Tennessee Department of Mental Health and Substance Abuse Services Planning and Policy Council
2025 Needs Assessment Summary

Identifying the most relevant behavioral health needs of Tennesseans is essential to the activities of the Tennessee Department of Mental Health and Substance Abuse Services (herein referred to as "TDMHSAS" or "Department"). TDMHSAS ensures that the most relevant needs are prioritized by asking the Statewide and Regional Planning and Policy Councils to complete an annual Needs Assessment. Each Spring, the seven Regional Planning and Policy Councils as well as the Statewide Planning and Policy Council's Committees (Adult, Children's, and Consumer Advisory Board) work independently to identify needs, data, available resources to address the need, and to prioritize one to three mental health and one to three substance abuse needs. Each identified need is supported by data supplied by the council or committee that identified the need and is submitted to the Department. Information from each Statewide Committee and Regional Planning and Policy Council is gathered, and a Needs Assessment summary is compiled. This summary is then shared with TDMHSAS leadership and assists in the development of the Department's Three-Year Plan.

TDMHSAS has created or expanded programs to address needs identified in this document in the past and on an ongoing basis and provides an update regarding its efforts to address needs identified through the annual needs assessment on a regular basis.

Regional Council	Priority	Category	Regional Council 1 Needs Assessment
Region 1	1	Mental Health	**Need:** Enhance workforce development to address shortages among therapists and other licensed mental health professionals in Region 1.
			Data: According to the Center for Disease Control's (CDC's) ranking of U.S. cities with the highest prevalence of depression, Tennessee has four (4) cities in the top 50 with Kingsport/Bristol (Region 1) ranked number two (2) in the country. Despite this need, the area has some of the lowest ratios of population to mental health providers. Per the County Health Rankings website, there are 320 people for every one (1) therapist in the U.S. However, in Region 1, seven of the eight counties have worse ratios with the highest being in Hancock County where there is one therapist to every 6,850 people. In Mental Health America's (MHA's) 2024 State of Mental Health in America Report, Tennessee ranked 10th in prevalence of mental illness and 9th in limited access to care. Recent events such as the devastation from Hurricane Helene have only continued to exacerbate the need for mental health treatment within the region. In 2022, the Health Resources and Services Administration (HRSA) projected that the demand for mental health services within the U.S. will increase by 58% by the year 2037 while the number of mental health providers will decrease. Without change, the projection estimates that by 2037, only 57% of the needs within the country (51% in Tennessee) will be met.
			Available Resources to Address Need: TDMHSAS continues to focus efforts on workforce development through bonuses. However, these bonuses are helpful with retaining current staff, but not expanding the workforce. There are also scholarships available to bring more individuals into the behavioral health field, however, funds are limited and salaries within the region upon graduation do not encourage graduates to stay.
	2	Mental Health	**Need:** Expand transportation resources within the region (particularly the Appalachian area) that will address the needs of its residents (those experiencing poverty as well as living in mountainous terrain that is often inaccessible to healthcare services).
			Data: Transportation is a barrier for many throughout rural communities of Tennessee. However, the Appalachian area faces unique health gaps,starting with the limited number of health care providers in the area. In 2020, the Kaiser Family Foundation (KFF) reported only 13.2% of the need for psychiatrists are being met in Tennessee. Many of the counties in Region 1 have a disproportionate ratio of mental healthcare providers in their local area. For this reason, many living in rural areas are required to travel longer distances for care. Unfortunately, poverty as well as a lack of adequate transportation prevents residents from accessing mental health resources.

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Regional Council	Priority	Category	Regional Council 1 Needs Assessment (continued)
Region 1	2	Mental Health	**Data (continued):** The County Health Council of Region 1 has also identified limited transportation resources as a leading barrier to healthcare in their local community needs assessment. For example, 56% of residents in Unicoi County surveyed stated transportation is a major problem in the area and ranked this as their top priority for improving the quality of life. **Available Resources to Address Need:** Local Human Resource Agencies (HRA) and Make A Way Transport.
	1	Substance Abuse	**Need:** Increase the number of available affordable housing options for persons with co-occurring disorders (CODs) including those who are affiliated with the criminal justice system. **Data:** The Continuum of Care (CoC) Point-In-Time (PIT) Count in 2024 reflects a large percentage of homeless individuals placed into two primary categories: individuals suffering from severe mental illness (SMI) (245) and individuals diagnosed with substance use disorder (SUD) (270) (Appalachian Regional Coalition on Homelessness (ARCH)). Within the region, the number of homeless individuals affected by SMI and/or SUD continues to increase. In February 2024, the Northeast Tennessee Association for Realtors (NETAR) reported the Kingsport-Bristol TN/VA Metro area ranked in the Top Ten Price Report, documenting a 19.2% increase in home median values year after year. The average median selling price for homes in the Tri-Cities metro at the beginning of 2025 was $355,082, far exceeding an affordable monthly mortgage payment for individuals dependent upon limited income. According to the National Low-Income Housing Coalition (NLIHC's) the Gap report for 2024, Tennessee has a shortage of 121,810 rental homes that are both affordable and available for extremely low-income renters. Renters are paying more than 30% of their monthly income toward rental costs. A renter receiving the state's $7.25 minimum wage rate would need to work 115 hours a week to afford a modest one-bedroom rental home at the state's Fair Market Rental (FMR) rate, and individuals who qualify for rental assistance provided through the Department of Housing and Urban Development (HUD) face long wait lists. **Available Resources to Address Need:** Community Targeted Transitional Service (CTTS); Inpatient Targeted Transitional Services (ITTS); Intensive Long-Term Support (ILS); Creating Homes Initiative (CHI); Kingsport Housing and Rural Authority (KHRA); and Johnson City Housing.
	2	Substance Abuse	**Need:** Expand transportation resources within the region (particularly the Appalachian area) that will address the needs of its residents (those experiencing poverty as well as living in mountainous terrain that is often inaccessible to healthcare services). **Data:** Transportation is a barrier for many throughout rural communities of Tennessee. However, the Appalachian region faces unique health gaps starting with the limited number of health care providers in the area. In 2020, the KFF reported only 13.2% of the need for psychiatrists are being met in Tennessee. Many of the counties in Region 1 have a disproportionate ratio of mental healthcare providers in their local area. For this reason, many living in rural areas are required to travel longer distances for care. Unfortunately, poverty as well as a lack of adequate transportation prevents residents from accessing behavioral health resources. The County Health Council of Region 1 has also identified limited transportation resources as a leading barrier to healthcare in their local community needs assessment. For example, 56% of residents in Unicoi County surveyed stated transportation is a major problem in the area and ranked this as their top priority for improving the quality of life. **Available Resources to Address Need**: Local Human Resource Agencies (HRA) and Make A Way Transport.

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Regional Council	Priority	Category	Regional Council 2 Needs Assessment
Region 2	1	Mental Health	**Need:** Increase "brick and mortar" housing options and continue supported services and operational funding to new and existing housing for those with mental health disorders to include group home living, supportive living apartments, and congregant independent living options across the state. **Data:** In 2023, approximately 10.5% of all individuals served by TDMHSAS were homeless or living in a shelter, which is up from 8.4% in 2021 and more than double the 4.4% national average among those served by state mental health departments. The United Way's ALICE (Asset Limited, Income Constrained, Employed) Report for Tennessee (2023) states "household costs are compared to household income to determine if households are below the ALICE Threshold. This includes both households in poverty, with income below the Federal Poverty Level (FPL), and those that are ALICE, with an income above the FPL but below the cost of basics." The ALICE Household Survival Budget represents the bare minimum cost of the household basics needed to live and work in the modern economy by household composition, in every county. FPL for a single adult is calculated at a monthly total of $1,073 and an annual total of $12,880. ALICE for a single adult is calculated at a monthly total of $2,098 and an annual total of $25,176. The average monthly amount of Supplemental Security Income (SSI) checks is $943. (SSI Federal Payment Amounts for 2024 www.ssa.gov). According to the ALICE Report, the average cost of rent and utilities, in 2021, for a single person household averaged around $2,000/month. The NLIHC tracks housing cost burden and available affordable housing by state, and in Tennessee as of 2022, 23% of renters making between 81% and 100% of area median income (AMI) were cost burdened. This means individuals spend 30% or more of their income on housing and utilities. Nearly half (47%) of renters making between 51% and 80% of AMI were cost-burdened (https://nlihc.org/gap/state/tn). Currently, Knoxville-Knox County has 357 units of Permanent Supportive Housing (PSH). However, these housing units do not have the capacity to meet the needs of the community's most vulnerable as they do not employ medical staff, cannot administer medication, and cannot provide the level of support needed for residents to age-in-place like an assisted living or skilled nursing facility. Support services including case management, mental health counseling, and job training are integral to the well-being of individuals in recovery. These services provide the necessary resources for individuals to thrive in permanent housing and reintegrate into the community. Operational funding for recovery residences, including salaries for qualified staff and funding for these support services, is equally crucial. Without sufficient resources to maintain these services, residences can struggle to meet the complex needs of individuals, potentially leading to relapse of symptoms and housing instability. **Available Resources to Address Need:** There are several Homeless Coalitions that are working towards affordable housing options, including for individuals with SMI. Additionally, Knoxville/Knox County has established an Office of Housing Stability, and Region 2 has a CHI Housing Facilitator and a CHI 2.0 Housing Facilitator.

