

**FORENSIC AND JUVENILE COURT SERVICES
ANNUAL REPORT FOR THE PERIOD
JULY 1, 2013-JUNE 30, 2014 (FY 14)**



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TENNESSEE CODE ANNOTATED
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 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 14

- In Fiscal Year 2014, the frequency of pre-trial outpatient and inpatient forensic mental health evaluations was lower than the previous ten 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 14, there were 1,899 initial outpatient evaluations which diverted 77% of that population from the need for an inpatient evaluation. There were 446 inpatient evaluations and 107 new commitments under T.C.A. § 33-7-301(b) for further inpatient treatment after the inpatient evaluation, a rate of 24% of inpatient evaluations to commitments, which is only 6% of the 1,899 initial outpatient evaluations.
- Training was provided to all the Regional Mental Health Institutes on the criteria for commitment under T.C.A. § 33-7-301(b) and the importance of attempting to complete restoration to competence while the defendant is being treated under T.C.A. § 33-7-301(a); the rate of recommendations for commitment was 25% in FY 14 compared to 32% in FY 13.
- Mandatory Outpatient Treatment (MOT) coordination and monitoring was assumed by the Office of Forensic and Juvenile Court Services. The MOT Coordinator position was established and MOT lists from the RMHIs and community providers were reconciled into a master list. The MOT Manual was updated, posted on the TDMHSAS website and distributed in hard copy to all inpatient and outpatient MOT coordinators. Nine MOT training sessions were held for community providers across the state in addition to training at each of the RMHIs.
- The forensic census at the end of FY 14 (107) was the same as the beginning of FY 14 and was still significantly lower than at the beginning of forensic census reduction efforts in December of 2008 (178).
- The frequency of juvenile court-ordered forensic evaluations (274) was within the range of 247-288 occurring in the previous four fiscal years.
- Between October 1, 2010 and June 30, 2014, 4,455 screenings had been conducted in the Tennessee Integrated Court Screening and Referral Project across ten counties resulting in over 3,100 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 2,100 outpatient pre-trial evaluations of competence to stand trial and mental condition at the time of the offense and 480 inpatient evaluations per year. At any point in time, forensic cases occupy 18%-20% of state facility beds (100-115 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 in order for reimbursement to be authorized, and an annual monitoring review is conducted on all contracted agencies. Agencies have maintained 95% compliance or better with the standards, and no plans of correction were necessary in FY 14.

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

is collaborating with other Divisions within the Department on projects such as the development and provision of a suicide prevention curriculum specifically for juvenile justice settings (the “Shield of Care”). 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.

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). 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.

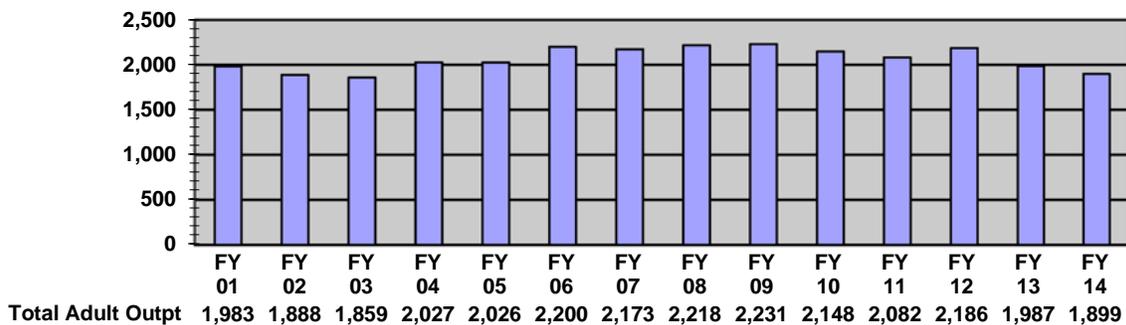
Court-ordered forensic mental health evaluation and treatment are not considered medically necessary procedures which are paid for by public or private insurance. These services are funded directly by the state budget with few exceptions, such as payment for medically appropriate treatment services of 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 2014, from July 1, 2013 to June 30, 2014, 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 2013-2014 (FY 14), 1,899 outpatient evaluations were conducted, slightly lower than in FY 13 (1,987).

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, 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 1,899 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 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
Centerstone	161	199	149	138	167	175	166	168	129	121
Cherokee	89	90	97	151	148	133	113	121	99	97
Frontier	133	170	129	162	159	132	141	151	127	120
H. R. McNabb	85	104	93	94	90	91	65	69	60	53
Pathways	211	207	240	232	240	226	230	199	193	198
Ridgeview	61	89	103	96	51	102	77	85	53	51
Vanderbilt	99	112	111	101	123	113	128	158	129	142
Volunteer	330	391	370	407	409	364	321	330	364	333
WTFS/Midtown	857	838	881	837	844	812	841	905	833	784
Total	2,026	2,200	2,173	2,218	2,231	2,148	2,082	2,186	1,987	1,899

Some variation from year to year can be observed for all providers, but overall trends remain consistent. 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 four years in the frequency of evaluations being 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.

The order of providers from highest to lowest frequency has remained stable. One notable finding is that WTFS, which serves Shelby County only, consistently has around 40% of the total evaluations while Shelby County has just under 15% of the Tennessee population. The Office of the Public Defender in Shelby County is quite active in advocating access to services

for defendants who may have a mental illness or intellectual disability, and they likely use the forensic evaluation process as a sort of diversion process from the criminal justice system to the mental health system for those clients.

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 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
Capital	1%	1%	1%	0.4%	1%	0.4%	0.3%	0.6%	0.6%	0.5%	0.3%	0.2%
Violent Felony	35%	36%	37%	38%	40%	37%	36%	36%	38%	37%	40%	40%
Sex Offense	8%	7%	8%	8%	7%	8%	9%	9%	8%	9%	8%	7%
Non-Violent Felony	25%	25%	22%	23%	22%	24%	22%	28%	29%	32%	31%	32%
Misdemeanor	31%	31%	32%	31%	30%	31%	32%	27%	23%	20%	19%	18%

MISDEMEANOR SERVICES:

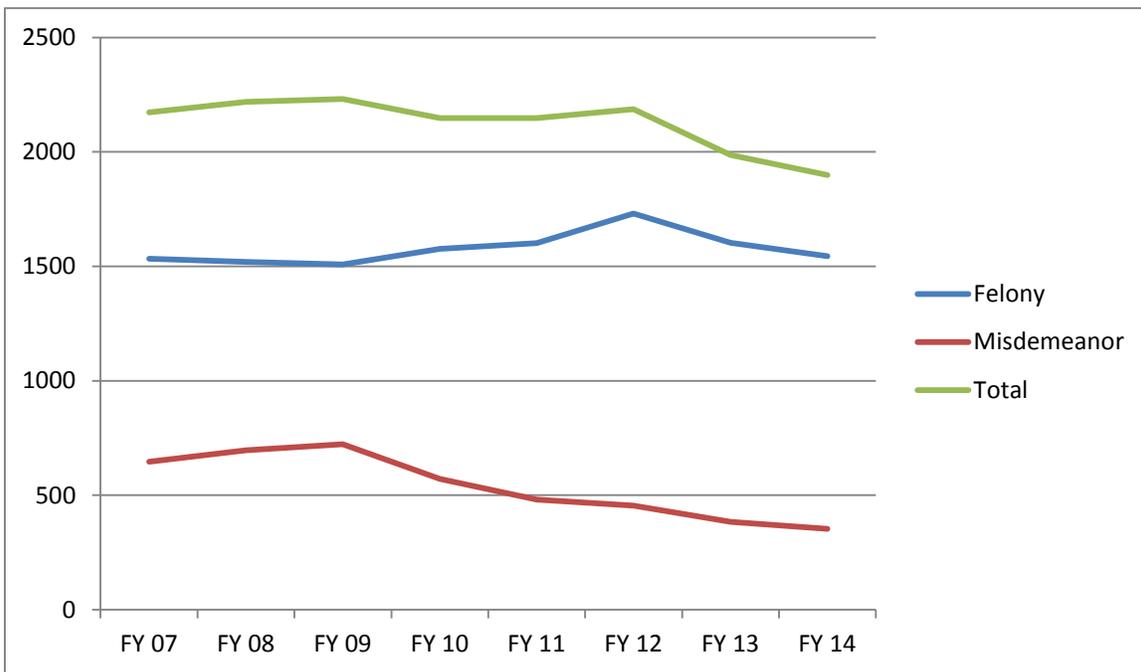
On June 26, 2009, T.C.A. § 33-7-304 became law, making counties responsible for the cost of forensic services ordered under Part 3 of Title 33, Chapter 7 when the defendant is charged only with a misdemeanor; this includes the outpatient forensic evaluations, the supplemental services used to help complete 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 fee for service rate for outpatient services that outpatient evaluators are reimbursed by the TDMHSAS (typically \$600 per evaluation). Counties are charged an all-inclusive *per diem* rate for inpatient services. The rate would vary between the Regional Mental Health Institutes between \$494 and \$1,220 per day. However, the TDMHSAS offers counties the option of contracting with the state to pay a standard *per diem* of \$450 per day, a rate similar to the reimbursement the hospitals receive from third-party payers. All counties who have used any inpatient services have agreed to a contract. Under the reduced rate, a 30-day inpatient stay would cost \$13,500. 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 12, with no significant change from FY 12 through FY 14. Tables 5 and 6 combine all felony categories for outpatient evaluations.

