.

(1) If, after review of the initial transfer request information, the designated forensic specialist and the Director of the Office of Forensic Services conclude that not all reasonable treatment interventions have been conducted prior to transfer to FSP, s/he may request, in writing to the Chief Officer/Designee of the referring RMHI, that more, specific interventions be attempted (e.g. behavioral plan, relocating service recipient to new unit, psychopharmacology consultation). The Director of Forensic/Juvenile Services will notify the Assistant Commissioner of Planning, Research and Forensics of this request. The Chief Officer/ designee may submit additional information at that time to clarify what attempts were made to manage the service recipient's behavior safely in the RMHI, or, after a reasonable period of time, reapply for this transfer after the recommended interventions have been tried, evaluated, and have been deemed not to have succeeded in ameliorating the conditions that triggered the original transfer request. Supporting documentation must accompany this second request.

(2) If the designated forensic specialist and the Director of Forensic/Juvenile Services concur with the request for transfer to the FSP (either upon initial request, upon review of additional information to the initial request, or in response to an updated request), the forensic specialist will prepare the following documents and forward them with the transfer packet [4.A.(1) through (7)] and any additional information submitted by the referring facility, to the Assistant Commissioner of Planning, Research and Forensics:

(a) a memo to the Director of Forensic/Juvenile Court Services from the forensic specialist recommending the transfer (Attachment D);
(b) a memo to the Assistant Commissioner of Planning, Research and Forensics from the Director of Forensic/Juvenile Court Services requesting approval (Attachment E)

Approval of the initial request with recommendation to the Assistant Commissioner of Planning, Research and Forensics or the request for a plan for more specific interventions with notification to the Assistant Commissioner must be completed within five (5) business days of the receipt of the request.

## C. Assistant Commissioner of Planning, Research and Forensics

The Assistant Commissioner of Planning, Research and Forensics will review the transfer request upon receipt of the recommendation for transfer from the Office of Forensic Services and the transfer packet.

(1) If the Assistant Commissioner concludes that not all reasonable treatment interventions have been conducted prior to transfer to FSP, s/he will instruct the Director of the Office of Forensic Services to request, in writing to the Chief Officer/Designee of the referring RMHI, that more, specific interventions be attempted (e.g. behavioral plan, relocating service recipient to new unit, psychopharmacology consultation). The Chief Officer/designee may submit additional information at that time to clarify what attempts were made to manage the service recipient's behavior safely in the RMHI, or, after a reasonable period of time, reapply for this transfer after the recommended interventions have been tried, evaluated, and have been deemed not to have succeeded in ameliorating the conditions that triggered the original transfer request. Supporting documentation must accompany this second request.

(2) If the Assistant Commissioner concurs with the request for transfer to the FSP (either upon initial request, upon review of additional information to the initial request, or in response to an updated request), the forensic specialist will prepare the following documents and forward them with the transfer packet [4.A.(1) through (7)] and any additional information submitted by the referring facility, to the Commissioner:

(a) a memo to the Commissioner from the Assistant Commissioner of Planning, Research and Forensics requesting approval for the transfer (Attachment F); and,

(b) three (3) authorization forms (Attachment G) to be signed by the Director of Forensic/Juvenile Court Services, the Assistant Commissioner of Planning, Research and Forensics and the Commissioner.

## D. Commissioner

The Commissioner will review the transfer request upon receipt of the recommendation for transfer from the Assistant Commissioner of Planning, Research and Forensics and the Office of Forensic Services and the transfer packet.

(1) If the Commissioner concludes that not all reasonable treatment interventions have been conducted prior to transfer to FSP, s/he will instruct the Director of the Office of Forensic Services to request, in writing to the Chief Officer/Designee of the referring RMHI, that more, specific interventions be attempted (e.g. behavioral plan, relocating service recipient to new unit, psychopharmacology consultation). The Chief Officer/designee may submit additional information at that time to clarify what attempts were made to manage the service recipient's behavior safely in the RMHI, or, after a reasonable period of time, reapply for this transfer after the recommended interventions have been tried, evaluated, and have been deemed not to have succeeded in ameliorating the conditions that triggered the original transfer request. Supporting documentation must accompany this second request.

(2) If the Commissioner concurs with the request for transfer to the FSP (either upon initial request, upon review of additional information to the initial request, or in response to an updated request), the forensic specialist will prepare the following letters for the Commissioner's signature addressed to:

(a) the Chief Officer of the referring facility ( Attachment H), along with a receipt of transfer notice form (Attachment I), authorization letter to the patient (Attachment J), a complaint form (Attachment K), and a signed authorization form (Attachment G),

**(b) the Chief Officer of MTMHI (Attachment L) along with a signed authorization form (Attachment G),**

(c) the appropriate relative or conservator (Attachment M), along with a complaint form (Attachment K), sent via certified mail, and,

(d) the committing court (Attachment N).

**E. Referring RMHI Chief Officer/Designee: Completing Approved Transfer**

(1) Upon receipt of the transfer approval, the Chief Officer/Designee will deliver the transfer authorization letter (Attachment J), along with the complaint form (Attachment K), and the receipt form to the service recipient being transferred (Attachment I);

(2) The Chief Officer/Designee will keep the signed receipt for their files and place a copy in the service recipient's medical record;

(3) The Chief Officer/Designee will send written notice regarding the transfer to the committing court (Attachment O);

(4) The Chief Officer/Designee will communicate with the Forensic Coordinator at FSP to arrange the transfer;

(5) The Chief Officer/Designee will arrange transportation of the service recipient.

F. A discussion between the receiving psychiatrist and the referring psychiatrist regarding diagnosis and medication decisions must be completed prior to transfer and this must be documented in the service recipient's record.

G. The transfer must occur within two (2) business days from the date that the transfer request is approved.

H. The Forensic Services Coordinator of FSP will notify the referring Forensic Services Coordinator of the admission of the transferred service recipient.

# Appendix E

## Transfer from FSP to RMHI

**1. PURPOSE:**

To provide guidelines for the forensic staff in the Office of Forensic Services for the transfer of a service recipient from the Forensic Services Program (FSP) at Middle Tennessee Mental Health Institute (MTMHI) to a regional mental health institute (RMHI).

**2. POLICY:**

The Commissioner may authorize the transfer of any service recipient who was admitted, committed, or hospitalized at the Forensic Services Program (FSP) at MTMHI to an RMHI when:

A. The person could more properly be cared for and treated in a non-secure facility, *and,*
B. The transfer is in the service recipient's best interest, *and,*
C. The transfer will not be contrary to the safety and welfare of the service recipient, other service recipients or the staff of the receiving facility*, and,*
D. The service recipient no longer requires treatment in a secure facility.

**3. SCOPE:**

This policy applies to the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), and to the Regional Mental Health Institutes (RMHI), including the Forensics Services Program (FSP).

**4. PROCEDURE:**

**A. FSP Responsibilities:**

(1). Upon recommendation by the treatment team, the FSP Forensic Coordinator must forward the following reports to the Chief Officer/Designee of MTMHI:

(a) A certified copy of the court commitment order,
(b) A copy of the most recent staff conference report,
(c) A copy of the most recent physical examination (completed within the last six (6) months and updated within the past twenty-four hours),
(d) A copy of the most recent risk assessment (if forensic),
(e) A report of mental assessment and evaluation for transfer (if not included in the staff conference report), and
(f) A copy of the notifications provided to the court, to the service recipient (Attachment I), to the service recipient's nearest relative/ conservator as applicable regarding the request for transfer.