Regional Council	Priority	Category	Regional Council 2 Needs Assessment (continued)
Region 2	2	Mental Health	**Need:** Increase the proportion of mental health providers per population in Region 2, ideally to approach the national average of one mental health provider for every 340 individuals.
			Data: According to the 2024 State of Mental Health in America Report, in Tennessee, there is one mental health provider for every 560 people. Tennessee ranks 42nd overall, with generally higher rates of mental illness and lower rates of access to care. Additionally, Tennessee ranks 43rd for access to care, 46th for youth (with a higher prevalence of mental illness and lower rates of access to care), and 46th for mental health workforce availability. The HRSA reports that every county within Region 2 is a shortage area for mental health providers. The Tennessee Association of Mental Health Organizations (TAMHO) 2019 white paper "All Hands On-Deck: Tennessee's Mental Health Workforce Shortage," estimates the number of mental health professionals needed to meet the demand for services in Tennessee are at least 550 psychiatrists, 600 mental health counselors, 900 psychologists, and 1,730 clinical social workers. The National Council on Mental Wellbeing reports that 57% of people who earn master's degrees in mental health face financial, time, and regulatory barriers to clinical licensure that may force them to walk away and never become licensed.
			Available Resources to Address Need: TDMHSAS has been working to increase reimbursement rates and support the mental health workforce shortage in various ways, which is much appreciated.
	3	Mental Health	**Need:** Improve recruitment and retention of mental health care providers for children and youth.
			Data: The 2024 State of the Child Report reveals that among all households with children in Tennessee, one (1) in nine (9) reported a child in the home needs mental health treatment, most reported among the highest income earners. Of households reporting a child needing mental health treatment, 64% reported all children needing treatment had received it. Of all who needed treatment, one (1) in five (5) found it very difficult to get treatment, were unable to do so, or did not try. Those making $100,000-$149,000 in annual income reported the most difficulty obtaining treatment, with 43% reporting it was very difficult. Among Tennessee youth with a major depressive episode (MDE) in the last year, 62% did not receive any treatment. Tennessee ranks 39th on this measure among youth (the national average is 56.1%). Additionally, according to the 2024 State of the Child Report, all measures of suicidal ideation among Tennessee high school students have been increasing since 2017. In 2023, Tennessee had a slightly higher rate of high school students considering suicide as compared to the rest of the nation.
			Available Resources to Address Need: TDMHSAS has been working to increase reimbursement rates and support the mental health workforce shortage in various ways, which is much appreciated.

Regional Council	Priority	Category	Regional Council 2 Needs Assessment (continued)
Region 2	1	Substance Abuse	**Need:** Increase the number of permanent, stable housing opportunities and support services for individuals with SUD transitioning from recovery programs.
			Data: Individuals with SUD often face significant housing instability, which can be a barrier to long-term recovery efforts. In 2022, 48.7 million people aged 12 or older within the United States had an SUD. The Substance Abuse and Mental Health Services Administration (SAMHSA) includes access to a stable and safe place to live as one of the four major dimensions of recovery. Research shows that stable housing is directly associated with improved treatment outcomes and reduced relapse rates. Without access to permanent, stable housing after completing a recovery program, individuals are at a higher risk of returning to unsafe environments that may trigger relapse and potentially further drug overdose deaths (https://opioidprinciples.jhsph.edu/how-stable-housing-supports-recovery-from-substance-use-disorders/). In addition to limited affordable housing options, many individuals leaving a recovery program may encounter other housing barriers such as poor credit history, insufficient income, and lack of rental references frequently disqualify individuals from housing opportunities. Past criminal charges, which are common among individuals with SUD, further reduce their chances of approval, as many landlords and property managers have strict policies against renting to individuals with a criminal record (https://nlihc.org/explore-issues/why-we-care/solution). Though the CHI aims to address some of these challenges, the growing demand continues to outpace availability, leaving many recovery program graduates without stable housing. Expanding affordable housing opportunities and removing common barriers is crucial in fostering long-term recovery and reducing the risk of homelessness or relapse among individuals with SUD. Additionally, it is critical to recognize that housing alone is not enough to ensure successful recovery outcomes. Support services including case management, mental health counseling, and job training, are integral to the wellbeing of individuals in recovery. These services provide the necessary resources for individuals to thrive in permanent housing and reintegrate into the community successfully. Operational funding for recovery residences, including salaries for qualified staff, and funding for these support services is equally crucial. Without sufficient resources to maintain these services, recovery residences may struggle to meet the complex needs of individuals, potentially leading to relapse. Ensuring that recovery housing programs receive adequate operational funding is key to sustaining these essential services and improving long-term recovery outcomes.
			Available Resources to Address Need: CHI, CHI 2.0, and CHI 3.0.
	2	Substance Abuse	**Need:** Increase access to substance use treatment and recovery supports, specifically for populations with no income, low income, and/or no insurance including youth who want to quit vaping.
			Data: For many individuals with low income, no income, and/or no insurance, accessing SUD treatment options is limited. Per the report of Region 2 Planning and Policy Council members who also represent the Metro Drug Coalition in Knoxville and Project Lifeline, the lack of recovery options for the uninsured/underinsured population is a barrier faced daily leading vulnerable individuals to endure long waiting lists for treatment and relapsing. For example, Lifeline Coordinator for Region 2 reports seeing many unhoused individuals seeking SUD treatment.

Regional Council	Priority	Category	Regional Council 2 Needs Assessment (continued)
Region 2	2	Substance Abuse	**Data:** However, due to limited options within Region 2, these individuals are often referred out to Buffalo Valley or Centerpointe. If transportation needs cannot be met, they end up not receiving treatment and going back to square one. The 2023 National Survey on Drug Use and Health (NSDUH) shows that people aged 12 or older who were classified as needing substance use treatment in the past year, about one (1) in four (4) (23.6% or 12.8 million people) received substance use treatment in the past year. Among those aged 18 and older who needed treatment but did not get it, 38.7% said they did not know how or where to get treatment, 42.4% said they thought treatment would cost too much and 31.9% said they did not have health insurance coverage for alcohol or drug use treatment. The most common reason given, at 74.1%, was that individuals thought they should have been able to handle their alcohol or drug use on their own. The 2023 NSDUH data dashboard estimates that 15.85% of Tennesseans aged 12 and over had an SUD in the past year. Region 2's Children and Youth Subcommittee has also identified a very specific need for recovery support for children and youth who are quitting vaping. The Tennessee Advisory Commission on Intergovernmental Relations (TACIR) Youth Vaping Research Plan (approved in May 2024) offers an excellent summary of the issue. "Vaping went from being virtually nonexistent in the last decade to 18% of high school students in Tennessee by 2023, versus 10% nationally."
			Available Resources to Address Need: Detox for adolescents is limited with only one option in the state. There are limited outpatient providers that offer SUD services for adolescents.
	3	Substance Abuse	**Need:** Enhance workforce development strategies within substance use treatment facilities to recruit and retain staff while also incorporating opportunities for peer support staff.
			Data: By 2037, the HRSA predicts a national shortage of 113,930 addiction counselors. Similarly, the National Association of Addiction Treatment Providers (NAATP) identifies the average turnover rate at substance use treatment programs as 30% to 60%, with top employee concerns being income and benefits, work-life balance, and contributing to the organization's mission. The top factors associated with addiction counselor turnover include ambiguous mission, poor compensation, and poor quality of clinical supervision. With high turnover rates and a shortage of qualified workers, the substance use treatment field faces significant staffing challenges that can negatively affect operations. Additionally, SAMHSA recognizes the importance of integrating peer support into treatment as "peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process."
			Available Resources to Address Need: TDMHSAS has been working to increase reimbursement rates and support the mental health workforce shortage in various ways, which is much appreciated. TDMHSAS' Certified Peer Recovery Specialists (CPRSs) are available to expand into substance use treatment settings.