Table 5: Felony vs. Misdemeanor Evaluation Frequencies

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

Table 6: Outpatient Felony vs. Misdemeanor Trends



From FY 10 to FY 12, the line for felony evaluations goes up while the line for misdemeanor evaluations goes down. Both lines decline between FY 12 and FY 14. Table 7 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 14
Capital	0.6%	0.4%
Violent Felony	36%	38%
Sex Offense	8%	8%
Non-Violent Felony	24%	30%
Misdemeanor	31%	21%

There is a 10% decline in misdemeanor evaluations and a 6% increase in the proportion of non-violent felony evaluations, with a 2% increase in Violent Felony and less than 1% decrease (meaning no real change) in capital offense evaluations. 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
Centerstone	32%	29%	22%	11%	11%	15%
Cherokee	28%	29%	16%	16%	22%	9%
Frontier	23%	20%	21%	15%	28%	23%
HR McNabb	33%	36%	34%	27%	3%	20%
Pathways	27%	8%	9%	5%	3%	2%
Ridgeview	41%	25%	30%	22%	16%	17%
Vanderbilt	34%	14%	4%	6%	2%	2%
Volunteer	34%	25%	19%	16%	12%	16%
WTFS	35%	34%	31%	30%	29%	27%
TOTAL	32%	27%	23%	20%	19%	18%

There were very slight declines or no change for most providers and a slight increase for Centerstone while H. R. McNabb (covering Knox County only) showed an increase from 3% in FY 13 to 20% misdemeanor evaluations in FY 14. In FY 13, H.R. McNabb conducted only two misdemeanor evaluations out of a total of 60; in FY 14 they conducted 11 misdemeanor evaluations out of a total of 53. Generally speaking the decline in frequency of misdemeanor-only evaluations appears to have stabilized.

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 generally consistent with the rate of referral for agencies contracted by the TDMHSAS. 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%

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, although this is rare (3% in FY 14).

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 88% in FY 14 and 90% on average for the four 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	121	5	4	80%
Cherokee	97	1	1	100%
Frontier	120	2	2	83%
HR McNabb	53	0	-	-
Pathways	198	0	-	-
Ridgeview	51	0	-	-
Vanderbilt	142	2	2	100%
Volunteer	333	1	1	100%
WTFS	784	29	25	86%
TOTAL FY 14	1,899	40	35	88%
TOTAL FY 13	1,987	64	60	94%
TOTAL FY 12	2,186	83	74	89%
TOTAL FY 11	2,082	71	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 13 has been 23%. The average rate for FY 14 was 23%.

Table 11: Frequency of Inpatient Referral by Provider

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

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 for each setting has typically run 80% to the regular RMHI and 20% to FSP, but was even lower than usual for FSP in FY 14 (15%).

Table 12: Inpatient Referrals to RMHIs and FSP

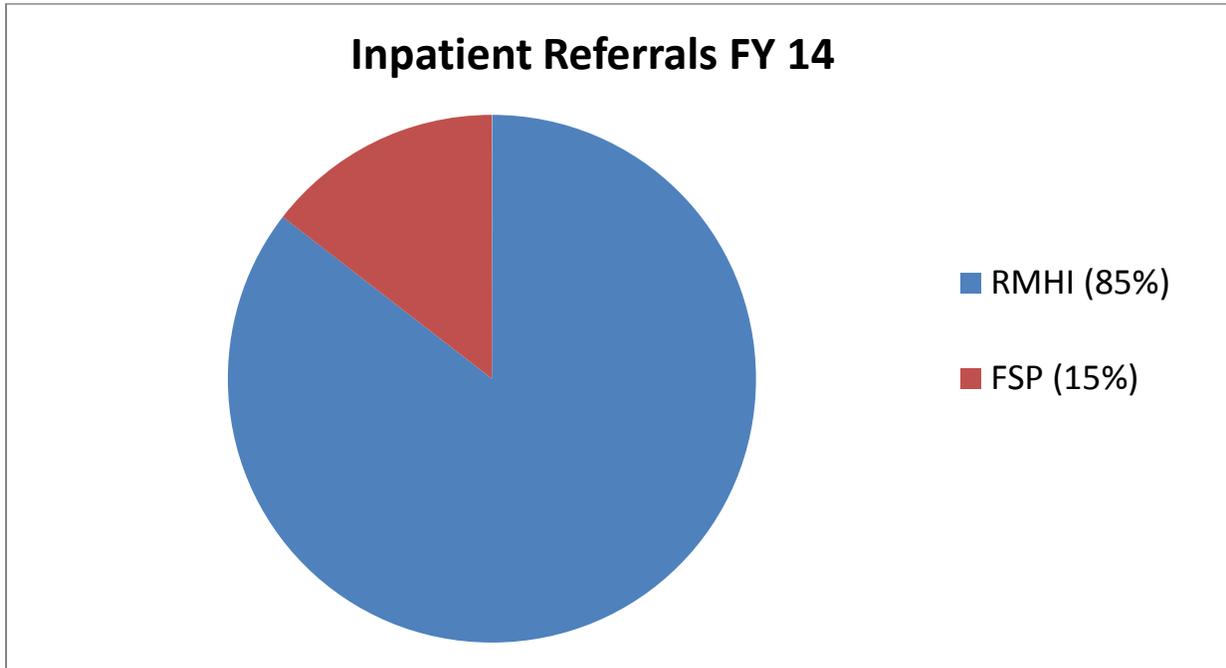
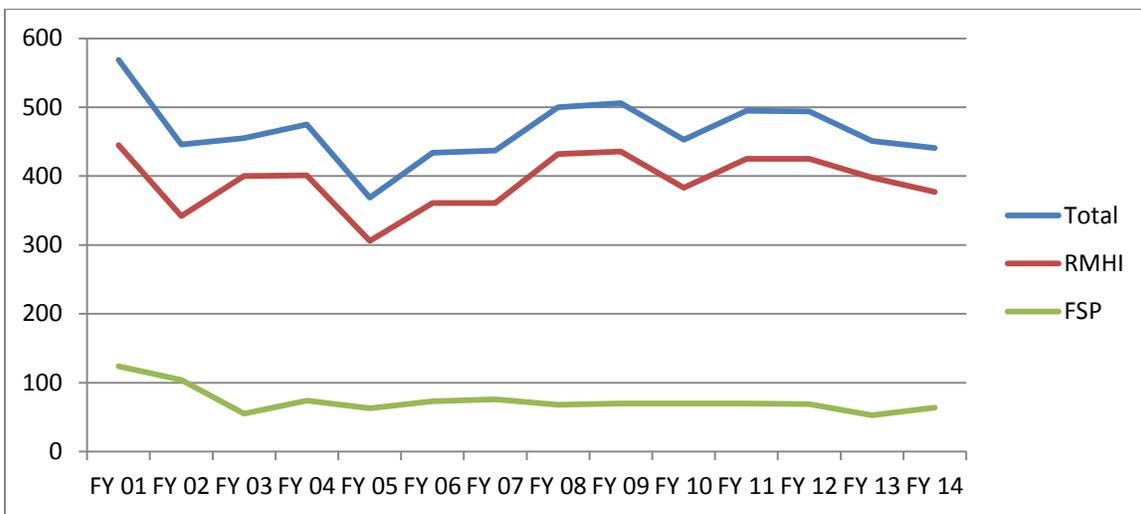


Table 13: Trends in Inpatient Referrals RMHI & FSP



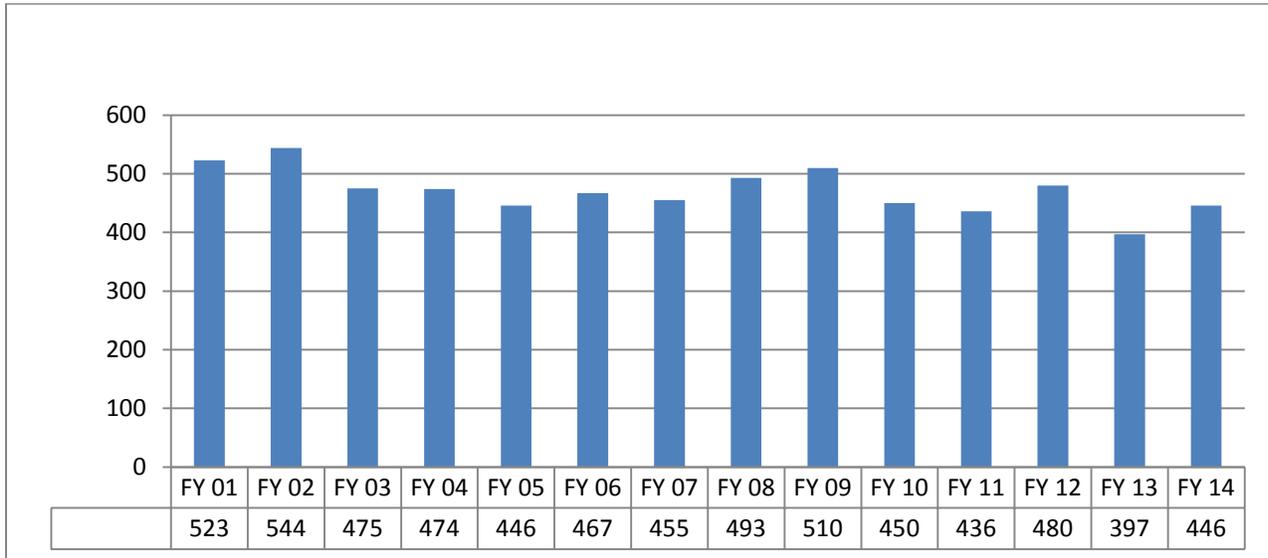
The statutory requirement for an outpatient evaluation prior to an inpatient evaluation, and the requirement that an inpatient evaluation can only be ordered when the outpatient evaluator recommends an inpatient evaluation is an effective means for preventing unnecessary forensic admissions and preserving 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. When this recommendation is made to the court, the court issues a new order for an inpatient evaluation. 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 he or she does not have 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. In any case, 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 condition 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 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)



