Forensic And Juvenile Court Services Annual Report for the Period July 1, 2017-June 30, 2018 (FY 18)

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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 Forensic Annual Report FY 18

- In Fiscal Year 2018 (FY 18), the frequency of pre-trial outpatient forensic mental health evaluations (2,005) rebounded to the ten-year average (~2,000) after the lowest total (1,801) in FY 17 since FY 1999 (1,765).
- 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 18, 2,005 initial outpatient evaluations diverted 76% of that population from the need for an inpatient evaluation.
- There were 512 inpatient evaluations under T.C.A. § 33-7-301(a) with recommendations for commitment for further inpatient evaluation and treatment at a rate of 21% state-wide. That is a rate of 4.5% of the pool of 2,005 total outpatient evaluations resulting in a recommendation for long-term commitment for inpatient evaluation and competency restoration.
- Of those cases referred for inpatient evaluations, 91% were completed in the Regional Mental Health Institutes and only 9% were admitted to the maximum security unit.
- There were 32 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) with 12 recommending commitment to an RMHI under T.C.A. § 33-7-303(c) (37%). During FY 18, forensic cases occupied 18%-23% of state facility beds.
- Mandatory Outpatient Treatment (MOT) coordination and monitoring has improved the timely renewal and review of MOT plans and follow-up with non-compliance proceedings. Data collected routinely during the process has provided accurate and current information on active MOTs, levels of compliance with MOT plans, and patterns in the initiation and termination of MOT plans. There were 333 patients on MOT at the close of FY 18, 165 of which were forensic patients (50%).
- The forensic census at the end of FY 18 (122) was slightly higher than the start (115), but still only 23% of the total RMHI population (530).
- The frequency of juvenile court-ordered forensic evaluations (325) in FY 18 was the largest one-year total: the range of the last six fiscal years was 247-308.
- The JJ-CANS screening instrument was revised to include a risk assessment consistent with the requirements of the Juvenile Justice Reform Act of 2018.

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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. Agencies have maintained 95% compliance or better with the standards, and no plans of correction were necessary in FY 18.

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").

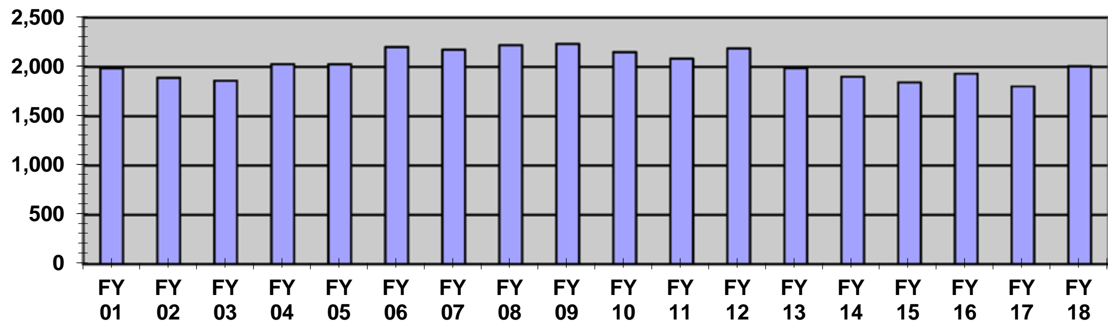
Court-ordered forensic mental health evaluation and treatment are not considered medically necessary procedures which are paid for by public or private insurance like an intake assessment at a mental health clinic or doctor's office. Forensic services are funded directly by the state budget with few 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 2018, from July 1, 2017 to June 30, 2018, along with the trends over previous years.

Outpatient Evaluations and Services for Pre-Trial Defendants

T.C.A. § 33-7-301(a) directs that court-ordered evaluation of a criminal defendant's competence to stand trial and/or mental capacity at the time of the offense be conducted by a community mental 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 2018 (FY 18), 2,005 outpatient evaluations were conducted, which is consistent with the average of 2,028 for the previous 17 years.

Table 1: State-wide Frequency of Adult Outpatient Pre-trial Evaluations



As described above, TDMHSAS has contracts with nine different community agencies to cover all the courts for outpatient forensic services. Table 2, on the following page, shows the community agency assigned to each county.

Table 2: County Distribution by Outpatient Forensic Services Provider

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

Table 3, on the following page, breaks out the total 2,005 adult outpatient evaluations into frequencies for each provider, displaying the same breakout for the previous 10 fiscal years for comparison.

Table 3: Frequency of Outpatient Evaluations by Provider

Provider	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Centerstone	138	167	175	166	168	129	121	137	143	128	155
Cherokee	151	148	133	113	121	99	97	90	79	100	104
Frontier	162	159	132	141	151	127	120	111	142	124	130
H. R. McNabb	94	90	91	65	69	60	53	73	75	96	88
Pathways	232	240	226	230	199	193	198	226	241	233	270
Ridgeview	96	51	102	77	85	53	51	41	50	68	64
Vanderbilt	101	123	113	128	158	129	142	137	155	164	217
Volunteer	407	409	364	321	330	364	333	346	358	314	328
WTFS/Midtown	837	844	812	841	905	833	784	680	687	574	649
Total	2,218	2,231	2,148	2,082	2,186	1,987	1,899	1,841	1,930	1,801	2,005

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 4, "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 4: Outpatient Evaluations by Type of Offense

Type of Offense	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Capital	0.4%	0.3%	0.6%	0.6%	0.5%	0.3%	0.2%	0.1%	0.1%	<0.01%	<0.01%
Violent Felony	37%	36%	36%	38%	37%	40%	40%	41%	44%	44%	42%
Sex Offense	8%	9%	9%	8%	9%	8%	7%	8%	8%	9%	10%
Non-Violent Felony	24%	22%	28%	29%	32%	31%	32%	31%	28%	29%	27%
Misdemeanor	31%	32%	27%	23%	20%	19%	18%	17%	19%	16%	20%

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 a misdemeanor; 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 4, 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 5: Outpatient Felony vs. Misdemeanor Trends

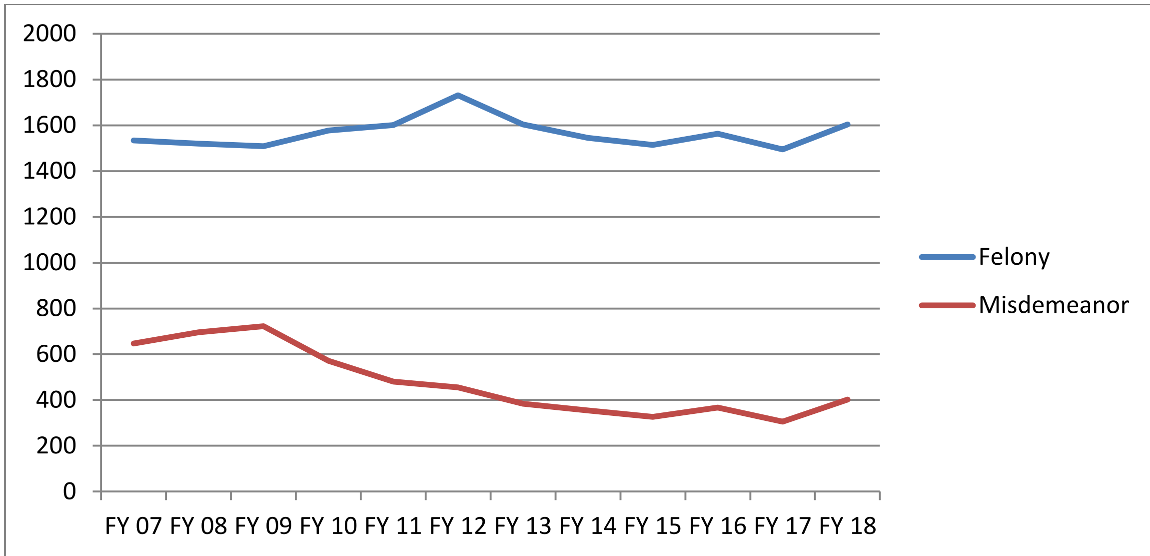


Table 5 shows that the frequency of misdemeanor evaluations has declined since the change in law concerning responsibility for payment even when the frequency of other evaluations increased (FY 12), and then increased slightly in FY 18. Table 6, below, breaks out the percentage of misdemeanor evaluations 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 6: Frequency of Misdemeanor Evaluations

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

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 7 shows the rates of recommendations from outpatient evaluations on competence to stand trial and the insanity defense.

Table 7: Recommendations of Outpatient Evaluations

Competence to Stand Trial					Insanity Defense		
Fiscal Year	Competent	Incomp.	Defer		Yes	No	Defer
FY 01	69%	0.3%	30%		2%	68%	30%
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%

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

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

7 shows 7% 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% in FY 18).

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). 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 90% in FY 17 and 90% on average for the six years this statistic has been kept.

Table 8: Outpatient Competency Training

Provider	Total # of cases	# of cases receiving training	# diverted	% of cases receiving training diverted
Centerstone	155	4	3	75%
Cherokee	104	1	1	100%
Frontier	130	5	4	80%
HR McNabb	88	2	2	100%
Pathways	270	4	3	75%
Ridgeview	64	7	6	86%
Vanderbilt	217	3	2	67%
Volunteer	328	0	-	-
WTFS	649	28	23	82%
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%
TOTAL FY 11	2,082	71 (3%)	63	89%

T.C.A. § 33-7-301(a) indicates that an inpatient evaluation of competence to stand trial and/or mental capacity at the time of the offense may be ordered "if and only if" the outpatient evaluator recommends an inpatient evaluation. The average rate of referral for all providers from FY 01 through FY 17 was 23%. The average rate for FY 18 was 24%.

Table 9: Frequency of Inpatient Referral by Provider

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

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/she 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%-85% to the RMHIs and 10%-15% to FSP. In FY 18, the proportion of referrals to FSP was even lower (9%).

Table 10: Trends in Inpatient Referrals to RMHIs and FSP

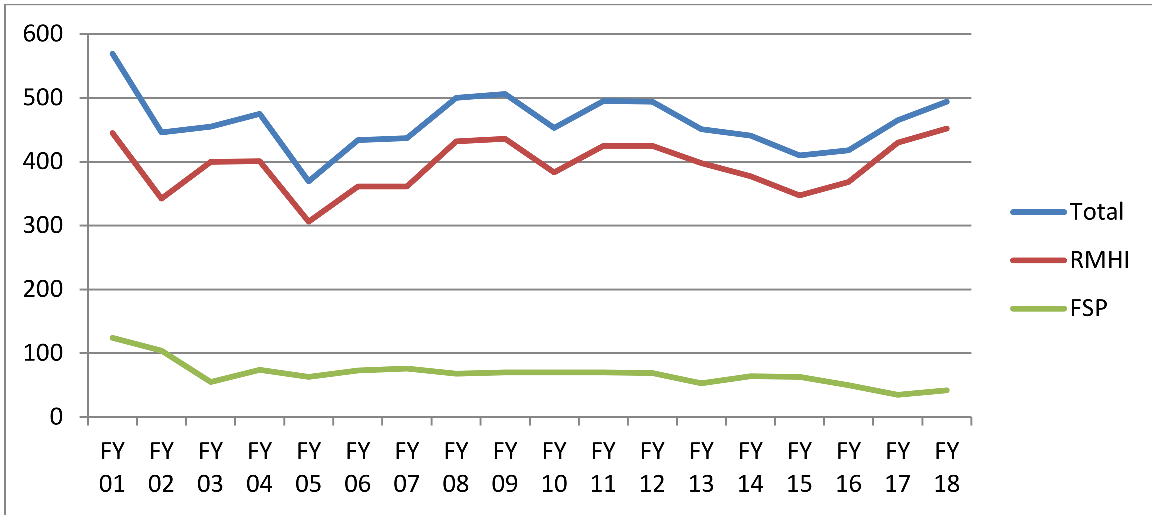
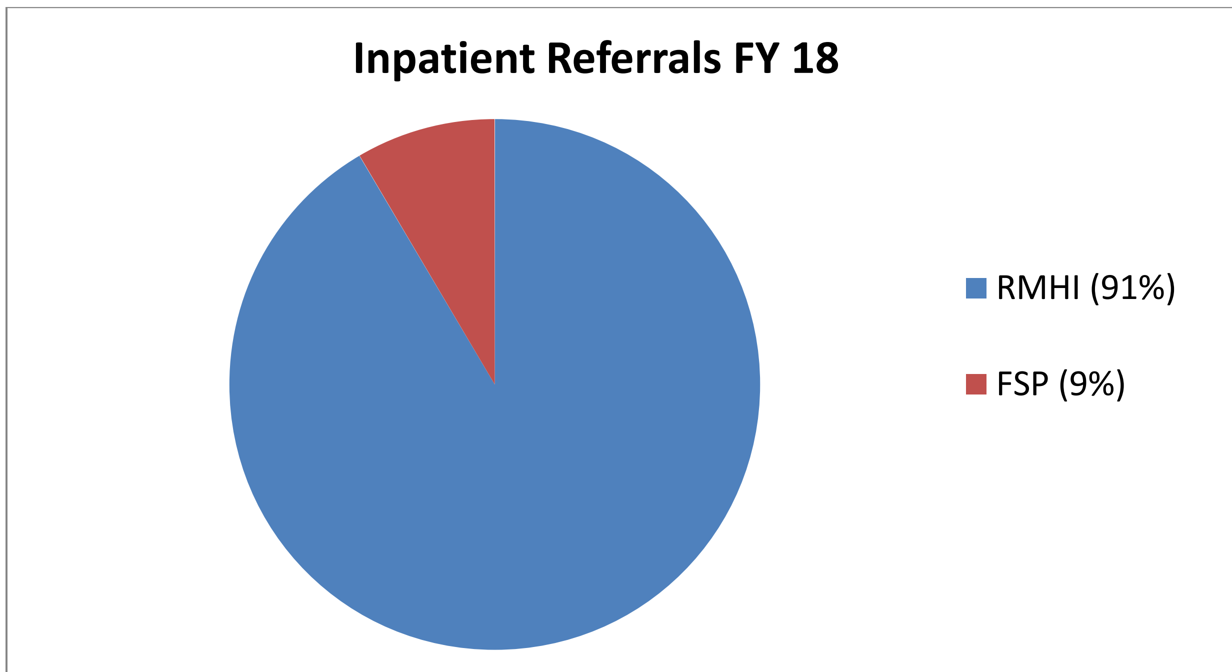


