

**FORENSIC AND JUVENILE COURT SERVICES
ANNUAL REPORT FOR THE PERIOD
JULY 1, 2014-JUNE 30, 2015 (FY 15)**



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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 15

- In Fiscal Year 2015, the frequency of pre-trial outpatient and inpatient forensic mental health evaluations was lower than the previous eleven fiscal years.
- 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. For FY 15, there were 1,841 initial outpatient evaluations which diverted 77% of that population from the need for an inpatient evaluation. There were 401 inpatient evaluations and 82 new commitments under T.C.A. § 33-7-301(b) for further inpatient treatment after the inpatient evaluation, a rate of 20% of inpatient evaluations to commitments under T.C.A. § 33-7-301(b). That is roughly a rate of 4% commitments under T.C.A. § 33-7-301(b) from an initial outpatient evaluation total of 1,841. There were 30 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) and 11 recommendations for commitment to an RMHI under T.C.A. § 33-7-303(c) (37%).
- Mandatory Outpatient Treatment (MOT) coordination and monitoring was enhanced with a thorough investigation of current status of all clients on the MOT master list established during FY 14 to determine whether each client was in services, and to update MOT documentation. A regular process for notifying MOT providers of upcoming renewals was established. The MOT Manual was updated, posted on the TDMHSAS website and distributed in hard copy to all inpatient and outpatient MOT coordinators. MOT training sessions continued for community providers and RMHI staff across the state.
- The forensic census at the end of FY 15 (94) was lower than at the beginning of FY 14 and significantly lower than at the beginning of forensic census reduction efforts in December of 2008 (178).
- The frequency of juvenile court-ordered forensic evaluations (289) in FY 2015 was the highest in the last five fiscal years (247-288).
- Between October 1, 2010 and June 30, 2015, 5,660 juvenile court screenings were conducted in the Tennessee Integrated Court Screening and Referral Project resulting in over 3,600 referrals for mental health, substance abuse, and/or family services.

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OVERVIEW OF FORENSIC SERVICES IN THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Tennessee's forensic mental health system includes the traditional services of evaluation and treatment of pre-trial criminal defendants and defendants found not guilty by reason of insanity (NGRI). Tennessee averages 2,000 outpatient pre-trial evaluations of competence to stand trial and mental capacity at the time of the offense and 430 inpatient evaluations per year. At any point in time, forensic cases occupy 15%-20% of state facility beds (90-114 of 562 beds). Tennessee's forensic mental health system is primarily community-based and decentralized: between 75% and 80% of all pre-trial evaluations are completed on an outpatient basis with no referral for inpatient services, and of those cases referred for inpatient evaluations, 80% are completed in the Regional Mental Health Institutes and only 20% are admitted to the maximum security unit. The average daily census for forensic cases in the maximum security unit is 17. Tennessee's forensic mental health system also includes providing comprehensive evaluations when ordered by juvenile courts on youth alleged to be delinquent. The budget for forensic services runs between \$15 and \$20 million annually, including the per diem hospital reimbursement for forensic inpatients.

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 15.

Special projects currently underway in forensic services include providing psychiatric evaluations and risk assessments for parole-eligible inmates to the Board of Parole, 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

participates in the Department of Intellectual and Developmental Disabilities' (DIDD) Behavioral Services Advisory Committee, supporting the development of an Intensive Residential Behavioral Service for DIDD clients and providing specific input on the development of the Behavioral Severity Index, a risk assessment instrument for DIDD clients.

Previously, the Office of Forensic Services has collaborated with the 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").

The core of forensic mental health services in Tennessee, as in virtually all states, is based on providing evaluations to the courts on a criminal defendant's 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) and confirmed in subsequent cases. 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.

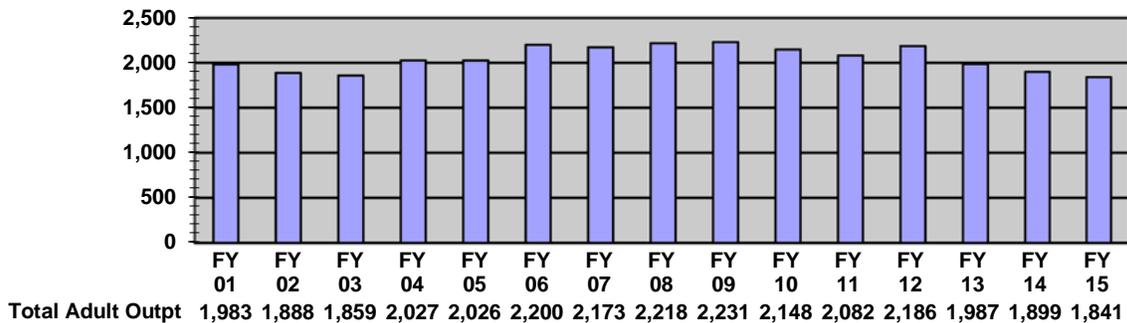
Court-ordered forensic mental health evaluation and treatment are not considered medically necessary procedures which are paid for by public or private insurance. These services are funded directly by the state budget with few exceptions, such as payment for medically appropriate treatment services of persons found Not Guilty by Reason of Insanity who are released to the community, and for subsequent medically necessary hospitalizations. The 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 2015, from July 1, 2014 to June 30, 2015, along with the trends observed in 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 setting 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 2015 (FY 15), 1,841 outpatient evaluations were conducted, the fourth straight year of decline.

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**

<i>Agency</i>	<i>Counties</i>
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 1,841 adult outpatient evaluations into frequencies for each provider, displaying the same breakout for the previous eight fiscal years for comparison.

Table 3: Frequency of Outpatient Evaluations by Provider

Provider	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Centerstone	199	149	138	167	175	166	168	129	121	137
Cherokee	90	97	151	148	133	113	121	99	97	90
Frontier	170	129	162	159	132	141	151	127	120	111
H. R. McNabb	104	93	94	90	91	65	69	60	53	73
Pathways	207	240	232	240	226	230	199	193	198	226
Ridgeview	89	103	96	51	102	77	85	53	51	41
Vanderbilt	112	111	101	123	113	128	158	129	142	137
Volunteer	391	370	407	409	364	321	330	364	333	346
WTFS/Midtown	838	881	837	844	812	841	905	833	784	680
Total	2,200	2,173	2,218	2,231	2,148	2,082	2,186	1,987	1,899	1,841

The 680 evaluations conducted by West Tennessee Forensic Services (WTFS, formerly Midtown) is the lowest in at least 10 years (no records available prior to FY 04, when Midtown conducted 870 evaluations). The unusually low rate for Ridgeview in FY 09 is due to that provider being without a certified forensic evaluator for eight months; their evaluations were referred to another community provider for that period. Many providers have reported a decline over the last five years in the frequency of evaluations ordered for defendants charged only with misdemeanors, discussed in reference to the following Tables 4-8. 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.

Although the media and the general public often associate forensic evaluations with murder cases, particularly concerning the insanity defense, in fact, these evaluations are ordered by courts on the full range of types of offense. The 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 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Capital	1%	1%	0.4%	1%	0.4%	0.3%	0.6%	0.6%	0.5%	0.3%	0.2%	0.1%
Violent Felony	36%	37%	38%	40%	37%	36%	36%	38%	37%	40%	40%	41%
Sex Offense	7%	8%	8%	7%	8%	9%	9%	8%	9%	8%	7%	8%
Non-Violent Felony	25%	22%	23%	22%	24%	22%	28%	29%	32%	31%	32%	31%
Misdemeanor	31%	32%	31%	30%	31%	32%	27%	23%	20%	19%	18%	17%

MISDEMEANOR SERVICES:

On June 26, 2009, **T.C.A. § 33-7-304** 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 \$600 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 from FY 10

through FY 15, with the most significant decline in the first two fiscal years following the change in law.

Table 5: Felony vs. Misdemeanor Outpatient Evaluation Frequencies

	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Felony	1,508 (68%)	1,577 (73%)	1,601 (77%)	1,731 (80%)	1,603 (79%)	1,545 (82%)	1,514 (82%)
Misd.	723 (32%)	571 (27%)	481 (23%)	455 (20%)	384 (19%)	354 (18%)	327 (18%)

Table 6: Outpatient Felony vs. Misdemeanor Trends

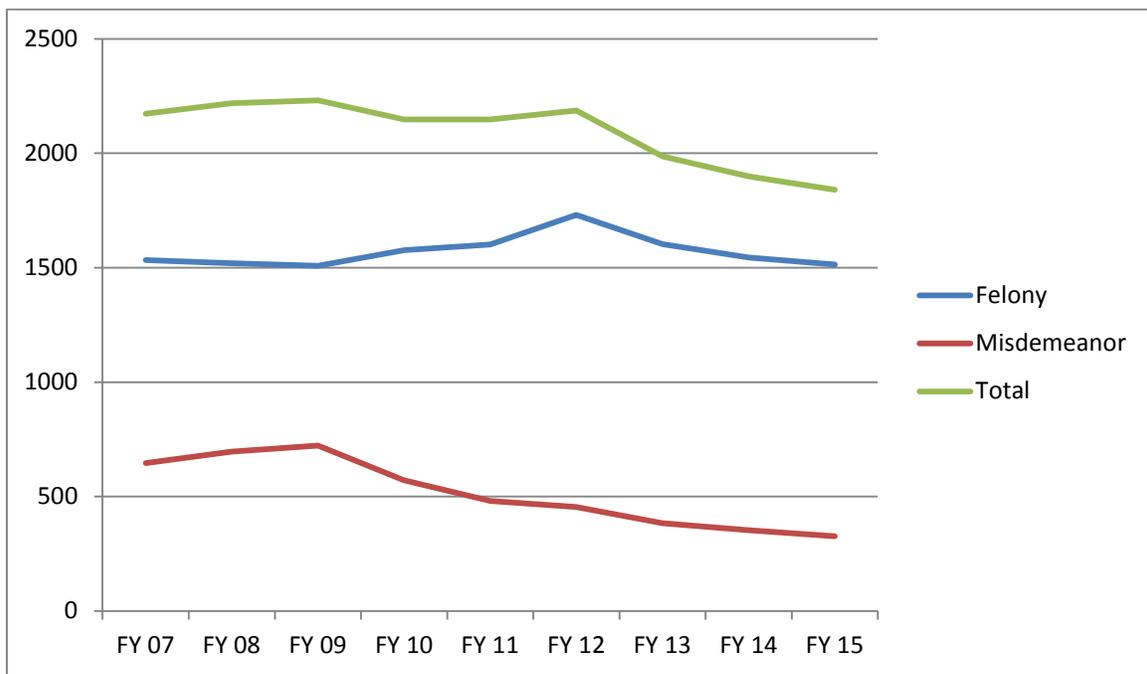


Table 6 shows that the frequency of misdemeanor evaluations has declined consistently since the change in law concerning responsibility for payment even when the frequency of other evaluations increased. Table 7 on the following page combines the proportions of total evaluations for each offense type category for the years FY 01–FY 09 (before the change in law) compared to FY 10–FY 14 (after the change in law).

**Table 7: Evaluations by Offense Type Before and After
T.C.A. § 33-7-304**

Type of Offense	FY 01-FY 09	FY 10-FY 15
Capital	0.6%	0.4%
Violent Felony	36%	39%
Sex Offense	8%	8%
Non-Violent Felony	24%	31%
Misdemeanor	31%	21%

Table 7 (above) shows that while the percentage of misdemeanor evaluations declined following the change in law, the percentage for non-violent felony evaluations increased while the percentage of evaluations for sex offenses, violent felonies and capital offenses were generally consistent. Table 8 shows the percentage of all evaluations that were misdemeanor-only cases for each provider.

Table 8: Frequency of Misdemeanor Evaluations

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

OUTCOMES:

Melton, Petrila, Poythress and Slobogin¹ 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. Typically when the outcome of an outpatient evaluation is a referral for further evaluation and treatment on an inpatient basis, no recommendation is made on whether the defendant should be considered competent or incompetent: that opinion is “deferred” to the inpatient provider. 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) and so the outpatient evaluator formally recommends a defendant be considered incompetent to stand trial without referring the defendant for an inpatient evaluation. Table 9 shows the rates of recommendations on competence to stand trial and the insanity defense.

Table 9: Recommendations of Outpatient Evaluations

Fiscal Year	Competence to Stand Trial			Insanity Defense		
	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%

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

A recommendation on competency to stand trial and 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 by the outpatient evaluator. Table 9 shows 4% 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. 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 provide opinions on both questions to the court without referral for an inpatient evaluation, an outcome which does not happen frequently (2% in FY 15).

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 3% of all outpatient cases, the success rate of diversion was 92% in FY 15 and 90% on average for the five years this statistic has been kept.