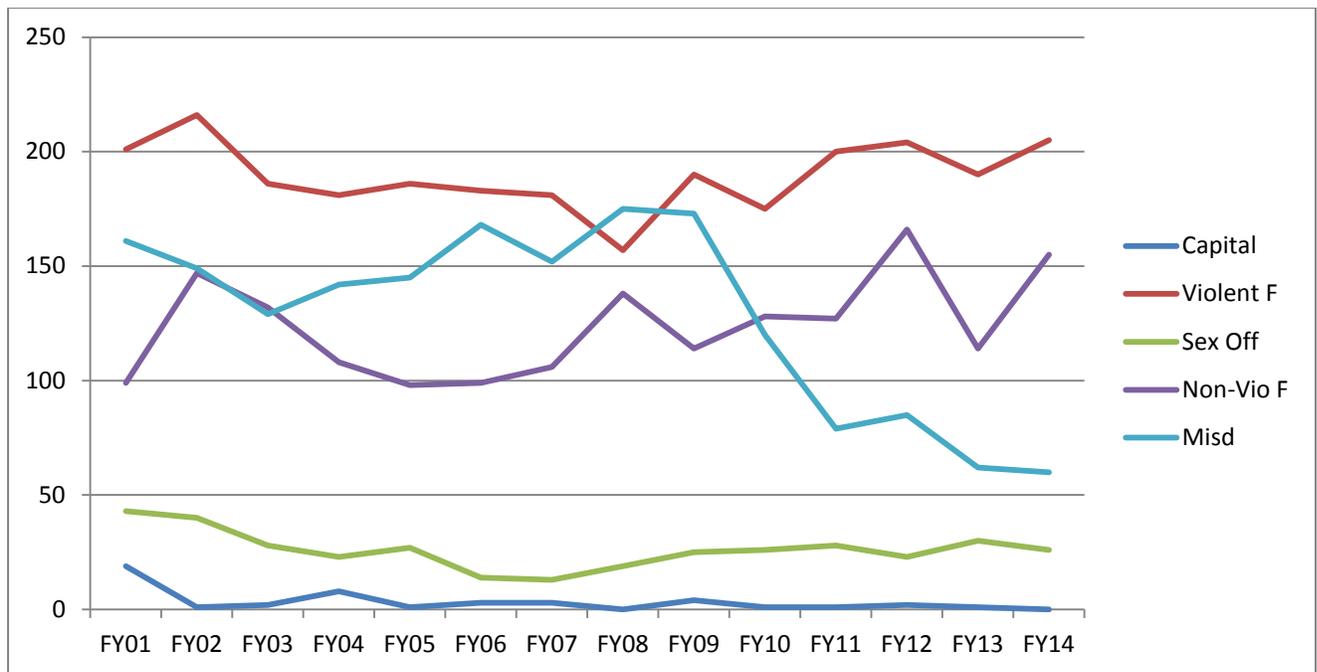
The FY 14 inpatient evaluation total is a 12% increase from FY 13, even though there was a 4% decrease in outpatient evaluations in the same time frame. A closer inspection of the referral-to-admission ratio reveals that nearly all referrals for inpatient evaluation in FY 14 resulted in an actual admission, while in FY 13, 3% of referrals (n=60) were not subsequently admitted. The total admissions for FY 13 would have been greater than that of FY 14 if all cases referred for admission in FY 13 had in fact been admitted.

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 in FY 13 and FY 14 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 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
Capital	0.4%	2%	0.2%	0.6%	0.7%	0	0.8%	0.2%	0.2%	.004%	.003%	0
Violent Felony	39%	39%	40%	39%	40%	32%	37%	39%	45%	42%	47%	45%
Sex Offense	6%	5%	6%	3%	3%	4%	5%	6%	6%	4%	7%	5%
Non-Violent Felony	28%	23%	21%	21%	23%	28%	22%	28%	29%	34%	28%	34%
Misdemeanor	27%	31%	32%	36%	33%	36%	34%	27%	18%	17%	15%	13%

Table 16: Inpatient Felony vs. Misdemeanor Trends



Most notable is the sharp decline in misdemeanor evaluations beginning in FY 10 just 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 14.

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, MBMHI the southeast, 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), though located on the grounds of MTMHI, is the maximum security facility for the entire state.

Table 17: Inpatient Evaluations by Facility

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
LMHI	66	56	51	67	68	67	66	70	48	45	0	0
MBMHI	56	64	73	74	55	64	69	39	53	67	99	108
MTMHI	43	67	44	58	55	56	71	70	65	84	74	89
WMHI	59	38	43	47	31	56	72	55	69	53	44	68
MMHI	168	154	148	132	164	170	140	128	129	146	105	109
FSP	83	95	67	89	82	80	92	88	74	85	75	72
TOTAL	475	474	446	467	455	493	510	450	436	480	397	446

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 13 year period FY 01-FY 13 was 21 days. The average length of stay statewide in FY 14 was also 21 days.

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

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

OUTCOMES:

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

Facility	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
LMHI	75%	59%	59%	67%	57%	59%	70%	69%	67%	79%	66%	-	-
MBMHI	81%	76%	69%	79%	66%	64%	69%	72%	59%	79%	79%	64%	77%
MTMHI	71%	59%	52%	67%	48%	52%	53%	40%	57%	76%	67%	58%	66%
WMHI	87%	75%	71%	80%	70%	67%	73%	78%	82%	66%	73%	84%	57%
MMHI	70%	75%	75%	72%	66%	75%	83%	69%	77%	69%	74%	62%	76%
FSP	73%	68%	67%	75%	74%	80%	70%	84%	78%	82%	77%	72%	73%
State-wide Average	76%	69%	66%	73%	66%	69%	73%	69%	72%	74%	73%	66%	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. Of those cases not considered competent to stand trial, 88% were recommended as meeting commitment criteria for further

inpatient treatment under T.C.A. § 33-7-301(b). (See below for additional detail on the frequency of recommendations for commitment.)

MTMHI’s annual rates were notably lower than all other facilities for years when the staff had the practice of committing many defendants for further inpatient treatment in order to provide more time to complete the forensic evaluation. Additional training was provided to MTMHI staff in FY 10 on the standards for competence and the insanity defense and on the standards for further involuntary commitment under Title 33, Chapter 6, Part 5. This resulted in an increase of evaluations completed during the initial 30-day admission and the percentage of defendants considered competent to stand trial at the end of the initial inpatient evaluation for FY 11 and FY 12. The percentage of defendants considered competent to stand trial in FY 13 (58%) returned to the level just prior to the training (FY 10: 57%), suggesting the need for additional training.

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

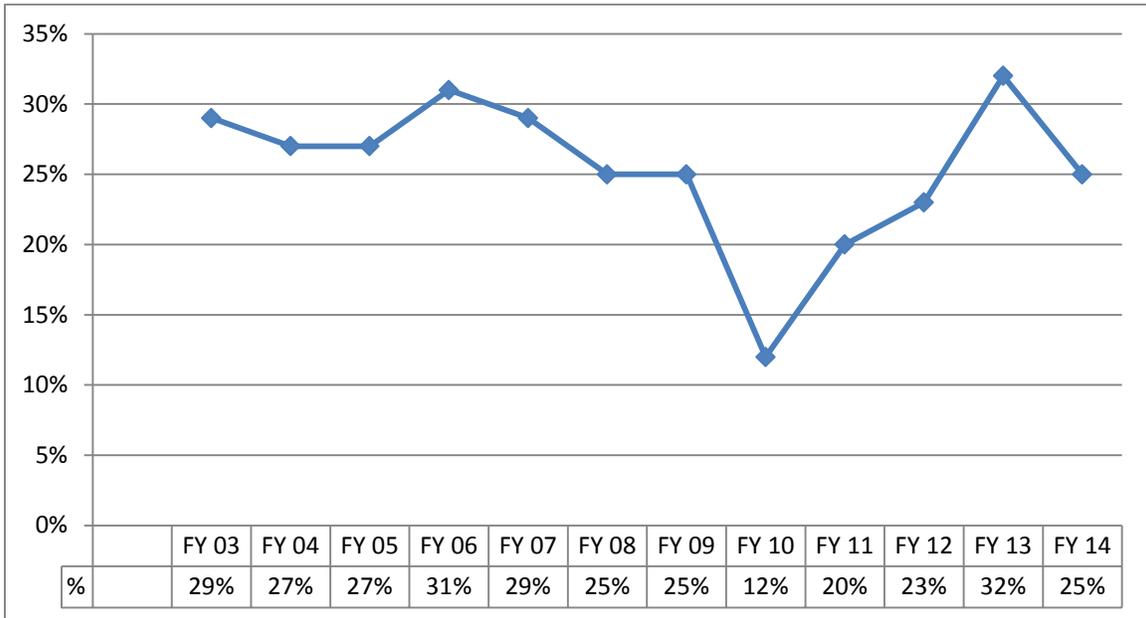
Table 20: Support for the Insanity Defense in Inpatient Evaluations

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

The state-wide total frequency of 14% represents support for the insanity defense in 66 cases out of the total of 446 evaluations conducted by the RMHIs and FSP in FY 14.

Inpatient evaluations conducted under T.C.A. § 33-7-301(a) also include a recommendation to the court on whether the defendant meets involuntary commitment criteria under Title 33, Chapter 6, Part 5, necessary for commitment for further evaluation and treatment under T.C.A. § 33-7-301(b). 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 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
LMHI	24%	26%	29%	33%	40%	27%	15%	0%	4%	0%	-	-
MBMHI	18%	24%	20%	31%	28%	21%	21%	21%	20%	16%	29%	15%
MTMHI	30%	34%	33%	43%	37%	49%	44%	10%	23%	34%	40%	32%
WMHI	21%	31%	22%	23%	37%	24%	21%	13%	24%	28%	15%	39%
MMHI	14%	18%	24%	26%	20%	12%	27%	16%	25%	26%	38%	16%
FSP	35%	37%	38%	34%	27%	35%	19%	15%	20%	24%	32%	30%
Total	29%	27%	27%	31%	29%	25%	25%	12%	20%	23%	32%	25%

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 25% in FY 14, consistent with 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 training provided to RMHI staff reminding them of 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 (T.C.A. § 33-7-301(a) period. Updated training was provided again for all the RMHIs in FY 14. Training was conducted at MBMHI, MTMHI/FSP and MMHI in November through January, and at WMHI in April due to scheduling conflicts with Joint Commission. The training at WMHI may have occurred too late in the fiscal year to affect the overall trend, as WMHI is the only facility with an increase in the rate of commitment recommendations from FY 13 to FY 14.

