Department of Mental Health & Substance Abuse Services

Forensic And Juvenile Court Services Annual Report for the Period July 1, 2019-June 30, 2020 (FY 20)

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Tennessee Code Annotated
Selected Forensic Evaluation and Treatment Statutes

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

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

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

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

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

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

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

Executive Summary Annual Forensic Report FY 20

- The coronavirus pandemic affected forensic services in April, May, and June with notable declines in evaluations, outpatient and inpatient, adult and juvenile, discharges of NGRI patients to the community, and juvenile court risk and needs screenings.
- In Fiscal Year 2020 (FY 20), the frequency of pre-trial outpatient forensic mental health evaluations (2,045) decreased slightly from FY 19 (2,156; the ten-year average is ~2,000). If not for the pandemic, there may have been an increase in FY 20 over FY 19.
- The combination of the Tennessee mental health statutes, the TDMHSAS system for training and monitoring evaluators, and the practices of the providers resulted in a highly effective screening and diversion of adult criminal defendants from RMHI bed usage while providing quality evaluations for the courts. For FY 20, outpatient evaluations diverted 76% of that population from the need for an inpatient evaluation.
- There were 489 inpatient evaluations under T.C.A. § 33-7-301(a) with recommendations for commitment for further inpatient evaluation and treatment at a rate of 14% state-wide. That is a rate of only 3% of the original pool of 2,045 total outpatient evaluations resulting in a recommendation for long-term commitment for inpatient evaluation and treatment.
- Of those cases referred for inpatient evaluations, 90% were completed in the Regional Mental Health Institutes and only 10% were admitted to the maximum security unit.
- There were 33 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) with 16 (48%) recommending commitment to an RMHI under T.C.A. § 33-7-303(c).
- Mandatory Outpatient Treatment (MOT) coordination and monitoring has improved the timely renewal of MOT plans and follow-up with non-compliance proceedings. There were 354 patients on MOT at the close of FY 20, and only 12% were subject to non-compliance proceedings during FY 20.
- The forensic census at the end of FY 20 (99) was lower than the start (115) in part due to coordinated efforts to keep the RMHI census low to manage the pandemic. During FY 20, forensic cases occupied 23%-27% of state facility beds.
- The number of juvenile courts with staff trained on the JJ-CANS screening instrument continued rapid growth with over 700 staff certified state-wide, likely in response to the requirements of the Juvenile Justice Reform Act of 2018 for evidence-based risk and needs screening.

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

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

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

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

Special projects currently underway in forensic services include a contract with the Board of Paroles to provide the Board with psychiatric evaluations and risk assessments for parole-eligible inmates, and a project to train youth service officers in juvenile courts to complete mental health and substance abuse screening, the Tennessee Integrated Court Screening and Referral Project. The juvenile court screening project is a partnership with the Administrative Office of the Courts with a task force guiding the project that also includes the Department of Children's Services, the Tennessee Commission on Children and Youth, Tennessee Voices for Children and the Vanderbilt University Center of Excellence for Children in State Custody.

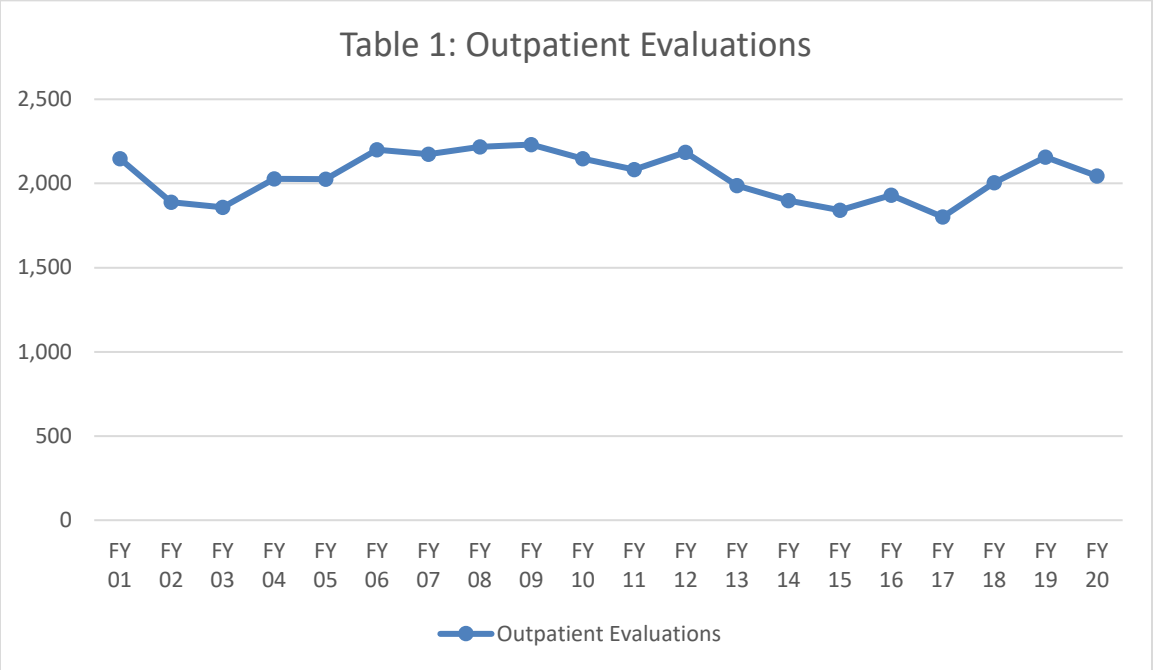
The Office of Forensic Services has collaborated with the Department's Office of Crisis Services and Suicide Prevention as well as the Division of Juvenile Justice in the Department of Children's Services in the development and provision of a suicide prevention curriculum specifically for juvenile justice settings (the "Shield of Care").

Court-ordered forensic mental health evaluation and treatment are not considered medically necessary procedures which are paid for by public or private insurance like an intake assessment at a mental health clinic or doctor's office. Forensic services are funded directly by the state budget with few exceptions, such as payment for medically appropriate treatment services of persons found Not Guilty by Reason of Insanity who are released to the community, and for subsequent medically necessary hospitalizations. The expenditures for forensic services run between $15 and $20 million annually, including the per diem hospital reimbursement for forensic inpatients.

The TDMHSAS has adopted policies which promote the provision of forensic mental health services of the highest quality in the most cost efficient manner. The emphasis is on using less costly and more clinically appropriate outpatient and lower security inpatient services, and using inpatient services only when clinically necessary and maximum security only when necessary for security. To accomplish this, it is necessary to monitor the frequency and outcome of forensic mental health services provided by the TDMHSAS. This report summarizes the services provided in Fiscal Year 2020, from July 1, 2019 to June 30, 2020, along with the trends over previous years. This report will note how all services were affected in some way by the COVOID-19 pandemic.

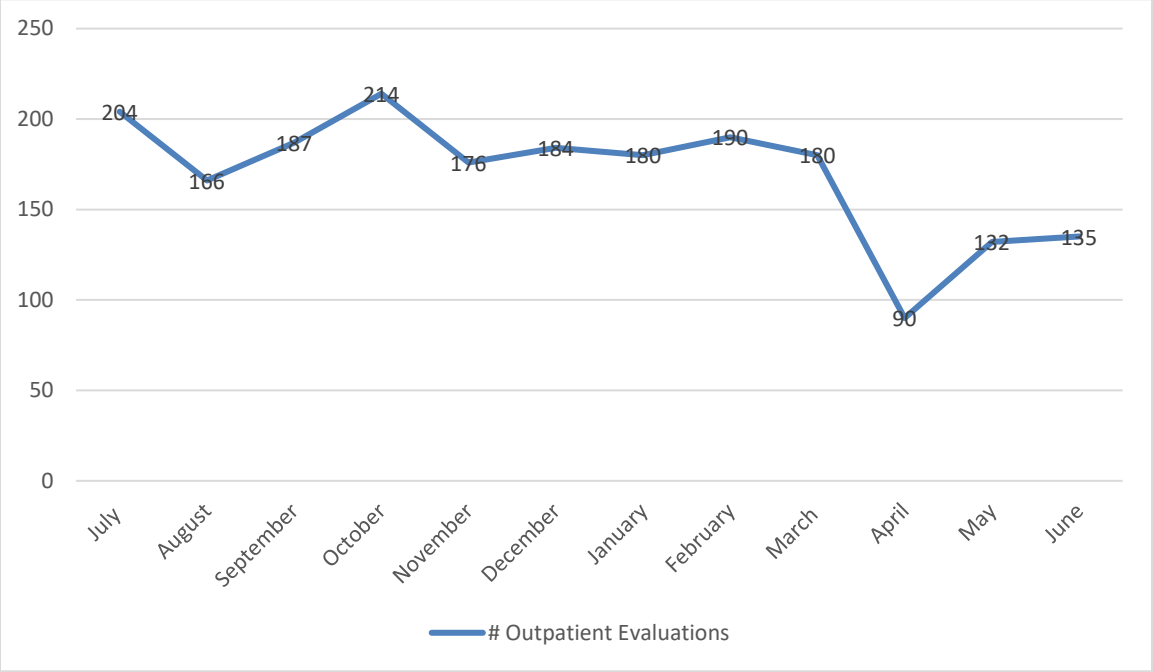
Outpatient Evaluations and Services for Pre-Trial Defendants

T.C.A. § 33-7-301(a) directs that court-ordered evaluation of a criminal defendant's competence to stand trial and/or mental capacity at the time of the offense be conducted by a community mental health agency or private practitioner designated by the Commissioner of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) on an outpatient basis, whether that's in a jail or at the agency's office. The TDMHSAS therefore has contracts with nine different agencies across the state to cover all jurisdictions; each court has an assigned outpatient forensic mental health evaluation provider. The TDMHSAS Office of Forensic and Juvenile Court Services provides training, certification, and ongoing technical assistance to professionals designated at each provider to conduct forensic mental health evaluations and associated services. In Fiscal Year 2020 (FY 20), 2,045 outpatient evaluations were conducted, which is consistent with the average of 2,035 for the previous 18 years.



In response to the COVOID-19 pandemic, the Tennessee Supreme Court issued emergency rules in March 2020 limiting in-person court business and postponing all trials. In April, jails began limiting visitation and many stopped transporting detainees for appointments that were not medical or psychiatric emergencies, making access to defendants for evaluation a challenge. Court business slowed, reducing the number of new orders. Table 2, below, shows the month-by-month frequency of completed outpatient forensic evaluations. As access to defendants was restricted and many agencies reduced in-person activity, providers eventually transitioned to using tele-health for evaluations and the frequency recovered somewhat in May and June after a precipitous dip in April.

Table 2: Frequency of Outpatient Evaluations by Month



As described above, TDMHSAS has contracts with nine different community agencies to cover all the courts for outpatient forensic services. Table 3, below, shows the community agency assigned to each county. Of note, this will be the last year for Centerstone who did not renew their contract for FY 21 following the retirement of their forensic psychologist June 30, 2020.

Table 3: County Distribution by Outpatient Forensic Services Provider

Agency	*Counties*
Frontier Health	Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington
Cherokee Health System	Blount, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Loudon, Monroe, Sevier, Union
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

Table 4, below, breaks out the total 2,045 adult outpatient evaluations into frequencies for each provider, displaying the same breakout for the previous 10 fiscal years for comparison.

Table 4: Frequency of Outpatient Evaluations by Provider

Provider	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Centerstone	175	166	168	129	121	137	143	128	155	170	162
Cherokee	133	113	121	99	97	90	79	100	104	109	95
Frontier	132	141	151	127	120	111	142	124	130	137	123
H. R. McNabb	91	65	69	60	53	73	75	96	88	90	77
Pathways	226	230	199	193	198	226	241	233	270	259	241
Ridgeview	102	77	85	53	51	41	50	68	64	66	81
Vanderbilt	113	128	158	129	142	137	155	164	217	267	308
Volunteer	364	321	330	364	333	346	358	314	328	329	314
WTFS/Midtown	812	841	905	833	784	680	687	574	649	729	644
Total	2,148	2,082	2,186	1,987	1,899	1,841	1,930	1,801	2,005	2,156	2,045

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

to a defendant charged with any felony sex offense, which is not duplicated in the "violent felony" category, and "misdemeanor" refers to a defendant charged *only* with a misdemeanor.

Table 5: Outpatient Evaluations by Type of Offense

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

Misdemeanor Services:

On June 26, 2009, **T.C.A.§ 33-7-304** (as described above) became law, making counties responsible for the cost of forensic services ordered under Part 3 of Title 33, Chapter 7 when the defendant is charged only with misdemeanors; this includes the outpatient forensic evaluations, the supplemental services used to help complete the evaluation on an outpatient basis so that the defendant is not referred for an inpatient evaluation (e.g. additional psychological testing, competency training sessions), inpatient evaluations and treatment, and inpatient commitments of pre-trial defendants and defendants found Not Guilty by Reason of Insanity. Counties are charged the same rate for outpatient services that outpatient evaluators are reimbursed by the TDMHSAS (typically $800 per evaluation). Counties are charged an all-inclusive rate of $450 per day for inpatient services. As can be noted in Table 5, above, there was a decline in the proportion of evaluations in which the defendant is charged only with misdemeanors since FY 10. In the six years for which data on type of offense is available prior to the new law (FY 04-FY 09), misdemeanor evaluations were consistently 30%-33% of all evaluations.

Table 6: Outpatient Felony vs. Misdemeanor Trends

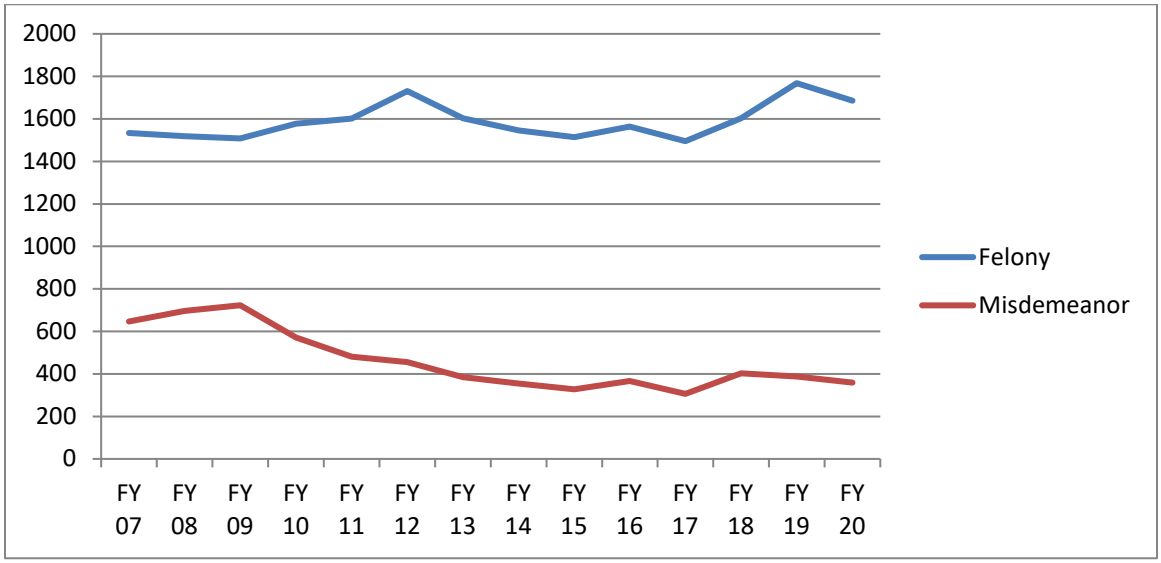


Table 6, above, shows that the frequency of misdemeanor evaluations has declined since the change in law concerning responsibility for payment even when the frequency of other evaluations increased (FY 12). Table 7, below, breaks out the percentage of misdemeanor evaluations for each provider as a proportion of all evaluations conducted by that provider, revealing some local differences in the frequency of misdemeanor evaluations. (Reminder: FY 10 is the first year of the new law.)

Table 7: Frequency of Misdemeanor Outpatient Evaluations

Provider	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Centerstone	32%	29%	22%	11%	11%	15%	8%	9%	11%	19%	7%	7%
Cherokee	28%	29%	16%	16%	22%	9%	12%	3%	5%	4%	6%	12%
Frontier	23%	20%	21%	15%	28%	23%	29%	21%	20%	22%	29%	26%
McNabb	33%	36%	34%	27%	3%	20%	31%	26%	31%	22%	26%	18%
Pathways	27%	8%	9%	5%	3%	2%	3%	2%	2%	3%	<1%	2%
Ridgeview	41%	25%	30%	22%	16%	17%	14%	20%	14%	10%	10%	8%
Vanderbilt	34%	14%	4%	6%	2%	2%	8%	10%	25%	33%	37%	33%
Volunteer	34%	25%	19%	16%	12%	16%	17%	14%	11%	9%	5%	10%
WTFS	35%	34%	31%	30%	29%	27%	23%	31%	23%	30%	24%	21%
TOTAL	32%	27%	23%	20%	19%	18%	18%	19%	19%	20%	17%	17%

OUTCOMES:

Melton, Petrila, Poythress and Slobogin[1] reported that studies on the rates of competency to stand trial have found that defendants receiving a mental health evaluation were considered competent to stand trial an average of 70% of the time which is consistent with the rate of recommendations of trial competence for agencies contracted by the TDMHSAS. Occasionally, a defendant is clearly incompetent to stand trial and would not benefit from inpatient psychiatric services at an RMHI (e.g. head injury, neurological disease), so the outpatient evaluator formally recommends a defendant be considered incompetent to stand trial without referring the defendant for inpatient evaluation and treatment. Table 8 shows the rates of recommendations from outpatient evaluations on competence to stand trial and the insanity defense.