(2). It is the responsibility of the Chief Officer to review and approve the transfer request within 72 hours of receipt and then provide a signed cover letter that includes the following:

(a) Documentation of specific reasons for transfer and the service recipient's past and present behavior,
(b) Statement (certification) that the transfer is in the best interest of the service recipient, and
(c) Statement (certification) that the transfer will not be contrary to the safety and welfare of the service recipient or other service recipients and staff of the receiving facility.

(3).(a) The signed cover letter, along with the required documents listed above (4.A.(1).(a)(e)) will be forwarded by the forensic coordinator of FSP to the Commissioner of TDMH via the designated forensic specialist in the Office of Forensic Services within twenty-four (24) hours of receipt from the chief officer.
(b) A copy of "Receipt of Transfer Notification" (Attachment I) will also be included with these documents.

(4). The Chief Officer/Designee of MTMHI shall send a referral letter to the Chief Officer of the receiving facility along with a copy of the documents listed above (4.A.(1).(a)-(e)) and a copy of the service recipient's record at the time the transfer request is made to the TDMH. The receiving Chief Officer has fifteen (15) days after this notice to challenge the transfer to the Commissioner. This must be done in writing and contain the justification for the challenge and an alternative RMHI transfer destination for the service recipient. A physician-to-physician teleconference may be conducted as a part of this review process.

**B. Office of Forensic Services:**

(1). Upon receipt of the transfer documents, the assigned forensic specialist for MTMHI will:
(a) Review these documents sent by the Chief Officer/Designee of MTMHI;
(b) Arrange an interview to be conducted by the forensic specialist and the Director of Forensic/Juvenile Court Services with the service recipient within 48 hours of receipt of the transfer request;
(c) Interview the staff members involved in the service recipient's treatment;
(d) Review the clinical chart at FSP.

(2). Following this review, the forensic specialist must prepare a summary report to the Director of Forensic/Juvenile Court Services within three (3) business days that summarizes the clinical and legal information specific to the service recipient, and includes the following:
(a) Statement that the transfer is/is not in the best interest of the service recipient, *and,*
(b) Statement that the transfer would/would not be contrary to the safety and well-being of other service recipients and staff, *and*
(c) A description of the service recipient's current behavior, *and*
(d) A recommendation for or against transfer with the rationale for this recommendation

(3). Upon completion of the above report (B.(1).(a)-(d)), the Director of Forensic/Juvenile Court Services will review the report and may either concur or not concur with the chief officer's request for transfer.

(a). If the Director concurs, he/she will complete a recommendation memo to the Assistant Commissioner of Planning, Research and Forensics (Attachment A) concurring with the chief officer's request for transfer.

(b). If the Director does not concur with the transfer request, he/she will consult with the Director of the Forensic Unit to identify barriers to transfer, develop a plan to eliminate barriers to transfer, and establish a time frame for reviewing progress. The Director will notify the Chief Officers of MTMHI and the receiving facility and the Assistant Commissioner of Planning, Research and Forensics of the decision and the recommended plan.

(c). Once the barriers to transfer have been eliminated, the Director of the Forensic Unit will submit an updated report to the Director of Forensic/Juvenile Court Services, and the Director of Forensic/Juvenile Court Services will complete a recommendation memo to the Assistant Commissioner of Planning, Research and Forensics (Attachment A) supporting the transfer request.

**C. Assistant Commissioner of Planning, Research and Forensics**

(1). The Assistant Commissioner will review the recommendation supporting the transfer request from the Director of Forensic/Juvenile Court Services upon receipt. If the Assistant Commissioner concurs with a request for transfer which the Director has supported, the Assistant Commissioner will complete a recommendation memo prepared by the Forensic Specialist addressed to the Commissioner of the TDMHSAS supporting the transfer request (Attachment B).

(2). If the Assistant Commissioner does not concur with a request for transfer which the Director has recommended, the Director of Forensic/Juvenile Court Services will consult with the Director of the FSP to identify barriers to transfer, develop a plan to eliminate barriers to transfer and establish a time frame for reviewing progress.

(3). Once the barriers to transfer have been eliminated, the Director of the FSP will submit an updated report to the Director of Forensic/Juvenile Court Services, and the Director of Forensic/Juvenile Court Services will submit the updated request to the Assistant Commissioner for review. If the Assistant Commissioner does not approve the updated request, consultation and planning as described under C.(2)., above, will continue until the Assistant Commissioner approves an updated request. If the Assistant Commissioner concurs with the request, then he/she will complete a recommendation memo prepared by the Forensic Specialist addressed to the Commissioner of the TDMHSAS supporting the transfer request (Attachment B).

**D. Commissioner**

(1). Once the Director of Forensic/Juvenile Court Services and the Assistant Commissioner of Planning, Research and Forensics concur with the transfer request, the Forensic Specialist will prepare:

(a) A letter from the Commissioner of TDMHSAS to the Chief Officer of MTMHI via Director of FSP approving the transfer request (Attachment C).

(b) A letter from the Commissioner of TDMHSAS to the Chief Officer of the receiving facility. This letter must indicate that the transfer is to occur within 30 days from the date of the approval. (Attachment D).
(c) Three (3) authorization forms (Attachment E), each with original signatures, to be signed by the Director of Forensic/Juvenile Court Services, the Assistant Commissioner of Planning, Research and Forensics, and the Commissioner of TDMHSAS. (These forms are also attachments to memos to the referring facility, the receiving facility, and for files of TDMHSAS).
(d) A letter from the Commissioner of TDMHSAS to the service recipient at FSP at MTMHI with a complaint form. (Attachments F and G). These may also be sent with the letter to the referring facility. (Attachment C).
(e) A letter from the Commissioner of TDMHSAS to the nearest relative/conservator of the service recipient with a complaint form. (Attachments G and H)
(f) A completed cover sheet (Attachment 1)

(2). The transfer request and above materials will be submitted to the Commissioner for review. If the Commissioner concurs with the transfer request, he/she will complete the above notifications which will be distributed to the appropriate parties by the Forensic Specialist.

(3). If the Commissioner does not concur with the transfer request, the Director of Forensic/Juvenile Court Services will consult with the Director of the FSP to identify barriers to transfer, develop a plan to eliminate barriers to transfer and establish a time frame for reviewing progress.

(4). Once the barriers to transfer have been eliminated, the Director of the FSP will submit an updated report to the Director of Forensic/Juvenile Court Services, and the Director of Forensic/Juvenile Court Services will submit the updated request to the Commissioner for review. If the Commissioner does not approve the updated request, consultation and planning as described under D.(3)., above, will continue until the Commissioner approves an updated request.

(5). Once the Commissioner approves a transfer request, he/she will complete the notifications prepared by the Forensic Specialist, and the Forensic Specialist will distribute them to the appropriate parties.

**E. Completing Approved Transfer**

(1). The Director of the FSP at MTMHI must schedule a conference call (either by phone or videoconference) to occur between the referring and receiving physician to discuss medical conditions, the rationale for diagnoses, and prescribed medication(s) prior to the transfer of the service recipient. This conference must be documented in the service recipient's medical record.