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Regional Council	Priority	Category	Regional Council 3 Needs Assessment
Region 3	1	Mental Health	**Need:** Increase Individual Placement and Support (IPS) funding and expand options to pair with the number of Crisis Stabilization Unit (CSU) admissions. **Data:** There is a need for additional IPS resources for individuals that utilize CSUs due to the increased risk of employment/wage loss. The duration of CSU stays, while extremely vital to stabilization, can be disruptive to employment and stability in the community upon discharge. IPS Supported Employment services offer individuals living with a mental illness supportive programming to help them obtain living wages through successful employment. According to published data from the TDMHSAS Employment Works Report, in 2024, participation within the program increased by 24%. However, Region 3 currently only has three IPS providers to serve the 23 counties. Comparing this information with data from the TDMHSAS Fast Facts Portal, in FY 2023, Region 3 had 1,347 Regional Mental Health Institute (RMHI) admissions, 3,127 walk-in center (WIC) contacts, and 10,805 total mobile and WIC assessments. Additionally, the Behavioral Health Safety Net (BHSN) served a total of 6,629 individuals within the 23 counties of Region 3 in 2024. While no formal data has been collected to fully realize the impact of job loss for individuals living with SMI that utilize CSU resources, IPS data estimates a cost savings to communities of $16,000 per person in treatment within the workforce, as compared to individuals that stay out of the workforce. Additional resources available upon discharge from a CSU to maintain/obtain employment can provide stability and support so that recipients of these services can thrive within their communities. **Available Resources to Address Need:** IPS and CSU programs are available, but collaboration between both programs is needed.
	2	Mental Health	**Need:** Increase utilization of the Respite Voucher program by 25% and make available a Planned Respite service provider in Region 3. **Data:** TDMHSAS funds respite services to aid caregivers providing care for dependents with an illness or disability. Raising children with serious emotional disturbance (SED) can take its toll on the caregiver, and respite services provide valuable breaks to maintain non-institutional, familial placements. Current trends reveal a need for greater utilization and availability of these services both statewide and in Region 3. In FY 2022-2023, of the 358 vouchers issued statewide from the Respite Voucher program, only 18 vouchers were issued in Region 3. Moreover, Planned Respite services currently serve nine counties statewide (Anderson, Carter, Knox, Madison, Rutherford, Shelby, Sullivan, Washington, and Unicoi). However, none of these are available in Region ~~3~~. The opportunity to provide caregivers with a much-needed break in taking care of children with special needs using Planned Respite or Respite Vouchers is underutilized. **Available Resources to Address Need:** The Respite Voucher program is available to anyone within Region 3. However, the program appears to be underutilized.

Regional Council	Priority	Category	Regional Council 3 Needs Assessment (continued)
Region 3	1	Substance Abuse	**Need:** Expand BHSN coverage to include inpatient SUD services.
			Data: In 2022, TDMHSAS and the Tennessee Department of Health (TDH) compiled data for Tennesseans living with an SUD and compared individuals insured through TennCare, private insurance, and the uninsured. The data estimated that 1,049,170 individuals have an SUD with an estimated 121,410 of those being uninsured. According to the FY24 Annual Report published by TN Recovery Navigators, 76% of the individuals served were uninsured. Moreover, the TN Recovery Navigators program experienced a 22% increase in the number of individuals served from FY23. According to TDMHSAS, FY24 BHSN data revealed that Region 3 served 6,629 individuals through the BHSN out of a statewide total of 34,325 served. Additionally, according to the TDMHSAS Fast Facts Portal, TDMHSAS-funded substance use recovery programs served a statewide total of 22,089 Tennesseans with 2,451 of those from Region 3. Despite resources such as TennCare, private insurance, BHSN, and other TDMHSAS-funded programs, there remains a gap for the uninsured to access inpatient SUD services. While 22,089 individuals served in recovery programs is impressive, it is not enough when compared to the reported 121,410 uninsured Tennesseans struggling with SUD.
			Available Resources to Address Need: Currently, the BHSN program does not provide coverage for inpatient SUD services.
	2	Substance Abuse	**Need:** Increase the number of children and youth SUD providers (outpatient and/or inpatient) in Region 3 who will provide services reimbursed by Medicaid and/or grant-funded programs.
			Data: There is a need for increased availability of options for both inpatient and outpatient SUD services for children and youth in Region 3. According to the 2024 Tennessee Commission on Children and Youth (TCCY) State of the Child Report, one (1) in three (3) youth have ever tried marijuana; one (1) in six (6) youth currently use marijuana; and one (1) in seven (7) youth have taken a prescription pain medication that was different than what was prescribed. According to 2021 SAMHSA data, 5.86% of the youth population in Tennessee ages 12-17 reported illicit drug use in the past month, and 9.47% reported having an SUD. However, according to the TDMHSAS website, there is only one active child and adolescent SUD provider in Region 3, Council for Alcohol & Drug Abuse Services (CADAS), which is contracted and licensed with TDMHSAS and funded by the federal Substance Abuse Prevention and Treatment (SAPT). There is another provider, the Endeavor Program, operated by Volunteer Behavioral Health (VBH) listed on the website. However, that program is no longer in operation. While there are other child and adolescent SUD providers in the region, they are typically for-profit and only accept commercial/private pay. The need for providers who accept Medicaid or grant-funded reimbursement is needed within the region.
			Available Resources to Address Need: Yes, currently CADAS provides both inpatient and outpatient SUD treatment for children and adolescents and provides services reimbursed by Medicaid and grant-funded programs.

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Regional Council	Priority	Category	Regional Council 4 Needs Assessment
Region 4	1	Mental Health	**Need:** Expand and continue to increase funding for existing supported services and operational costs to new and existing congregate housing including group homes that house individuals with SMI and CODs who also have complex health needs.
			Data: TDMHSAS has continued to increase funding to expand supportive housing, now including funding options to expand permanent housing options to more than 108 individuals reentering the community from incarceration. TDMHSAS' initiatives and collaborations with other agencies to support housing growth through the CHI have made a great impact to the availability of housing for individuals with SMI, SUD, and CODs. Funds such as Inpatient Targeted Transitional Support (ITTS), Community Targeted Transitional Support (CTTS), and other client-specific programs are available to help individuals secure and maintain housing, thus decreasing homelessness for many within our region. However, there continues to be an increasing need for providers who are able to house individuals who are not covered by TennCare (uninsured and those with Medicare) and need additional services in place to be able to maintain placement in housing, particularly those with complex health needs. According to TDMHSAS' Office of Licensure data, the total number of beds located in Region 4 for individuals with mental health needs is 508 (332 Adult Supportive Residential Facilities, 189 Mental Health Supportive Living Facilities, and 47 Mental Health Adult Residential Treatment Services). In addition to licensed homes that accept uninsured individuals with mental illness and co-occurring needs, these numbers represent: a) providers who require the individual have TennCare, which also means TennCare must approve placement of the individual in the home; b) providers who accept commercial insurance or whose costs exceed what our target population can afford; c) housing that targets a specific population, such as veterans or human trafficking survivors; and d) the Davidson County Sheriff's Office (DCSO) Behavioral Care Center (BCC) and Mental Health Cooperative's (MHC's) Intensive Intervention Center (aka Respite). Additionally, according to the 2023 Annual Homeless Assessment Report (AHAR) Part 1 to Congress, the state's number of homeless individuals decreased by 12.8% between 2022 and 2023. While it is an improvement from the 45.6% increase of homeless individuals between the years 2021 and 2022, there is still room for progress to be made. In the year 2023, there continued to be 9,215 individuals experiencing homelessness in Tennessee (7,615 adults). More than one (1) in five (5) people experiencing homelessness were ages 55 and older, with almost half of these individuals being "unsheltered in places not meant for human habitation". This number reflects the increased need we are seeing for housing that offers supportive services for those who may be experiencing complex health needs related to aging. Safe, affordable housing is a basic need, and without it, individuals who experience SMI, SUD, CODs, and other co-morbidities are at greater risk of homelessness, which also increases their risk of being victimized as well as at a greater risk of suicide. Research has shown that safe and affordable housing is a significant part of building a person's strength and resiliency (Center on Budget and Policy Priorities, 2016).
			Available Resources to Address Need: Yes; TDMHSAS' Office of Housing and Homeless Services (OHHS) provides resources such as Intensive Long-Term Support (ILS), Projects for Assistance in Transition from Homelessness (PATH), CHI, CTTS, and ITTS. There are also other consumer-specific resources to assist with funding, but these do not contribute to housing services and operational costs on a program level.