Table 11: Inpatient Referrals RMHI & FSP



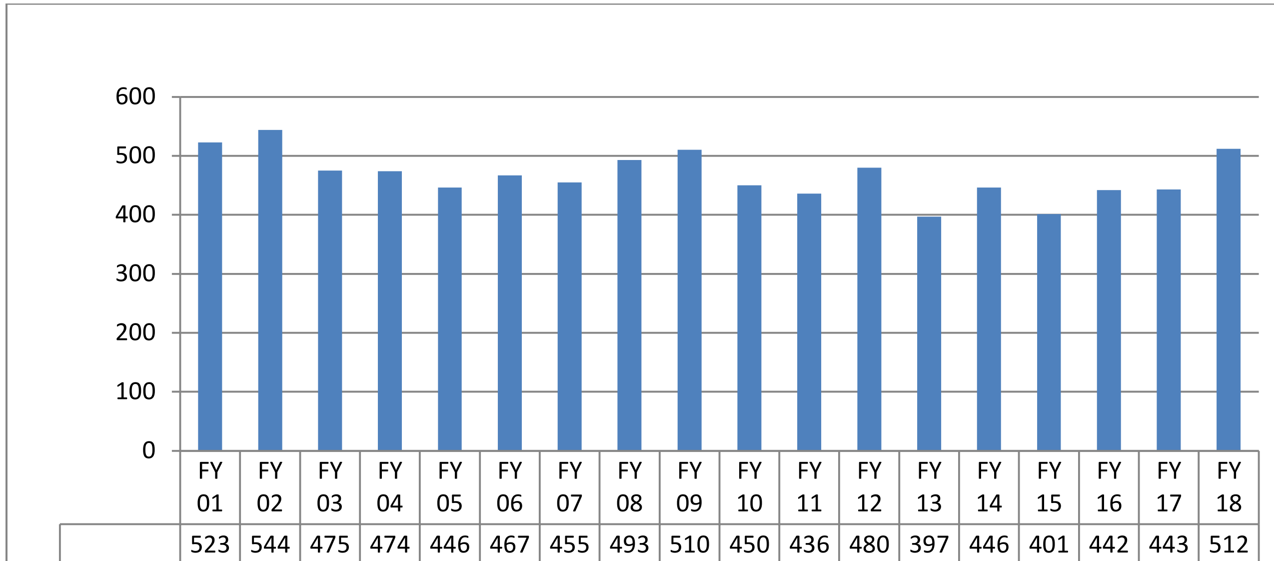
The statutory requirement that an outpatient evaluation be conducted prior to an inpatient evaluation, and the requirement that an inpatient evaluation can only be ordered when the outpatient evaluator recommends an inpatient evaluation is an effective means for preventing unnecessary forensic admissions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

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
	523	544	475	474	446	467	455	493	510	450	436	480	397	446	401	442	443	512

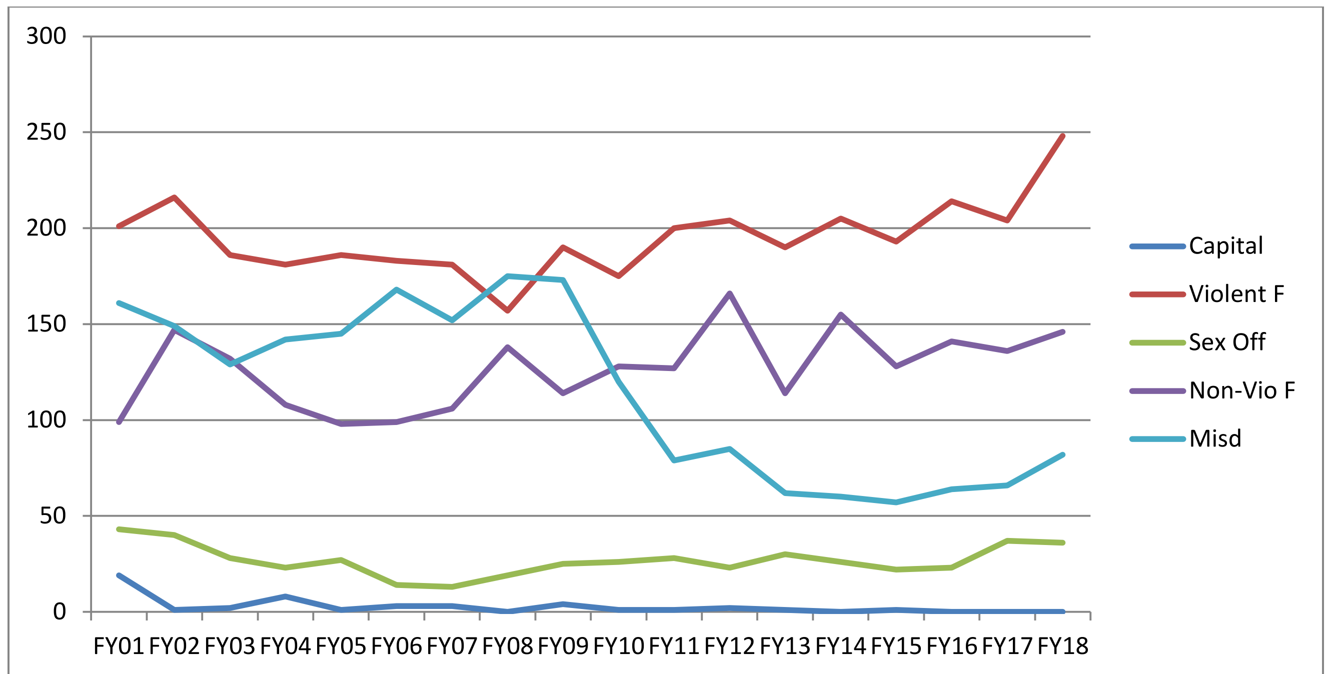
Table 12 shows the total number of admissions for inpatient evaluation state-wide each fiscal year since FY 01. The FY 18 inpatient evaluation total of 512 is higher than the average of 464 per year over the previous 17 years (+10%) and the highest in the last 15 years. The average for the nine years since counties were billed for the cost of misdemeanor evaluations (FY10-FY 18) of 437 is still 10% 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 distribution of inpatient evaluations by type of offense shown in Tables 13 and 14 on the following page indicates a decline in the proportion of misdemeanor cases with the largest decline after the first year of counties being billed for misdemeanor evaluations (FY10) and that the rate has remained roughly half what it was prior to the change in billing the counties. In the last fiscal year prior to counties being billed for misdemeanors (FY 09), 34% of inpatient evaluation cases were misdemeanor cases, while in the last four fiscal years the rate has remained 14%-16%. 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 13: Pre-Trial Inpatient Evaluations by Offense Type

	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Capital	0.7%	0	0.8%	0.2%	0.2%	.004%	.003%	0	0.2%	0	0	0
Violent Felony	40%	32%	37%	39%	45%	42%	47%	45%	48%	48%	46%	48%
Sex Offense	3%	4%	5%	6%	6%	4%	7%	5%	5%	5%	8%	7%
Non-Violent Felony	23%	28%	22%	28%	29%	34%	28%	34%	31%	31%	30%	28%
Misdemeanor	33%	36%	34%	27%	18%	17%	15%	13%	14%	14%	14%	16%

Table 14: 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 18, there were more than twice as many evaluations of violent felony evaluations (248) than misdemeanor evaluations (82).

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 15: 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 16: Inpatient Evaluations by Facility

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
LMHI	68	67	66	70	48	45	0	0	0	0	0	0
MBMHI	55	64	69	39	53	67	99	108	122	132	131	156
MTMHI	55	56	71	70	65	84	74	89	69	98	93	132
WMHI	31	56	72	55	69	53	44	68	53	56	69	50
MMHI	164	170	140	128	129	146	105	109	90	89	104	118
FSP	82	80	92	88	74	85	75	72	67	67	46	56
TOTAL	455	493	510	450	436	480	397	446	401	442	443	512

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 17 year period FY 01-FY 17 was 21 days. The average length of stay statewide in FY 18 was also 21 days.

Table 17: Average Length of Stay in Days for Inpatient Pre-Trial 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
LMHI	22	23	20	16	20	21	-	-	-	-	-	-
MBMHI	19	18	21	21	21	16	21	18	21	19	22	22
MTMHI	25	22	24	20	22	22	27	26	27	23	20	19
WMHI	22	22	23	21	19	20	21	22	24	20	23	23
MMHI	17	15	16	14	19	17	18	19	24	21	20	22
FSP	27	26	26	26	26	26	26	23	20	15	15	20
Statewide	21	20	20	19	21	19	22	21	22	20	20	21

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 18: Recommendations That a Defendant is Competent to Stand Trial Following Inpatient 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
LMHI	59%	70%	69%	67%	79%	66%	-	-	-	-	-	-
MBMHI	64%	69%	72%	59%	79%	79%	64%	77%	72%	83%	70%	76%
MTMHI	52%	53%	40%	57%	76%	67%	58%	66%	68%	84%	82%	81%
WMHI	67%	73%	78%	82%	66%	73%	84%	57%	66%	66%	69%	52%
MMHI	75%	83%	69%	77%	69%	74%	62%	76%	73%	53%	47%	50%
FSP	80%	70%	84%	78%	82%	77%	72%	73%	74%	82%	71%	87%
State-wide Average	69%	73%	69%	72%	74%	73%	66%	71%	71%	75%	67%	70%

Table 19 shows the frequency of inpatient evaluations which indicated support for the insanity defense.

