

Mental Health in Tennessee's Courts

**A Procedural Manual for Judges,
Defense Attorneys and
District Attorneys**

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**Tennessee Department of
Mental Health and
Developmental Disabilities**

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Introduction

This manual is intended as an introductory guide to assist legal and judicial personnel with developing fair and effective adjudication of defendants with mental illness. Basic information is provided with sources for further investigation.

Information is provided on recognizing mental illness and on types of mental health services available in Tennessee. Principles and methods are explored regarding misdemeanor, felony and juvenile cases involving defendants with mental illness. Considerations for capital cases involving mentally ill defendants are briefly reviewed.

Title 33, Tennessee Code Annotated, the mental health code in Tennessee, stipulates legal procedures for forensic evaluation, mandatory outpatient treatment (MOT) and psychiatric hospitalization. These procedures are described to assist counsel and the court with appropriate usage in legal proceedings.

Mental health care in jails is described to provide an overview of treatment that is, and is not available for those who are incarcerated, realizing that services in Tennessee jails vary considerably from county to county. Components and challenges of release planning, probation and parole for this population are described with the intent of encouraging realistic release planning and community supervision in accordance with accepted best practices.

The Problem

The Problem:

Criminalization of Mental Illness

There are more than four times as many individuals with mental illness in the Tennessee county jails (19.1%)¹ as in the general population (5%) (Kessler et al, 1999)². On any given day in Tennessee there is an average of 3339 jail inmates with a diagnosis of serious mental illness, while there are 942 in state psychiatric institutions. Reduction in the size of state psychiatric institutions is generally regarded as having an overall positive effect, giving many individuals the opportunity to live productively in the community³. Unfortunately, increase in community-based mental health treatment has not grown as psychiatric inpatient beds were reduced⁴ leaving individuals with severe mental illness underserved. Nationally, almost a quarter (23.2%) of the jail inmates with mental illness are arrested and incarcerated for public order offenses that could be connected to symptoms of untreated mental illness⁵.

The public perception is that most individuals with mental illness are prone to violence. Research has repeatedly shown that, when treated, individuals with mental illness are no more likely to commit a violent act than the average person. When not in treatment and when abusing substances, individuals with mental illness do commit more acts of violence⁶. Conversely, individuals with mental illness are at increased risk of crime victimization⁷.

Encounters between law enforcement and individuals with mental illness are frequent. The National Consensus Project (Council of State Governments) reports, "In the police departments of the U.S. with populations over 100,000, approximately 7 percent of all police contacts, both investigations and complaints, involve a person believed to have mental illness"⁸. Despite the frequency of contact, it is by no means standard for law enforcement agencies to

¹ Department of Mental Health and Developmental Disabilities, (2004, January 8). Survey of County Jails in Tennessee: One Year Follow Up. Retrieved June 1, 2006 from <http://www.state.tn.us/mental/cj/cj6.html>.

² Kessler, RC (1999) *A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness*, In Mental Health United States 1999, Manderscheid, RW and Henderson MJ eds., Rockville, MD, Center for Mental Health Services.

³ Lamb, R.H. & Bachrach, L.L (2001) Some Perspectives on Deinstitutionalization. *Psychiatric Services, American Psychiatric Association*, Vol. 52, August, 2001 pp.1039-1045. Rothbard, A.B., Kuno, E. (2000) The Success of Deinstitutionalization Empirical findings from Case Studies on State Hospital Closures. *International Journal of Law and Psychiatry*, Vol 23 (3-4), pp. 329-344.

⁴ Council of State Governments, (2002). Criminal Justice / Mental Health Consensus Project. New York: Council of State Governments.

⁵ Ditton, PM (1999) *Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers*. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

⁶ Steadman, H.; et al (1998) Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods, *Archives of General Psychiatry* 55, pp. 393-401.

⁷ Virginia Hiday, et al., "Criminal Victimization of Persons with Severe Mental Illness," pp. 62-68; also J.A. Marley and S. Buila, "When violence happens to people with mental illness: Disclosing victimization," *American Journal of Orthopsychiatry*, 69:3, 1999, pp. 398-402.

⁸ Dean et al (1999) Emerging Partnerships between Mental Health and Law Enforcement. *Psychiatric Services*, 50(1) pp. 99-101.

have specialized response procedures for calls involving an individual with mental illness⁹. The result is that individuals with mental illness are frequently arrested and incarcerated when diversion to mental health treatment may be a viable option.

The county detention facility is an inappropriate setting for most individuals with mental illness who are convicted of misdemeanors. While incarcerated, jail inmates with mental illness are less likely to receive appropriate treatment or rehabilitation, more likely to decompensate, more likely to misbehave and more likely to be victimized by other inmates¹⁰. Detention facilities are also negatively impacted by the requirement to house this population. Research has shown that inmates with mental illness are more costly and troublesome than other types of inmates due to needs for psychiatric treatment and high surveillance¹¹. Correctional personnel typically receive little training in recognition of psychiatric symptoms or methods for effective de-escalation of psychiatric disturbances.

Prisons face similar supervisory and budgetary challenges in housing an increasing number of mentally ill inmates. The Bureau of Justice Statistics reported that one in 10 state inmates received psychotropic medications while 1 in 8 participated in therapy or counseling¹². Annual spending for mental health services in Georgia's prisons rose from \$2.6 million in 1991 to \$24.1 million in 2001 with \$6.6 million for psychiatric medications alone. In Pennsylvania, lack of community services raised barriers to release so that inmates with mental illness were denied parole at a higher rate (27%) than the inmate population as a whole (16%)¹³.

The Court may have difficulty obtaining determination of mental illness in defendants. Forensic Evaluation in Tennessee (T.C.A. § 33-7-301a) has specific and narrow purposes and is not appropriate for simply preparing to divert the defendant to community treatment. Purposes and procedures for Forensic Evaluation are described in this manual, as are alternative methods of obtaining psychiatric evaluation.

Legal remedies and service models exist to divert defendants with mental illness into treatment in the pretrial or post-conviction level of court proceedings. Community services are described in this manual to acquaint counsel and the court with possible alternatives to incarceration. In order to implement diversion remedies, Counsel and the court will need assistance to develop viable psychiatric treatment alternatives.

⁹ Ibid

¹⁰ Roy, B.; Ruddell, R.; Diehl, S (2004) Diverting Persons with Mental Illness from Jail: A tale of two states. *Corrections Compendium*, 29, 1- 5, 38 – 42.

¹¹ Roy, B.; Ruddell, R. (2004) Diverting mentally ill inmates from California Jails. *American Jails*, 18, 14 - 18

¹² Bureau of Justice Statistics (2001) *Mental Health Treatment in State Prisons, 2000*. US Department of Justice, NCJ 188215.

¹³ Couturier, L. (2002) Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation and Co-Occurring Disorders. IN: *The Consensus Project Report*, Council of State Governments.

Understanding Mental Illness

“Mental health” is a relative term. It can mean many things to many people. Generally, mentally healthy people have a positive self-image and can relate successfully to others. Mental health is the ability to integrate one’s self with one’s environment.

Serious mental illnesses are brain disorders that impair thinking, feeling, and behavior. These disorders disrupt a person’s ability to function in activities of daily living such as social interaction, employment, education, and self-care. Mental illness can be caused or triggered by genetic transmission, biochemicals in the brain, prolonged or very intense social stress, alcohol and drug use, and environmental toxins.

Jackie Massaro, MSW, in the Overview of the Mental Health Service System for Criminal Justice Professionals, published by the Technical Assistance and Policy Analysis Center, states the following:

People with mental illness become involved with the criminal justice system for a variety of reasons. The symptoms of mental illness may result in bizarre or unusual behaviors that are disturbing to other people and result in complaints to law enforcement. A lack of understanding on the part of the general public about mental illness often leads people to perceive behaviors associated with mental illness as frightening or threatening. Individuals with mental illness in the community may display these disconcerting symptoms if they are not receiving any treatment or if they are not participating fully in treatment (e.g., not attending therapy, not taking medications). For a variety of reasons, people with mental illness are not always willing to participate in treatment. The illness itself may make some people fearful of authority figures or of being controlled; others may object to the treatments offered. Mental health providers are challenged to find ways to engage these individuals and to create (or adjust) treatment plans that keep people involved in treatment.

People with mental illness may also become involved with the criminal justice system due to aggressive behavior. To date, research concludes that only a weak association exists between mental illness and violence in the community (MacArthur Research Network on Mental Health and the Law, 2004). However, under certain circumstances, a person with mental illness may be at greater risk for exhibiting aggressive or violent behavior that must be sanctioned. The symptoms of mental illness alone do not necessarily increase risk; however risk increases with the presence of certain other factors, the most significant being the use of alcohol or other drugs. Other factors that increase risk include a history of violence, anger, violent fantasy, and psychopathy, which is a disorder characterized by the lack of concern for other people and impulsive behavior (Monahan et al., 2001).

Of course for some people, mental illness is secondary to involvement in criminal behavior. For example, co-occurring substance use disorders may result in illegal activities such as possession or sale of controlled substances or crimes of opportunity of support substance abuse.

The presence of a mental illness does not necessarily prevent people from acting in a responsible and socially adaptive manner. However, the symptoms of mental illness may interfere with social functioning. Treatment of these symptoms can help to restore responsible social behavior. Responsibility for criminal behavior should not be automatically excused due to the presence of mental illness (Rotter al., 1999).

Types of Mental Disorders

These are the most common disorders of mental illness and severe emotional disturbance found among both adults and children in this country. For more in depth and specific information, please consult the Diagnostic and Statistical Manual, Fourth Edition.

Psychotic Disorders

Psychotic disorders are a condition where malfunctions in the brain cause the person to be overwhelmed by inner perceptions and thoughts that they lose contact with reality. Classical characteristics of psychosis include hallucinations (alterations in sensory perception, usually involving hearing voices or seeing images that do not exist) and delusions (beliefs about events or circumstances that have no basis in reality). Schizophrenia is one of the most disabling mental disorders. In the past, it was thought that people with schizophrenia and other psychotic disorders could not function normally in their families or communities. With new, effective medications and services, many people with psychotic disorders are able to live and work productively in the community. Some people who need the new medications and services don't get them due to a variety of reasons and end up in the criminal justice system for behaviors that could be attributed to untreated psychosis.

Mood Disorders

Mood or Affective Disorders are a group of clinical conditions characterized by a disturbance of mood (the internal emotional state of an individual), a loss of sense of control, and a subjective experience of great distress; mood disorders include depression and mania. Depression is a serious medical illness and is the most recognizable mental illness in the community. Untreated depression may lead to suicide and law enforcement is frequently called when an individual has made a suicide attempt. Risk of suicide is also higher for persons who are incarcerated, estimated at ten times that of the general population.

Bipolar Disorder is a mood disorder; it is also known as manic depression. It is a biologically based mental illness. Manic symptoms include mood swings from an intense high of excitement, irritability and inflated sense of self-importance, while depression is characterized by intense lows of sadness, hopelessness and lethargy. Bipolar Disorder can vary from mild to severe and can involve only a

few episodes of mania, alternating mania and depression, or mood swings associated with seasons.

There is an increased risk of suicide in individuals with Bipolar Disorder who are experiencing the depressive cycle. In a manic phase, the individual is more likely to engage in violence or high-risk behavior such as truancy or occupational absenteeism, substance abuse, spending sprees or sexual promiscuity. At either of these extremes, individuals' behavior may bring them into contact with the criminal justice system.

Anxiety Disorders

Anxiety disorders are conditions in which anxiety and extreme worry/nervousness disrupt ordinary functioning or cause significant distress to the sufferer. "Anxiety" refers to one's response to any perceived threat of danger (real or imagined), and includes physical (such as increased heart rate and shortness of breath), mental (attention drawn to the perceived threat), and behavioral (avoidance or escape) components. Anxiety itself is a normal and healthy part of human experience that signals a need to protect oneself from potential dangers; it only becomes dysfunctional when it is overly frequent or intense, occurs repeatedly in response to situations that are not really dangerous, and/or disrupts the ordinary functioning and enjoyment of one's life.

Personality Disorders

Personality disorders are groups of personality "traits" resulting in ongoing, troublesome patterns of thought, feeling and behavior. To be considered a personality disorder, these patterns must cause major problems in self-care, social relationships, work or school. Personality disorders usually become apparent in late adolescence or early adulthood and continue throughout life unless treated. Personality disorders are usually associated with a difficult childhood or early environment.

Substance Abuse Disorders

There are a multitude of substance abuse diagnoses, ranging from Alcohol Abuse to Hallucinogen Dependence. Abuse indicates the person is misusing the substance and may be suffering ill effects from the substance, and dependence indicates more serious consequences exist due to the use, including addiction, problems at work, in home life and interpersonally. Substance abuse disorders can be difficult to distinguish from mental illnesses, because the symptoms can present in similar ways. It is important to note that substance abuse disorders are not considered mental illnesses and are treated with very different methods.

Co-Occurring Disorders

Co-occurring disorders refers to two disorders in the same individual. The most common co-occurring disorders for individuals with mental illness are substance abuse disorders, mental retardation, and physical disabilities such as traumatic brain injury. In the criminal justice system, the most common is the co-

occurrence of mental disorders and substance abuse disorders (alcohol and/or drug dependence or abuse).

It is not uncommon for people with mental illness to also abuse alcohol and drugs. This is problematic because many people use substances to escape the symptoms of their illness, but the use makes their symptoms worsen in the long-term. There is an interactive decline and degeneration of mental health symptoms when substances are combined with mental illness.

Childhood Specific Behavior Disorders

Oppositional Defiant Disorder

Oppositional Defiant Disorder is a childhood behavioral disorder involving ongoing patterns of defiant attitudes; and disobedient, hostile behavior toward authority figures. Serious marital discord, parental mood disorders, and parental substance abuse are common in families of children with this disorder. The diagnosis is not usually made before the age of 8 or after the onset of adolescence.

Behaviors Associated with Oppositional Defiant Disorder (*From DSM-IV¹⁴*)

- Often loses temper;
- Often argues with adults;
- Often refuses to comply with rules or adults' requests;
- Often deliberately annoys people;
- Easily annoyed by others;
- Often blames others for his or her mistakes or behavior;
- Often spiteful and vindictive.

Conduct Disorder

Conduct disorder is a childhood behavioral disorder consisting of a persistent pattern of violating the rights of others or basic age-appropriate societal norms or rules. Estimated at 1% - 10% of the population, conduct disorder has increased over the last decades. Research shows that conduct disorder has both genetic and environmental influences. It is often preceded by oppositional defiant disorder. Conduct disorder may go into remission by adulthood, but may develop into antisocial personality disorder.

Behaviors Associated with Conduct Disorder (*From DSM-IV¹⁵*)

- Aggression to people and animals;
- Destruction of property;
- Deceitfulness or theft; and
- Serious violations of rules.

¹⁴ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

¹⁵ Ibid.

Mental Retardation

Mental retardation is a disability consisting of impaired intellectual functioning. It is caused by any condition that impairs development of the brain before birth, during birth or in the childhood years. There is a wide range in level of disability among individuals with mental retardation. About 87% are mildly affected, while 13% with IQs below 50, have serious limitations in functioning.

Diagnostic criteria for Mental Retardation generally are as follows:

- IQ below 70-75;
- The condition is manifested before age 18; AND
- Significant limitations exist in two or more skill areas:
 - Communication
 - Self-care;
 - Home living;
 - Social skills;
 - Leisure;
 - Health and safety;
 - Learning (reading, writing, basic math);
 - Capacity for independent living;
 - Economic self-sufficiency;
 - Community Use;
 - Self Direction.

Mental retardation is often confused with mental illness, but the two conditions are very different. Some people with mental retardation also have a mental illness.

As more people with mental retardation move into the community from institutions, they are becoming involved in the criminal justice system as victims, witnesses, or suspects. Many individuals unintentionally give "misunderstood responses" to officers, which increases their vulnerability to arrest and incarceration.

When attempting to access service for persons with mental retardation, it is important to have proof of the disability. For mental retardation, this would include a psychological evaluation that includes an intelligence test. The first step in accessing services would be calling the Division of Mental Retardation Services (DMRS) to locate an appropriate agency in your area.

Tennessee Mental Health Service System

Most individuals with mental illness live in the community and participate in treatment with community mental health providers. Brief periods of psychiatric hospitalization may be necessary to resolve psychotic, suicidal or manic episodes or to adjust medications in a controlled environment, but very few individuals require long-term hospitalization or residential treatment. Community treatment is the foundation of mental health service delivery.

However, a 1999 national study by the Bureau of Justice Statistics shows that 23% of jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of mental illness. Inadequacies in public funding have resulted in barriers to care that include waiting lists and high caseloads. In addition, individuals may be unwilling or too disorganized to adhere to treatment regimens. Although most individuals with mental illness never come in contact with the law, some who are untreated or inadequately treated may become disturbed to the point that they commit crimes or create a public nuisance.

Funding for Mental Health Services

Public mental health services in Tennessee are funded through TennCare (Medicaid), Medicare and other public programs. Most community mental health agencies also accept private insurance payment, although coverage may not be sufficient for the types and quantities of service necessary to treat severe and persistent mental illness. Please see enclosed chart on the following page.

Funding for Mental Health Services in Tennessee

Program	Funding Source	Eligibility Requirements	Services Available	Where to Apply
Medicaid/TennCare	Federal Medicaid monies with State match	<ul style="list-style-type: none"> Receiving SSI (disable and under 100% of FPL) Pregnant and low income Eligible child under the age of 6 Eligible for Families First Other categories, please contact DHS Not incarcerated 	Case management, therapy, medication management, day treatment, A&D treatment (not residential), up to five prescriptions with small co-pays	DHS – Department of Human Services For SSI (Supplemental Security Income), contact SSA (Social Security Administration)
Medicare	Federal government	<ul style="list-style-type: none"> Age 65 and older Received SSDI for at least 24 months Not incarcerated 	Therapy, medication management, partial hospitalization, A&D treatment (some, and not residential), prescriptions with co-pays	Social Security Administration
State Only	TDMHDD	<ul style="list-style-type: none"> Uninsured, psychiatrically disabled individuals who are below 100% of FPL and Have a severe mental illness Not incarcerated 	Same mental health services as TennCare, No medical benefits are included	Local Community Mental Health Center
Safety Net	TDMHDD	<ul style="list-style-type: none"> TennCare disenrollees who were receiving mental health services in the year previous to the disenrollment Not incarcerated 	Assessment, limited case management and therapy, small prescription discount and benefit No medical benefits are included	Local Community Mental Health Center
Private Insurance	Employers, Unions, and private pay	<ul style="list-style-type: none"> Determined by each individual employer and insurance plan 	Consult individual policy	Individual insurance companies, unions, or employers

Mental Health Coverage for Inmates

Federal law prohibits Medicaid (TennCare) or Medicare funds from covering inmates. Community mental health agencies which have contracts for crisis services are required to provide crisis response services to the public regardless of ability to pay and to local jails; but payment is required for most other services. Other mental health services to inmates of county jails are the financial responsibility of the county. Counties decide the types and levels of care to be provided in jails.

Service is often interrupted when individuals are incarcerated because of differences between TennCare or Medicaid coverage and services provided in jails. Disruption in care (especially medication) may exacerbate symptoms of mental illness and increase the individual's likelihood of misbehavior while incarcerated. When stabilized prior to release from jail, but not successfully linked to mental health services in the community, symptoms may re-appear and the individual may cause a disturbance repeating the cycle of arrest and incarceration.

Mental Health Services

Criminal Justice/ Mental Health Liaisons

Criminal Justice/Mental Health Liaisons are boundary spanners available in some judicial districts designated to facilitate coordination between the community, criminal justice and mental health systems; to promote diversion activities; and provide service linkage to adults with serious mental illness who are incarcerated or at risk of incarceration. As of July 2006, there are 18 liaisons offering services in 23 counties. A list that includes specific contact information is included in the Resource section.

The Criminal Justice/Mental Health Liaisons are available to facilitate local system level arrangements to improve community mental health service access. Liaisons identify barriers to continuity of care and develop action plans, identify system gaps, promote the development of diversion services, monitor system interaction, provide solutions to system barriers, and identify system breakdowns that contribute to criminalization of mental illness. Liaisons provide regularly scheduled training sessions to criminal justice personnel.

Criminal Justice/Mental Health Liaisons also work with individuals. They identify arrested individuals for assessment of mental illness. Arresting agencies are provided with viable diversion strategies such as hospitalization, respite, alternative housing or re-engaging with mental health services and case management. If diversion options are limited or not available, liaisons work with the community and mental health system to develop or improve diversion options.

When an individual with mental illness is arrested, the liaison provides information on treatment needs to the arresting agency. If applicable, the individual's mental health providers are contacted regarding the defendant's legal

status, and the liaison gathers information and encourages contact between mental health and criminal justice agencies.

If the individual is incarcerated, the liaison helps the jail establish viable mental health care for the inmate. When the individual is due for release, the liaison develops and coordinates a release plan with the defendant and mental health provider. Liaisons also follow up with the defendant and/or the mental health provider to ensure the services were accessed upon release and to assist with barriers that may have occurred.

Criminal Justice/Mental Health Liaisons are available to consult with the court to facilitate recommendations concerning mental health needs of defendants with mental illness. They can provide assistance with release or sentencing planning including mental health services and community support. They may also aid defense counsel in recommending appropriate mental health assessments for an individual.

Crisis Response Services

Specific community mental health agencies designation is for mandatory prescreening only, crisis teams contracted provide crisis intervention, pre-screening and diversion services in a defined services area.

Crisis response service provides 24 hours a day, 7 seven days a week face-to-face and telephone mental health crisis intervention to adults and children in facility and community based settings. Crisis services are available to anyone living in Tennessee regardless of insurance type or ability to pay. There is a twenty-four (24) hour toll free telephone line answered in real time by a trained crisis specialist and face-to-face crisis services including, but not limited to triage, intervention, evaluation/referral for additional services/treatment and follow-up services. The statewide Mental Health Crisis Response Service can be reached at **800-809-9957**.

An individual, family member, law enforcement, hospital staff or others can access crisis response services when there is a perception of a crisis. A crisis can be either an **emergency** or **urgent** in nature. An emergency is defined as an acute onset of a behavioral health condition that manifests itself by an immediate substantial likelihood of serious harm by one or more of the following:

- Threaten or attempted suicide or serious bodily harm;
- Threatened or attempted homicide or violent behavior;
- Placed others in reasonable fear of violent behavior and serious physical harm; or
- The person is unable to avoid severe impairment or injury from specific risks.

An **urgent** condition is defined as an acute onset of behavioral health related condition, not constituting an immediate substantial likelihood of harm, but if left untreated, may deteriorate into a mental health emergency or cause the individual unnecessary anxiety.