Regional Council	Priority	Category	Regional Council 4 Needs Assessment (continued)
Region 4	2	Mental Health	**Need:** Expand the crisis services continuum to fund and evaluate pilots for voluntary alternatives to inpatient psychiatric hospitalization such as Peer Respite and Open Dialogue. **Data:** TDMHSAS FY 2023 data indicates that 66% of individuals who received a face-to-face crisis assessment were diverted from inpatient hospitalization and were able to be served in a less restrictive environment. The remaining 34% represent approximately 25,000 Tennesseans who were referred for psychiatric hospitalization and waited 1-2 days, on average, to be admitted. While CSUs, 24/7 Crisis Walk-in Centers (WICs) and Crisis Respite Centers (CRCs) are all vital components of the crisis system, implementing additional innovative options for in-home and peer-based crisis programs could help even more individuals avoid inpatient hospitalization and achieve recovery. There are now almost 50 Peer Respite sites spanning 14 states. A Peer Respite site is a voluntary community-based residence staffed by peer specialists, offering a supervised, supportive, home-like environment for individuals experiencing a mental health crisis. Participants typically stay up to one week, sometimes longer, and remain connected to a community of peer supporters thereafter. One study showed participants were 70% less likely to utilize inpatient or emergency services compared to those who received other types of services. Another study found that Peer Respite reduced Medicaid expenditures and hospitalizations. There are at least 140 Open Dialogue teams operating in 24 countries, with programs expanding throughout the U.S. Open Dialogue dispatches a specialized clinical team (typically including family therapists and sometimes peers) within 24 hours to help resolve acute mental health crisis in a person's home environment. The program focuses on engaging an individual's family and social network to facilitate open discussion, collaborative learning, and mutual participation. Studies of Open Dialogue have shown reduced hospitalization rates, lower overall time in treatment, and healthcare cost savings. **Available Resources to Address Need:** While Davidson County has access to CSUs and WICs, programs like Peer Respite and Open Dialogue do not exist in the region.
	3	Mental Health	**Need:** Increase and expand the workforce of outpatient clinical mental health providers within the public behavioral healthcare system who can serve adults and children from varied backgrounds. **Data:** According to the article, "Rompiendo Barreras: Dismantling Barriers to Latino Mental Health", one (1) in five (5) Latino adults report having a mental illness, yet only 36.1% of individuals who received mental health care in 2021 were Hispanic (compared to 52.1% of white individuals). Language barriers, among other issues, continue to contribute to this gap. Additionally, according to the *2021 Strategies for Meeting the Need in Our Communities* publication provided by the Tennessee Public Health Workforce Workgroup, the state will face "troubling staffing shortages for several different behavioral health professions". Median incomes for these professions in Tennessee continue to be lower than the national average. A much needed and appreciated $17,995,000 was approved for the FY 2023 budget to fund provider rate increases. Further, $10 million in non-recurring funding has been approved in FY 2024 to fund sign-on bonuses, scholarships, and an internship portal. While this is a giant step forward, it does not target the specific need for increased variety of clinicians within the behavioral health field. Current efforts and proposed funding are beneficial and will likely support bringing in and retaining individuals who are already interested in providing services within the public behavioral healthcare system. However, we need to ensure that we are exploring other potential barriers to increasing the variety of service providers.

Regional Council	Priority	Category	Regional Council 4 Needs Assessment (continued)
Region 4	3	Mental Health	**Available Resources to Address Need:** The Tennessee Behavioral Health Pathways (TBHP) Scholarship has been launched and will provide tuition assistance for eligible students to pursue a master's degree in one of the designated behavioral health fields. Funding has also been approved to provide incentives such as sign-on bonuses, retention bonuses, and an internship portal, all of which aim to increase and retain qualified mental health professionals in Tennessee.
	1	Substance Abuse	**Need:** Increase access to medication-assisted treatment (MAT) (to include both oral and injectable versions of Vivitrol) for those who are diagnosed with alcohol use disorder (AUD) and do not have or qualify for a diagnosis of opioid use disorder (OUD). **Data:** Currently, uninsured individuals have limited access to these medications due to the cost barrier, particularly for Vivitrol, despite it often being clinically more appropriate than an oral version. However, even with prescription assistance, these medications may be unaffordable. According to the CDC, deaths related to excessive alcohol use during 2020 – 2021 increased by 29% compared to the 2016 – 2017 year. For FY 2022 in Davidson County, 39.6% of individuals over the age of 12 who received services funded through TDMHSAS received treatment for alcohol use. This is up from 37% in FY 2021, and 35.3% in FY 2020. **Available Resources to Address Need:** Currently, those diagnosed with AUD are not eligible to receive assistance through existing state grants surrounding MAT unless they also have an OUD. If the person with AUD is receiving treatment for a mental illness from a community mental health provider, they might be able to receive Naltrexone or Vivitrol through this provider but not if they have an AUD alone. According to the TDMHSAS' Treatment Provider Directory updated on August 3, 2023, there are only four treatment providers located in Davidson County identified as providing Vivitrol that is not identified as being for "Opioids Only". Of these, two of the providers also provide residential treatment for women only, and it is not specified if Vivitrol is available to those who have not or are not receiving residential treatment**.**
	2	Substance Abuse	**Need:** Increase supplies and expand distribution of effective overdose prevention tools, specifically xylazine test strips (XTS), fentanyl test strips (FTS), and naloxone, while also providing wound care services related to the use of substances adulterated with xylazine and increasing vending machines and boxes/drop boxes that consistently stock free naloxone and/or test strips **Data:** At least 3,826 Tennesseans died from an overdose in 2022, more than 10 lives lost per day (source). Tennessee continues to have the 2nd highest overdose death rate of any state in the nation, while Nashville has the 2nd highest rate of any metro area. Xylazine was involved in 192 of the state's overdose deaths in 2022, up from 23 deaths in 2019 (source). Fentanyl was involved in 2,797 Tennessee overdose deaths in 2022, up from 1,087 deaths in 2019. In Region 4 (Nashville), fentanyl has been found in 78% of overdose deaths, and xylazine in 5.4% (source). Approximately 85% of those who used a fentanyl test strip in Tennessee reported a positive behavior change related to their drug use (source). While research is ongoing regarding the newer XTS, early anecdotal reports indicate that many Tennesseans will choose not to use their drugs if they test positive for xylazine. Additionally, naloxone vending machines and drop boxes have been associated with reductions in overdose deaths (source/source).

Regional	Priority	Category	Regional Council 4 Needs Assessment (continued)

Council			
Region 4	2	Substance Abuse	**Available Resources to Address Need:** The DCSO installed two publicly accessible naloxone vending machines in their facilities. This is a positive step, though more vending machines are needed given those most at risk for overdose are likely to avoid law enforcement facilities. Many large community events in Nashville present excellent opportunities to distribute more naloxone, XTS, and FTS. The Metro Public Health Department (MPHD) is tracking overdose data closely.
	3	Substance Abuse	**Need:** Establish Recovery Community Centers (RCCs) within the region. **Data:** According to recoveryanswers.org, RCCs are defined as "peer-operated centers that serve as local resources of community-based support". There is currently one RCC that operates under this definition and is in Johnson City, TN. RCCs are physical spaces (not housing) accessible to the community and dedicated specifically to addiction recovery. No formal screening or diagnosis is required to access the RCC services that promote building of recovery capital at the community level through "advocacy training, recovery information and resource mobilization". In Davidson County, there were 529 drug overdose deaths in 2021, up from 438 in 2020 despite tremendous efforts to increase access to treatment and recovery supports. Research shows that peer recovery coaching, such as that provided at RCCs, promotes improved relationships with treatment providers, increased treatment retention, increased satisfaction with overall treatment experience, improved access to social supports, decreased criminal justice involvement, decreased emergency service utilization, reduced relapse rates, reduced rehospitalization rates, and reduced substance use and greater housing stability. (Value of Peers Infographics: Peer Recovery, https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf). **Available Resources to Address Need:** TDMHSAS currently has the CPRS program. As of April 2025, there were 1,500 CPRSs in the state and the number continues to grow. CPRSs located in Davidson County can be called on to help develop a Recovery Community Organization (RCO) that will engage with community resources to support the services provided by an RCC.