Table 10: Diversion from Inpatient Evaluation with Competency Training

Provider	Total # of cases	# of cases receiving training	# diverted	% of cases receiving training diverted
Centerstone	137	15	13	87%
Cherokee	90	0	-	-
Frontier	111	0	-	-
HR McNabb	73	0	-	-
Pathways	226	0	-	-
Ridgeview	41	0	-	-
Vanderbilt	137	1	1	100%
Volunteer	346	1	1	100%
WTFS	680	31	29	94%
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 14 has been 23%. The average rate for FY 15 was 21%.

Table 11: Frequency of Inpatient Referral by Provider

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

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) in that 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 he/she might attempt to escape) or a risk of violence beyond what the RMHIs can safely manage (primarily based on the defendant’s behavior in jail, particularly the use of property in jail as a weapon). The rate of referral has typically run 80% to the regular RMHI and 20% to FSP, but the referral rate was 15% to FSP in both FY 14 and FY 15.

Table 12: Inpatient Referrals to RMHIs and FSP

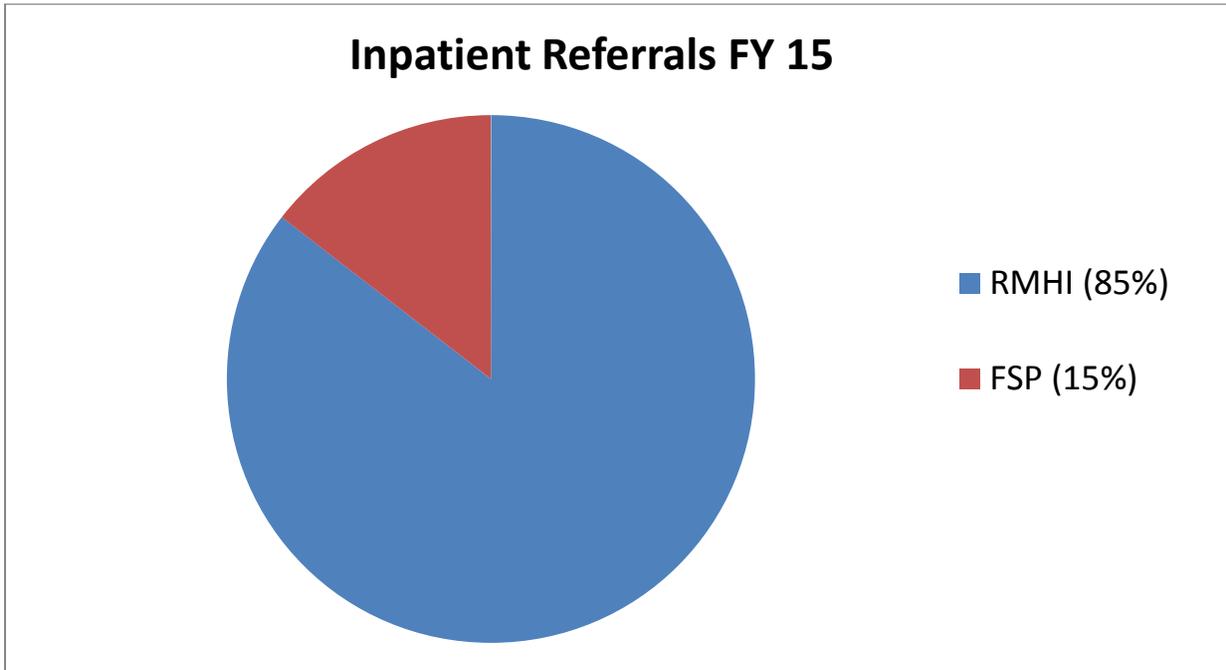
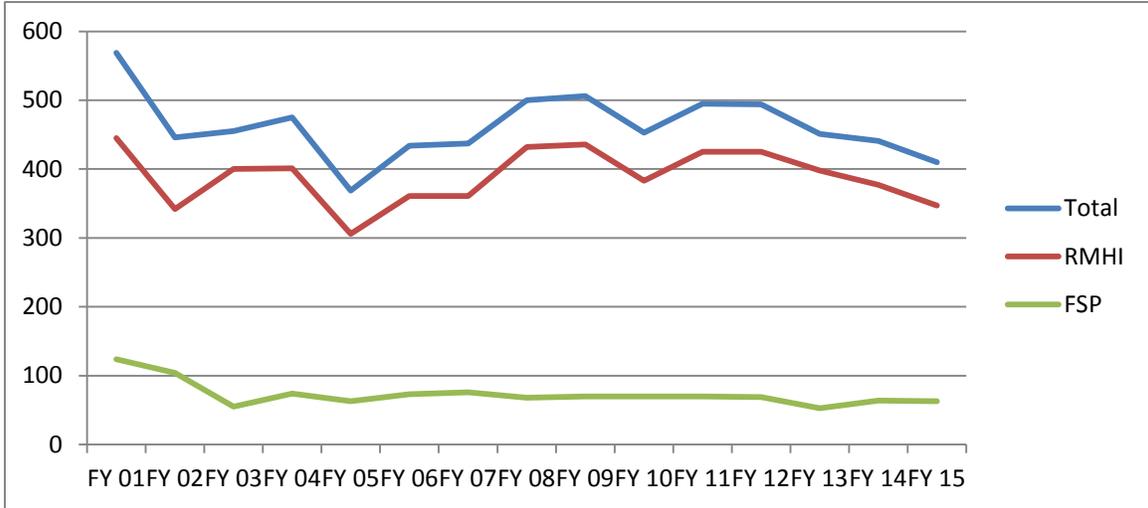


Table 13: Trends in Inpatient Referrals RMHI & FSP



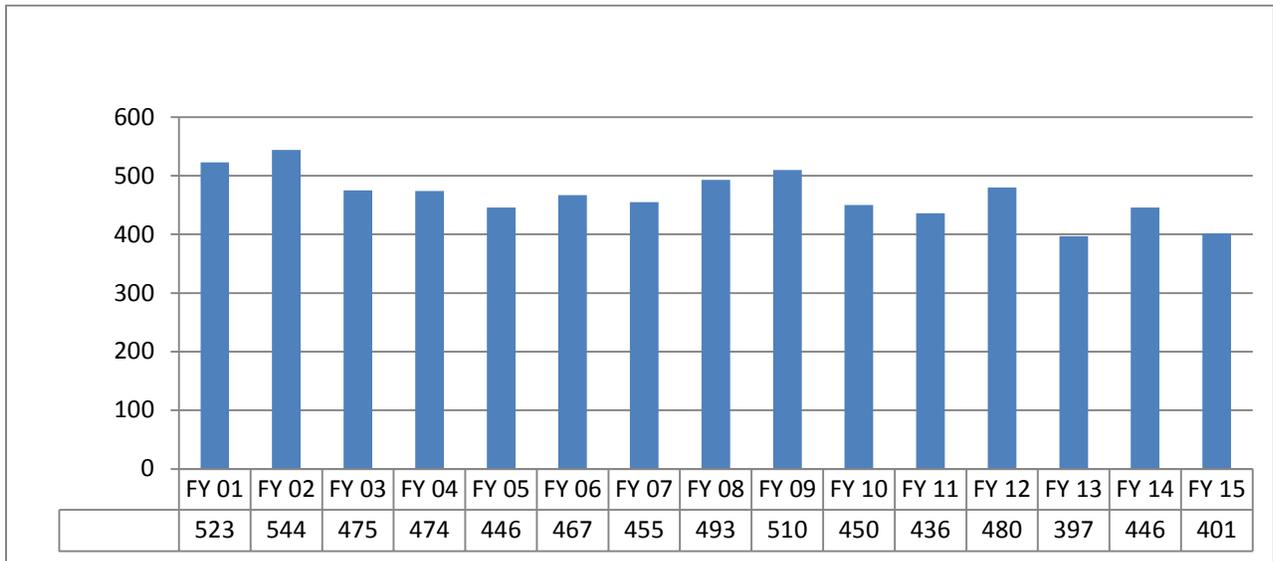
The statutory requirement that an outpatient evaluation be conducted prior to an inpatient evaluation, and the requirement that an inpatient evaluation can only be ordered when the outpatient evaluator recommends an inpatient evaluation is an effective means for preventing unnecessary forensic admissions 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, either faking symptoms of mental illness or intellectual disability or exaggerating symptoms/impairments he or she has or has had in the past. 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 are 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 outpatient evaluation. Defendants who are admitted for inpatient evaluation and treatment under T.C.A. § 33-7-301(a) may be held for a maximum of 30 days.

Table 14: Inpatient Admissions under T.C.A. § 33-7-301(a)



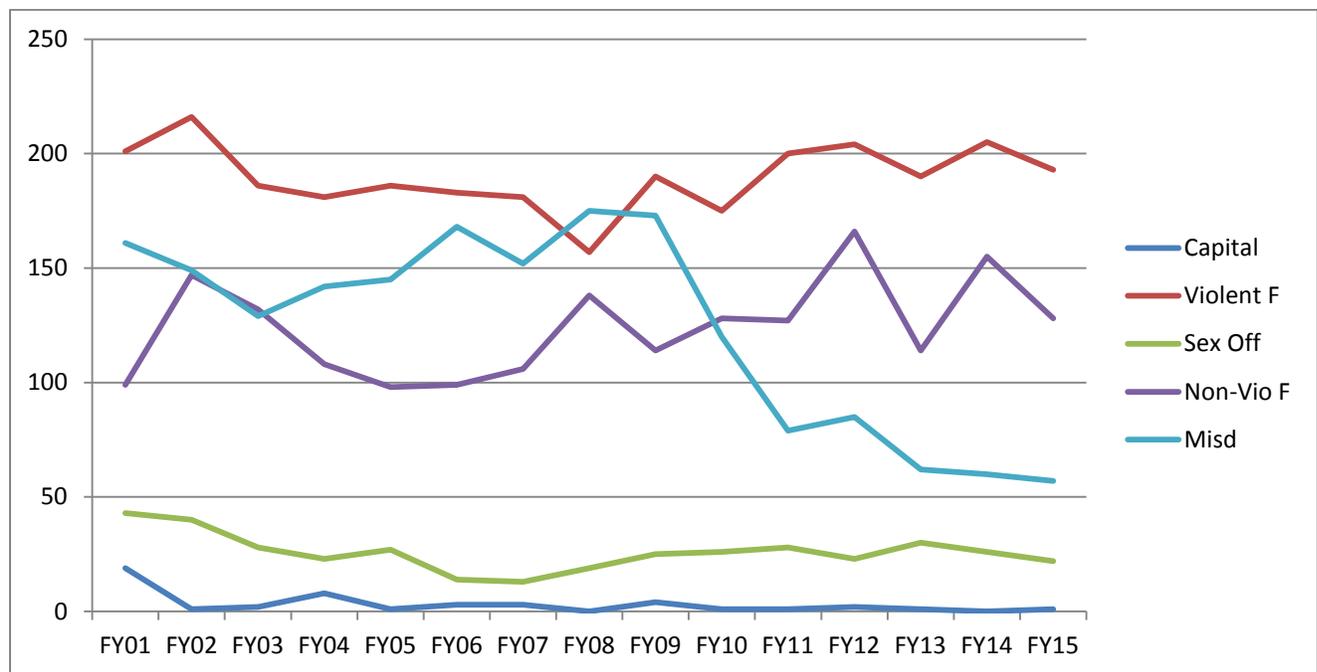
The FY 15 inpatient evaluation total of 401 is a 10% decline from FY 14’s total of 446, which was a 12% increase from FY 13 (397). Table 14 shows an uneven decline of 21% from FY 09 (510) through FY 15.

The distribution of inpatient evaluations by type of offense shown in Tables 15 and 16 on the following page show a decline in the proportion of misdemeanor cases with an increase in the proportion of non-violent felony cases. Anecdotal evidence from outpatient providers suggests that some misdemeanor cases which were evaluated on an outpatient basis and might have been referred for an inpatient evaluation were diverted by the justice system entirely by retiring or continuing the charges while arrangements are made for mental health and substance abuse services in the community. For example, the court administrator for the Davidson County (Nashville Metro area) General Sessions Court indicated that misdemeanor-only cases were being routed to their mental health court rather than referred for inpatient evaluations due to the cost.

Table 15: Pre-Trial Inpatient Evaluations by Offense Type

	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Capital	2%	0.2%	0.6%	0.7%	0	0.8%	0.2%	0.2%	.004%	.003%	0	0.2%
Violent Felony	39%	40%	39%	40%	32%	37%	39%	45%	42%	47%	45%	48%
Sex Offense	5%	6%	3%	3%	4%	5%	6%	6%	4%	7%	5%	5%
Non-Violent Felony	23%	21%	21%	23%	28%	22%	28%	29%	34%	28%	34%	31%
Misdemeanor	31%	32%	36%	33%	36%	34%	27%	18%	17%	15%	13%	14%

Table 16: 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. That number was relatively flat between FY 13 and FY 15.

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. Currently, MBMHI serves the eastern counties, Middle Tennessee Mental Health

Institute (MTMHI) the middle counties, Western Mental Health Institute (WMHI) the western counties outside of Shelby County and Memphis Mental Health Institute (MMHI) serves Shelby County. The Forensic Services Program (FSP; located on the grounds of MTMHI), is the maximum security facility for the entire state.