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

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

Court	Outpatient	Inpatient	Total
General Sessions	1,169 (61%)*	290 (65%)**	1,459 (62%)***
Criminal Court	537 (28%)*	97 (21%)**	634 (27%)***
Circuit Court	135 (7%)*	39 (8%)**	174 (7%)***
Municipal	58 (3%)*	20 (4%)**	78 (3%)***

*% of total outpatient orders

**% of total inpatient orders

***% of total orders, inpatient and outpatient

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: 81% male, 18% female

Inpatient: 83% male, 16% female

Age:

	<u>Outpatient</u>	<u>Inpatient</u>
0-18:	2%	<1%
19-30:	36%	31%
31-43:	27%	30%
44-64:	29%	29%
>64:	2%	4%

Race:

	<u>Outpatient</u>	<u>Inpatient</u>
Alaskan Native:	<1%	<1%
American Indian:	<1%	<1%
Asian/Pacific Islander:	<1%	<1%
Black/African American:	50%	55%
White/Caucasian:	45%	41%
Unknown:	<1%	0
Other:	1%	2%

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:	25%	57%	Borderline IQ:	2%	0
Affective D/O:	20%	9%	Neurological:	3%	<1%
Deferred:	14%	<1%	Medical:	<1%	3%
Substance Related:	12%	6%	Other:	<1%	3%
Intellectual Disability:	4%	0	Malingering:	1%	0
Personality D/O:	4%	1%	None:	1%	2%
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.

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 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
Centerstone	5	4	16	24	8	21	15	22	4
Cherokee	3	7	8	9	9	7	7	3	2
Frontier	1	6	7	4	8	13	13	11	6
H R McNabb	2	1	2	1	0	2	3	0	1
Pathways	2	7	15	22	9	6	12	10	1
Ridgeview	4	2	5	4	16	7	6	7	2
Vanderbilt	5	9	11	25	21	17	21	9	0
Volunteer	14	11	24	17	14	16	11	11	3
WTFS/Midtown	21	38	31	65	43	23	46	39	2
Outpt. Total	57 (2%)*	85 (4%)	119 (5%)	171 (7%)	128 (6%)	112 (5%)	134 (6%)	112 (6%)	21 (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
FSP	5	0	0	2	1	4	0	0	0
LMHI	3	4	3	1	0	0	2	0	0
MBMHI	0	5	9	4	1	5	1	4	1
MMHI	2	10	5	10	11	12	9	2	0
MTMHI-Adult	3	1	1	4	3	0	6	4	0
WMHI	4	1	3	2	4	4	0	1	4
Inpt. Adult Total	17 (4%)*	21 (5%)	21 (4%)	23 (4.5%)	20 (6%)	25 (6%)	18 (4%)	11(3%)	5 (1%)

*percentage of total number of inpatient forensic evaluations

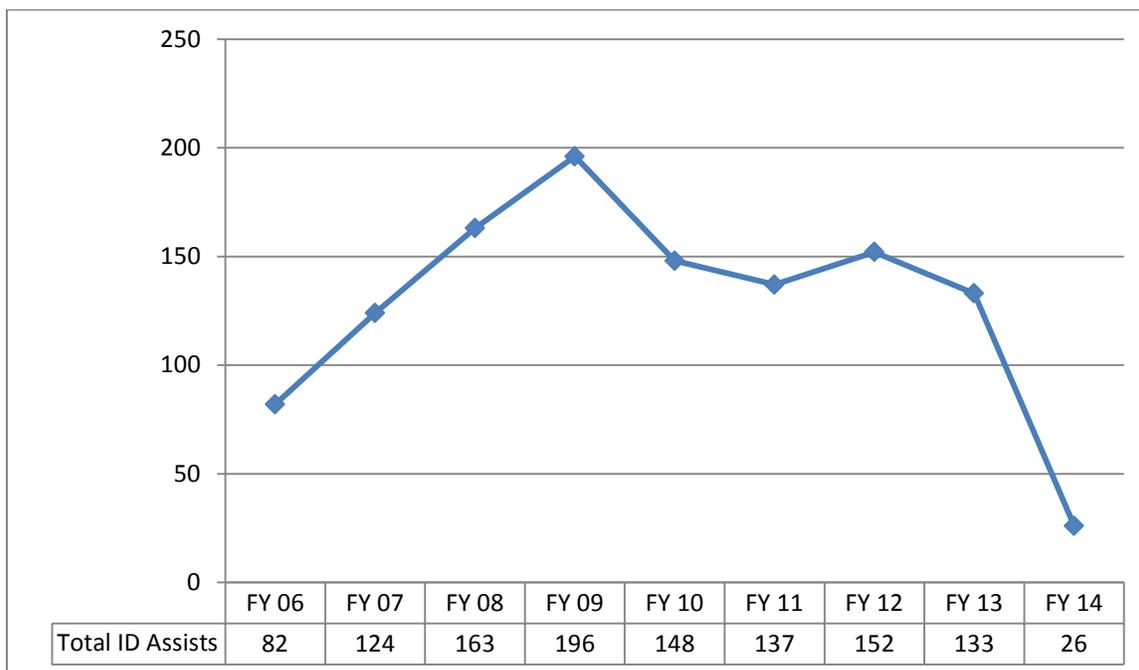
24c: Total ID Assist Requests

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

*percentage of total forensic evaluations, outpatient and inpatient

Three of the 26 ID Assist Requests were for committability, resulting in two commitments.

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 02.) Twenty five of the 45 admissions under T.C.A. § 33-7-301(b) to WMHI (56%) were Shelby County cases (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 admitted 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 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
LMHI	15	15	12	17	11	12	13	9	1	1	2	-	-
MBMHI	7	9	16	18	21	11	9	6	2	8	10	19	21
MMHI	0	0	0	0	0	0	0	1	0	0	1	0	0
MTMHI	18	22	26	24	26	28	28	35	7	16	16	32	28
FSP	11	7	12	6	12	10	10	8	5	10	13	11	9
WMHI	36	31	42	39	43	37	42	38	33	39	54	51	45
TOTAL	87	84	108	104	113	98	102	97	48	74	96	113	103

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 they remain committed to 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 FY 14, 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 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
LMHI	15	17	14	11	18	14	9	7	22	2	1	3	-	-
MBMHI	9	11	4	15	19	19	12	16	9	1	8	7	21	23
MMHI	1	0	0	1	0	0	0	0	1	0	0	1	0	0
MTMHI	18	20	26	23	32	25	33	24	39	11	18	15	19	30
FSP	9	11	4	10	12	7	7	9	10	5	14	11	11	10
WMHI	37	32	31	40	42	41	43	45	43	36	32	51	57	40
TOTAL	89	91	79	100	123	106	104	101	124	55	73	87	107	103

Of the 103 cases closed during FY 14, 50 were discharged while still pre-trial criminal defendants under T.C.A. § 33-7-301(b) and 52 had their charges dismissed or retired (one patient was considered competent but still committable and stayed at the RMHI until he was adjudicated NGRI and found to still meet commitment criteria following an evaluation under T.C.A. § 33-7-303(a)). Of those 52 who had their charges dismissed, 28 (52%) were subsequently released to the community and 24 (46%) were still in the hospital on June 30, 2014. This pattern of cases being changed from pre-trial criminal defendants facing prosecution to involuntarily committed civil patients amounts to a type of diversion mechanism, moving some patients from the criminal justice system to the mental health/substance abuse treatment system. This is not the most efficient way to access mental health services for persons in the criminal justice system. Most diversion mechanisms occur earlier in the criminal process, such as after being arrested and jailed but prior to booking, and do not require evaluation of forensic issues such as competency to stand trial when the primary goal is accessing mental health services.

The use of this diversion option naturally varies among different jurisdictions. The rate of cases having charges dismissed was higher at WMHI (68%) and MBMHI (60%) than at FSP (30%) or MTMHI (17%). At WMHI, 14 (of 29) defendants had their charges dismissed within the first month following admission, all from Shelby County, while charges were dismissed in that same time frame for only two (of 14) cases at MBMHI, one (of five) cases at MTMHI, and no cases (of three dismissals) at FSP. The Shelby County Public Defender's office has long been an advocate for mental health and substance abuse treatment and is the most active in supporting diversion.

Table 27, below, shows defendants discharged from T.C.A. § 33-7-301(b) during FY 14 categorized by their length of stay. The most frequent length of stay is between one and three months (34%); 22% were discharged in fewer than 31 days, and 82% of those discharged were discharged in the first six months.

Table 27: Length of Stay Under T.C.A. § 33-7-301(b)

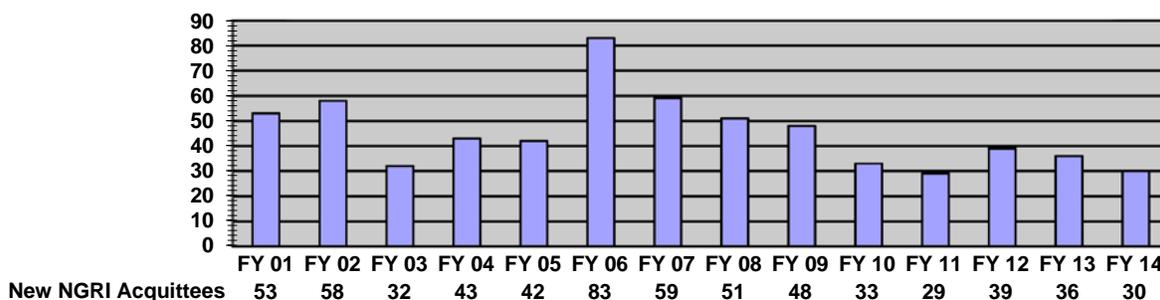
Facility	0 – 30 Days	31-90 Days	3-6 Mos.	6 Mo.- 1 Yr.	1-2 Yrs.	2-5 Yrs.	5 Yrs. +	Avg. LOS in days	Range in days
MTMHI	5	8	8	1	2	0	0	133	27-694
FSP	0	4	0	3	0	0	0	132	39-315
WMHI	1	2	5	1	1	0	0	157	29-472
MBMHI	5	3	0	1	0	0	0	65	10-270
Totals	11	17	13	6	3	0	0	124	10-694

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 and afterward have all been conducted under the amended statute, while evaluations conducted in FY 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 14. Nine (31%) were in Davidson County courts. Of the 30 acquittees, 20 (67%) were acquitted on a violent felony (not sex offense) offense (primarily aggravated assault), 7 (23%) were acquitted on a non-violent felony, 2 (7%) were acquitted of a misdemeanor offense and one was acquitted of a sex offense.