Table 19: Support for the Insanity Defense in Inpatient Evaluations

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
17%	18%	14%	17%	16%	17%	19%	15%	14%	18%	16%	21%	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 20 and 21 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 20: Recommendations for Commitment under T.C.A. § 33-7-301(b) State-wide

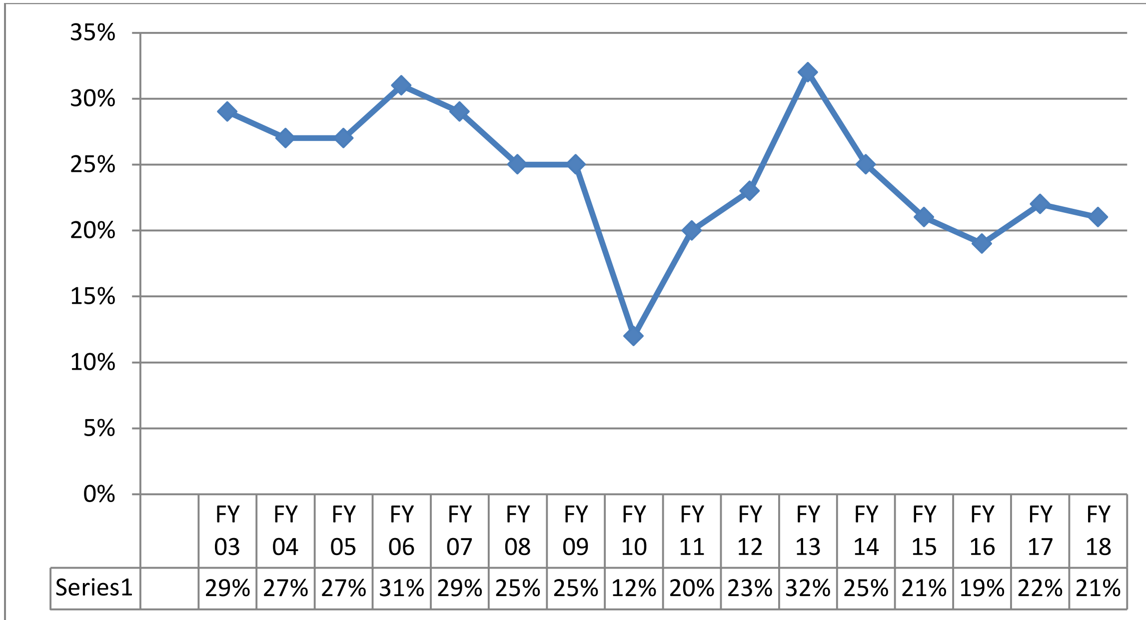


Table 21: Recommendations for Commitment under T.C.A. § 33-7-301(b) by RMHI

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

Table 22 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 22 is very consistent with previous years.

Table 22: Court of Origin for T.C.A. § 33-7-301(a) Orders

Court	Outpatient	Inpatient
General Sessions	1,238 (61%)*	307 (59%)**
Criminal Court	517 (25%)*	136 (26%)**
Circuit Court	189 (9%)*	60 (11%)**
Municipal	61 (3%)*	9 (1%)**

*% 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: 82% male, 17% female

Inpatient: 81% male, 18% female

Age:

	Outpatient	Inpatient
0-18:	2%	<1%
19-30:	35%	33%
31-43:	31%	33%
44-64:	27%	28%
>64:	3%	2%

Race:

	Outpatient	Inpatient
Alaskan Native:	<1%	0
American Indian:	<1%	<1%
Asian/Pacific Islander:	<1%	<1%
Black/African American:	47%	51%
White/Caucasian:	49%	44%
Unknown:	<1%	0
Other:	1%	2%

Primary Diagnosis Outpatient Evaluations:

Psychotic D/O:	23%	Borderline IQ:	<1%
Affective D/O:	19%	Neurological:	2%
Deferred:	23%	Medical:	<1%
Substance Related:	12%	Other:	<1%
Intellectual Disability:	3%	Malingering:	1%
Personality D/O:	3%	None:	2%
Adjustment/Behavior:	1%	Anxiety:	3%

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 or 2) for commitment to HJC. This was the standard for requesting an ID Assist throughout FY 18.

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 Title 33, Chapter 5, Part 5 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 23: ID Assist Frequencies

23a: Outpatient Referrals

Referred by:	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Centerstone	24	8	21	15	22	4	2	7	4	8
Cherokee	9	9	7	7	3	2	4	3	2	3
Frontier	4	8	13	13	11	6	4	8	4	8
H R McNabb	1	0	2	3	0	1	0	1	2	1
Pathways	22	9	6	12	10	1	0	0	0	0
Ridgeview	4	16	7	6	7	2	4	1	5	2
Vanderbilt	25	21	17	21	9	0	3	6	5	7
Volunteer	17	14	16	11	11	3	4	5	1	2
WTFS/Midtown	65	43	23	46	39	2	5	6	3	7
Outpt. Total	171 (7%)*	128 (6%)*	112 (5%)*	134 (6%)*	112 (6%)*	21 (1%)*	26 (1%)*	37 (2%)*	26 (1%)*	38 (2%)*

*percentage of total number of outpatient forensic evaluations

23b: Inpatient Referrals

Facility	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
FSP	2	1	4	0	0	0	0	0	0	0
MBMHI	4	1	5	1	4	1	0	0	0	2
MMHI	10	11	12	9	2	0	0	1	0	0
MTMHI	4	3	0	6	4	0	0	1	1	1
WMHI	2	4	4	0	1	4	0	2	3	1
Inpt. Adult Total	23 (4.5%)*	20 (6%)*	25 (6%)*	18 (4%)*	11 (3%)*	5 (1%)*	0 (0%)*	4 (1%)*	4 (1%)*	4 (<1%)*

*percentage of total number of inpatient forensic evaluations

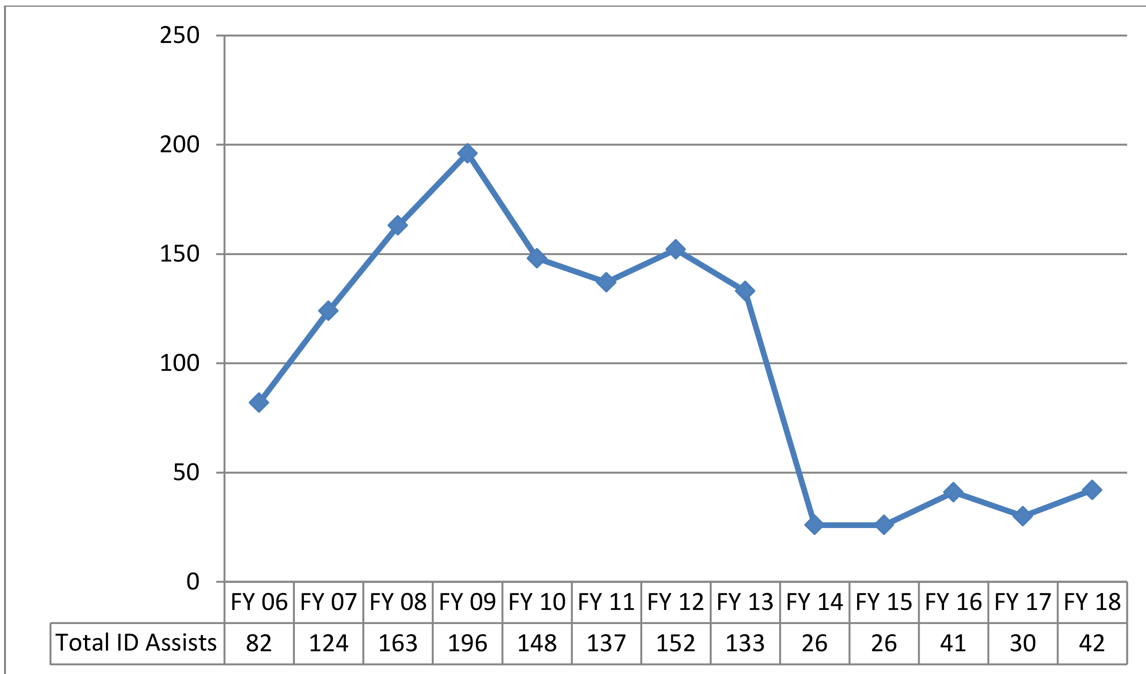
23c: Total (inpatient + outpatient) ID Assist Requests

	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY14	FY15	FY16	FY17
TOTAL	163 (4%)*	196 (7%)*	148 (6%)*	137 (5%)*	152 (6%)*	133 (5%)*	26 (1%)*	26 (1%)*	41 (2%)*	42 (2%)*

*percentage of total forensic evaluations, outpatient and inpatient

Of the 42 total ID Assist requests in FY 18, nine (9) were for committability and 33 were for competency training.

23d: Total ID Assist Request Trend



	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Total ID Assists	82	124	163	196	148	137	152	133	26	26	41	30	42

Table 23d 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 92 new admissions in FY 18 (see Table 24, 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-eight of the 53 admissions under T.C.A. § 33-7-301(b) to WMHI (72%) were Shelby County cases (higher than the 68% in FY 17 but down from 82% in FY 13). Shelby County defendants were 48% of all admissions under that statute state-wide, comparable to the 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 24: Admissions Under T.C.A. § 33-7-301(b)

Facility	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
LMHI	11	12	13	9	1	1	2	-	-	-	-	-	-
MBMHI	21	11	9	6	2	8	10	19	21	16	12	15	12
MMHI	0	0	0	1	0	0	1	0	0	0	0	1	4
MTMHI	26	28	28	35	7	16	16	32	28	27	11	20	16
FSP	12	10	10	8	5	10	13	11	9	12	7	7	7
WMHI	43	37	42	38	33	39	54	51	45	27	29	65	53
TOTAL	**113**	**98**	**102**	**97**	**48**	**74**	**96**	**113**	**103**	**82**	**59**	**108**	**92**

There were 21 cases state-wide coded as misdemeanors (23%) up slightly from FY 17 (18%). The 23% is a higher frequency of misdemeanor cases than either outpatient (20%) or inpatient (16%) evaluations ordered under T.C.A. § 33-7-301(a). Just under three quarters (73%) of all the misdemeanor admissions under T.C.A. § 33-7-301(b) were from Shelby County courts.

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 25 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 15 fiscal years, either by discharge from the hospital or by having their charges dismissed.

Table 25: T.C.A. § 33-7-301(b) Cases Closed

Facility	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
LMHI	11	18	14	9	7	22	2	1	3	-	-	-	-	-	-
MBMHI	15	19	19	12	16	9	1	8	7	21	23	17	10	15	15
MMHI	1	0	0	0	0	1	0	0	1	0	0	0	0	1	4
MTMHI	23	32	25	33	24	39	11	18	15	19	30	20	12	15	15
FSP	10	12	7	7	9	10	5	14	11	11	10	11	7	4	10
WMHI	40	42	41	43	45	43	36	32	51	57	40	48	27	46	53
TOTAL	**100**	**123**	**106**	**104**	**101**	**124**	**55**	**73**	**87**	**107**	**103**	**96**	**56**	**81**	**97**

The decrease evident from FY 13 through FY 16 reflects the lower number of new cases during the same period (see Table 24, p. 25). Of the 97 cases closed during FY 18, a little less than half (42 cases; 43%) were discharged while still pre-trial criminal defendants under T.C.A. § 33-7-301(b) and a little more than half (53 cases; 55%) had their charges retired and remained committed to the RMHI under Title 33, Chapter 6, Part 5 (2 still-incompetent cases were released on bond with charges still pending). That rate of cases with charges being retired is slightly higher than the last three fiscal years (FY 15 and FY 16 = 48%; FY 17 = 49%).

Table 26, below, shows defendants discharged from T.C.A. § 33-7-301(b) with charges still pending during FY 18 categorized by their length of stay. In FY 18, the most frequent length of stay was less than one month (39%); 29% were discharged between one and three months, for a total of 89% discharged in the first six months. This is a slight increase in the frequency of brief lengths of stay (primarily at MTMHI): in FY 16, 22% were discharged in less than one month and 33% were discharged between one and three months, which is the most common pattern in previous years.

Table 26: Length of Stay

Discharges Under T.C.A. § 33-7-301(b) during FY 18

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	5	1	0	1	0	0	79	13-423
FSP	3	4	1	0	0	0	0	38	14-90
WMHI	3	5	7	3	2	0	0	143	21-470
MBMHI	1	1	1	0	0	0	0	64	16-109
Totals	**11**	**15**	**10**	**3**	**3**	**0**	**0**	**81**	**13-470**

While Table 26 shows the length of stay for patients discharged during FY 18, Table 27 shows the lengths of stay for those patients still in 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).