Table 17: Inpatient Evaluations by Facility

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
LMHI	56	51	67	68	67	66	70	48	45	0	0	0
MBMHI	64	73	74	55	64	69	39	53	67	99	108	122
MTMHI	67	44	58	55	56	71	70	65	84	74	89	69
WMHI	38	43	47	31	56	72	55	69	53	44	68	53
MMHI	154	148	132	164	170	140	128	129	146	105	109	90
FSP	95	67	89	82	80	92	88	74	85	75	72	67
TOTAL	474	446	467	455	493	510	450	436	480	397	446	401

As previously noted, a defendant admitted for an inpatient evaluation may only be held a maximum of 30 days. Most defendants respond to treatment initiated upon admission in a shorter time, and 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 14 year period FY 01-FY 14 was 21 days. The average length of stay statewide in FY 15 was 22 days.

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

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
LMHI	25	25	24	22	23	20	16	20	21	-	-	-
MBMHI	19	12	14	19	18	21	21	21	16	21	18	21
MTMHI	20	22	24	25	22	24	20	22	22	27	26	27
WMHI	24	24	22	22	22	23	21	19	20	21	22	24
MMHI	22	21	18	17	15	16	14	19	17	18	19	24
FSP	26	26	27	27	26	26	26	26	26	26	23	20
Statewide	23	21	21	21	20	20	19	21	19	22	21	22

OUTCOMES:

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

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
LMHI	59%	67%	57%	59%	70%	69%	67%	79%	66%	-	-	-
MBMHI	69%	79%	66%	64%	69%	72%	59%	79%	79%	64%	77%	72%
MTMHI	52%	67%	48%	52%	53%	40%	57%	76%	67%	58%	66%	68%
WMHI	71%	80%	70%	67%	73%	78%	82%	66%	73%	84%	57%	66%
MMHI	75%	72%	66%	75%	83%	69%	77%	69%	74%	62%	76%	73%
FSP	67%	75%	74%	80%	70%	84%	78%	82%	77%	72%	73%	74%
State-wide Average	66%	73%	66%	69%	73%	69%	72%	74%	73%	66%	71%	71%

The overall rate of defendants considered competent to stand trial after a period of inpatient evaluation and treatment is consistent with the 70% standard previously noted in discussion of the outpatient evaluation recommendations. Defendants who are not recommended to be considered competent to stand trial may be recommended for commitment for further inpatient treatment under T.C.A. § 33-7-301(b) or recommended 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 will be 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.

Table 20 shows the frequency of inpatient evaluations which indicated support for the insanity defense.

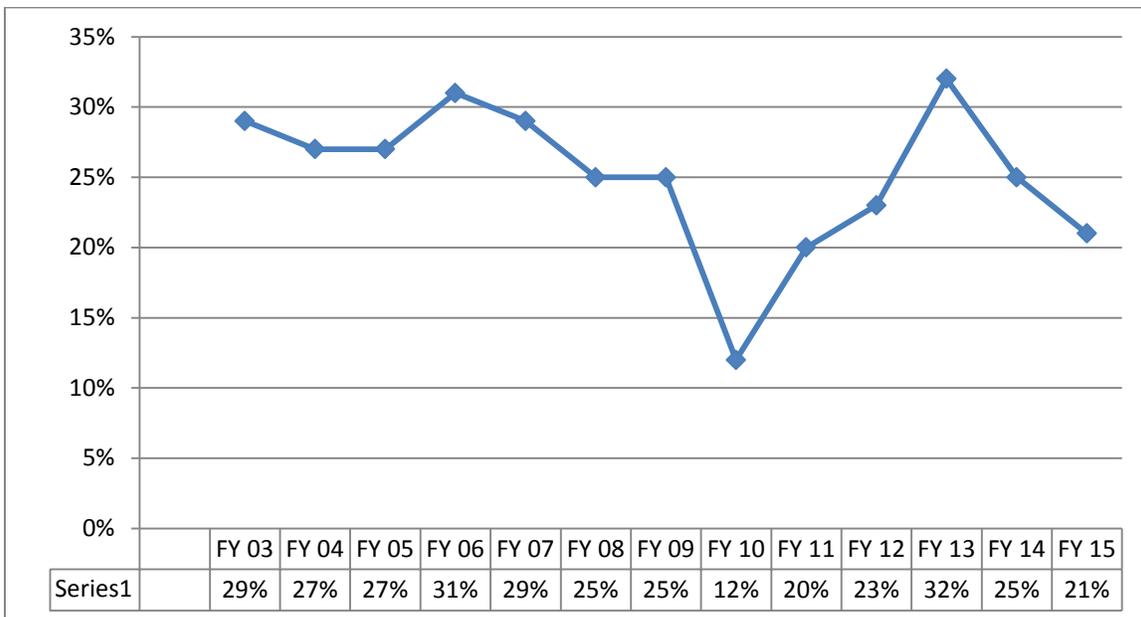
Table 20: Support for the Insanity Defense in Inpatient Evaluations

| FY |
|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 |
| 21% | 16% | 17% | 17% | 18% | 14% | 17% | 16% | 17% | 19% | 15% | 14% | 18% |

The state-wide total frequency of 18% represents support for the insanity defense in 73 cases out of the total of 401 evaluations conducted by the RMHIs and FSP in FY 15.

As noted above, 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). Defendants 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) or may be committed to one of the other RMHIs if the defendant no longer requires maximum security. Tables 21 and 22 show the frequency with which recommendations were made to the court for commitment out of all evaluations conducted under T.C.A. § 33-7-301(a).

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



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

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
LMHI	26%	29%	33%	40%	27%	15%	0%	4%	0%	-	-	-
MBMHI	24%	20%	31%	28%	21%	21%	21%	20%	16%	29%	15%	15%
MTMHI	34%	33%	43%	37%	49%	44%	10%	23%	34%	40%	32%	33%
WMHI	31%	22%	23%	37%	24%	21%	13%	24%	28%	15%	39%	32%
MMHI	18%	24%	26%	20%	12%	27%	16%	25%	26%	38%	16%	10%
FSP	37%	38%	34%	27%	35%	19%	15%	20%	24%	32%	30%	25%
Total	27%	27%	31%	29%	25%	25%	12%	20%	23%	32%	25%	21%

The state-wide rate of recommendations for commitment under T.C.A. § 33-7-301(b) decreased from 32% in FY 13 (the 11-year high) to 21% in FY 15, slightly below the average of 26% for the baseline period from FY 01 to FY09. The reduction between FY 09 and FY 10 may be attributable to additional training provided to RMHI staff on the commitment standard for T.C.A. § 33-7-301(b) (which is the civil involuntary standard in Title 33, Chapter 6, Part 5) and encouragement toward providing aggressive treatment for patients at risk for commitment during the initial evaluation under T.C.A. § 33-7-301(a). Updated training was provided again for all the RMHIs in FY 14 and this material has been included in all Initial Evaluator Training beginning in FY 10.

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

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

Court	Outpatient	Inpatient
General Sessions	1,110 (60%)*	242 (60%)**
Criminal Court	509 (27%)*	109 (27%)**
Circuit Court	166 (9%)*	34 (8%)**
Municipal	56 (3%)*	16 (3%)**

*% of total outpatient orders

**% of total inpatient orders

DEFENDANT CHARACTERISTICS T.C.A. § 33-7-301(a)

The gender, age and race characteristics listed below are more consistent with the distribution of those factors in correctional settings than in the general population.

Gender:

Outpatient: 80% male, 20% female

Inpatient: 79% male, 21% female

Age:

Race:

	<u>Outpatient</u>	<u>Inpatient</u>		<u>Outpatient</u>	<u>Inpatient</u>
0-18:	2%	<1%	Alaskan Native:	<1%	<1%
19-30:	36%	32%	American Indian:	<1%	<1%
31-43:	30%	34%	Asian/Pacific Islander:	<1%	<1%
44-64:	26%	28%	Black/African American:	47%	53%
>64:	3%	3%	White/Caucasian:	48%	42%
			Unknown:	<1%	0
			Other:	1%	3%

The comparison of frequencies of diagnostic categories in outpatient and inpatient evaluations demonstrates common patterns in pre-trial forensic mental health evaluations. The primary reason for referral for an inpatient evaluation is that the defendant is showing symptoms

of a psychosis or mood disorder which requires inpatient treatment; this is reflected in the increased base rate of psychotic and mood disorder diagnoses in the inpatient population and a higher rate of deferred diagnoses on an outpatient basis.

Primary Diagnosis

	<u>Outpatient</u>	<u>Inpatient</u>		<u>Outpatient</u>	<u>Inpatient</u>
Psychotic D/O:	21%	53%	Borderline IQ:	1%	0
Affective D/O:	21%	10%	Neurological:	3%	<1%
Deferred:	17%	<1%	Medical:	<1%	1%
Substance Related:	13%	5%	Other:	<1%	7%
Intellectual Disability:	3%	0	Malingering:	1%	0
Personality D/O:	4%	<1%	None:	1%	1%
Adjustment/Behavior:	2%	<1%	Anxiety:	5%	<1%

INTELLECTUAL DISABILITY IN PRE-TRIAL FORENSIC EVALUATIONS:

In FY 14, manpower limitations in the Department of Intellectual and Developmental Disabilities (DIDD) significantly curtailed the availability of consultation on defendants with intellectual disabilities. Previously, whenever a forensic evaluator believed that a defendant might have been incompetent to stand trial due to intellectual disability, or there might have been support for the insanity defense based on an intellectual disability, or the defendant might have met commitment criteria to the Harold Jordan Center (HJC: the inpatient facility operated by DIDD), under Title 33, Chapter 5, Part 4, the evaluator requested a consultation from a certified forensic evaluator designated by DIDD. The threshold for requesting an “ID Assist” changed in FY 14 so that consultation was only requested for outpatient competency training or for commitment to HJC. This was the standard for requesting and ID Assist throughout FY 15.

If a forensic evaluator believed that a defendant was incompetent to stand trial due to intellectual disability, but might be trained to competence 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 DIDD expert would then arrange for training sessions with the defendant upon receipt of a court order for training. If a forensic evaluator believed that a defendant was incompetent to stand trial and committable to HJC, the evaluator would request an ID Assist prior to communicating anything to the court. If the DIDD

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 forensic evaluator would complete the other and forward both to the court with a recommendation for commitment under T.C.A. § 33-5-403. If the DIDD expert did not find the defendant to be committable, the DIDD expert would indicate whether training should be attempted on an outpatient basis and the recommendations would be submitted to the court. 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, the defendant would be referred for inpatient evaluation and treatment to stabilize the mental illness before a final determination would be made about the level of intellectual functioning and any impairment related to the forensic issues.

Table 24: ID Assist Frequencies

24a: Outpatient Referrals

Referred by:	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Centerstone	5	4	16	24	8	21	15	22	4	2
Cherokee	3	7	8	9	9	7	7	3	2	4
Frontier	1	6	7	4	8	13	13	11	6	4
H R McNabb	2	1	2	1	0	2	3	0	1	0
Pathways	2	7	15	22	9	6	12	10	1	0
Ridgeview	4	2	5	4	16	7	6	7	2	4
Vanderbilt	5	9	11	25	21	17	21	9	0	3
Volunteer	14	11	24	17	14	16	11	11	3	4
WTFS/Midtown	21	38	31	65	43	23	46	39	2	5
Outpt. Total	57 (2%)*	85 (4%)*	119 (5%)*	171 (7%)*	128 (6%)*	112 (5%)*	134 (6%)*	112 (6%)*	21 (1%)*	26 (1%)*

*percentage of total number of outpatient forensic evaluations

24b: Inpatient Adult Referrals

Facility	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 14
FSP	5	0	0	2	1	4	0	0	0	0
LMHI	3	4	3	1	0	0	2	0	0	0
MBMHI	0	5	9	4	1	5	1	4	1	0
MMHI	2	10	5	10	11	12	9	2	0	0
MTMHI-Adult	3	1	1	4	3	0	6	4	0	0
WMHI	4	1	3	2	4	4	0	1	4	0
Inpt. Adult Total	17 (4%)*	21 (5%)*	21 (4%)*	23 (4.5%)*	20 (6%)*	25 (6%)*	18 (4%)*	11(3%)*	5 (1%)*	0 (0%)*