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Regional Council	Priority	Category	Regional Council 5 Needs Assessment
Region 5	1	Mental Health	**Need:** Increase support via maternal health coordination/navigation. **Data:** According to the 2024 TDH Maternal Mortality Report: • Overdose deaths represented approximately 20% of all pregnancy-associated deaths in 2017-2019, increasing to 34% in 2020-2022 • The State of Tennessee is encouraged to prioritize the creation of family-friendly treatment centers and mental healthcare facilities for the care of pregnant and postpartum women that are also inclusive of their families • Mental health conditions were the leading cause of pregnancy-related mortality, accounting for 28% of deaths • SUD accounted for 70% of deaths due to mental health conditions, while depressive disorder accounted for 18% • The vast majority of deaths due to mental health conditions were among women living in urban areas (90%) and among non-Hispanic white women (88%) • One in four pregnancy-related deaths due to mental health conditions was found to be a confirmed or probable suicide **Available Resources to Address Need:** Nurses for Newborns (NFN) provides in-home support and resource referrals for pregnant women and new mothers; DrugFree Dickson Coalition has implemented additional support via their Maternal Health Coordinator; Care Net provides support and navigation for pregnant women and new mothers; Centerstone early childhood development services provides support to pregnant women and new mothers; and the THD's Chant Program assists in care coordination for pregnant women and new mothers.
	2	Mental Health	**Need:** Increase outreach and access to mental health services such as counseling, therapy, psychiatric support, life-skills training, and crisis intervention for young adults ages 18-24. **Data:** Young adults are uniquely vulnerable to mental health challenges between the ages of 18-24 as they transition into adulthood and face increased stressors (many for the first time) such as managing finances, securing housing, entering the workforce, building a new support system, and advancing their education. During early adulthood, the prefrontal cortex is still developing, and many young adults are learning how to navigate the system on their own. Additionally, some young adults who were involved in mental health services as children often lose access to these services on their 18th birthday due to insurance limitations. As young adults begin their journey into adulthood, they need access to information and resources to build a cornerstone of support as they move into this new season of life. There are barriers to accessing mental health services such as cost, stigma, and lack of information about available resources. The National Alliance on Mental Illness (NAMI) reports that 20% of young adults experience a diagnosable mental illness each year, yet only 50% of individuals receive the care they need. Further, according to TDH, 71% of youth with major depressive disorder did not receive health services in 2021, and according to the 2024 TCCY State of the Child Report, between 2019 and 2022, Tennessee experienced a suicide rate of 12.4 per 100,000 among individuals aged 18 to 24, notably higher than the national average of 8.8 per 100,000. Awareness of and access to services can be lifesaving for these young adults, and a bridge to services can help ensure they maintain a path to mental wellness throughout their lifetime. **Available Resources to Address Need:** Resources include Youth Villages' program LifeSet, TDMHSAS' Youth and Young Adult (Y/YA) programs, local shelters, Oasis Center, Launch Pad, and university counselors.

Regional Council	Priority	Category	Regional Council 5 Needs Assessment (continued)
Region 5	1	Substance Abuse	**Need:** Improve access to physical health and mental health medications for those in SUD facilities. **Data:** With the focus of integrated services for those seeking treatment for their active addiction, a missing gap in delivering integrated SUD, mental health, and physical health is medication cost coverage. Individuals are increasingly presenting with heightened physical health acuity, which is exacerbated by drugs being laced with dangerous substances like fentanyl, synthetic cannabinoids, and other synthetic opioids. The presence of multiple substances mixed with unknown dangerous drugs creates unpredictable interactions, complicating treatment protocols and amplifying the adverse effects on the physical health of individuals. During active addiction, many physical health conditions are often masked or mitigated by the symptoms of substance use, which can lead to long-term and, in some cases, life-threatening consequences once treatment begins. Addressing these co-occurring physical health issues is critical, and many of them can be managed or alleviated by providing access to the necessary medications for conditions such as, but not limited to: • Hypertension (HTN) • Diabetes (NIDDM/IDDM) • Asthma • Dental pain/abscess • Chronic pain • Seizure disorders • Cardiac disease (e.g., DVT history, chest pain, hyperlipidemia) • Mental health conditions (e.g., anxiety, depression, PTSD) • Urinary Tract Infections (UTIs) • Sexually transmitted infections (STIs) Providing access to the appropriate medications for these conditions is essential for improving the overall well-being of individuals and ensuring they can fully engage in SUD treatment. SUD providers have been offering integrated treatment for substance use and mental health issues; however, a major challenge is ensuring that mental health medications are covered when clients are unable to afford them. When left untreated, clients may prematurely leave treatment early because of the consequences and pain when not actively using. Buffalo Valley Inc. (BVI) Data from September - December 2024 and January - April 2025 (sample size is based on the number of admissions with physical/mental health medications): For September - December 2024, the sampling size was 45 of which 291 physical/mental health medications were brought into treatment with 50% being prescription medications. Of that total, 25% required additional prescriptions but unless the medication is on the $4.00 prescription list or family/friends assist with payment, these individuals had to be referred out. From January - April 2025, the sampling size was 51 with 376 physical/mental health medications were brought in with 48% being prescription medications. In this case, 30% needed additional assistance.

Regional Council	Priority	Category	Regional Council 5 Needs Assessment (continued)
Region 5	1	Substance Abuse	**Data:** Trying to find additional payment resources and calling previous physicians/pharmacies to see if there were any refills can be labor-intensive and time-consuming. **Available Resources to Address Need:** In the rural areas of Region 5, there are limited physical health resources available to address the needs of the indigent population. While each county has a health department, not all of them offer primary care services. However, 69% of the counties in the region have at least one rural health clinic and 46% have at least one Federally Qualified Health Center (FQHC). These resources operate on a sliding scale based on income, which can still be difficult for individuals with limited or no resources, especially those who are ineligible for TennCare. Other resources include BHSN, Community & Faith-Based Organizations (FBOs), the Tennessee Charitable Care Network (TCCN), the Tennessee Primary Care Association (TNPCA), and Project Access to expand healthcare access for uninsured adults, offering services such as primary care, dental care, and behavioral health support.
	2	Substance Abuse	**Need:** Establish Bridge Treatment/ SUD Respite Options for Pre-Treatment and Post-Treatment **Data:** • **Lag Time for Treatment Access**: Some SUD providers in Region 5 report challenges related to the time it takes individuals to access treatment services, particularly those who are unhoused and have nowhere to stay while waiting for a treatment bed. • **Irregular Discharges**: Some clients are discharged from treatment services for irregular reasons, and this creates a safety concern. A program offering a temporary, safe environment would ensure clients are supported until a bed can be found, which maintains the therapeutic environment. • **Transition and Recovery Housing**: Some SUD providers in Region 5 have reported challenges with lag time in providing clients with a "warm handoff" to transitional and/or recovery housing, especially when such housing is not immediately available. This transition period can take up to a week which could hinder a client's recovery process.

<table>
<tr><th>Regional Council</th><th>Priority</th><th>Category</th><th>Regional Council 5 Needs Assessment (continued)</th></tr>
<tr><td>Region 5</td><td>2</td><td>Substance Abuse</td><td>
Data:

Data from Buffalo Valley’s Electronic Health Record (EHR) system highlights the number of prescreens, admissions, homelessness rates, and average wait times for treatment. This data underscores concerns about where individuals stay while waiting for treatment, especially in terms of preventing life loss and offering a safe place away from the “using environment.”

<table>
<tr><th>Year</th><th>Prescreens</th><th>Admissions</th><th>% of Admissions</th><th>Homeless</th><th>Overall Wait List (days)</th></tr>
<tr><td>2021-22</td><td>4,125</td><td>1,577</td><td>38%</td><td>92%</td><td>7.15</td></tr>
<tr><td>2022-23</td><td>2,500</td><td>1,053</td><td>42%</td><td>82%</td><td>8.7</td></tr>
<tr><td>2023-24</td><td>9,388</td><td>4,350</td><td>46%</td><td>45%</td><td>6.5</td></tr>
<tr><td>2024-Current (as of 2-28-25)</td><td>6,623</td><td>2,656</td><td>40%</td><td>46%</td><td>6.0</td></tr>
</table>

Prescreens: The number of prescreens has increased significantly from 4,125 in 2021-22 to 9,388 in 2023-24, with a decrease to 6,623 by 2024.
Admissions: The percentage of admissions has varied between 38% in 2021-22, peaking at 46% in 2023-24, and then dropping to 40% in 2024-25.
Homelessness: The percentage of individuals self-identifying as homeless decreased from 92% in 2021-22 to 45% in 2023-24, with a slight increase to 46% in 2024-25.
Wait Times: The overall wait list time has improved, decreasing from 7.15 days in 2021-22 to 6.0 days in 2024-25.