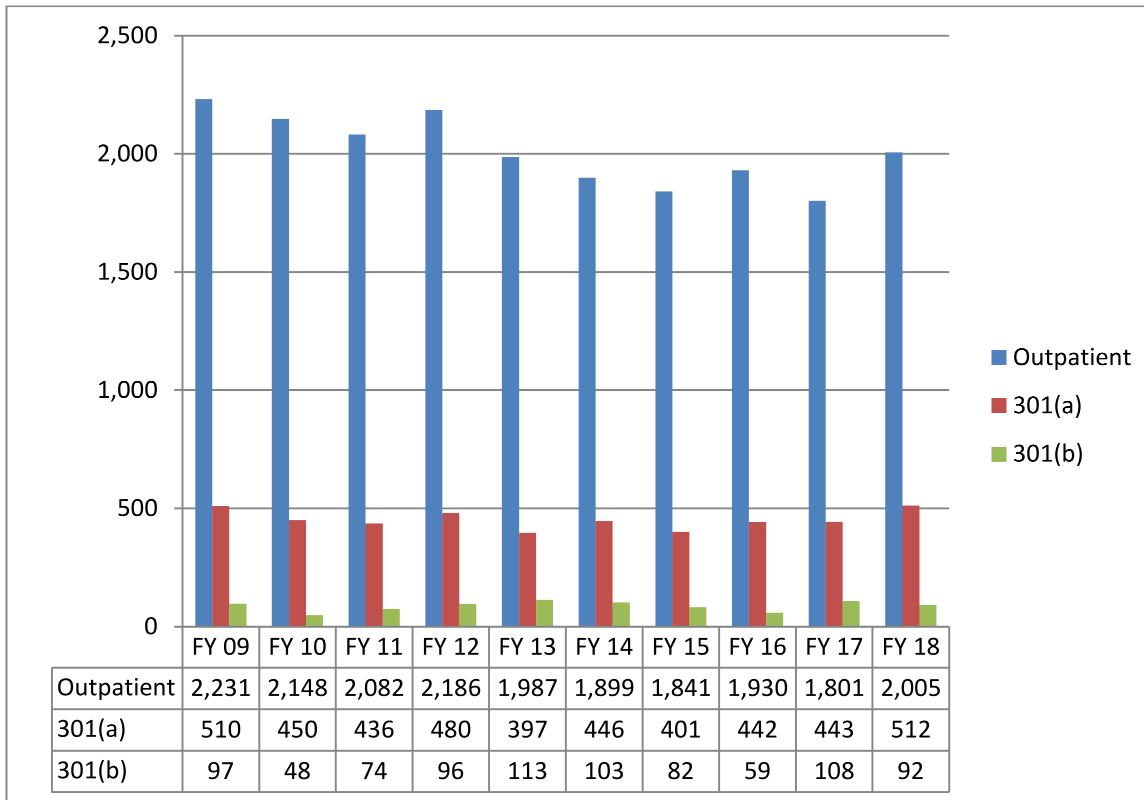
Table 27: Length of Stay for Patients On Census

Under T.C.A. § 33-7-301(b) on June 30

LOS	# of patients 6/30/2015	# of patients 6/30/2016	# of patients 6/30/2017	# of patients 6/30/2018
0-6 mos	7	12	26	23
6-12 mos	9	6	9	5
1-2 years	3	5	3	3
2-3 years	2	0	2	2
3 years +	0	0	0	0
total	21	23	40	33

Table 28, 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 28: Forensic Evaluation Services



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

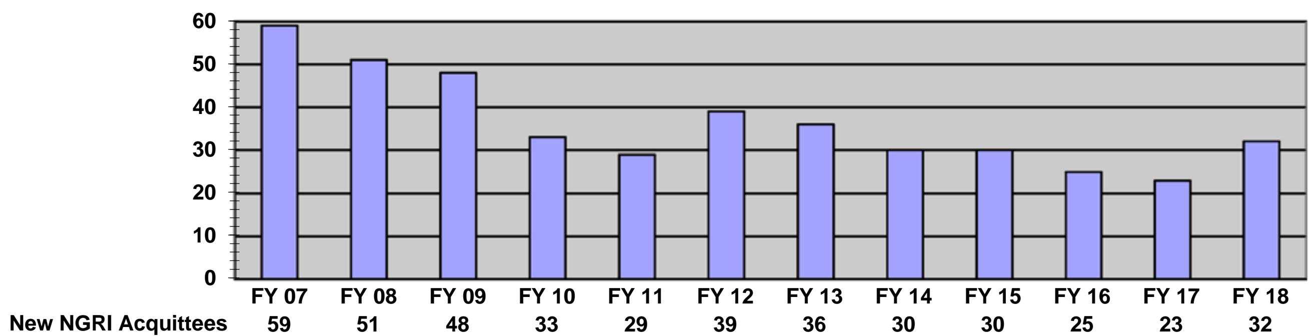
Evaluation and Treatment of Defendants Found Not Guilty by Reason of Insanity

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 32 new NGRI acquittees in FY 18.

Table 29: New NGRI Acquittees



Of the 32 acquittees, 15 (46%) were acquitted on a violent felony (not sex offense) offense, 11 (34%) were acquitted on a non-violent felony, four (12%) were acquitted of a sex offense, and two (6%) were acquitted of a misdemeanor offense. Of the 15 acquitted on a violent felony, 12 were acquitted of aggravated assault, one was acquitted of attempted murder and two were acquitted of murder.

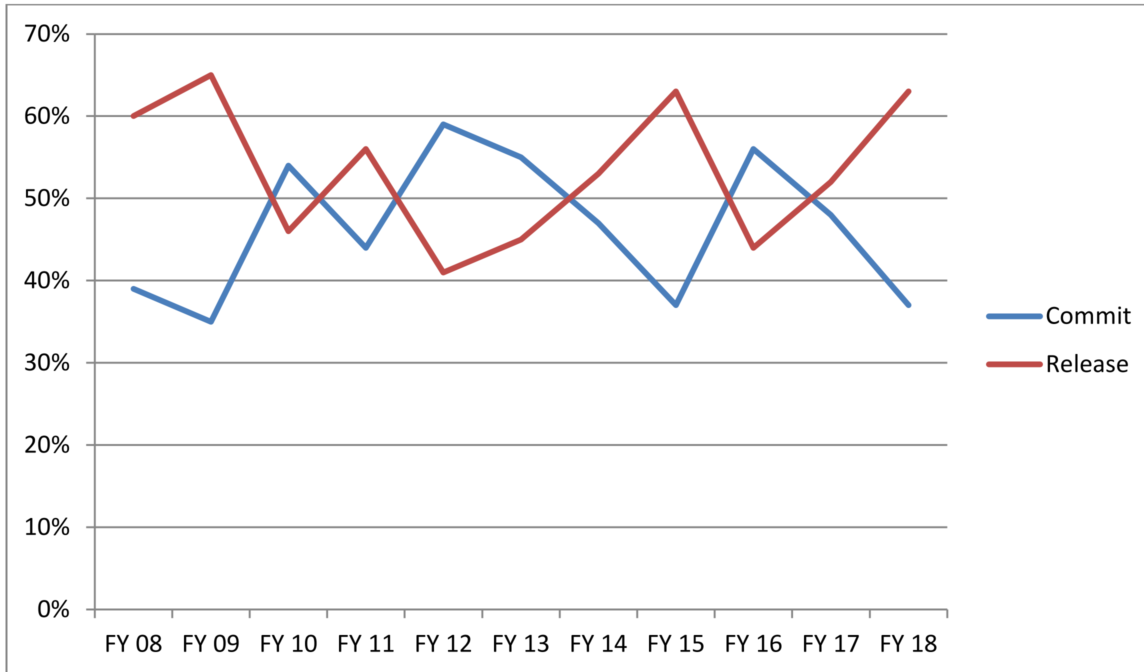
Through the end of FY 18, there were four possible outcomes of an evaluation conducted under T.C.A. § 33-7-303(a): (1) commitment to an RMHI under T.C.A. § 33-7-303(c), (2) release to the community with an Mandatory Outpatient Treatment (MOT) plan under T.C.A. § 33-7-303(b), (3) release to the community 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. 59, below, for the requirement for MOT for certain cases at any point of release to the community). Table 30, below, shows the outcomes in FY 18 with recommendations broken out by provider.

Table 30: Recommendations following Evaluation Under T.C.A. § 33-7-303(a) in FY 18

	Commit	MOT	release w/o MOT	release w/o tx
Centerstone	2	0	0	0
Cherokee	0	1	1	0
Frontier	1	0	4	0
HR McNabb	0	1	3	0
Pathways	4	1	5	0
Ridgeview	0	0	0	0
Vanderbilt	1	0	0	0
Volunteer	2	2	1	0
WTFS	2	1	0	0
Total FY 18	12 (37%)	6 (18%)	14 (43%)	0

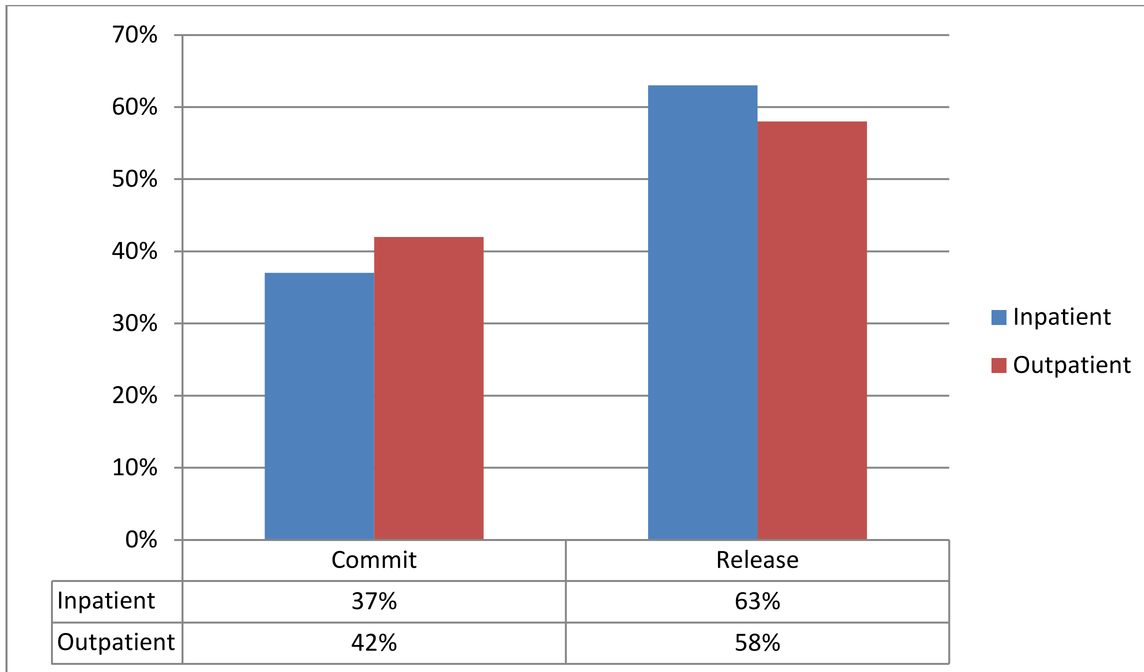
The relative frequency of recommendations for commitment vs. release has not been consistent across the last 11 years, with some years showing a greater rate of commitment and some a greater rate of release. Table 31 shows the percentage of recommendations for commitment vs. release. The total number of evaluations per year (as shown in Table 29, 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.

Table 31: Commitment vs. Release under T.C.A. § 33-7-303(a)



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 17 & FY 18; n= 55) shows little difference between rates of commitment, with a slightly greater frequency of commitment from outpatient evaluations (see Table 32 on the following page).