*percentage of total number of inpatient forensic evaluations

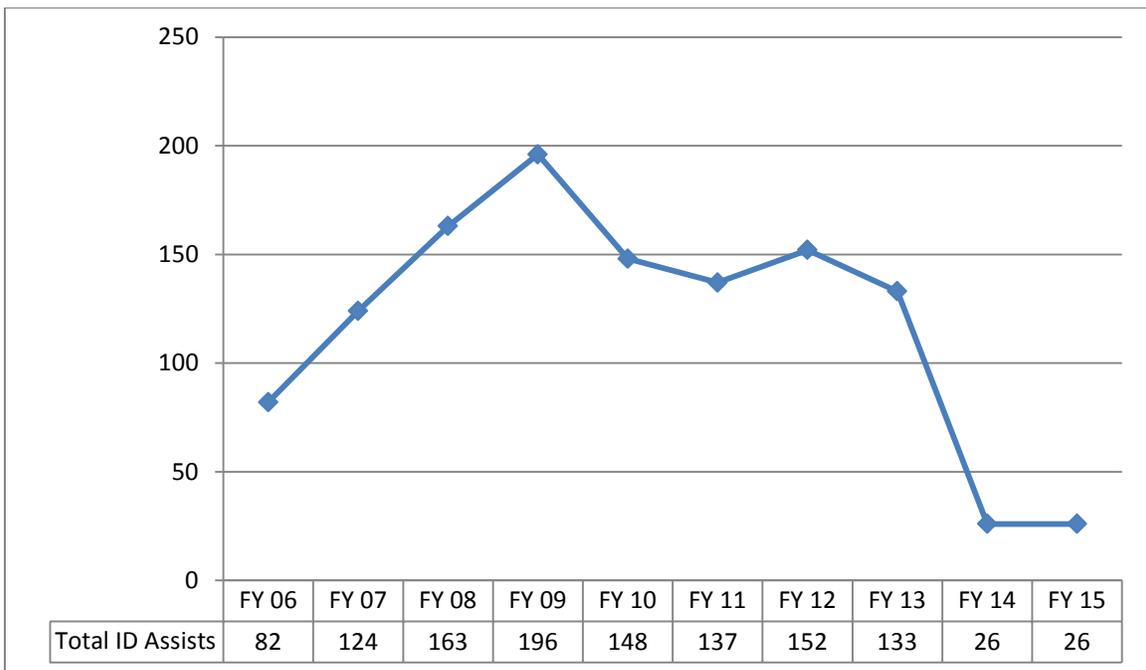
24c: Total ID Assist Requests

	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY14	FY15
TOTAL	82	124	163	196	148	137	152	133	26	26
	(2%)*	(4%)	(4%)	(7%)	(6%)	(5%)	(6%)	(5%)	(1%)	(1%)*

*percentage of total forensic evaluations, outpatient and inpatient

Five of the 26 ID Assist Requests were for committability: all five (5) resulted in commitment.

24d: Total ID Assist Request Trend



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 paragraph (b) of T.C.A. § 33-7-301. 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 paragraph (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 paragraph (b). (Table 25 shows two exceptions to that practice since FY 03.) Sixteen of the 27 admissions under T.C.A. § 33-7-301(b) to WMHI (59%) were Shelby County cases (consistent with 56% in FY 14, and down from 82% in FY 13). Defendants admitted to and evaluated under paragraph (a) at the maximum security Forensic Services Program (FSP) may be committed to FSP under paragraph (b) or may be committed to a Regional Mental Health Institute if they no longer require maximum security.

Table 25: Admissions Under T.C.A. § 33-7-301(b)

Facility	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
LMHI	15	12	17	11	12	13	9	1	1	2	-	-	-
MBMHI	9	16	18	21	11	9	6	2	8	10	19	21	16
MMHI	0	0	0	0	0	0	1	0	0	1	0	0	0
MTMHI	22	26	24	26	28	28	35	7	16	16	32	28	27
FSP	7	12	6	12	10	10	8	5	10	13	11	9	12
WMHI	31	42	39	43	37	42	38	33	39	54	51	45	27
TOTAL	84	108	104	113	98	102	97	48	74	96	113	103	82

WMHI admitted five (5) defendants under T.C.A. § 33-7-301(b) charged only with misdemeanors (all from Shelby County). Five (5) of the 16 defendants admitted to MBMHI were misdemeanor-only defendants, as were two (2) of the 27 admitted to MTMHI for a total of 12 misdemeanor-only defendants out of the total of 82 (15%). This frequency is consistent with

the frequency of misdemeanor-only outpatient evaluations (18%) and inpatient evaluations under T.C.A. § 33-7-301(a) (14%).

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 26 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 13 fiscal years, either by discharge from the hospital or by having their charges dismissed.

Table 26: T.C.A. § 33-7-301(b) Cases Closed

Facility	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
LMHI	14	11	18	14	9	7	22	2	1	3	-	-	-
MBMHI	4	15	19	19	12	16	9	1	8	7	21	23	17
MMHI	0	1	0	0	0	0	1	0	0	1	0	0	0
MTMHI	26	23	32	25	33	24	39	11	18	15	19	30	20
FSP	4	10	12	7	7	9	10	5	14	11	11	10	11
WMHI	31	40	42	41	43	45	43	36	32	51	57	40	48
TOTAL	79	100	123	106	104	101	124	55	73	87	107	103	96

Of the 96 cases closed during FY 15, 48 were discharged while still pre-trial criminal defendants under T.C.A. § 33-7-301(b) and two (2) others were adjudicated Not Guilty by Reason of Insanity while still being committed to the hospital and then evaluated under T.C.A. § 33-7-303(a) for further disposition. The remaining 46 (48%) had their charges dismissed or retired. Of those 46 who had their charges dismissed, half (23) were subsequently released to the community and half were still in the hospital on June 30, 2015.

Table 27, below, shows defendants discharged from T.C.A. § 33-7-301(b) during FY 15 categorized by their length of stay. The most frequent length of stay is between one and three months (40%); 27% were discharged in fewer than 31 days, and 88% of those discharged were discharged in the first six months. This distribution is very consistent with previous fiscal years.

**Table 27: Length of Stay Under T.C.A. § 33-7-301(b)
Discharges during FY 15**

Facility	0 – 30 Days	31-90 Days	3-6 Mos.	6 Mo.- 1 Yr.	1-2 Yrs.	2-5 Yrs.	5 Yrs. +	Avg. LOS in days	Range in days
MTMHI	6	7	2	1	1	0	0	80	13-528
FSP	3	5	1	0	0	0	0	49	15-109
WMHI	3	6	6	3	1	0	0	146	27-713
MBMHI	1	1	1	0	0	0	0	65	1-146
Totals	13	19	10	4	2	0	0	99	1-713

While Table 27 shows the length of stay for patients discharged during FY 15, Table 28 shows the lengths of stay for those patients still in the RMHIs at the end of FY 15 (June 30, 2015), 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 28: Length of Stay for Patients On Census Under T.C.A. § 33-7-301(b) on June 30, 2015

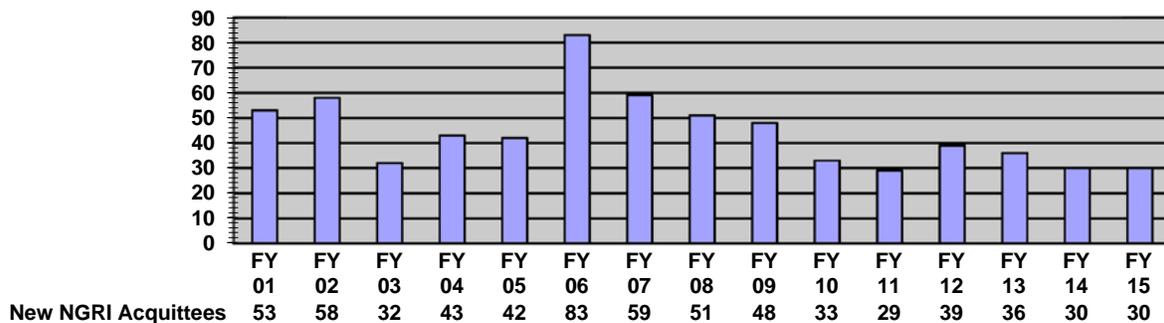
LOS	# of patients
0-6 mos	7
6-12 mos	9
1-2 years	3
2-3 years	2
3 years +	0
total	21

EVALUATION AND TREATMENT OF DEFENDANTS FOUND NOT GUILTY BY REASON OF INSANITY

EVALUATION OF INSANITY ACQUITTEES UNDER T.C.A. § 33-7-303(a):

Legislation signed into law in June of 2009 amended T.C.A. § 33-7-303(a) so that all evaluations of defendants found Not Guilty by Reason of Insanity (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 under the amended statute, 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. Evaluations address 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. Recommendations for release include a recommended aftercare plan if the acquittee requires treatment and an indication of whether the acquittee requires the legal obligation of Mandatory Outpatient Treatment under T.C.A. § 33-7-303(b). There were 30 new NGRI acquittees in FY 15.

Table 29: New NGRI Acquittees



Of the 30 acquittees, 19 (63%) were acquitted on a violent felony (not sex offense) offense, 8 (27%) were acquitted on a non-violent felony, and 3 (10%) were acquitted of a misdemeanor offense. Of the 19 acquitted on a violent felony, 12 (63%) were acquitted of aggravated assault, two (2) were acquitted of murder charges and one (1) was acquitted of aggravated child neglect which resulted in the death of the infant.

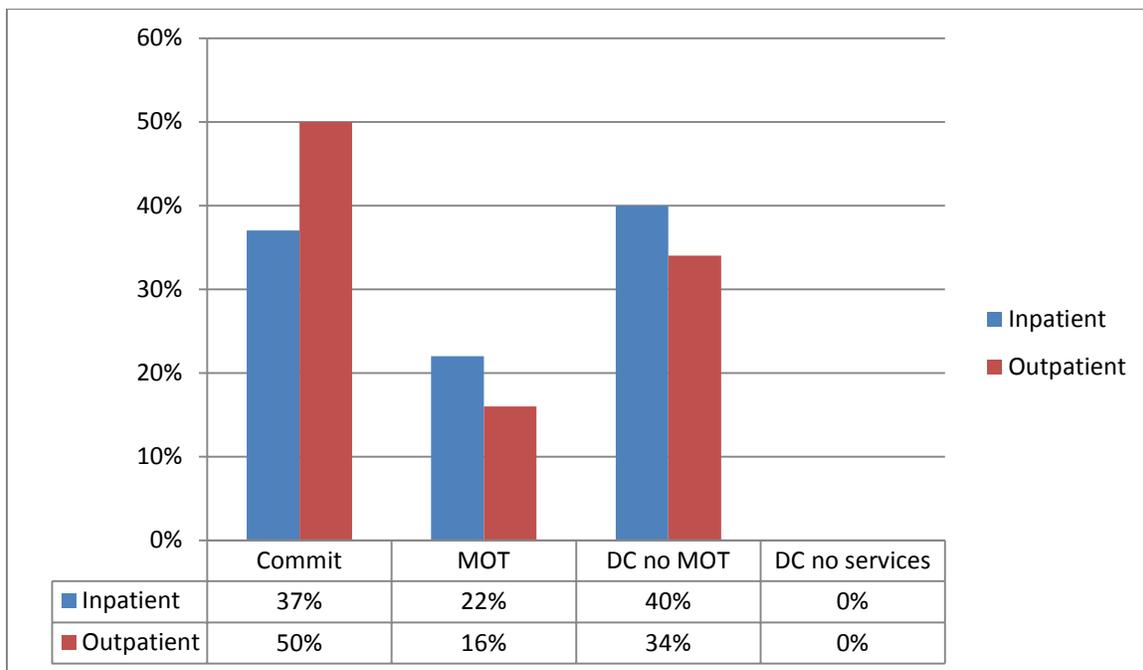
There are four possible outcomes of an evaluation conducted under T.C.A. § 33-7-303(a): (1) commitment to an RMHI under T.C.A. § 33-7-303(c), (2) release to the community with an Mandatory Outpatient Treatment (MOT) plan under T.C.A. § 33-7-303(b), (3) release to the community with an outpatient treatment 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. Table 30, below, shows the outcomes over the last six fiscal years, with FY 15 recommendations broken out by provider.

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

	Commit	MOT	D/C w/o MOT	D/C w/o tx
Centerstone FY 15	0	0	0	0
Cherokee FY 15	0	0	0	0
Frontier FY 15	0	0	7	0
HR McNabb FY 15	0	0	0	0
Pathways FY 15	0	2	3	0
Ridgeview FY 15	0	0	0	0
Vanderbilt FY 15	4	1	1	0
Volunteer FY 15	4	5	1	0
WTFS FY 15	3	0	0	0
Total FY 15 (Outpatient)	11 (37%)	8 (27%)	11 (37%)	0
Total FY 14 (Outpatient)	14 (47%)	4 (13%)	12 (40%)	0
Total FY 13 (Outpatient)	20 (55%)	6 (16%)	10(28%)	0
Total FY 12 (Outpatient)	23 (59%)	6 (15%)	10 (26%)	0
Total FY 11 (Outpatient)	13 (44%)	2 (6%)	14 (48%)	0
Total FY 10 (Outpatient)	18 (54%)	6 (18%)	9 (27%)	0
Total FY 09 (Inpatient)	17 (35%)	9 (19%)	22 (47%)	0
Total FY 08 (Inpatient)	20 (39%)	13 (25%)	18 (35%)	0

A comparison of outcomes between the sum of the last two years of inpatient evaluations under T.C.A. § 33-7-303(a) (n= 99) and the first six years of outpatient evaluations (n= 197) shows a greater frequency of commitment from outpatient evaluations (see Table 31).