Conclusion: The data shows a growing number of prescreens and admissions for treatment services, although the number of individuals identified as homeless remains significant. The decrease in wait times is a positive trend, but there is still a notable gap in the ability to provide immediate respite options or bridge treatment for clients in need of a safe environment while waiting for a treatment bed or transitional housing. This indicates a clear need for bridge treatment and SUD respite services to improve access to care and provide stability for clients before and after treatment.

Available Resources to Address Need: None at this time.
</td></tr>
</table>

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Regional Council	Priority	Category	Regional Council 6 Needs Assessment
Region 6	1	Mental Health	**Need:** Increase the number of transitional/supported housing options for individuals with SMI.
			Data: West Tennessee continues to struggle to meet the need for transitional/supported housing options for individuals with mental health disorders. In 2024, Tennessee counted 8,280 homeless individuals and 53% of those were unsheltered (2024 HUD Report). According to NAMI, 1 in 6 homeless individuals in Tennessee have serious mental health issues. While the number of homeless individuals in West Tennessee varies, the CoC in Madison County served over 300 total individuals last year.
			Available Resources to Address Need: CHI; Quinco, Carey Counseling, Professional Care Services (PCS), Behavioral Health Initiatives (BHI), and MSHN Enterprises all currently operate group homes for individuals with mental health disorders in the region. Carey Counseling has four group homes with a total of 21 beds for individuals with mental health disorders and two homes for individuals who have SMI and are medically fragile with a total of 42 beds. Clients at MSHN Enterprises' group homes must have an income from any source to be eligible. Quinco has three homes with a total of 27 beds. BHI has six homes with a total capacity of 32, but five of these have waiting lists for admission.
	2	Mental Health	**Need:** Provide specialized training for clinicians surrounding neurodivergent mental health care.
			Data: With the increase of more accurate diagnosis and early intervention, more children are being diagnosed and treated for autism and attention-deficit hyperactive disorder (ADHD). In the U.S., 1 in 36 children have a diagnosis of autism and 1 in 9 children have a diagnosis of ADHD. In rural areas, there are limited resources for specialized autism and ADHD care as those children who do have access to care are often referred to general practitioners for treatment due to a lack of available mental health providers in their areas. General practitioners are often ill-equipped to design treatment protocols, interventions, and family practices for this population due to a lack of initial training, reflective supervision, and ongoing development. Region 6 requests TDMHSAS to develop training symposiums for Pediatric Neurodivergence similar to that of the Psychosis Summits to allow for annual training on topics of Neurodivergence. Online platforms would be low cost, but a face-to-face training curriculum would be best to allow for more question-and-answer interaction. Reflective supervision calls and support would also be a beneficial process to develop for an agency to provide training for agencies. It is also possible that TDMHSAS could create a train-the-trainer curriculum to imbed this in major agencies as a way to perpetuate and have ongoing updates of this training. This training would allow for more children in rural areas to have their needs met without traveling to major metros or being on a waiting list for specialized care that is months long, allowing earlier intervention and potential success.
			Available Resources to Address Need: There are occasional trainings offered at conferences on this topic but there has not been a strong concerted effort to target the mental health needs of this population.

Regional Council	Priority	Category	Regional Council 6 Needs Assessment (continued)
Region 6	1	Substance Abuse	**Need:** Expand affordable transportation options to SUD treatment services and facilities, specifically for low-income individuals with limited/no insurance.
			Data: Treatment facilities for individuals with SUD are vital to successful recovery. However, treatment is not possible if clients do not have transportation to those services. When transportation is a barrier, there is a greater risk for relapse and continued substance misuse. Barriers to transportation tend to be caused by a lack of public transportation, not having a driver's license, long travel distance, and high transit costs (Harweth et al., 2022). These barriers lead individuals to not starting or completing treatment programs. According to the National Institute on Drug Abuse (NIDA), 40.3 million people in the United States had an SUD in 2020, yet only 6.5% of them received treatment (NIDA, 2020). The simple lack of rides to the doctors' offices, ambulatory care centers or other places for treatment has contributed to this gap in treatment for millions with mental illness across the country (Locatelli et al., 2017; Bellamy et al., 2016). That said, it is of great importance to increase transportation options, so all individuals can have the opportunity to receive treatment. According to a 2023 Vanderbilt University (VU) and Tennessee Department of Transportation (TDOT) study, West Tennessee was shown to have the greatest need for these transportation services (Camp, 2023). The highest need is in rural counties with high poverty rates, like the counties of West Tennessee. Individuals in Tennessee may drive as far as 100 miles to access treatment centers, equating to over $40 per one-way trip. This research establishes that rural counties in West Tennessee have a crucial need for transportation to SUD services.
			Available Resources to Address Need: For rural counties, Southwest Human Resources Agency (SWHRA) operates the Rural Public Transportation system. However, they do not cover the Jackson Urbanized Zone, but they do cover eight counties: Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, McNairy, and Madison. While there are affordable services for individuals with TennCare or other qualified agencies, there is no affordable services for those without healthcare insurance. BHSN is a resource through Carey Counseling and Pathways in the region, but an individual must meet certain eligibility requirements like a qualifying mental health diagnosis.
	2	Substance Abuse	**Need:** Establish ease of access for adolescent substance abuse service (including detox, residential and intensive outpatient program (IOP) levels)
			Data: At this time there is one adolescent detox program in the entire state (Lakeside in Memphis). Children who use certain substances or who have consistent patterns of use can be declined by private hospitals for co-morbid/dual diagnosis issues that present with a mental health emergency due to the fear the child will detox in their program and medically disrupt. Children/adolescents seeking residential treatment for substance use lack immediate access to beds and, while waiting for a bed to become available, are at risk of destabilizing or eloping before admission into a program. Adolescent decision-making can be tenuous. It is important to be able to capitalize on their desire to admit to treatment in a timely manner. Per the 2024 State of the Child Report, 19% of Tennessee high school students are currently drinking alcohol, and one (1) in six (6) students reported taking prescription medication without a prescription or differently than prescribed.
			Available Resources to Address Need: There is one adolescent detox program in the state (Lakeside in Memphis).

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Regional Council	Priority	Category	Regional Council 7 Needs Assessment
Region 7	1	Mental Health	**Need:** Establish an additional peer support center in Region 7. **Data:** There are currently two peer support centers in Region 7 that are hosted by Alliance Healthcare Services and the Tennessee Mental Health Consumers Association (TMHCA). Region 7 has a large TennCare population (27%) and only 700:1 mental health providers (US is 400:1). **Available Resources to Address Need:** There are currently two peer support centers in a highly populated region that serve consumers needing mental health services (Alliance Healthcare Services and TMHCA).
	2	Mental Health	**Need:** Provide education to increase knowledge of youth-facing community members to identify youth at risk for completion of suicide and create a safe environment for young children, adolescents, and young adults who experience suicidal ideations, make attempts, or have lost a loved one to suicide. **Data:** According to the TDH's Suicide Prevention Annual Report 2023, the rate of intentional harm that required hospital assistance in Tennessee children under 10 rose from 5.3 per 100,000 to 7.1 per 100,000. For older adolescents, 2021 survey data collected through the CDC's Youth Risk Behavior Survey (YRBS) found that 43.3% of high school youth in Shelby County were feeling sad or hopeless, higher than both Tennessee state prevalence (42.2%) and national prevalence (42.3%). In terms of considering suicide, 23.7% of Shelby County high school youth reported having considered suicide in 2021 (31.8% of female youth and 14.8% of male youth), higher than the overall prevalence in Tennessee youth (22.8% overall; 28.2% of female youth and 17.0% of male youth) and overall United States high school youth (22.2% overall, 30.0% of female youth and 14.3% of male youth). Regarding suicide attempts reported, 16.8% of Shelby County youth reported having made a suicide attempt (20.4% of female youth and 11.9% of male youth); this is higher than Tennessee (13.4% total, 17.2% of female youth, 9.3% of male youth) and also higher than that reported by overall United States high school students (10.2% total, 13.3% of female youth, 6.6% of male youth). **Available Resources to Address Need:** The Tennessee Suicide Prevention Network (TSPN) funds some programming to increase capacity of community members, such as intermittent Applied Suicide Intervention Skills Training (ASIST); Mental Health First Aid is available, but not currently in Region 7; Talk Saves Lives (https://afsp.org/talk-saves-lives/); School-Based Behavioral Health Liaisons (SBBHLs), and Question, Persuade, Refer (QPR).