(2). The transfer must occur within 30 days of the receipt of the letter from the Commissioner to the Chief Officer of the receiving RMHI, with the Director of FSP having the responsibility of arranging the transportation of the service recipient to the receiving facility.

(3). The Chief Officer of MTMHI shall notify the committing court of the date for transfer (Attachment J).

# Appendix F – Sample Letters

Appendix F includes a selection of sample letters to the court on forensic cases under various circumstances. These samples are not intended to cover every possible situation, but to provide examples based on the most common case outcomes.

**T.C.A. § 33-7-301 (a); Competent, No Insanity Defense, Not Committable**

(Date)

Judge (Name)
(County Criminal/Circuit/General Court)
(Address)
(City), Tennessee (Zip Code)

RE: State of Tennessee vs. (Name)
Case # (######)

Dear Judge (Name):

(Name) was admitted to (RMHI) on (Date), by order of your Court. (He/She) was sent here for an evaluation of (his/her) ability to stand trial on the charge(s) of (Charges), and an assessment of (his/her) mental status at the time of the alleged offense.

After completion of the competency evaluation, we have concluded that (he/she) has sufficient present ability to consult with (his/her) lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against (him/her). In making this determination, it was concluded that (he/she) does understand the charges pending against (him/her) and the consequences that may follow, and is able to advise counsel and participate in (his/her) own defense.

With regard to (Name)'s mental condition at the time of the alleged offense, it is the opinion of the staff that at the time of the commission of the acts constituting the alleged offense(s), severe mental disease or defect did not prevent the defendant from appreciating the nature or wrongfulness of such acts pursuant to T.C.A. § 39-11-501.

The staff are further of the opinion that (Name) does not meet the standards of judicial commitment to a mental health institute pursuant to the provisions of T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann.

(Mr./Ms.) (Name) was discharged and returned to the custody of the (County) Sheriff's Department.

We have informed (Name), Forensic Coordinator at (CMHC), of our evaluation recommendations. We have recommended that that outpatient provider provide follow-up forensic services.

**T.C.A. § 33-7-301 (a); Competent, No Insanity Defense, Not Committable (cont.)**



If you have any questions about this case, please do not hesitate to contact me at (###) ###-####.

Sincerely,

(Name)
(Title)

cc: (Name), District Attorney General's Office
(Name), Defense Attorney
(Name), (CMHC)
(Name), TDMHSAS Forensic Specialist

Enclosures

## T.C.A. § 33-7-301(a); Competent/Insanity Defense Supported/Committable

(Date)

Judge (Name)
(County Criminal/Circuit/General Court)
(Address)
(City), Tennessee (Zip Code)

RE: State of Tennessee vs. (Name)
Case # (######)

Dear Judge (Name):

(Name) was admitted to (RMHI) on (Date) by order of your court under T.C.A. § 33-7-301(a). (He/She) was sent here for an evaluation of (his/her) competency to stand trial and for an assessment of (his/her) mental condition at the time of the alleged offense on the charge(s) of (Charges).

After completion of the competency evaluation, we have concluded that (he/she) has sufficient present ability to consult with (his/her) lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against (him/her). In reaching this determination, it was concluded that (he/she) has the ability to cooperate with (his/her) attorney in (his/her) own defense, and that (he/she) has an awareness and understanding of the nature and consequences of the proceedings.

With regard to (Name)'s mental condition at the time of the alleged offense, it is the opinion of the staff that at the time of the commission of the acts constituting the alleged offense(s), severe mental disease or defect did prevent the defendant from appreciating the nature or wrongfulness of such acts pursuant to T.C.A. § 39-11-501.

The staff is further of the opinion that (Mr./Ms.) does meet the standards of judicial commitment to a mental health institute pursuant to the provisions of T.C.A. § 33-7-301(b) and T.C.A. § 33-6-502. Therefore, we are recommending that (Mr./Ms.) be returned for commitment through Circuit or Criminal Court. Attached are two affidavits for use in proceeding with the commitment under T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Annotated. The staff of (Institute) is available to assist with the judicial commitment. Please notify us as to the action desired for the arrangement of the release of (Mr./Ms.) back to the custody of the (County) Sheriff's Department. Arrangements may be made by contacting me at _____.

If we may provide further information regarding this case, please contact me at the above telephone number.

Sincerely,

(Name)
(Title)

cc:
Enclosures

**T.C.A. § 33-7-301(a); Competent, No Insanity Defense, Committable**

(Date)

Judge (Name)
(County Criminal/Circuit/General Court)
(Address)
(City), Tennessee (Zip Code)

RE: State of Tennessee vs. (Name)
Case # (######)

Dear Judge (Name):

(Name) was admitted to (RMHI) on (Date), by order of your Court. (He/She) was sent here for an evaluation of (his/her) ability to stand trial and an assessment of (his/her) mental status at the time of the offense of (Charges).

After completion of the competency evaluation, we have concluded that (he/she) has sufficient present ability to consult with (his/her) lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against (him/her). In making this determination, it was concluded that (he/she) does understand the charges pending against (him/her) and the consequences which may follow, and is able to advise counsel and participate in (his/her) own defense.

With regard to (Name)'s mental condition at the time of the alleged offense, it is the opinion of the staff that at the time of the commission of the acts constituting the alleged offense(s), severe mental disease or defect did not prevent the defendant from appreciating the nature or wrongfulness of such acts pursuant to T.C.A. § 39-11-501.

The staff are further of the opinion that (Name) does meet the standards of judicial commitment to a mental health institute pursuant to the provisions of T.C.A. § 33-7-301 (b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann. The staff recommends that (Name) be committed to (RMHI). The facility contact individual at this institute is (Name), Forensic Coordinator, who may be contacted at (###) ###-####. The staff of (RMHI) is willing to assist with the judicial commitment procedures. Please notify us as to what action is desired. Enclosed you will find the commitment certifications.

(Mr./Ms.) (Name) was discharged from inpatient status and returned to the custody of the (County) Sheriff's Department. We have informed (Name), Forensic Coordinator at (CMHC), of our evaluation recommendations.

We have not recommended that follow-up forensic services be provided by that outpatient provider. Should there be a future need for mental health services for this defendant, then contact should be made with the forensic coordinator or the local crisis stabilization team.

If you have any questions about this case, please do not hesitate to contact me at (###) ###-####.

Sincerely,

(Name)
(Title)

cc: (Name), District Attorney General's Office
(Name), Defense Attorney
(Name), (CMHC)

**T.C.A. § 33-7-301(a); Competent**

(Date)

Judge *(Name)*
(County Criminal/Circuit/General Court)
(Address)
(City), TN (Zip Code)

RE: State of Tennessee vs. (*Name)*
Case # *(######)*

Dear Judge *(Name)*:

*(Name)* was admitted to *(RMHI)* on *(Date)*, by order of your Court. *(He/She)* was sent here for an evaluation of *(his/her)* ability to stand trial on the charge(s) of *(Charges).*

After completion of the competency evaluation, we have concluded that (*he/she)* has sufficient present ability to consult with (*his/her)* lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against (*him/her)*. In making this determination, it was concluded that *(he/she)* does understand the charges pending against *(him/her)* and the consequences that may follow, and is able to advise counsel and participate in *(his/her)* own defense.