Table 31: Inpatient & Outpatient Evaluation Outcomes under T.C.A. § 33-7-303(a)



Under the inpatient evaluation scheme prior to July 1, 2009, 100% of acquittees were admitted to an RMHI at least for the evaluation under T.C.A. § 33-7-303(a) by law, while under the outpatient scheme after July 1, 2009, 50% were hospitalized with a commitment under T.C.A. § 33-7-303(c), meaning 50% were not hospitalized at all.

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

Table 32 shows the frequency of commitments of NGRI acquittees to the RMHIs under T.C.A. § 33-7-303(c). 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.

Table 32: T.C.A. 33-7-303(c) Commitments

←Inpatient Evaluation | Outpatient Evaluation→

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
LMHI	7	9	5	10	10	2	4	3	3	-	--	--
MBMHI	1	3	2	3	1	0	1	0	2	4	0	0
MMHI	0	0	0	1	0	0	0	0	0	0	0	0
MTMHI	4	9	5	15	9	4	7	10	20	15	6	0
FSP	0	1	1	1	0	0	1	1	2	1	3	2
WMHI	1	4	5	6	5	5	7	1	4	1	5	12
TOTAL	13	26	18	36	25	11	20	15	31	21	14	14

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 15, seven (7) of the 12 commitments to WMHI were from courts outside the counties regularly served by WMHI (MTMHI = 5, MBMHI = 2).

Once committed, NGRI acquittees begin a process of preparing for discharge when they no longer meet the commitment criteria of Title 33, Chapter 6, Part 5 and an alternative less drastic alternative to hospitalization has been identified in the community. Table 33 summarizes the length of stay for all 11 patients discharged to the community during FY 15 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.

**Table 33: Length of Stay Under T.C.A. § 33-7-303(c)
Discharges during FY 15**

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	0	0	0	1	2	1	1	1,127	252-3,609
WMHI	0	0	1	5	0	0	0	234	154-316
Totals	0	0	1	6	2	1	1	640	154-3,609

The average length of stay for those discharged was 640 days (just over one year and nine months). MTMHI discharged one patient who had been hospitalized almost 10 years. Most of the discharged NGRI patients had a length of stay between 6 and 12 months. If the length of stay for the patient discharged after almost 10 years is eliminated, the average length of stay drops from 640 days to 343 days (just under one year).

While Table 33 shows the length of stay for patients discharged during FY 15, Table 34 shows the length of stay for those patients still in the RMHIs at the end of FY 15.

Table 34: Length of Stay for Patients On Census Under T.C.A. § 33-7-303(c) on June 30, 2015

LOS	# of NGRIs
0-6 mos	7
6-12 mos	7
1-2 years	7
2-5 years	14
5-10 years	7
10-15 years	2
15-20 years	1
20-25 years	1
25 years +	0
total	46

FORENSIC CENSUS

The Office of Forensic and Juvenile Court Services monitors the forensic census in all the RMHIs closely to help maintain the lowest possible forensic census while minimizing wait times for admissions and providing all forensic mental health services mandated by statute and sound clinical practice. These efforts focus on monitoring those points which result in a new forensic admission and supporting efforts to discharge forensic cases no longer meeting commitment criteria. These critical points are:

- 1) Referral for an inpatient pre-trial evaluation under T.C.A. § 33-7-301(a) following an outpatient evaluation. The referral rate has historically been around 25% state-wide over a 12 month period. When an agency's referral rate exceeds 25%, Office of Forensic Services staff investigate to determine if there is a systemic cause, such as a change in agency staffing or need for additional training on the use of supplemental services (e.g. competency training, additional testing) that could reduce the need for inpatient services.
- 2) Recommendations for commitment of defendants being evaluated on an inpatient basis under T.C.A. § 33-7-301(a) for further inpatient evaluation and treatment under paragraph (b) of T.C.A. § 33-7-301. This rate of commitment can vary widely based on the level of clinical severity in the forensic evaluation population and the fact that the number of commitments is generally small (a few cases more or less can affect the rate significantly). These commitments are indefinite, so even a few can consume a significant amount of inpatient service capacity. As shown in Table 22, the rate of recommendations for commitment at MTMHI was 49% in FY 08 and 44% in FY 09 and then fell to 10% in FY 10. Several training sessions were held for all clinical staff in the last half of FY 09 on the commitment standards under Title 33, Chapter 6, Part 5 necessary for commitment under T.C.A. § 33-7-301(b). This training emphasized the goal of completing treatment for defendants during the 30-day period of evaluation and treatment under T.C.A. §33-7-301(a). This training is now included in all Initial Forensic Evaluator Training sessions. Rates of recommendations for further commitment in FY 15 ranged from 10% to 33% among the RMHIs with a state-wide average of 21%.
- 3) Evaluation of defendants found NGRI under T.C.A. § 33-7-303(a) to determine committability under the standards of Title 33, Chapter 6, Part 5. These commitments are

also indefinite and so may result in the use of a significant amount of inpatient service capacity. Most of the community agencies contracted to complete these evaluations have expertise in community aftercare plan development but special support from the Office of Forensic Services can be helpful to agencies that don't provide an array of outpatient services or whose forensic evaluators function independently from the service planning providers in their agencies. In these cases, the forensic evaluators are connected with jail-based criminal justice liaisons to help identify less drastic alternatives to hospitalization for defendants found NGRI.

- 4) Monitoring discharge readiness of the NGRI population committed to the RMHIs. Each RMHI maintains a discharge readiness list for all NGRI patients in the facility to track their clinical process and to identify any barriers to discharge. The lists are reviewed monthly in the Office of Forensic Services with the goal of assisting facility staff to identify resources to overcome discharge barriers.

These efforts along with regular training on forensic services have helped to reduce and maintain the inpatient forensic census at or below a target maximum capacity of 114 statewide. Tables 35 and 36 show the state-wide totals for the long-term commitment patients under T.C.A. § 33-7-301(b) and T.C.A. § 33-7-303(c), respectively while Table 37 displays the change in forensic census for all categories combined between December of 2008, just before the focus on census management was undertaken, and the end of FY 15.

Table 35: T.C.A. 33-7-301(b) Cases on Census

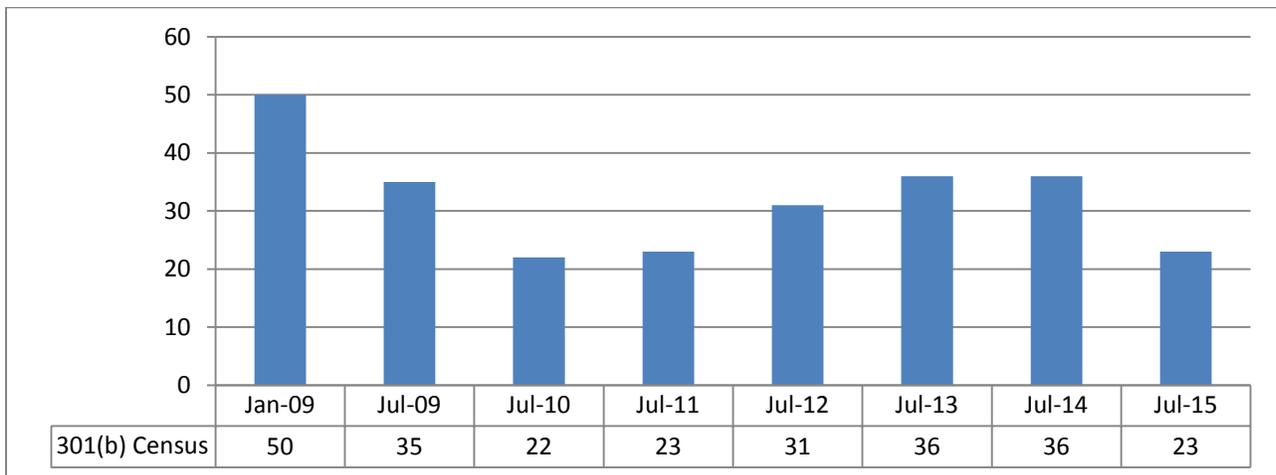


Table 36: T.C.A. 33-7-303(c) Cases on Census

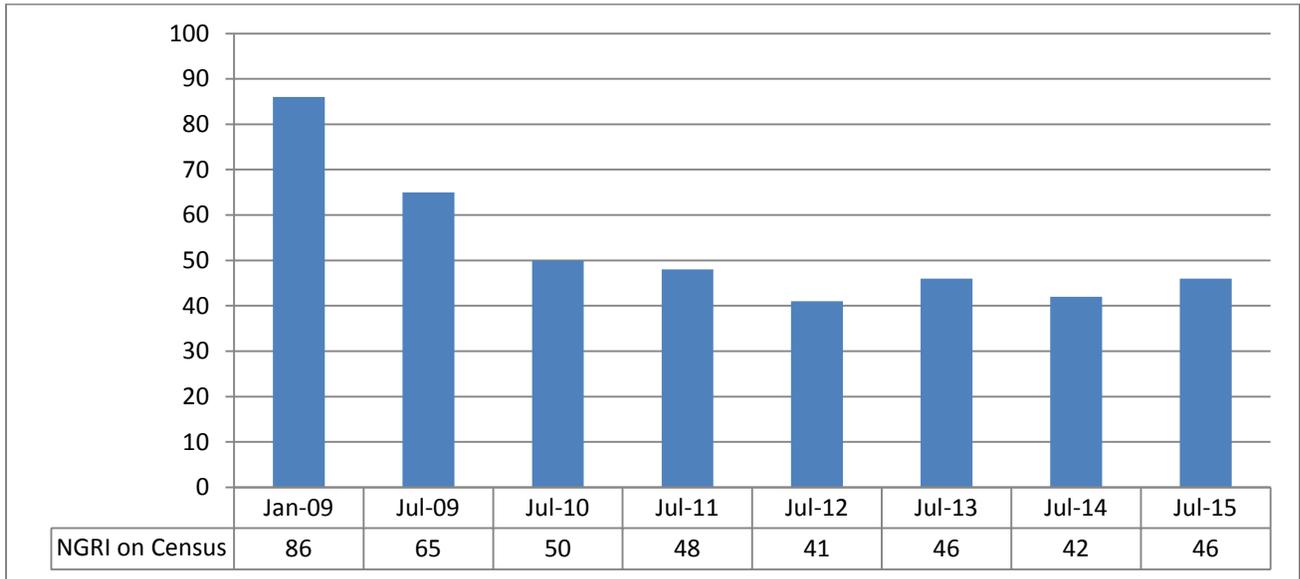
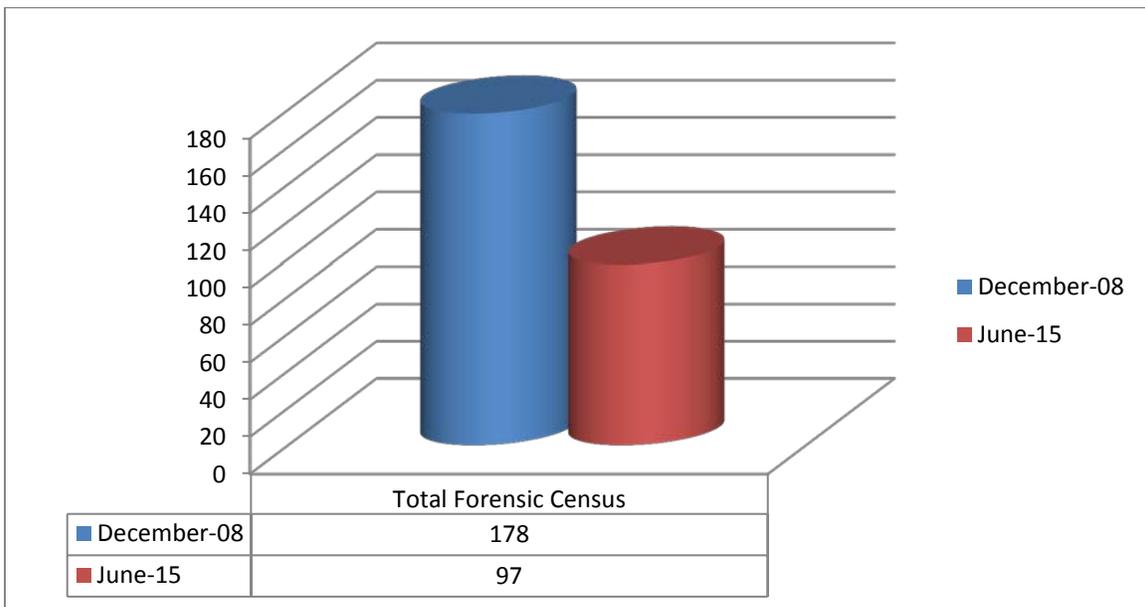


Table 37: Total Forensic Census State-Wide



Forensic Census Shift to WMHI:

As previously noted, during FY 14 the overall census at MTMHI and MBMHI was often at maximum capacity, resulting in the diversion of emergency civil involuntary admissions to the available suitable accommodations at WMHI. 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 courts, and patients committed to MTMHI or MBMHI under T.C.A. § 33-7-301(b) or T.C.A. § 33-7-303(c) who had been in the hospital 90 days and were not likely to be discharged in the next 30 days were considered for transfer to WMHI. Transfers were completed in accordance with the facility-to-facility policy and procedure managed by the Division of Hospital Services.