Services that help individuals stabilize in the community include crisis response services, respite care (accessed through crisis response services), crisis stabilization units, 24 hour walk-in assessment facilities and targeted transitional support programs with financial assistance with supports and services to effect timely discharge.

In Tennessee there are Crisis Response Teams statewide that are responsible for providing crisis response services. The best way to determine who is responsible for mental health crisis response services in your area, contact the community mental health agency or the TN Department of Mental Health and Developmental Disabilities.

Youth Villages is a community mental health agency that works specifically with children and youth across the state. Youth Villages is responsible for providing mental health crisis response services for all children and youth in Tennessee.

Pre-screening

Pre-screening is a face-to-face evaluation of individuals in mental health crisis to assess eligibility for emergency involuntary hospital admission and to determine whether all available less drastic alternative services and supports are unsuitable to meet the individual's needs.

Mandatory Pre-screening

Mandatory Pre-screening is a community-based screening process designed to provide alternatives to hospitalization, minimize length of confinement, promote speedy return to the community, and maximize service recipient's ability to remain in the community setting.

A mandatory pre-screening agent (MPA) is a qualified mental health professional (QMHP) as defined in T.C.A §33-1-101 (18), who is licensed or certified to practice in TN, has satisfactorily completed MPS training and is designated by the Commissioner of Department of Mental Health and Developmental Disabilities to complete a certificate of need (CON) for persons requiring involuntary in-patient treatment.

A mandatory pre-screening agent is required to complete one (1) of the certificates of need (CON) prior to an emergency admission to a State-operated Regional Mental Health Institute (RMHI). If a MPA is not available within two (2) hours, then a physician or psychologist with a health service provider designation may complete the CON after consultation with crisis response service for less restrictive alternative treatment options. Private hospitals that have been approved by TDMHDD and accept the authority of an MPA may also accept CONs from an MPA for emergency involuntary admissions.

In-Patient Psychiatric Treatment

Psychiatric in-patient facilities are available across the state. TDMHDD operates five Regional Mental Health Institutes (RMHI). RMHIs are consistently at or over capacity, and as a result, the beds are reserved for involuntary admissions.

Most in-patient admissions are brief, offering crisis stabilization, observation for suicidal, self-injurious or aggressive behavior, assessment and diagnosis, medication management, individual and group therapy and discharge planning. Discharge plans should address: treatment (including medication management), case management, and if appropriate, housing, support groups, and family and illness education.

Medication Management

Psychiatric medication is one of the most effective tools used to treat serious mental illness. In the past, psychiatric medications have involved uncomfortable and sometimes harmful side effects and it was common for individuals to refuse to take medication or not to take it as prescribed. Modern psychiatric medications are much more effective and comfortable, but most are very expensive.

A psychiatrist, other medical doctor, physician's assistant, or nurse practitioner may prescribe psychiatric medication. Best practices indicate that the prescribing professional should have psychiatric training and expertise. Medication management involves the following services:

- **Prescribing professional;** psychiatrist, other medical doctor, physician's assistant, nurse practitioner: The prescribing professional must diagnose the individual through psychiatric interview, observation of behavior, and consideration of medical history. Since medications are used to treat symptoms of psychiatric disorder, more than one medication may be prescribed to an individual based on the pattern of symptoms presented. Diagnosis and prescription are part of an ongoing process. Changes in prescription may be due to factors such as changes in symptoms, changes in the effects of medication on the individual, or lack of tolerance for side effects.
- **Pharmacy:** Medications may be purchased from a locally owned pharmacy, pharmacy franchise, wholesale pharmaceutical supplier, or a firm delivering a broader array of health services. The state of Tennessee also provides the option for county governments to utilize the state pharmaceutical contract at greatly reduced cost. (For more information contact General Services: 615-532-9857)
- **Medication administration:** The majority of individuals with mental illness self-administer their medication. Some receive medications from a nurse. A nurse or other qualified professional must administer injections.
- **Medication monitoring:** Medication for severe mental illness requires periodic monitoring by a nurse or prescribing professional to identify effects on symptoms, side effects, and compliance with prescription regimen. Part of medication monitoring may involve laboratory tests for level of medication in the individual's system and presence of complicating biological factors.

For jail inmates, medication costs are usually paid by the county of incarceration and/or by the individual, family or private insurance. Because of high medication costs, jails may not pay for some of the newer, more effective medications. An abrupt change in medication may lead to increased symptoms and behavioral outbursts. The state of Tennessee has provisions by which county jails may purchase medications at reduced cost through the state contract. Jails may be able to work with prescribing professionals to obtain samples or reduce costs in other ways.

Psychiatric medications are grouped by the symptoms they address. Those that alleviate symptoms of major mental illness are anti-depressants, mood stabilizers, anti-anxiety and anti-psychotic agents.

Most psychiatric medications are powerful drugs that must be monitored to ensure that they are actually improving the desired symptoms and to reduce side effects. Some psychiatric medications, such as benzodiazepines and stimulants, can be abused, which is a point to consider when these drugs are being used in correctional or detention settings. Because these drugs are powerful, switching from one to another, or reducing dosage should be done carefully to avoid adverse reactions.

Common psychiatric medications are included in this section.

Case Management

Mental health case managers link individuals with severe mental illness to needed services and resources such as Supplemental Security Income and Social Security Disability Income, primary medical care, housing and employment programs. Individuals can be referred to case management by hospitals, crisis response services, community-based service providers, or can self-refer. Mental health case management services consist of the following components:

- **Assessment and prioritization of needs:** Includes examination of the individual's strengths, current situation, aspirations, needs and prioritized goals in the life domains of behavioral health, physical health, living arrangements, financial and social support, vocation/education and recreation.
- **Service planning:** The case management service plan is a written action plan mutually developed by the case manager and the individual and is part of an ongoing assessment/monitoring/evaluation process. It includes prioritized areas of service; needs and skill development; short and long term measurable goals; strategies to meet defined goals; identification of agencies and contacts necessary to accomplish strategies; and examination of barriers to service delivery.
- **Crisis response:** Case managers provide direct crisis assistance during working hours and are also available to work with crisis services to meet the individual's needs. Case managers help the individual develop skills

that will enable them to deal effectively with crisis and prevent the need for more restrictive services.

- **Assistance in daily living:** Assistance in daily living includes ongoing support and development of individual skills needed to enhance the individual's ability to live independently (example, aid in prompting for caring for hygiene, grooming, cleaning, nutrition habits, etc.).
- **Linkage, referral, and advocacy to other community services:** The case manager assesses and mobilizes resources to meet needs of the individual, including referring and insuring that needed services are provided. All types of resources and services are included such as income, housing, primary health care, social support and legal/criminal justice services.
- **Monitoring overall service delivery plan:** The case manager is responsible for monitoring delivery of all services in the plan and assessing the extent to which services delivered are helping the individual achieve goals.

TennCare case managers must terminate cases when an individual has been incarcerated for more than thirty days. Mental health agencies vary in their policies regarding continuity of care to incarcerated clients. However, with a signed consent to release information from the client, case managers can assist with jail diversion, communicating treatment information to the jail, encouraging clients to participate in treatment while incarcerated, and release planning and service linkage.

Psychotherapy and Counseling

Psychotherapy and counseling, sometimes referred to as talk therapy, help individuals to examine thoughts and feelings and to adopt more healthy modes of behavior. Psychotherapy is used in certain aspects of treatment for severe psychiatric disorders. It is also used in substance abuse treatment, child and adolescent treatment and resolution of situational, marital, or family problems.

Most psychotherapy delivered in the public mental health system is brief, and solution-focused for individuals or families and is conducted by doctoral level psychologists or masters level social workers or counselors. Case managers provide supportive counseling to individuals with severe mental illness.

Psychosocial Rehabilitation

Psychosocial rehabilitation is a group of services that use a strengths-based approach to help individuals with psychiatric disabilities gain skills necessary to successfully integrate into the community. Psychosocial rehabilitation helps the individual build on vocational, educational, interpersonal and living skills.

Psychosocial clubhouses provide a daily environment in which individuals learn entry-level employment skills in clerical, maintenance and food preparation fields. The clubhouse becomes a community and social support system for members.

- **Transitional employment** provides entry-level employment opportunities in real job settings to individuals with severe mental illness. The psychosocial agency contracts for the position, then trains and places individual members in the position for several months. If the individual is not able to fill the job, another client is placed in the position.
- **Supported employment** offers individuals the opportunity to work with a job coach to formulate employment goals and seek desired employment. Once the individual is employed, the job coach offers assistance to help the employee perform the work as expected.

Many psychosocial programs offer supported housing in the community with various levels of assistance to help the individual progress to stable, independent housing.

Peer Services

Several types of services are staffed by people with mental illnesses or their family members, offering peer-support, role modeling, peer-education and advocacy.

Peer centers exist across the state and offer gathering places for adults with mental illness during the day, evenings and weekends. Members plan and participate in activities and service projects. Food and transportation are usually provided by the center.

Support groups and peer-taught classes are offered to persons with mental illness by the Tennessee Mental Health Consumers Association (TMHCA) and to family members by the National Alliance on Mental Illness (NAMI). Classes and support groups occur on a regular basis in most communities.

Peer taught classes have been successfully offered to probationers with mental illness and to drug court defendants who have co-occurring mental illness and substance use disorders. NAMI offers social support and education to family members of individuals with mental illness who have been arrested and incarcerated.

Housing and Residential Services

Persons with mental illness can and do live successfully in the community. A continuum of decent, affordable housing options is under continual development through the Tennessee Department of Mental Health and Developmental Disabilities in cooperation with mental health agencies across the state. Eligibility for the various types of housing is based on the individual's need for supervision and assistance with living skills. Independent Living Assistance funds are available to supplement rent and utility costs. These funds can be accessed by contacting the community mental health agency in your area. Housing specialists can assist individuals with criminal records to access subsidized housing through specific programs.

From least to most independent, housing options include:

- Supervised group housing with on-site staff and 24-hour care;
- Partially supervised group housing with staff on-site as needed;
- Independent congregate housing;
- Rental housing with minimal staff support; and
- Home ownership.

Mental Health Service Referral

An individual can be referred to a community mental health agency or private mental health provider for assessment, diagnosis and treatment.

Mental health providers are bound by professional ethics and the law (Title 33, Tennessee Code Annotated) to protect confidentiality of information disclosed, and records maintained in mental health treatment. Generally, mental health providers do not disclose whether the individual is a service recipient of the agency or anything else about treatment unless the individual has signed an “Authorization to Release Information” document.

Privacy standards have been reinforced with the recent implementation of a federal law: The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Exceptions to privacy standards do exist under HIPAA, some of which concern criminal justice situations.

If the individual is currently in treatment and the court requires information, an “Authorization to Release Information” document signed by the appropriate person Under T.C.A. §33-3-104 must be presented to allow the mental health agency, psychiatrist, or other mental health professional to provide protected health information. This can include information on diagnosis, medications, treatment, the defendant’s stability when taking medications as prescribed, and reasons why the defendant might not currently be in treatment. A sample of the “Authorization to Release Information” used by TDMHDD, and the Order Granting the Disclosure of Confidential and Protected Mental Health Records AND Information Under T.C.A. §33-3-105(3) and pursuant to HIPAA are included in this section.

If the individual with mental illness appears to be experiencing a mental health crisis, the court would need to contact the person’s mental health provider or the Crisis Response Team in the county for assessment of need for services.

Common Psychiatric Medications

Anti-Depressant Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
SSRI: Most frequently prescribed type of anti-depressant			
fluoxetine	Prozac	20 - 40	Anxiety Nausea Headaches Weight Loss Activating rather than sedating; may trigger mania or psychosis. Lethality level low
sertraline	Zoloft	50 - 200	
paroxetine	Paxil	10 - 50	
citalopram	Celexa	20 - 40	
escitalopram	Lexapro	10 - 20	
Tri-cyclic			
desipramine	Norpramin Pertofrane	150 - 300	Dry mouth, tremors, blurred vision Bloating and weight gain, Urinary retention, Lightheadedness on standing up suddenly, Sweating Constipation, Change in sexual desire High dose: irregular heartbeat Can be lethal: Use with caution
imipramine	Tofranil	150 - 300	
nortriptyline	Aventyl Pamelor	75 - 100	
doxepin	Sinequan Adapin	150 - 300	
amitriptyline	Elavil	150 - 300	
MAOI: Stringent dietary restrictions, Use with caution!			
phenelzine	Nardil	45 - 90	Weight Gain Dizziness Sleep disturbances Impaired sexual functioning Swelling of legs and ankles
tranylcypromine	Parnate	20 - 60	
L-deprenyl	Eldepryl	10	
Atypical Anti-depressants			
bupropion	Wellbutrin	150 - 450	<i>Weight loss, agitation, risk of seizures.</i>
trazodone	Desyrel	50 - 400	<i>Very sedating; used in lower doses for insomnia.</i>
venlafaxine	Effexor	37.5 - 300	<i>Activating, headache,, sleepiness, nausea, constipation</i>
nefazodone	Serzone	200 - 600	<i>Headache, sleepiness, agitation, nausea, tremor, constipation</i>
mirtazapine	Remeron	15 - 45	<i>Increased appetite, weight gain, sleepiness, dizziness</i>

Anti-Anxiety Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
Benzodiazepines			
lorazepam	Ativan	2 - 6 mg. effective for 15 hrs.	Tolerance, Withdrawal syndrome, Does not mix with alcohol
alprazolam	Xanax	0.5 - 6 mg. effective for 12 hrs.	
diazepam	Valium	2 - 60 effective for 100 hrs.	
clonazepam	Klonopin	0.5 - 10 mg. effective 34 hrs.	
Other Anti-Anxiety Medications			
buspirone	BuSpar	15 to 60	<i>Dizziness, headache, sleepiness, nausea</i>
zolpidem	Ambien	10	
diphenhydramine	Benadryl	25 - 150	

Psychiatric Medication, cont.

Mood Stabilizing Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
lithium carbonate	Eskalith Lithane Lithonate Lithobid Lithotabs	450 to 1500	Nausea, Lethargy, Thirst, Hand tremors, Weight gain, Acne, Increased urination Hypothyroidism Risk of Toxicity: Blood level monitoring required **Keeping hydrated is vital
Anti-Convulsant Medication: Effective for stabilizing moods			
divalproex sodium valproic acid	Depakote Depakene	500 -1500	Weight gain, nausea, indigestion, sedation; Liver damage (rare)
gabapentin	Neurontin	300 - 2400	Tiredness, dizziness, fatigue
lamotrigene	Lamictal	50 - 400	Dizziness, sleepiness, hazardous rash
carbamazepine	Tegretol	400 - 800	Nausea, clumsiness, Aplastic anemia (rare)
topiramate	Topimax	50 - 200	Fatigue, dizziness, sleepiness, tremor

Anti-Psychotic Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
Typical Neuroleptics			
fluphenazine (Injectable or pill form)	Prolixin	10	Drowsiness, shakiness, Increased stiffness, Dizziness, sensitivity to sunburn, Muscular spasms, Mouth movements, Sexual difficulties SERIOUS: Tardive Dyskinesia, Neuroleptic malignant syndrome
haloperidol (Injectable or pill form)	Haldol	10	
thiothixene	Navane	20 X 2	
thioridazine	Mellaril	500 X50	
chlorpromazine	Thorazine	500 X50	
Atypical Antipsychotics			
clozapine	Clozaril	300 - 900	Weight gain, sedation salivation, seizures SERIOUS: low white blood cell count. Need blood tests.
risperdone (has injectable, pill, and dissolvable form)	Risperdal	1 - 10	Weight gain, headache sedation, dizziness, low blood pressure, Parkinsonism, restlessness.
quetiapine	Seroquel	150 - 800	Sleepiness, low blood pressure.
olanzapine	Zyprexa	5 - 20	Sedation, weight gain, minimal anti-cholinergic effects.
ziprasidone (has injectable, pill, and dissolvable form)	Geodon	20 - 80	Headache, sleepiness, irregular heartbeat, abnormal movements
aripiprazole	Abilify	20 – 30 mg.	Headache, insomnia, anxiety

AUTHORIZATION TO RELEASE INFORMATION

Instructions: This form Allows the Release of Information about a Recipient of Services under Title 33, Tennessee Code Annotated, and the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. I understand that this Authorization is Voluntary, and that if the Person or Organization Authorized to Receive the Information is Not a Health Plan or Health Care Provider, the Released Information May No Longer Be Protected by Federal Privacy Regulations (HIPAA).

I, _____ / _____, authorize
(Print name of service recipient) (Print date of birth)

(Print name of agency/program making disclosure) and (Mailing address of agency/program making disclosure)

To disclose to _____ / _____
(Print name of person(s) or organization to which disclosure is to be made, and their mailing address)

The following information: _____
(Describe the specific information to be used or disclosed)

The purpose of the authorized disclosure is to: _____
(Specific purpose/use of the disclosure)

I understand that I Am Not Required to Sign this Authorization, and that my treatment, payment, enrollment, or eligibility for benefits, is Not Conditioned on my Execution of this Authorization. I may Revoke this Consent in Writing at Any Time, Except to the extent that Action has been Taken in Reliance on it, and that, in any event, this Consent Expires Automatically as follows:

(Specify the date, event, or condition of expiration)

X _____ X _____
(Signature of service recipient who is 16 years of age or older) (Date)

(All blanks must be filled in before signing)

*Signature of individual acting on behalf of the service recipient if the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian-ad-litem of the service recipient but only for the purposes of the litigation in which the guardian-ad-litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased recipient; and (6) the treatment review committee, acting within the authority and scope of §33-6-107, Tennessee Code Annotated. The signature of any individual other than a parent of a child is insufficient to permit release of information unless the individual intending to act on behalf of the individual produces proof of her or his authority to act on behalf of the service recipient.

X _____ X _____
*(Signature of individual acting on behalf of the service recipient) (Date)

(All blanks must be filled in before signing)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

**If a service recipient gives oral consent or signs with an X, the form must be signed by two (2) witnesses:

X _____ / _____ X _____ / _____
**(Witness) (Date) **(Witness) (Date)

IN THE _____ COURT FOR _____ COUNTY

_____)
Petitioner,)
vs.) NO.:
_____)
Defendant.)

ORDER GRANTING THE DISCLOSURE OF CONFIDENTIAL and PROTECTED MENTAL HEALTH RECORDS AND INFORMATION UNDER T.C.A. §33-3-105(3) and pursuant to HIPAA

This matter came to be heard on the ___ day of _____ 200__, before the Honorable _____, Judge of Division _____ of the _____ Court of _____ County, upon the motion/petition of _____. It was determined at this hearing that the confidential mental health information contained in the records of the Defendant are necessary for the conduct of proceedings before it, and that failure to make such disclosure would be contrary to public interest or to the detriment of a party to the proceedings, pursuant to T.C.A. §33-3-105(3).

IT IS THEREFORE ORDERED THAT:

- 1. Information that is confidential under T.C.A. §33-3-103 and considered to be protected health information under HIPAA for the defendant shall be released pursuant to this Order by the following institutions/or physicians:

- 2. That the disclosure of information be limited to the following information (please note that the medical record may contain protected health information such as name, social security number, diagnosis, information about drug & alcohol treatment and diagnosis, as well as information related to HIV/AIDS):

3. That all information released to the Petitioner shall be released for the sole purpose of concluding the above-mentioned legal matter before this Court. The information obtained will not be used for any purpose other than the litigation or proceeding. Information requested pursuant to this Order shall be sent to the following address:

4. That a reasonable cost for copying all records requested pursuant to this Order shall be paid by parties making the request, and such fees may be required prior to producing the same.
5. That all medical and mental health information obtained pursuant to this Order, and any copies made, must either be returned to the entity that provided the information or destroyed at the conclusion of the above-mentioned legal matter, resolution of all disputes, or the running of any statute of limitations, whichever last occurs.

ENTERED this _____ day of _____, 20____,

JUDGE

The Law

Mental Illness in Criminal Cases: The Legal Standard

There are three basic types of issues involving the mental health of criminal defendants that can arise in the course of typical criminal cases. They each involve substantively different inquiries, different legal standards, and different procedures. The court and the lawyers must understand and be facile with all three issues.

The three basic types of issues involve:

- the defendant's present ability to participate in judicial process,
- the defendant's present danger to himself or others based on current mental status and,
- the defendant's mental state at the time of the offense.

These issues are commonly referred to as competence, commitability (also known as judicial hospitalization) and sanity (or insanity).

The results of each of these inquiries are independent. A defendant may meet the standard for any one, two or all three of these conditions.

Mental health issues can arise at any point in the criminal proceedings. Forensic evaluations may be initiated in circuit/criminal or general sessions court. T.C.A. §33-7-301(a). Commitment for a person charged with a criminal offense may only be done in circuit/criminal court. T.C.A. §33-7-301(b)(1). A verdict of not guilty by reason of insanity, and subsequent mandatory hospitalization for 30 to 60 days, can only be entered in circuit/criminal court. T.C.A. §33-7-303.

Competence

Issues of competence involve the defendant's present ability to participate in the criminal process.

The legal standard of competence involves whether the defendant has sufficient present ability to:

- consult with a lawyer with a reasonable degree of rational understanding, and
- have a rational as well as factual understanding of the proceedings against him. [Dusky v. United States, 362 U.S. 402, 80 S.Ct. 788, 4 L.Ed.2d 824 (1960).] "Both Tennessee decisions and the federal constitution prohibit the trial of a defendant whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel and to assist in preparing his defense" [Mackey v. State, 537 S.W.2d 704 (Tenn. Crim. App. 1975)].

Competence is a legal issue, not a factual one. There is thus no right to a jury trial on the issue of competence to stand trial [State v. Johnson, 673 S.W.2d 877,

880 (Tenn.Crim.App. 1984)]. Competence to stand trial and competence to plead guilty are the same thing in Tennessee [Berndt v. State, 733 S.W.2d 119, 123 (Tenn.Crim.App. 1987) at 123]. (“The standard for determining the competency of an accused to stand trial, i.e. the capacity to understand the nature and object of the proceedings, consult with counsel, and assist in the preparation of his or her defense, is the same standard to be applied in determining the competency of an accused to plead guilty or nolo contendere. A person who has been found competent to stand trial has the requisite mental competence to waive his or her rights and enter a plea of guilty or nolo contendere. This is the prevailing view in this country.”)

Competence is a question of present ability; since it is temporally dependent, a defendant may go in and out of competence, be always competent or never competent. Thus, an evaluation of competence may occur at any time during the life of a case. Likewise, a defendant may be the subject of more than one competence evaluation during the life of a case if there is a change in mental status over time.

The Procedure for Determining Competence (T.C.A. §33-7-301)

Who may request an evaluation to determine competence to stand trial?

Either party or the court (General Sessions or Circuit/Criminal Court), whenever a person is believed to be incompetent to stand trial [T.C.A. §33-7-301(a)].

Who performs the evaluation?