Table 8: Recommendations of Outpatient Evaluations

	Competence to Stand Trial				Insanity Defense		
Fiscal Year	Competent	Incomp.	Defer		Yes	No	Defer
FY 02	72%	0.2%	28%		0.2%	70%	30%
FY 03	72%	0.1%	27%		3%	71%	26%
FY 04	74%	2%	24%		3%	73%	24%
FY 05	76%	0.2%	22%		3%	75%	21%
FY 06	75%	2%	23%		3%	74%	23%
FY 07	75%	3%	22%		3%	75%	22%
FY 08	74%	3%	24%		3%	72%	25%
FY 09	72%	3%	23%		2%	70%	23%
FY 10	73%	4%	21%		2%	72%	21%
FY 11	72%	3%	24%		2%	73%	23%
FY 12	72%	3%	22%		2%	69%	22%
FY 13	72%	4%	22%		3%	66%	21%
FY 14	71%	4%	23%		3%	66%	23%
FY 15	71%	4%	23%		2%	67%	23%
FY 16	72%	4%	22%		2%	69%	22%
FY 17	68%	5%	25%		2%	65%	26%
FY 18	67%	7%	23%		2%	64%	25%
FY 19	68%	7%	23%		2%	64%	27%
FY 20	64%	9%	26%		2%	62%	29%

[1] Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin, C. (2007) Psychological Evaluations for the Courts, 3rd Edition. Guilford Press, NY

A recommendation on competency to stand trial and/or the insanity defense is typically deferred to the inpatient evaluators when the defendant is referred for further evaluation on an inpatient basis without a formal opinion provided to the court by the outpatient evaluator. Table 8 shows 9% in the column labeled "incompetent," meaning that the outpatient provider specifically recommended to the court that the defendant be considered incompetent, which typically means that the defendant was considered to be incompetent due to intellectual disability, or unrestorably incompetent, due, for instance, to a head injury or dementia and was not referred for inpatient evaluation. (Percentages do not sum to 100% due to rounding error.) When a defendant clearly appears to be competent to stand trial by the outpatient evaluator and the evidence supporting the insanity defense is also clear, the outpatient evaluator will recommend the defendant be considered competent with support for the insanity defense without referral for an inpatient evaluation (an outcome which does not happen frequently; 2%-3%).

Outpatient evaluators can attempt to divert a defendant from an inpatient referral by seeing the defendant for competency training (they can be reimbursed for two additional sessions).

Table 9: Outpatient Competency Training

Provider	Total # of cases	# of cases receiving training	# diverted	% of cases receiving training diverted
Centerstone	162	5	4	80%
Cherokee	95	2	2	100%
Frontier	123	1	1	100%
HR McNabb	77	2	2	100%
Pathways	241	4	2	50%
Ridgeview	81	2	2	100%
Vanderbilt	308	2	2	100%
Volunteer	314	1	0	0%
WTFS	644	51	46	90%
TOTAL FY 20	2,045	70	61	87%
TOTAL FY 19	2,156	41	35	85%
TOTAL FY 18	2,005	54 (3%)	44	81%
TOTAL FY 17	1,801	40 (2%)	36	90%
TOTAL FY 16	1,930	29 (2%)	25	86%
TOTAL FY 15	1,841	49 (3%)	45	92%
TOTAL FY 14	1,899	40 (2%)	35	88%
TOTAL FY 13	1,987	64 (3%)	60	94%
TOTAL FY 12	2,186	83 (4%)	74	89%

This can allow for either training on content related to competency to stand trial or for re-assessment after a trial of medication while the defendant is still in the community. While these training sessions are only used in around 2%-3% of all outpatient cases, the success rate of diversion was 87% in FY 20 and 88% on average for the nine years this statistic has been kept.

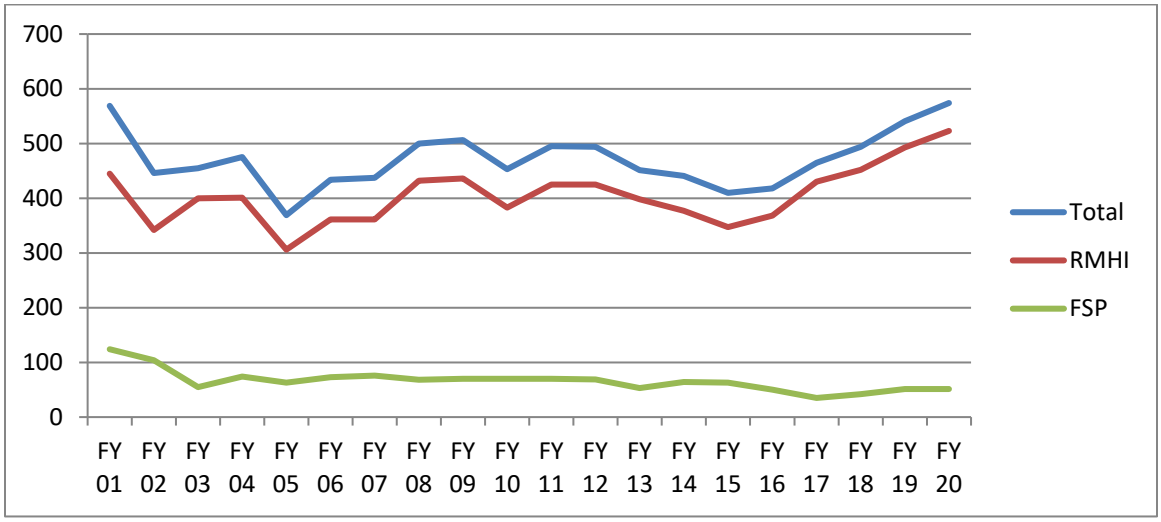
T.C.A. § 33-7-301(a) indicates that an inpatient evaluation of competence to stand trial and/or mental capacity at the time of the offense may be ordered "if and only if" the outpatient evaluator recommends an inpatient evaluation. The average rate of referral for all providers from FY 01 through FY 19 was 23%. The average rate for FY 20 was 27%.

Table 10: Frequency of Inpatient Referral by Provider

Provider	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Centerstone	21%	31%	30%	32%	31%	23%	36%	41%	49%	39%
Cherokee	13%	11%	13%	8%	14%	16%	12%	13%	16%	15%
Frontier	11%	11%	12%	8%	15%	8%	12%	13%	13%	17%
HR McNabb	22%	33%	21%	37%	28%	35%	45%	32%	26%	27%
Pathways	28%	21%	26%	27%	25%	25%	28%	16%	25%	38%
Ridgeview	18%	29%	27%	22%	19%	18%	23%	18%	15%	16%
Vanderbilt	24%	33%	38%	41%	38%	33%	37%	28%	27%	27%
Volunteer	22%	31%	29%	26%	22%	25%	32%	30%	27%	33%
WTFS	19%	17%	16%	18%	15%	15%	17%	20%	20%	22%
State-wide	20%	24%	22%	23%	21%	21%	24%	24%	24%	27%

When an outpatient evaluator makes a recommendation for a referral for an inpatient evaluation, the evaluator also indicates when the referral should be to the maximum security Forensic Services Program (FSP) or the Regional Mental Health Institute (RMHI) serving the area. FSP referrals are made when there is a risk of escape (the defendant has a history of attempted escape or faces such a long prison sentence if convicted that he might attempt to escape) or a risk of violence beyond what the RMHIs can safely manage (based primarily on the defendant's behavior in jail, particularly the use of property in jail as a weapon). The rate of referral has typically run approximately 90% to the RMHIs and 10% to FSP. In FY 20, the proportion of referrals to FSP was even lower (4%).

Table 11: Trends in Inpatient Referrals to RMHIs and FSP



The statutory requirement that an outpatient evaluation be conducted prior to an inpatient evaluation, and the requirement that an inpatient evaluation can only be ordered when the outpatient evaluator recommends an inpatient evaluation is an effective means for preventing unnecessary forensic admissions and preserving scarce inpatient resources for persons most in need.

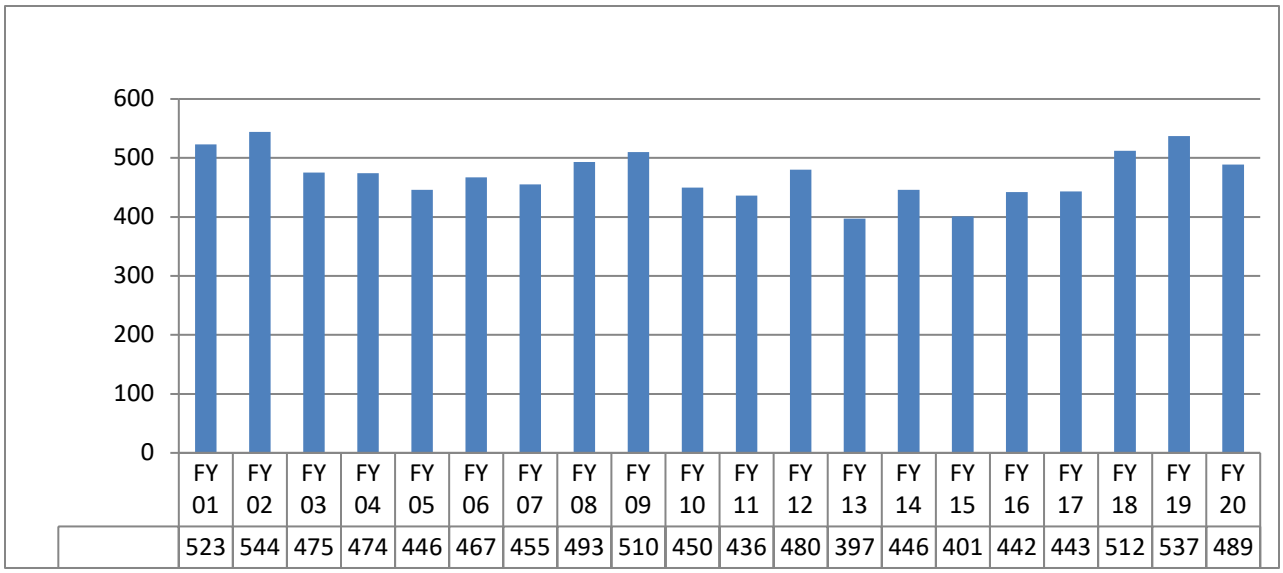
Inpatient Evaluations and Treatment Services for Pre-Trial Defendants

As previously noted, defendants may be referred for inpatient evaluation and treatment under T.C.A. § 33-7-301(a) by the outpatient evaluator to one of the Regional Mental Health Institutes (RMHIs). An informal poll of outpatient evaluators indicates that the primary reason for inpatient referral is the need for inpatient psychiatric treatment (i.e. the defendant is showing symptoms of psychosis rendering him incompetent to stand trial and can only be treated in an inpatient setting). The second most common reason for inpatient referral is that the outpatient evaluator suspects the defendant may be malingering, that is, faking symptoms of mental illness or intellectual disability or exaggerating symptoms/impairments he has or has had in the past for

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

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

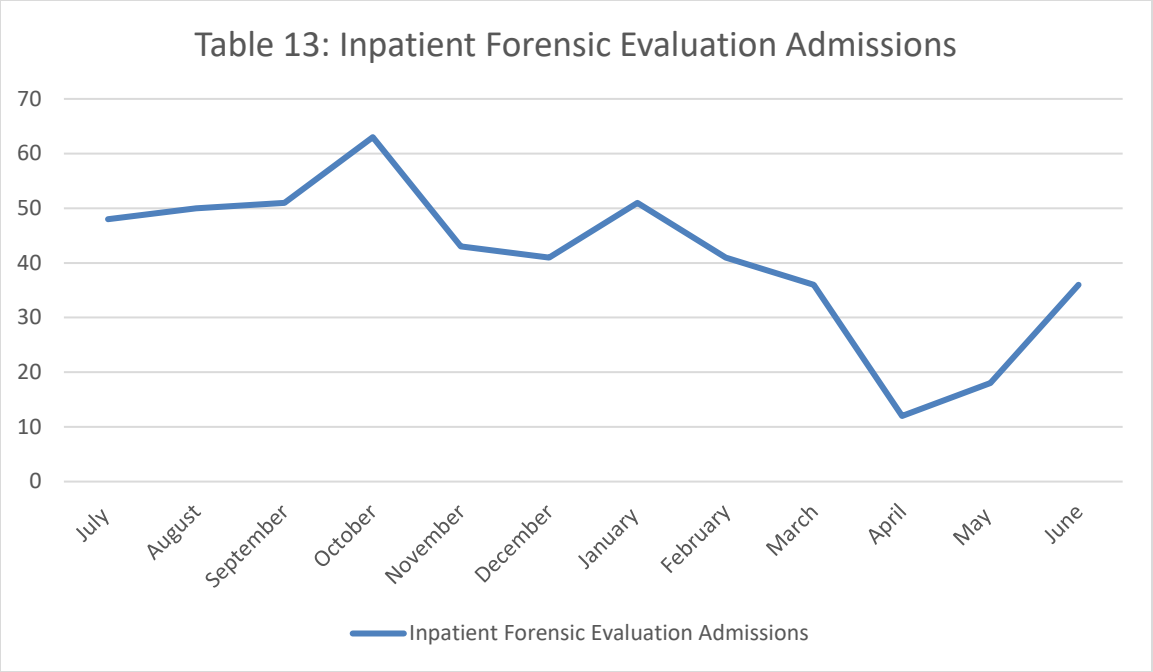
Table 12: Inpatient Admissions under T.C.A. § 33-7-301(a)



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

Table 12, above, shows the total number of admissions for inpatient evaluation state-wide each fiscal year since FY 01. The FY 20 inpatient evaluation total of 489 is higher than the average of 471 per year over the previous 20 years (+4%) yet was clearly impacted by changes in

admission procedures due to the COVOID-19 pandemic. As outbreaks of infection were reported in nursing homes, the Department determined that it was essential to prevent similar outbreaks in the RMHIs. Each facility developed a plan to reduce the census so as to allow for isolation and spacing depending on the size and available space for that facility, and to minimize the coming-in-and-going-out of patients to help prevent spread of the infection. Emergency admissions from the community were the priority. Forensic evaluation admissions were paused or slowed at all facilities until testing materials and procedures were available, adequate physical protection equipment was available for staff, isolation procedures were developed and jails were able to test detainees. Memphis Mental Health Institute (MMHI) paused forensic evaluation admissions on 3/27/2020 and resumed 6/11/2020. Moccasin Bend Mental Health Institute (MBMHI) paused forensic evaluation admissions 4/1/2020 and resumed 5/8/2020. Middle Tennessee Mental Health Institute (MTMHI) slowed admissions to one per week for the Forensic Services Program (FSP) and one per week for the main building 4/2/2020 and then returned to standard frequencies on 6/5/2020. Western Mental Health Institute (WMHI) paused 4/3/2020 and resumed 5/21/2020. When detainees were admitted from jails as emergency admissions through the crisis teams, if the RMHI had previously received an order for an inpatient forensic evaluation, the evaluation was typically conducted before the detainee was discharged to avoid a re-admission at a later date, so the number of forensic evaluation cases didn't go to zero for any facility in any month despite the much lower rate of admission, as can be seen in Table 13, below.

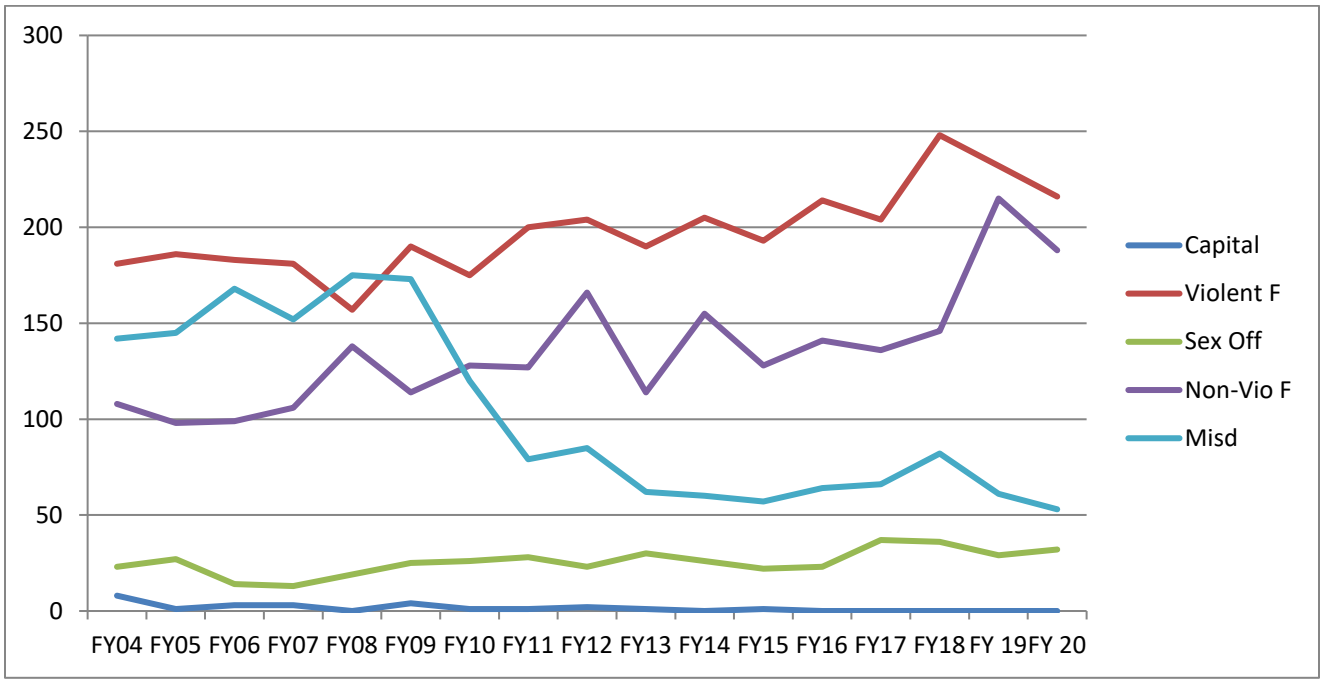


The distribution of inpatient evaluations by type of offense shown in Tables 14 and 15 on the following page indicates the lowest proportion of misdemeanor cases in FY 20. In the last fiscal year prior to counties being billed for misdemeanors (FY 09), 34% of inpatient evaluation cases were misdemeanor cases. The average for the 10 years since counties were billed for the cost of misdemeanor evaluations (FY10-FY 19) of 447 is still 8% less than the average of 487 per year for the nine years prior to the change in law on billing counties for misdemeanors (FY01-FY09). The cost of inpatient evaluations has a much greater impact on county budgets than outpatient evaluations. An outpatient evaluation for competency to stand trial and mental condition at the time of the crime costs $800, while an inpatient evaluation at $450 per day would be $13,500 for the full 30 days, or $9,450 for the 21 days of the average length of stay.