The staff are further of the opinion that *(Name)* does not meet the standards of judicial commitment to a mental health institute pursuant to the provisions of T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann.

*(Mr./Ms.) (Name)* was discharged and returned to the custody of the *(County)* Sheriff's Department.

We have informed *(Name)*, Forensic Coordinator at *(CMHC)*, of our evaluation recommendations. We have recommended that that outpatient provider provide follow-up forensic services.

If you have any questions about this case, please do not hesitate to contact me at *(###) ###-####.*

Sincerely,

(Name)
(Title)

cc: *(Name)*, District Attorney General's Office
*(Name),* Defense Attorney
(Name), (CMHC)
(*Name),* TDMHSAS Forensic Specialist

**T.C.A. § 33-7-301(a); Incompetent, Support for Insanity Defense, Committable, ID Services**

(Date)

Judge *(Name)*
(County Criminal/Circuit/General Court)
(Address)
(City), Tennessee (Zip Code)

RE: State of Tennessee vs. (*Name)*
Case # *(######)*

Dear Judge *(Name)*:

*(Name)* was admitted to *(RMHI)* on *(Date)*, by order of your Court. *(He/She)* was sent here for an evaluation of *(his/her)* ability to stand trial on the charge(s) of *(Charges)*, and an assessment of *(his/her)* mental status at the time of the alleged offense.

The evaluation was conducted by clinical staff with expertise in mental health as well as intellectual and developmental disabilities. This report addresses the recommendations regarding the defendant's competency to stand trial, mental status at the time of the alleged offense, and need for further treatment. It is the opinion of the mental health clinicians that *(Name)* is not mentally ill, i.e., *(he/she)* does not have a diagnosable mental illness. The matters of competency to stand trial, insanity defense, and commitment to a mental health facility as a result of mental illness are therefore, moot issues.

The opinion, however, of the clinician from intellectual and developmental disabilities is that *(Name)* is functioning at a *(mild/moderate/severe)* level of intellectual disability. It is the opinion of this expert that *(Name)* is currently incompetent to stand trial as a result of the intellectual disability. It is also the opinion of this expert that *(Name)*'s condition was such he/she was unable to appreciate the nature or the wrongfulness of the acts constituting the offense pursuant to T.C.A. § 39-11-501.

It is also the opinion of the clinicians that the standards for commitment to a secure intellectual disability facility have been met pursuant to the provisions of T.C.A. § 33-5-403. Two commitment certifications have been enclosed for the purpose of filing a motion.

We have notified *(Name)*, at *(CMHC)*, of our recommendations. We have not made a referral for aftercare services during this interim period in the jail. If there is a need for any emergency mental health services in jail, then it is suggested that the forensic coordinator be contacted. The contact for testimony and commitment to the intellectual disability/mental retardation facility would be *(Name)* at *(###) ###-####*.

Please feel free to contact me at *(###) ###-####* if you have questions about this matter.

Sincerely,

(Name)
(Title)

cc: *(Name)*, District Attorney General's Office
*(Name)*, Defense Attorney
*(Name)*, Dept. of Intellectual & Developmental Disabilities
TDMHSAS

**T.C.A. § 33-7-301(a); Incompetent, Support for Insanity Defense, Committable, Out of General Sessions Court**

(Date)

Judge *(Name)*
(County Criminal/Circuit/General Court)
(Address)
(City), Tennessee (Zip Code)

RE: State of Tennessee vs. (*Name)*
Case # *(######)*

Dear Judge *(Name)*:

*(Name)* was admitted to *(RMHI)* on *(Date)*, by order of your Court. *(He/She)* was sent here for an evaluation of *(his/her)* ability to stand trial on the charge(s) of *(Charges)*, and an assessment of *(his/her)* mental condition at the time of the alleged offense.

After completion of the competency evaluation, the staff is of the opinion that *(Name)*'s condition is such that *(he/she)* is not capable of adequately assisting in *(his/her)* defense in a court of law. In making this determination, it was concluded that *(he/she)* does not understand the charges pending against *(him/her)* and the consequences which may follow, and is not able to advise counsel and participate in *(his/her)* own defense.

With regard to *(Name)*'s mental condition at the time of the alleged offense, it is the opinion of the staff that at the time of the commission of the acts constituting the alleged offense(s), severe mental disease or defect *did* prevent the defendant from appreciating the nature or wrongfulness of such acts pursuant to T.C.A. § 39-11-501.

The staff are further of the opinion that *(Name)* does meet the standards of judicial commitment to a mental health institute pursuant to the provisions of T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann. The staff recommends that *(Name)* be committed to *(RMHI)*. If the Court determines that *(Name)* is judicially committable and desires to have *(him/her)* committed under T.C.A. § 33-7-301(b), then *(his/her)* case will need to be transferred to the jurisdiction of a criminal or circuit court. The staff of *(RMHI)* is willing to assist with the judicial commitment procedures. Please notify us as to what action is desired. Enclosed you will find the commitment certifications.

*(Mr./Ms.) (Name)* has been discharged from inpatient status and returned to the custody of the *(County)* Sheriff's Department. We have informed *(Name)* at *(CMHC)*, of our evaluation recommendations. We have recommended that follow-up services be arranged by the outpatient provider.

If you have any questions about this case, please do not hesitate to contact me at (###) ###-####.

Sincerely,

(Name)
(Title)

Enclosures
cc: *(Name)*, District Attorney General's Office
*(Name),* Defense Attorney
(Name), (CMHC)
*(Name),* TDMHSAS Forensic Specialist

**RMHI Six-Month Report on T.C.A. Section 33-7-301(b)**

(Date)

Judge _____
(County Criminal/Circuit/General Court)
(Address)
(City), Tennessee (Zip Code)

RE: State of Tennessee vs. (Name)
Docket # (######)
Report on Competency

Dear Judge (Name):

(Name) was admitted to (RMHI) on (Date), by order of the (County) Court. (He/She) was sent here for observation and an evaluation of (his/her) ability to stand trial on the charge(s) of (Charges).

(Name) was committed as not competent to stand trial and in need of inpatient hospitalization by order of your court on (Date), under T.C.A. § 33-7-301(b) and Title 33 Chapter 6, Part 5, Tenn. Code Ann.

Regarding the matter of the defendant's competency to stand trial, it is the opinion of the staff that (Name) remains incompetent to stand trial and unable to assist (his/her) attorney in matters related to (his/her) trial.

It also continues to be the clinical staff's opinion that (Name) remains committable and in need of continued hospitalization in accordance with the current order pursuant to T.C.A.§ 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann.

Please contact me at (###) ###-#### if you have any questions or wish to discuss this matter.

Sincerely,

(Name)
(Title)

cc: (County Criminal/Circuit/General Court Clerk)
(Name), District Attorney General's
(Name), Defense Attorney
(Name), (CMHC)
(Patient Name)
(Name Nearest Relative/Conservator as applicable)

**T.C.A. § 33-7-301(b); Competent, Remains Committable**

(Date)

Judge *(Name)*
(County General/Circuit/Criminal Court)
(Address)
(City), TN (Zip Code)

RE: State of Tennessee vs. (*Name)*
Case # *(######)*

Dear Judge *(Name)*:

*(Name)* was admitted to *(RMHI)* on *(Date)*, by order of your Court. *(He/She)* was sent here for treatment and ongoing evaluation of *(his/her)* ability to stand trial for the charge(s) of *(Charges)*. *(Mr./Ms.) (Name)* was committed as not competent to stand trial, but in need of inpatient hospitalization by order of your Court on *(date)*, pursuant to the provisions of T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann.