Regional Council	Priority	Category	Regional Council 7 Needs Assessment (continued)
Region 7	1	Substance Abuse	**Need:** Increase the amount of medical detox services for the uninsured or underinsured in Shelby County.
			Data: There is a need for a safety net type of solution for addiction services in Shelby County. The lack of medical detox services available, outside of MAT programs and private insurance-based programs, creates a backlog at area hospitals that are not equipped to detox and treat SUD long-term. According to the US Census, in 2018, nearly 12% of people living in Shelby County were uninsured and more than 20% were living under the poverty level. While there are many resources for those with insurance, those without sometimes face long wait lists which can ultimately lead to individuals falling deeper into their addiction or dying from the disease resulting in a need for interim care. According to the Shelby County Health Department, in 2018, there were 854 emergency department (ED) visits related to OUD and 163 opioid-related deaths (a steady increase from the 113 deaths in 2014). Epidemiologists anticipate an average of over 250 opioid-related deaths within the county by 2022. The desired outcome is to create a brick-and-mortar center located in Memphis that can create adequate access to care for patients seeking addiction and mental health treatment after being stabilized in nearby hospitals. This center would enable someone to be safely monitored while referral resources and availability are secured. Staff for the center would begin with CPRSs and volunteers assisting patients who spend 24-48 hours at the facility while services become available at an appropriate treatment center.
			Available Resources to Address Need: Alliance Health Services opened a Crisis Wellness Center in March 2025; there are other detox services in the region, but these are limited for the uninsured.
	2	Substance Abuse	**Need:** Increase the number of licensed clinicians treating adolescents who have been trained/are certified in evidence-based behavioral health/substance use treatment practices.
			Data: Behavioral health practices that are evidence-based have been established to improve patient outcomes. The American Psychological Association (APA) describes the use of evidence-based psychotherapy as "empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention". Evidence-based psychotherapy, by definition, is the use of a scientific protocol that, when facilitated by an experienced provider, has been repeatedly proven to be effective at helping individuals recover from a set of mental health symptoms (Rathmell, 2024). Evidence-based therapy relies on the integration of the best available research evidence to inform treatment decisions. Evidence-based therapy is empirically supported (utilizing treatments that have been tested and proven effective through clinical trials and randomized trials) and encourages continuous learning (therapists must stay updated with the latest research and incorporate new findings into practice) (Shamsian, 2024). At this time, there is not a centralized database that helps patients and families distinguish between outcomes-oriented, evidence-based care, and providers who only provide talk therapy. This results in insurance funding adolescent behavioral health treatment, especially related to substance use treatment, that lacks an evidence basis.
			Available Resources to Address Need: Training resources that exist are online (delivered by organizations outside Region 7) and can be expensive for individual providers to access, especially individual providers who are providing treatment to adolescents at highest risk. For example, the cost of a Trauma-Focused CBT training with certification is $1,350 for a 10-month virtual training (https://tfcbt.org/training/).

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Committee	Priority	Category	Consumer Advisory Board (CAB) Needs Assessment
CAB	1	Mental Health	**Need:** Enhance case management/care coordination services for those with SMI to include long-term care. **Data:** In Tennessee, there are wonderful short-term case management services. However, there is a need for long-term/permanent, holistic, wrap-around care/case management services for those with SMI. The overreaching goal would be that this long-term case management would provide support that allows individuals experiencing SMI to maintain stable housing. These services would include but would not be limited to access to insurance, Disability and Social Security services, employment, budgeting/financial literacy, transportation access to service appointments and job interviews, permanent housing, assistance with obtaining driver's licenses, photo IDs, birth certificates and Social Security cards. In August 2024, Tennessee hosted focus groups on housing needs in each of Tennessee's nine development districts. Focus group participants in the Northwest and East development districts shared that affordable rental units sometimes do not pass inspections for housing safety and quality, and landlords are sometimes unwilling to remedy these findings. As a result, some affordable apartments are not available to people experiencing homelessness because they do not meet quality standards. Participants also mentioned additional challenges households face that can recreate housing instability even after an individual has secured permanent housing. These challenges include finding a job with a wage that can support rental payments without assistance, finding reliable transportation to and from work and/or school, and obtaining other essentials such as childcare, food, clothing, laundry, household items, and basic furniture. These same focus groups also expressed that individuals experiencing homelessness in rural areas often face a lack of transportation which prevents them from accessing CoC resources. In addition, even when transportation is available, accessing CoC resources often requires people to travel long distances, which some are reluctant to do without support. Resource: https://thda.org/pdf/Tennessee-Housing-Needs_GNRC_FINAL.pdf **Available Resources to Address Need:** ILS; ITTS; CTTS; PATH (though this is only available in 36 counties and limited to 90 days); and SOAR SSI/SSDI Outreach, Access, and Recovery (SOAR).

Committee	Priority	Category	Consumer Advisory Board (CAB) Needs Assessment (continued)
CAB	1	Substance Abuse	**Need:** Expand affordable transportation options to SUD treatment services and facilities, specifically for low-income individuals with limited/no insurance. **Data:** Treatment facilities for individuals with SUD are vital to successful recovery. However, treatment is not possible if clients do not have transportation to those services. When transportation is a barrier, there is a greater risk for relapse and continued substance misuse. Barriers to transportation tend to be caused by a lack of public transportation, not having a driver's license, long travel distance, and high transit costs (Harweth et al., 2022). These barriers lead individuals to not starting or completing treatment programs. According to the NIDA, 40.3 million people in the United States had an SUD in 2020, yet only 6.5% of them received treatment (NIDA, 2020). The simple lack of rides to the doctors' offices, ambulatory care centers or other places for treatment has contributed to this gap in treatment for millions with mental illness across the country (Locatelli et al., 2017; Bellamy et al., 2016). That said, it is of great importance to increase transportation options, so all individuals can have the opportunity to receive treatment. According to a 2023 VU and TDOT study, West Tennessee was shown to have the greatest need for these transportation services (Camp, 2023). The highest need is in rural counties with high poverty rates, like the counties of West Tennessee. Individuals in Tennessee may drive as far as 100 miles to access treatment centers, equating to over $40 per one-way trip. This research establishes that rural counties in West Tennessee have a crucial need for transportation to SUD services. **Available Resources to Address Need:** For rural counties, the SWHRA operates the Rural Public Transportation system. However, they do not cover the Jackson Urbanized Zone, but they do cover eight counties: Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, McNairy, and Madison. While there are affordable services for individuals with TennCare or other qualified agencies, there is no affordable services for those without healthcare insurance. BHSN is a resource through Carey Counseling and Pathways in the region, but an individual must meet certain eligibility requirements like a qualifying mental health diagnosis that may make it challenging.

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Committee	Priority	Category	Adult Committee Needs Assessment
Adult	1	Mental Health	**Need:** Expand and continue to increase funding for existing supports services and operational costs to new and existing housing for those with mental health disorders that require group home living, supportive living apartments, and congregant independent living options across the state.
			Data: The Committee appreciates the recent and ongoing efforts from TDMHSAS to expand supportive housing and supports, specifically with the increase in reentry programs from incarceration. The department's initiatives and collaborations with several agencies to support growth via the CHI, CHI 2.0, and CHI 3.0 are valuable programs to meet various needs across the state. In addition, the longstanding CTTS and ITTS funds have greatly impacted an individual's ability to mitigate homelessness. However, across the state, individuals continue to struggle to find affordable housing including the necessary services to wraparound and maintain housing, particularly for those who are struggling with SMI. Various sources continue to estimate that 25-30% of individuals without homes also suffer with mental health disorders, and the gap appears to be in providing onsite case management or other wraparound services within the housing structure. In FY24, the CHI did not have a grant cycle, leaving many providers without the opportunity to apply for new funding to expand housing options. In FY25, the decrease in funding impacted organizations' plans to expand housing opportunities. While the CHI has shown success in creating housing opportunities for individuals with mental health and SUDs, its funding level limits its ability to meet the growing demand for permanent housing solutions across the state. Additionally, it is critical to recognize that housing alone is not enough to ensure successful outcomes. Support services including case management, mental health counseling, and job training are integral to the well-being of individuals in recovery. These services provide the necessary resources for individuals to thrive in permanent housing and reintegrate into the community. Operational funding for recovery residences including salaries for qualified staff and funding for these support services, is equally crucial. Without sufficient resources to maintain these services, residences can struggle to meet the complex needs of individuals, potentially leading to relapse of symptoms and housing instability. Ensuring housing programs are adequately staffed with target services in place and that providers receive adequate operational funding is key to sustaining these essential services and improving long-term stability outcomes. Per HUD, in 2023, approximately 10.5% of all individuals served by TDMHSAS were homeless or living in a shelter, which is up from 8.4% in 2021 and more than double the 4.4% national average among those served by state mental health departments.
			Available Resources to Address Need: TDMHSAS' Office of Housing and Homeless Services' ILS, CTTS, ITTS, Residential Re-entry Housing Program (RRHP), the CHI, and BHSN.