Table 14: Pre-Trial Inpatient Evaluations by Offense Type

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

Table 15: Inpatient Felony vs. Misdemeanor Trends



Most notable is the sharp decline in misdemeanor evaluations beginning in FY 10 after the law changed to make counties responsible for the cost of misdemeanor evaluation and treatment services. In FY 08 there were more inpatient evaluations on defendants charged with misdemeanors only (175) than on defendants with at least one violent felony charge (157). In

FY 19, there were just over four times as many evaluations of violent felony evaluations (216) than misdemeanor evaluations (53).

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

Table 16: RMHI Counties Served

RMHI	*Counties*
MBMHI	Anderson, Bedford, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Clay, Cocke, Coffee, Cumberland, DeKalb, Fentress, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Handcock, Hawkins, Jackson, Jefferson, Johnson, Knox, Lincoln, Loudon, Macon, Marion, McMinn, Meigs, Monroe, Moore, Morgan, Overton, Pickett, Polk, Putnam, Rhea, Roane, Scott, Sequatchie, Sevier, Smith, Sullivan, Unicoi, Union, Van Buren, Washington, Warren, White
MTMHI	Cannon, Cheatham, Davidson, Dickson, Giles, Hickman, Houston, Humphries, Marshall, Maury, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, Wilson
WMHI	Benton, Carroll, Chester, Crockett, Decatur, Dyer, Gibson, Fayette, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Lawrence, Lewis, Madison, McNairy, Obion, Perry, Tipton, Wayne, Weakly (+ commitments under T.C.A. §§ 33-7-301(b) & -303(c) from Shelby County; see pp. 24, 32)
MMHI	Shelby (T.C.A. § 33-7-301(a) only)

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

Table 17: Inpatient Evaluations by Facility

Facility	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
LMHI	67	66	70	48	45	0	0	0	0	0	0	0	0
MBMHI	64	69	39	53	67	99	108	122	132	131	156	143	134
MTMHI	56	71	70	65	84	74	89	69	98	93	132	123	130
WMHI	56	72	55	69	53	44	68	53	56	69	50	66	78
MMHI	170	140	128	129	146	105	109	90	89	104	118	136	100
FSP	80	92	88	74	85	75	72	67	67	46	56	69	47
TOTAL	493	510	450	436	480	397	446	401	442	443	512	537	489

As previously noted, a defendant admitted for an inpatient evaluation may only be held a maximum of 30 days under T.C.A. § 33-7-301(a). Most defendants respond to treatment initiated upon admission in a short time, so the average length of stay is actually shorter than the allotted 30 days. The average length of stay under T.C.A. § 33-7-301(a) statewide for the 19 year period FY 01-FY 19 was 21 days. The average length of stay statewide in FY 20 was 22 days.

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

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

Outcomes:

The rate of finding defendants competent to stand trial was notably lower at MMHI and WMHI than at the other facilities, though similar rates have been observed at other facilities in previous years.

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

Facility	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
LMHI	70%	69%	67%	79%	66%	-	-	-	-	-	-	-	-
MBMHI	69%	72%	59%	79%	79%	64%	77%	72%	83%	70%	76%	77%	72%
MTMHI	53%	40%	57%	76%	67%	58%	66%	68%	84%	82%	81%	85%	71%
WMHI	73%	78%	82%	66%	73%	84%	57%	66%	66%	69%	52%	62%	75%
MMHI	83%	69%	77%	69%	74%	62%	76%	73%	53%	47%	50%	54%	55%
FSP	70%	84%	78%	82%	77%	72%	73%	74%	82%	71%	87%	75%	59%
State-wide Average	73%	69%	72%	74%	73%	66%	71%	71%	75%	67%	70%	71%	67%

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

Table 20: Support for the Insanity Defense in Inpatient Evaluations

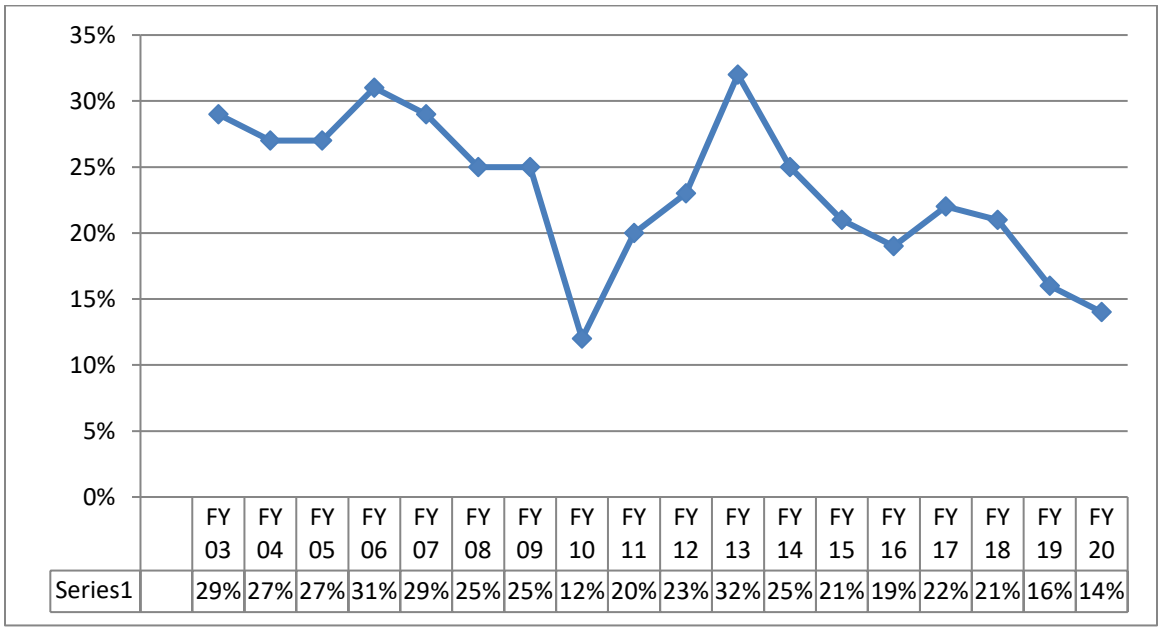
FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
18%	14%	17%	16%	17%	19%	15%	14%	18%	16%	21%	14%	14%	14%

Inpatient evaluations conducted under T.C.A. § 33-7-301(a) also include a recommendation to the court on whether the defendant meets involuntary commitment criteria under Title 33, Chapter 6, Part 5, necessary for commitment for further evaluation and treatment under T.C.A. § 33-7-301(b), or if the defendant meets criteria for commitment to outpatient

treatment including competency training under T.C.A. § 33-7-401. A small number of defendants are considered unrestorably incompetent to stand trial (e.g. due to brain injury or disease or significant intellectual impairment) and do not meet commitment standards for further inpatient treatment, and are returned to court. In these cases, RMHI staff reach out to mental health providers for the jail to support the identification of community resources for defendants who cannot be prosecuted and are released from jail.

Defendants from Shelby County courts evaluated initially at MMHI and committed for further evaluation and treatment under T.C.A. § 33-7-301(b) are admitted to WMHI. Defendants evaluated initially at FSP may be committed to FSP under T.C.A. § 33-7-301(b) when maximum security is needed or may be committed to one of the other RMHIs if the defendant no longer requires maximum security. Tables 21 and 22 on the following page show the frequency with which recommendations were made to the court for commitment out of all evaluations conducted under T.C.A. § 33-7-301(a).

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



	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Series1	29%	27%	27%	31%	29%	25%	25%	12%	20%	23%	32%	25%	21%	19%	22%	21%	16%	14%

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

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

Table 23 shows that the majority of orders for evaluation under T.C.A. § 33-7-301(a) were received from General Sessions courts. An order received from a General Sessions Court typically indicates that an evaluation was ordered relatively early in the prosecution process of a criminal case. The pattern shown in Table 23 is very consistent with previous years.

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

Court	Outpatient	Inpatient
General Sessions	1,313 (64%)*	302 (61%)**
Criminal Court	476 (23%)*	108 (22%)**
Circuit Court	194 (9%)*	61 (12%)**
Municipal	62 (3%)*	18 (3%)**

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

Defendant Characteristics

Below is a summary of the characteristics of defendants evaluated under T.C.A. § 33-7-301(a).

***Gender**:*

Outpatient: 83% male, 16% female

Inpatient: 80% male, 19% female

Age:

	Outpatient	Inpatient
0-18:	2%	1%
19-30:	33%	33%
31-43:	33%	31%
44-64:	27%	30%
>64:	4%	3%

Race:

	Outpatient	Inpatient
Alaskan Native:	<1%	0
American Indian:	<1%	0
Asian	<1%	0
Black/African American:	45%	50%
White/Caucasian:	51%	47%
Unknown:	<1%	0
Other:	1%	2%

Primary Diagnosis Outpatient Evaluations:

Psychotic D/O:	29%	Personality D/O:	2%
Affective D/O:	16%	Adjustment/Behavior:	1%
Deferred:	17%	Malingering:	1%
Substance Related:	16%	None:	1%
Intellectual Disability:	3%	Borderline IQ:	<1%
Anxiety	3%	Medical:	<1%
Neurological	3%	Other:	<1%

Intellectual Disability in pre-trial Forensic Evaluations:

When a defendant who has been referred for a forensic evaluation appears to be intellectually disabled (ID), the evaluator designated by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) may request assistance from evaluators in

the Tennessee Department of Intellectual and Developmental Disabilities (TDIDD) who have completed the TDMHSAS forensic training, a process referred to as an "ID Assist" request. For many years, an ID Assist was requested whenever a forensic evaluator believed that a defendant might be incompetent to stand trial due to intellectual disability, or there might be support for the insanity defense based on an intellectual disability, or the defendant might meet commitment criteria under Title 33, Chapter 5, Part 4 to the Harold Jordan Center (HJC), the inpatient facility operated by TDIDD. The threshold for requesting an ID Assist changed in FY 14 due to TDIDD manpower limitations so that an ID Assist request was made only for 1) outpatient competency training which a court would have authority to order under T.C.A. § 33-5-501 or 2) for commitment to HJC. This was the standard for requesting an ID Assist throughout FY 20.

If a forensic evaluator believed that a defendant was incompetent to stand trial and committable to the HJC, the evaluator would request an ID Assist prior to communicating anything to the court. If the TDIDD expert found that the defendant did meet commitment criteria under Title 33, Chapter 5, Part 4, he/she would complete one certificate of need and the TDMHSAS forensic evaluator (in these cases a licensed psychologist with Health Service Provider designation) would complete the other certificate of need and forward both to the court with a recommendation for commitment under T.C.A. § 33-5-403. If the TDIDD expert did *not* find the defendant to be committable, the TDIDD expert would indicate whether training should be attempted on an outpatient basis and the recommendations would be submitted to the court.

Alternatively, if a TDMHSAS forensic evaluator believed that a defendant charged with a felony was incompetent to stand trial due to intellectual disability, was not committable, but might be trained to competence on an outpatient basis by an expert in intellectual disability, the evaluator would recommend that the court order training under T.C.A. § 33-5-501 and would simultaneously request an ID Assist. The TDIDD expert would then arrange for training sessions with the defendant upon receipt of a court order for training. For defendants charged only with misdemeanors, the TDMHSAS evaluator would simply report to the court that the defendant was not competent to stand trial and efforts would be made to arrange for services to address safety and habilitation needs depending on the location of the defendant.

Requests for an ID Assist could be made on an outpatient or inpatient basis. If a defendant suspected to be intellectually disabled showed signs of psychosis (known as "dual diagnosis"), the defendant would be referred for inpatient evaluation and treatment to stabilize

the mental illness before a final determination is made about the level of intellectual functioning and any impairment related to the forensic issues.

Table 24: ID Assist Frequencies

	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Outpatient Req % of outpatient evaluations	112 (5%)	134 (6%)	112 (6%)	21 (1%)	26 (1%)	37 (2%)	26 (1%)	38 (2%)	32 (1%)	28 (1%)
Inpatient Req % of inpatient evaluations	25 (6%)	18 (4%)	11 (3%)	5 (1%)	0 (-)	4 (1%)	4 (1%)	12 (2%)	11 (2%)	9 (2%)
Total ID Assists % of Total Evaluations	137 (5%)	152 (6%)	133 (5%)	26 (1%)	26 (1%)	41 (2%)	30 (1%)	40 (2%)	43 (2%)	37 (1%)

Of the 80 total ID Assist requests in FY 19 and FY 20, 15 were for committability and 65 were for competency training.

Table 25: Total ID Assist Request Trend

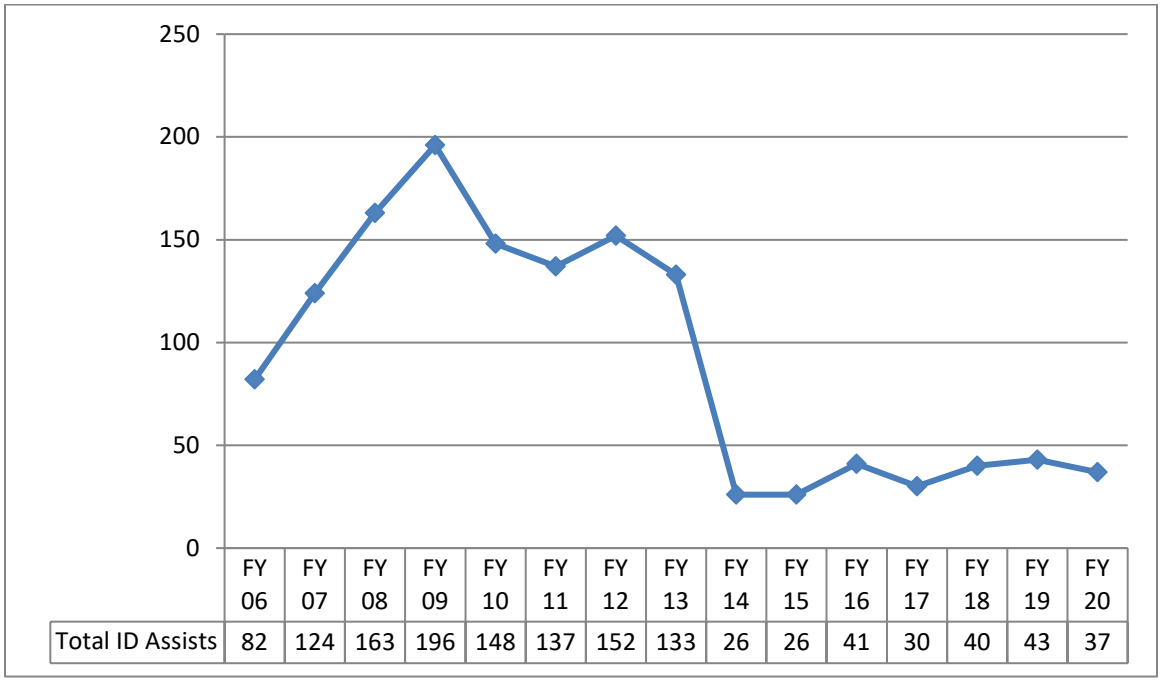


Table 25, above, shows the significant decrease in the total number of ID Assist requests in FY 14 when the threshold was changed for initiation of an ID Assist.

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

Pre-trial defendants who meet the commitment criteria in Title 33, Chapter 6, Part 5 at the end of the evaluation under T.C.A. § 33-7-301(a) may be committed for further inpatient evaluation and treatment under subsection (b) of T.C.A. § 33-7-301; there were 75 new admissions in FY 20 (see Table 26, below). These defendants are typically considered incompetent to stand trial, although a very few may be considered competent to stand trial but would pose a substantial likelihood of serious harm due to mental illness if discharged to the jail to await further court proceedings. Shelby County defendants are admitted to Memphis Mental Health Institute (MMHI) for evaluation under subsection (a) of T.C.A. § 33-7-301 for the initial evaluation and then are admitted to Western Mental Health Institute (WMHI) when commitment is necessary under subsection (b), with occasional exceptions. Thirty-two (32) of the 51 admissions under T.C.A. § 33-7-301(b) to WMHI (63%) were Shelby County cases (generally consistent with the 66% in FY 19 and the 72% in FY 18 but down from 82% in FY 13). Shelby County defendants were 48% of all admissions under that statute state-wide (including 11 of the 12 misdemeanor cases), consistent with 48% in FY 19 and FY 18 and 44% in FY 17. Defendants admitted to and evaluated under subsection (a) at the maximum security Forensic Services Program (FSP) may be committed to FSP under subsection (b) or may be committed to a Regional Mental Health Institute if they no longer require maximum security.

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

Facility	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
LMHI	12	13	9	1	1	2	-	-	-	-	-	-	-	-
MBMHI	11	9	6	2	8	10	19	21	16	12	15	12	1	3
MMHI	0	0	1	0	0	1	0	0	0	0	1	4	0	0
MTMHI	28	28	35	7	16	16	32	28	27	11	20	16	14	15
FSP	10	10	8	5	10	13	11	9	12	7	7	7	9	6
WMHI	37	42	38	33	39	54	51	45	27	29	65	53	64	51
TOTAL	98	102	97	48	74	96	113	103	82	59	108	92	88	75

There were 12 cases state-wide coded as misdemeanors (16%; 11 of the 12 from Shelby County) consistent with FY 19 (14%) and FY 17 (18%), and down slightly from FY 18 (23%).

At any time that a defendant is considered to have been restored to competence, the court is notified so that the trial may proceed, whether or not the defendant stays in the hospital. Defendants who no longer meet the commitment criteria under Title 33, Chapter 6, Part 5 are discharged regardless of whether they are considered to be competent to stand trial or not (typically the defendant is competent and not committable). Some defendants have their charges dismissed or retired, so they are no longer pre-trial criminal defendants, but if they remain committable, they remain in the hospital under Title 33, Chapter 6, Part 5 and are discharged to the community when a less drastic alternative to hospitalization is identified and outpatient treatment arranged. Table 27 shows the number of patients committed under T.C.A. § 33-7-301(b) whose legal status under that statute ended in each of the last 16 fiscal years, either by discharge from the hospital or by having their charges dismissed.