Table 28: New NGRI Acquittees



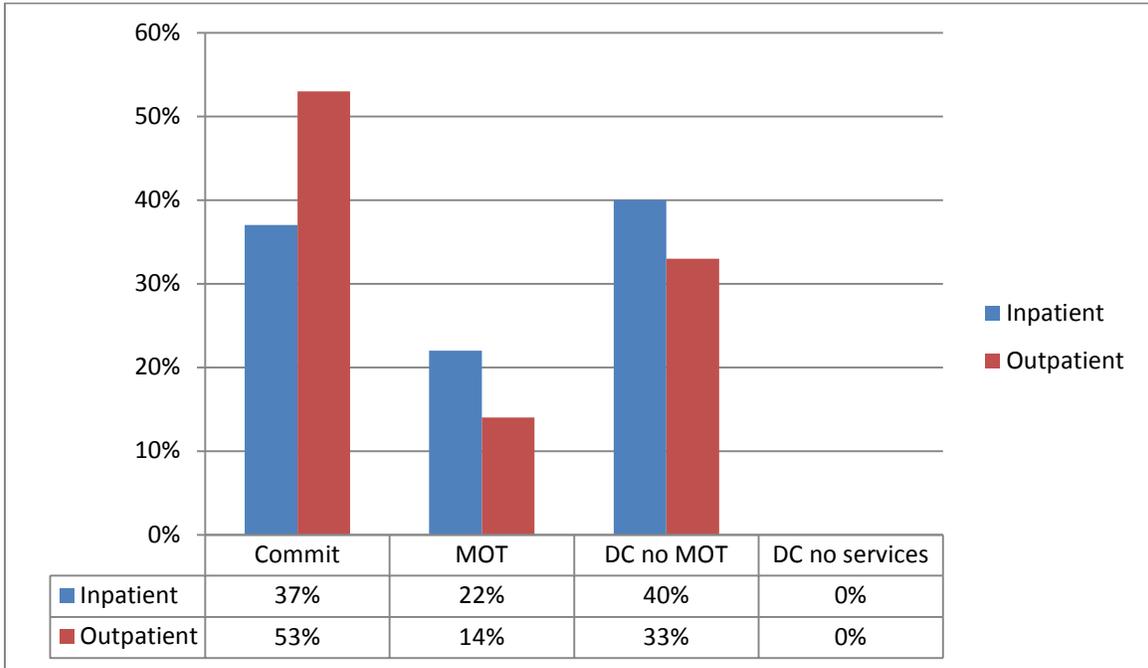
There are four possible outcomes of an evaluation conducted under T.C.A. § 33-7-303(a): 1) commitment to an RMHI under T.C.A. § 33-7-303(c), 2) release to the community with an Mandatory Outpatient Treatment (MOT) plan under T.C.A. § 33-7-303(b), 3) release to the community with an outpatient treatment plan but 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 29 on the following page shows the outcomes over the last six fiscal years, with FY 14 recommendations broken out by provider.

Table 29: 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 14	0	0	0	0
Cherokee FY 14	0	0	0	0
Frontier FY 14	1	0	9	0
HR McNabb FY 14	0	0	0	0
Pathways FY 14	2	0	0	0
Ridgeview FY 14	0	0	0	0
Vanderbilt FY 14	8	0	1	0
Volunteer FY 14	1	4	1	0
WTFS FY 14	2	0	1	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 four years of outpatient evaluations (n= 137) shows a greater frequency of commitment from outpatient evaluations (see Table 30, on the following page).

**Table 30: 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, 53% were hospitalized with a commitment under T.C.A. § 33-7-303(c), meaning 47% were not hospitalized at all.

The trend of a higher rate of commitment recommendations for Davidson County acquittees made by Vanderbilt University persisted in FY 14 (see Table 29, above). A recommendation from the FY 13 Annual Report was to “(a)ssure that all outpatient providers conducting evaluations under T.C.A. § 33-7-303(a) have the expertise in and access to aftercare planning services so that less drastic alternatives to inpatient commitment may be identified for NGRI acquittees clinically appropriate for release to the community. Establish a direct communication link with jail liaison services for support in community aftercare planning. In FY 14, a procedure was established in which the Mental Health Cooperative jail liaison working in the Davidson County Criminal Justice Center and Hill Detention Center evaluated all

defendants who were considered to have support for the insanity defense following a forensic evaluation for aftercare planning should the defendant be found NGRI. Only one of nine cases was diverted from commitment, suggesting that additional inpatient treatment and more extensive discharge planning was commonly necessary for these acquittees before a less drastic alternative to hospitalization was available. This procedure will continue through FY 15 in order to divert as many acquittees from commitment as possible.

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

Table 31 shows the frequency of commitments of NGRI acquittees to the RMHIs under T.C.A. § 33-7-303(c). The commitments in fiscal years 2001 through 2009 occurred following an **inpatient evaluation** under T.C.A. § 33-7-303(a) and were based on recommendations from RMHI staff, while the commitments in fiscal years 2010-2013 occurred after an **outpatient evaluation** based on recommendations from community agency staff.

Table 31: T.C.A. 33-7-303(c) Commitments

←Inpatient Evaluation | Outpatient Evaluation→

Facility	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
LMHI	4	6	7	9	5	10	10	2	4	3	3	-	--
MBMHI	3	1	1	3	2	3	1	0	1	0	2	4	0
MMHI	0	0	0	0	0	1	0	0	0	0	0	0	0
MTMHI	5	4	4	9	5	15	9	4	7	10	20	15	6
FSP	0	0	0	1	1	1	0	0	1	1	2	1	3
WMHI	5	7	1	4	5	6	5	5	7	1	4	1	5*
TOTAL	17	18	13	26	18	36	25	11	20	15	31	21	14

*two acquittees were admitted to WMHI from MTMHI's area

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. Two of the five commitments under T.C.A. § 33-7-303(c) admitted to WMHI during FY 14 were from MTMHI's area.

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 32 summarizes the length of stay for all 16 patients discharged to the community during FY 14 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. MMHI did not have any patients in this legal status during FY 14.

Table 32: Length of Stay Under T.C.A. § 33-7-303(c)

Facility	0 – 30 Days	31-90 Days	3-6 Mos.	6 Mo.- 1 Yr.	1-2 Yrs.	2-5 Yrs.	5 Yrs. +	Avg. LOS in days	Range in days
MBMHI	0	0	1	0	2	0	0	346	194-425
MTMHI	0	1	2	5	1	1	0	308	70-416
WMHI	0	0	1	0	0	0	2	3,244	127-7,194
Totals	0	1	4	5	3	1	2	865	

The average length of stay for those discharged was 865 days (just over two years and four months). WMHI discharged one patient who had been hospitalized over 19 years, and another who had been hospitalized over seven years. Most of the discharged NGRI patients had a length of stay between four and 14 months. If the length of stay for the patient discharged after 19 years is eliminated, the average length of stay drops from 865 days to 443 days (just under one year and three months).

FORENSIC CENSUS

An initiative to reduce the size of the forensic census when clinically indicated began in January of 2009 focusing on three main areas: 1) decrease the census of patients committed under T.C.A. § 33-7-301(b) by reducing the frequency of new commitments, resolving existing cases and resolving new cases sooner in the process, 2) assuring that options for community release of NGRI patients evaluated for commitment under T.C.A. § 33-7-303(a) have been considered, and 3) increase the rate of discharges of NGRI patients committed under T.C.A. § 33-7-303(c).

As noted above (see Tables 21 and 22, p. 19), the rate of recommendations for commitment under T.C.A. § 33-7-301(b) decreased in FY 14 after having increased each year since FY 10. The average rate of recommendations for commitment under T.C.A. § 33-7-301(b) for FY 01-09 was 26%. It was 12% in FY 10, following training conducted in FY 09 on the importance of avoiding the need for commitment under T.C.A. § 33-7-301(b) with treatment as indicated during the initial evaluation period under T.C.A. § 33-7-301(a), but then rose to 32% in FY 13. Refresher training similar to that provided in FY 09 was provided at each RMHI in FY 14 which may have contributed to the decrease in recommendations for commitment. Table 33 displays the number of patients committed under T.C.A. § 33-7-301(b) who were in the RMHIs on the first day of January and the first day of July from January 2009 through July 2014. The census has levelled off to the mid-30s, state-wide.