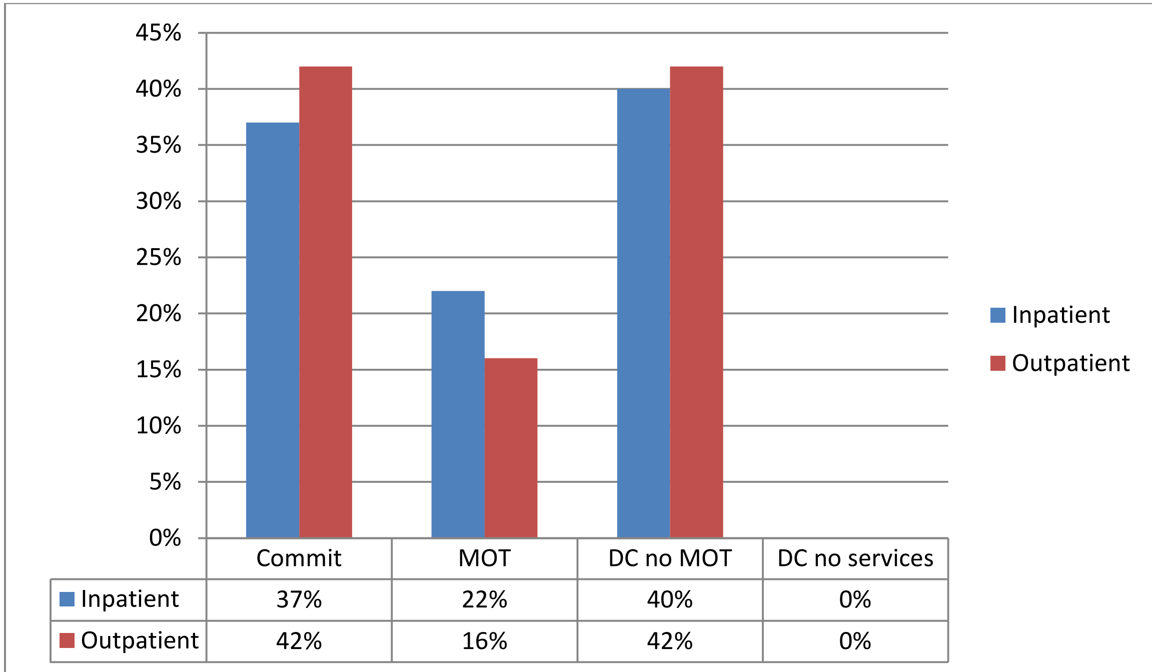
Table 32: Inpatient & Outpatient Evaluation Outcomes under T.C.A. § 33-7-303(a)



	Commit	Release
Inpatient	37%	63%
Outpatient	42%	58%

Breaking out the recommendations for release into those recommended for release with MOT vs. those recommended for release with no MOT requirement (Table 33, below) shows that release without conditions (but with an aftercare plan) has consistently been more frequent that recommending release with MOT.

Table 33: 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	42%	16%	42%	0%

Commitment of Patients under T.C.A. § 33-7-303(c):

Table 34 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 34, below. The numbers in Table 34 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 34: T.C.A. 33-7-303(c) Commitments

←Inpatient Evaluation | Outpatient Evaluation→

Facility	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
LMHI	5	10	10	2	4	3	3	-	--	--	--	--	--
MBMHI	2	3	1	0	1	0	2	4	0	0	0	2	3
MMHI	0	1	0	0	0	0	0	0	0	0	0	0	0
MTMHI	5	15	9	4	7	10	20	15	6	0	0	8	5
FSP	1	1	0	0	1	1	2	1	3	2	0	2	0
WMHI	5	6	5	5	7	1	4	1	5	12	17	3	9
TOTAL	**18**	**36**	**25**	**11**	**20**	**15**	**31**	**21**	**14**	**14**	**17**	**15**	**17**

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 35 on the following page.

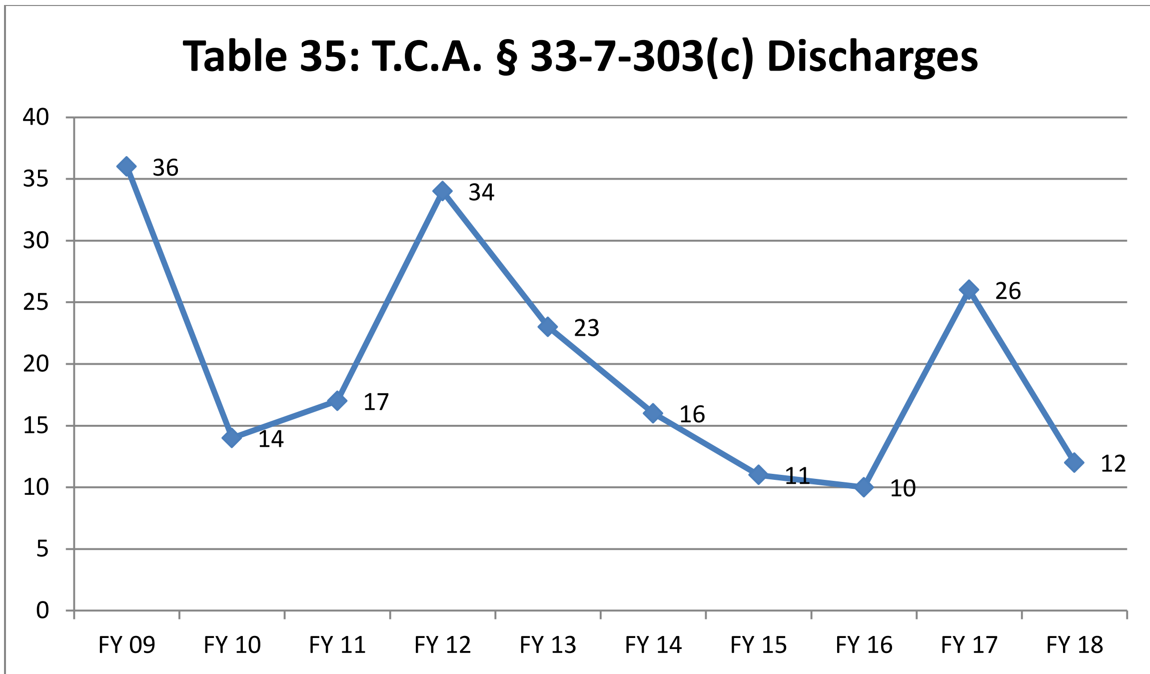


Table 36 summarizes the length of stay for all 12 patients discharged to the community during FY 18 who had been committed under T.C.A. § 33-7-303(c). This length of stay includes all days in all facilities for acquittees who have been transferred between FSP and an RMHI prior to discharge, or transferred between RMHIs.

Table 36: Length of Stay Under T.C.A. § 33-7-303(c) Discharges during FY 18

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	1	0	0	0	0	147	147
MTMHI	0	0	2	2	1	2	0	616	126-1,549
WMHI	0	0	1	0	2	1	0	528	139-984
Totals	**0**	**0**	**4**	**2**	**3**	**3**	**0**	430	**126-1,549**

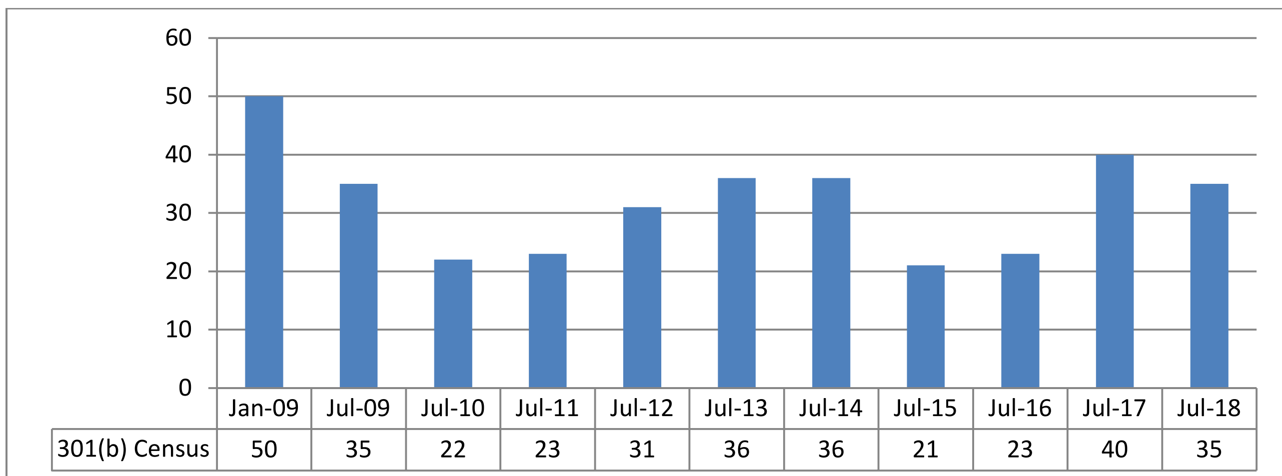
The shortest length of stay was just over four months and the longest length of stay was four years and three months with an average length of stay of one year and three months. This pattern is consistent with previous years. In FY 17, one patient was discharged after 24 years and 8 months, and the average 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).

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.

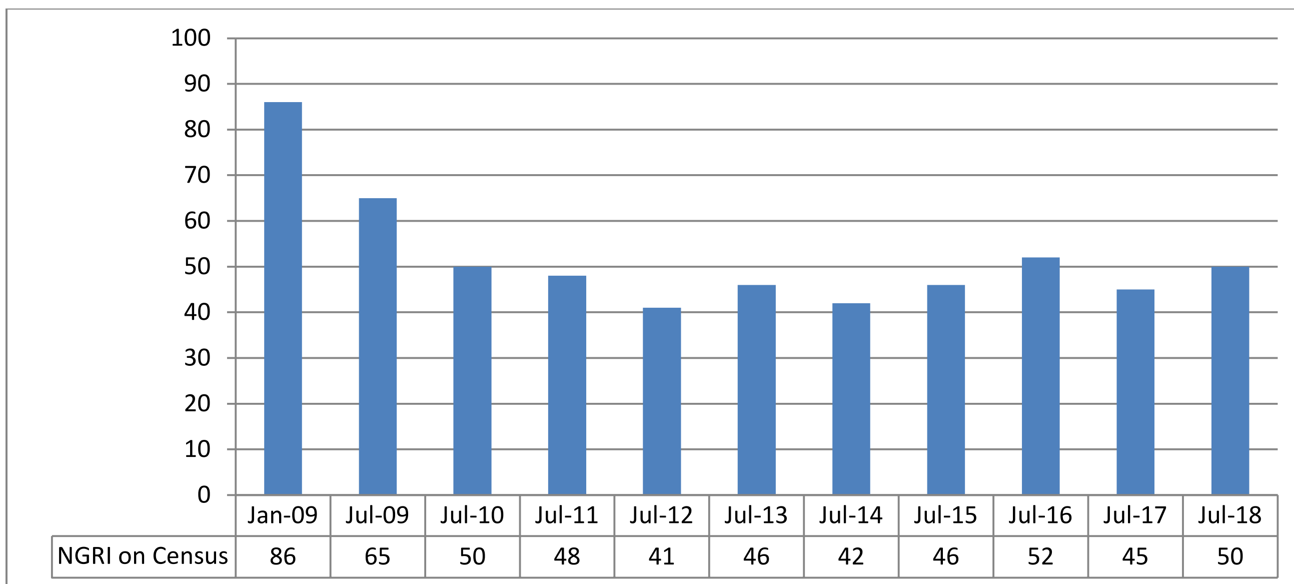
The tables below show the total number of patients in the facilities under T.C.A. § 33-7-301(b) (Table 37) and under T.C.A. § 33-7-303(c) (Table 38) who were on census on the first day of each month listed.