The initial evaluation is performed on an outpatient basis by the local community mental health center, or a private practitioner designated to serve the court by the Commissioner of the Department of Mental Health and Developmental Disabilities or, in some cases, on a outpatient basis by the state mental health hospital or by a state supported hospital designated by the Commissioner.

The initial evaluation may conclude that the defendant is:

- competent,
- not competent or
- requires a 30 day inpatient evaluation to determine competence.

A determination that an inpatient evaluation is required should be promptly followed up so that the issue of competence can be addressed in a timely manner. Since a case can not proceed until the issue of competence is addressed, prompt action assures that a defendant in custody does not remain in a procedural limbo for an unnecessarily extended period of time.

If the outpatient evaluator concludes that further evaluation and treatment are needed, the court may order the defendant hospitalized, and if in a Department of Mental Health and Developmental Disabilities facility, in the custody of the Commissioner, for not more than 30 days for further evaluation and treatment for competence to stand trial.

Where is the evaluation done?

For incarcerated defendants, the initial/outpatient evaluation may be performed in the jail or at the community mental health agency (CMHA), depending on the agreement between the CMHA and the jail. For defendants on bond, it is conducted at the evaluator's office. All inpatient evaluations ordered to TDMHDD are performed at one of the five Regional Mental Health Institutes.

What do the evaluators consider?

What does it mean to be able to rationally consult with the lawyer and have a rational understanding of the proceedings? One scale cited by Tennessee Courts, [State v. Benton, 759 S.W.2d 427, 430, n.2 (Tenn.Crim. App. 1988)] is the McGarry Scale, a thirteen point checklist, to aid in the competency evaluation:

- 1) Ability to appraise the legal defenses available
- 2) Level of unmanageable behavior
- 3) Quality of relating to attorney
- 4) Ability to plan legal strategy
- 5) Ability to appraise roles of various participants in courtroom proceedings
- 6) Understanding of courtroom proceedings
- 7) Appreciation of charges
- 8) Appreciation of range and nature of possible penalties
- 9) Ability to appraise likely outcomes
- 10) Capacity to disclose to attorney available pertinent facts surrounding defense
- 11) Capacity to challenge prosecution witness realistically
- 12) Capacity to testify relevantly
- 13) Manifestation of self-serving versus self-defeating motivation.

[Department of Health, Education, and Welfare, Pub. No. 73-9105 (Study conducted at Harvard Medical School by McGarry, et al., 1973)].

It is important to note that, "not all people who have a mental problem are rendered by it mentally incompetent" [Bouchillon v. Collins, 907 F.2d 589, 593 (5th Cir. 1990), see also, Galowski v. Berge, 78 F.3d 1176, 1182 (7th Cir. 1996) at 1182], "not every manifestation of mental illness demonstrates incompetence to stand trial" [United States v. Hogan, 986 F.2d 1364, 1373 (11th Cir. 1993)]. "Mental illness is not, in itself, enough to establish incompetence" [People v. Eddmonds, 143 Ill. 2d 501, 578 N.E.2d 952, 960, 161 Ill. Dec. 306 (Ill. 1991)] ("[a] defendant may be competent to participate at trial even though his mind is otherwise unsound").

Conversely, courts have acknowledged that even a criminal defendant with an intellectual understanding of the charges against him may be incompetent if an impaired sense of reality substantially undermines judgment and prevents rational cooperation with the defense lawyer. [United States v. Hemsj, 901 F.2d 293, 296 (2nd Cir. 1990); Lafferty v. Cook, 949 F.2d 1546, 1551 (10th Cir. 1991)]. In other words, sufficient contact with reality is the touchstone for ascertaining the existence of a rational understanding of the proceedings (Lafferty, 949 F.2d at 1551).

One observer has suggested the following rationale for the requirement that a criminal defendant be competent to stand trial:

In this country we hold autonomy of the individual as one of our highest values. This respect for personal autonomy supplies the foundation for the power the accused has to defend him or herself. After all, it is the life or freedom of the accused that hangs in the balance. It follows, therefore, that the accused should be granted authority in the process determining the outcome. If the mental state of the accused prevents a rational understanding of the proceeding, the foundation for the accused's power to control the defense is lacking. An incompetent is no longer "in control" of his decision-making process and is therefore incapable of making the decisions required by the process that may result in a finding of blame and an imposition of punishment.

Norma Schrock, Defense Counsel's Role in Determining Competency to Stand Trial, 9 Geo. J. Legal Ethics 639, 654 (Winter, 1996).

The Defense Attorney has significant responsibilities during the evaluation process:

1. The attorney should have a position concerning the client's competence, with a rationale based on the client's behavior, history or both. The defendant's lawyer is an expert in issues of a particular defendant's competence.
2. The attorney should identify and collect all records concerning the client, which could affect the competence determination. For example, the attorney should collect jail or institutional records, available records concerning the pending criminal charges, school records, medical records, mental health records, military records, employment records, etc.
3. The attorney should forward relevant records to each evaluation team in a timely fashion.
4. The attorney should explain his/her position concerning the meaning of the records to each evaluation team.
5. The attorney should obtain the records of the client's evaluation after it is completed.

In sum, the competence of a criminal defendant is critically important, because defendants have exclusive authority to make the ultimate decisions about their cases, once having been fully informed of the rights and the potential consequences involved [Zagorski v. State, 983 S.W.2d 654, 658-661 (Tenn. 1998), affirming a competent defendant's right to decline to present mitigating evidence during the sentencing phase of his capital trial]. [See also Sup. Ct. Rule 8, RPC 1.2.] Consistent with this rationale, the American Bar Association's Standards for Criminal Justice provide that defense counsel should move for evaluation of a defendant's competence to stand trial whenever there is a good

faith doubt as to the defendant's competence, even if the client objects to such a motion being made. [ABA Standards for Criminal Justice § 7-4.2(c) (1986)].

Commitability

Issues of commitability involve the question of whether the defendant poses a substantial likelihood of serious harm because of the mental illness or serious emotional disturbance.

T.C.A. §33-7-301(b)(1) provides for commitment if the court determines on the basis of the mental health evaluation and other relevant evidence:

(A) That the defendant is incompetent to stand trial because of mental illness, or

(B)(i) That the defendant is competent to stand trial but that the failure to hospitalize would create a likelihood to cause the defendant serious harm by reason of mental illness, and

(ii) The defense attorney agrees with those findings, the district attorney general or the attorney for the defense may petition the criminal court before which the case is pending or which would hear the case, if the defendant were bound over to the grand jury to conduct proceedings for judicial hospitalization under chapter 6, part 5, of this title (Title 33).

Please see the section entitled Psychiatric Hospitalization for a complete explanation on commitment criteria.

The District Attorney or the defendant may demand a jury trial on the issue of judicial hospitalization. T.C.A. §33-7-301(b)(2).

What happens to a person who is committed?

Persons committed pursuant to T.C.A. §33-6-501 may be discharged by the Commissioner of Mental Health & Developmental Disabilities when they no longer meet the standards for commitment (i.e., they are not mentally ill, their illness is in remission, they no longer pose a likelihood of serious harm or there is a less drastic alternative to hospitalization), unless the committing court finds by clear and convincing evidence that the patient is not eligible for discharge. T.C.A. §33-6-708(f).

What is the effect of commitment on a criminal charge?

Technically, the two determinations (competence and commitability) are separate, and a person who has been committed may be prosecuted criminally, if he/she has been determined to be competent to proceed in the criminal case.

Judicial Hospitalization of Defendants Determined to Be Mentally Retarded

T.C.A. §33-5-402 provides that if a circuit, criminal or general sessions court determines on the basis of an evaluation pursuant to §33-7-301(a) that a defendant is incompetent to stand trial due to mental retardation, then the District Attorney may file a complaint to require involuntary care and treatment under §33-5-403. The involuntary commitment procedure set out in §33-5-403 is substantially similar to the process described above for §33-7-301(b)(1), except that the underlying basis for the involuntary hospitalization is mental retardation rather than mental illness.

Sanity

Issues of sanity or insanity involve the defendant's state of mind at the time of the crime.

The legal standard for insanity changed dramatically effective July 1, 1995. To excuse criminal conduct, the defendant must now, "as a result of a severe mental disease or defect," have been unable "to appreciate the nature or wrongfulness of their acts", T.C.A. §39-11-501(a). This is a departure from the Model Penal Code definition, which is probably still the law in the majority of jurisdictions.

What's new?

1. It is no longer enough that the defendant simply couldn't conform his conduct to the law as a result of mental disease or defect.
2. The mental disease or defect must now be "severe", which may be a subjective determination in many cases.
3. The defendant has the burden of proving the defense of insanity by clear and convincing evidence.
4. No expert witness may testify as to whether the defendant was or was not insane at the time of the alleged offense.
5. The distinction between the standards becomes increasingly less significant, but for offenses alleged to have occurred before 7/1/95, the Model Penal Code second prong (inability to conform conduct to the requirements of the law) would still apply.

The procedures for evaluation for sanity are the same as those for competence [T.C.A. §33-7-301(a)].

- Rule 12.2(a), Tennessee Rules of Criminal Procedure, requires that if a defendant intends to rely upon the defense of insanity at the time of the alleged offense then the defense must give written notice to the District Attorney and file a copy of the notice with the clerk of the court.
- Rule 12.2(b), Tennessee Rules of Criminal Procedure, requires that if a defendant intends to introduce expert testimony related to a mental disease, defect or condition of the defendant bearing on the issue of his or her guilt, then the defense must give written notice to the District Attorney and file a copy of the notice with the clerk of the court.
- Rule 12.2(c), Tennessee Rules of Criminal Procedure, provides that, upon motion by the District Attorney in an appropriate case, the court may order

a defendant to submit to a mental examination by a mental health expert. Pursuant to the Rule:

No statement made by the defendant in the course of any examination provided for by this rule..., no testimony by the expert based upon such statement and no other fruits of the statement shall be admitted in evidence against the defendant in any criminal proceeding except for impeachment purposes or on an issue respecting mental condition on which the defendant has introduced testimony.

Sentencing Credits

T.C.A. §33-5-406 and §33-7-102 provide that whenever a defendant is hospitalized, or receives evaluation, training or treatment pursuant to Chapters 5 or 7 of Title 33 in connection with a criminal charge or conviction, the defendant shall receive credit toward the satisfaction of any sentence for the time spent in the custody of the Commissioner of Mental Health and Developmental Disabilities.

Death Penalty and Mental Illness

Mental health issues are likely to be present in most, if not all, death penalty litigation. Current case law should be consulted as issues arise. Tennessee, by statute, prohibits the execution of mentally retarded defendants. See T.C.A. §39-13-203.

The Forensic Evaluation: Process and Procedure

The forensic evaluation is an important and useful tool to both defense attorney and the court in general. As explained in the previous chapter, the forensic evaluation is the tool and process used by the criminal justice system to ensure that defendants understand the charges against them, can aid in their defense and had the mental condition at the time of the offense occurred to be criminal responsible.

The Adversarial Process

Though the forensic evaluation is a scientific and therefore objective process, the adversarial process is still operative: The difference is that in this circumstance the tryer of fact is not a judge or jury but the psychological evaluator. Just as the defense and the prosecution have an opportunity to offer evidence to the judge and jury at a trial, they have an opportunity to provide information to the evaluator during the forensic process.

Though the evaluator will make efforts to obtain various records, it is incumbent upon the attorneys to provide any available information in order to allow the evaluator to make an informed decision regarding the mental health issues of the defendant.

Many times defense attorneys file the order with a bare bones rationale of why they are requesting an evaluation without including records, observations and affidavits from individuals who support their contention of incompetence and/or insanity. Likewise, prosecutors often do not to access information available from police, victims and other sources that might throw into question that the defendant's mental status affects the case in a significant way. Both parties are strongly urged to provide information to the examiner.

Competency to Stand Trial

Though there are many instruments and assessment tools used to determine a defendant's competency to stand trial, clinicians base their determination on the common law criteria for competency:

1. an ability to cooperate with one's attorney in one's own defense;
2. an awareness and understanding of the nature and object of the proceedings; and
3. an understanding of the consequences of the proceedings.

Mental Condition at the Time of the Alleged Offense

The statute that defines the insanity defense was amended in 1995 and is extracted from Title 39 as written (T.C.A. §39-11- 501):

- (a) It is an affirmative defense to prosecution that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature or wrongfulness of such defendant's acts. Mental disease or defect does not otherwise constitute a defense. The defendant has the burden of proving the defense of insanity by clear and convincing evidence.
- (b) As used in this section, "mental disease or defect" does not include any abnormality manifested only by repeated criminal or otherwise antisocial conduct.
- (c) No expert witness may testify as to whether the defendant was or was not insane as set forth in subsection (a). Such ultimate issue is a matter for the trier of fact alone.

[Acts 1989, ch. 591, §1; 1995, ch. 494, §1.]

Procedure for Pre-trial evaluation under T.C.A. § 33-7-301(a)

A pre-trial forensic evaluation may be ordered by a judge with criminal jurisdiction when it is thought that a defendant is mentally ill or mentally retarded and because of the mental illness or mental retardation may be incompetent to stand trial. The court may include in the order an evaluation of mental status at the time of the alleged offense. Ninety percent of forensic evaluations include both a request for competency to stand trial and mental condition at the time of the alleged offense. (See sample T.C.A. §33-7-301(a) court order)

The order must be signed by the presiding judge and forwarded to the Community Mental Health Center (CMHC) that serves the county in which the charges arose. It is beneficial if the affidavit of complaint(s) or warrant(s) is sent at the time of the order for the forensic evaluation.

When the order is received by the CMHC, a staff member from the CMHC will request releases signed to obtain information from all relevant sources. This request will include the local jail (if the defendant is in the jail), the defense and district attorney, previous treatment providers, school records, witness statements and any other pertinent information. Most often the defense attorney is relied on to obtain as much information as possible from outside sources. (See sample letters for request for information) Pertinent information possessed by either the prosecution or defense should be sent to the evaluator.

Once the information is obtained, the forensic evaluation is scheduled.

When the forensic evaluator completes the evaluation (See sample outline for forensic evaluation), a letter is sent to the court that contains the outcome of the evaluation (see sample letter to the court). If the outpatient evaluator is unable to complete the determination of competency and/or mental condition at the time of the offense of the defendant on an outpatient basis, the letter to the court will recommend an order for an inpatient evaluation for up to thirty days in a Regional Mental Health Institute (RMHI) or at the Forensic Services Program (FSP) at Middle Tennessee Mental Health Institute (MTMHI).

T.C.A. § 33-7-301(b)

If the court determines that, based on the mental health evaluation and the submission of complaints for involuntary commitment under Title 33, Chapter 6, Part 5, Tenn. Code Ann., that the defendant is incompetent to stand trial or is competent but committable to an inpatient facility because of his/her mental illness, the court may order the defendant hospitalized for an indefinite period of time. The defendant will remain hospitalized until such time that he/she is determined competent to stand trial or until he/she is no longer committable to an inpatient facility.

T.C.A. §33- 7-303(a)

If the defendant is adjudicated Not Guilty By Reason Of Insanity (NGRI), the criminal or circuit court must order a 30-60 day evaluation of the service recipient under T.C.A. §33-7-303(a). This evaluation is for committability only. The service recipient, under law, cannot remain hospitalized longer than the 60 days and cannot be discharged prior to the 30th day without authorization of the committing court. A service recipient not committable at the end of the evaluation period may be discharged under a mandatory treatment plan or may be discharged to the community with mental health services in place. If the service recipient is committable at the time of the evaluation, the inpatient facility will supply certification under Title 33, chapter 6, part 5, Tennessee Code Annotated. The criminal court shall enter an order for judicial hospitalization.

T.C.A. §33-7-303(c)

If the court enters an order for judicial hospitalization following an evaluation for committability, the service recipient must remain hospitalized until such time that he/she is no longer committable. At the time of discharge, the service recipient may be discharged under the requirements of a Mandatory Outpatient Treatment plan, or discharged with community mental health services or discharged without any follow-up recommended, depending on the clinical needs of the service recipient.

Judicial Review of Release

A criminal or juvenile court which has committed a person involuntarily under Title 33, Chapter 6, Part 5 may determine at the time of commitment that, due to the nature of the person's criminal conduct which created a serious risk of physical harm to other persons, the person should not be discharged from the commitment without proceedings to review eligibility for discharge. A complete explanation of Judicial Review of Release is in this section.

SAMPLE LETTER TO REQUEST INFORMATION

Date: _____

To: _____, Office of Public Defender

Re: _____

Docket(s): _____

Dear:

The _____ Mental Health Center has been ordered to provide an evaluation on the above referenced defendant. The court has requested the following evaluation(s) for the _____ Court in _____ County:

- Competency to Stand Trial
- Mental Condition at the Time of the Alleged Crime

In order to complete the evaluation, it is essential that we receive the following information from **both attorneys** before meeting with the defendant. If this information is not available to the defense, we ask the defense to provide what is available and for the prosecution to provide the rest of the information.

1. Warrants/Affidavits, prosecutor's information, indictment, and other legal documents detailing the alleged offense(s).
2. Information regarding the arrest including police reports, defendant's statements to the police, witness statements, 911 tapes, as well as any other information around the time of the alleged offense(s).
3. Defendant's criminal record

Defense: We also ask that you send us the following:

4. Inpatient and outpatient mental health records, including previous psychiatric, psychological, and social history evaluations and treatment, if existing, OR signed blank releases of information so that we may obtain the records.
5. Please complete the attached "Request for Forensic Mental Health Evaluation" form (2 pages)

It has been our experience that waiting until the evaluation interview is scheduled to request past treatment records can cause significant delays in the evaluation process. Therefore, if mental health records are not in your possession, we are requesting your assistance in obtaining them. Please either have the defendant sign a release of information form and fax the form to the identified record sources (e.g., mental health centers, hospitals, etc.) and send the information to our office or send the releases directly to our office and we will process them.

Thank you for your attention to this matter. Please forward this information to our office as soon as possible. If you would like to discuss the evaluation, please do not hesitate to contact _____ at _____.

Sincerely,

SAMPLE LETTER TO REQUEST INFORMATION

Date: _____

To: _____, **Office of the District Attorney General**

Re: _____

Docket(s): _____

Dear:

The _____ Mental Health Center has been ordered to provide an evaluation on the above referenced defendant. The court has requested the following evaluation(s) for the _____ Court in _____ County:

- Competency to Stand Trial
- Mental Condition at the Time of the Alleged Crime

In order to complete the evaluation, it is essential that we receive the following information from **both attorneys** before meeting with the defendant. If this information is not available to the defense, we ask the defense to provide what is available and for the prosecution to provide the rest of the information.

1. Warrants/Affidavits, prosecutor's information, indictment, and other legal documents detailing the alleged offense(s).
2. Information regarding the arrest including police reports, defendant's statements to the police, witness statements, 911 tapes, as well as any other information around the time of the alleged offense(s).
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Defense: We also ask that you send us the following:

4. Inpatient and outpatient mental health records, including previous psychiatric, psychological, and social history evaluations and treatment, if existing, OR signed blank releases of information so that we may obtain the records.
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It has been our experience that waiting until the evaluation interview is scheduled to request past treatment records can cause significant delays in the evaluation process. Therefore, if mental health records are not in your possession, we are requesting your assistance in obtaining them. Please either have the defendant sign a release of information form and fax the form to the identified record sources (e.g., mental health centers, hospitals, etc.) and send the information to our office or send the releases directly to our office and we will process them.

Thank you for your attention to this matter. Please forward this information to our office as soon as possible. If you would like to discuss the evaluation, please do not hesitate to contact _____ at _____.

Sincerely,

SAMPLE LETTER TO REQUEST INFORMATION

Date

Mental Health Coordinator
_____ County Sheriff's Office

Re: _____

Docket(s): _____

Dear _____:

The _____ Mental Health Center has been ordered by the _____ Court of _____ County to provide a forensic evaluation of the above referenced defendant.

In order to complete the information, we request the following information from the Sheriff's Department:

1. A description of the individual's behavior while in jail, including any treatment records and incident reports.

Thank you for your attention to this matter. If you have questions, please do not hesitate to call _____ at _____.

Sincerely,

SAMPLE EVALUATION REPORT FORM
Competency and Mental Condition

Forensic Evaluation

Date: _____

Defendant's Name: _____

Docket Number: _____

Charge(s): _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Criminal Court | <input type="checkbox"/> Incarcerated | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> General Sessions | <input type="checkbox"/> On Bond | <input type="checkbox"/> African American |
| <input type="checkbox"/> Circuit Court | | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Juvenile Court | <input type="checkbox"/> Male | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Other | <input type="checkbox"/> Female | <input type="checkbox"/> Other |
| <input type="checkbox"/> Capital Crime | Location of Evaluation | <input type="checkbox"/> Competency |
| <input type="checkbox"/> Violent Felony | <input type="checkbox"/> Jail | <input type="checkbox"/> Insanity |
| <input type="checkbox"/> Sexually Violent Felony | <input type="checkbox"/> DOC | <input type="checkbox"/> Both |
| <input type="checkbox"/> Non-Violent Felony | <input type="checkbox"/> Mental Health Center | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Misdemeanor | | |

Date of Birth _____ Age _____ SSN _____

Judge _____

District Attorney _____

Defense Attorney _____

Date of Court Order _____

Date Court Order Received _____

Confidentiality Statement

1. Inform the defendant of the following:

- Purpose of the evaluation (the court has ordered a pre-trial forensic evaluation to assess the defendant's competency to stand trial at the present time and/or to assess the defendant's mental condition at the time of the alleged offense(s))
- Attorney's involvement (the defendant's attorney know of the forensic evaluation)
- Confidentiality (a report will be prepared for the court that contains the conclusions of this evaluation and will be shared with the judge, the defense and prosecuting attorney and the jail)
- Defendant's opportunity to ask questions before the evaluation begins.

2. Note whether:

- Defendant understood the process
- Defendant did not understand the process

Information obtained (collateral data)

- Cite all collateral information obtained
- For personal or telephone contacts, include name of person, their professional title/affiliation and date of contact
- List all records reviewed with facility name, address, telephone number and always include police report
- List any correspondence with others with names, affiliations and dates
- Note that defendant signed appropriate releases of information/refused to sign

Legal Situation/Statement of Facts

- State current charges and date of charges
- Detailed description of incident from reports submitted and from the defendant's perspective
- Name of defense attorney
- Incarcerated, on bond

Background Information

The following information may be obtained from the defendant and/or sources previously listed; if no collateral information, then note that.