The staff are of the opinion that *(Name)*'s condition has improved such that *(he/she)* now has sufficient present ability to consult with (*his/her)* lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against (*him/her)*. In making this determination, it was concluded that *(he/she)* is able to advise counsel and participate in *(his/her)* own defense.

It is also the opinion of the staff that *(Name)* continues to meet the standards for commitment to this regional mental health institute pursuant to T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann. This continuing commitment, however, in no way precludes the setting of a date for a resolution of the pending criminal charges.

If you have any further questions about this case, please do not hesitate to contact me at (###) ###-####.

Sincerely,

(Name)
(Title)

cc: *(Name)*, District Attorney General's Office
*(Name)*, Defense Attorney
*(Name)*, (CMHC)
(Patient Name)
*Name (*Nearest Relative/Guardian as applicable*)*
TDMHSAS, Forensic Specialist

**T.C.A. § 33-7-301(b); Now Competent, No Longer Committable**

(Date)

Judge *(Name)*
(County Criminal/Circuit/General Court)
(Address)
(City), TN (Zip Code)

RE: State of Tennessee vs. (*Name)*
Case # *(#######)*

Dear Judge *(Name)*:

*(Name)* was admitted to *(RMHI)* on *(Date)*, by order of your Court. *(He/She)* was sent here for treatment and an evaluation of *(his/her)* ability to stand trial on the charge(s) of *(Charges)*. *(Mr./Ms.) (Name)* was committed as not competent to stand trial, but in need of inpatient hospitalization by order of your Court on *(date)*, pursuant to the provisions of T.C.A. § 33-7-301(b).

The staff is of the opinion that *(Name)*'s condition has improved such that *(he/she)* now has sufficient present ability to consult with (*his/her)* lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against (*him/her)*. In making this determination, it was concluded that *(he/she)* is able to advise counsel and participate in *(his/her)* own defense.

It is also the opinion of the staff that *(Name)* no longer meets the standards for commitment pursuant to T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann. We will be releasing him to the custody of the *(County Name)* County Sheriff's Department as soon as arrangements can be made for *(him/her)* to return to jail.

We have notified *(name)*, Forensic Coordinator at *(CMHC)*, of our recommendations, and have made a referral for follow-up forensic aftercare services while the defendant is in jail pending a resolution of the charges.

If you have any further questions, please feel free to contact me at *(###) ###-####*.

Sincerely,

(Name)
(Title)

cc: *(Name)*, District Attorney General's Office
*(Name)*, Defense Attorney
(Name), (CMHC)
*(Name),* TDMHSAS Forensic Specialist
(Patient Name)
*Name* (Nearest Relative/Guardian as applicable)

**Sample - RMHI Recommending Mandatory Community Based Services**

RMHI LETTERHEAD

The Honorable _____
Judge, (County, Criminal/Circuit/General Court)
Address
City, State Zip

RE: State of Tennessee v. (Name of defendant)
Docket # _____

Dear Judge _____:

_____ was admitted to _____ Mental Health Institute on _____, by order of your court. *He/she* was *evaluated/committed* pursuant to the provisions of T.C.A. § 33-7-301(a) or T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5 Tenn. Code Ann. on the charge of _____.

After completion of the most recent period of evaluation and/or treatment, we have concluded that (*he/she)* does not have sufficient present ability to consult with (*his/her)* lawyer with a reasonable degree of rational understanding nor a rational as well as factual understanding of the proceedings against (*him/her)*. In making this determination, it was concluded that *he/she* lacks the ability to cooperate with *his/her* attorney in *his/her* own defense, that *he/she* lacks an awareness and understanding of the nature and object of the proceedings, and lacks an understanding of the consequences of the proceedings. It has been determined that *Mr./Mrs.* _____ may possess the ability to gain competence if further training is provided.

The staff further determined that *Mr./Mrs*. _____ does not meet the standards for judicial commitment to a mental health institute pursuant to Title 33, Chapter 6, Part 5, Tenn. Code Ann., but is at risk of becoming committable if community services are not provided.

Therefore, the treatment team recommends that _____ be discharged under the provisions of Mandatory Community Based Services in accordance with the statutory guidelines presented in Title 33, Chapter 7, Part 4, Tenn. Code Ann.

A Mandatory Community Based Services Plan has been developed in conjunction with _____ Mental Health Center. Attached is a copy of the plan developed for *Mr./Mrs.* _____, who has agreed to participate in the plan developed. Enclosed is a sample court order for Mandatory Community Based Services determination by the court in accordance with the provisions of Title 33, Chapter 7, Part 4, Tenn. Code Ann.

**Sample - RMHI Recommending Mandatory Community Based Services (cont.)**

*Mr./Mrs*. _____ has been released back to _____. Please feel free to call if you have any further questions or concerns.

Sincerely,

Forensic Coordinator

**Sample – Request for Information**

Date: _____

TO: _____, District Attorney General
_____, Defense Attorney
_____, Detention Medical Staff

RE: _____

Dear Sir,

The (Name of Provider _____) has been ordered to provide a mental health evaluation pursuant to T.C.A. Section 37-1-128(e) for _____ Court.

In order to complete an appropriate evaluation, we are requesting any information that you may be able to provide on the above referenced individual. The requested evaluation will be pending receipt of this information. Please see a list of the needed information below.

1. Information regarding the arrest and nature of charges which are pending against the individual and particularly any information surrounding the alleged offense and the behavior of the individual around that time;

2. Information regarding the individual's interaction with family and friends (social history);

3. Any record of past hospitalizations, both psychiatric and medical;

4. A description of the individual's behavior while in detention;

5. A description of the individual's behavior while in the community.

Thank you for your prompt attention to this matter. If you have any questions, please do not hesitate to contact _____ at (area code) _____.

Sincerely,

_____
Signature

# Appendix G

## Inpatient Adult Forensic Standards

**REVISED MAY 2014**

### I. For All Inpatient Forensic Work

Standard 1: There must be a designated professional who has completed the TDMHSAS Forensic Training to coordinate the forensic services within the facility.

Standard 2: The facility has policies and procedures specific to forensic services, including but not limited to, the process for:

- Scheduling and completing a forensic evaluation (including forensic certification requirements);
- Obtaining assistance from the Division of Intellectual Disabilities Services;
- Recommending passes, privileges and/or furloughs;
- Reporting elopements;
- Submitting billing/claims and other required documentation;
- Obtaining interpreter services;
- Documenting changes in legal status;
- Recommending release with a judicial right of review imposed;
- Completing an evaluation on an outpatient basis; and
- Recommending release with Mandatory Outpatient Treatment in accordance with T.C.A. § 33-6-602. Forensic coordinator should be familiar Mandatory Outpatient Treatment under T.C.A. § 33-7-303(b).