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

Facility	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
LMHI	18	14	9	7	22	2	1	3	-	-	-	-	-	-	-	-
MBMHI	19	19	12	16	9	1	8	7	21	23	17	10	15	15	1	3
MMHI	0	0	0	0	1	0	0	1	0	0	0	0	1	4	0	0
MTMHI	32	25	33	24	39	11	18	15	19	30	20	12	15	15	13	18
FSP	12	7	7	9	10	5	14	11	11	10	11	7	4	10	8	4
WMHI	42	41	43	45	43	36	32	51	57	40	48	27	46	53	67	60
TOTAL	123	106	104	101	124	55	73	87	107	103	96	56	81	97	89	85

Of the 85 cases closed during FY 20, just under half (40 cases; 47%) were discharged while still pre-trial criminal defendants under T.C.A. § 33-7-301(b) and just over half (45 cases; 53%) had their charges retired and remained committed to the RMHI under Title 33, Chapter 6, Part 5. That rate of cases with charges being retired is consistent with the five previous fiscal years (FY 15 and FY 16 = 48%; FY 17 = 49%; FY 18= 55%; FY 19=52%).

Table 28, below, shows defendants discharged from T.C.A. § 33-7-301(b) with charges still pending during FY 20 categorized by their length of stay. In FY 20, the most frequent length of stay was between one and three months (39%); 20% were discharged in less than one month; 25% were discharged with a length of stay between three and six months, for a total of 84% discharged in the first six months. This is the most common pattern for lengths of stay; 80+% discharged within six months and the highest frequency being between one and three months.

Table 28: Length of Stay
Discharges Under T.C.A. § 33-7-301(b) during FY 19

Facility	0 – 30 Days	31-90 Days	3-6 Mos.	6 Mo.-1 Yr.	1-2 Yrs.	2-5 Yrs.	5 Yrs. +	Avg. LOS in days	Range in days
MTMHI	4	7	1	1	0	0	0	68	21-219
FSP	1	1	2	0	0	0	0	68	11-105
WMHI	3	8	7	6	0	0	0	125	28-365
MBMHI	1	1	1	0	0	0	0	59	13-101
Totals	**9**	**17**	**11**	**7**	**0**	**0**	**0**	**80**	**11-365**

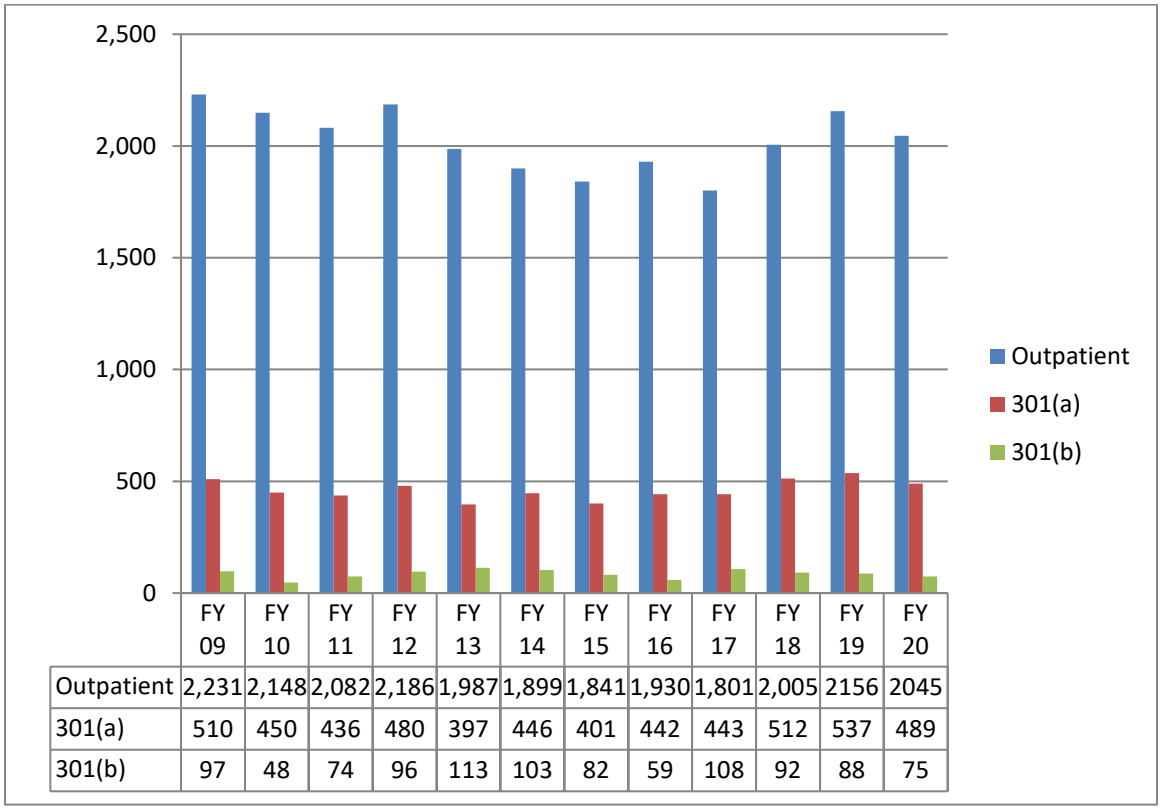
While Table 28 shows the length of stay for patients discharged during FY 20, Table 29 shows the lengths of stay for those patients still on census at the RMHIs at the end of each of the last three fiscal years (June 30), providing a point-in-time view of the range in length of stay for patients committed under T.C.A. § 33-7-301(b).

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

LOS	# of patients 6/30/2016	# of patients 6/30/2017	# of patients 6/30/2018	# of patients 6/30/2019	# of patients 6/30/2020
0-6 mos	12	26	23	22	7
6-12 mos	6	9	5	2	8
1-2 years	5	3	3	2	3
2-3 years	0	2	2	1	0
3 years +	0	0	0	2	1
Total	23	40	33	29	19

Table 30, below combines tables 3, 12 and 24 to illustrate how the Tennessee forensic evaluation system established in law and carried out by TDMHSAS focuses services in the community and minimizes demand on inpatient facilities.

Table 30: Forensic Evaluation Services

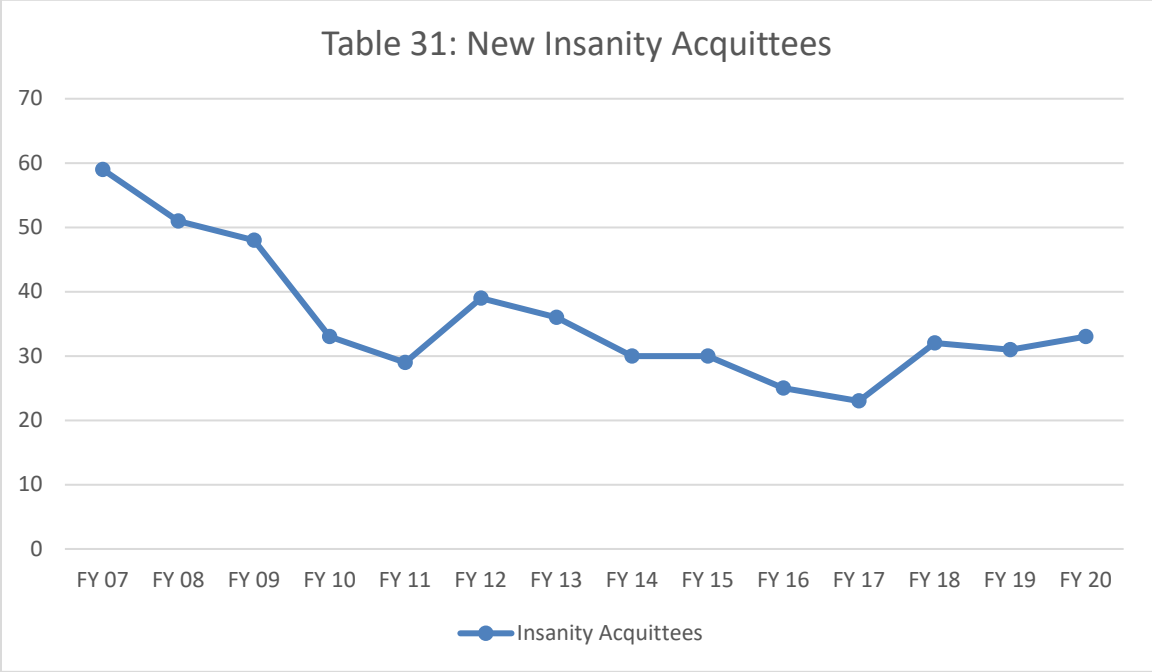


	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Outpatient	2,231	2,148	2,082	2,186	1,987	1,899	1,841	1,930	1,801	2,005	2156	2045
301(a)	510	450	436	480	397	446	401	442	443	512	537	489
301(b)	97	48	74	96	113	103	82	59	108	92	88	75

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

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

Defendants adjudicated Not Guilty by Reason of Insanity (NGRI) are required by law under T.C.A. § 33-7-303(a) to be evaluated to determine whether the acquittee meets the standards for indefinite commitment to an RMHI under Title 33, Chapter 6, Part 5, or should be released to the community. Legislation signed into law in June of 2009 amended T.C.A. § 33-7-303(a) so that all evaluations of defendants found NGRI are conducted on an outpatient basis when previously the statute required an inpatient evaluation. Evaluations conducted in FY 2010 (beginning July 1, 2009) and afterward have all been conducted on an outpatient basis, while evaluations conducted in FY 2009 (ending June 30, 2009) and prior years were conducted on an inpatient basis. The outpatient evaluations are conducted by the same agencies which are contracted for outpatient pre-trial evaluations. There were 33 new NGRI acquittees in FY 20.



Of the 33 acquittees, 19 (57%) were acquitted on a violent felony (not sex offense) offense, 13 (39%) were acquitted on a non-violent felony, and one person was acquitted of misdemeanors (five counts of misdemeanor assault). None were acquitted of a sex offense.

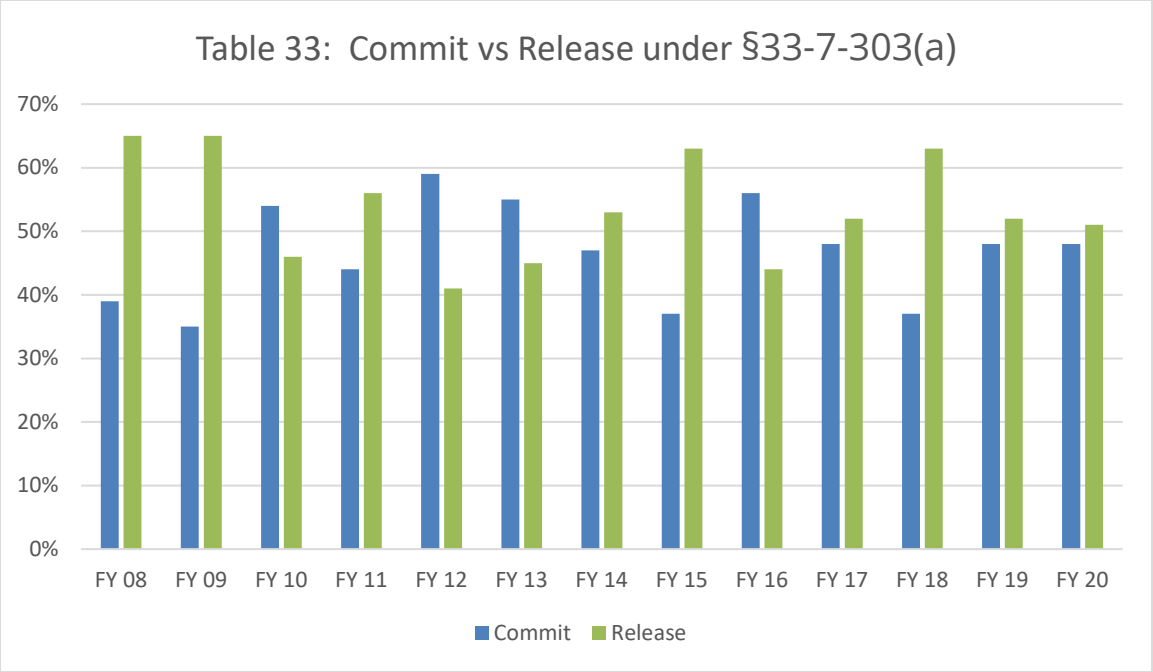
Through the end of FY 20, there were four possible outcomes of an evaluation conducted under T.C.A. § 33-7-303(a): (1) commitment to an RMHI under T.C.A. § 33-7-303(c), (2) release to the community with an Mandatory Outpatient Treatment (MOT) plan under T.C.A. § 33-7-303(b), (3) release to the community with an outpatient treatment plan and no legal obligation under MOT, and (4) release to the community with no outpatient treatment plan when the defendant does not require outpatient treatment (see also p. 61, below, for the requirement for MOT for certain cases at any point of release to the community). Table 32, below, shows the outcomes in FY 20 with recommendations broken out by provider.

Table 32: Recommendations following Evaluation Under T.C.A. § 33-7-303(a) in FY 20

	Commit	MOT	release w/o MOT	release w/o tx
Centerstone	2	0	0	0
Cherokee	0	0	3	0
Frontier	0	0	8	0
HR McNabb	0	0	2	0
Pathways	2	2	1	0
Ridgeview	0	0	0	0
Vanderbilt	8	0	1	0
Volunteer	1	0	0	0
WTFS	3	0	0	0
Total FY 20	16 (48%)	2 (6%)	15 (45%)	0

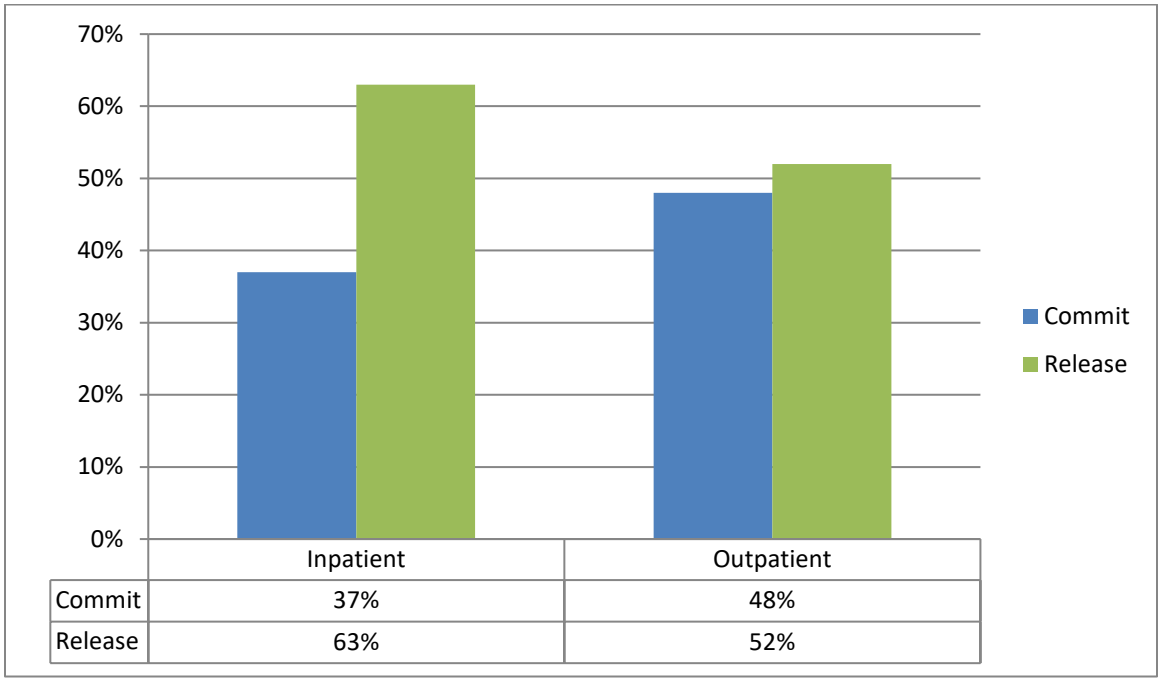
The relative frequency of recommendations for commitment vs. release has not been consistent across the last 11 years, with some years showing a greater rate of commitment and some a greater rate of release. Table 33 shows the percentage of recommendations for commitment vs. release. The total number of evaluations per year (as shown in Table 31, above)

ranges from a high of 51 in FY 08 to a low of 23 in FY 17. Evaluations in FY 08 and FY 09 were completed after a 60 day period of inpatient observation and evaluations conducted from FY 10 were conducted entirely on an outpatient basis. This appears to have little effect on the likelihood of a recommendation of commitment vs. release.



A comparison of outcomes between the sum of the last two years of inpatient evaluations under T.C.A. § 33-7-303(a) (FY 08 & 09; n= 99) and the last two years of outpatient evaluations (FY 19 & FY 20; n= 64) shows little difference between rates of commitment, with a slightly greater frequency of commitment from outpatient evaluations (see Table 34 on the following page). It should be noted that although there was a slightly greater frequency of release after a 60-day inpatient evaluation prior to FY 10, none of those recommended for release following an outpatient basis were hospitalized at all.