- Place of birth and current residence; brief description of family origin including siblings
- School and last grade completed, quality of adjustment, academic achievement, behavior problems, special vs. regular classes, vocational training, etc.
- Military experience
- Employment history
- Marriage, children
- Current source of income, including entitlements; if defendant receives SSI or SSDI, specify reason
- Arrest history (if relevant) including charges, convictions, probation, incarceration, and
- Other unusual circumstances, if relevant

Medical/Substance Use/Psychiatric History

- Medical history, current symptoms and/or diagnosis, current medication(s), compliance with treatment, cite source of this information,
- Substance use history (specific substance, age of onset, pattern of use, route of administration, treatment history, current use, etc.),
- Past and current psychiatric treatment history, symptoms and/or diagnosis, current medication(s), compliance with treatment, name of provider if currently in treatment.

Mental Status Examination

- How defendant presented for examination
- Orientation
 - General estimate of level of intellectual functioning
- Quality of speech
- Form of thinking (i.e., coherent, disorganized)
 - Content of thinking (i.e., delusions, hallucinations)

- Memory
- Mood/affect (include symptoms of depression, suicidal ideation, homicide ideation)
- Attention/Concentration
- Ability to abstract
- Fund of knowledge

Competency Issues (Include outcome of Mental Retardation evaluation if this was provided).

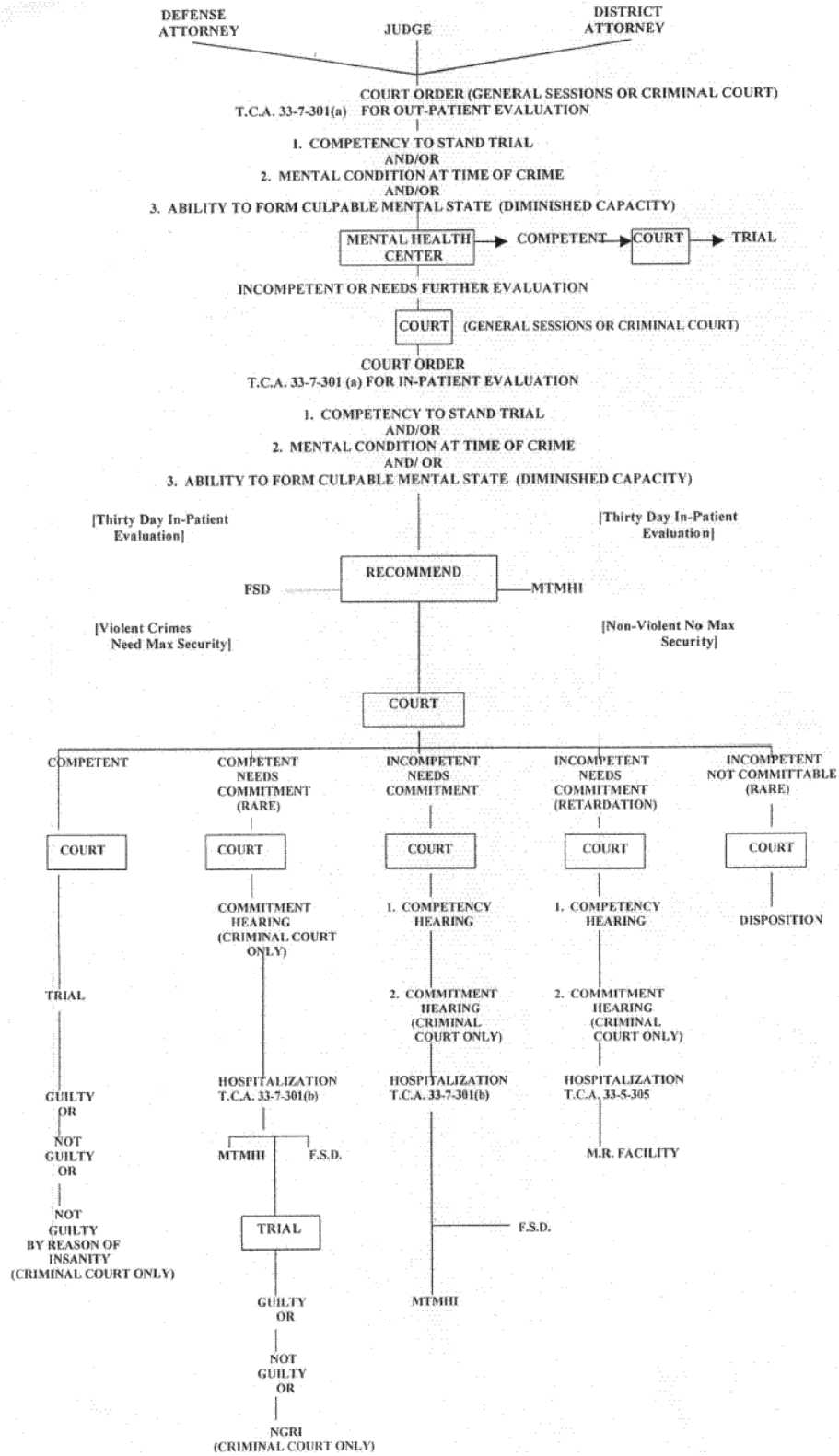
Mental Condition at the Time of the Alleged Crime (Include outcome of Mental Retardation evaluation if this was provided)

Conclusion

- State opinion based on language of statute and basis for the opinion (Include conclusions from Mental Retardation evaluation if their services were provided).
- Recommendations and basis for recommendations

Signature/Credentials

Forensic Evaluation Flowchart



Forensic Evaluation T.C.A. Codes

T.C.A. Code	Type of Services
Civil	Civil
Title 33, Section 6, Part 4	Emergency involuntary hospitalization at an inpatient psychiatric facility. Admission is time limited. Private facilities may admit under this statute.
Title 33, Section 6, Part 5	Indefinite involuntary judicial hospitalization at an inpatient facility. Indefinite length of hospitalization. Private facilities may admit under this statute.
Pre-Trial	Forensic - Adults
T.C.A. §33-7-301(a)	Outpatient evaluation for competency to stand trial and/or mental condition at the time of the alleged offense. Then, if recommended by the outpatient provider, an inpatient evaluation (for up to 30 days) may follow.
T.C.A. §33-7-301(b)	Indefinite commitment to a Mental Health Institute for treatment, following an inpatient T.C.A. § 33-7-301(a) evaluation, after finding the defendant either incompetent and committable or competent but committable. The defendant must meet the commitment standards of Title 33, Section 6, Part 5.
Post- Adjudication	Forensic - Adults
T.C. A. §33-7-301(a)(4)	Competency Evaluation of a defendant to determine competency to assist counsel or otherwise participate in a post-conviction proceeding. Limited to the Court's own motion.
Post-Trial	Forensic - Adults
T.C.A. §33-7-303(a)	A 30-60 day inpatient evaluation to determine committability after a finding of Not Guilty by Reason of Insanity (NGRI). The individual cannot be discharged before 30 days without a court order and must be discharged by the 60th day. Possible Outcomes: Release with No Service Recommendation, or Referral for Outpatient Services, or Forensic MOT under T.C.A. § 33-7-303(b), or Indefinite commitment under T.C.A. § 33-7-303(c) and Title 33, Section 6, Part 5.
T.C.A. §33-7-303(b)	Forensic Mandatory Outpatient Treatment (MOT), as ordered by the court, following a T.C.A. § 33-7-303(a) 30-60 day evaluation. This outpatient treatment can ONLY be terminated by the court.
T.C.A. §33-7-303(c), and Title 33, Section 6, Part 5	Indefinite involuntary commitment to an inpatient psychiatric facility by a criminal court, following a T.C.A. § 33-7-303(a) 60-90 day evaluation. Possible Outcomes, once an individual is no longer committable: Release - No services, or <i>Civil MOT (T.C.A. 33-6-Part 6), or</i> Referral to Outpatient Services.
Pre-Trial	Juvenile Services
T.C.A. §37-1-128	Outpatient evaluation by a community mental health center or an inpatient evaluation for up to 30 days to evaluate the need for mental health services, including committability (under Title 33, Chapter 6, Part 5 standards). The order, from a juvenile court, may include competency and/or mental condition.

Mandatory Outpatient Treatment

The State of Tennessee first enacted mandatory outpatient treatment (MOT) legislation in 1982. In 1987 the American Psychiatric Association endorsed the use of MOT under certain conditions. Currently 41 states have commitment statutes permitting MOT in some form. MOT generally refers to court directing a person suffering from severe mental illness to comply with a specific, individualized treatment plan that has been designed to prevent relapse and deterioration.

The success of implementing MOT relies heavily on the court's understanding of its role in the process and the need for all parties to take appropriate and timely action.

The state laws governing the use of mandatory outpatient treatment can be found in Title 33, Chapter 6, Part 6 ("Civil MOT") and Title 33, Chapter 7, Part 3 ("303(b) MOT"), Tennessee Code Annotated for those with charges.

Overview of Mandatory Outpatient Treatment

(A more in-depth explanation of the process and the required forms can be found at <http://www.state.tn.us/mental/t33/MOT2004.pdf>.)

Mandatory outpatient treatment is for individuals who require:

- continued treatment to maintain psychiatric stabilization and appropriate behavior,
- who will not do so voluntarily, but
- will respond to an authority imposing this upon them, and
- who prefer the MOT obligation over continued hospitalization.

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 a deterioration in their mental condition, and
- who will respond to a legal obligation to participate in outpatient treatment.

Mandatory outpatient treatment always follows indefinite judicial hospitalization. Initiation of MOT should always be carefully and rigorously done since it involves a loss of liberty for the service recipient. The service recipient may request a hearing in the court that committed him or her to the hospital to review the decision to renew the mandatory outpatient treatment obligation. MOT is similar to mandatory inpatient treatment in that it constitutes an abridgement of certain individual rights. The recipient has the right to request review of need for MOT.

There are 2 types of MOT:

(1) T.C.A. §33-6-602 (Civil):

Applies to service recipients who are judicially committed to involuntary care under Title 33, Chapter 6, Part 5, Tenn. Code Ann. who meet the criteria for MOT; this includes persons under "forensic" commitment T.C.A. Section 33-7-301(b) or T.C.A. Section 33-7-303(c).

(2) T.C.A. §33-7-303(b):

Applies only to service recipients admitted under T.C.A. Section 33-7-303(a) (30-60) day evaluation and treatment after adjudication of not guilty by reason of insanity) who have been found to not meet commitment standards under Title 33, Chapter 6, Part 5, Tenn. Code Ann., and who meet the criteria for MOT.

Judicial Review of Release (T.C.A. §33-6-708)

A criminal or juvenile court which has committed a person involuntarily under Title 33, Chapter 6, Part 5 may determine at the time of commitment that, due to the nature of the person's criminal conduct which created a serious risk of physical harm to other persons, the person should not be discharged from the commitment without proceedings to review eligibility for discharge.

When the chief officer of an inpatient facility where the service recipient has been involuntarily committed determines that the person is eligible for discharge under T.C.A. Sections 33-6-705--33-6-706 or T.C.A. Section 33-6-602 (MOT), the chief officer shall notify the committing court of the desire to discharge and of the outpatient treatment plan approved by the releasing facility and the qualified mental health professional. The court may order a hearing to be held within 21 days of receipt of the chief officer's notice. The court must send a notice to the service recipient, the chief officer, the service recipient's attorney, the service recipient's next of kin, and the district attorney general.

If the service recipient is a child, and the child is proposed to be released under MOT, the releasing hospital shall provide a clear written statement of what the service recipient shall do to stay in compliance with the Mandatory Outpatient Treatment (MOT) plan to the service recipient, and the service recipient's parents, legal custodian, or legal guardian. The statement shall specify the duties of the child's parents, legal custodian, or legal guardian.

Identifying Community Support

There are over (24) community mental health agencies in the state of Tennessee that are established and prepared to provide various services for recipients assigned to Mandatory Outpatient Treatment (MOT). The mandatory outpatient treatment (MOT) process is a combined effort of the inpatient treating facility and the outpatient provider. It is the responsibility of the mental health institute or facility in which the patient is hospitalized to approve an aftercare and MOT plan, in agreement with the community mental health agency prior to discharge. The outpatient provider has

no obligation to participate in providing services under MOT without involvement and agreement in developing the plan. The MOT plan must include necessary outpatient treatment including but not limited to: psychotherapy, medication management, day treatment, support services and case management services.

Civil MOT

Non-Compliance with the Civil MOT Plan and Filing Affidavits

When a service recipient is non-compliant with his or her MOT plan without good cause, an affidavit of non-compliance may be filed showing that the service recipient is out of compliance and is not likely to comply voluntarily. Affidavits of non-compliance can be filed by: qualified mental health professional (QMHP) as defined in Title 33, parent, legal guardian, conservator, spouse, responsible relative, persons who initiated the commitment proceeding or chief officer of the discharging facility.

The affidavit may be filed in the committing court or any court with jurisdiction under Title 33, Chapter 6, Part 5 in the county where the person is being treated or staying. The court may require an attorney to file the affidavit. After the affidavit is filed, responsibility for further action falls upon the court.

Court Proceedings

After the affidavit is filed with the court, the court may issue an order for the service recipient to appear in court no later than five business days after issuance of the court order. A copy of the affidavit and court order must be sent to:

- the service recipient,
- the service recipient's attorney,
- the QMHP and
- the District Attorney if the discharge required judicial review of release (T.C.A. Section 33-6-708).

Service Recipient Appears In Court

If the service recipient responds to the notice and appears in court, the court shall hold a hearing to determine whether the service recipient is required to be participating in outpatient treatment and is not, without good cause, complying with the treatment plan (T.C.A. Section 33-6-610(a)).

If the court determines that the service recipient

- is complying with the treatment plan,
OR
- is out of compliance for good cause and will be restored to compliance without further action,
THEN

the court shall release the service recipient (T.C.A. Section 33-6-610(b)) and the MOT plan continues. [See Form 6, MHDD –5215]

If the court determines that the service recipient

- is out of compliance with the plan without good cause and can be put immediately in compliance with the treatment plan and can be expected to stay in compliance without further hospitalization,

THEN

the court shall make a written finding, order the service recipient to comply immediately, and dismiss the proceedings upon showing that the service recipient is in compliance (T.C.A. Section 33-6-610(c)). [See Form 6, MHDD-5215].

If the court determines that the service recipient:

- is out of compliance with the plan without good cause,

AND

- cannot be put in compliance with the plan immediately,

OR

- cannot be expected to stay in compliance without further hospitalization,

THEN

the court shall order the service recipient recommitted to the hospital from which he or she was discharged. The sheriff shall transport the service recipient as ordered and the hospital shall admit the person (T.C.A. Section 33-6-610(d)). [See Form 6, MHDD-5215]

If a person is ordered to be re-hospitalized for noncompliance with the treatment plan,

after a hearing under T.C.A. Section 33-6-610, the person shall be held under the authority of the original court order of commitment entered in the proceedings under

Title 33, Chapter 6, Part 5.

Service Recipient Does Not Appear In Court and Affidavit Filed By QMHP

If the QMHP has filed an affidavit of non-compliance, and the service recipient does not

respond to the order to appear, the court shall order the service recipient taken into

custody, and the sheriff shall immediately transport the person to the hospital from which the person was discharged (T.C.A. Section 33-6-611). [See Form 7, MHDD-5216]

The hospital shall admit the person and give notice of the temporary recommitment and

that a hearing under T.C.A. Section 33-6-610 be scheduled. See court proceedings in the hospital section below. [See Form 8, MHDD-5217]

Service Recipient Does Not Appear In Court and Affidavit Filed By Someone Other Than The QMHP

If the service recipient does not respond to the order to appear, the court shall order that he or she be taken into custody and transported to the qualified mental health professional for examination. The officer who serves the order on the person shall take the person to the qualified mental health professional or the professional's appointed substitute (T.C.A. Section 33-6-612). [See Form 9, MHDD-5217]

If the QMHP determines that the service recipient

- is complying with the treatment plan,

OR

- is out of compliance for good cause and will be restored to compliance without further action,

THEN

the QMHP shall release the service recipient (T.C.A. Section 33-6-614(a)) and notify the Court of the basis for the release. [See Form 10, MHDD-5219]

If the QMHP determines that the service recipient

- is out of compliance with the plan without good cause and can be put immediately in compliance with the treatment plan and can be expected to stay in compliance without further hospitalization,

THEN

the QMHP shall release the service recipient (T.C.A. Section 33-6-614(b)) and notify the court of the basis for the release. [See Form 10, MHDD-5219]18.

If the QMHP determines that the service recipient

- is out of compliance with the plan without good cause,

AND

- cannot be put in compliance with the plan immediately,

OR

- cannot be expected to stay in compliance without further hospitalization,

THEN

the QMHP shall contact the sheriff and the sheriff shall immediately transport the person to the hospital from which he or she was discharged. [See Form 10, MHDD-5219]

The hospital shall admit the person and give notice of the temporary recommitment and that a hearing under T.C.A. Section 33-6-610 be scheduled. See court proceedings in the hospital section below. [See Form 8, MHDD-5217]

Court proceedings in the Hospital

If the person did not respond to the order to appear following an affidavit filed by the

QMHP, or if the QMHP has evaluated the person following the filing of the affidavit and determines that the service recipient is out of compliance without good cause, the sheriff will transport the person to the hospital from which the person was discharged.

The inpatient facility shall admit the person and make arrangements to hold a noncompliance hearing under T.C.A. Section 33-6-610. Notice of the temporary recommitment, and notice that a hearing will be held under T.C.A. Section 33-6-610, must be given to the

- service recipient;
- service recipient's attorney;
- legal guardian;
- legal custodian;
- conservator, if any;
- spouse or nearest adult relative (including parent of a minor);
- outpatient provider qualified mental health professional;
- court which ordered the temporary recommitment of the person; and
- court where the hospital is located that has the same jurisdiction as the recommitting court.

The court shall schedule a hearing to be held under T.C.A. Section 33-6-610 within five (5) business days.

UNDER NO CIRCUMSTANCES SHOULD THE INDIVIDUAL BE CONVERTED TO TITLE 33, CHAPTER 6, PART 2, TENN. CODE ANN. (VOLUNTARY) STATUS PRIOR TO THE NON-COMPLIANCE HEARING. Conversion to voluntary status renders the individual ineligible for discharge under MOT.

The court shall hold a hearing to determine whether the person is required to be participating in outpatient treatment and is, without good cause, not complying with the treatment plan.

If the court determines that the service recipient

- is complying with the treatment plan,
OR
- is out of compliance for good cause and will be restored to compliance without further action,
THEN

the court shall release the service recipient (T.C.A. Section 33-6-610(b)).
[See Form 6, MHDD-5215]

If the court determines that the service recipient

- is out of compliance with the treatment plan without good cause and can be put

immediately in compliance with the treatment plan and can be expected to stay in compliance without further hospitalization,
THEN
the court shall make written findings of fact and conclusions of law on the issues, order the person to comply immediately with the treatment plan, and dismiss the proceedings upon a showing the person is in compliance (T.C.A. Section 33-6-610(c)). [See Form 6, MHDD-5215]

If the court determines that the service recipient

- is out of compliance with the plan without good cause,

AND

- cannot be put in compliance with the plan immediately,

OR

- cannot be expected to stay in compliance without further hospitalization,

THEN

the court shall make written findings of fact and conclusions of law on the issues and order the person re-committed to the hospital. [See Form 6, MHDD-5215]

If a person is ordered to be re-hospitalized for noncompliance with the treatment plan,

after a hearing under T.C.A. Section 33-6-610, the person shall be held under the authority of the original court order of commitment entered in the proceedings under

Title 33, Chapter 6, Part 5, and any other pending proceedings under Title 33, Chapter 6, Part 4 or 5, shall be dismissed.

Forensic MOT

Non-Compliance with the Forensic MOT Plan and Filing Affidavits

The agency staff working with the service recipient (case manager, physician, and/or

therapist) should be familiar with the service recipient's MOT plan and should inform the

MOT Coordinator and the qualified mental health professional who is the assigned

"treating professional" when the service recipient is non-compliant. The treating QMHP should enlist the aide of the treatment team and make every attempt to restore the service recipient to compliance.

If the service recipient cannot be restored to compliance with the MOT plan, the outpatient qualified mental health professional shall:

- Immediately notify the district attorney general by phone and promptly file a written
- report with the district attorney general of the non-compliance. The district attorney
- general may move the criminal court to cite the person for civil or criminal contempt

- for the non-compliance and may file a complaint in the criminal court under the
- provisions of Title 33, Chapter 6, Part 5;
- Provide a copy of the written notice to the service recipient;
- Provide a copy of the written notice to the service recipient's attorney;
- Document the basis of non-compliance in the service recipient's clinical record; and
- Provide court testimony as appropriate.

If noncompliance is documented in the six-month review, or a report of non-compliance is filed, the review or report should clearly indicate:

- Specific components of the MOT plan with which the service recipient is out of compliance;
- Actions the QMHP has taken to restore the service recipient to compliance with the MOT plan; and
- The recommended plan of action to the district attorney general (How do you want the court to respond to your report of non-compliance? What type of action or assistance is necessary to bring the service recipient into compliance?).

Court Proceedings

If, following a complaint from the district attorney general, the criminal court holds a non-compliance hearing, the court may:

- Terminate the MOT if the criteria are no longer met;
- Restore the service recipient to compliance and continue MOT.
- Find the service recipient in civil or criminal contempt of court and detain them accordingly.
- Request additional evaluation to determine if the service recipient currently meets commitment standards under Title 33, Chapter 6, Part 4 or 5.

Admission of a Service Recipient on 303(b) MOT

A service recipient cannot be readmitted directly to a hospital under the provisions of T.C.A. Section 33-7-303(b). However, the Criminal Court could ask that the person be reevaluated to determine if they currently meet commitment standards, and this could lead to commitment under Title 33, Chapter 6, Part 5. A service recipient might be admitted for reasons unrelated to the 303(b) MOT (e.g. emergency involuntary hospitalization).

Admission unrelated to 303(b) MOT

The obligation to participate in mandatory outpatient treatment is suspended while the service recipient is hospitalized but will resume when discharged unless terminated by the court.

Inpatient Facility Responsibilities

In the case of an emergency hospitalization under Title 33, Chapter 6, Part 4 or a commitment under Title 33, Chapter 6, Part 5:

- The admission would proceed as usual per statutory provisions.
- Notify the QMHP and/or MOT Coordinator at the outpatient provider as soon as possible to inform them of the admission and involve them in assessment and discharge planning.

Discharge Considerations

If committed under Title 33, Chapter 6, Part 4

If the service recipient has been admitted as an emergency and is going to be discharged prior to a judicial commitment under Title 33, Chapter 6, Part 5, the inpatient facility staff must notify the QMHP of the discharge and help coordinate the continuance of MOT. The obligation to participate in mandatory outpatient treatment resumes upon discharge unless the obligation has been terminated by the Court. The inpatient facility must provide information or recommendations about possible changes in the MOT plan (e.g. changes in medication) to the service recipient and the QMHP.