Standard 3: There must be documentation that all staff completing a forensic evaluation are properly licensed and certified:

- A licensed physician with an expertise in psychiatry and with current forensic certification participates in the evaluation of a defendant charged with a capital offense (death penalty);
- Staff completing competency evaluations meet the criteria set forth in Departmental Rules 0940-03-03-.02 and -.03 and are currently certified by the TDMHSAS;
- Staff completing evaluations of mental condition at the time of the crime, including diminished capacity, meet the criteria set forth by Departmental Rules 0940-03-03-.02 and -.04 and are currently certified by the TDMHSAS.

Standard 4: A copy of a valid court order is maintained in the record upon the initiation of a forensic evaluation:

- A judge sitting in a criminal, circuit or general sessions court has signed the court order;
- The court order specifies the legal code and/or identifies the specific issues to be evaluated;
- The type of court and county is included on the order;

- The court order is date stamped or hand dated upon receipt by the facility (the date the court order is received by the facility is the effective date for the purpose of scheduling the admission and for transferring from one legal status to another); and
- There must be a court order reflecting any change in legal status. If charges are dropped, TDMHSAS must be notified in writing.

Standard 5: When the defendant requires an interpreter;

- If interpreter services are required, the RMHI shall request an order for interpreter services from the court ordering the forensic evaluation and this is documented.
- There is documentation in the record of each interaction provided by the interpreter.

Standard 6: There must be documentation in the forensic record that the defendant was told the purpose of the evaluation and/or treatment and the limits of confidentiality.

Standard 7: The staff conference progress reports must address the forensic issues requested in the court order.

Standard 8: The treatment plan must address the forensic issues ordered by the court and reflect the defendant's current legal status.

Standard 9: There is documentation that a court order was requested when the evaluator was asked to provide expert witness testimony.

- There must be documentation of the court attendance in the defendant's forensic record.

Standard 10. A copy of the data report form submitted to TDMHSAS within two (2) business days of a discharge or legal status change is maintained in the forensic record.

Standard 11. When the RMHI performs an outpatient evaluation, there must be documentation that the evaluator/RMHI complies with the outpatient evaluation standards.

Standard 12. There must be documentation that defendants admitted to the Forensic Services Program at MTMHI meet specific criteria:

- Identified need for security due to specific risks of harm to self or others identified by the outpatient evaluator; and/or
- High risk for elopement.

## II. T.C.A. § 33-7-301(a) Specific Standards

Standard 1: There must be a signed consent in the record for release of information requested from other treatment providers.

Standard 2: There is documentation that Information is requested from:

- defense attorney;
- district attorney;

- Jail medical staff (if the defendant is in jail);
- other treatment providers or any other relevant sources of information.

Standard 3: If indicated, ID Assist must be requested simultaneously with a recommendation to the court that the defendant either a) is incompetent due to intellectual disability and requires training by an expert provided by the DIDD or b.) that the defendant is incompetent due to intellectual disability and meets commitment criteria under T.C.A. §33-5-403 to the Harold Jordan Center.

Standard 4: The interim staff conference report, completed within 15 days, must address the court-ordered issues and the status of the evaluation process and must be signed or co-signed by staff certified to conduct evaluations on the relevant forensic issues.

Standard 5: There must be progress notes that address the forensic issues and committability written by staff forensically certified to address those issues at a minimum of two (2) times per week, with no more than four (4) days between MD /PhD visits /progress notes. Notes concerning committability and mental condition at the time of the offense must be written by an M.D. with specialty in psychiatry or Ph.D. with HSP designation.

Standard 6: There must be documentation that appropriate personnel are present at staff conferences, including, but not limited to:

- a doctoral-level psychologist, licensed in Tennessee with health service provider designation and with forensic certification; and/or
- a physician licensed in the state of Tennessee with expertise in psychiatry and with forensic certification.

Standard 7: There must be documentation that the treatment plan addresses all of the court ordered forensic issues.

Standard 8: Documentation in the forensic evaluation report must include, but not limited to:

- A list of all the sources of information used in the evaluation;
- information obtained from pre-admission contact with the referring agency;
- information obtained from the jail, the defense attorney, and the district attorney and other treatment providers;
- evaluation of the defendant's competency to stand trial, if ordered;
- evaluation of the defendant's mental condition at the time of the alleged crime, if ordered;
- evaluation of diminished capacity, if ordered;
- evaluation of committability under T.C.A. §33- 7-301(b) and Title 33, Chapter 6, Part 5, Tenn. Code Ann. and the need for security;
- ID assist, report findings;
- a summary of the findings/outcome of the evaluation, along with follow-up recommendations to the court; and
- a summary of the recommendations for the community mental health center that will be providing services after discharge.

Standard 9. There must be documentation that the final staff conference was held within thirty (30) calendar days of admission and addresses all of the court-ordered issues.

Standard 10. Defendants hospitalized under T.C.A. § 33-7-301(a) must be released on or before the thirtieth ($30^{th}$) day following admission. Documentation reflects:

- Defendants are discharged upon completion of the evaluation;
- Defendants that do not meet commitment criteria are referred back to jail, or community, if on bond; and/or
- Defendants that require continued hospitalization must meet the required Title 33, Chapter 6, Part 5, Tenn. Code. Ann. criteria and cannot be managed safely in jail prior to return to the hospital if the court finds they meet criteria for commitment under T.C.A. § 33-7-301[b].

Standard 11. Letters to the court contain the information ordered by the court, including:

- competency to stand trial (if ordered);
- mental condition at the time of the crime (if ordered),
- committability under T.C.A. § 33-7-301(b) or Title 33, Chapter 6, Part 5, Tenn. Code Ann., and, if committable, the need for maximum security;
- the need for follow-up services from the appropriate outpatient mental health provider;
- the need for intellectual disability services (if indicated), including competency training and,
- the need for competency training for defendants who are incompetent and not committable.

Standard 12. Letters to the court must be sent to the judge and copied to the following people, unless otherwise indicated by the court;

- the defense attorney;
- the district attorney; and
- the outpatient provider.

Standard 13. Release of Full Evaluation and/or other Clinical Information

- The judge or referee may receive a copy of the full evaluation and/or other information from the medical record with a written court order under T.C.A. § 33-3-105(3).
- The defendant or family member of the defendant may receive a copy of the full evaluation and/or other information from the medical record upon request with an authorization to release information signed by the defendant unless the evaluation provider determines that release of the report or other information would result in a substantial risk of serious harm to the defendant or another person.
- The defense attorney may receive a copy of the full evaluation and/or other information from the medical record upon request with an authorization for release of information signed by the defendant or with a court order under T.C.A. § 33-3-105(3).
- The district (prosecuting) attorney may only receive a copy of the full evaluation and/or other information from the medical record when ordered by the court under T.C.A. § 33-3-105(3).

Standard 14. There is evidence that two certificates of need for commitment accompanied the letter to the court recommending hospitalization under T.C.A. § 33-7-301(b).

Standard 15. There must be documentation that the jail is informed of the prescribed medication, the supplies given and any special precautions for defendants returning to jail.

Standard 16. There must be documentation that the notice to the outpatient forensic provider includes the specific need for follow-up services, including, but not limited to:

- competency training and/or maintenance that identifies the specific competency deficits or concerns;
- need for physician consultation with the jail staff or the defendant;
- medication management and the need for monitoring of compliance;
- time frame for initial contact with the defendant, using the agreed upon Discharge Plan Form and priority codes.