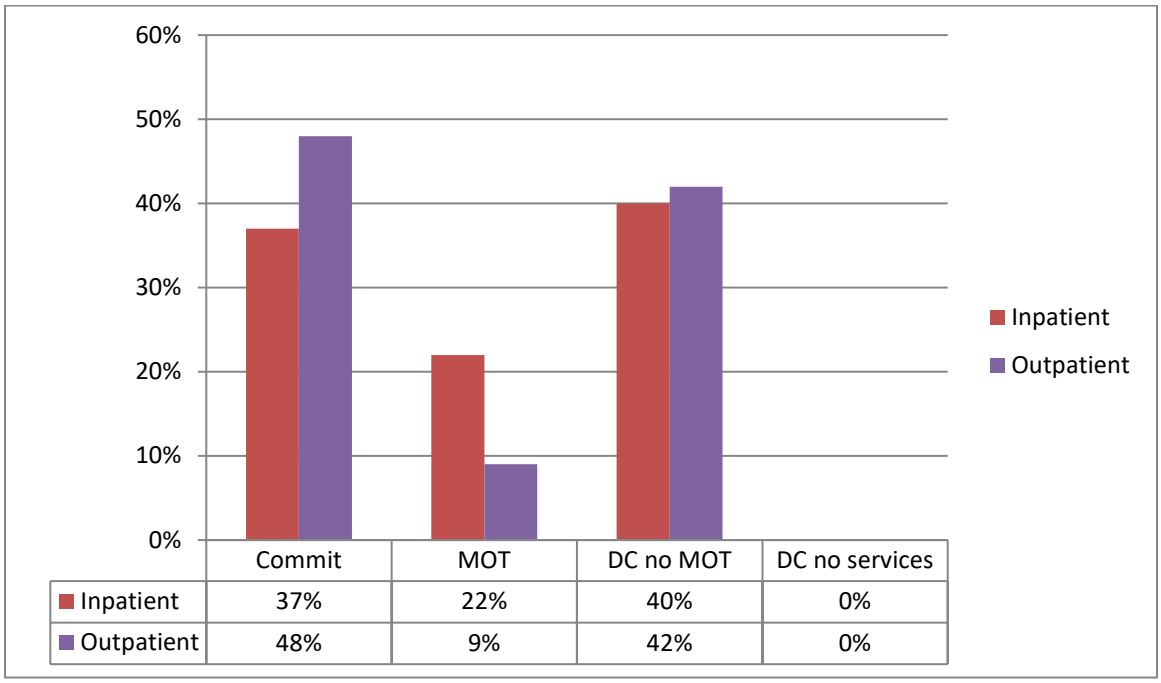
Table 34: Inpatient & Outpatient Evaluation Outcomes under T.C.A. § 33-7-303(a)



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

Breaking out the recommendations for release into those recommended for release with MOT vs. those recommended for release with no MOT requirement (Table 35, below) shows that release without conditions (but with an aftercare plan) has consistently been more frequent that recommending release with MOT.

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



	Commit	MOT	DC no MOT	DC no services
Inpatient	37%	22%	40%	0%
Outpatient	48%	9%	42%	0%

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

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

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

of FSP. In FY 16, 10 of the 17 commitments to WMHI were from courts outside the counties regularly served by WMHI (MTMHI = 9, MBMHI = 1).

This policy was reversed on October 1, 2016. All new commitments under T.C.A. § 33-7-303(c) were admitted directly to the RMHI which also accepted civil involuntary commitments from the same locality (see Table 15 on page 15 for breakout by county). Additionally, 12 NGRI patients who were not originally from WMHI's area were transferred to MTMHI on October 11th and 12th of 2016. Those transfers are not counted as new admissions to MTMHI in Table 36, below. The numbers in Table 36 are an unduplicated count of new NGRI admissions. Two of the admissions to WMHI were from courts outside the counties regularly served by WMHI and occurred prior to October 1, 2016.

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

←Inpatient Evaluation | Outpatient Evaluation→

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

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

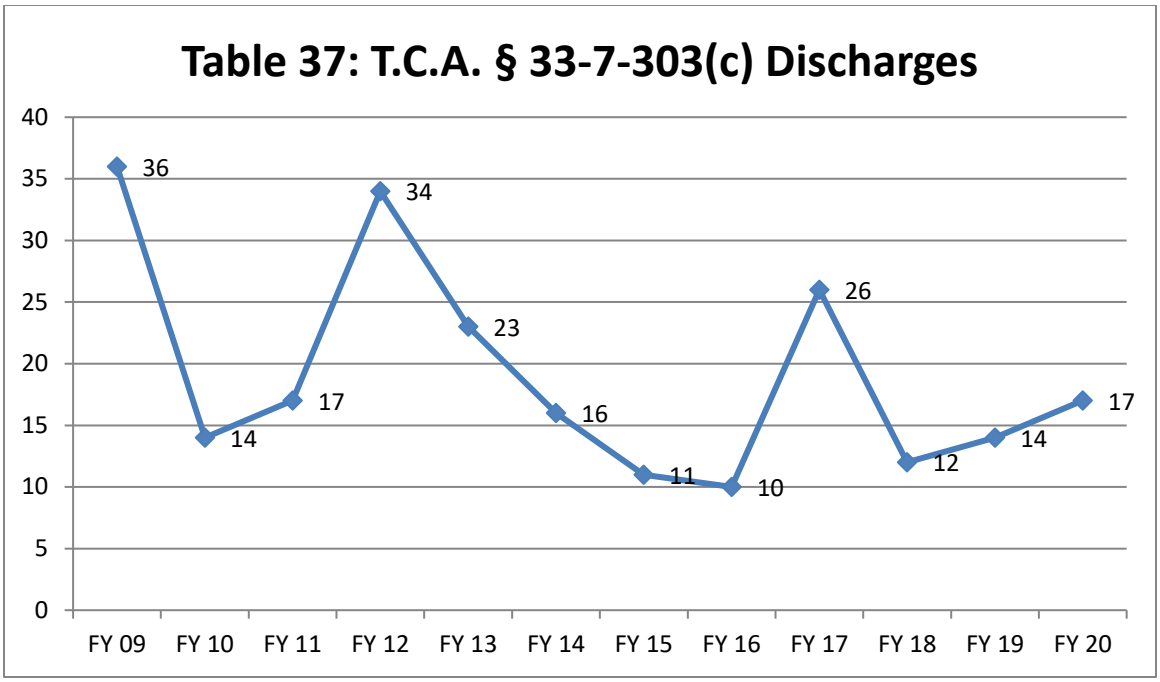


Table 38 summarizes the length of stay for all 14 patients discharged to the community during FY 20 who had been committed under T.C.A. § 33-7-303(c). This length of stay includes all days in all facilities for acquittees who have been transferred between FSP and an RMHI prior to discharge or transferred between RMHIs.

Table 38: Length of Stay Under T.C.A. § 33-7-303(c)
Discharges during FY 20

Facility	0 – 30 Days	31-90 Days	3-6 Mos.	6 Mo.-1 Yr.	1-2 Yrs.	2-5 Yrs.	5 Yrs. +	Avg. LOS in days	Range in days
MBMHI	0	0	0	1	1	0	0	489	324-653
MTMHI	0	1	1	1	2	0	0	318	56-678
WMHI	0	0	0	2	5	3	0	705	216-1,523
Totals	**0**	**1**	**1**	**4**	**8**	**3**	**0**	**504**	**56-1,523**

The shortest length of stay was just under two months and the longest length of stay was four years and two months. The average length of stay for all discharges was about one year and four months. FY 20 was unusual in that there no discharges of patients with a length of stay five years or more. In FY 19, for example, of the 14 discharges, one had a length of stay of eight and half years and another 14 and a half years. Including those patients, the average length of stay was two and a half years. Removing those two outlier patients (14 and a half years and 8 and a half years), the average length of stay was 364 days. That pattern is consistent with previous years. In FY 18, the average length of stay was one year and three months. In FY 17, one patient was discharged after 24 years and 8 months, and the average length of stay for the remaining patients was one year and three months. In FY 16, one patient was discharged after 16 years, with the average length of stay for all the other patients being just under a year (360 days). In FY 15, one patient was discharged after just over 10 years, with the average length of stay for all the other patients being just under a year (343 days).

Table 39 shows the lengths of stay for those patients still on census at the RMHIs at the end of the fiscal year (June 30), providing a point-in-time view of the range in length of stay for patients committed under T.C.A. § 33-7-303(c). The longest length of stay on June 30, 2020 was 11 years, eight months and 16 days. The lengths of stay appear to be fairly evenly distributed.

Table 39: Length of Stay for Patients On Census Under T.C.A. § 33-7-303(c) on June 30, 2020

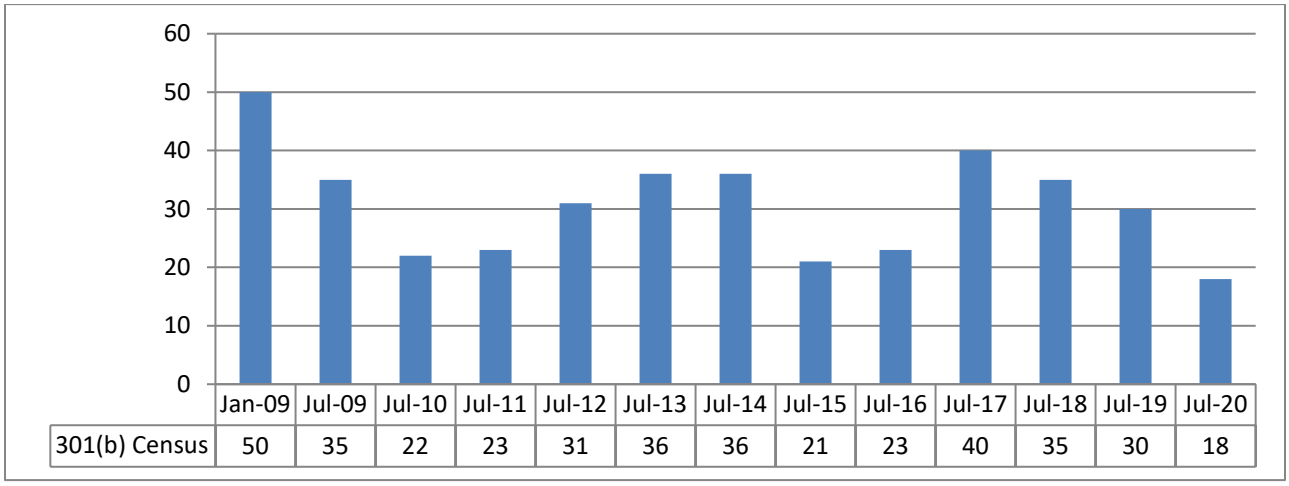
LOS	# of patients 6/30/2020
0-6 mos	7
6-12 mos	9
1-2 years	5
2-3 years	5
3-5 years	9
5-10 years	6
10 years +	4
Total	45

Forensic Census

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

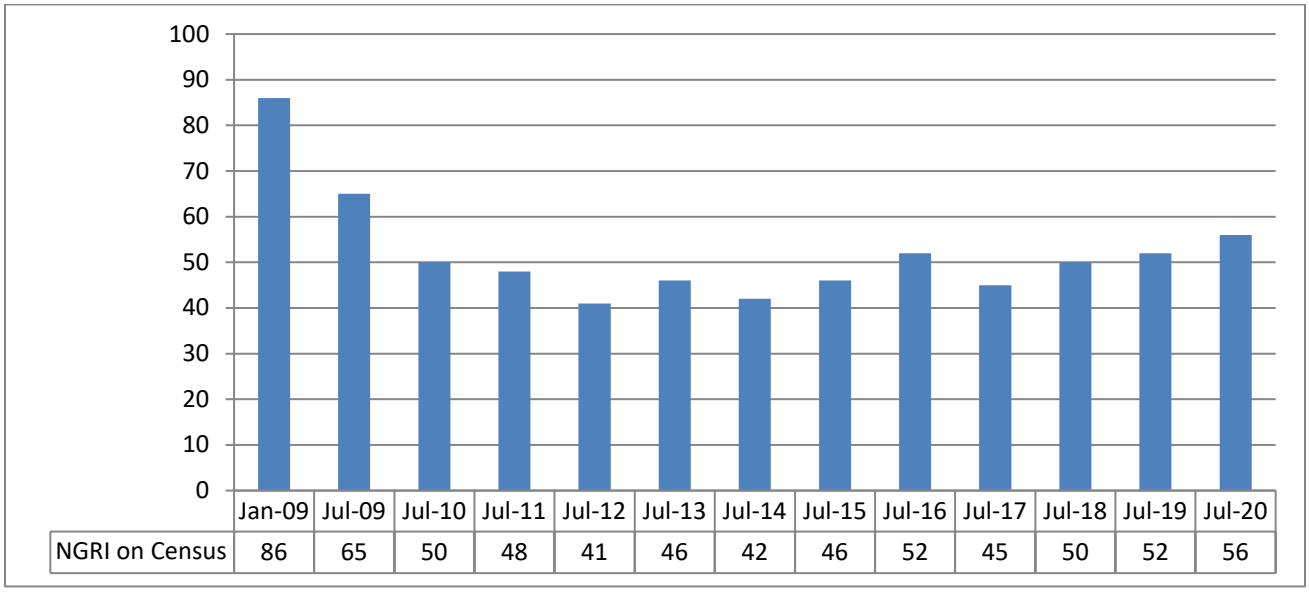
The tables below show the total number of patients in the facilities under T.C.A. § 33-7-301(b) (Table 40) and under T.C.A. § 33-7-303(c) (Table 41) who were on census on the first day of each month listed. The number of patients on census under T.C.A. §33-7-301(b) was clearly affected by the practice of slowing admissions in the last few months of FY 20 due to the pandemic.

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



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

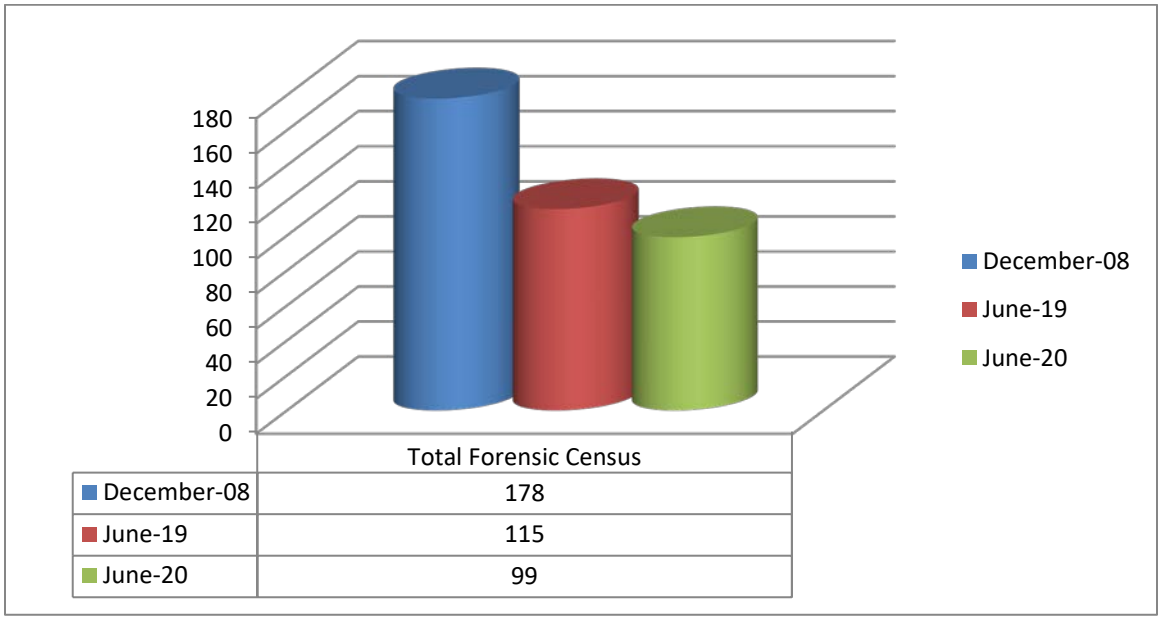
Table 41: T.C.A. 33-7-303(c) Cases on Census



	Jan-09	Jul-09	Jul-10	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17	Jul-18	Jul-19	Jul-20
NGRI on Census	86	65	50	48	41	46	42	46	52	45	50	52	56

Table 42 shows the total forensic census for all facilities comparing December of 2008 (the formal beginning of census monitoring and management), the end of FY 19, and the end of FY 20, which was affected by intentional efforts to reduce overall hospital census to facilitate isolation and general prevention of the spread of COVOID-19.

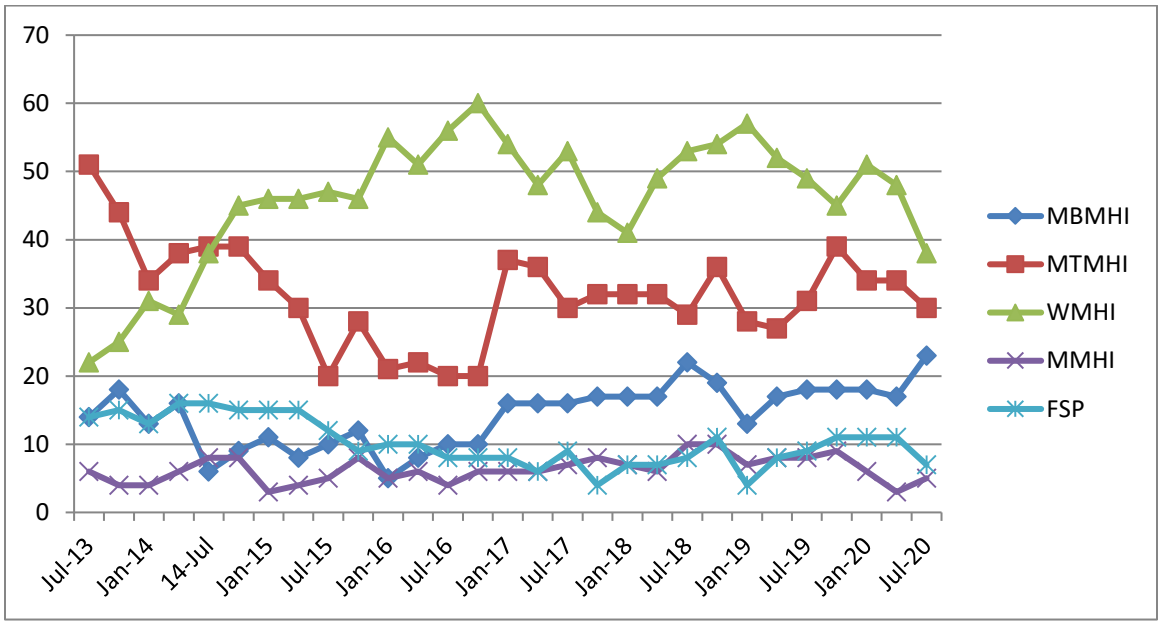
Table 42: Total Forensic Census State-Wide



	Total Forensic Census
December-08	178
June-19	115
June-20	99

As noted above (pp. 33-34) a determination was made to shift the commitment of all new NGRI admissions and incompetent defendants committed for longer than 90 days to WMHI from the other RMHIs beginning April 1, 2014. This policy continued until October of 2016 and the effects can be most clearly seen in Table 43, below. The census for WMHI increased while the census for MTMHI decreased and they actually crossed three months after implementation of the policy (July 2014).