If committed under Title 33, Chapter 6, Part 5

If the service recipient is involuntarily committed under Title 33, Chapter 6, Part 5, the inpatient facility shall consider whether:

- the court desires resumption of MOT under 303(b);
OR
- the service recipient meets the criteria for Civil MOT (T.C.A. Section 33-6-602);
AND/OR
- to voluntary outpatient treatment with the court's permission

Following an involuntary commitment, it is possible that a service recipient already under 303(b) MOT could also be placed under a Civil MOT. This would be done primarily if it were felt that the ability to quickly rehospitalize the service recipient for non-compliance was necessary. In that case, the provisions of both would need to be followed, including reporting to the district attorney general and the committing court at six-month intervals.

When the decision is made that the person shall be discharged to Civil MOT, or to 303(b) MOT, the inpatient facility should notify the following of the decision:

- the committing court, if Civil;
- the district attorney general , if 303(b);
- the outpatient MOT Coordinator and/or the qualified mental health professional;
- TDMHDD MOT Coordinator;
- the service recipient; and
- the service recipient's attorney.

The following sample forms are included. This list does not include all forms that are available. Please visit the MOT website for a complete list, <http://www.state.tn.us/mental/t33/MOT2004.pdf>.

- Order Following Non-compliance Hearing Under T.C.A. §33-6-610
- Order Redirecting Temporary Recommitment of Person who Failed to Appear Before Court Under T.C.A. §33-6-611
- Order Directing Service Recipient Taken into Custody and Evaluated Under T.C.A. §33-6-612
- Notice that Mandatory Outpatient Treatment Obligation is Renewed for Six Months Under T.C.A. §33-6-621
- Order Following hearing on Service Recipient's Obligation to participate in Mandatory Outpatient Treatment Under T.C.A. §33-6-622
- Order Under T.C.A. §33-7-303(b) Approving a Mandatory Outpatient Treatment Plan
- Notice of Review of Mandatory Outpatient Treatment Under T.C.A. §33-7-303(b)
- Affidavit Regarding Defendant's Failure to Comply with Mandatory Outpatient Treatment Plan Under T.C.A. §33-7-303(b)

IN THE _____ OF _____ COUNTY,
TENNESSEE

In the Matter of _____)
_____))
_____))
_____) Docket No. _____)
_____))
Service Recipient)

**ORDER FOLLOWING NON-COMPLIANCE HEARING UNDER
T.C.A. §33-6-610**

This matter was heard on _____ day of _____, 20____, based on
affidavit of _____ under
(Name of Affiant)

T.C.A. §33-6-609, which alleges

- (a) the service recipient is required to be participating in mandatory outpatient treatment under T.C.A. §33-6-602 and
- (b) the service recipient is, without good cause, out of compliance with the treatment plan and
- (c) the treating professional believes the non-compliance is not likely to be corrected voluntarily.

At the hearing, _____

testified and the service recipient had all rights afforded a service recipient under T.C.A. §33-6-618.

As a result of the hearing, the Court determines that the service recipient:

1. _____ Is complying with the treatment plan OR is out of compliance with the treatment plan for good cause and will be restored to compliance without further action.
2. _____ Is out of compliance with the plan without good cause and can be put immediately in compliance with the treatment plan and can be expected to stay in compliance without further hospitalization.
3. _____ Is out of compliance with the plan without good cause and can not be put in compliance with the plan immediately or cannot be expected to stay in compliance without further hospitalization.

The Court bases its conclusions on the following findings of fact: (Enter facts as to 2 and 3 above.)

It is, therefore, **ORDERED**:

1. _____ That the service recipient be released and the treatment plan continues.
2. _____ That the service recipient be ordered to comply immediately and dismiss the proceedings upon the showing that the person is in compliance.
3. _____ That the service recipient be recommitted to the hospital from which the person was released. The sheriff shall immediately transport the person to the hospital and the hospital shall admit the person and give notice of the recommitment to the person's attorney and others required under T.C.A. §33-6-610(d)(2).
4. _____ That the costs of these proceedings and a reasonable attorney fee be assessed to the State of Tennessee in accordance with T.C.A. §33-3-503.

Judge

Entered this _____ day of _____, 20__.

Approved for entry:

Attorney for Service Recipient

Attorney for Mental Health Service Provider

IN THE _____ OF _____ COUNTY, TENNESSEE

In the Matter of _____)
)
 _____)
) Docket No. _____)
 _____)
 Service Recipient)

**ORDER DIRECTING SERVICE RECIPIENT TAKEN INTO CUSTODY
AND EVALUATED UNDER T.C.A. §33-6-612**

This matter is based on the affidavit of _____
under T.C.A. §33-6-609. (Name of affiant)

1. The affidavit was introduced as evidence.
2. The affiant is not the treating qualified mental health professional of the service recipient.
3. The service recipient failed to appear in this court as ordered.

The court makes the following findings of fact: [Enter facts as to 1, 2, and 3, above.]

Therefore it is ORDERED:

1. The sheriff or a law enforcement officer shall serve this order on the service recipient and take him or her into custody.

2. The sheriff or law enforcement officer shall take the service recipient to:

(Name of treating qualified mental health professional or professional's substitute)

or, if unavailable, to:

(Name of community mental health center)

to determine whether the service recipient is in compliance with the mandatory outpatient treatment plan.

3. The sheriff shall transport the service recipient to

(Name of Hospital)
if the treating professional under 2 determines:

- (1) The service recipient is out of compliance with the treatment plan without good cause, and
- (2)
 - (a) the service recipient cannot be put immediately in compliance with the mandatory outpatient treatment plan, or
 - (b) the service recipient cannot be expected to stay in compliance without further hospitalization, or
 - (c) the service recipient does not comply immediately with the mandatory outpatient treatment plan.

This recommitment is temporary pending a hearing disposing of these issues under T.C.A. §33-6-610.

4. If the treating professional does not refer the service recipient to the hospital as stated in 3, the sheriff shall release the person from custody.
5. The costs of these proceedings and a reasonable attorney's fee shall be assessed to the State of Tennessee in accordance with T.C.A. §33-3-503.

Judge

Entered this _____ day of _____, 20__.

Attorney for Service Recipient

Attorney for Service Provider

TO:

Name of service recipient under mandatory outpatient treatment obligation

Name of service recipient's attorney

Name of service recipient's former hospital

Name of court which committed service recipient under T.C.A. §33-6-501

**NOTICE THAT MANDATORY OUTPATIENT TREATMENT
OBLIGATION IS RENEWED FOR SIX MONTHS
UNDER T.C.A. §33-6-621**

1. I am the qualified mental health professional treating the above-named service recipient, whose obligation to participate in mandatory outpatient treatment under T.C.A. §33-6-602 expires on (date) _____ without renewal under T.C.A. §33-6-621.

2. I have decided to renew the service recipient's obligation to participate in mandatory outpatient treatment for six (6) months based on the following conclusions:

- 2.1 the service recipient has a mental illness or serious emotional disturbance or has a mental illness or serious emotional in remission, and
- 2.2 the service recipient's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the service recipient will pose a likelihood of serious harm as defined in T.C.A. §33-6-501 unless treatment is continued, and
- 2.3 the service recipient is not likely to participate in outpatient treatment unless legally obligated to do so, and
- 2.4 mandatory outpatient treatment is a suitable less drastic alternative to commitment.

3. I base my conclusions under 2 above on the following facts: _____

4. The service recipient may request a hearing in the court that committed him or her to the hospital, to review my decision to renew the mandatory outpatient treatment obligation.

Date

Name of Qualified Mental Health Professional

Telephone Number

Agency

Address

IN THE _____ OF _____ COUNTY,
TENNESSEE

In the Matter of _____)
_____)
_____) Docket No. _____
_____)
Service Recipient _____)

**ORDER FOLLOWING HEARING ON SERVICE RECIPIENT'S
OBLIGATION TO PARTICIPATE IN MANDATORY OUTPATIENT
TREATMENT UNDER T.C.A. §33-6-622**

This matter was heard on _____ day of _____, 20____, based on the
petition of _____ who requested judicial
(Name of Service Recipient)

review of the treating qualified mental health professional's decision to renew the service
recipient's obligation to participate in mandatory outpatient treatment under
T.C.A. §33-6-621.

At the hearing, _____ testified and the
service recipient was afforded all rights of a service recipient under T.C.A. §33-6-618.

As a result of the hearing and from testimony presented and evidence produced, the Court
concludes: [Choose A or B]

A. _____ The obligation to participate in mandatory outpatient treatment is renewed. In
making this determination, the Court has concluded that the following requirements for
renewal have been satisfied:

1. The service recipient has a mental illness or serious emotional disturbance or has
a mental illness or serious emotional disturbance in remission,
2. The service recipient's condition, resulting from mental illness or serious
emotional disturbance, is likely to deteriorate rapidly to the point that the service
recipient will pose a likelihood of serious harm as defined in T.C.A. §33-6-501
unless treatment is continued,
3. The service recipient is not likely to participate in outpatient treatment unless
legally obligated to do so, and

4. Mandatory outpatient treatment is a suitable less drastic alternative to commitment.

B. _____ An insufficient basis exists to support renewal of service recipient's obligation to participate in mandatory outpatient treatment because the legal requirements for renewal have not been satisfied.

Therefore, it is **ORDERED** that the obligation of the service recipient to participate in mandatory outpatient treatment:

1. _____ is renewed for six months under T.C.A. §33-6-621.
2. _____ is terminated.
3. The costs of these proceedings and a reasonable attorney fee be assessed to the State of Tennessee in accordance with T.C.A. §33-3-503.

Judge

Entered this _____ day of _____, 20__.

Approved for entry:

Attorney for Service Recipient

Attorney for Mental Health Service Provider

IN THE _____ OF _____ COUNTY,
TENNESSEE

STATE OF TENNESSEE)
)
 vs.)
) Docket No. _____
)
 _____)
 DEFENDANT)

**ORDER UNDER T.C.A. §33-7-303(b) APPROVING A
MANDATORY OUTPATIENT TREATMENT PLAN**

This matter was heard on the _____ day of _____, 20____, based on the complaint requesting that the defendant be ordered to seek mandatory outpatient treatment under T.C.A. §33-7-303(b) with _____ (qualified mental health professional).

At the hearing, it appeared to the satisfaction of the Court that the defendant was examined at the _____
(Name of Facility)
for 60-90 days for diagnosis and evaluation after defendant was adjudicated not guilty by reason of insanity on the charge(s) of _____.

The staff of the facility recommend mandatory outpatient treatment with _____
_____ (qualified mental health professional).

As a result of the hearing the Court finds:

1. That the defendant is mentally ill, and
2. The defendant is not committable under Title 33, Chapter 6, Part 5, Tenn. Code Ann. and T. C. A. §33-7-303(c), and
3. That the defendant's condition resulting from mental illness is likely to deteriorate rapidly to the point that the defendant will pose a substantial likelihood of serious harm as defined in Title 33, Chapter 6, Part 5, Tenn. Code Ann. unless treatment is continued.

Therefore it is ORDERED:

- (1) That the defendant seek outpatient treatment with _____(qualified mental health professional); and
- (2) The court clerk provide a copy of this order to _____(qualified mental health professional); and
- (3) That the qualified mental health professional file a report with the District Attorney General every six (6) months as to the defendant's continuing need for treatment; and
- (4) That the cost of treatment be taxed as court costs.

Entered this _____ day of _____, 20__.

Defense Attorney

Judge

District Attorney General

TO: _____

District Attorney General

Name of service recipient's attorney

Name of discharging inpatient facility

RE: _____

Name of service recipient

**NOTICE OF REVIEW OF MANDATORY OUTPATIENT TREATMENT
UNDER T.C.A. §33-7-303(b)**

1. I am the qualified mental health professional treating the above-named service recipient, who is obligated to participate in mandatory outpatient treatment under T.C.A. §33-7-303(b).

This case is due for review no later than _____.

Please mark the statement which is true.

2. _____ This service recipient has been compliant with his or her mandatory outpatient treatment obligations under T.C.A. §33-7-303(b).

_____ This service recipient has not been compliant with his or her mandatory outpatient treatment obligations under T.C.A. §33-7-303(b).

3. I base my conclusions under 2 above on the following facts: _____

_____.

4. I make the following recommendations: _____

_____.

Date

Name of Qualified Mental Health Professional

Telephone Number

Agency

Address

IN THE _____ OF _____ COUNTY,
TENNESSEE

STATE OF TENNESSEE)
)
 vs.)
) Docket No. _____
)
 _____)
 DEFENDANT)

**AFFIDAVIT REGARDING DEFENDANT'S FAILURE TO COMPLY
WITH MANDATORY OUTPATIENT TREATMENT PLAN UNDER T.C.A.
§33-7-303(b)**

1. I, _____ state that I have personal
(Name of Qualified Mental Health Professional)
knowledge of _____ and his or her
(Name of Defendant)
condition as of this date.

2. I state that:
2.1 the defendant is required to be participating in mandatory outpatient treatment
under T.C.A. §33-7-303(b), and
2.2 the defendant is out of compliance with the mandatory outpatient treatment plan.

3. I base my beliefs on the following facts (include the potential for voluntary compliance):

_____.

Signature of Qualified Mental Health Professional Date

Sworn to and subscribed before me this _____ day of _____, 20__.

Notary Public

My commission expires _____(Date)

Psychiatric Hospitalization

Hospitalization is expensive and often more restrictive than necessary to meet the individual's needs. Psychiatric hospitalization should be used only when all other less limiting choices are not enough to meet the treatment needs of the person and/or to assure the safety of the person or other people. This treatment may occur at a public or private institution that specializes in mental health treatment or on a psychiatric unit in a general hospital. For a list of free-standing psychiatric hospitals, please contact the TDMHDD Licensure Office at (615) 532-6590. For a list of general hospitals with psychiatric units, please contact the Department of Health at (615) 741-3111 or visit their website at <http://www.2state.tn.us/health/HCF/index.htm>.

There are several types of psychiatric admissions and each type requires a civil process. The types of civil admission to a psychiatric hospital are voluntary, emergency involuntary and indefinite involuntary.

Voluntary Psychiatric Admissions [Title 33, Chapter 6, Part 2]

To obtain voluntary hospitalization, the following persons may apply for admission at a hospital or treatment resource:

- A person who is 16 years of age or older and has capacity to apply;
- A parent, legal custodian, or legal guardian acting on behalf of the a child;
- A conservator who has been appointed by the court and has the authority to apply for the person's admission;
- A qualified mental health professional acting on the basis of a person's declaration for mental health treatment;
- A person's attorney in fact under a durable power or attorney for health care;
- A caregiver under Title 34, Chapter 6, Part 3, who is acting on behalf of a child.

Before admitting a person to the hospital, a physician must evaluate the person to determine the need for hospitalization; if the person is a child, the parent, legal guardian or legal custodian must be notified. Admission is subject to availability of suitable accommodations.

Involuntary Psychiatric Admissions [Title 33, Chapter 6, Part 4 and Part 5]

To obtain involuntary psychiatric hospitalization on an **emergency** basis, the person must first be evaluated in the community. The evaluator (mandatory pre-screening agent, physician, or licensed psychologist) must determine if the person meets the legal conditions for emergency involuntary commitment.

To be eligible for emergency hospitalization, the individual must meet the following criteria (T.C.A. §33-6-403):

1. The person has a mental illness or serious emotional disturbance, AND
2. The person poses an immediate substantial likelihood of serious harm** because of the mental illness or serious emotional disturbance, AND
3. The person needs care, training, or treatment because of the mental illness or serious emotional disturbance, AND
4. All available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.

**“Substantial likelihood of serious harm” means

1. A person has threatened or attempted suicide or to inflict serious bodily harm on such person, OR
2. The person has threatened or attempted homicide or other violent behavior; OR
3. The person has placed others in reasonable fear of violent behavior and serious physical harm to them, OR
4. The person is unable to avoid severe impairment or injury from specific risk, AND
5. There is substantial likelihood that such harm will occur unless the person is placed under involuntary treatment. (T.C.A. §33-6-501).

A Mandatory Pre-screening Agent designated by TDMHDD must evaluate any person referred to a Regional Mental Health Institute for emergency involuntary admission. If a Mandatory Pre-screening Agent is not available to assess within 2 hours of the request, then a licensed physician or psychologist may conduct the evaluation and consult with the local crisis team for less restrictive alternatives to hospitalization .

Following the evaluation in the community, the person meeting emergency commitment criteria will then be transported to a hospital that accepts emergency involuntary admissions. At the hospital, the person will receive a second evaluation, which must be performed by a licensed physician to assure the person needs to be admitted based on the above conditions. Admission is not subject to suitable available accommodations at a state hospital.

To obtain involuntary psychiatric hospitalization on a non-emergency basis, two physicians (or a physician and a psychologist) must evaluate the person. The person is evaluated to see if the person poses a substantial likelihood of serious harm (see above) because of a mental illness or serious emotional disturbance. Each evaluator must complete a Certificate of Need for involuntary hospitalization. The Certification of Need and a petition must be filed in court and a court hearing must be held within 5 working days. If the judge orders the person committed to a psychiatric hospital, admission is subject to suitable available accommodations.

Juvenile Services

Mental Health Services and Outreach in Juvenile Court

Prior Identification of Mental Illness

There are several different mechanisms for identifying mental illness when children are referred to juvenile court for prosecution. Because the nature and purpose of the court is very different than criminal court, mental health history of a child is and should be a much more standard piece of the child's juvenile court file. Some of the most common avenues for court recognition of mental health history or needs include:

- The child has prior contact with the juvenile court as a neglected or dependant or unruly child,
- The delinquent charge was a result of an action at school,
- The child's mental health provider accompanies them to court,
- The child's attorney or case manager raises mental health concerns.

The child has prior contact with the juvenile court as a neglected or dependant or unruly child.

A large percentage of cases referred to court are charges against youth already in the custody of Department of Children's Services (DCS) as a result of the actions of their parent/s. In these cases, the court should have a permanency plan on file that addresses any mental health history. Additionally, the child should have been assigned a guardian ad litem who is charged with the obligation of looking out for the child's welfare, including advocacy for proper mental health treatment. In many cases, the child may be charged with an action that is consistent with their previously identified mental health issues. It is imperative in these cases that DCS justify the reasoning behind the court referral given their legal obligation to meet the mental health needs of the child pursuant to state and federal law.

Parents and custodians may bring their child to the attention of the court when the child is exhibiting unruly behaviors. The child and his/her parents appear before an officer of the court and eventually the judge. The court should have made attempts to uncover any mental illnesses that may be contributing to the child's unruliness, including conducting assessments, interviews, and referring the child to outside treatment or classes.

The delinquent charge was a result of an action at school.

Another significant sub-section of juvenile court referrals are the result of allegations from schools. Depending on the nature of the referral, an Individualized Education Plan (IEP) or other school document may reference a mental health history of the child. Only those children already classified as "special needs" will have an IEP. Schools should not make referrals to juvenile court without a review of the child's Individualized Education Plan to ensure that

the act allegedly committed was not a manifestation of the child's previously identified disability.

The child's mental health provider accompanies them to court.

When a child has a strong relationship with a mental health caseworker, perhaps from a community mental health center, that mental health worker may appear in court with the child. This can be a useful way to immediately identify mental health needs.

The child's attorney raises mental health concerns.

If the case is not diverted (see diversion section below), it is paramount that the attorney raise mental health concerns, both pre-adjudication and at disposition. Because the role of the juvenile court is treatment and rehabilitation, advocacy requires proof on all mental health issues when the parent/guardian, or child of appropriate age, so consents.

Identification of Mental Illness at the Juvenile Court

The juvenile court also should have mechanisms in place for the identification of mental illness. Some court systems and juvenile detention facilities have screening processes that are standard protocol with juvenile offenders. These screenings may be requested by the Court, a parent, or counsel for the child. While there is significant concern on behalf of defense counsel that mental health screeners are questioning the juveniles about the offense, this screening mechanism is used by the court and can lead to a referral for services through the Department of Children's Services or mental health services through the community mental health center.

Each jurisdiction has access to emergency psychiatric assessments if the juvenile is in an acute crisis situation, for example, is suicidal, homicidal based on his/her mental illness, or is severely psychotic. The Department of Mental Health and Developmental Disabilities has established Crisis Response Teams that assess the juvenile's mental status, likelihood for risk for harm, and potential need of psychiatric hospitalization or another less restrictive alternative. Other alternatives would include medication management and/or suicide watch at the detention facility.

The Case for Diversion

Depending on the seriousness of the charge, a child with a significant history of mental illness referred to juvenile court for prosecution may be diverted. Diversion is available to children with or without a mental illness. The juvenile court has at its disposal a wide range of services, both through the Department of Children's Services, and through private providers, to address the concerns of these youth. Given that children are by law dependant upon another for care, it is essential that the caregiver be made part of any plan to address the problem that leads to a juvenile court referral. By referring the child and parent to services, the court can better address the underlying issues.

Additionally, children are required to attend school every day and federal law requires that the educational system address the mental health needs of children. Because of the daily contact schools have with these children, they are most often the best environment for addressing mental health concerns and working with parents to address emerging problems. Federal law states that schools are obligated to meet the needs of children with behavioral issues and special education needs. Many petitions in the juvenile court system originate in the school system, after disruptive behavior occurs on the school campus. This is an opportunity to educate and plan as a community how to handle these and upcoming situations while consideration for the most appropriate disposition for the child remains paramount.

At trial, the Referee or Judge will, should counsel raise it, assess the services currently in place to determine if any further action is necessary. Because the finder of fact may not be a mental health expert, it can be a difficult process. The court is charged with looking at the treatment and rehabilitation needs of the child, but is best equipped to do this in cases where mental illness does not play a significant role in the problematic behavior.

The diversionary process, including a referral to DCS or to a pre-trial program, allows the problem to be addressed immediately. The wide range of family services available to the court and the immediacy of their availability provide that mentally ill children will receive the treatment that they need in most cases.

Diversion Options

Juvenile courts across Tennessee will be able to divert cases at different phases of the court proceedings and to different degrees, greatly depending on available community resources and the seriousness of the charge. Some of the services that the court uses include: referral for parenting classes in the community, referral to current mental health providers or schools where the action taken by the child was a manifestation of their mental illness, referral to Crisis Response, referral to in-home counseling providers, or the Department of Children's Services, and probation. Court personnel may request a report from the agency indicating compliance with services by their child or parent. When it becomes apparent that there may be an issue of medical neglect, the case may be referred to Child Protective Services for investigation.

Once a case has been placed upon a settlement docket, the attorney for the child and the Assistant Attorney General (if applicable) may reach an agreement to divert the charge or to continue the case for monitoring services. The Juvenile Code delineates two formal diversion options, an informal adjustment and a pre-trial diversion. Neither of these options requires the child to enter a plea of guilty. Rather, they allow the child to meet certain requirements worked out by counsel or court staff, after which their case is dismissed.