Between April 1, 2014 and June 30, 2015, MBMHI transferred one patient committed under T.C.A. § 33-7-301(b) and one patient committed under T.C.A. § 33-7-303(c). One patient committed to MBMHI under T.C.A. § 33-7-301(b) was not transferred due to community ties in the MBMHI area. MTMHI transferred 17 patients committed under T.C.A. § 33-7-301(b) and four (4) patients committed under T.C.A. § 33-7-303(c); seven (7) patients committed under T.C.A. § 33-7-301(b) and 21 patients committed under T.C.A. § 33-7-303(c) were not transferred to WMHI due to community ties in the MTMHI area. As of June 30, 2015, eight (8) of the 23 patients transferred to WMHI had been discharged (all committed under T.C.A. § 33-7-301(b)).

Between April 1, 2014 and June 30, 2015, nine (9) patients were admitted to WMHI directly from the community after having been committed under T.C.A. § 33-7-303(c); seven (7) from MTMHI's area and two (2) from MBMHI's area. As of June 30, 2015, six (6) of those nine (9) patients had been discharged. New commitments under T.C.A. § 33-7-301(b) continue to be admitted to MTMHI and MBMHI since 75% of those patients tend to be discharged in less than 90 days.

A review of the forensic census including all legal categories under Title 33, Chapter 7, Part 3 for each RMHI (Table 38, below) shows an increase at WMHI subsequent to the re-

direction of long-term forensic commitments there and a decrease at MTMHI due in part to the re-direction of cases to WMHI and in part due to a temporary hold on forensic evaluations for the last two weeks of June, 2015 due to staffing changes in psychiatry coverage (about six fewer cases than would be expected). New forensic cases from the area previously served by LMHI were re-directed to MBMHI beginning April 1, 2012. LMHI was closed at the end of FY 12, resulting in a temporary increase at MBMHI evident in Table 38.

Table 38: Forensic Census (all categories) by RMHI

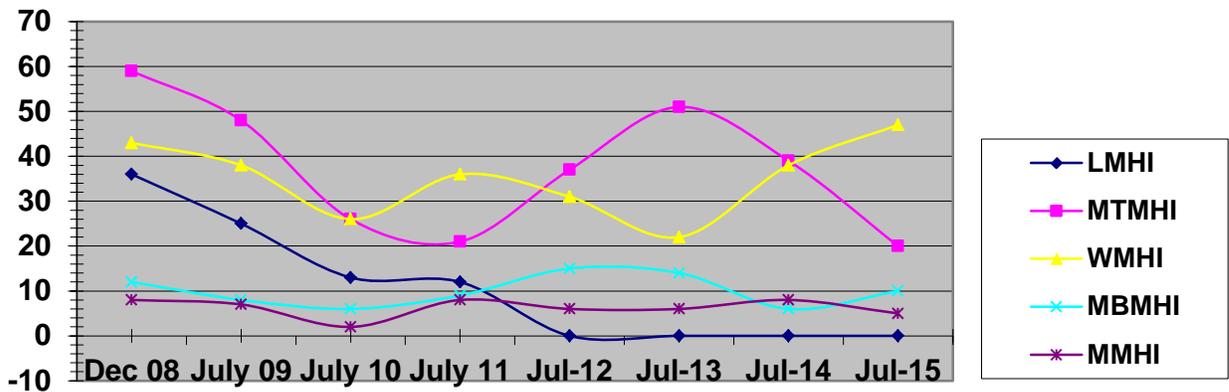


Table 39 (below) allows for an inspection of the census of each legal status within each facility and state-wide, comparing mid-December 2008 (just before census reduction efforts began) with the end of FY 15. The number of patients in all legal categories was reduced, particularly those of longer term commitments both of pre-trial defendants and insanity acquittees. 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.

Table 39: Forensic Census Comparison: December 2008 and July 2014

December 19, 2008

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

July 1, 2015

Facility	MTMHI	FSP	WMHI	MBMHI	MMHI	Total
301(a)	0	4	8	8	5	25
301(b)	2	5	15	1	0	23
303 (a)	0	0	0	0	0	0
303(c)	18	3	24	1	0	46
Total (% of total Census)	20 (15%)	12 (57%)	47 (36%)	10 (7%)	5 (9%)	94 (20%)

RISK ASSESSMENT EVALUATIONS FOR THE BOARD OF PAROLE

Beginning in 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 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. There have been 266 evaluations conducted since the beginning of FY 11, 101 (38%) sex offender evaluations and 165 (62%) violent offender risk assessments. This total

includes eight (8) female offenders (2 for sex offenses, 6 for violent offenses) and 258 male offenders (97 for sex offenses, 159 for violent offenses).

Evaluations are conducted by a psychiatrist from the Department of Psychiatry at the Vanderbilt University Medical School who has completed the TDMHSAS Forensic Evaluator certification and the Sex Offender Treatment Board training. Evaluations include the use of at least one actuarial risk assessment instrument (e.g. the Violence Risk Appraisal Guide² and/or the STATIC-99 revised scoring rules³) 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) completed by a DOC forensic social worker. The LSI is an actuarial measure of the risk of general criminal recidivism, not limited to violent or sexual offenses. The results of the LSI 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 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 may be nuanced, 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 less than or equal to/greater than the Department of Correction baseline for re-offense (TDOC Recidivism Study: Felon Releases 2001-2007). There were 98 evaluations completed in FY 15, significantly more than in previous years, as indicated in Table 40:

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 40: 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
Total	101	165	266

The distribution of high, medium and low risk estimates for violent offenders in FY 15 was consistent with the trend over the previous four fiscal years, as displayed in Table 41:

**Table 41: Risk Assessments for the BOP:
Violent Offenders**

	High	Medium	Low
FY 11	8	2	4
FY 12	4	20	14
FY 13	3	8	10
FY 14	5	11	14
Total FY11-14	20 (19%)	41 (40%)	42 (41%)
FY 15	12 (19%)	25 (40%)	25 (40%)
Grand Total	32 (19%)	66 (40%)	67 (41%)

Similarly, 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 in FY 15 with the rate from the previous four fiscal years.

**Table 42: 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
Total FY 11-14	11 (17%)	54 (83%)
FY 15	7 (19%)	29 (81%)
Grand Total	18 (18%)	83 (82%)

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:

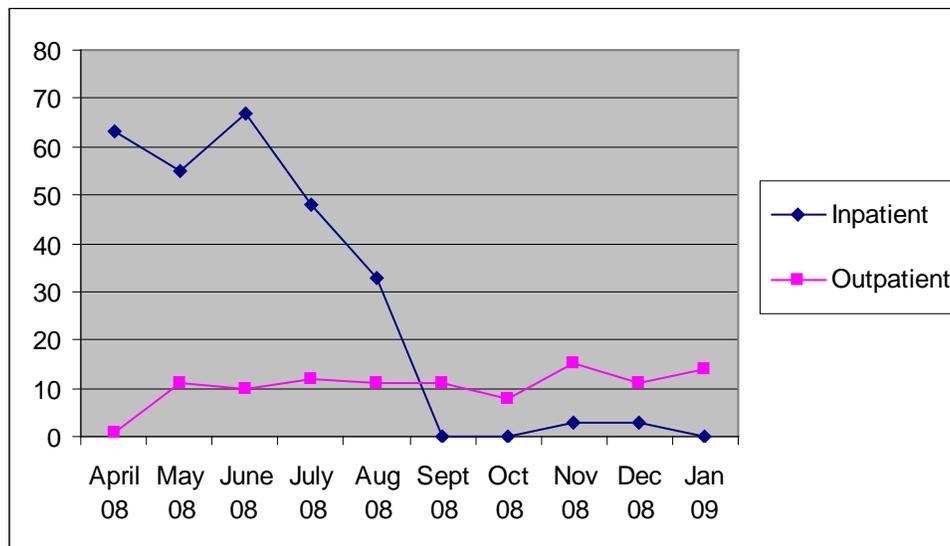
- whether the juvenile is mentally ill and/or developmentally disabled,
- what, if any, treatment is recommended,
- whether or not the juvenile meets commitment criteria, and
- legal questions such as competency to stand trial.

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 was 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 admitted to an RMHI and 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 43, below, showing the monthly frequency of inpatient and outpatient

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

juvenile court-ordered evaluations for the ten month period around the Court of Appeals decision, April 2008-January 2009⁵.

Table 43: Inpatient and Outpatient Juvenile Court Ordered Evaluations



These changes were codified when the statutes governing the process for juvenile courts to order mental health evaluations and the responsibility for the cost of the evaluations were amended during FY 09. T.C.A. § 37-1-128(e) was amended to require that all evaluations be ordered on an outpatient basis first, and only ordered inpatient if the outpatient evaluator recommended inpatient evaluation. T.C.A. § 37-1-150 was amended to clarify that the city or county would be responsible for the cost of inpatient evaluations. The children and youth unit at WMHI (Timber Springs Adolescent Center) was closed in January of 2009 due to its consistently low census following the drop in juvenile court ordered inpatient evaluations and then the children and youth unit at MTMHI closed in April of 2010 for the same reason (TDMHSAS now has no dedicated inpatient beds for children and youth). Juvenile courts have increased the use of outpatient evaluations as they have become more familiar with the providers, although the annual state-wide frequency has leveled off in the 250-290 evaluation range.

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

Table 44: Annual Totals of Inpatient and Outpatient Juvenile Evaluations

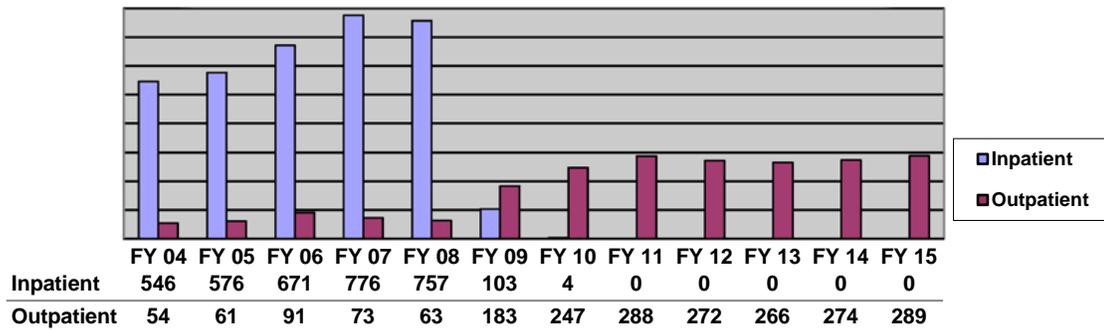


Table 45: Frequency of Outpatient Juvenile Evaluations by Provider

CMHA	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Centerstone	4	10	1	5	14	23	16	23	42	43	32
Cherokee	4	21	3	11	20	24	15	20	8	10	8
Frontier	3	5	2	5	5	9	3	11	7	9	11
Helen Ross McNabb	0	1	0	0	2	1	1	1	0	0	0
Pathways	0	2	2	5	43	79	88	70	79	77	53
Ridgeview	4	6	2	4	2	2	1	3	2	6	2
Vanderbilt	7	3	6	9	44	41	43	40	32	33	30
Volunteer	34	37	46	15	47	68	116	102	87	82	116
WTFS/Midtown	5	6	11	9	6	0	5	2	9	14	37
Total	61	91	73	63	183	247	288	272	266	274	289

Table 46 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 46: Type of Offenses Inpatient and Outpatient Juvenile Evaluations

	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Capital	0.1% (1)	0.7% (2)	- (0)	0.3% (1)	- (0)	0.0	0.0	0.0
Violent Felony (not Sex Offense)	54% (420)	57% (148)	50% (126)	43% (124)	40% (110)	41% (110)	43% (120)	39% (114)
Sex Offense	22% (176)	26% (68)	32% (81)	39% (115)	43% (118)	44% (118)	44% (121)	42% (122)
Non-Violent Felony	23% (179)	18% (46)	17% (42)	15% (45)	15% (43)	14% (38)	12% (33)	18% (53)
Misdemeanor	- (0)	- (0)	0.4% (1)	1% (3)	0.3% (1)	0.0	0.0	0.0

Table 47 indicates the frequency with which specific forensic issues were requested by juvenile courts in evaluation orders. Please note a single evaluation may include multiple requests (e.g. psychosexual and competency to stand trial).