Table 43: Quarterly Forensic Census by RMHI 2013-2020



NOTE: Data points are every three months; January, April, July, October, repeat.

The forensic census at MTMHI stayed low in 2015 while the forensic census at WMHI continued to grow until the policy was reversed in October 2016 and 15 forensic patients were moved from WMHI to MTMHI; note the increase at MTMHI between October 2016 and January 2017. However, the MTMHI forensic census stabilized and has not returned to the highest point of July 2013 as discharges of forensic patients have kept pace with new forensic

admissions (see also Table 44, below). This suggests that it was difficult for staff at WMHI to arrange aftercare and discharge for patients returning to the Middle Tennessee region, and that RMHIs are best able to arrange discharge and aftercare in those communities routinely served by that RMHI (county breakdown shown in Table 15, page 15, above).

As previously noted, all facilities stopped or paused non-emergency forensic admissions around April 1, 2020 to reduce census to help manage infection risk in the pandemic and then resumed admissions sometime in May; MBMHI resumed sooner than the other facilities.

Table 44 shows the RMHI forensic census since 2008, with one data point for each year. Since 2009, the forensic census has comprised about 20% of the overall census, in a range from 14% to 28%.

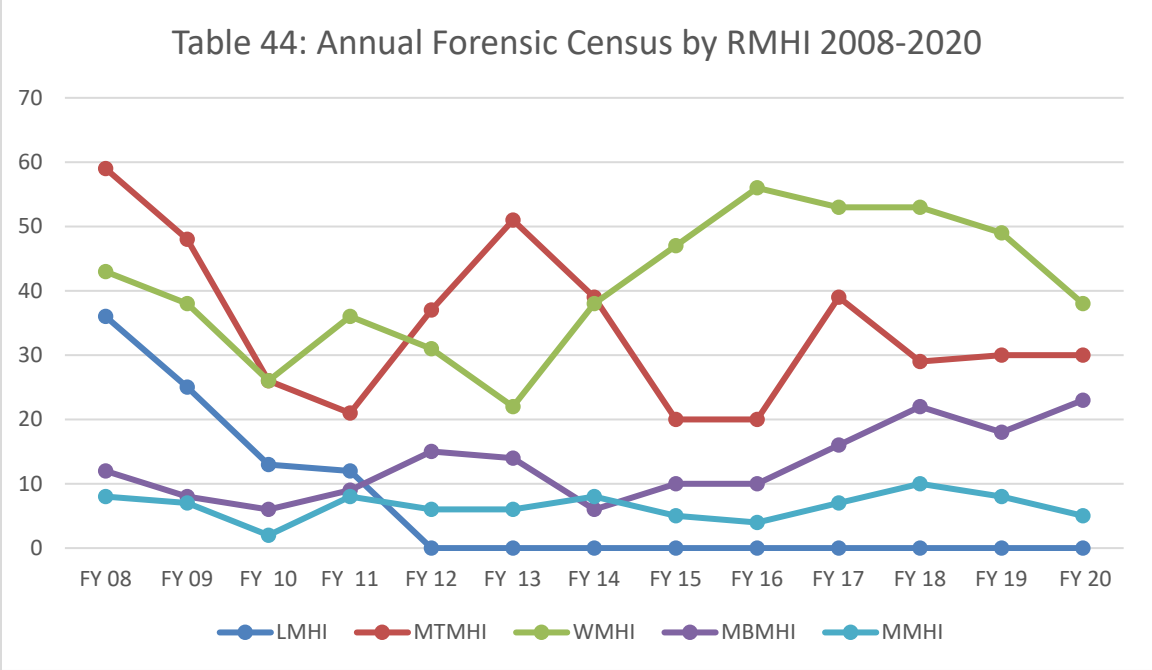


Table 45 on the following page allows for an inspection of the census of each legal status within each facility and state-wide, comparing mid-December 2008 with the end of FY 20 (July 1, 2020). The change in law requiring that evaluations of new insanity acquittees under T.C.A. § 33-7-303(a) be conducted on an outpatient basis is reflected as that census goes to zero. Patients served at LMHI in 2008 were served at MBMHI in 2020.

Table 45: Forensic Census Comparison: December 2008 and July 2020

December 19, 2008

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

July 1, 2020

	LMHI	MTMHI	FSP	WMHI	MBMHI	MMHI	Total
301(a)	0	4	2	6	12	5	29
301(b)	0	1	3	13	1	0	18
303(c)	0	25	2	19	10	0	56
Total (% Census)	0	30 (21%)	7 (44%)	38 (32%)	23 (20%)	5 (15%)	**103 (24%)**

Risk Assessment Evaluations for the Board of Parole

Since Fiscal Year 2011 (July 1, 2010-June 30, 2011), the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) has had a Memorandum of Understanding with the Board of Parole (BOP) for TDMHSAS to provide risk assessment evaluations on certain parole eligible inmates in the Tennessee Department of Corrections (TDOC) as requested by the BOP. Statute requires a risk assessment of inmates convicted of certain sex offenses prior to consideration by the BOP (*see* T.C.A. § 40-28-116), but the majority

of requests from the Board are for an assessment of propensity for violent re-offense on offenders sentenced for violent offenses. There have been 836 evaluations conducted FY 11-FY 20, 242 (29%) sex offender evaluations and 594 (71%) violent offender risk assessments. This total includes 22 female offenders (3 for sex offenses, 19 for violent offenses).

Evaluations are conducted by doctoral-level evaluators from the Department of Psychiatry at the Vanderbilt University Medical School who have completed the TDMHSAS Forensic Evaluator certification and the Sex Offender Treatment Board provider training. Evaluations include the use of at least one actuarial risk assessment instrument for the male offenders (e.g. the Violence Risk Appraisal Guide[2] and/or the STATIC-99 revised scoring rules[3]) as part of a comprehensive psychiatric evaluation and recommendations for treatment and risk reduction. Often, the institutional records will also contain the results of the Level of Service Inventory (LSI) and/or the STRONG-R completed by a TDOC forensic social worker. The LSI and STRONG-R are both measures intended to estimate the risk of general criminal recidivism, not limited to violent or sexual offenses. The results of the LSI and/or STRONG-R are in themselves useful in identifying the relevant amount of services necessary to reduce the risk of criminal re-offense and the specific issues to be addressed. Contrasting the results of the LSI and/or STRONG-R with other risk assessment instruments provides a useful view of the inmate's pattern of risk (e.g. an inmate may have a relatively low risk of a specific type of offense, such as violence or sexual offending, but a higher risk for criminal offending in general).

Recommendations to the BOP are nuanced and case-specific, but for data collection purposes the Office of Forensic Services categorizes each evaluation as finding low, medium, or high risk for re-offense of violent offenders. For offenders falling under one of the sex offense statutes, each evaluation is categorized as finding that the offender's risk for re-offense is either greater than or equal to the TDOC baseline for re-offense (TDOC Recidivism Study: Felon Releases 2001-2007) or less than the TDOC baseline for re-offense.

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

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

Table 46: Total Evaluations Conducted for the BOP

	Sex Offense	Non-Sex Offense	Total
FY 11	6	14	20
FY 12	20	38	58
FY 13	17	21	38
FY 14	22	30	52
FY 15	36	62	98
FY 16	20	94	114
FY 17	21	76	97
FY 18	41	98	139
FY 19	31	82	113
FY 20	28	80	108
Total	**242**	**594**	**836**

Table 47: Violent Offenders Risk Estimates

	High	Medium	Low
FY 11	8	2	4
FY 12	4	20	14
FY 13	3	8	10
FY 14	5	11	14
FY 15	12	25	25
FY 16	27	33	34
FY 17	13	39	24
FY 18	15	47	35
FY 19	7	48	27
FY 20	4	45	31
Grand Total	**98 (16%)**	**278 (47%)**	**218 (37%)**

In FY 20, the rate of sex offenders whose risk for sexual re-offense upon release was estimated to be equal to or greater than that of the known base rate for TDOC-released sex offenders (7%) was much lower the rate from the previous fiscal years (21% for FY 11-FY 19).

Table 48: Risk Assessment for the BOP:

Sex Offenders

	Equal to or Greater Than Base rate for Re-Offense	Less Than Base rate for Re-Offense
FY 11	1	5
FY 12	4	16
FY 13	3	14
FY 14	3	19
FY 15	7	29
FY 16	6	14
FY 17	5	15
FY 18	10	32
FY 19	6	25
FY 20	2	26
Grand Total	**47 (19%)**	**195 (81%)**

Juvenile Court Ordered Evaluations

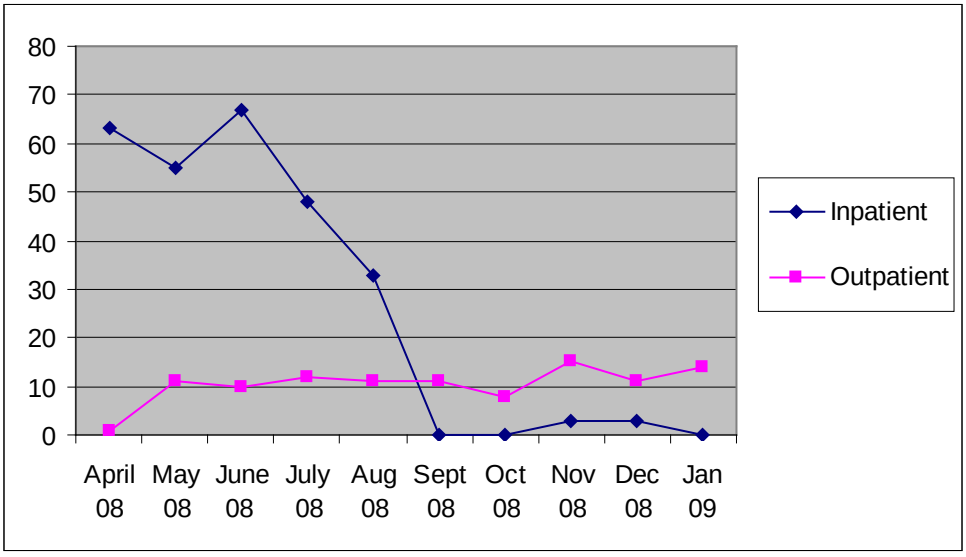
T.C.A. § 37-1-128(e) grants juvenile courts the authority to order mental health evaluations by an evaluator designated by the Commissioner of the TDMHSAS. While evaluations ordered for adult criminal defendants are limited strictly to competency to stand trial and/or mental capacity at the time of the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

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

Prior to July of 2008, juvenile court judges made the determination of whether to order an evaluation to be conducted on an inpatient or outpatient basis. During FY 09, the Office of Forensic and Juvenile Court Services began to work with the Administrative Office of the Courts (AOC) on a project to transform the juvenile forensic evaluation service from a predominantly

inpatient service to a more community-based service, a project which was supported by a Transfer Transformation Initiative (TTI) grant awarded by the Substance Abuse and Mental Health Service Administration and administered by the National Association of Mental Health Program Directors. On June 30, 2008, however, the Tennessee Court of Appeals released a decision in the case *In re: J.B.*[4] in which the Court found that the city or the county and not the state is responsible for the direct cost of evaluations ordered under this statute. State contracts with providers of inpatient juvenile court ordered evaluations were terminated as of September 1, 2008 and the courts were notified that while juvenile court judges and referees (now "magistrates") retained the authority to order either inpatient or outpatient evaluations, inpatient evaluations ordered on or after that date would be billed to the county and outpatient evaluations would continue to be provided by the same local agencies and reimbursed by the TDMHSAS. This resulted in a dramatic change in the pattern of usage, demonstrated in Table 49, below, showing the monthly frequency of inpatient and outpatient juvenile court-ordered evaluations for the ten month period around the Court of Appeals decision, April 2008-January 2009[5].

Table 49: Inpatient and Outpatient Juvenile Court Ordered Evaluations



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

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

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

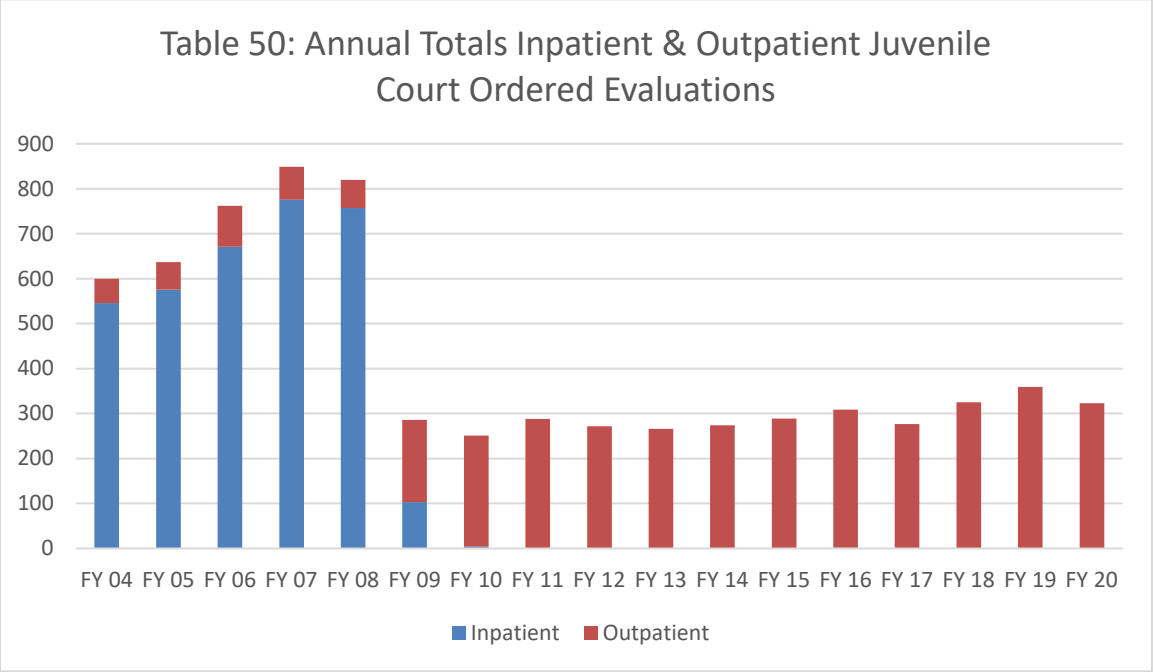


Table 51: Frequency of Outpatient Juvenile Evaluations by Provider

CMHA	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20
Centerstone	5	14	23	16	23	42	43	32	46	35	23	40	40
Cherokee	11	20	24	15	20	8	10	8	10	7	14	17	9
Frontier	5	5	9	3	11	7	9	11	8	10	8	4	6
McNabb	0	2	1	1	1	0	0	0	0	0	1	3	0
Pathways	5	43	79	88	70	79	77	53	75	70	93	67	59
Ridgeview	4	2	2	1	3	2	6	2	3	4	2	3	4
Vanderbilt	9	44	41	43	40	32	33	30	19	20	41	26	17
Volunteer	15	47	68	116	102	87	82	116	96	86	109	164	147
WTFS/Midtown	9	6	0	5	2	9	14	37	51	45	34	35	41
Total	63	183	247	288	272	266	274	289	308	277	325	359	323

Tables 52 shows sex offenses to be the most frequent type of offense for a youth subject to a court-ordered evaluation.

Table 52: Type of Offenses Inpatient and Outpatient Juvenile Evaluations

	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Violent Felony (not Sex Offense)	43% (124)	40% (110)	41% (110)	43% (120)	39% (114)	40% (124)	44% (122)	44% (143)	29% (105)	31% (103)
Sex Offense	39% (115)	43% (118)	44% (118)	44% (121)	42% (122)	43% (133)	40% (112)	33% (108)	47% (169)	41% (134)
Non-Violent Felony	15% (45)	15% (43)	14% (38)	12% (33)	18% (53)	16% (51)	15% (43)	22% (73)	23% (85)	26% (84)

Table 53 indicates the frequency with which specific forensic issues were requested by juvenile courts in evaluation orders. Please note that a single evaluation may include multiple requests (e.g. psychosexual and competency to stand trial).

Table 53: Rate of Specific Forensic Requests (Outpatient and Inpatient FY 08-16)

	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Competency	240 (87%)	219 (88%)	244 (85%)	206 (76%)	212 (80%)	223 (81%)	235 (80%)	245 (78%)	228 (82%)	254 (78%)	245 (67%)	232 (71%)
Mental Condition at the Time of the Crime	170 (61%)	99 (40%)	95 (33%)	104 (38%)	100 (38%)	115 (42%)	127 (43%)	128 (39%)	117 (42%)	131 (40%)	137 (37%)	122 (37%)
Psychosexual	71 (26%)	72 (29%)	110 (38%)	99 (36%)	111 (42%)	111 (40%)	109 (37%)	121 (39%)	107 (38%)	92 (28%)	160 (44%)	119 (36%)

Just under one fourth (22%) of all juvenile court ordered mental health evaluations were for youth ages 13-14. The frequency of evaluations for youth ages 15-18 was 67%, making 89% of evaluations for youth ages 13 and above.