Involuntary Commitment to the Department of Mental Health and Developmental Disabilities

Tennessee law does provide for involuntary commitment of youth to a mental hospital for evaluation. T.C.A. § 37-1-128(e)(1) also provides that when a court proceeding is pending, a child may be ordered to complete a mental health or mental retardation assessment on an outpatient basis. When however, the court determines that the child is mentally ill and “poses an immediate substantial likelihood of serious harm . . . because of mental illness” the court may order the child placed in a hospital or treatment resource for the purposes of evaluation and for treatment necessary to the evaluation for up to thirty days. A detailed report of the evaluation is returned to the court, after which the court may, if appropriate, order that involuntary commitment procedures commence.

Should further treatment be necessary before returning the child to the community, T.C.A. 37-1-175 provides for temporary legal custody to be granted to the Department of Children’s Services (DCS) upon a finding that there is no less drastic alternative. This custody must be terminated as soon as community-based treatment is available to the child.

In practice, this provision is rarely exercised: either the child is stabilized making the proceeding unnecessary, or the child is referred to the Department of Children’s Services. Because DCS contracts with a wide variety of facilities across the state, including residential treatment facilities, the Department can often meet the needs of a mentally ill child in a less restrictive environment.

Forensic Evaluations

In the juvenile context, forensic evaluations are used to determine:

- whether a child is competent to stand trial,
- whether an insanity defense is supported by the evidence, and
- whether a child has diminished capacity due to mental illness
- whether a child is committable.

Attorneys can obtain forensic evaluations by 1) requesting that the court order an evaluation pursuant to T.C.A. §37-1-128; or 2) employing a qualified practitioner to conduct the evaluation *ex parte*.

Court-ordered evaluations

T.C.A. §37-1-128 provides that:

“If, during the pendency of any proceeding...there is reason to believe that the child may be suffering from mental illness, the court may order the child to be evaluated on an outpatient basis by a community mental health center, mental health institute or licensed private practitioner.

If, during the pendency of any proceeding...there is reason to believe that the child may be suffering from developmental

disability, the court may order the child to be evaluated on an outpatient basis by the community mental health center, developmental center or licensed private practitioner designated by the commissioner of mental health and developmental disabilities to serve the court.

If the professional attempting to perform the evaluation for mental illness or developmental disabilities determines that the evaluation cannot be performed properly on an outpatient basis, the court may order the child placed in a hospital or treatment resources...for the purposes of evaluation and for treatment necessary to the evaluation, for not more than thirty days...

If an evaluation is ordered under this subsection, the evaluator shall file a complete report with the court which shall include: A) Whether the child is mentally ill or developmentally disabled; B) Identification of the care, training or treatment required to address conditions of mental illness or developmental disability which are found, and recommendations as to resources which may be able to provide such services; C) Whether the child is subject to voluntary or involuntary admission or commitment for inpatient or residential services or for commitment to the custody of the department of mental health and developmental disabilities for such conditions...; and D) *Any other information requested by the court which is within the competence of the evaluator.*" (emphasis added).

Under T.C.A. §37-1-128, an attorney may ask the court to order that the evaluation include a determination of whether a child is competent to stand trial or whether an insanity defense is supported by the evidence.

Ex parte forensic evaluations

Attorneys may also employ a qualified practitioner to conduct an *ex parte* forensic evaluation. An *ex parte* evaluation may be obtained with private funds if the client is not indigent. Attorneys of indigent clients can obtain funds using Rule 13 of the Tennessee Supreme Court Rules. Rule 13 establishes the requirements and procedure for obtaining such funds. A court must find that there is a particularized need for the services, and that such services must be necessary to ensure that the constitutional rights of the defendant are properly protected. A signed court order approving the funds must be sent to the Administrative Office of the Courts for final approval and processing.

What Can Be Done?

Best Practices

According to the *Department of Justice Source Book: Criminal Justice Statistics*, at least 16% of the total jail and prison population have a serious mental illness at a cost of \$50,000 per person annually. Reducing those numbers should be a priority in every jurisdiction. Because of this, it is important to identify strategies that have been recognized as best practices in effectively managing both the criminal justice needs and mental health needs of individuals while maintaining a commitment to public safety. A discussion of diversion, mental health care in jails, release planning, and other model program strategies follows.

Diversion

According to the National GAINS Center, a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people in contact with the justice system, there are six features essential for successful diversion.

- Interagency collaboration with the community, including social services, housing, mental health, substance abuse agencies and corrections;
- Active involvement and information-sharing;
- Boundary spanners: these persons are trained staff who can bridge mental health and substance abuse agency systems. They often act as liaison between attorney/corrections and resources available in the community. A list of Tennessee boundary spanners is included in the appendix;
- A strong leader for coordination;
- Early identification; and
- Cross-trained case managers.

Stages of Diversion

Before Incarceration

On the street or at time of arrest.

- An attempt should be made to educate police officers.
- An officer should be taught how to recognize the signs of a mental illness, developmental disability and substance use.
- Officers should be given simple tools and mechanisms to de-escalate a situation without resorting to arrest.
- Improve crisis response to law enforcement officers;
- Teach officers what their diversion options might be.

After arrest and at booking, this is the most prevalent type of diversion.

- Teach staff how to recognize mental illness.
- Encourage booking staff to ask pertinent questions during intake regarding mental illness.

- Draw up a simple assessment form in order to encourage self-reports of mental illness.
- Some individuals are released pre-trial on the condition that they receive treatment.
- Pre-trial diversion in which a person arrested is released from jail with a court date and time. In many jurisdictions, this will mean studying and revising the tool used to determine who might qualify for pre-trial diversion.
- Mental Health Courts and Drug Courts are also set up on the diversion model and can be utilized.

In Jail

- Identify seriously mental ill individuals in jail.
- Coordinate service provision with existing treatment provider, such as community mental health centers, primary care physician, private psychiatrist.
- Ensure that persons with mental illness have access to effective psychotropic medications.

At trial/sentencing

- Work with the public defender or private attorney and the district attorney general's office to negotiate a settlement for timely access to appropriate community mental health center services.
- Present diversion options to the judge for approval.
- There are different kinds of probation that are often recommended in tandem with mental health treatment. These include:
 1. The least restrictive kind of probation which can either be unsupervised or supervised.
 2. Intensive probation.
 3. The most intensive kind of probation is Community Corrections.

Post Sentencing

- Work with probation officers to ensure timely access to community services.
- Educate probation and parole officers how to recognize mental illness.
- Develop relationships with community mental health providers to help ensure rapid access to treatment for those persons who are identified and referred.

Involving Families of Defendants with Mental Illness

Family support improves outcomes for individuals under court supervision, reducing recidivism rates and substance abuse. Families can assist counsel or the court with identifying resources and creating successful supervision plans. Families of defendants with mental illness can be a valuable resource when attempting to find the most appropriate disposition for defendants. They can tell

the court what has worked in the past, what hasn't been effective and why, and can promote assurance that the defendant has the support needed in the community to accomplish the conditions set by the court.

The National Alliance on Mental Illness (NAMI) is an organization of individuals with mental illness and their families. NAMI has long advocated for family inclusion and diversion strategies for individuals with mental illness who are in the criminal justice system. The key to developing effective family support is education on mental illness and support of families with a similar experience. NAMI offers support groups and educational opportunities to families free of charge. The Mental Health Association offers similar opportunities in many cities.

Conversely, some families have a culture of chaos, abuse, criminality and addiction that exacerbates the condition of defendants with mental illness. In those cases the individual may better be served by distancing them from family influence in order to reduce the likelihood of re-offense.

Mental Health Care in Jails

There are more people with mental illness in Tennessee's jails and prisons than in all the public and private mental health facilities combined. With the deinstitutionalization of thousands of people with mental illness that began in the 1970's and continues through to today, many individuals access mental health care for the first time in county jails and the Tennessee Department of Correction.

Adopting policies and standards that address mental health service needs for persons with mental illness who are incarcerated promotes staff safety, improves the ability to protect people with mental illness, and promotes a safer environment for other inmates.

Standards of Care

The Tennessee Corrections Institute Minimum Standards for Local Correctional Facilities have the following references regarding the care of the people with mental illness in Tennessee jails:

Rule 1400-1-.08(1), Socially, mentally, or physically impaired inmates shall be assisted by staff members in understanding the rules.

Rule 1400-1-.13(5), A more complete examination shall be completed on prisoners within fourteen (14) days of their initial confinement date....this examination shall include....inquiry into current illness and health problems.....inquiry into medications taken and special health requirements...behavioral observation, including state of consciousness and mental status.

Rule 1400-1-.16 (1), All prisoners shall be personally observed by a staff member at least once every hour on an irregular schedule. More frequent observation shall be provided for prisoners who are violent,

suicidal, mentally ill, intoxicated, and for prisoners with other special problems or needs.

The American Correctional Association (ACA), which is more prison than jail oriented, has much more stringent standards regarding the care of inmates with mental illness in a correctional setting. Currently there is only one jail in Tennessee that is fully accredited by ACA. Jails of all sizes, however, can try to meet the intent, if not the letter of the standards with the resources available. Specific areas concerning the care of inmates with mental illness that are addressed in the ACA standards and where jails could begin to focus attention include:

- **Access and Continuity of Care** – when inmates with mental illness are admitted to the jail, they are informed how to access health services, and continuity of care is considered from admission to transfer or discharge from the facility, including referral to community-based providers
- **Mental Health Screening** – all inmates are screened for signs and symptoms of mental illness at the time of admission. The screening should be conducted by mental health trained professionals and should include history of mental illness, history and presence of suicidal ideations, history and presence of prescribed psychotropic medications, history of psychiatric hospitalizations, history of mental health treatment, and current mental health complaints
- **Mental Health Appraisal/Assessment** – inmates should receive a comprehensive assessment of their mental health status within 14 days of admission to the jail. This assessment should include mental status, suicidality (past and present), history of inpatient and outpatient treatment, alcohol and drug issues and history of treatment, educational history, and history of trauma.
- **Mental Health Care Services** – mental health care in jails should minimally include screening for mental health problems, referral to appropriate outpatient services, crisis intervention and management, stabilization of the illness and attempts to prevent psychiatric deterioration, referral and admission to licensed mental health facilities when appropriate, obtaining and documenting informed consent, and mental health services are approved by the appropriate mental health authority.
- **Medication** – inmates with mental illness should have access to psychotropic medications appropriate to treat their disorders. Medication management includes the use of a formulary and medication procurement, storage, distribution, administration, and disposal. Other issues to consider is the cost/benefit analysis of using different classes and/or types of medications, use of potentially addictive medications in the jail, and medications that are being used in the surrounding community and how use of similar or different medications could affect continuity of care issues (both at admission and at release).

- **Suicide Prevention and Crisis Situations** – because suicide is nine times more likely in a jail than in the general population, a suicide prevention program that includes training is essential. A training program on suicide prevention in jails should include identifying warning signs and symptoms of suicidal behavior; responding to suicidal and depressed inmates; communication between correctional and mental health care personnel; and clear policies and procedures on referrals to outside agencies (including inpatient hospitals), use of restraints for psychiatric purposes, housing observation and suicide watch level procedures, and follow up monitoring of inmates who make a suicide attempt or gesture.
- **Housing Inmates with Mental Illness** – Most inmates with mental illness can be appropriately and effectively housed in the general population of county jails. There are circumstances, however, that need to be considered when making a decision regarding the housing placement of the inmate: behavior, vulnerability, medication compliance or abuse, acuity of illness and current level of functioning.

Release Planning

The release of a mentally ill defendant from jail is a critical part of the jail experience. If a continuum of care is developed for offenders when they are released, the chances of re-offending are reduced.

Identifying Community Support

The release plan begins with a complete assessment. Ideally, a mental health professional would complete the assessment. Items that need to be known include:

- What is the client's diagnosis?
- Does the defendant abuse substances and if so, what kind?
- Is the defendant developmentally disabled or mentally retarded?
- Does the defendant have medical problems?
- Does the defendant have family or other community support?
- What is the defendant income level? Do they get disability or can they work?
- Does the defendant get TennCare, Medicare or some other type of health insurance?
- Is there a history of physical and/or sexual abuse?
- Do they have access to safe, affordable housing?
- Do they have case management in the community?
- Where will they receive their medication?

A primary support in the community may begin with the Criminal Justice/Mental Health Liaison. These individuals are trained in the areas of mental health, the jails and community service providers. A promising first step is to get in touch

with your CJ/MH liaison, if there is one in your area. The CJ/MH liaison is also available to provide training for jail staff, law enforcement and attorneys.

A majority of offenders in jails have co-occurring disorders or a diagnosis of mental illness/substance abuse. Proper identification of a client's special needs is key.

Housing

Locating safe, affordable housing for this population is challenging at best. An assessment provides a good overview of what kind of housing would be optimal. Types of housing that exist in the community include:

- **Independent Living** -- For those individuals who are independent and high-functioning, an apartment would be an option provided they can afford one. However, this process could take time and may not be able to be pursued until they are released from jail. Applying for Section 8 is also an option but these vouchers are not always available. As a rule, offenders need to live in another setting, such as a shelter or halfway house while they apply for an apartment. Some cities have housing that is set up to aid only those individuals who are mentally ill or have co-occurring disorders.
- **Halfway House or Recovery House**--For the defendants who have been diagnosed with a co-occurring disorder, a recovery house is a good idea. Recovery houses provide a sober environment for offenders who have an addiction to drugs or alcohol. While living there they can be working on permanent placement elsewhere. The CJ/MH liaison will know of halfway houses in your area. Also, for those offenders coming out of prison the Probation and Parole board provides a list of approved houses. Please contact the Board of Probation and Parole at (615) 741-4543, or email at bop.webmail@state.tn.us.
- **Supportive Living Facilities (SLF)** – For defendants with mental illness that have a significant impairment of functioning, supportive living facilities may be the most appropriate option. These homes provide food, group living situations, and are usually staffed during the day. Defendants who are most appropriate for this living situation would be those who have difficulty caring for their basic needs, such as hygiene, preparing food, cleaning, etc. Board and Care homes can be expensive, and are allowed to adjust their fee based on the person's income, to charge all but \$30 of the defendant's income. To obtain a listing of licensed SLF in your area, please contact your local SETH coordinator (www.tennessee.gov/mental/ohpd/reg_fac_map.html).
- **Homeless Shelters** -- For a defendant who is homeless and has no income, it is best to contact one of the homeless providers in

the community. Many agencies have special programs designed to help homeless individuals.

Day Programs

A referral to a day program is useful in helping to reduce recidivism, and such programs are an appropriate alternative to the employment criteria for probationers. In jurisdictions that have day programs, they serve as a place during the day for specific services. Types of day programs include:

- **Job training centers** -- The client is given the opportunity to learn vocational skills in one area of specialty, for example, restaurant, janitorial and clerical work. Once the client is performing at a reliable level, the center can assist them in getting a part-time job. These centers also offer case management and support meetings for individuals with a co-occurring disorder.
- **Social centers** --These centers offer clients a place to come to for companionship. Clients often play games and go on field trips.
- **Partial Hospitalization or Intensive Outpatient Programs (IOP)** – Although relatively short-term in nature (usually a month to 6 weeks), these programs provide at least 3 days a week of professionally conducted group sessions. Most IOP programs are for persons with co-occurring disorders and provide an entry point into the recovery community.

Release with Medication

Every jail varies in its approach to medication. Many jails may not, as a policy, release offenders from jail with medication. However, it would be poor practice to release a person with mental illness to the community without their medication since they generally cannot get an appointment with a physician right away. Additionally, these inmates are at risk to become psychotic and may quickly reoffend.

Ideally, a designated person/release planner will identify persons with mental illness who are scheduled for release on any given day. The discharge planner should:

- Review the person's "Medication Administration Record" or MAR to determine if the person is taking medication;
- See that the person is released with a certain amount of medication until he or she can see a doctor in the community, ideally in blister packages, when available;
- If the person with mental illness has medication in their property and it is usable, it may be provided as a substitute medication;
- Evaluate any medication the person has in his or her property for current appropriateness;

- Schedule follow-up mental health appointments.

Model Programs

Crisis Intervention Teams (CIT)

Crisis Intervention Teams (CIT) are innovative models of community policing which focus on the most effective and respectful way of resolving mental health crises. There are several jurisdictions across the country that have implemented and are successfully utilizing CIT to aid in the appropriate resolution of police calls involving mental health issues. The model began in Memphis in 1988, when the Memphis Police Department joined with the Alliance for the Mentally Ill to address the needs and problems of a disproportionate number of persons with mental illness who were being incarcerated.

Though the implementation of the model differs from jurisdiction to jurisdiction, there are commonalities that lead to the success of the teams. The participation by officers on the team is voluntary. The duties associated with CIT are in addition to the officer's other duties as patrol officers. Another commonality is partnership with local mental health consumer, family and advocacy groups, mental health providers, and other community resources. The participation of these groups and agencies in the training of officers is key.

Essentially, CIT works by having specialized trained officers on each shift, and usually in each precinct, that will be the first responders to calls involving a mental health crisis. The officer(s) will assess the situation and resolve the situation using mental health tools and techniques, including consulting with the individual's mental health provider, referring the individual to outpatient services, referring the individual to the crisis response team and aiding the individual in accessing inpatient care when necessary.

CIT has resulted in a decrease in the arrest and incarceration rates of people with mental illness. It is a proactive model that promotes the care, welfare, and security of both the individual needing aid, the community at large, and the officers themselves, while providing appropriate and respectful interventions.

Pre-trial Services

Pre-trial services are an alternative to bonding and incarceration in which individuals are released on their own recognizance and diverted to appropriate treatment services rather than held in jail. If a person has minimal prior contact with the criminal justice system and meets several other special conditions (i.e., history of stable housing, strong support system including family, employment, involvement in mental health or substance abuse treatment, etc) they may qualify for release through the Pre-trial Services Program. These special conditions are also weighed with the seriousness of the offense and history of criminal justice involvement.

Often, if a person with mental illness is arrested, Pre-trial Services will be considered assuming their participation in mental health treatment can be verified, and other eligibility criteria is met. Having specially trained Pre-trial

service workers in mental health is essential, so that appropriate conditions of release are determined and the supervision plan can be modified as appropriate. Specially trained staff also aids in accurately identifying qualified participants and encourages appropriate treatment.

Mental Health Courts

Mental Health Courts are effective tools in addressing the “revolving door” phenomenon of a small fraction of people with mental illness who are repeatedly arrested and jailed. Most often these arrests result from manifestations of the person’s mental illness, or are a direct result of the poor coping mechanisms employed by individuals who have mental illness.

Mental Health Courts are specialized court dockets “which employ a problem-solving approach to court processing in lieu of traditional court processing for certain defendants with mental illness.”¹⁶ Most courts share the following characteristics:

- Judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement;
- Regular status hearings at which treatment plans and other conditions are periodically reviewed for appropriateness, incentives are offered to reward adherence to court conditions, and sanctions are imposed on participants who do not adhere to the conditions of participation; and
- Criteria defining a participant’s completion (sometimes called graduation) of the program.”¹⁷

The goals of Mental Health Courts include reducing recidivism of people with mental illness, increasing access to and participation in mental health treatment for this traditionally disenfranchised group, and providing sound, respectful, and effective mental health treatment.

One of the key components of a Mental Health Court is collaboration. It is essential that open communication exists and that criminal justice (sheriffs, judges, prosecutors, defense attorneys, probation officers), mental health, and advocacy groups come together and work as a team toward the common goals of the court. Another component, which is often times overlooked, is outcome data. It is important for the court, jail administrators, and other governmental personnel, as well as mental health professionals, family and participants in the program to see the efficacy of the court and its impact on the overall community. This aids in continued support and viability of the court itself.

Forensic Mental Health Case Management

Case management is a widely used term that has several different meanings, depending on the profession or context in which it is used. For the purposes of this manual, the mental health definition will be used, as it was described in the

¹⁶ The Essential Elements of a Mental Health Court (Third Edition, Draft) p.2.

¹⁷ The Essential Elements of a Mental Health Court (Third Edition, Draft) p.2.

Section on Tennessee's Mental Health Service System. Case management is linkage to appropriate resources and aiding the individuals in accessing various services. Services actually provided by case managers includes:

- Assessment and prioritization of needs
- Service planning
- Crisis response
- Assistance in daily living
- Linkage, referral, and advocacy to other community services
- Monitoring of overall service plan.

When the specialty of forensics is added to case management, the model is only changed slightly. The target population of forensic case management teams are individuals with severe mental illness who are involved in the criminal justice system or who are at risk of arrest. These individuals could have a significant history of arrests and convictions, be on probation or parole, or have significant behaviors that place them at an increased risk for arrest.

Forensic case management is focused on the legal needs of the individual as a primary treatment goal, rather than a passive life domain that may need to be addressed over time. Case managers will actively engage the individual in the legal system, accompany them to court or probation meetings, remind of appointments and conditions of release. The case manager becomes involved in the planning for the completion of conditions required by the court, and is an advocate in the criminal justice system for fair and appropriate treatment and realistic goal setting.

Unfortunately, the population served by forensic case management is extremely marginalized in most communities, and often overlaps with the homeless population as well. It is often difficult to engage these individuals in treatment, due to many factors, including: reporting severe symptoms of mental illness that may preclude trust and rapport building, history of negative experiences in the criminal justice system, as well as some report having had negative experiences with the mental health system in the past. In order to be effective in serving the forensic population, it is necessary that the case managers have small caseloads, so they can spend more time bonding and establishing trust and rapport. These relationships, when built solidly, can be the key to aiding an individual navigate criminal justice system successfully.

Outcome data for forensic case management teams (often called FACT, Forensic Assertive Community Treatment), shows a significant decrease in recidivism rates, as well as a reduction in the severity of offenses, number of offenses, and days spent in jail, if the individual is arrested again.

Jericho Project

A non-specialty court post-booking diversion model for persons with serious mental illness and co-occurring substance use.

The Jericho Project targets individuals with serious mental illness and co-occurring substance use whose level of criminal justice involvement makes them

ineligible for prebooking diversion through other available programs/resources in the area.

Different in concept from many mental health courts, this approach combines quality social work with legal advocacy and is designed for use before all criminal courts. The model is an inexpensive, flexible approach to the complicated problem of post-booking jail diversion and does not require special court resources or dockets.

The Jericho Project offers courts quality alternatives to pretrial detention utilizing an array of supervised, conditional release strategies. At the heart of these strategies is the *Community Linkage Plan (CLP)*, a comprehensive transition plan developed by boundary spanners and tailored to the individual needs of the detainee. Based on the GAINS Center's APIC best practice transition planning model, CLPs address critical domains of service (access to treatment, safe housing, bridge medication, restoration of benefits, transportation, supervision, etc.) with an emphasis on evidence-based integrated treatment for co-occurring disorders. As a voluntary program, CLPs are developed with full defendant input and seek to form a network of supportive relationships that will sustain the consumer and break the recidivism cycle.