Table 37: 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
301(b) Census	50	35	22	23	31	36	36	21	23	40	35

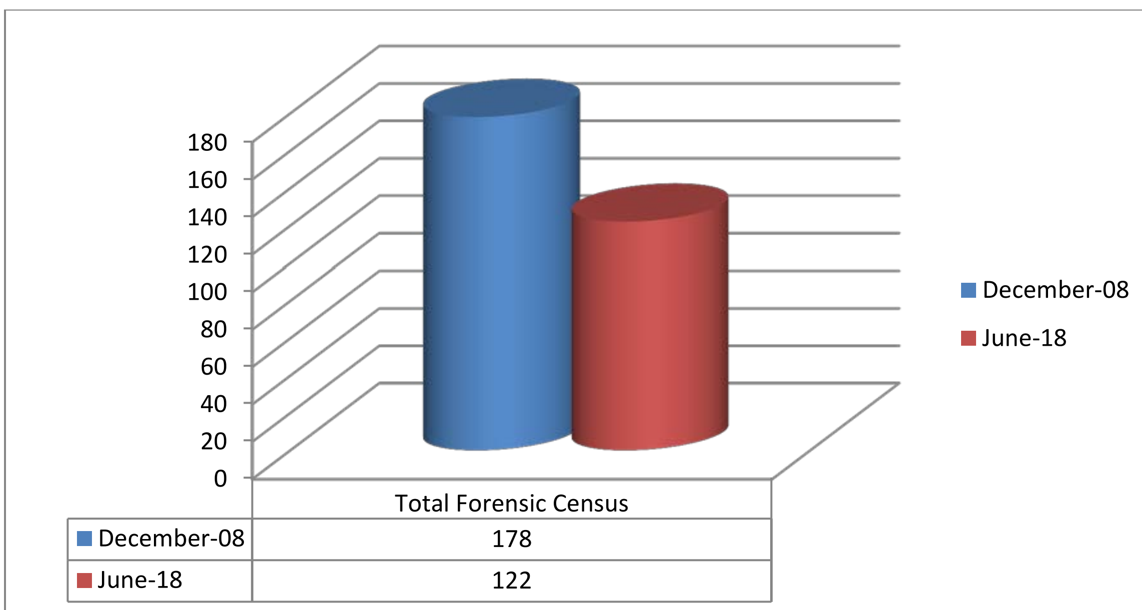
Table 38: T.C.A. 33-7-303(c) Cases on Census



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

Table 39 shows the total forensic census for all facilities comparing December of 2008 (the formal beginning of census monitoring and management) and the end of FY 18.

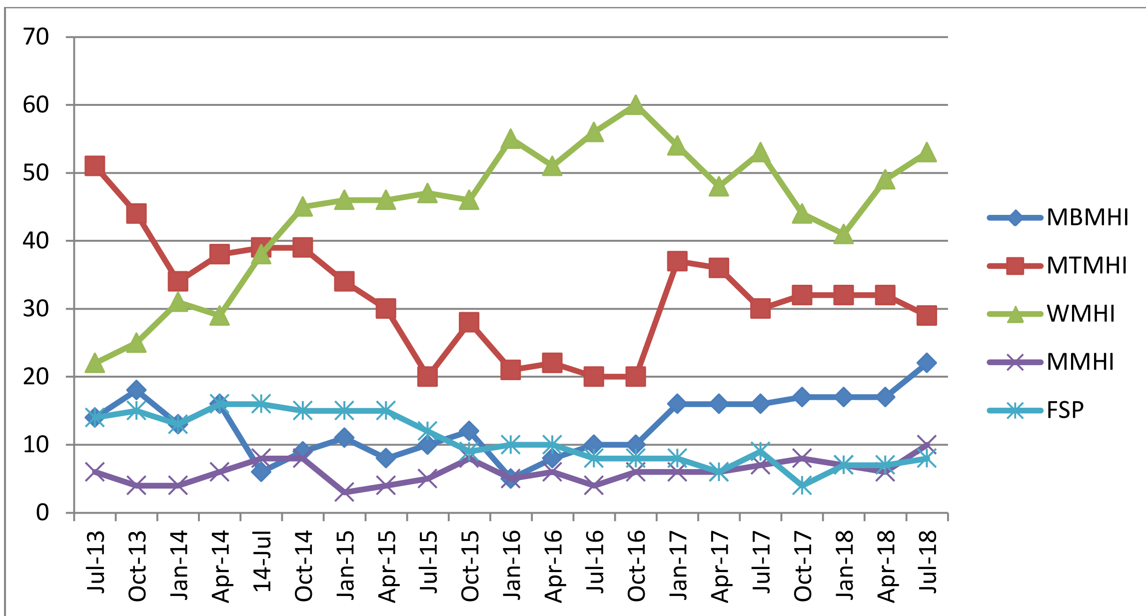
Table 39: Total Forensic Census State-Wide



	Total Forensic Census
December-08	178
June-18	122

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 40, 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 40: Quarterly Forensic Census by RMHI 2013-2018

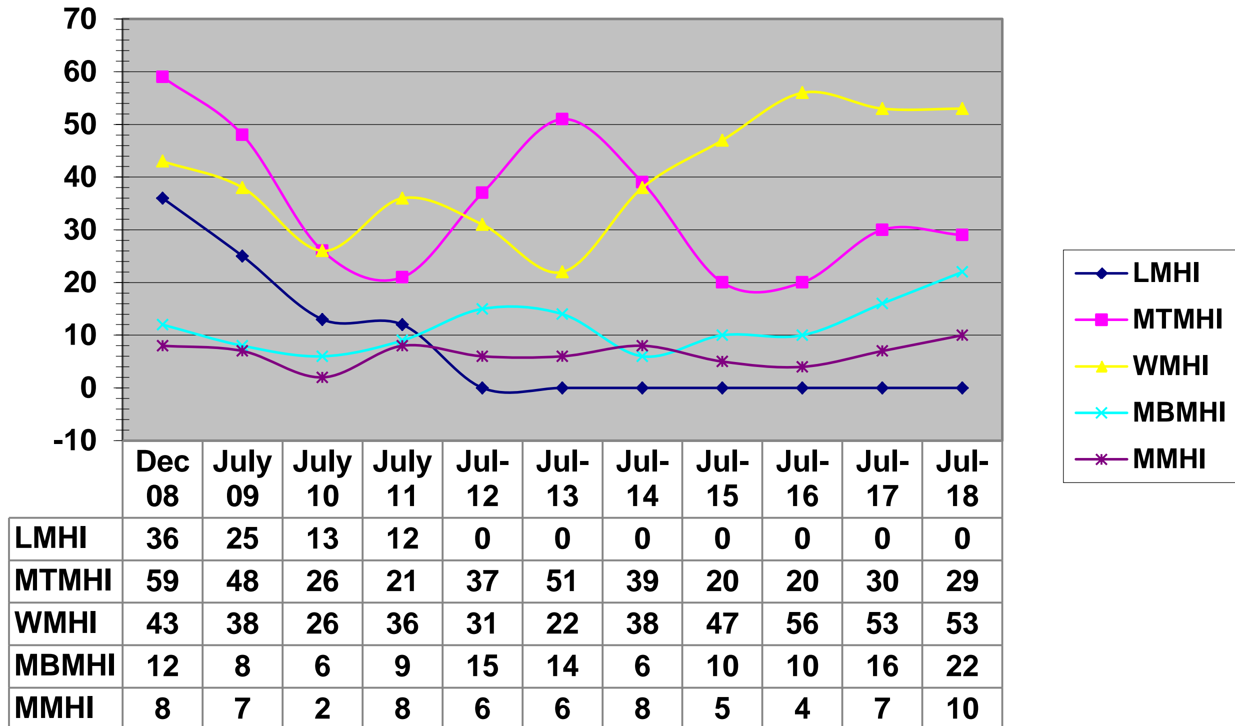


NOTE: Data points are every three months; January, April, July, October, repeat.

The forensic census at MTMHI stayed low 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 41, on the following page). 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).

Table 41 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 24%.

Table 41: Annual Forensic Census by RMHI 2008-2018



	Dec 08	July 09	July 10	July 11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17	Jul-18
LMHI	36	25	13	12	0	0	0	0	0	0	0
MTMHI	59	48	26	21	37	51	39	20	20	30	29
WMHI	43	38	26	36	31	22	38	47	56	53	53
MBMHI	12	8	6	9	15	14	6	10	10	16	22
MMHI	8	7	2	8	6	6	8	5	4	7	10

Table 42 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 18. 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 2018.

Table 42: Forensic Census Comparison: December 2008 and June 2017

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%)

June 30, 2018

	LMHI	MTMHI	FSP	WMHI	MBMHI	MMHI	Total
301(a)	0	7	5	2	13	10	37
301(b)	0	4	1	28	2	0	35
303 (a)	0	0	0	0	0	0	0
303(c)	0	18	2	23	7	0	50
Total (% of total Census)	0	29 (20%)	8 (38%)	53 (36%)	22 (14%)	10 (20%)	**122 (23%)**

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 psychiatric evaluation 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 615 evaluations conducted FY 11-FY 18, 184 (30%) sex offender evaluations and 431 (70%) violent offender risk assessments. This total includes 14 female offenders (2 for sex offenses, 12 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 (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 (non-sexual) offenders. For sex offenders, 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 43: 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
Total	**183**	**432**	**615**

Table 44: 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	48	35
Grand Total	**87 (20%)**	**186 (43%)**	**160 (37%)**

In FY 18, 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 was consistent with the rate from the previous fiscal years.

Table 45: 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	31
Grand Total	**39 (21%)**	**143 (79%)**

Juvenile Court Ordered Evaluations

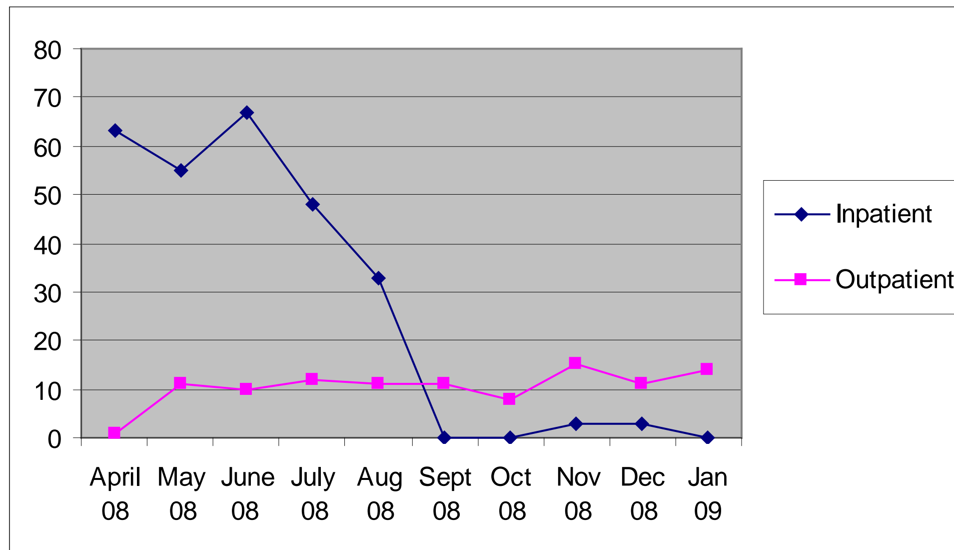
T.C.A. § 37-1-128(e) grants juvenile courts the authority to order mental health evaluations by an evaluator designated by the Commissioner of the TDMHSAS. While evaluations ordered for adult criminal defendants are limited strictly to competency to stand trial and/or mental capacity at the time of the 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 46, 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 46: Inpatient and Outpatient Juvenile Court Ordered Evaluations



These changes were codified when the statutes governing the process for juvenile courts to order mental health evaluations and the responsibility for the cost of the evaluations were

[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

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 47: Annual Totals of Inpatient and Outpatient Juvenile Evaluations

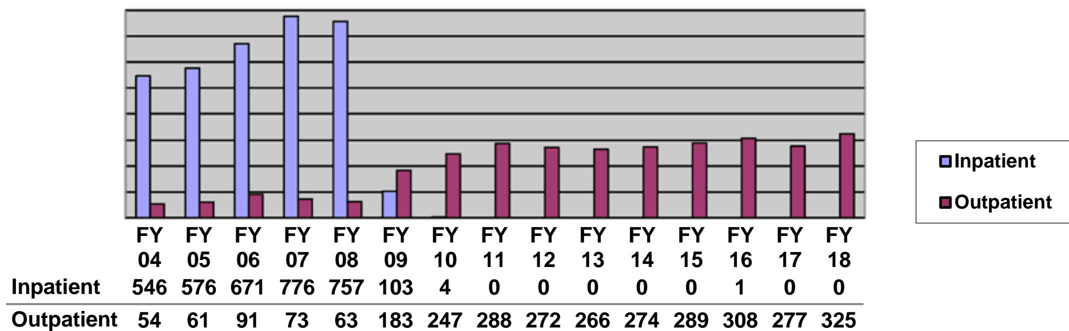


Table 48: Frequency of Outpatient Juvenile Evaluations by Provider

CMHA	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18
Centerstone	1	5	14	23	16	23	42	43	32	46	35	23
Cherokee	3	11	20	24	15	20	8	10	8	10	7	14
Frontier	2	5	5	9	3	11	7	9	11	8	10	8
Helen Ross McNabb	0	0	2	1	1	1	0	0	0	0	0	1
Pathways	2	5	43	79	88	70	79	77	53	75	70	93
Ridgeview	2	4	2	2	1	3	2	6	2	3	4	2
Vanderbilt	6	9	44	41	43	40	32	33	30	19	20	41
Volunteer	46	15	47	68	116	102	87	82	116	96	86	109
WTFS/Midtown	11	9	6	0	5	2	9	14	37	51	45	34
Total	73	63	183	247	288	272	266	274	289	308	277	325

Table 49 shows the rate of evaluations by type of offense. The distribution has remained very stable since FY 11, the second full year of evaluations being done primarily or exclusively on an outpatient basis.