Standard 17. There must be documentation that defendants being considered for release under T.C.A Title 33, Chapter 7, Part 4, (Mandatory Community Based Services), meet the following criteria:

- Charged with a felony;
- Incompetent to stand trial;
- Not committable under T.C.A. Title 33, Chapter 6, Part 5; and
- At risk of becoming committable.

Standard 18. Letters to the court recommending release under Title 33, Chapter 7, Part 4, Tenn. Code Ann. must indicate the following:

- The defendant's name, legal status, date of admission, alleged crime, reason for admission, competency status;
- That the defendant does not meet commitment criteria;
- The reasons for release under Title 33, Chapter7, Part 4, Tenn. Code Ann.; and
- the community-based services plan developed in cooperation with the outpatient provider.

## III. T.C.A. §33-7-301(b) Specific Forensic Standards

Standard 1. A copy of a valid court order is maintained in the forensic record and reflects that the defendant committed under T.C.A. § 33-7-301(b) meets the following criteria:

- The defendant is incompetent to stand trial and committable; or
- The defendant is competent to stand trial and committable; and
- The court order for T.C.A. § 33-7-301(b) finds the need for treatment in the Forensic Services Program (FSP), if indicated.

Standard 2. The medical record contains the following documentation:

- a social history completed within the prior six months with an addendum completed within 48 hours of admission;
- a psychiatric evaluation, if readmitted; and
- a physical examination completed within the prior six months with an addendum completed within 24 hours of admission.

Standard 3. There must be documentation of regularly scheduled treatment team meetings that is sent to the assigned forensic specialist in the Office of Forensic Services in the following time frames:

a. every month for the first 3 months, (progress note may be substituted for the staff conference report if the information is comparable); then,
b. every 3 months thereafter, (with the completion of a staff conference report and risk assessment);
c. at any time there is a change in status that warrants an update; or
d. if requested by TDMHSAS.

Standard 4. A risk assessment completed by the 30th day of admission and updated every ninety (90) days thereafter and/or prior to discharge or furlough is maintained in the forensic record.

Standard 5. The VRAG completed by the 60th day of hospitalization is maintained in the forensic record.

Standard 6. Documentation includes:

- the staff's evaluation of competency and the reasons for the need for continued commitment;
- documentation of competency training groups or individual sessions at a minimum of once weekly reflecting competency status (there must be documentation for exclusion if the service recipient is too delusional or unable to attend); or
- documentation of the status of the defendant's competency at a minimum of once monthly for long-term service recipients that are unlikely to become competent;
- progress notes and treatment plan that reflect the issues of the current legal status, and any change in legal status;
- documentation by the M.D. or Ph.D., certified in forensics, at a minimum of two (2) times per week for the first week of hospitalization, then a minimum of one (1) time per week thereafter. If certified by TDMHSAS, a nurse practitioner may document on competency to stand trial issues; however, the M.D. or Ph.D. must still document the need for committability; and,
- documentation in the medical record of any transfer from FSP/RMHI and a letter from the Commissioner of TDMHSAS authorizing the transfer.

Standard 7. All passes, privileges, and furloughs comply with TDMHSAS policy and procedures and are documented in the medical record.

Standard 8. The forensic record contains a letter to the court that is sent every six months, during the course of hospitalization, and addresses the defendant's current condition, current competency status, his/her likelihood of regaining competency, and the specific reasons for the need for continued commitment.

Standard 9. The documentation in the medical record must be complete when the defendant who was hospitalized under T.C.A. § 33-7-301(b) is returned to jail or community. Treatment team recommendations must include:

a. a written assessment of readiness for release by the attending physician, including rationale for the decision;

b. documentation that the staff considered issues relative to findings of the T.C.A. § 33-7-301(a) evaluation (as well as any issues that were deferred in the –301(a) evaluation);
c. documentation of consideration of the defendant's returning to jail or community (if on bond) while awaiting trial;
d. documentation from the physician to the chief officer, or his/her designee, regarding the release; and documentation from the chief officer, or his/her designee, to the committing court regarding the defendant's release;
e. documentation of the need for follow-up services; and
f. if needed, competency maintenance or training for defendants that are incompetent and no longer committable.

Standard 10. There must be appropriate documentation when the defendant admitted under T.C.A. § 33-7-301(b) is to be released under Title 33, Chapter 7, Part 4, Tenn. Code Ann. (Mandatory Community Based Services), including documentation that the defendant meets the following criteria;

- is charged with a felony;
- is incompetent to stand trial;
- not committable under T.C.A. § 33-6-502; and
- is at risk of becoming committable.

Standard 11. The letter to the court regarding the release of the defendant pursuant to Title 33, Chapter 7, Part 4, Tenn. Code Ann. (Mandatory Community Based Services) includes the following;

- a statement that the defendant meets the criteria for mandatory community based services (as outlined in the previous standard),
- the request for an order for competency training under Title 33, Chapter 7, Part 4, Tenn. Code Ann.,
- a copy of the treatment plan that is signed by the participating outpatient provider (including the contact person and the address), and agreed upon by the defendant, or
- the request for a hearing on the community based competency treatment plan that has been contested by the defendant.

Standard 12. Letters to the court recommending the release of a defendant hospitalized under T.C.A. § 33-7-301(b) are copied to the following people, unless otherwise indicated by the court:

- the defendant,
- the district attorney,
- the defense attorney,
- the conservator/closest relative, and,
- TDMHSAS, Forensic Services.

Standard 13. There must be documentation of consideration of the criteria for release under Title 33, Chapter 6, Part 6, Tenn. Code Ann. (Mandatory Outpatient Treatment- civil MOT) including.

- The person is mentally ill or is suffering from mental illness in remission; and

- The person's condition resulting from mental illness is likely to deteriorate rapidly to the point that he/she will pose a likelihood of serious harm as defined under Title 33, Chapter 6, Part 5, Tenn. Code Ann. unless treatment is continued; and
- The person is likely to participate in outpatient treatment with a legal obligation to do so; and
- The person is unlikely to participate in outpatient treatment unless legally obligated to do so; and
- Mandatory outpatient treatment is a suitable less drastic alternative to commitment.

Standard 14. There must be appropriate documentation when the defendant admitted under T.C.A. § 33-7-301(b) is released under Title 33, Chapter 6, Part 6, Tenn. Code Ann. (civil MOT), including:

- review and recommendation by the attending physician;
- development of a mandatory outpatient treatment plan, with the written agreement from the outpatient provider,
- consideration of the defendant residing in the community (if on bond) while awaiting trial;
- written recommendation to the chief officer or his/her designee concerning the release;
- the chief officer's or his/her designee's authorization to release the defendant under Title 33, Chapter 6, Part 6, Tenn. Code Ann. (civil MOT); and
- chief officer's notice of release to the committing court.