The Jericho Project seeks to serve the needs of persons whose contact with the criminal justice system is related to symptoms of untreated mental illness. There are no preset restrictions on eligibility for program consideration other than medical confirmation of serious mental illness and a candidate's willingness to embrace treatment options. Each linkage proposal is judged on its particular merits by the presiding judge after consideration of all relevant case circumstances (charge, arrest history, quality of treatment resources). Judges have approved 95% of all linkage plans presented to date, in the pioneering model in Shelby County (Memphis), Tennessee.

The model is an effective approach to diversion of more serious felony offenders, those facing probation violations and persons with extensive arrest histories who are often excluded under other diversion models. Success during supervised release frequently improves ultimate case disposition, with impact ranging from full suspension of sentence to reduced (or dismissal) of charges. Evaluation data indicates reduced caseload and recidivism, plus increased quality of life and treatment compliance.

Resources

Helpful Websites

TN Mental Health Information

TN Statewide Mental Health Crisis Response Service 1-800-809-9957

TN Dept. of Mental Health/Developmental Disabilities www.state.tn.us/mental

Title 33, Tennessee Code Annotated www.state.tn.us/mental/t33/title33.html

TDMHDD/Office of Consumer Affairs www.state.tn.us/mental/oca/oca2.html

Mental Health Association of TN www.mhatn.org

Disability Law and Advocacy Center of TN www.DLACTN.org

Tennessee Association of Mental Health Organizations www.tamho.org

TN Suicide Prevention Network www.tspn.org

Where To Find Help In Tennessee www.state.tn.us/mental/reslinksabc.html

Bureau of Alcohol and Drug www2.state.tn.us/health/A&D/index.htm

TennCare www.tennessee.gov/TennCare/phonenumbers.html

Disability Law and Advocacy Center of TN www.dlactn.org

TennCare Partners Advocacy Line www.tpal.org

Mental Health Association of TN www.mhatn.org

National Alliance for Mentally Ill – TN www.namitn.nami.org

TN Mental Health Consumer Association www.tmhca-tn.org

Tennessee Voices for Children, Inc. www.tnvoices.org

Tennessee Commission on Children and Youth www.tennessee.gov/tccy

Criminal Justice Information

- Directory of TN Sheriffs, Public Defenders
& Judges www.tbi.state.tn.us/CJ_directory
- Tennessee Department of Correction:
(*Information about state prisons*) www.state.tn.us/correction
- Tennessee Criminal Law:
(*Information about legal issues in Tennessee*) www.tncrimlaw.com
- Tennessee Administrative Office of the Courts: www.tsc.state.tn.us
(*Information about the Tennessee court system*)
- Tennessee Board of Probation and Parole www.state.tn.us/bop
- Office of Criminal Justice Programs
(*Tennessee*) www.state.tn.us/finance/rds/ocjp.htm

National Mental Health and Criminal Justice Information

- National Alliance for the Mentally Ill: (NAMI) www.NAMI.org
- National Association of Rights Protection
and Advocacy:
(NARPA) *National organization to advocate
for civil rights of persons with mental illness*) www.narpa.org
- SAMHSA Center for Mental Health Services information site: www.samhsa.gov
(*Substance Abuse & Mental Health Services Administration
Information about mental health and substance abuse issues and services*)
- National Mental Health Association: www.nmha.org
(*Information about mental health issues*)
- The Bazelon Center for Mental Health Law: www.bazelon.org
(*Information about mental health law
and rights of persons with mental illness*)

The Consensus Project: www.consensusproject.org
*(Information about bridging gaps between
the mental health and criminal justice systems)*

The Institute of Mental Health Law: www.imhl.com
*(Information about mental health legislation
around the world)*

The GAINS Center www.gainscenter.samhsa.gov

U. S. Department Of Justice www.usdoj.gov/

Bureau of Justice Statistics www.ojp.usdoj.gov/bjs

Office of Justice Programs (U.S.) www.ojp.usdoj.gov/

Criminal Justice/Mental Health Liaison Projects

The Criminal Justice/Mental Health (CJ/MH) Liaison Project is a community service that works with the courts, jails, and law enforcement agencies, mental health and community service providers on behalf of adults with mental illness who are incarcerated or at risk of incarceration.

Services include:

- Early identification of persons with mental illness who are incarcerated or in court
- Jail diversion activities: working with the court to facilitate release from jail
- Continuity of care: Assuring consumers are linked with appropriate mental health services while incarcerated
- Release planning and follow-up: making referrals to services on release from jail
- consultation with court officials: to assist with disposition plans
- training and education activities

As of January 2006 there are 18 CJ/MH Liaison projects offering services in 23 counties.

Area	Contract Agency	Contact Number
Madison County, Jackson	Pathways	731-421-4530
Hardeman, Bolivar	Pathways	731-659-3854
Montgomery, Clarksville	Centerstone	931-920-7244
Cheatham, Ashland City	Centerstone	931-920-7244
Dickson, Dickson	Centerstone	615-460-4485
Houston, Dickson	Centerstone	931-920-7244
Humphreys, Waverly	Centerstone	615-460-4485
Stewart, Dover	Centerstone	615-460-4485
Mauzy, Columbia	Centerstone	931-353-0306
Rutherford, Murfreesboro	Volunteer	423-756-2740
Putnam, Cookeville	Volunteer	931-528-8484
Bradley, Cleveland	Volunteer	423-479-5454
Hamilton, Chattanooga	Volunteer	423-634-8884
Sumner, Gallatin	Volunteer	615-452-1354
Anderson, Oak Ridge	Ridgeview	865-481-6170
Washington, Johnson City	Frontier	423-232-4323
Sullivan, Kingsport	Frontier	423-224-1475
Greene, Greenville	Frontier	423-639-1104
Davidson, Nashville	Mental Health Coop.	615-744-7479
Shelby, Memphis	Shelby County Gov't.	901-545-6526
Knox, Knoxville	Helen Ross McNabb	865-329-9194
Gibson, Trenton	Carey Counseling	731-642-0521
Henry, Paris	Carey Counseling	731-642-0521

Each CJ/MH Liaison is assigned to judicial district(s) to ensure availability of statewide coverage for training activities.

If you have any questions or would like to discuss, please contact Liz Ledbetter at 615-741-9137 or e-mail: liz.ledbetter@state.tn.us. For the most updated CJ/MH Liaison

Contact information please go to: <http://www.state.tn.us/mental/cj/cjmhliaisonlist.pdf>

Resource Worksheet

Please copy this page and enter the contact person and phone numbers for each agency available in your area.

Agency	Contact Person	Phone #	Fax#
Sheriff's Office			
Jails	Male		
	Female		
Public Defender's Office			
District Attorney's office			
Court Clerk			
Correctional Mental Health Provider			
Community Mental Health Agencies			
Alcohol and Drug Treatment Providers			
Regional Mental Health Institute			
Other Psychiatric Hospitals			
RMHI Forensic Coordinator			
Outpatient Forensic Evaluator			
Crisis Response Team			
Veteran's Administration			
Homeless Mission			
Other			

Definitions of Common Terms

CJ: Criminal justice term

MH: Mental health term

33-6-404 (MH & CJ): The part of the Tennessee mental health law (Title 33) that deals with involuntarily committing a person to psychiatric hospital on an emergency basis whether or not they want to be there. In order to be put in hospital against their will, all of the following things must be true. The person must:

- Have a mental illness, AND
- Be of immediate danger to self or others, AND
- Need care or treatment because of the mental illness, AND
- Other ways of dealing with the problem will not meet the needs of the person.

One doctor and a Mandatory Pre-Screening Agent or two doctors have to assess the person to see if the points above are true. Only then can the person be committed to hospital.

33-6-406 (MH & CJ): The part of the Tennessee mental health law (Title 33) that requires police or sheriffs officers to transport people to the psychiatric hospital for assessment for admission.

acquit (CJ): a court decision to find the defendant not guilty of a crime

advanced directive (MH): A document written ahead of time when a person is able, telling what actions should be taken if the person becomes unable to make his or her own decisions.

advocacy (MH): Having someone speak in defense, support, and favor of another person.

affect (MH): How a person's emotions look to an observer.

affidavit (CJ): a voluntary written statement of facts that is sworn to be true by the person making the statement.

alcohol and drug, A&D (MH): Services to people with alcohol and drug addiction. The Department of Health's Alcohol and Drug Bureau funds, observes, and evaluates alcohol and drug services.

alleged (CJ): said to be true, but not yet proven.

alias (CJ): another name by which a person is known.

anxiety (MH): Feeling of worry caused by fears of danger.

appeal (CJ): request for another chance to present a case. Appeals can be filed on a conviction, a sentence or rulings on motions affecting the evidence of the case. An appeal can be filed only if the judge did not follow the law or the defendant was prevented from properly exercising his/her rights.

arraignment (CJ): A process by which the court finds out if the defendant has a lawyer; and if not, whether the defendant qualifies for a Public Defender. The judge asks questions, gets written documentation of income and financial resources. If not able to afford a lawyer a Public Defender will be appointed. Lawyer will enter a “not guilty” plea.

arrest (CJ): To take into legal custody. Most arrests happen spontaneously because a police officer has observed a crime or been told that one just occurred. The police officer has the power to arrest the person believed to have committed the crime and take that person into custody. Once arrested, the officer has the right to search the person. If anything illegal is found on the person, those charges will be added to the original ones.

Assessment (MH): An evaluation of an individual at the time of admission to a mental health agency or institution. This usually includes a medical examination, mental health history, alcohol and drug usage, behavior observations, and evaluation of suicide possibility.

attorney (CJ): a lawyer, a professional who presents legal cases.

auditory command (MH): Hallucination in which voices are heard ordering the person to do something.

auditory commenting (MH): Hallucination in which voices being heard in head are talking about the person having them.

behavioral health care (MH): Mental health services

behavioral health organization, BHO (MH): A health insurance organization that is financially in charge of mental health services.

best interest (CJ): There are two approaches to advocating for the client’s best interest. The legal approach is to negotiate the best protection of the client’s legal rights. For example, advocating for the least serious charges or the least possible time in jail or prison. The defense attorney is also bound to advocate for the client’s wishes.

The second approach, the mental health approach is to help the client get the services and resources necessary for recovery and quality of life. Those services might include some time in residential or inpatient treatment to stabilize the client.

Conflict between the legal approach and the mental health approach happens when the client has committed only a minor crime, but is in a serious episode of mental illness.

beyond a reasonable doubt (CJ): The person making a legal decision is fully satisfied that what is said to be proven is true.

blunted, flat, constricted affect (MH): Terms used to refer to emotion not showing as much as would be expected.

Building Recovery of Individual Dreams and Goals through Education and Support, BRIDGES (MH): A program on mental illness and mental health services for consumers of mental health services taught by peer-instructors.

capital punishment (CJ): death penalty, execution. Sometimes sentenced in cases where the alleged offense is first degree murder.

capitation (MH): A method of payment/reimbursement for mental health services in which a mental health organization providing care receives the same amount of money per covered individual per month regardless of the cost of services provided.

case management agencies (MH): Organizations that provide case management services.

case management service plan (plan of care/ individualized service plan) (MH): A plan developed by a case manager to get services and resources necessary to help the person in care.

case manager (MH): A type of mental health care provider that helps get basic human services, such as employment, housing, and social and medical services. The case manager's role is to, 1) assess needs, 2) plan the type of services needed, 3) link the person with those resources, 4) help with crisis, 5) help with activities of daily living, and 6) check overall use of service. Case managers advocate with other service providers for the consumer.

care coordination (MH): Care coordination focuses on people who receive intensive services. The case coordinator, an employee of an insurance company, directs the process of health care delivery by matching the patient to the most appropriate clinician, level of care and intensity of services, and following this patient through the care episode, or until all needed systems are in place.

categorically needy (MH): A term that refers to a person who is automatically able to receive Medicaid due to income and circumstances. (i.e. pregnancy, blindness, TANF recipient, income below 100% of the poverty level, etc.

Center for Medicare and Medicaid Services (MH): The federal agency in charge of public health services.

Center for Mental Health Services (CMHS) (MH): A division of the Substance Abuse and Mental Health Services Administration, the federal agency in charge of mental health services across the nation. CMHS plans, checks, and evaluates services by giving money to state and private agencies. State Mental Health Block Grants are managed by CMHS.

clinically related groups (CRG) (MH): Categories of need for service levels based on an assessment usually performed by a case manager.

community mental health agency (CMHA) (MH): A private, not-for-profit agency that offers mental health services. This agency may focus on a particular age group, sub-population, or type of service.

community mental health center (CMHC) (MH): A private, not-for-profit agency that offers a range of mental health services for all ages and serves the different mental health problems experienced by members of the community.

community mental health services block grant (MH): Federal funds given to states to support complete, community-based services for adults with serious mental illness and children with serious emotional disturbance.

community-based services/ treatment (MH): Services in the community rather than in an institute or hospital. Community services help clients reduce symptoms of mental illness and improve quality of life in the community.

competent to stand trial (CJ): The legal system has very specific standards for judging whether someone is able to stand trial:

- Does the defendant understand the charges?
- Can and will the defendant cooperate with a defense attorney?
- Can and does the defendant understand what will happen if he or she is found guilty?

concrete thinking (MH): A term which means everything said is taken literally.

concurrent review (MH): Insurance term, referring to certain points in a patient's treatment in which progress, treatment setting, and level of treatment are compared to the patient's condition. These reviews are set up at a point in time when the patient may be expected to have made progress.

confidential (CJ): private. Information about the facts of the case are best held private between the defendant and the defense attorney. The exception is when the defense attorney advises telling someone such as a probation officer or a judge.

confidential (MH): Private. The service provider is not allowed to share client information unless the client gives written permission or unless there is an immediate concern of harm to him/herself or others. The court may also order that confidential information be released (see T.C.A. 33-3-104).

consumer (mental health consumer, or primary consumer) (MH): A person who has been diagnosed with a mental disorder who has received mental health services.

consumer-focused (MH): Services that are 1) designed to meet needs of consumers and family members and, 2) place the needs of consumers before the needs of service providers or the mental health system.

contempt of court (CJ): Something done to embarrass the court or get in the way of the judicial process.

continuance (CJ): Postponing a case because the required people are not present at court or a case is not ready to go on to the next step in the legal process. Once the case is ready, it will either go back to the previous step or on to the next.

Continuous Treatment Team, CTT (MH): The group of mental health professionals, including case managers, a nurse and physician, who provide intensive case management and a range of clinical treatment, rehabilitation, and support services. Through clinical management and teaching of coping skills, CTT staff help the consumer achieve the best quality of life. Staff members are available twenty-four hours a day and no consumer is terminated because of failure to agree with a specific service or treatment intervention. Services are provided mostly in the consumer's own environment rather than in an office or clinic.

conviction (CJ): A decision has been made that the defendant committed a crime and must receive punishment.

co-occurring disorders, COD or dual diagnosis (MH): Diagnosis of mental illness combined with another disabling condition such as mental retardation or substance abuse.

court (CJ): A formal legal procedure to decide whether a wrong has been committed.

night court: A pre-arraignment hearing where it is decided whether the person can be released with or without bail, or if the person should be jailed until the court hears the case.

general sessions court: The first court where cases are heard by a judge. There is no jury and no one keeping official court records of proceedings.

Misdemeanors may be settled in general sessions court. Felonies will go on to criminal court unless charges are reduced or dropped, or there is a plea bargain.

misdemeanor court: The general sessions court where misdemeanor cases are heard.

circuit court or criminal court: The place where jury trials are held.

Judges in this court:

- decide on misdemeanor and felony trials;
- accept pleas on all criminal charges;

- decide punishment for persons who plead guilty or are convicted in a jury trial.

supreme court: The highest court in the state (state supreme court) or the nation (supreme court). The supreme court does not hold trials, but reviews decisions made by judges in lower courts to see whether or not they were in line with the constitution and existing laws.

corrections (CJ): the part of the criminal justice system involving jail or prison

Creating Homes Initiative, CHI (MH): A program of the Tennessee Department of Mental Health and Developmental Disabilities, designed to develop and expand permanent housing options and services for people with mental illness.

crisis (MH): A psychiatric crisis, or mental health crisis, is when someone with mental illness becomes upset, confused or excited to the point that he or she is a danger to self or others, or causes a public disturbance.

crisis plan (MH): A document, written ahead of time with the consumer describing the consumer's choices for treatment in case he or she experiences a mental health crisis.

crisis services (MH): Twenty-four hour telephone lines for crisis intervention and mobile crisis response teams. Mobile crisis teams (MCTs) or Crisis Response Teams (CRTs) provide quick response, immediate mental health consultation, and fast evaluation, diagnosis and treatment.

Crisis Response Team (CRT) (MH): See crisis services

cross examination (CJ): the attorney for the opposing side asks questions of a witness.

current situational stressors (MH): Events or people that make it difficult for a person to function in a healthy manner.

custody (CJ): being held under guard.

pre-arraignment custody: being held in a local jail or holding cell before appearing before a court to receive charges for a criminal offense. The first court appearance must take place within 48 hours after arrest. While the defendant is in custody, a probation officer will get information on family and community ties and decide whether person should be released or granted probation. The prosecutor (DA) looks at the criminal record to learn about other offenses and charges against the defendant.

custody (MH): To be responsible for the care of someone.

day treatment (MH): A service consisting of therapeutic activities in a structured and supervised environment, to help a person achieve a better level of functioning. Each day treatment program is designed for a specific population; older adults, addicts/alcoholics, those with mental illness, or those with dual diagnosis.

defendant (CJ): someone charged with a crime in a court of law.

delusion (MH): False belief kept in spite of strong evidence to the opposite.

delusion of control (MH): The false belief that one's will, thoughts, or feelings are being controlled by outside forces.

delusions of grandeur (MH): The false belief that one's importance, power, or identity is greater than it is in reality.

delusion of persecution (MH): False belief that one is being cheated, harassed, or persecuted by someone.

delusion of reference (MH): False belief that the behavior of others refers to them; that events, objects, or other people have unusual meaning. Ex: believing that people on TV or radio are talking to them or talking about them.

Department of Correction (DOC) (CJ): The state department in charge of running prisons and community correction programs.

Department of Health (DOH) (MH): The state department in charge of different public health functions including county health departments, alcohol and drug abuse services, and many public health outreach services.

Department of Human Services (DHS) (MH): The state department in charge of planning, monitoring, and evaluation of social services in Tennessee. DHS provides a wide range of services through offices in each county, and through a network of community contract agencies. DHS is responsible for TANF and Food Stamps programs.

Department of Mental Health and Developmental Disabilities (DMHDD) (MH): The state authority for mental health and developmental disabilities. The different divisions provide a range of prevention, early intervention, education, treatment, rehabilitative and forensic or juvenile court ordered services to children and adults. This department is also referred to as the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD).

diagnosis (MH): Identifying diseases or disorders by their symptoms.

Diagnostic and Statistical Manual, Version IV (DSM-IV) (MH): A complete manual of psychiatric diagnoses by the American Psychiatric Association. DSM describes groups of symptoms that identify each disorder, sometimes including age of onset, gender, prevalence, and genetic predisposition.

direct presentment (CJ): a case is dismissed for lack of evidence, but the lawyers may go back for more information and then present the case directly to the Grand Jury.

discretion (CJ): The right of a police officer to make certain types of choices when on the scene of a crime. Examples: the choice to arrest or not arrest, to fine or not fine.

disciplinary (CJ): If the person gets in trouble in prison, he or she will have to serve extra time over and above the sentence.

discovery (CJ): actions that can be taken by one party to get facts and information about the case from the other party in order to prepare a case for trial.

dismissal (CJ): “Case dismissed” means that there is not enough evidence for the judge to try the case. The attorneys have to go back and gather more information if they want to continue with the case.

disposition (CJ): decision on a case. The defendant may be found:

- not guilty (acquitted), or
- guilty and sentenced to
 - pay a fine,
 - go to probation,
 - go to jail or prison..

district attorney, DA (CJ): An attorney appointed by the county to represent the state. In legal terms, crimes are not officially committed against victims, but against the “peace and tranquility of the state of Tennessee”.

disorientation (MH): Confusion about time, place, person, or current situation.

diversion program (CJ & MH): A program that addresses the needs of a consumer who has been redirected from the criminal justice system, before arrest, before incarceration, or before trial.

docket (CJ): A list of cases to be tried. Cases on the list are heard in court.

bond docket: A list of general sessions cases where the defendant was released on bond.

jail docket: A list of general sessions cases where the defendant was held in jail.

review docket: A list of general sessions cases that have not been resolved on the jail docket and need to be reviewed to see if they need to go to criminal court.

settlement docket: A list of criminal court cases that are reviewed to see if they can be settled or if they need to go to trial.

drop-in center, DIC (MH): Staffed by mental health consumers, these centers provide a place to meet other consumers through social and recreational activities. Peer counseling and peer support activities are usually offered. Frequently drop-in centers are open in the evening and on weekends.

dual diagnosis, or co-occurring disorders (MH): A diagnosis of mental illness combined with another disabling condition such as mental retardation or substance abuse.

Dual Diagnosis Recovery Network (MH): Advocacy organization for people with a dual diagnosis of mental illness and substance abuse.

Dual Recovery Anonymous, DRA (MH): A twelve-step self-help program for people who have a dual disorder of chemical dependency and an emotional or psychiatric illness.

Emergency Community Services Homeless Program (MH): Run by the federal Department of Health and Human Services, this program provides grants to state community action agencies for emergency assistance to homeless people. Up to twenty-five percent of these funds can be used to prevent homelessness for individuals or families who have received notice of evictions, foreclosures and termination of utility services.

emergency shelter grant, ESG (MH): Housing and Urban Development (HUD) grants to state or local governments and to non-profit organizations to convert buildings for use as emergency shelters and for payment of certain operating and social service expenses.

emergency shelters (MH): Shelters for homeless families and homeless adults. These centers are open twenty-four hours a day and provide the following services: 1) protection from the weather and from the streets, 2) basic needs for food, clothing and shelter, 3) identify immediate and long-term needs, and 4) help with formulating a realistic plan by which the individual/family can have the support and skills needed to return to the mainstream community life. Emergency shelters are also used as temporary placements for children who are no longer able to stay in their caretakers' homes. This resource offers minimal structure and programming and is intended for the immediate needs of children for a limited period of time (forty-five days). This type of facility typically does not offer any form of structured therapeutic intervention with the clients it serves.

employment services (MH): Services to help mental health consumers prepare for, obtain, and maintain employment. Services include job assessment and counseling, pre-vocational job readiness, career development, job development, on-the-job training, and on-the-job support to the consumer and the employer.

empowerment (MH): Feeling able to advocate for oneself, one's peers and loved ones. Being able to make a difference in one's life.

escobedo (CJ): Part of the 5th Amendment of the Constitution; where

- The police did not tell the defendant about the right to remain silent,
- The defendant is in custody,
- The defendant has asked for defense counsel that has been denied.