**Table 47: Rate of Specific Forensic Requests
(Outpatient and Inpatient FY 07-15)**

Requests	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Competency	497 (64%)	540 (71%)	240 (87%)	219 (88%)	244 (85%)	206 (76%)	212 (80%)	223 (81%)	235 (80%)
Mental Condition at the Time of the Crime	405 (52%)	509 (67%)	170 (61%)	99 (40%)	95 (33%)	104 (38%)	100 (38%)	115 (42%)	127 (43%)
Psychosexual	169 (22%)	205 (27%)	71 (26%)	72 (29%)	110 (38%)	99 (36%)	111 (42%)	111 (40%)	109 (37%)

Nearly two-thirds (65%) of all juvenile court ordered mental health evaluations were for youth age 15 or older.

Table 48: 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%

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. Originally a two-and-a-half year grant (October 1, 2009-March 31, 2012) in the amount of \$196,750, it 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. Youth who appear to need mental health or substance abuse services are then referred to locally available services by the Department of Children's Services (DCS) court liaisons. 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 service and test the usefulness and effectiveness 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 and 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 the TDMHSAS Office of Consumer Affairs. 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).

Project Expansion:

Juvenile Court staff in nine additional counties received training and certification to complete the JJ-CANS in FY 14: Bradley, Davidson, Dyer, Haywood, Lauderdale, Knox, Montgomery, Putnam and Stewart. Staff from the Dyer County Public Schools and Dyersburg City Schools offices of truancy prevention were trained at the same time that Dyer County Juvenile Court staff were trained. Some courts (e.g. Bradley, Dyer) also receive custody prevention grants from DCS which require the use of an evidence-based screening procedure, and the JJ-CANS satisfies that requirement. FSPs in Davidson and Knox counties began meeting with the juvenile court staff in those courts to develop a referral process, and Davidson County FSPs received their first referrals in June 2014.

Expansion activities continued through FY 15. The AOC facilitated presentations on the TICSRP at a conferences for juvenile court judges (February 2015) and at a conference for Youth Service Officers (June 2015). The project was also presented at two Juvenile Justice Policy Academies involving juvenile court staff and children/youth service providers from the Middle Tennessee and East Tennessee regions. Coffee County Juvenile Court staff were trained and certified, as were the staff of Davidson County Juvenile Court's re-organized Assessment Unit. Dickson County Juvenile Court staff who had previously been trained were re-trained along with new staff for that court. Meetings to facilitate the training of screeners for the Shelby County Juvenile Courts were held with training scheduled for FY 16 (August, 2015).

There were 1,205 screening conducted in FY 15, for a total of 5,660 screenings conducted since October of 2010. In FY 15, 244 of the 1,205 screenings were coded as “subsequent screenings,” indicating that a youth previously screened has returned to juvenile court on a new matter and a new screening is conducted. Some of the 244 subsequent screenings may be for youth who also had an initial screening during FY 15, or they may have had their initial screening prior to FY 15. There were 243 screenings which were not coded as either initial or subsequent screenings. The results of those screenings are included in the All Screenings column of Tables 49 and 50, but not in either the Initial or Subsequent columns.

Table 49: TICSRP JJ-CANS Demographics FY 15

July 1, 2014 – June 30, 2015	All Screenings	Initial	Subsequent
Number of screenings	1,205	718	244
Average Number of Charges	1.75	1.76	1.31
Average Age	15.6	15.9	15.4
Age Category			
16 to 18	51.84%	51.19%	53.11%
13 to 15	37.63%	36.75%	41.49%
5 to 12	10.54%	12.06%	5.39%
Gender			
F	30.21%	32.31%	28.69%
M	69.79%	67.69%	71.31%
Race			
African American	37.76%	38.58%	60.25%
Caucasian	54.36%	55.15%	32.38%
Other	7.88%	6.27%	7.38%
Offense Type			
Non-Violent	89.79%	88.72%	94.67%
Violent	10.21%	11.28%	5.33%

Youth ages 5 to 12 were less common among subsequent screenings. It is not surprising that an already low frequency of the youngest juveniles would be even lower among youth who have more than one alleged juvenile offense, 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. 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. The rate of a violent offense is generally low.

Table 50 shows the frequency of screenings on which some action (treatment referral or intervention) was needed in four domains on the JJ-CANS. Action was rarely needed in the domain of Internalizing behaviors (suicide risk, self-mutilation, other self-harm, depression, anxiety, and trauma). Action was needed 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 a significant increase 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 smaller increase was noted in the domain of Academic risk (School attendance, school behavior, and school achievement.)

Table 50: TICSRP JJ-CANSFY 15 Action Needed

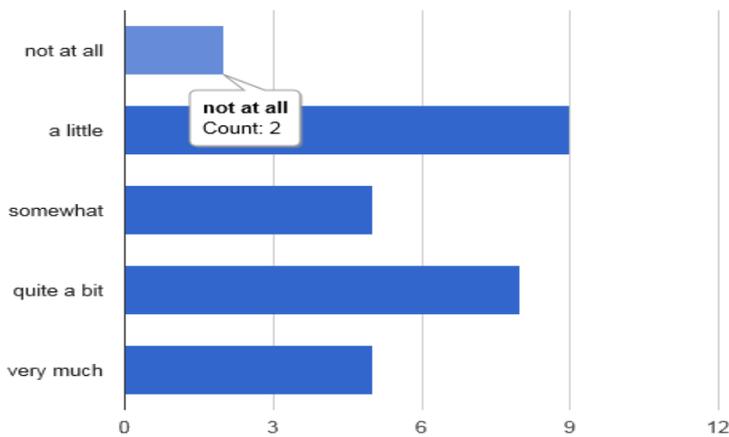
Internalizing Behaviors	All Screenings	Initial	Subsequent
Action Needed	28.13%	25.63%	37.30%
No action needed	71.87%	74.37%	62.70%
Externalizing Behaviors			
Action needed	50.54%	47.77%	72.13%
No action needed	49.46%	52.23%	27.87%
Juvenile Justice Risk			
Action Needed	32.28%	25.07%	68.03%
No action needed	67.72%	74.93%	31.97%
Academic Risk			
Action needed	43.15%	38.02%	56.15%
No action needed	53.44%	59.89%	36.07%

Family Service Providers:

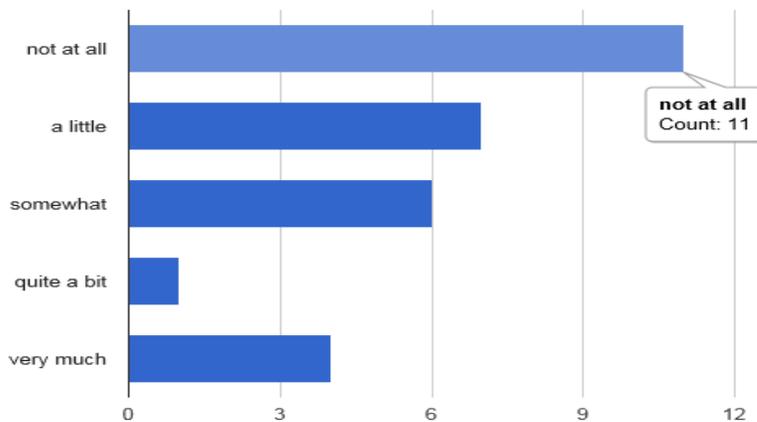
FSPs were active in Macon, Dickson, Davidson and Knox counties during FY 15. The FSP previously serving Madison County resigned and a replacement could not be identified. A total of 50 families were served, mostly in Davidson County where a bilingual FSP was added to the staff to assist families whose first language was Spanish. The Caregiver Strain Questionnaire was offered to participating family members and showed improvement after FSP intervention. TVC’s annual report included the following graphs:

Table 51: Caregiver Strain Questionnaire

“How much of a toll has your child’s problems been on your family?” BEFORE:



“How much of a toll has your child’s problems been on your family?” AFTER:



Willing participants also provided a general customer satisfaction rating on six items. All were high among the 12 caregivers who completed the survey. The rating scale ranged from 0 = Poor to 5 = Excellent.

Table 52: FSP Customer Satisfaction Ratings

Question	Average
I have been treated in a courteous and friendly manner.	4.67
TVC staff returned my calls in a reasonable time frame.	4.67
TVC staff were professional and pleasant.	4.67
TVC staff listened to my concerns.	4.58
I received the information I requested.	4.58
The information was helpful.	4.45

Unfortunately, there were insufficient grant funds available at the end of FY 15 to renew the contract with TVC for FSPs for FY 16.

MANDATORY OUTPATIENT TREATMENT COORDINATION

Mandatory Outpatient Treatment (MOT) refers to a legal obligation for a person to participate in outpatient treatment. The purpose of mandatory outpatient treatment (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 two 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) and one in T.C.A. § 33-7-303(b). Differences are summarized in Table 53, below:

Table 53: Two Types of MOT

T.C.A. § 33-6-602	T.C.A. § 33-7-303(b)
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)
Expires six months after release or previous renewal unless renewed	Does not expire
Can be modified or terminated by provider	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

The responsibility for tracking MOT cases was transferred from the Division of Hospital Services to the Office of Forensic and Juvenile Court Services in FY 14, and expanded beyond keeping a list of active MOT cases to include providing technical assistance to community agencies providing services to clients obligated to participate under MOT and providing training for staff at the RMHIs and community agencies. The position of MOT Coordinator was created and filled during FY 14, to be supervised by the Director of the Office of Forensic and Juvenile Services.

Beginning in FY 14, the MOT Coordinator collected and compiled lists of active MOT cases from all the RMHIs and community providers and developed a single accurate list. The

MOT Manual was revised and posted on the TDMHSAS website (<http://www.tn.gov/behavioral-health>) → Forensic & Juvenile Court Services → Mandatory Outpatient Treatment (MOT Manual). Hard copies were provided to the MOT Coordinators at the RMHIs and all community agencies. Training sessions were held at each RMHI and at eight separate sessions for community providers across the state. The MOT Coordinator made direct contact with coordinators at all community agencies, including the few who did not participate in a formal training.

In FY 2015, the MOT Coordinator continued to provide monthly notifications to MOT providers of renewals and reviews due during the coming month and began tracking the number of new MOT cases and closed MOT cases monthly. MOT activity in FY 15 is displayed in Table 54.

Table 54: Mandatory Outpatient Treatment Cases FY 2015

	New	Terminated	Total Active 6/30/2015
T.C.A. § 33-6-602	27	10	227
T.C.A. § 33-7-303(b)	6	1	101
Total	33	11	328

As noted above, patients committed to an RMHI under Title 33, Chapter 6, Part 5 may be released on MOT under T.C.A. § 33-6-602. Table 55 shows that WMHI uses MOT in discharge planning much more frequently than other RMHIs, due to a combination of WMHI having more judicially committed patients and the larger number of outpatient service providers in West Tennessee interested in and willing to use the provisions of MOT in aftercare services.

Table 55: Frequency of Discharge with MOT by RMHI FY 15

Originating RMHI	Total
WMHI	22
MTMHI	3
MMHI	2
MBMHI	0
Total	27

Table 56: New MOT Cases by Provider

Name of Community Agency	Total
Generations West	12
Alliance	8
Volunteer	6
Pathways	2
Case Management Inc.	1
Generations East	1
Harbert Hills Nursing Home	1
Health Quest Services	1
MCK Behavior Services	1
Total	33

FORENSIC SERVICES FINANCIAL REPORT

OUTPATIENT SERVICES

Outpatient services are reimbursed on a fee-for-service basis. Table 57 reflects the reimbursements for outpatient adult and juvenile evaluation and treatment services by provider. 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. Adult and juvenile 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. These figures do not include the evaluations provided for the Board of Parole, which simply reimburses the TDMHSAS at the same rate TDMHSAS reimburses the outpatient provider (i.e. \$900 per evaluation). The past two fiscal years have seen slight decreases (2% in FY 14 and 1% in FY 15) after a larger decrease of 7.5% between FY 12 and FY 13.

Table 57: Outpatient Expenditures, Adult and Juvenile Services

	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Centerstone	\$81,600	\$70,200	\$127,600	\$132,100.00	\$138,600.00	\$131,300.00
Cherokee Health Systems	\$56,000	\$48,050	\$91,300	\$68,950.00	\$70,950.00	\$63,000.00
Frontier Health, Inc.	\$91,300	\$95,250	\$104,950	\$86,350.00	\$91,050.00	\$85,700.00
Helen Ross McNabb	\$53,300	\$37,800	\$42,100	\$35,550.00	\$29,250.00	\$42,050.00
Pathways	\$131,850	\$148,400	\$183,100	\$188,800.00	\$182,700.00	\$189,400.00
Ridgeview	\$63,350	\$48,550	\$54,050	\$33,150.00	\$36,750.00	\$24,800.00
Vanderbilt	\$115,650	\$123,500	\$147,800	\$119,150.00	\$126,300.00	\$117,550.00
Volunteer	\$288,200	\$302,050	\$291,700	\$303,850.00	\$280,400.00	\$325,600.00
WTFS	\$484,000	\$503,900	\$531,350	\$487,200.00	\$471,400.00	\$429,250.00
TOTAL	\$1,365,250	\$1,377,700	\$1,573,950	\$1,455,100.00	\$1,427,400.00	\$1,408,650.00

As previously noted (see pp. 38-40), 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 98 evaluations in FY 15 cost \$88,200.