Standard 15. Letters to the court recommending release under Title 33, Chapter 6, Part 6, Tenn. Code Ann. (civil MOT) must include the following:

- defendant's name, legal status, date of admission, alleged crime, reason for admission, current competency status;
- a note that the defendant no longer meets involuntary commitment standards under Title 33, Chapter 6, Part 5, Tenn. Code Ann.;
- reasons for release under Title 33, Chapter 6, Part 6, Tenn. Code Ann.;
- a copy of the mandatory outpatient treatment plan signed by the outpatient provider; and,
- The letter to the court must be copied to the defendant, the district attorney, the defense attorney, the defendant's closest relative, conservator, if any, and the TDMHSAS.

Standard 16. If the defendant requests judicial review of the mandatory treatment plan, there must be documentation that the facility provided notice to the court and of the court's response to the requirement to hold a hearing within seven (7) days of receipt of the request for review.

Standard 17. The release of the defendant committed under T.C.A. § 33-7-301(b), having a judicial review of release under T.C.A. § 33-6-708, must include the following documentation:

- an assessment by the treatment team that the defendant is ready for release,
- a review and recommendation from the attending physician,
- a letter to the chief officer from the attending physician regarding the release,

- the notice of intent to release sent to the court by certified mail (including a statement that the defendant will be released within fifteen (15) days if the court does not set a hearing and notify the chief officer), and
- that the outpatient provider has agreed to the treatment plan, if applicable.

## V. T.C.A. 33-7-303(c) Specific Forensic Standards

Standard 1. There is a valid court order committing the service recipient under T.C.A. § 33-7-303(c) maintained in the forensic record.

Standard 2. There must be documentation of regularly scheduled treatment team meetings sent to Forensic Services within the following time frames:

a. every month for the first three (3) months, (forensic progress note may be substituted for the staff conference report if the information is comparable); then,
b. every three (3) months thereafter, (with the completion of a staff conference report and risk assessment);
c. at any time there is a change in status that warrants an update; or
d. if requested by TDMHSAS.

Standard 3. The treatment plan identifies the specific reasons for the need for commitment and other treatment needs.

Standard 4. There is documentation during treatment team reviews of the need for continued commitment, progress toward discharge, tentative discharge plans and aftercare needs identified during treatment team meetings (staff conferences).

Standard 5. The Risk Assessment Checklist is completed by the 30$^{th}$ day of admission and every ninety (90) days thereafter, and/or, just prior to discharge, pass and/or furlough and is maintained in the forensic record.

Standard 6. Documentation in the forensic record includes:

- the staff's evaluation of the specific reasons for the need for continued commitment; and
- documentation by the M.D. and/or Ph.D. addressing the specific reasons for the need for continued commitment at a minimum of one(1) time per week for sixty (60) days then monthly until discharge.

Standard 7. If there has been a transfer, there must be a letter in the chart from the Commissioner of the TDMHSAS directing the transfer.

Standard 8. When there is recommendation for release, documentation in the medical record must include:

- evidence that the treatment team, including a physician, has assessed the service recipients clinical status, including committability;
- review of the need for follow-up services;
- review of the circumstances of the crime for which the person was acquitted;

- a written assessment of readiness for release by the attending physician, and another physician including rationale for their decision;
- if applicable, documentation that the service recipient meets the criteria for mandatory outpatient services under Title 33, Chapter 6, Part 6, Tenn. Code Ann. (civil MOT);
- if applicable, a copy of the outpatient treatment plan developed in cooperation with and signed by the outpatient provider; and
- evidence that the request for release has been referred to the chief officer for review and recommendation.

Standard 9. If the chief officer does not concur with the recommendation for release, a notice must be sent to the service recipient and the physicians stating that hospitalization is to continue under T.C.A. § 33-7-303(c), and a copy placed in the chart.

Standard 10. If the chief officer concurs with the recommendation for release, prior to release, a request for release (or furlough prior to release) must be submitted to the Risk Management Review Committee via the Director of Forensic and Juvenile court services. The request must include:

- Summary of Request
- Commitment Order
- Initial Psychosocial Assessment
- VRAG, Initial RAC and most recent RAC
- Most recent Staff Conference Note
- Furlough/Discharge Plan
- MOT Plan (if recommended) or aftercare plan

For requests approved for discharged by the Risk Management Review Committee, prior to release, there must be a copy of the chief officer's notice of the intent to release that has been sent to:

- the committing court
- the service recipient,
- the district attorney of the committing court,
- the defense attorney,
- the closest relative or conservator (by certified mail with return receipt requested),
- the physicians who recommended the release, and
- the outpatient treatment provider.

Standard 11. The notice to the court must contain the following:

- the service recipient's name, legal status, date of admission, the crime for which the person was adjudicated NGRI, reason for admission, a statement that he/she no longer meets judicial commitment standards, and a statement that the service recipient will be referred to an outpatient provider for follow-up mental health services,
- a copy of the outpatient treatment plan, if there is an MOT, and
- a statement making the court aware of the right of the victim (if felony charges) to receive notification of the service recipient's proposed discharge.

Standard 12. If a judicial review of release under T.C.A. § 33-6-708 has been imposed, there must be a letter, sent by certified mail, of the intent to release sent to the court in the record at least 15 days in advance of the planned date of discharge. If the court does not respond within 15 days of receipt of this letter, then the service recipient may be released.

# SUGGESTED READING: Forensic Evaluation
# Selected Bibliography


Brodsky, S. L. (1991). *Testifying In Court: Guidelines and Maxims for the Expert Witness.* Washington, D.C.: American Psychological Association.

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Rogers, R. (Ed.) (2008). *Clinical Assessment of Malingering and Deception (*3rd ed.). New York: Guilford Press.

Shapiro, D. L. (1999). *Criminal Responsibility Evaluations: A Manual For Practice.* Sarasota, FL: Professional Resources Press.

# APPENDIX OF SELECTED FORMS

**ALL FORMS AVAILABLE AT WEBSITE:**
http://www.tn.gov/behavioral-health/topic/sample-court-orders
http://www.tn.gov/behavioral-health/topic/forms

1. MH5266 – Order Directing Forensic Evaluation by the CMHC Under T.C.A. § 33-7-301(a)

2. MH5428 – Order For Outpatient Evaluation of a Child Under T.C.A. § 37-1-128(e)(1)

3. MH5267 - Order Directing Forensic Evaluation by the RMHI Under T.C.A. § 33-7-301(a)

4. MH5270 – Order Directing Judicial Forensic Hospitalization at an RMHI Under T.C.A. § 33-7-301(b)

5. MH5272 - Order Directing Judicial Forensic Hospitalization at the Forensic Services Unit of MTMHI Under T.C.A. § 33-7-301(b) and Title 33, Chapter 6, Part 5

6. MH5032 – Certificate of Need -- **AVAILABLE AT WEBSITE:**
http://www.tn.gov/assets/entities/behavioral-health/attachments/MH-5032R3.pdf

7. MH5275 – Order Directing Community Based Services to Be Provided by the Mental Health Center Under T.C.A. § 33-7-401

8. MH5263 – TDMHSAS Outpatient Forensic Data Report (Rev. 8/13)

9. MH5282 – Pre-authorization Request for Forensic Community Services

10. MH5253 – Referral for Inpatient Forensic Evaluation

11. MH5281 – RMHI Forensic Intake Report

12. MH5284 – Inpatient Forensic Data Report

13. MH5280 – RMHI Forensic Team Meeting Progress Note

14. MH5265 – Level III and Level IV Competency Training / Maintenance Progress Report