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

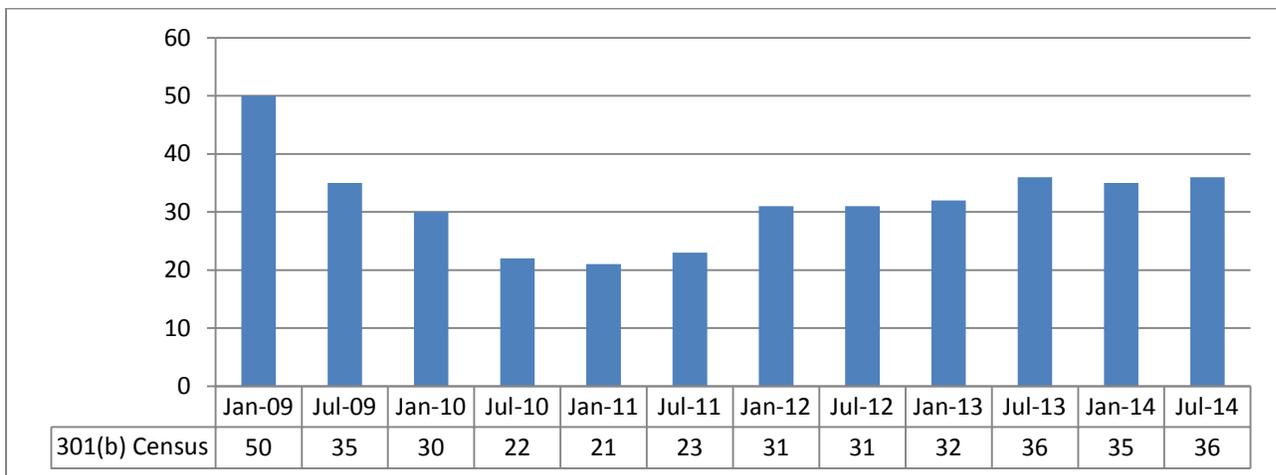


Table 34 displays the number of insanity acquittees who were in the RMHIs on the first day of January and the first day of July from January 2009 through July of 2014.

Table 34: T.C.A. 33-7-303(c) Cases on Census

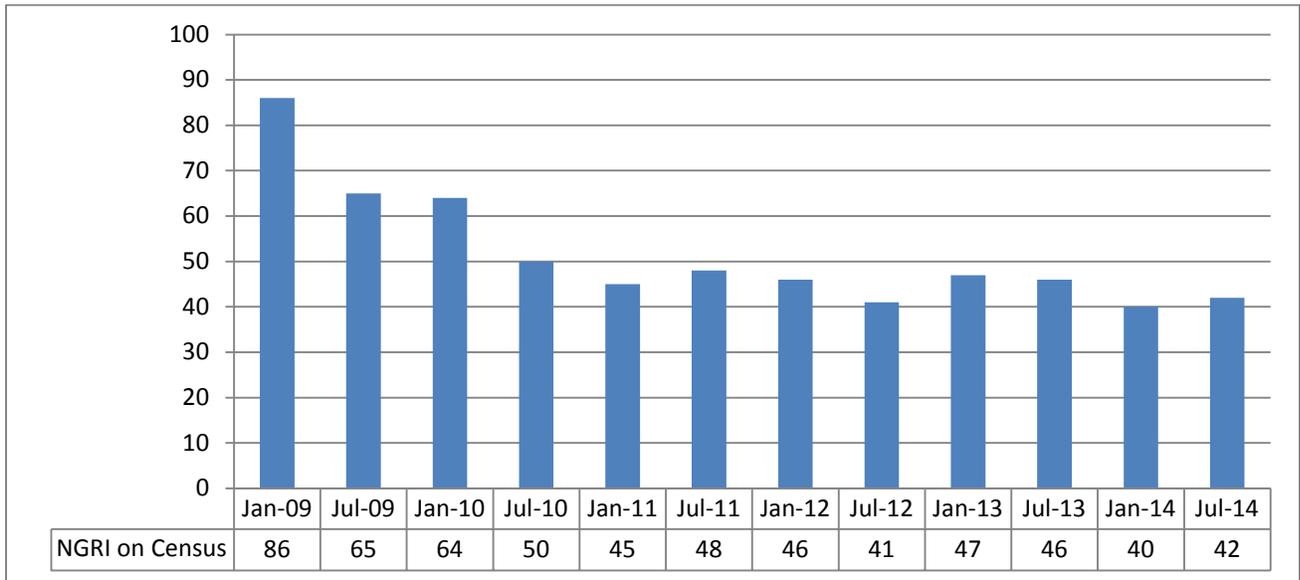
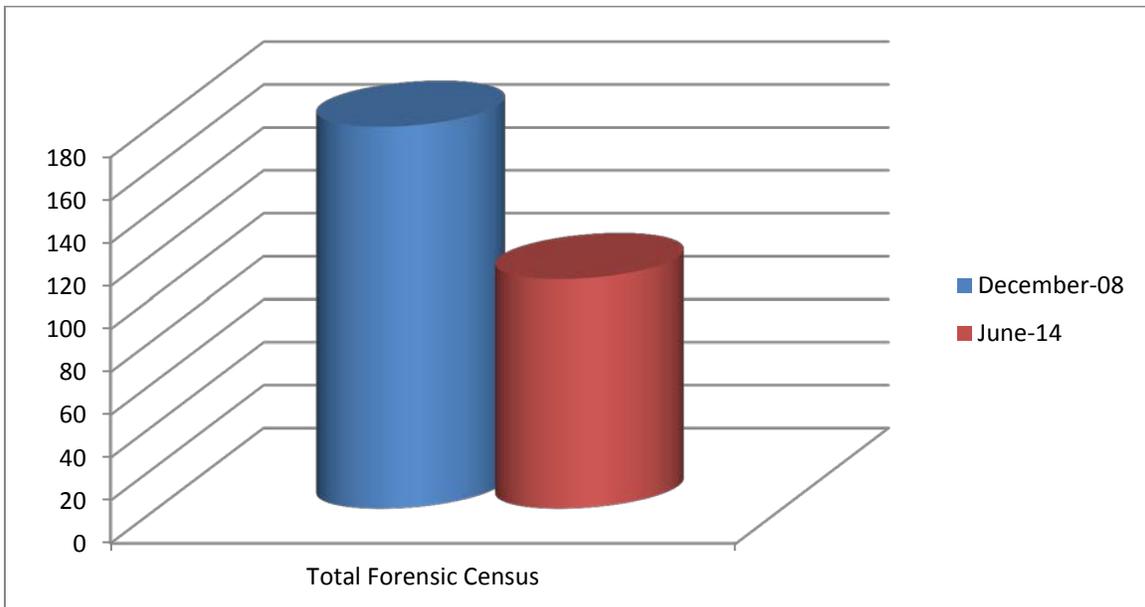


Table 35: Total Forensic Census State-Wide



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 and June 30, 2014, 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); MTMHI transferred two patients committed under T.C.A. § 33-7-301(b) and one patient committed under T.C.A. § 33-7-303(c); two patients were admitted to WMHI directly from the community after having been committed under T.C.A. § 33-7-303(c) by courts in MTMHI's area. New commitments under T.C.A. § 33-7-301(b) continued to be admitted to MTMHI and MBMHI since 75% of those patients tend to be discharged in less than 90 days. Many of the patients committed under T.C.A. § 33-7-303(c) at MTMHI had significant local ties and family visits and it was not considered to be in their best interests to transfer to WMHI. At the close of FY 14, MTMHI still had more NGRI patients (22) than WMHI (15). MBMHI had none.

A review of the forensic census including all legal categories under Title 33, Chapter 7, Part 3 for each RMHI shows a rebound at MTMHI and a flattening at WMHI. 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 36.

Table 36: Forensic Census (all categories) by RMHI

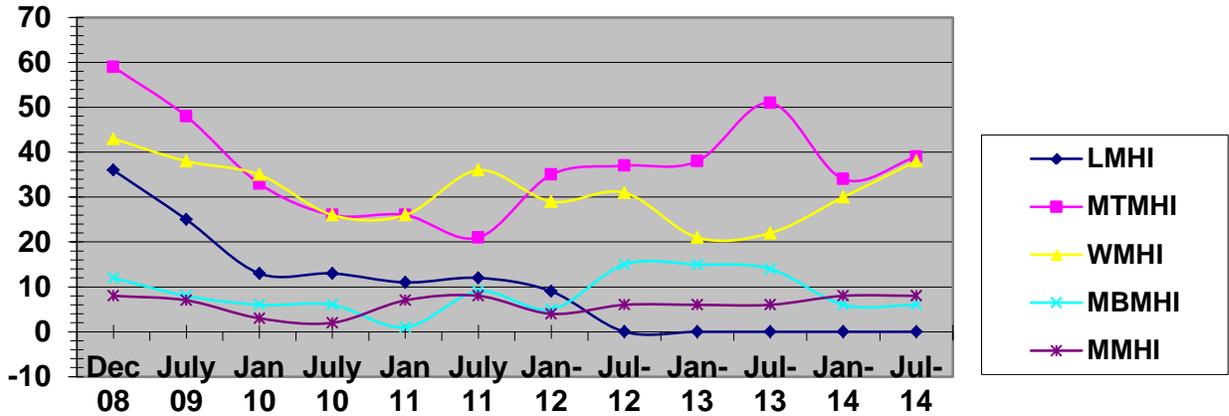


Table 37 (below) allows for an inspection of the census of each legal status within each facility and state-wide, comparing mid-December 2008 (just before census reduction efforts began) with the end of FY 14. The number of patients in all legal categories was reduced, particularly those of longer term 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 37: 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, 2014

Facility	MTMHI	FSP	WMHI	MBMHI	MMHI	Total
301(a)	6	7	4	4	8	29
301(b)	11	4	19	2	0	36
303 (a)	0	0	0	0	0	0
303(c)	22	5	15	0	0	42
Total (%Census)	39 (23%)	16 (72%)	38 (31%)	6 (5%)	8 (15%)	107 (22%)

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 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. There have been 168 evaluations conducted since the beginning of FY 11, 65 (39%) sex offender evaluations and 103 (61%) violent offender risk assessments. All offenders were male until this past fiscal year during which there was one female offender evaluated under the sex offender statute and one female offender evaluated as a violent offender.

Evaluations are conducted by a psychiatrist from the Vanderbilt University Medical School Department of Psychiatry 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

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.

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 greater or less than the Department of Correction baseline for re-offense. There were 52 evaluations completed in FY 14, including 22 (42%) on sex offenders and 30 (58%) on violent non-sex offenders.