Table 54: Age Range for Outpatient Juvenile Evaluations

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

Tennessee Integrated Court Screening and Referral Project

In September 2009, the TDMHSAS and the Administrative Office of the Courts (AOC) were awarded a Criminal Justice/Mental Health Collaboration Grant by the Bureau of Justice Assistance to implement a process of conducting mental health and substance abuse screenings on youth referred to juvenile courts as unruly or delinquent. A two-and-a-half year grant (October 1, 2009-March 31, 2012) in the amount of $196,750 was extended through March 31 of 2013. The project was intended to improve access to mental health and substance abuse services for youth in juvenile court, increasing the opportunities for diversion from the juvenile justice system and reducing recidivism. The project trains juvenile court staff, typically the courts' youth service officers (YSOs), to complete a 33-item juvenile justice screening version of the Child and Adolescent Needs and Strengths inventory (JJ-CANS) on youth at the point of intake into juvenile court for youth alleged to be unruly or delinquent (this instrument has been subsequently revised to a JJ-CANS 2.0 version; see p. 50, below).

The JJ-CANS is an evidence-based screening practice on which each individual item identifies a need and the screener rates the level of urgency on a four-point scale (0-3) for an action to address the need from "none" to "immediate." Items scored 2 or 3 are considered "actionable items" when analyzing results (as in Table 56, below). During the initial implementation of the project, youth who appeared to need mental health, substance abuse, or family services (including crisis services) were referred by the Department of Children's Services (DCS) court liaisons to locally available services. The original grant task force included DCS, the Vanderbilt University Center of Excellence (VUCOE), Tennessee Voices for Children, and the Tennessee Commission on Children and Youth along with the TDMHSAS and the AOC.

The pilot project began with 12 courts in 11 counties: Dickson, Marion, Sevier, Madison, Macon, McNairy, Morgan, Obion, Hawkins, Lawrence and Washington (which includes both Washington County Juvenile Court and Johnson City Juvenile Court). Local task force meetings were held in each county in June and July of 2010 and JJ-CANS training was completed in all the pilot courts so that screenings began August 1, 2010. These services were supported by a second and third round Transfer Transformation Initiative grant.

Three of the counties were selected to pilot an additional family support service and test the usefulness of this service with this population: the TDMHSAS contracted with Tennessee Voices for Children (TVC) beginning in FY 11 for Family Service Providers (FSP) to assist children and families in navigating the mental health and substance abuse services system to help insure that referrals result in actual contact with a service provider (Dickson, Macon, and Madison counties). FSPs are self-identified caregivers of children who have been involved in mental health and/or substance abuse services. The FSPs completed a certification process through TDMHSAS. Examples of the wide variety of support provided by FSPs:

- ✓ Arranging a meeting with school staff and interpreter to insure that materials sent home about opportunities for activities and other communications are provided in Spanish in accordance with federal regulations;
- ✓ Coordinating in-home services for youth with aggressive behavior to insure that the service provider was able to complete intake and implement services around the mother's medical treatments (family likely would have dropped out without coordination);
- ✓ Supporting family to follow through with school to develop Behavioral Intervention Plan for youth referred by juvenile court;
- ✓ Completing Family Caregiver Stress questionnaire and a User Satisfaction Survey for families using FSP services as part of the project.

Project Expansion:

By the end of FY 17, YSOs from 33 juvenile courts[6] had completed training and certification for the JJ-CANS. In Shelby County, clinicians from the providers Camelot, Alliance, and the Family Institute of Tennessee were trained in FY 16. These clinicians completed the screenings on youth in Shelby County Juvenile Court as part of the Tennessee Mental Health-Juvenile Justice Policy Academy Action Network funded by a grant from the MacArthur Foundation to Shelby County. This was a time-limited project and the providers did not continue to conduct screenings for Shelby County Juvenile Courts beyond March 31, 2016.

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

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

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

The algorithm for combining 11 items of information into a juvenile justice risk score was derived from a sample of youth who had been scored on the CANS and rated for risk of re-offense using the Youth Level of Services Inventory (YLS[7]). The JJ-CANS 2.0 risk algorithm has face validity in that it contains the same 8-12 factors widely found to be associated with the risk of re-offense in youth[8] and concurrent validity in producing the same high-medium-low rating as the much longer YLS. The AOC, Vanderbilt University COE, TDMHSAS and the Madison County Juvenile Court are currently working on a design for predictive validity.

In the 2018 legislative session, the Tennessee General Assembly passed the Juvenile Justice Reform Act (Public Chapter 1052), a comprehensive package of reforms to the juvenile justice process with 58 sections, amending 22 existing statutes and creating six new ones. One such new statute, T.C.A. §37-1-164, requires that a validated risk and needs assessment shall be used in all delinquent cases post disposition in making decisions and recommendations concerning treatment and programming. Four other new statutes require that service plans for youth in juvenile court be "consistent with previously administered risk and needs assessment" (see T.C.A.§§37-1-129(a), -131(a)(2)(A), -137(f), and -173). The JJ-CANS 2.0 meets all the statutory requirements (see T.C.A. §37-1-102(b) for definition) for this process at no additional

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

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

cost to the courts, so a significant expansion of TICSRP began in FY 19 and continued in FY 20. The number of courts with at least one staff member certified in JJ-CANS scoring increased from 33 in FY 18 to 86 by the end of FY 20, with over 700 juvenile court staff certified on the JJ-CANS 2.0. This expansion is expected to continue.

A de-identified data extract from the AOC was analyzed by Kelly Hill, MTS, M.Ed. of the Vanderbilt University Center of Excellence, including data for Tables 55-57, below. The original version of the JJ-CANS was phased out in FY 19 so all screenings in FY 20 were conducted using the JJ-CANS 2.0. There were 2,290 screenings conducted state-wide in FY 20, compared to 1,695 screenings in FY 19 (combined 69 with JJ-CANS 1.0 and 1,626 with JJ-CANS 2.0). The 2,290 screenings in FY 20 brings the grand total to 11,943 screenings conducted since October 2010.

As with court-ordered evaluations for "adult" courts (i.e. general sessions, circuit, and criminal courts), the frequency of evaluations was impacted by courts and schools closing or slowing business due to the pandemic, particularly in April and May (see Table 2, p. 4 and Table 13, p. 15, above). Table 55 shows month-by-month totals for FY 20.

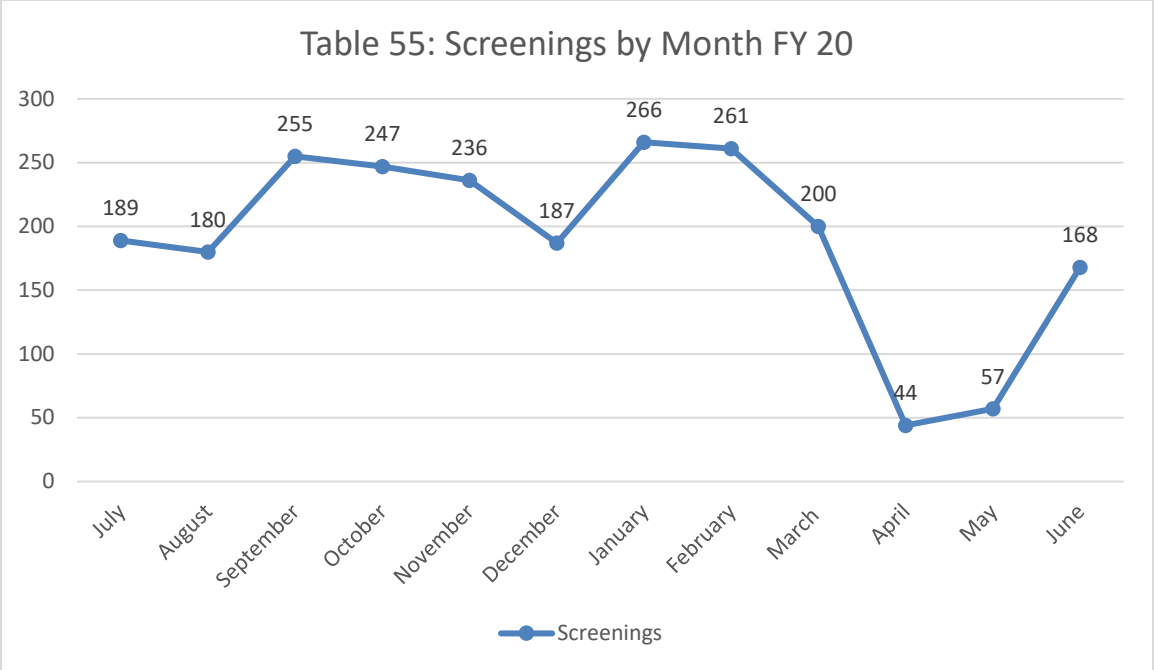


Table 56: TICSRP JJ-CANS Demographics FY 19

Age Category	
16 to 18	61%
13 to 15	34%
9 to 12	5%
Gender	
F	32%
M	68%
Race	
African American	33%
Caucasian	57%
Other	10%
Offense Type	
Non-Violent	66%
Violent	34%

Table 57 shows the frequency of ratings of the automatically-generated ratings of Juvenile Justice Risk (re-offense) the distribution of the number of trauma items coded "yes."

Table 57: TICSRP JJ-CANS Risk Ratings

Juvenile Justice Risk	
Low	85%
Medium	14%
High	0.3%
# Trauma Experiences	
None	24%
1 - 3	42%
4 - 6	20%
7 - 9	5%
Comm Sex Exploit Risk	
Low	92%
Medium	7%
High	1%

Implementation of the Juvenile Justice Reform Act was delayed due to the pandemic, but training and certification on the JJ-CANS 2.0 had been provided via Zoom meetings for months before the pandemic to provide access to YSOs all across the state. Sessions have been held approximately every other month and include YSOs getting re-certified annually as well as first-time trainees, for a total of 50-70 participants at each training. The next phase of implementation will be to improve the use of JJ-CANS scores in the development of service plans, including the use of the Community Risk score for determining level of supervised probation and other scores for identifying service needs.

Mandatory Outpatient Treatment (MOT)

The annual report concerning Mandatory Outpatient Treatment (MOT) was prepared by Debbie Wynn, L.C.S.W., TDMHSAS MOT Coordinator. Her full report is posted elsewhere on the Forensics page of the TDMHSAS website (https://www.tn.gov/behavioral-health/mental-health---substance-abuse-law/mental-health---substance-abuse-law/forensic---juvenile-court-services-1.html). This section provides a summary of that report.

Mandatory Outpatient Treatment (MOT) refers to a legal obligation for a person to participate in outpatient treatment. The purpose of MOT is to provide a less restrictive alternative to inpatient care for service recipients with a mental illness who require continued treatment to prevent deterioration in their mental condition and who will respond to a legal obligation to participate in outpatient treatment. There are three main types of MOT in Tennessee law, one in Title 33, Chapter 6, Part 6 (the requirements for which are defined in T.C.A. § 33-6-602), one in T.C.A. § 33-7-303(b), and one in T.C.A. § 33-7-303(g). Differences are summarized in Table 54, below:

Table 58: Three Types of MOT

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

Table 59: Total MOTs
June 30, 2020

Type of MOT	Active MOTs	Suspended MOTs Due to Hospitalization	Total MOTs
303b	94	4	98
303g	5	1	6
602	226	22	248
Both 303b and 602	2	0	2
Totals	327	27	**354**

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

In FY 20 there were 179 forensic patients on MOT (51%) and 175 non-forensic patients on MOT (49%). In FY 19 there were 107 forensic patients on MOT (30%) and 248 non-forensic patients on MOT (70%). In FY 18 there were 165 forensic cases on MOT and 168 non-forensic cases on MOT. Many of the non-forensic MOTs were originally forensic cases in the RMHIs under 33-7-301(b) but had their charges retired prior to discharge and so were no longer pre-trial criminal defendants.

New MOT Cases

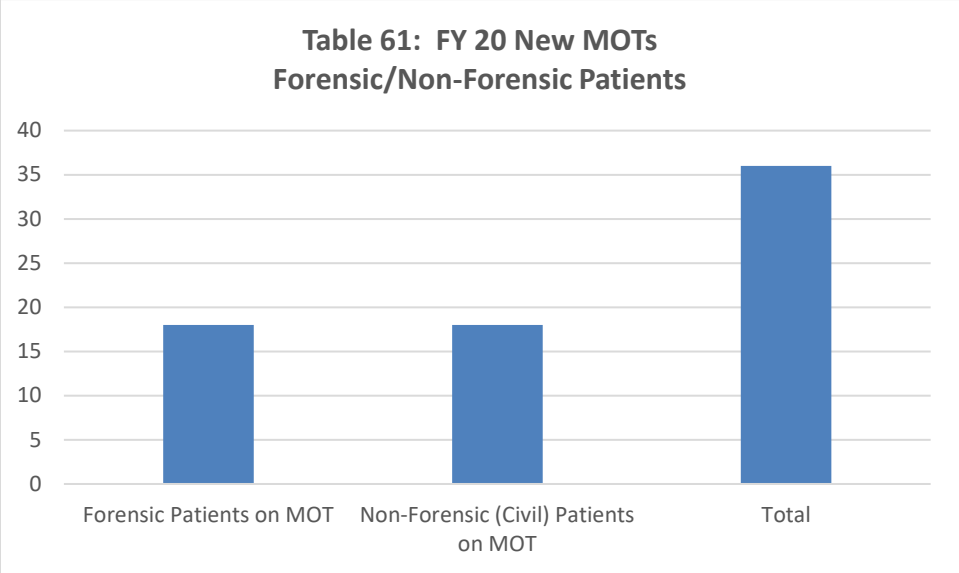
In FY 2020, 36 new MOT cases were initiated. Of these cases, 30 were initiated under TCA § 33-6-602, three were initiated under TCA § 33-7-303(b) and three were initiated under T.C.A. § 33-7-303(g). This was a decrease from FY 2019 in which 45 new MOT cases were

initiated. Of the new FY 19 cases, 41 were initiated under TCA § 33-6-602, two were initiated under TCA § 33-7-303(b) and two were initiated under T.C.A. § 33-7-303(g). That was an increase from FY 18 in which 30 new MOT cases were initiated and more consistent with FY 17 in which 41 new MOT cases were initiated. The four-year range of new cases per year has been 30-45.

Table 60: FY 2020 Added MOTs by Month

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTALS
Added Total	4	5	4	2	5	2	4	5	1	0	2	2	36
303b	1	0	0	0	0	0	1	1	0	0	0	0	3
303g	0	2	0	0	1	0	0	0	0	0	0	0	3
602	3	3	4	2	4	2	3	4	1	0	2	2	30

TCA § 33-6-602 patients may have been in either forensic or non-forensic legal status, whereas all TCA § 33-7-303(b) and 303(g) MOTs are considered forensic patients having been found NGRI on a criminal offense. Eighteen of the FY 20 new MOT cases had non-forensic legal statuses and 18 had forensic legal statuses. The breakout by month, above, shows releases slowed during the last three months as movement was restricted due to the pandemic.



Twenty-one of the 36 new MOT consumers had legal charges that originated in Shelby County. Four had legal charges that originated in Davidson and four in Madison County. Hamilton, Henderson, Hickman, Lewis, Robertson, Rutherford, and Sumner Counties had one each.

Terminations

In FY 2020, there were 36 MOT consumers whose MOT services were terminated. Five of these were terminated due to the death of the consumer (due to natural causes). Twenty-nine others had their MOT terminated by decision of the MOT agency's Treatment Team or by court order. Two of the consumers had MOTs that were not renewed by their MOT agencies, so their MOT was allowed to lapse. Three of the 31 consumers whose MOT were terminated or lapsed received MOT services under the auspices of T.C.A. § 33-7-303(b), and 28 received MOT services under the auspices of T.C.A. § 33-6-602.

The length of MOT service for all 36 consumers whose MOT was terminated for whatever reason is displayed below:

Table 62: FY 2020 MOT Terminations
By Number of Years on MOT at Time of Termination

0 – 1 Year	1 – 2 Years	2 – 5 Years	5 – 10 Years	10 + Years
4	5	8	11	8

The most common reason for a MOT to be terminated was that the person had successfully adjusted to the community and no longer needed MOT. Seventeen individuals were doing well on their MOT and no longer needed a legal obligation under MOT to remain compliant. Five individuals moved out of the service area of their MOT agency. Three individuals had their MOT terminated subsequent to being incarcerated on new legal charges. Three consumers entered nursing homes. One of the consumers was not compliant even with a MOT obligation, so the agency chose to terminate his contract based on his lack of compliance.

One MOT was terminated by court order, and one MOT was terminated after the consumer eloped and could not be located. As mentioned earlier, five individuals were deceased.

Table 63: FY 2020 MOT Terminations

By Reason

MOT no longer necessary for compliance	Moved out of state or out of service area	Incarcerated with new legal charges	Entered nursing home	Not compliant even with a legal obligation	Terminated by court order	Terminated following elopement of consumer	Deceased
17 (47%)	5 (14%)	3(8%)	3 (8%)	1 (3%)	1 (3%)	1 (3%)	5 (14%)

Affidavits of Non-Compliance

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

A wide range of differing outcomes can result following the filing of an affidavit of non-compliance. A previously non-compliant consumer may become compliant upon learning of the potential court hearing. If they meet commitment criteria they may be admitted on an emergency basis to a private or a state hospital. If they are receiving MOT services under the auspices of T.C.A. § 33-6-602, the court may order that they be re-admitted to the hospital of their original commitment after a hearing on the affidavit. If they are receiving MOT services under the auspices of T.C.A. 33-7-303(b) the court may order civil or criminal contempt charges.

During FY 2020, a total of 42 new Affidavits of Non-Compliance were filed, however one individual had affidavits filed twice, so 41 individuals were involved. There was an average of 357 individuals on MOT at any one point during FY 20; 41 individuals with non-compliance affidavits is 12% of the total. The majority of the non-compliant MOT consumers had legal charges that originated in Shelby County, which also had 54% of the total number of MOTs.

The majority of the non-compliant MOT consumers had legal charges that originated in Shelby County, which also had 54% of the total number of MOTs.