No statement from such an interrogation can be used in a court of law.

euphoria (MH): Intense happiness and sense of well-being.

family members (MH): People who have at least one relative with a mental illness. Family members are sometimes referred to as secondary consumers, because they are concerned with services that are being provided to a family member rather than to himself or herself.

family support program (MH): A program that gives funding that is meant to help people with severe disabilities (including children with serious emotional disturbance) to remain in their homes and communities. Services, which may be funded under this initiative, include the following: respite care, transportation, health-related costs not otherwise covered, mental health services, behavioral training and specialized nutrition/clothing/supplies.

fee for service (MH): The method of paying for medical services where patients, or their insurance companies, pay doctors, hospitals, and health care providers for each service rendered.

felony (CJ): a serious crime that can be punished by a year or more in jail or prison.

flight of ideas (MH): Constant changing from one idea to another.

forensic evaluation (CJ & MH): A psychiatric evaluation ordered by the court to see if the defendant is “not guilty by reason of insanity (NGRI) or if there are other concerns about the defendant’s mental health. A forensic evaluation will determine if the defendant:

- is competent to stand trial,
- was mentally ill at the time of the offense AND did not appreciate that the act he or she committed was wrong.

Forensic evaluations can be done at community mental health agencies or Regional Mental Health Institutes (state psychiatric hospitals). In Tennessee outpatient forensic evaluations must be done within 30 days of the court order and inpatient forensic evaluations must be done in 60 – 90 days. An order for a forensic evaluation will severely slow down the case. The person will wait for a longer time in jail.

good time (CJ): Time served in jail while waiting to get to prison can shorten the prison sentence if the person behaves well and does everything that is required.

grievance procedure (MH): A process by which an organization responds to complaints. All agencies licensed by the Tennessee Department of Mental Health and Developmental Disabilities to provide mental health services, must have a grievance procedure.

guilty plea (CJ): See “plea”

hallucination (MH): Things seen, heard, or experienced that are not real or present.

visual hallucination: sight

auditory hallucination: sounds or voices

olfactory hallucination: smell

tactile hallucination: touch or surface sensation

gustatory hallucination: taste

Health Maintenance Organization, HMO (MH): Prepaid health insurance plans that provide a range of services in return for fixed monthly premiums.

homicide (CJ): the killing of one human being by another. A homicide may be murder or manslaughter, or it might not have criminal intent as in self-defense.

Housing and Urban Development, HUD (MH): The federal agency in charge of regulation and financing of public housing.

Hypochondriasis (MH): Unrealistic or inaccurate explanation of physical symptoms or sensations, leading persons to believe they have serious diseases for which no medical cause can be found.

illness self-management (MH): Client self-education on symptoms and stresses, in order to reduce the need for professional intervention.

illusion (MH): Having a different interpretation of real external sensory stimuli.

indictment (CJ): The defendant has been charged with a crime.

sealed indictment: The defendant is charged with a serious crime and holding a preliminary hearing would weaken the case. The case goes straight to criminal trial.

information (CJ): an accusation against a person for some criminal offense, without having been heard by the grand jury.

information agreement (CJ): A written contract between the defendant and the District Attorney that the defendant will plead guilty to the charge in criminal court and the District Attorney will offer a particular sentence. An information agreement by-passes the grand jury and goes to criminal court arraignment.

inpatient facility (MH): A hospital, or treatment center, where consumers live for a period of time to have treatment.

Insight (MH): Ability to understand true cause and meaning of a situation.

institutional care (MH): Long-term in-patient mental health treatment usually in a state mental health facility.

International Code of Diseases, ICD-9-CM (MH): The international manual of psychiatric disorders. It is comparable to the DSM-IV, which is used in the United States.

Investigation (CJ): the process of discovering the facts of a case.

pre-sentence investigation (PSI): a probation officer gathers information necessary for a judge to decide the sentence of a defendant. The PSI report will include a statement of the facts of the case, the defendant's criminal record, family background, employment history and possibly a statement from the defendant.

jail (CJ): An adult facility run by the county to hold defendants who are awaiting trial or are convicted of a crime with a sentence of less than a year. Some jail inmates, serving sentences longer than a year, are held in jail until they can be transferred to state prison.

Journey of Hope (MH): A program on mental illness and mental health services and a method for facilitating support groups taught by family members to family members.

Judgment (MH): Ability to look at a situation correctly and to act fitting to that situation.

Judgment (CJ): A legal decision made by a judge.

judicial (CJ): having to do with judges and courts.

judicial district (CJ): One of 30 court systems across Tennessee. Each judicial district has its own set of judges, district attorneys, public defenders, and probation officers.

jurisdiction (CJ): the authority by which courts and judges decide cases.

jury (CJ): a group of citizens from the community who are chosen by the government to decide whether or not the defendant should be found guilty of the crime charged against him or her.

Grand Jury: a group of thirteen people that are chosen by the government to look at all of the current criminal cases. The Grand Jury only decides:

- Was the crime committed?
- Is it likely that this person is guilty?

law enforcement (CJ): police or sheriff's officers who keep the peace and come to the scene of the crime.

least restrictive environment (MH): A legal requirement and treatment rule by which consumers are served in the setting that is least limiting to a natural lifestyle while still having enough supports to manage symptoms and effects of mental illness (i.e. a group home is less restrictive than a hospital).

lethargic (MH): When an individual seems to lack energy.

lifetime limit (MH): The maximum amount of money per person an insurance plan will pay for a certain type of service during an individual's lifetime.

loosening of associations (MH): When an individual's flow of thought changes from one subject to another in an unrelated way.

magical thinking (MH): The thinking that thoughts, words, or actions assume power, and can cause or prevent events from occurring.

mainstreaming (MH): Placing consumers back in their homes, jobs, and communities with the help of a community treatment program.

managed care (MH): An insurance term for putting together networks of health care providers and hospitals in order to give people access to quality, cost-effective health care. Services are "bundled" and generally given out as a package at set rates rather than on a fee-for-service basis.

Managed Care Organization (MCO) (MH): Health care organization that is financially in charge of providing range of health services to adults and children. Either Preferred Provider Organizations (PPOs) or Health Maintenance Organizations (HMOs) are in charge of regulating and financing a range of health care in each region in which they operate. MCO's approve level of care, services needed, and length of stay.

Mandatory Prescreening Authority (MH): An agency chosen by the Tennessee Department of Mental Health and Developmental Disabilities to regulate admission to any Regional Mental Health Institute. Mandatory prescreening authorities try to assure the best care for individuals in state mental health institutes. This purpose is to reduce the time for the consumer in the institute, allow the person to return to the community quickly and help the person remain in the community.

Medicaid (MH): A state administered federal medical insurance plan for disabled individuals, the elderly, and children with limited financial resources. TennCare is Tennessee's Medicaid program.

medically necessary (MH): A measure used by insurance companies to decide whether to pay for a service. Services must be needed to maintain the enrollee in the least restrictive environment that is fit for his/her special needs, to prevent unnecessary visits to the hospital, and to improve his or her functioning level and quality of life.

medically needy (MH): A category for Medicaid and TennCare insurance for individuals whose medical expenses are higher than their ability to pay.

Medicare (MH): A federally administered medical insurance plan for people age 65 and older or individuals of any age who receive Social Security Disability Insurance (SSDI).

medication management (MH): This service consists of medication assessment, prescription, and review provided by a physician or a nurse. Medication services also include educating the consumer and family members about the effects of medication and any potential side effects.

mental illness (MH): Term that refers to all diagnosable mental disorders described as mild to severe impairment in thought, mood, or behavior.

Mental Health Association (MH): A national organization that provides education, support, and advocacy on mental health issues. There are chapters of the Mental Health Association in several cities in Tennessee.

Miranda rights (CJ): When taking someone into custody, the police must tell the person:

- that s/he has a right to remain silent;
- that any statement s/he does make may be used as evidence against him;
- that s/he has a right to an attorney;
- that if s/he cannot afford an attorney, one will be appointed if he or she wants one.

misdemeanor (CJ): a crime that is less than a felony, usually with a sentence of less than a year in jail or a fine.

Mobile Crisis Team, MCT (MH): see crisis services.

Mood (MH): The feeling a patient has that is reported by others. For example, depressed, angry, or happy.

mood swings (MH): Changing mood between very happy, depressed, or anxious.

motion (CJ): A written request to the judge from an attorney. A motion usually requests that the judge decide something regarding the case.

discovery motion: a written request from the defense attorney to the court for witness lists, statements, reports and other information about the case.

motion in limine: the motion filed by the prosecutor to bring the case to trial.

Mute (MH): Not speaking, or remaining silent. The inability to speak.

National Alliance for the Mentally Ill, NAMI or NAMI-TN (MH): A nationwide support and advocacy organization mostly made up of family members and mental health consumers.

natural supports (MH): Family, friends, and members of a community who add to the ability of an individual (with or without a mental illness) to have good quality of life.

NGRI: Not guilty by reason of insanity (CJ): A defense in which the defense attorney must prove by clear and convincing evidence that the defendant:

- Because of mental disease or defect'
- Did not appreciate the wrongfulness of the criminal act(s) with which he or she is charged.

nolle prosequi (CJ): a prosecutor's decision not to prosecute the case further. It does not prevent the charge from being brought up at a future time.

normalized (MH): A principle by which services are meant to help the consumer have a lifestyle that, as much as possible, is like that of other citizens of the community.

outcomes (MH): Criteria to rate the success of services that look at whether services make a difference in an individual's life.

outpatient intake and counseling (MH): This service includes intake and assessment of people new to the mental health system, as well as individual or group counseling, and outpatient forensic evaluation services.

panic attack (MH): An acute, intense attack of anxiety linked with feelings of dread. Symptoms may include shortness of breath, heart throbbing, sweating, dizziness, fear of dying of a heart attack, fear of "going crazy," or "losing control."

parity laws (MH): Both state and federal laws make insurance companies remove barriers and limitations to accessing mental health care. Mental health services are to be delivered with equal co-payments and service limitations as for general health care. This may not apply to all behavioral health conditions, as alcohol and drug treatment has strict limitations on amount of inpatient and outpatient per year and per lifetime.

parole (CJ): The supervision of someone who has returned to the community after serving a sentence in state prison. Parolees must report to a parole officer and comply with specific conditions set by the parole officer. If the person violates any condition of parole, the parole officer can arrest the person immediately. The person will be sent to jail awaiting hearing on whether parole violation occurred, and the person could be sent back to prison.

phobia (MH): Heightened fear of a specific type of situation. Some phobias include:

specific phobia: fear of object or situation; spiders, snakes, etc.

social phobia: fear of public embarrassment; public speaking, eating in public places, etc.

agoraphobia: fear of being around other people.

plaintiff (CJ): the person who first brings a charge against the defendant in court.

plea (CJ): a defendant's answer to the charge brought in court when the defendant confesses to doing the crime.

guilty: The defendant admits to committing the crime. When pleading guilty the defendant gives up the right to trial, to confront witnesses and to remain silent. There is no appeal for a guilty plea.

not guilty: a plea entered when:

- The defendant claims not to be guilty of the crime,
- The defendant is not sure which plea to enter
- There is not enough evidence to prove guilt, OR
- The defendant wants to stand trial.

nolo contendere (no contest): a plea entered when the defendant does not admit guilt, but the judge finds the person guilty. The person gives up the right to a trial, to confront witnesses and to remain silent.

plea agreement, plea bargain (CJ): The district attorney agrees to reduce the charge, dismiss some or all charges, or recommend a sentence in return for a plea of guilty or nolo contendere.

pre-admission review (MH): Given for insurance purposes, this is the first assessment of a patient before hospital admission or treatment. The factors looked at in this review include diagnosis, how severe the illness is, and how appropriate the match of treatment to patient needs.

pre-admission screening and annual resident review, PASARR (MH): A federal law stating that anyone who applies for admission to a nursing home with a diagnosis of mental illness, mental retardation, or developmental disability, must be evaluated to see if nursing home care is fit for the person or if the need for specialized services is greater than the need for nursing home care.

Preferred Provider Organization, PPO (MH): A health insurance term referring to an organization of care providers and hospitals that agrees to provide a discount on their service to an insurance company or employer.

pre-release center (CJ): an incarceration facility where inmates can leave during the day to work at a regular job.

pressured speech (MH): Rapid speech that is increased in amount and difficult to interrupt.

presumption of innocence (CJ): the principle used in the first stage of the criminal process that a person is thought to be innocent until proven guilty.

pre-trial release or pre-trial diversion (CJ): Alternative mainly for first offenders. To be accepted for pre-trial diversion, the defendant must be screened by the sheriff's department, recommended by the district attorney and accepted by the judge. Pre-trial release places people on probation without any finding of guilt. If probation is completed the charge is dismissed. If probation is violated the defendant goes back to court.

priority population (MH): Persons who have been found to be in special need of intensive mental health services.

prison (CJ): a facility for incarcerating individuals with felony convictions.

state prison: a facility for incarcerating individuals whose sentence is more than 6 years.

federal prison: facilities for the incarceration of inmates who have been sentenced to imprisonment for Federal crimes and the detention of individuals awaiting trial or sentencing in Federal court.

probable cause (CJ): having more evidence for than against

probation (CJ): Probation is a sentence where a person lives in the community, but must do what is ordered by the court and must report to a probation officer for a certain amount of time. If the person does not do what is required, the court may send out an arrest warrant. The judge will decide whether to continue probation or sentence the defendant to incarceration.

Program for Assertive Community Treatment, PACT (MH): An intensive community based program with case management, medication management, therapy and supported employment for persons with serious mental illness.

Projects for Assistance in Transition from Homeless, PATH (MH): Federally funded projects with two goals: 1) to identify mentally ill homeless persons in the state and, 2) to provide for these individuals necessary and appropriate services.

prosecutor (CJ): The lawyer hired by the government to prove that the defendant committed the crime. The prosecutor is also called a District Attorney (DA).

psychiatric (MH): Having to do with mental and emotional disorders.

psychosis (MH): When an individual is not able to tell the difference in reality and fantasy. This person may experience hallucinations or delusions.

psychosocial center (MH): An agency that provides rehabilitation services, including socialization, employment, and housing support.

psychosocial rehabilitation (MH): Helps consumers with employment, housing, and social skills. Consumers take an active part in planning their services, and participate in activities to help run the psychosocial center.

public mental health system (MH): Mental Health services funded partially or fully by state or federal dollars.

quality assurance (MH): The process of evaluating the quality and appropriateness of services.

reasonable doubt (CJ): see “beyond a reasonable doubt”.

Regional Mental Health Institutes, RMHI (MH): Regional psychiatric hospitals owned and operated by the Tennessee Department of Mental Health and Developmental Disabilities.

rehabilitation (MH): A type of service that seeks to help the client return to healthy daily living in employment, independent housing and natural social supports.

representative payee (MH): An individual who receives and manages a benefit check on behalf of the recipient. The representative payee is to make sure that the recipient's basic expenses are paid out of the benefits check.

residential services (MH): Housing and services to prepare individuals for more independent living in the community. This service also refers clients to housing developers, HUD housing supplement and permanent housing supplements. These services help consumers access safe and affordable housing, including supervised and unsupervised housing, group living and independent apartments.

respite service (MH): Services to provide a safe environment and staff support for individuals who cannot stay in their homes during a mental health crisis, and who otherwise might be hospitalized. These might include foster family-like placements, a bed in a board and care home, or support for a volunteer-staffed apartment. Respite services must be planned through a crisis response team.

restitution (CJ): A requirement for a convicted criminal to pay money to the victim or victim's family. If the criminal is in prison he or she will be required to work and give money earned to the victim.

restraining order (CJ): A legally binding requirement from a judge that one person may not be in the presence of, or communicate with, another person.

revoke (CJ): to take something away such as privileges

Safety Net (MH): A system of limited health and mental health services available to TennCare disenrollees. Information about health services is available at 1-800-722-7474, about mental health services at 1-800-758-1638.

Section 8 (MH): A federal program in which low income applicants get certificates to pay the difference between twenty five percent of their income and the monthly rent charged to their home. Some Section 8 dwellings were built for the purpose of providing low-income housing and are on fifteen-year contracts. Some Section 8 dwellings are existing units where the landlord agrees to accept federal subsidy as part of the rent.

self incrimination (CJ): things said or done by a defendant that would give evidence that he or she had committed a crime. The 5th Amendment of the U.S. Constitution and Article I, Section 9, of the Tennessee Constitution, states that a government cannot require a person to be a witness or give evidence against himself or herself.

sentence (CJ): the punishment of a guilty defendant decided on in a court of law.

sentencing hearing: court appearance where a judge decides the punishment for someone who has been determined to be guilty of a crime.

split sentence: the defendant is locked in jail for a period of time, then is on probation.

service provider (MH): Term used to describe an agency or individual who provides placement, treatment, or rehabilitation to an adult, child, or family.

settle (CJ): to make an agreement outside of the court between the prosecution (district attorney) and defense in order to avoid trial.

settlement (CJ): An agreement between the defendant and the prosecutor that the defendant will accept a particular sentence in order that the case will not go to trial.

settlement docket: A court procedure where a defendant can enter a plea if defendant, and prosecutor have reached a settlement agreement. It is the defendant's decision whether to enter a plea or take a case to trial. The defense attorney gives advice, but cannot make the choice for the defendant.

Severe and Persistent Mental Illness, SPMI (MH): A diagnosable mental disorder that, if left untreated, would seriously limit a person's ability in self-care, social relations, work or school. These disorders often result in impairment of one or more major life activities such as self-care, social interaction, or employment. The term SPMI is designated for people who are eighteen years of age or older.

Social Security Disability Insurance, SSDI (MH): Income and medical benefits given through Social Security to a person over the age of twenty-one who has paid enough years of social security for coverage (roughly half the years since age twenty-one) or to the dependent of a retired, disabled, or deceased worker. To qualify for SSDI the individual must be: 1) medically disabled or the dependent of a disabled worker, and 2) not working, or if working, earning less than \$700 per month.

special needs (MH): The needs of disabled people for goods or services in order to do major life activities.

state (CJ): legal term used in a court of law to describe the government, whether local, state or federal

State Mental Health Planning Council (MH): Also known as the Tennessee Mental Health Planning Council, is a group of citizens that serves as an advisor to the Department of Mental Health and Developmental Disabilities to do the following: 1) to review the annual plan for community mental health service, 2) to advocate for adults with serious and persistent mental illness and children with serious emotional disturbance, and 3) to monitor, review and evaluate the allocation and adequacy of mental health services within the state. The State

Planning Council is the central coordination point for the Regional Mental Health Planning Councils.

stigma (CJ) (MH): The quality of being marked, or isolated, for a condition considered by society to be socially undesirable.

stupor (MH): The condition of tiredness, not being responsive with some or total unconsciousness.

subpoena (*suh-pee-na*) **(CJ):** a written order to appear in court at a particular time and place.

Substance Abuse and Mental Health Services Administration, SAMHSA (MH): The federal agency charged with improving prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

suicidality (MH): A term referring to thoughts, plans, actions, and/or attempts of suicide.

Supplemental Security Income, SSI (MH): Income and medical benefits given through Social Security to aged adults and blind or disabled adults and children who have limited income and resources. People who receive SSI automatically receive Medicaid (TennCare).

symptom management (MH): Symptom management includes ongoing monitoring of consumer's mental illness symptoms, studying the persons response to treatment, helping with developing coping skills, and consultation with significant others to promote understanding of mental illness. Services designed to alleviate problems caused by consumers dropping out of traditional mental health services. These services are provided in the consumer's home or workplace.

Temporary Assistance to Needy Families, TANF (MH): Time limited welfare payments to families based on income and the number of children in the home under the age of eighteen.

TennCare (MH): The insurance plan for public health care in Tennessee using a managed care approach. TennCare was developed to replace Medicaid and to expand health insurance coverage to Tennesseans who were uninsured or uninsurable. Currently it is only available to those citizens who receive SSI, and therefore Medicaid. This program is currently being redesigned and eligibility criteria may change over time.

TennCare Consumer Advocacy Line (MH): A statewide toll free telephone service to help TennCare enrollees access necessary health care. The number is 1-800-722-7474.

TennCare Partners Program, TCPP (MH): The program, which provides mental health services to individuals in Tennessee via managed care (TennCare).

TennCare Partners Advocacy Line, TPAL (MH): A statewide toll free telephone service to help people who are enrolled in TennCare Partners Program get needed mental health care. The number is 1-800-758-1638.

TennCare Standard, TCS (MH): The TennCare program for a person who cannot receive Medicaid. A person who is on TennCare Standard is one of the following: 1) uninsured, 2) uninsurable, or 3) medically eligible. Most individuals in this category have been disenrolled from TennCare, but may qualify for Safety Net services.

Tennessee Association of Mental Health Organizations, TAMHO (MH): The statewide organization of community mental health agencies.

Tennessee Code Annotated, TCA (MH): A listing and description of current state laws in Tennessee.

Tennessee Mental Health Consumers Association, TMHCA (MH): A self-help and advocacy organization composed of and advocating for consumers of mental health services in Tennessee.

testify (CJ): to speak in a court of law.

therapist (MH): A person skilled in a particular type of counseling for mental health issues.

thought broadcasting (MH): Delusion that one's thoughts can be heard by others, as though the thoughts were broadcast into the air.

thought insertion (MH): Delusion that one's thoughts are being implanted in one's mind by other sources or people.

thought withdrawal (MH): Delusion that one's thoughts are being removed from one's mind by other people or forces.

tic (MH): The continual, irregular muscle twitch or spasm, often the facial muscles.

transitional services (MH): Transitional services include independent living programs, counseling and case management. Youth can transition from the children's case management system to the adult case management system.

treatment plan (MH): An individualized program or method worked out ahead of time to meet goals of services and therapy.

trial (CJ): a procedure where the facts of a case are examined by a judge in a court of law.

bench trial: a judge decides the defendant's case without the help of a jury.

jury trial: a judge presides and people from the community decide whether or not the defendant is guilty.

utilization review, UR (MH): An insurance term, this process evaluates the need for resources used in treatment. Utilization review should balance the clinical needs of patients with the larger public need for appropriate use of available resources. (Also known as Utilization Management)

V Codes (MH): From the DSM IV, conditions that are not due to a mental disorder but need mental health treatment, such as problems with school or marriage.

voir dire (CJ): "To speak the truth." Attorneys for the defense and prosecution question people waiting to be chosen as jurors to decide who will give the case a fair hearing at a trial.

waiver (MH): An agreement through which regulations are relaxed to better meet the need/spirit of the law.

warrant (CJ): a legal notice to the police that someone should be sought and arrested.

There is no time at which a warrant expires until the person is brought into legal custody.

witness (CJ): someone who knows facts about an alleged crime.

eye witness: someone who has seen someone commit the crime or part of the crime.

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