**Table 38: 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	20 (19%)	41 (40%)	42 (41%)

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

**Table 39: Risk Assessment for the BOP:
Sex Offenders**

	Greater Than Baserate for Re-Offense	Less Than Baserate for Re-Offense
FY 11	1	5
FY 12	4	16
FY 13	3	14
FY 14	3	19
Total	11 (17%)	54 (83%)

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 condition at the time of the offense, juvenile court-ordered evaluations are much broader in nature. These evaluations address:

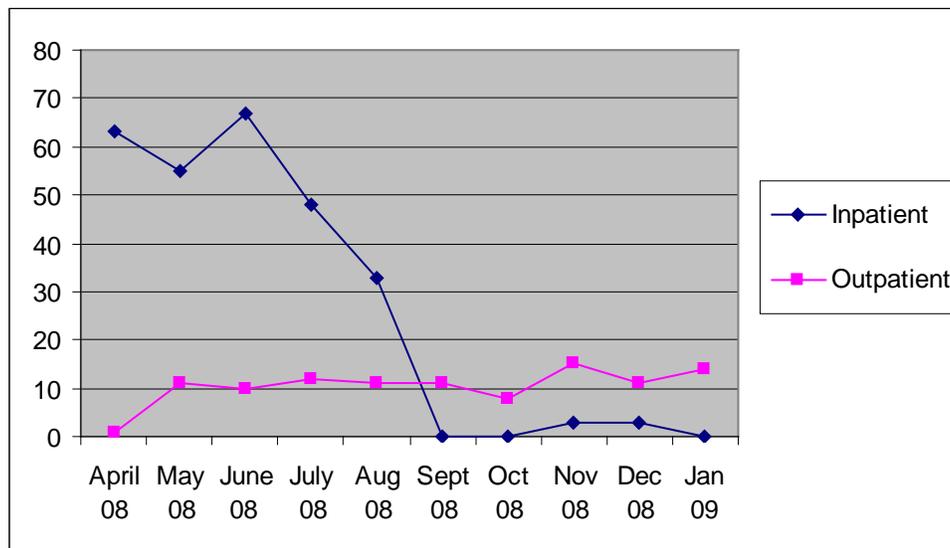
- whether the juvenile is mentally ill and/or developmentally disabled,
- what if any treatment is recommended,
- whether or not the juvenile meets commitment criteria, and
- legal questions such as competency to stand trial.

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. 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 40, 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 40: 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. The Department’s only remaining children and youth unit, which was at MTMHI, was closed in April of 2010 for the same reason. Juvenile courts have increased the use of outpatient evaluations as they have become more familiar with the providers, although the annual state-wide frequency appears to have 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 41: Annual Totals of Inpatient and Outpatient Juvenile Evaluations

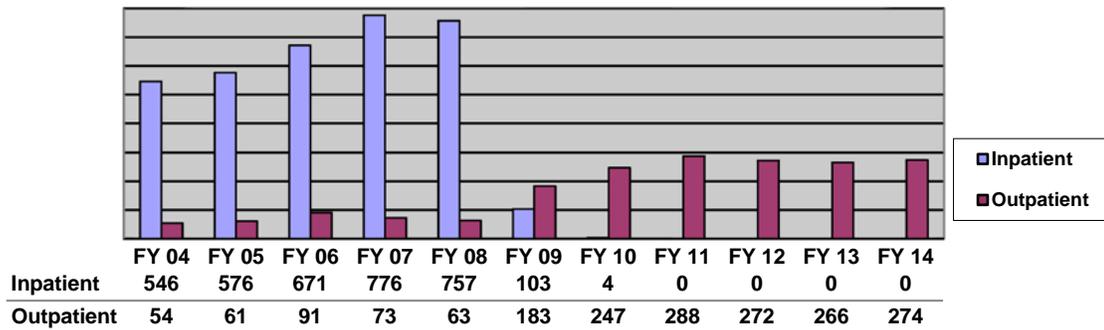


Table 42: Frequency of Outpatient Juvenile Evaluations by Provider

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

Table 43 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 43: Type of Offenses Inpatient and Outpatient Juvenile Evaluations

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

Table 44 indicates the frequency with which special 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 44: Rate of Specific Forensic Requests
(Outpatient and Inpatient FY 07-14)**

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

Over half (60%) of all juvenile court ordered mental health evaluations were for youth age 15 or older.

Table 45: 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%

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 (CANS) on youth at the point of intake into juvenile court for youth alleged to be unruly or delinquent. Those 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 grant task force includes 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). As a control group, five of the counties were also selected to have an additional service: the TDMHSAS contracted with Tennessee Voices for Children 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, Sevier, Macon, Madison

and Obion 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. The recidivism and custody rates of the counties with FSP services will be compared to those counties without FSPs at the conclusion of the project. Local task force meetings were held in each county in June and July of 2010 and CANS training was completed in all courts so that screenings began August 1, 2010. These services were supported by a second round Transfer Transformation Initiative grant.

The AOC and VUCOE provided extensive technical assistance and trouble-shooting throughout FY 11 and FY 12. Once the project was underway, the Sevier County Juvenile Court staff discovered that administering the CANS was redundant with the mental health assessment process they already had in place, and so they dropped out of the project. Screening continued in 10 courts in the remaining 9 counties, with FSPs in 4 of those counties, throughout FY 11. In FY 12, Lawrence and Marion counties encountered manpower challenges and those courts dropped out, leaving 8 courts in 7 counties. In FY 14, 862 screenings were completed, with 52 referrals for additional mental health services (6%), 33 referrals for substance abuse services (4%) and 484 referrals for family services (56%). Table 46 shows the number of screenings and referrals from October 2010 through the end of FY 14.

Table 46: TICSRP Screenings and Referrals

Total Screened	4,455	100%
MH Referrals	432	10%
SA Referrals	284	6%
Family Services	2,454	55%

Family Service Providers served two of the courts throughout the year: Macon and Madison Counties. Both courts provided anecdotal reports of very positive contributions and actually requested more time from their FSPs when available. Davidson County Juvenile Court staff requested FSP services and met in June with TVC staff to plan for a referral process. All FSPs have been trained to complete a family caregiver stress questionnaire and a user satisfaction survey for family members to be used with new cases as they are opened.

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;

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).

Expansion in FY 14:

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 of these courts (e.g. Bradley, Dyer) 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.

Full implementation of the juvenile court screening project includes assignment of user id and passwords for staff completing the JJ-CANS to access the AOC's web portal and testing of data entry and statistical reports in addition to the orientation and training on administering the JJ-CANS. Implementation was ongoing in the expansion courts at the end of FY 14 (NOTE: no screenings from these courts or the Dyer County/Dyersville schools were included in Table 44, above.) Expansion will continue through FY 15, and additional sources of funding will be sought to continue beyond FY 15.

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 47, below:

Table 47: 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.

During 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/mental/t33/MOT%20Manual%20Rev%20Oct%202013.pdf>). 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. Planning sessions were held with the Office of Information Technology to develop MOT database functions in the Forensic Billing system, a project planned for kickoff in October 2014. By the close of FY 14, the MOT Coordinator had identified 141 active MOT cases under T.C.A. § 33-7-303(b) and 257 active cases under T.C.A. § 33-6-602 for a total of 368 active MOT cases state-wide.

FORENSIC SERVICES FINANCIAL REPORT

OUTPATIENT SERVICES

Outpatient services are reimbursed on a fee-for-service basis. Table 45 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). There was a small decrease of 2% in expenditures from FY 13 to FY 14 after a 7.5% decrease between FY 12 and FY 13.

Table 48: Outpatient Expenditures, Adult and Juvenile Services

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

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 52 evaluations in FY 14 cost \$46,800.

INPATIENT SERVICES

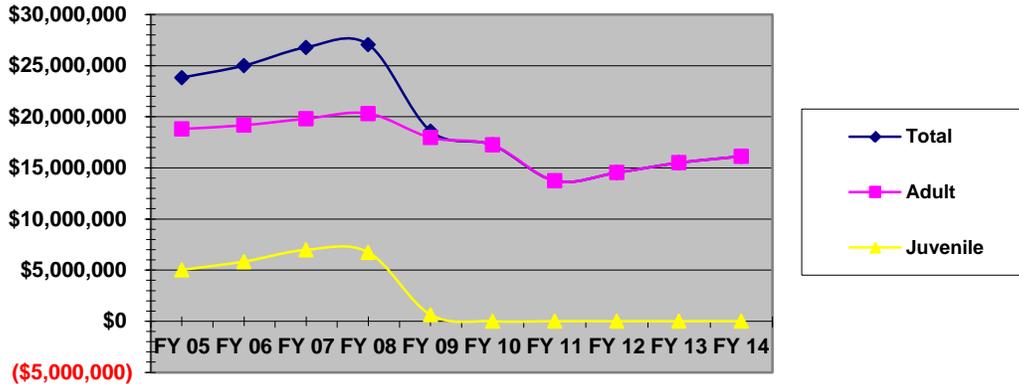
The Regional Mental Health Institutes are reimbursed for forensic services at the rate of \$450 per day. Documentation is required from the facilities to allow the TDMHSAS forensic specialists to authorize payment. This helps insure that proper procedures are followed in forensic cases and that patients 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 a 4% increase in FY 14 over FY 13, which follows a 6% increase in FY 12 over FY 13 and another 6% increase from FY 11 to FY 12. FY 14 expenditures were still 21% lower than adult inpatient expenditures in FY 08 (\$20,318,000).