Table 64: FY 19 Outcome of Non-Compliance Affidavit

Hospitalized for non-compliance or as emergency	15
Awaiting non-compliance hearing	10
MOT terminated by court or by agency	8
Deceased	3
Consumer became compliant prior to court hearing	2
Warrant issued when consumer did not appear for hearing	2
Referred for forensic evaluation under T.C.A. § 33-7-301(a)	2
Total	**42**

Types of Original Legal Charges by Frequency

Table 65 on the following page shows the different types of criminal offenses that MOT consumers were charged with associated with the process that led to them being placed on MOT. As described above, patients committed to an RMHI under Title 33, Chapter 6, Part 5 may not have had any criminal charges associated with the hospitalization prior to their release on MOT under T.C.A. § 33-6-602. Those consumers are categorized in Table 65 as "none." Patients with multiple charges are only counted once under the most serious charge.

Table 65: FY 2020 Types of Original Legal Charges by Frequency

Charge(s)	Number of Occurrences
Aggravated Assault (felony)	97
None	64
Simple Assault (misdemeanor)	48
Vandalism/Trespassing/Nuisance	28
Theft	28
Murder	19
Attempted Murder	17
Sex Offense	15
Arson	9
Weapons Offenses	9
Escape/Failure to Comply/Obstruction of Justice	6
Robbery	5
Obstruction of Justice	5
Kidnapping	4
Total	**354**

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

Effective 7/1/2017 legislation took effect which requires persons found not guilty by reason of insanity (NGRI) of a charge of first degree murder or a Class A felony under Title 39, Chapter 13, to participate in mandatory outpatient treatment (MOT) when discharged from the hospital or released by the court following the outpatient evaluation under T.C.A. § 33-7-303(a) who are not committable to a hospital. This legislation mandates that any person ordered by the trial court to participate in outpatient treatment must do so for an initial period of six months. The court may continue the MOT beyond the initial six-month period. After the initial six-month period the court shall review the person's need for continued MOT on an annual basis.

The Legislature appropriated some funds for FY 20 to pay for MOT services for persons on MOT under the new law who do not have insurance or income to meet their treatment or housing needs. During FY 20 three consumers were discharged under the new law, bringing the

total number of persons on MOT under the auspices of T.C.A. § 33-7-303(g) to six. At this point other resources have been available to meet the treatment and housing needs of these consumers.

Forensic Services Financial Report

Outpatient Services

Outpatient services are reimbursed on a fee-for-service basis. Table 66 reflects the reimbursements for outpatient adult and juvenile evaluation and treatment services by provider. Reimbursement rates for evaluations were increased in FY 17 from $300 per evaluation of competency to stand trial and $300 per evaluation of mental capacity at the time of the crime (i.e. $600 for both issues) to $400 per each evaluation (i.e. $800 for both questions). Reimbursement for the required elements of a juvenile court-ordered evaluation was also increased, though the reimbursement for additional elements such as competency to stand trial was decreased. Services other than direct forensic evaluation include competency training sessions, additional testing necessary to complete evaluations on an outpatient basis and physician visits, all of which are intended to help reduce the need for inpatient referrals. Reimbursement rates for these services remained unchanged. Adult and juvenile outpatient services are counted together. Each provider submits a monthly invoice with documentation on each case. The TDMHSAS forensic specialists check each case for proper documentation that the appropriate service was provided and authorizes payment on those cases with adequate documentation. Denial of payment for a case is rare.

Table 66: Outpatient Expenditures, Adult and Juvenile Services

	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Centerstone	$131,300	$152,100	$149,650	$156,750	$193,350	$177,850
Cherokee Health Systems	$63,000	$60,500	$88,550	$98,600	$106,250	$88,550
Frontier Health, Inc.	$85,700	$100,250	$118,000	$113,850	$119,200	$113,300
Helen Ross McNabb	$42,050	$43,500	$71,800	$69,000	$72,950	$61,200
Pathways	$189,400	$208,300	$260,800	$308,700	$280,800	$256,100
Ridgeview	$24,800	$34,500	$63,250	$64,755	$57,650	$69,750
Vanderbilt	$117,550	$125,300	$184,450	$253,450	$297,450	$318,800
Volunteer	$325,600	$321,750	$338,850	$366,700	$418,450	$387,350
WTFS	$429,250	$449,650	$497,600	$543,350	$609,350	$561,750
TOTAL	$1,408,650	$1,495,850	$1,772,950	$1,966,700	$2,155,450	$2,034,650

Inpatient Services

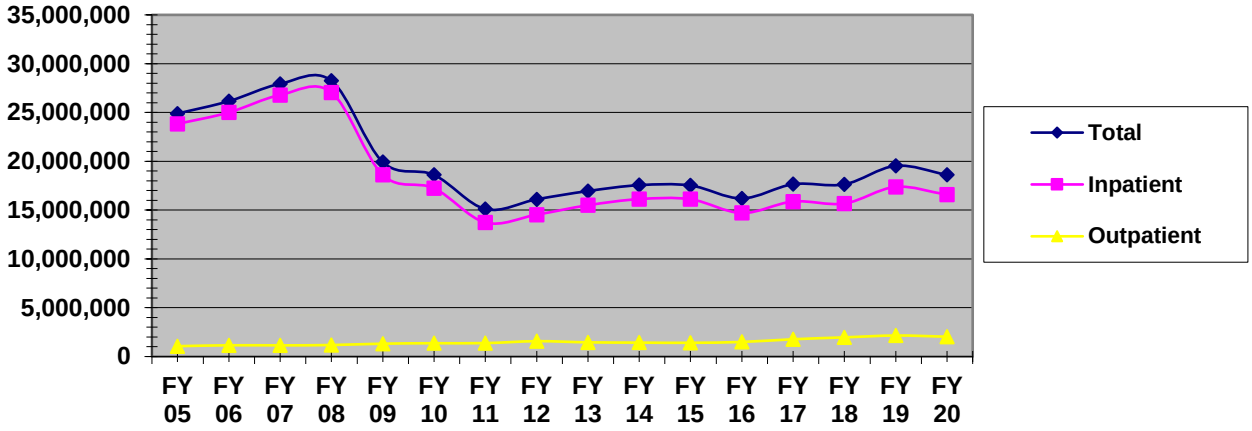
The Regional Mental Health Institutes are reimbursed by the Office of Forensic Services for forensic services at the rate of $450 per day. Documentation is required from the facilities to allow the TDMHSAS forensic specialists to authorize payment. This helps insure that proper procedures are followed in forensic cases and that patients stay only as long as necessary. Documentation is submitted by the facilities on an ongoing basis for active cases, and the invoices are reconciled at the end of each month. A facility would not be reimbursed, for instance, for the days that a patient was on leave in the community and not actually at the facility. The notable increases at Western Mental Health Institute (WMHI) in FY 15 and FY 16 in Table 67 reflect the shift of long-term forensic commitments to that facility (see pp. 33-34, above). The overall decrease from FY 15 to FY 16 and increase from FY 16 to FY 17 are due to multiple factors, the largest single factor being the frequency of commitments under T.C.A. § 33-7-301(b) (see p.25, above).

Table 67: Inpatient Forensic State Expenditures

	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
MBMHI	$2,258,100	$2,150,100	$1,226,250	$1,174,500	$1,715,400	$2,525,850	$2,510,100	$2,356,200
MMHI	$539,100	$563,850	$564,750	$558,900	$634,950	$666,450	$882,900	$634,500
MTMHI	$8,771,400	$8,689,500	$7,380,450	$4,782,150	$5,944,050	$5,539,950	$5,819,400	$6,523,200
WMHI	$3,931,650	$4,725,900	$6,942,600	$8,190,000	$7,587,000	$6,944,400	$8,169,300	$2,065,450
TOTAL	$15,500,250	$16,129,350	$16,114,050	$14,703,750	$15,881,400	$15,676,650	$17,381,700	$16,579,350

Combining total inpatient expenditures with outpatient expenditures over the last five years shows a significant decrease between FY 08 and FY 09 when the change in payment for juvenile inpatient evaluations occurred. Notable declines can be seen in FY 10 and FY 11 following the changes in billing for misdemeanor-only evaluations (see p. 14, above) and the change in evaluations of NGRIs under T.C.A. § 33-7-303(a) from inpatient to outpatient. The lowest point in expenditures was FY 11, which was a 47% decrease from the peak in FY 08.

Table 68: Overall Forensic Expenditure Trend



Misdemeanor Billing:

At the beginning of FY 10 (July 1, 2009), T.C.A. § 33-7-304 (actually signed into law June 26, 2009) made counties responsible for the cost of forensic evaluation and treatment services ordered under Title 33, Chapter 7, Part 3 for cases in which the defendant was charged only with a misdemeanor. TDMHSAS bills counties for outpatient services for misdemeanor cases the same amount that outpatient providers are reimbursed. Inpatient services are billed to the counties directly by the RMHIs at the *per diem* rate at $450 for all counties regardless of which RMHI provides the services. This rate is established by contract between TDMHSAS and each county. It is consistent with reimbursement rates from most third-party payers, it provides consistency for all counties across the state, and is in fact a reduction of the "private pay" rate established under T.C.A. § 33-2-1101 which varies across facilities.

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

Table 69: Outpatient Misdemeanor Billing July 1, 2009-June 30, 2020

	Billed
FY 10	$150,900
FY 11	$257,900
FY 12	$263,300
FY 13	$249,000
FY 14	$250,200
FY 15	$194,300
FY 16	$217,400
FY 17	$234,700*
FY 18	$322,000
FY 19	$307,000
FY 20	$333,600
Total	**$2,780,300**

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

Shelby County billing ($124,100) accounted for 33% of billing in FY 20, down from 44% in FY 19 in large part because Davidson County's billing has steadily increased. Davidson County's FY 20 outpatient total of $108,600 accounted for another 33% of the total FY 20 billing. Davidson County had averaged $4,050 per year FY 13-16, and then was billed $34,400 in FY 17 (which would have been $25,800 under the previous $600-per-evaluation rate). $70,300 in FY 18, and $92,500 in FY 19, showing an increased willingness to bear the cost of outpatient evaluation of misdemeanor defendants.

Table 70: Inpatient Misdemeanor Services Billing

	Billed
FY 10	$985,150
FY 11	$918,450
FY 12	$1,776,150
FY 13	$997,100
FY 14	$702,450
FY 15	$1,019,250
FY 16	$959,400
FY 17	$1,306,350
FY 18	$1,340,100
FY 19	$1,044,900
FY 20	$904,500
Total	**$11,953,800**

Forensic Targeted Transitional (TTS) Funds:

Forensic TTS funds are used primarily as "bridge" funding to help forensic patients in RMHIs be discharged to the community and to stay in the community longer. Disability benefits are typically discontinued for most forensic patients during the period after their arrest while they are incarcerated during the criminal justice process. For those eventually found not guilty by reason of insanity and committed to an RMHI, benefits may not start again until an administrative process to confirm eligibility is completed after their discharge to the community. Forensic TTS funds are used to pay for housing and treatment services until benefits are restored, and are used primarily to support patients who had been found Not Guilty by Reason of Insanity and committed to an RMHI. Defendants found incompetent to stand trial and committable to an RMHI who are on bond and returning to the community rather than to jail when no longer committable are also eligible for forensic TTS funds, though this is rare.

In FY 20, $335,731.59 was spent which was 61% of the funds available for direct services from the grant ($551,000). Housing support accounted for over 90% of expenditures, with smaller expenditures for mental health services, and necessities such as clothing, eyeglasses, and utilities. The effects of a slow down in furloughs and discharges of long-term patients due to the pandemic was evident with monthly expenditures in April, May, and June being nearly half of the monthly expenditures in the previous July and August.

Conclusions and Recommendations

1. The coronavirus pandemic impacted forensic services in several ways. Courts slowed or eliminated in-person activity in mid-to-late March 2020, though orders for forensic evaluations never stopped entirely. Jails limited or eliminated in-person visitation and transport for community evaluation appointments, creating barriers for access to defendants to conduct court-ordered evaluations. Agencies contracted to conduct forensic evaluations limited or eliminated face-to-face services and increased the use of tele-health where available. These changes were made at different times and to different degrees across the state, further complicating the process. Central Office staff began working from home in mid-March. The Regional Mental Health Institutes took measures to lower their census to allow for isolation when needed and to reduce the risk of

infection. Testing procedures were developed and protective gear acquired. Admissions for forensic evaluations were paused or slowed at all the facilities by the first of April and resumed at different paces and on different dates in May, depending on each facility's ability to minimize the rate of infection and risk of transmission. The lists of cases referred for inpatient evaluation grew substantially in April, May, and June and remained longer at the end of the fiscal year than they had been for many years. Procedures for safely conducting forensic evaluation and treatment have gradually been developed, but routines have been disrupted so that providing forensic services was significantly more time and effort-intensive than prior to the pandemic. Courts and jails have been generally understanding of the limitations in providing forensic evaluation and treatment services. *Recommendations: The increased use of tele-health should continue even beyond any practical end to the coronavirus pandemic for the time and travel saved. Defendants ordered for inpatient evaluation whose admission has been delayed should be encouraged to take prescribed medication in the community and re-evaluated by the community evaluators for the need for inpatient services. Mobile crisis teams should continue to respond to jails for defendants that may need to be hospitalized on an emergency basis. Once the RMHIs are able to resume admissions at the rate previous to the pandemic and manage an increased census, all available resources should be used to assist the facilities with the longest referral lists.*

2. The basic features of Tennessee's current forensic mental health system include using outpatient, community-based services whenever possible and using inpatient services only after outpatient services have been attempted. This approach has been in place since the underlying statutes became law in 1974. There have been some changes in law and in policy and procedure since then, but the foundation remains unchanged. The combination of the Tennessee mental health statutes, the TDMHSAS system for training and monitoring evaluators, and the expertise of the providers results in a highly effective screening and diversion of adult criminal defendants from RMHI bed usage while providing quality evaluations for the courts: for FY 20, 2,045 initial outpatient evaluations diverted 76% of that population from the need for an inpatient evaluation. There were 489 inpatient evaluations under T.C.A. § 33-7-301(a) with recommendations for commitment for further inpatient evaluation and treatment at a rate of 14% state-wide.

That is a rate of 3% of the pool of 2,045 total outpatient evaluations resulting in a recommendation for long-term commitment for inpatient evaluation and treatment (see Table 30, p. 28). There were 33 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) with 16 recommending commitment to an RMHI under T.C.A. § 33-7-303(c) (48%).

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

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

3. Over the past five fiscal years, about half of all defendants committed under T.C.A. § 33-7-301(b) as incompetent to stand trial and meeting judicial commitment criteria had their charges retired during the commitment (it was 53% in FY 20). This pattern supports conclusion #1, above, that defendants who may be competent or restored to competence are screened out by the requirement for outpatient evaluation prior to inpatient evaluation, and then an inpatient evaluation limited to 30 days (during which defendants receive treatment which restores between two-thirds and three-fourths of those defendants to trial competence).

   Recommendations: Additional attention should be paid to early intervention and criminal justice diversion services in Shelby County due to the large number of people who enter the mental health service system through the criminal justice system in that jurisdiction. Defendants whose charges are retired and remained committed to an RMHI under Title 33, Chapter 6, Part 5 would likely be good candidates for The Move Initiative (TMI), a program established by the Division of Mental Health Services in FY 17 to provide additional support for transition from the RMHIs to the community for patients with significant barriers to discharge. Patients who were admitted to the RMHI as a pre-trial defendant and then had their charges retired are likely to have significant barriers to discharge having been incarcerated prior to admission to the RMHI and may not have a ready network of benefits and community resources in place. Forensic staff in the

facilities should support the inclusion of forensic patients and patients whose charges have been retired in TMI referrals for resources to overcome barriers to discharge. The Office of Forensic Services should coordinate with the Division of Hospital Services in assisting facilities to return defendants committed under T.C.A. § 33-7-301(b) to court and to discharge those whose charges have been retired to the community.

4. Over the past five fiscal years, WMHI has admitted 55% of all new defendants committed under T.C.A. § 33-7-301(b). During the same period, WMHI and MMHI (whose -301(b) cases go to WMHI) conducted only 36% of all inpatient evaluations under T.C.A. § 33-7-301(a). In FY 20 alone, WMHI admitted 68% of all new cases under T.C.A. § 33-7-301(b) while WMHI and MMHI conducted only 36% of initial inpatient evaluations (in FY 19, WMHI admitted 73% of all new cases under T.C.A. § 33-7-301(b) while WMHI and MMHI conducted only 37% of initial inpatient evaluations). WMHI and MMHI both tend to find a lower percentage of defendants competent at the end of the -301(a) evaluation and have a higher rate of recommendations for commitment. Table 45 (p. 41) shows a much larger accumulation of defendants committed under T.C.A. § 33-7-301(b) at WMHI than other facilities.
   Data specific to the length of stay of incompetent defendants should be presented to WMHI forensic staff and clinical leadership and updated training on competency and committability standards should be provided due to staff turnover. The use of tele-video for case conferences with staff from all facilities participating should be explored to help address regional differences in practices around restoration of incompetent defendants.
5. RMHIs that serve the localities in which defendants are found Not Guilty by Reason of Insanity and committed for inpatient treatment are in the best position to develop an aftercare plan and discharge acquittees to the community. Tables 43 (above, p. 39) and 44 (p. 40) show how the census at WMHI began a steady increase after all newly committed NGRI patients were admitted there from all over the state until 15 patients were transferred to MTMHI in October of 2016 and each RMHI resumed admitting NGRI patients from their catchment area. Those tables show MTMHI's census going up in October 2016 in response to the transfer, but then starting back down as they were able to discharge forensic patients in their catchment area where MTMHI staff were familiar with available services.

Forensic patients who must be hospitalized and who do not need maximum security should be admitted to the same RMHI which serves involuntary civil commitments through the crisis teams in that region. Keeping a person as close to their community as possible can minimize the length of stay.

6. Mandatory Outpatient Treatment (MOT) appears to be a useful less drastic alternative to hospitalization that helps patients return to and stay in the community. The most common cause for termination of MOT is that the person no longer requires MOT to remain compliant with treatment (Table 63, p. 59) and only 12% of all MOT clients (41 of 357) had compliance problems significant enough for affidavits of non-compliance to be filed and not withdrawn after attempts to bring the client back into compliance.
   The MOT Coordinator should continue to seek opportunities to provide MOT training and support to community agencies to facilitate the use of MOT when appropriate.