Table 49: Type of Offenses Inpatient and Outpatient Juvenile Evaluations

	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Capital	- (0)	0.3% (1)	- (0)	0.0	0.0	0.0	0.0	0.0	0.0
Violent Felony (not Sex Offense)	50% (126)	43% (124)	40% (110)	41% (110)	43% (120)	39% (114)	40% (124)	44% (122)	44% (143)
Sex Offense	32% (81)	39% (115)	43% (118)	44% (118)	44% (121)	42% (122)	43% (133)	40% (112)	33% (108)
Non-Violent Felony	17% (42)	15% (45)	15% (43)	14% (38)	12% (33)	18% (53)	16% (51)	15% (43)	22% (73)
Misdemeanor	0.4% (1)	1% (3)	0.3% (1)	0.0	0.0	0.0	0.0	0.0	<1%

Table 50 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 50: Rate of Specific Forensic Requests (Outpatient and Inpatient FY 08-16)

Requests	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Competency	540 (71%)	240 (87%)	219 (88%)	244 (85%)	206 (76%)	212 (80%)	223 (81%)	235 (80%)	245 (78%)	228 (82%)	254 (78%)
Mental Condition at the Time of the Crime	509 (67%)	170 (61%)	99 (40%)	95 (33%)	104 (38%)	100 (38%)	115 (42%)	127 (43%)	128 (39%)	117 (42%)	131 (40%)
Psychosexual	205 (27%)	71 (26%)	72 (29%)	110 (38%)	99 (36%)	111 (42%)	111 (40%)	109 (37%)	121 (39%)	107 (38%)	92 (28%)

Almost two-thirds (64%) of all juvenile court ordered mental health evaluations were for youth age 15 or older. The frequency of evaluations for youth ages 13-14 was 26%, making 90% of evaluations for youth ages 13 and above.

Table 51: 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%

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.

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 50, below). Youth who appear to need mental health, substance abuse, or family services (including crisis services) are then 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.

Outcome Study in FY 13:

The Vanderbilt University Center of Excellence for Children completed an outcome study in March of 2013 (Richard Epstein, Ph.D., primary investigator). Counties with consistent levels of screening and data entry were included, and Washington County and Johnson City juvenile courts were combined (Johnson City is in Washington County), resulting in six counties: Dickson, Hawkins, Macon, Madison, Obion and Washington (including Johnson City). Screenings that occurred from October 2010 through January 2013 were included, and screenings with an atypical social security number or missing data were excluded. Youth were screened each time they appeared in court on a new matter, meaning that some youth could be screened more than once. The frequency of youth having more than one screening was taken as a rough estimate of recidivism. The resulting data pool included 2,774 screenings on 2,268 individual juveniles, suggesting a recidivism rate of 17%. Recidivism rates have been reported in the literature ranging from 12% to 31%. Youth in the TICSRP outcome study who were screened more than once were more likely to be African American, to be from a county with a poverty level worse than the state average, and to have at least one externalizing behavior (e.g. assaultive, running away, substance abuse) noted on the screening.

Three counties (Hawkins, Dickson and Macon) showed reductions in the number of youth committed to DCS custody compared to the four years prior to the project. Two counties showed reductions in commitment to DCS custody compared to nearby counties not in the TICSRP with similar population size and poverty levels (Dickson as compared to Cheatham, Macon as compared to Smith). These two counties were also two of the three counties with FSPs (i.e. Dickson, Macon and Madison counties). Some counties showed significant effects of TICSRP, but not all did.

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

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[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

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.

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 (Appendix A) 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. Predictive validity studies in selected Tennessee juvenile courts are planned for FY 19.

A de-identified data extract from the AOC was analyzed by April Shaffer, MPH of the Vanderbilt University Center of Excellence, including data for Tables 52 and 53, below. There were 964 screenings conducted with JJ-CANS 1.0 in FY 18 and 213 screenings conducted with JJ-CANS 2.0 for a total of 1,177 screenings in FY 18 and 9,653 screenings conducted since October 2010. In FY 18, 13.9% of the screenings were coded as "subsequent screenings,"

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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.

indicating that a youth previously screened has returned to juvenile court on a new matter and a new screening was conducted. Some of the subsequent screenings may be for youth who also had an initial screening during FY 18, but it is more likely that they had their initial screening prior to FY 18 (the median length of probation in juvenile court is 10 months; a screening would be coded as "subsequent" if conducted after the youth completed probation and returned to court with a new offense). There were 16% screenings which were not coded as either initial or subsequent screenings.

Table 52: TICSRP JJ-CANS Demographics FY 18

Demographic			**Location**		
			Tennessee		
FY 18			**Referral Type**		
			Initial Intake	**Subsequent Offense**	**Unknown**
N			70.2%	13.9%	16%
Number of Charges		Average	1.57	1.44	1.42
Age		Average	15.34	15.21	14.98
	Age Category				
	16 to 18		49.8%	49.6%	39.6%
	13 to 15		36.7%	37.8%	41.6%
	5 to 12		13.6%	12.6%	18.8%
	Gender				
	F		35.9%	35.9%	40.4%
	M		64.1%	64.1%	59.6%
	Race				
	African American		38.2%	45%	19.2%
	Caucasian		49.5%	33.6%	64.2%
	Other		8.3%	17.6%	14.6%
	Missing		4.1%	3.8%	2%
	Offense Type				
	Non-Violent		83.9%	72.5%	84.1%
	Violent		16.1%	27.5%	15.9%

Half of all screenings were with youth ages 16-18. Youth ages 5 to 12 were less common among subsequent screenings than at initial screening. It is not surprising that an already low frequency of the youngest juveniles would be even lower among youth who have a subsequent screening, and it is possible that some youth age 12 at the time of their first screening had turned 13 by the time of their subsequent offense, moving their subsequent screening into the higher age category. The higher percentage of African American youth having a subsequent screening is confounded by other factors like poverty, parental incarceration, and other environmental (e.g. neighborhood) factors which may be more directly associated with the risk of juvenile justice involvement. However, this may also reflect a disproportionate rate of minority contact with the juvenile justice system similar to that seen in the adult criminal justice system. The rate of a violent offense is generally low.

Table 53 on the following page shows the frequency of screenings for which some action (treatment referral or intervention) was needed in four domains on the JJ-CANS. Action was needed in a little less than one third of all screenings on items in the domain of Internalizing behaviors (suicide risk, self-mutilation, depression, anxiety, and trauma). Action was needed more often for Externalizing behaviors (danger to others, impulsivity, oppositional, conduct, anger, family problems, and problems with living situation), both at initial screenings and even more so at subsequent screenings. There was very little change in the frequency of action needed in the domain of Juvenile Justice Risk (seriousness of current offense, juvenile justice history, planning involved in current offense, community safety, and non-compliance with legal sanctions) between initial and subsequent screenings. A small increase was noted in the domain of Academic Risk (School attendance, school behavior, and school achievement.) These trends are consistent with previous years of data.

Table 53: TICSRP JJ-CANS Actionable Items FY 18

Internalizing Behaviors*	Initial Intake	Subsequent Offense	Unknown
No	69.5%	66.4%	62.3%
Yes	30.5%	33.6%	37.7%
Externalizing Behaviors			
No	52.6%	45%	58.9%
Yes	47.4%	55%	41.1%
Juvenile Justice Risk			
None	54%	48.9%	64.9%
Academic Risk			
Missing	3.6%	3.8%	3.3%
No	56%	51.9%	67.5%
Yes	40.4%	44.3%	29.1%

Once juvenile court staff have been trained to complete the JJ-CANS, each court must then integrated the screening into the regular court procedures. This includes deciding which youth will be screened (All youth referred as delinquent or unruly? Only youth placed on probation?), when the screening will occur and how the information will be managed in that court. The JJ-CANS items were selected to make intake systematic for all youth identified to be screened and to avoid adding significant assessment time to information already routinely collected about youth in juvenile court. Nevertheless, some courts have found integrating a new procedure challenging given demands on time and workload for juvenile court staff. In FY 18, only 20 of the 33 counties trained to use the JJ-CANS actually entered screenings in the system.

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 to be in Title 37, Chapter 1, Part 1 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. The JJ-CANS 2.0 would meet all the statutory requirements for this process at no additional cost to the courts, so a significant expansion of TICSRP is expected in FY 19.

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 54: 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

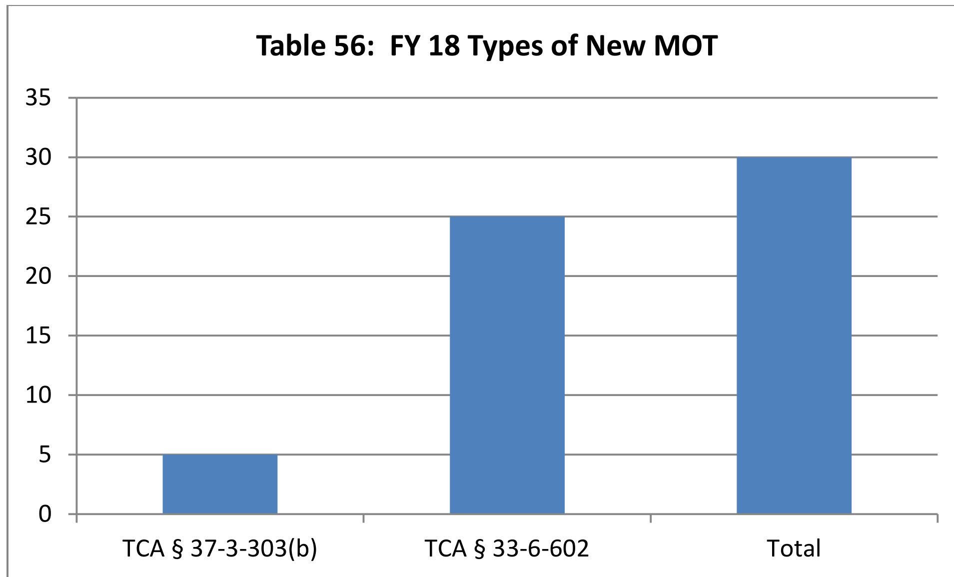
Table 55: Total MOTs
July 1, 2018

Type of MOT	Active MOTs	Suspended MOTs Due to Hospitalization	Total MOTs
303b	100	3	103
303g	0	0	0
602	216	14	230
Totals	316	17	333

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 MOGT 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 18 there were 165 forensic cases placed on MOT and 168 non-forensic cases placed 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

Thirty new MOT cases were initiated in FY 2018. Of these cases, 25 were initiated under TCA § 33-6-602 and five were initiated under TCA § 33-7-303(b). This was a decrease from FY 2017 in which 41 new MOT cases were initiated.



Terminations

In FY 2018, there were 40 MOT consumers whose MOT services were terminated. Five of these were terminated due to the death of the consumer (all due to natural causes). Thirty-five others had their MOT terminated by decision of the MOT agency's Treatment Team or by court order.