Table 49: Inpatient Forensic State Expenditures

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

A review of inpatient forensic reimbursements over the last nine fiscal years (Table 50) 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 50: Inpatient Forensic Expenditure Trends



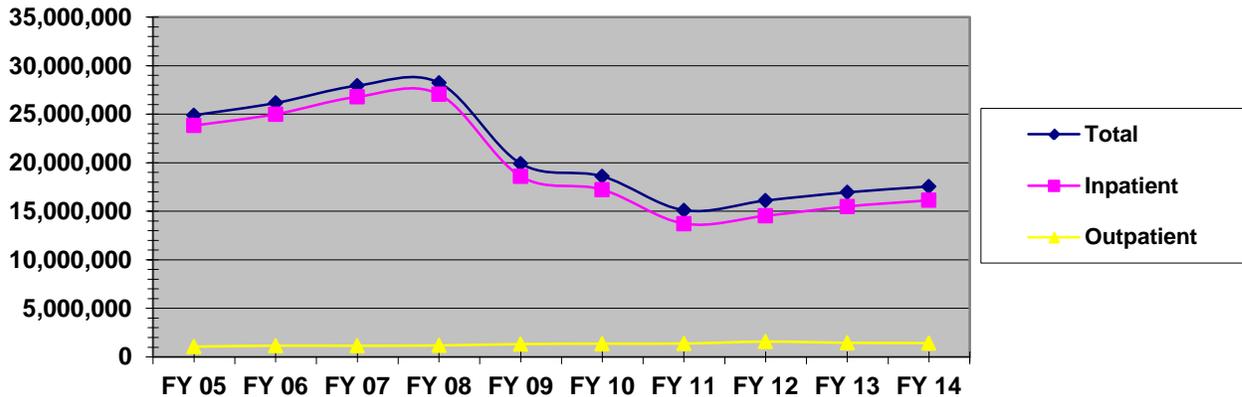
OVERALL FORENSIC EVALUATION AND TREATMENT SERVICE EXPENDITURES:

Combining total inpatient expenditures with outpatient expenditures over the last five years shows a gradual increase until FY 09 when the change in payment for juvenile inpatient evaluations and the (adult) Forensic Census Reduction Project initiated a decline which continued with the change in billing misdemeanor-only evaluations to the counties in FY 10. The lowest point in expenditures was FY 11, which was a 47% decrease from the peak in FY 08, while the FY 14 total is 38% lower than FY 08.

Table 51: 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

Table 52: 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 based upon the estimate of the actual per diem cost for that unit at that RMHI, which ranges from \$494 a day to \$1,220 a day. The cost can be reduced if the county enters a contract with the TDMHSAS to set the *per diem* rate at \$450. All counties who have actually used inpatient services have signed a contract.

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 Office of Fiscal Services, the Office of Forensic Services and Information Technology 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.

In the third quarter of FY 14 (April-June), the Office of Fiscal Services undertook the task of reconciling spreadsheets on billing and collections for outpatient services with data from the Edison system on billing and collections, a task still underway at the end of FY 14. The outpatient billing and collection amounts in Table 53 on the following page are from the Office of Fiscal Services spreadsheets and only include billing and payments through March 31, 2014.

**Table 53: Outpatient Misdemeanor Services Billing and Collections
July 1, 2009-March 31, 2014**

	Billed	Collected	% Collected
FY 10	\$257,700	\$101,380	39%
FY 11	\$255,900	\$94,440	37%
FY 12	\$261,900*	\$99,039	38%
FY 13	\$212,600*	\$81,000	38%
FY 14	\$139,800	\$27,400	25%
Total	\$1,127,900*	\$403,259	36%

*reduced to reflect negotiated settlements

The inpatient billing and collection amounts in Table 54, below, are from Avatar and include all of FY 14.

**Table 54: Inpatient Misdemeanor Services Billing and Collections
July 1, 2009-June 30, 2014**

	Billed	Collected	% Collected
FY 10	\$985,150*	\$958,240	97%
FY 11	\$918,450	\$799,325	87%
FY 12	\$1,776,150*	\$1,519,421	86%
FY 13	\$997,109*	\$949,979	95%
FY 14	\$694,350	\$147,600	21%
Total	\$5,510,159*	\$4,374,565	79%

The discrepancy between the percentage of outpatient billing collected (36%) and the percentage of inpatient billing collected (79%) is due almost entirely to Shelby County not yet having paid for outpatient services. The Office of Fiscal Services' preliminary report on Edison

billing and collections showed \$686,700 owed by Shelby County, or 60% of all outpatient billing.

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 14, \$264,084 was spent assisting 44 forensic patients. This was 66% of the funds available for direct services. Housing support accounted for 59% of expenditures, mental health services accounted for 40%, 1% for necessities such as clothing, eyeglasses, and utilities, and less than 1% for transportation.

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 practices of the providers results in a highly effective screening and diversion of adult criminal defendants from RMHI bed usage: for FY 14, 1,899 initial outpatient evaluations diverted 77% of that population from the need for an inpatient evaluation. There were 446 inpatient evaluations and 107 new commitments under T.C.A. § 33-7-301(b), a rate of 24% of inpatient evaluations to commitments under

T.C.A. § 33-7-301(b). Only 6% of the 1,899 initial outpatient evaluations became commitments under T.C.A. § 33-7-301(b). There were 36 NGRI outpatient evaluations conducted under T.C.A. § 33-7-303(a) resulting in 20 recommendations for commitment to an RMHI under T.C.A. § 33-7-303(c) (56%).

Recommendations: This pattern underscores the importance of maintaining the current outpatient provider network and of the training and monitoring of the performance of inpatient as well as outpatient certified forensic evaluators. Expertise should be maintained with updated training. The efficiency of the current system is due in part to the technical support which the staff of the Office of Forensic and Juvenile Court Services provides to evaluators. This activity is as essential as the data entry and monitoring of billing.

2. Despite the efficiencies created with the focus on community-based services noted in conclusion #1, some outpatient providers continue to have rates of referral that exceed the goal of 24% (Table 11 from p. 12 is reproduced here)

Table 11: Frequency of Inpatient Referral by Provider

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

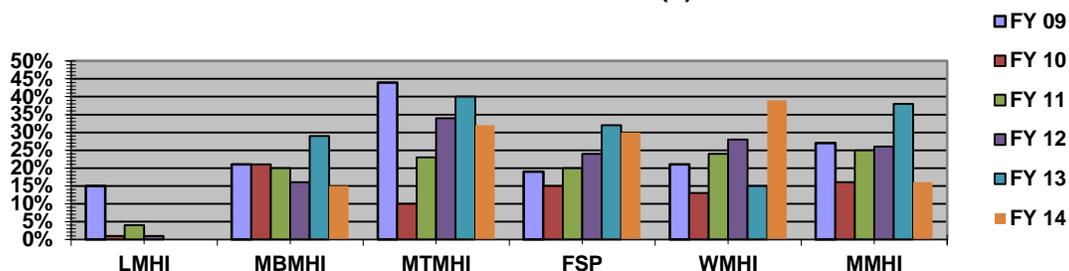
Recommendations: Referral rates should be monitored with regular quarterly reports during the year and providers exceeding a 25% referral rate should be prompted to increase use of supplemental services to reduce inpatient referrals. Barriers to access to jail-based mental health services should be examined in jurisdictions with referral rates exceeding 25%.

3. A review of outcomes for patients committed under T.C.A. § 33-7-301(b) revealed that fully half of these defendants were not prosecuted but instead had charges dismissed or otherwise retired. 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). Additionally, the very short length of time between commitment and the dismissal of charges for Shelby County cases at WMHI suggests that this process functions as a “back-door” diversion of patients from the criminal justice system to the mental health system for courts in that jurisdiction.

Recommendations: The frequency of dismissals and the length of time from commitment to dismissal should be studied over multiple years to confirm the frequency of this pattern and rule out the possibility that the rate of dismissal was unusually high in FY 14.

4. As recommended in the FY 13 Annual Report, feedback on forensic census trends was presented to the leadership and forensic staff of all the RMHIs, including clinical staff identified by leadership as handling forensic cases. Training on the commitment standards for forensic patients, the importance of completing evaluations under T.C.A. § 33-7-301(a) during the evaluation period rather than committing under T.C.A. § 33-7-301(b) to complete the evaluation was updated and repeated at all RMHIs with a special focus on MTMHI (three separate trainings were held in order to cover all clinical staff). Policies and procedures were reviewed and the RMHI Manual was updated. Training at WMHI was delayed until the last quarter of the fiscal year by a Joint Commission visit. The rate of recommendations for commitment under T.C.A. § 33-7-301(b) was reduced at every facility except WMHI.

Table 55: Frequency of Recommendations for Commitment Under T.C.A. Section 33-7-301(b)



Recommendations: Feedback on forensic census trends should be presented to the leadership and forensic staff of all the RMHIs annually. Training on the commitment standards for forensic patients, the importance of completing evaluations under T.C.A. § 33-7-301(a) during the evaluation period rather than committing under T.C.A. § 33-7-301(b) to complete the evaluation should be updated and repeated at all RMHIs every other year.

- Supplemental services for outpatient cases resulted in the diversion of 35 cases from the need for an inpatient evaluation. This was the lowest number of diverted cases and lowest number of cases in which training sessions were attempted prior to inpatient referral in the past four fiscal years. Still, the rate of diversion was 88% of all cases in which pre-trial competency training was attempted in FY 14, and is 90% for the last four years combined. With an average length of stay of 21 days, those 35 cases represent 735 potential bed days, which would have a significant impact on available suitable accommodations, and which is at a cost of \$330,750 at the \$450 per diem from the Forensic Services budget. The total cost of pre-trial competency training was approximately \$3,500.

Recommendation: The incentive for attempting to divert an inpatient evaluation with outpatient training sessions could be improved 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 14 frequencies, this could have increased the cost of pre-trial training from \$3,500 to \$9,800 (if all 35 cases used four sessions at \$70), but diverting just two inpatient referrals with an average length of stay of 21 days would save an

additional \$18,900. As noted above, 232 of 258 cases were diverted under the existing procedures since July 1, 2010.

6. 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 what 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.

7. The FY 12 and FY 13 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 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, and the Office of Fiscal Services in the Division of Administrative Services undertook a project to reconcile internal records with Edison accounts. Shelby County bills remained unpaid, but the Office of Fiscal Services was able to create a comprehensive statement of charges owed which was forwarded to Shelby County through the Division of Legal Counsel working to collect delinquent balances.

Recommendation: The Office of Forensic and Juvenile Court services should continue to work with Administrative Services to complete testing and implementation of outpatient misdemeanor billing and collections in the Forensic Billing system.

8. The Tennessee Integrated Court Screening and Referral Project conducted to 4,455 screenings for youth in juvenile courts between October 1, 2010 and June 30, 2014. 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.