INPATIENT SERVICES

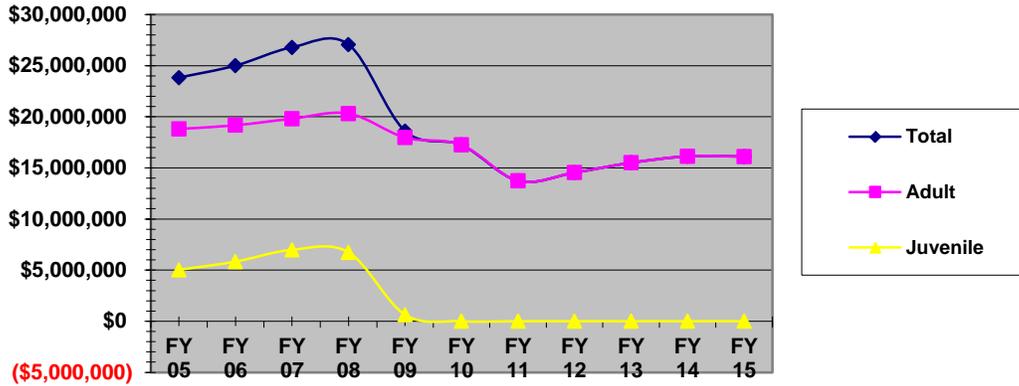
The Regional Mental Health Institutes are reimbursed for forensic services at the rate of \$450 per day. Documentation is required from the facilities to allow the TDMHSAS forensic specialists to authorize payment. This helps insure that proper procedures are followed in forensic cases and that patients 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. There was no significant change between FY 15 and FY 14 after three years of slight increases (4% increase in FY 14 over FY 13; 6% increase in FY 13 over FY 12; 6% increase from FY 11 to FY 12). FY 15 expenditures were still 21% lower than adult inpatient expenditures in FY 08 (\$20,318,000).

Table 58: Inpatient Forensic State Expenditures

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

A review of inpatient forensic reimbursements over the last 10 fiscal years (Table 59) shows a significant decline coinciding with the elimination of inpatient juvenile court ordered evaluations, the billing of counties for inpatient evaluations on defendants charged only with misdemeanors, the change from inpatient to outpatient evaluations under T.C.A. § 33-7-303(a), and general efforts at forensic census reduction.

Table 59: Inpatient Forensic Expenditure Trends



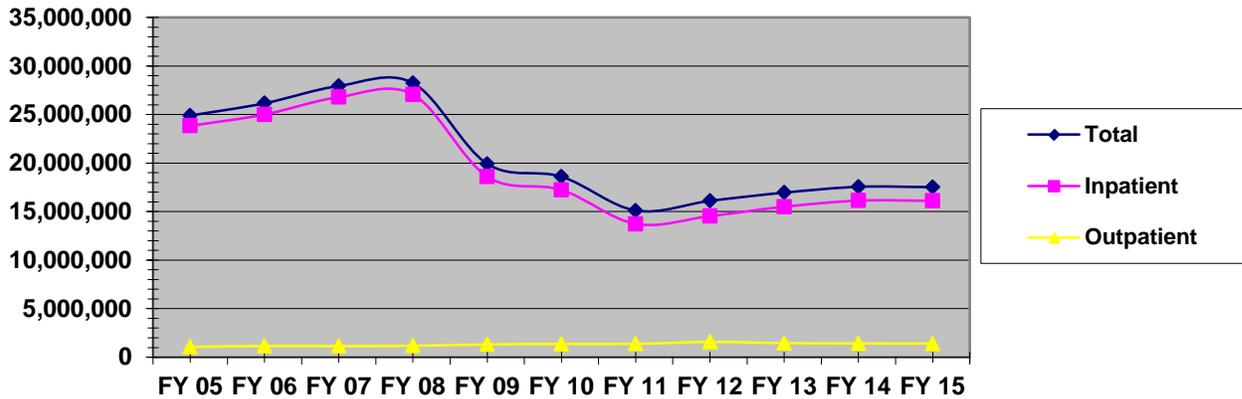
OVERALL FORENSIC EVALUATION AND TREATMENT SERVICE EXPENDITURES:

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. 60), the change in evaluations under T.C.A. § 33-7-303(a) from inpatient to outpatient and concerted efforts at the reduction of long-term forensic commitments in the RMHIs. The lowest point in expenditures was FY 11, which was a 47% decrease from the peak in FY 08, while the FY 15 total is 38% lower than FY 08.

Table 60: Overall Forensic Evaluation and Treatment Expenditures

Fiscal Year	Outpatient	Inpatient	Total
FY 05	\$1,106,450	\$23,832,570	\$24,896,020
FY 06	\$1,155,600	\$25,004,675	\$26,160,275
FY 07	\$1,147,990	\$26,791,625	\$27,939,615
FY 08	\$1,181,450	\$27,060,465	\$28,241,915
FY 09	\$1,319,700	\$18,606,302	\$19,926,002
FY 10	\$1,365,250	\$17,239,825	\$18,605,075
FY 11	\$1,377,700	\$13,731,250	\$15,108,950
FY 12	\$1,573,950	\$14,536,800	\$16,110,750
FY 13	\$1,455,100	\$15,500,250	\$16,955,350
FY 14	\$1,427,400	\$16,129,350	\$17,556,750
FY 15	\$1,408,650	\$16,114,050	\$17,522,700

Table 61: Overall Forensic Expenditure Trend



MISDEMEANOR BILLING:

At the beginning of FY 10, T.C.A. § 33-7-304 became law and the counties became responsible for the cost of forensic evaluation and treatment services ordered under Title 33, Chapter 7, Part 3 for cases in which the defendant was charged only with 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.

The FY 12 and FY 13 Forensic Services Annual Reports noted that there appeared to be a significant difference in the rate of collections of misdemeanor billing for outpatient evaluations (conducted state-wide by the Office of Fiscal Services in the Department’s Central Office) and misdemeanor billing for inpatient evaluations (conducted by each RMHI). Efforts began with collaboration between the department’s Office of Fiscal Services, the Office of Forensic and Juvenile Court Services and the Information Technology office to follow up on unpaid bills and to add functions to the Forensic Billing system which would allow for automatic creation of billing and correspondence with the counties on unpaid bills. Those functions went live in FY 14.

The Office of Fiscal Services began reconciling spreadsheets on billing and collections for outpatient services with data from the Edison system (the state’s system for managing billing and collections, among other functions) at the end of FY 14 and completed the task in FY 15. The outpatient billing and collection amounts in Table 62 are from the Office of Fiscal Services spreadsheets and include billing and collections through June 30, 2015.

**Table 62: Outpatient Misdemeanor Services Billing and Collections
July 1, 2009-March 31, 2015**

	Billed
FY 10	\$150,900
FY 11	\$257,000
FY 12	\$260,900
FY 13	\$240,300
FY 14	\$248,700
FY 15	\$189,200
Total	\$1,347,000

At the close of FY 15, \$1,326,500 had been collected (98%). A significant development during FY 15 was that the Office of Forensic and Juvenile Court Services, the Office of Fiscal Services, and the Shelby County mayor’s office worked to secure payment for outpatient services that had accumulated since FY 10 in the amount of \$686,700.

**Table 63: Inpatient Misdemeanor Services Billing and Collections
July 1, 2009-June 30, 2015**

	Billed
FY 10	\$985,150
FY 11	\$918,450
FY 12	\$1,776,150
FY 13	\$997,109
FY 14	\$702,450
FY 15	\$1,003,950
Total	\$6,383,259

At the close of FY 15, \$5,807,770 had been collected (91%).

FORENSIC TARGETED TRANSITIONAL 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 can be 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 15, \$231,038 was spent assisting 29 forensic patients. This was 58% of the funds available for direct services. Housing support accounted for 96% of expenditures, mental health services accounted for 3%, 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: for FY 15, 1,841 initial outpatient evaluations diverted 77% of that population from the need for an inpatient evaluation. There were 401 inpatient evaluations under T.C.A. § 33-7-301(a) and 82 new commitments under T.C.A. § 33-7-301(b), a rate of 20% of inpatient evaluations to commitments under T.C.A. § 33-7-301(b). That is roughly a rate of 4% commitments under T.C.A. § 33-7-301(b) from an initial evaluation total of 1,841.

There were 30 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) and 11 recommendations for 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. Additionally the current rate of reimbursement for outpatient evaluation services should be reviewed during FY 16 for increases for all providers beginning with the FY 17 contracts to support continued participation in the system by community providers.

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. Previous reports have noted the high rate of successful diversion of outpatient cases from inpatient referral with the use of supplemental services for outpatient cases, especially competency training sessions. In FY 15, training sessions were used in 49 cases, resulting in the diversion of 45 cases (92%) from the need for an inpatient evaluation. The diversion rate for the past five years combined is 90%. With an average length of stay of 22 days, those 45 cases represent 990 potential bed days, which would have a significant impact on available suitable accommodations, and which is at a cost of \$445,500 at the \$450 per diem from the Forensic Services budget. The total cost of pre-trial competency training was approximately \$4,900. However, the 49 cases for which competency training was provided represent just 3% of all outpatient evaluations. Previous annual reports have recommended improving the incentive for attempting diversion with competency training by increasing the rate of reimbursement from \$50 per session to \$70 per session and increasing the number of allowable sessions from two to four. A defendant who is not competent after four training sessions should either be considered unrestorably incompetent or should be referred for inpatient services. Using FY 15 frequencies, this could have increased the cost of pre-trial training from \$4,900 to \$13,720 (if all 49 cases used four sessions at \$70), but diverting just two inpatient referrals with an average length of stay of 22 days would save an additional \$19,800.

Recommendation: The recommendation for conclusion #1 of increasing the basic rate of reimbursement for outpatient evaluations is the first priority in order to maintain the existing network of expert community providers, which may mean deferring action on increasing the rate of reimbursement competency training. However, consideration should be given to including the recommended increase of rate of reimbursement from \$50 per session to \$70 per session and increasing the number of allowable sessions from two to four since the potential savings from diversion from inpatient evaluations could offset the costs of both rate increases.

3. 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. As noted on p. 26, 48% of defendants committed under T.C.A. § 33-7-301(b) in FY 15 were not prosecuted but instead had charges dismissed or otherwise retired, consistent with the frequency in FY 14. 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: Continue to track the rate of dismissal of charges.

4. The establishment of Mandatory Outpatient Treatment (MOT) coordination in the Office of Forensic and Juvenile Court Services successfully completed the initial steps of reconciling all RMHI and community provider MOT lists into a current and accurate master list. This process revealed numerous errors in the identification of the type of MOT some patients were obligated to as well as whether MOT cases on the list were active or inactive, underscoring the need for centralized coordination. Community providers would benefit from significant coordination and technical support from the TDMHSAS MOT Coordinator.

The MOT Coordinator should work with the Office of Information Technology to develop automated processes that would provide regular reports to community MOT providers,

and should develop procedures for monitoring the compliance of individual patients with MOT plans.

5. The Tennessee Integrated Court Screening and Referral Project conducted 5,660 screenings for youth in juvenile courts between October 1, 2010 and June 30, 2015. The pace of expenditures over the last two fiscal years indicates that all remaining funds from the last Transfer Transformation Initiative grant (original amount of \$210,000) and the \$20,000 of state funds for TICSRP expansion in Planning Regions I and II will be exhausted by the end of FY 15.

Recommendation: The TICSRP task force should explore funding and support options for sustaining the project in participating counties and continuing the expansion to support the use of a single screening instrument for juvenile courts throughout the state. The Task Force should also continue to identify courts willing and interested in implementing the juvenile court screening project and provide the training and technical support necessary for successful implementation.

6. The FY 12, FY 13 and FY 14 Forensic Services Annual Reports recommended that the Office of Forensic and Juvenile Court Services work with the Division of Administrative Services to review the process for billing for outpatient misdemeanor evaluation services, for following up on unpaid bills, and for documenting the process. Significant progress was made during FY 14 in the development of automatic functions in the Forensic Billing system to support billing and collection for outpatient misdemeanor evaluations and in researching unpaid bills. Testing of the new functions revealed the need to flag accounts settled by negotiation as paid. In FY 15, the Office of Fiscal Services in the Division of Administrative Services completed a project to reconcile internal records with Edison accounts. This allowed the Division of Administrative Services to create a comprehensive statement of charges owed by Shelby County which facilitated a back payment of delinquent balances. At the close of FY 15, 98% of billed services for all jurisdictions, including Shelby County, had been collected.

Recommendation: The Office of Forensic and Juvenile Court services should continue to work with Administrative Services to monitor the billing and collections procedure to determine if this project can be considered completed.