Table 57: FY 2018 MOTs Terminated

TCA § 33-7-303(b)	TCA § 33-6-602
3	37

The length of MOT service of those 40 consumers whose MOT was terminated by the MOT agency or by court order varied as outlined below:

Table 58: FY 2018 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
5	7	9	11	18

The most common reason for an MOT to be terminated was that the person had successfully adjusted to the community and no longer needed MOT, which was the case for 20 of the 40 MOT terminations in FY 18. As mentioned earlier, five individuals were deceased. Ten of the consumers were not compliant even with an MOT obligation, so the agency chose to terminate their contracts based on their lack of compliance. Two individuals moved out of the service area of their MOT agency (one out-of-state, one to an area without an available MOT agency). One MOT was terminated by court order, one was hospitalized for a lengthy time, and one moved into long-term care.

Table 59: FY 2018 MOT Terminations
By Reason

MOT no longer necessary for compliance	Not compliant even with a legal obligation	Deceased	Hospitalized with extended stay or placed in long-term care	Moved out of state or out of service area	Terminated by Court Order
20 (50%)	10 (25%)	5 (12.5%)	2 (5%)	2 (5%)	1 (2.5%)

Affidavits of Non-Compliance

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

A wide range of differing outcomes can result following the filing of an Affidavit of Non-Compliance. A previously non-compliant consumer may become compliant upon learning of the potential court hearing. If they meet commitment criteria they may be admitted on an emergency basis to a private or a state hospital. If they are receiving MOT services under the auspices of T.C.A. § 33-6-602 at the court hearing they may be re-admitted to the hospital of their original commitment. 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 2018, a total of 31 new Affidavits of Non-Compliance were filed concerning 29 individuals (two individuals had affidavits filed twice during the year). That's 9% of the 333 active MOT clients. Four clients came back into compliance without needing re-hospitalization

meaning 25 or 8% had significant compliance problems. Of the 29 non-compliant consumers, 19 had MOT under the auspices of T.C.A. § 33-6-602, and 10 under the auspices of T.C.A. § 33-7-303(b).

Ten of the non-compliant MOT consumers were hospitalized either by court order (nine) or by emergency status (one). Seven were awaiting a court hearing concerning their non-compliance at the end of FY 18. Five were terminated due to non-compliance by court action or by the agency (one consumer was terminated by the court after they moved out of state without permission and four were terminated by the MOT agency after they were unable to bring them into compliance despite consistent attempts). Four consumers became compliant with their MOT contract after the Affidavit of Non-Compliance was filed. Three of the non-compliant consumers have unknown locations.

Table 60: Outcome of Non-Compliance Affidavit

Hospitalized	10
Awaiting Non-Compliance Hearing at End of FY 18	7
Terminated by Court or by MOT Agency for Non-Compliance	5
Became Compliant after Affidavit Filed	4
Location Unknown	3
Total	**29**

Types of Original Legal Charges by Frequency

Table 61 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 20 as "none." Patients with multiple charges are only counted once under the most serious charge.

Table 61: FY 2018 Types of Original Legal Charges by Frequency

Charge(s)	Number of Occurrences
Aggravated Assault (felony)	91
None	67
Simple Assault (misdemeanor)	45
Vandalism/Trespassing/Nuisance	34
Theft/Robbery/Fraud	31
Murder	19
Attempted Murder	16
Sex Offense	8
Weapons Offenses	7
Arson	6
Escape/Failure to Comply/Obstruction of Justice	6
Kidnapping	3

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 18 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 18 no consumers were discharged under the new law.

Forensic Services Financial Report

Outpatient Services

Outpatient services are reimbursed on a fee-for-service basis. Table 62 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 62: Outpatient Expenditures, Adult and Juvenile Services

	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
Centerstone	$132,100	$138,600	$131,300	$152,100	$149,650	$156,750
Cherokee Health Systems	$68,950	$70,950	$63,000	$60,500	$88,550	$98,600
Frontier Health, Inc.	$86,350	$91,050	$85,700	$100,250	$118,000	$113,850
Helen Ross McNabb	$35,550	$29,250	$42,050	$43,500	$71,800	$69,000
Pathways	$188,800	$182,700	$189,400	$208,300	$260,800	$308,700
Ridgeview	$33,150	$36,750	$24,800	$34,500	$63,250	$64,755
Vanderbilt	$119,150	$126,300	$117,550	$125,300	$184,450	$253,450
Volunteer	$303,850	$280,400	$325,600	$321,750	$338,850	$366,700
WTFS	$487,200	$471,400	$429,250	$449,650	$497,600	$543,350
TOTAL	**$1,455,100**	**$1,427,400**	**$1,408,650**	**$1,495,850**	**$1,772,950**	**$1,966,700**

As previously noted (see pp. 40-42), TDMHSAS has a Memorandum of Understanding with the Board of Parole (BOP) for TDMHSAS to provide risk assessment evaluations on certain parole eligible Department of Corrections inmates as requested by the BOP. Statute requires psychiatric evaluation 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 on violent non-sex offenders for an assessment of propensity for violent re-offense. The Office of Forensic and Juvenile Court Services reimburses Vanderbilt University $900 per evaluation and then the BOP reimburses TDMHSAS at the same rate. The 139 evaluations in FY 18 cost $125,100 (not included in Table 62, above).

Inpatient Services

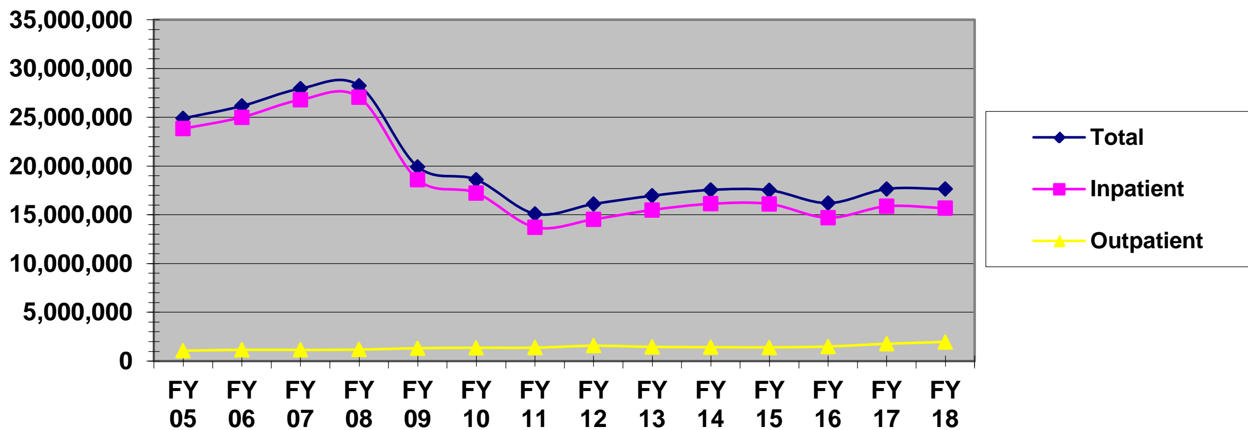
The Regional Mental Health Institutes are reimbursed by the Office of Forensic Services for forensic services at the rate of $450 per day. Documentation is required from the facilities to allow the TDMHSAS forensic specialists to authorize payment. This helps insure that proper procedures are followed 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 63 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 63: Inpatient Forensic State Expenditures

	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18
LMHI	$1,293,300	0.0	0.0	0.0	0.0	0.0	0.0
MBMHI	$864,900	$2,258,100	$2,150,100	$1,226,250	$1,174,500	$1,715,400	$2,525,850
MMHI	$689,850	$539,100	$563,850	$564,750	$558,900	$634,950	$666,450
MTMHI	$7,234,650	$8,771,400	$8,689,500	$7,380,450	$4,782,150	$5,944,050	$5,539,950
WMHI	$4,454,100	$3,931,650	$4,725,900	$6,942,600	$8,190,000	$7,587,000	$6,944,400
TOTAL	**$14,536,800**	**$15,500,250**	**$16,129,350**	**$16,114,050**	**$14,703,750**	**$15,881,400**	**$15,676,650**

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 64: 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.

The outpatient billing amounts in Table 65 are from the Office of Fiscal Services spreadsheets and include billing and collections through June 30, 2018. 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 65: Outpatient Misdemeanor Billing July 1, 2009-June 30, 2018

	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
Total	**$2,139,700**

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

Shelby County billing ($142,900) accounted for 44% of billing in FY 18. Davidson County had averaged $4,050 per year over the previous four years and then was billed $34,400 in FY 17 (which would have been $25,800 under the previous $600-per-evaluation rate) and $70,300 in FY 18, showing an increased willingness to bear the cost of outpatient evaluation of misdemeanor defendants.

Table 66: Inpatient Misdemeanor Services Billing

July 1, 2009-June 30, 2018

	Billed
FY 10	$985,150
FY 11	$918,450
FY 12	$1,776,150
FY 13	$997,109
FY 14	$702,450
FY 15	$1,019,250
FY 16	$959,400
FY 17	$1,306,350
FY 18	$1,340,100
Total	**$9,984,409**

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. Benefits were 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. 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 18, $577,080 was spent assisting 43 forensic patients. This was 100% of the funds available for direct services from the initial grant ($399,840) plus $177,240 of additional funds made available by the TDMHSAS because of the high demand. Housing support accounted for 96% of expenditures, mental health services accounted for 1%, transportation was 2%, and 1% for necessities such as clothing, eyeglasses, and utilities.

Conclusions and Recommendations

1. 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 a number of 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 18, 2,005 initial outpatient evaluations diverted 76% of that population from the need for an inpatient evaluation. There were 512 inpatient evaluations under T.C.A. § 33-7-301(a) with recommendations

for commitment for further inpatient evaluation and treatment at a rate of 21% state-wide. That is a rate of 4.5% of the pool of 2,005 total outpatient evaluations resulting in a recommendation for long-term commitment for inpatient evaluation and treatment (see Table 28, p. 28). There were 32 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) with 12 recommending commitment to an RMHI under T.C.A. § 33-7-303(c) (37%).

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.

2. The FY 14 report noted that fully half of defendants committed under T.C.A. § 33-7-301(b) were not prosecuted but instead had charges dismissed or otherwise retired. It was recommended that this pattern be studied "over multiple years" to confirm the consistency of this pattern and determine whether that was an unusually high rate. In FY 15, 48% of defendants committed under T.C.A. § 33-7-301(b) were not prosecuted but instead had charges dismissed or otherwise retired. In FY 16 the rate was 52%, in FY 17 the rate was 49% and in FY 18 the rate was 55%. 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. This rate of charges being retired raises the question of whether it was necessary for these patients to have been arrested and charged in the first place if there were sufficient diversion alternatives.

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.

3. The census of defendants committed under T.C.A. § 33-7-301(b) to WMHI without an equal rate of discharge is having a significant impact on that facility. Table 27 (p. 27) shows a significant increase in patients with that legal status at the end of FY 18. Table 41 (p. 39) shows a much larger accumulation of defendants committed under T.C.A. § 33-7-301(b) at WMHI than other facilities. Table 24 (p. 25) shows that 58% of all new commitments under that statute were admitted to WMHI, mostly from Shelby County. This is despite the outpatient evaluation provider for Shelby County (West Tennessee Forensic Services) consistently having one of the lowest inpatient referral rates of all providers (20% in FY 18; see Table 9, p. 10). The rates of recommendation for the commitment of defendants being evaluated under T.C.A. § 33-7-301(a) for further inpatient treatment under T.C.A. § 33-7-301(b) appear larger at MMHI (where commitments go to WMHI) and WMHI (see Table 21, p. 19) over the past two fiscal years which has contributed directly to the increase at WMHI.
   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.
4. 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. Table 40 (above, p. 38) shows 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. Table 40 shows 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.

5. 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 59, p. 57) and only 8% of all MOT clients (25 of 333) 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.

6. The high demand for TTS funds remained high in FY 18 despite a decline in the number of discharges of NGRI patients from FY 17 (see Table 35, p. 35). It is clear that the demand is for resources to pay for housing, with 96% of the funds going to that service. There were anecdotal reports in FY 18 of increased difficult getting patient's TennCare benefits started or re-started combined with housing providers requesting a larger rate of reimbursement to accept a "forensic" client.

   The Office of Forensic and Juvenile Court Services should work with the Office of Housing and Homelessness to enhance available housing opportunities and improve access to existing opportunities.