Committee	Priority	Category	Adult Committee Needs Assessment (continued)
Adult	2	Mental Health	**Need:** Continue to work to enhance workforce development to provide needed treatment, care, and support to meet the community's mental health needs by creating an ongoing work group and/or public-facing strategy to encourage therapists, case managers, peer support specialists, direct support specialists, and nurses to enter and stay in the behavioral health field.
			Data: While the department has led many initiatives to support recruitment and retention of qualified staff, we continue to see deficits in workforce numbers. TDMHSAS' work with the Tennessee General Assembly (TGA), Governor Bill Lee, and other state departments has been powerful in increasing rates for services to more sustainable revenue. The request for and receipt of funds earmarked to address recruitment and retention have assisted greatly. However, this assistance has run parallel to the rising cost of living so individuals are not necessarily feeling the positive effects of the increase. Organizations across the state continue to struggle with being able to acquire quality resumes that meet the needs of the services offered. There is a need to focus on the development of recruits to serve in positions dealing with behavioral health disorders. While TDMHSAS has partnered with University of Tennessee (UT) and the University of Memphis (U of M) to initiate outreach to high schools with education about careers in the behavioral health field, we would ask that this be continued and expanded to other higher education programs with a look to impact rural students. As of January 2025, 93 of Tennessee's 95 counties have been designated as mental health professional shortage areas, with 91 counties designated a shortage area for the entire county (HRSA). According to the latest HRSA workforce projections for 2026, Tennessee is expected to have only half (50%) the number of addiction counselors needed to meet demand, 41% of adult psychiatrists, 33% of child psychiatrists, 56% of psychiatric physician assistants, and 37% of psychologists (projection data is unavailable for clinical social workers, psychiatric technicians, and marriage and family therapists, but the projected met need for mental health counselors is 97%).
			Available Resources to Address Need: The behavioral health community has positive relationships with our legislators and should continue to educate legislators and the public as to the value of mental health services. We now have a curriculum to share with young people about the behavioral health field and can work to build on the efforts of UT and U of M in encouraging young people to join the field. The state-funded Tennessee Behavioral Health Pathways Scholarship program has reportedly been highly successful, and we are grateful for the additional funding slated for 2025-26..
	3	Mental Health	**Need:** Expand crisis services to fund and evaluate pilots for voluntary alternatives to inpatient psychiatric hospitalization.

Committee	Priority	Category	Adult Committee Needs Assessment (continued)
Adult	3	Mental Health	**Data:** Tennessee's Crisis System is viewed as one of the best in the nation with a strong continuum of crisis care to include WICs, CSUs, mental health navigators, call centers, and 988. Additionally, CSUs also have imbedded peer support teams who assist with discharge outreach and follow-up. TDMHSAS FY23 data indicates that 66% of individuals who received a face-to-face crisis assessment were diverted from inpatient hospitalization and were able to be served in a less restrictive environment, which comes with significant cost savings. The remaining 34% represent approximately 25,000 Tennesseans who were referred for psychiatric hospitalization and waited multiple days to be admitted. While CSUs, 24/7 CSUs, and Crisis Respite Services are all vital crisis system components, implementing additional innovative options including co-response models, alternative response models, Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) units, and in-home and peer-based crisis programs could help even more Tennesseans avoid inpatient hospitalization, jail, and increase recovery options. These services can increase diversion from a more restrictive placement due to the ability to intervene quickly and offer interventions and crisis-focused services. Examples: Co-response Models- (data from October 2020-December 2025) responding to high-level mental health acuity with Master's Level Clinicians riding with crisis intervention team (CIT) trained officers- data has yielded that inpatient reduction- approximately less than 41% taken to the ED for further assessment and possible inpatient; 51% able to remain in home with resources and appointments, and 7% were transported to residential community programs. REACH- (data from February 2023- June 2024) pairing mental health clinicians with a paramedic addressing non-emergency mental health calls in the field - reducing ED visits and jail by further reducing escalation of symptoms; 37% resulted in a transport to ED; 90% of events would have resulted in an ED transport in traditional responses. EmPATH Unit- psychiatric ED model with 24/7 access to prescriber and supporting clinical staff; 95% reduction in inpatient hospitalizations. Peer Respite – There are now almost 50 Peer Respite sites spanning 14 states. A Peer Respite is a voluntary community-based residence staffed by peer specialists offering a supervised, supportive, home-like environment for individuals experiencing a mental health crisis. Participants typically stay for up to one week – sometimes longer – and remain connected to a community of peer supporters thereafter. One study showed participants were 70% less likely to utilize inpatient or emergency services. **Available Resources to Address Need:** Tennessee has a strong and vibrant CoC and a strong foundation to pilot alternative levels of care. The department is known for evaluating/piloting programs where gaps are identified to assist those with behavioral health crisis needs. We also have a strong peer support program and certification process for peer support specialists which can be built upon.
	1	Substance Abuse	**Need:** Continue to work to enhance workforce development to provide needed treatment, care, and support to meet the community's substance use needs by creating an ongoing work group and/or public-facing strategy to encourage therapists, case managers, peers support specialists, direct support specialists, and nurses to enter and stay in the substance use field. These efforts should include promoting MAT options as evidenced-based treatment and care.

Committee	Priority	Category	Adult Committee Needs Assessment (continued)
Adult	1	Substance Abuse	**Data:** As mentioned in a previously identified need, we appreciate the department's efforts and advocacy in bringing attention to and responses to the recruitment and retention of qualified staff. Workforce shortage continues to be a need within the services to individuals with SUD. The National Center for Drug Abuse Statistics reports that 2,089 Tennesseans die by drug overdoses each year (31.2 per 100,000 Tennesseans) and this number has increased by 8.49% over the last three years. Tennessee is 50.72% higher than the national average with the second highest overdose death rate in the nation. This impacts both families as well as the economy. We want TDMHSAS to remain committed to the education and growth of qualified substance use treatment providers to reverse these numbers for our state. As of January 2025, 93 of Tennessee's 95 counties have been designated as mental health professional shortage areas, with 91 counties designated a shortage area for the entire county (HRSA). According to the latest HRSA workforce projections for 2026, Tennessee is expected to have only half (50%) the number of addiction counselors needed to meet demand, 41% of adult psychiatrists, 33% of child psychiatrists, 56% of psychiatric physician assistants, and 37% of psychologists (projection data is unavailable for clinical social workers, psychiatric technicians, and marriage and family therapists, but the projected met need is 97%). **Available Resources to Address Need:** The behavioral health community has positive relationships with our legislators and should continue to educate legislators and the public as to the value of mental health services. We now have a curriculum to share with young people about the behavioral health field and can work to build on the efforts of UT and U of M in encouraging young people to join the field. Additionally, the department website can be used to highlight individual success stories of the current initiatives.
	2	Substance Abuse	**Need:** Increase the number of "bricks and mortar" recovery housing options specifically for those with limited financial resources and/or are utilizing MAT and provide intentional education to current recovery housing management regarding MAT as an evidence-based model of care. **Data:** The Committee is grateful for the advocacy and work the CHI program brought to the development of housing in Tennessee. The focus of CHI 2.0 has demonstrated a remarkable impact for housing for those with SUD. Additionally, the CHI programs have been impactful in helping to reduce the stigma regarding mental health and SUDs as it relates to housing and community tenure. Despite the increase in Oxford Housing beds (146), there remains a need for transitional housing support across the state, especially for individuals participating in MAT programs. The need for transitional housing is important to help individuals to build the recovery skills needed to be more effective and successful in permanent supportive housing or commercial housing options. Specifically, there is a need for financial support to provide the physical structures necessary to build recovery skills and networks as a transitional opportunity. While Tennessee-specific data is not yet available regarding the number of recovery housing locations that will accept residents who participate in MAT, a recently published study found that more than half (53%) of recovery homes in South Florida completely prohibited buprenorphine patients. Anecdotal reports indicate there are many buprenorphine patients in Tennessee who experience similar barriers in accessing recovery housing.

<table>
<tr><th>Committee</th><th>Priority</th><th>Category</th><th>Adult Committee Needs Assessment (continued)</th></tr>
<tr><td rowspan="2">Adult</td><td>2</td><td>Substance Abuse</td><td>Available Resources to Address Need: CHI 2.0 programming and housing coordinators; Oxford Housing; ONE Tennessee is an organization that exists to provide academic detailing to pharmacists and other providers to help educate and reduce stigma regarding MAT for OUD with medications such as buprenorphine.</td></tr>
<tr><td>3</td><td>Substance Abuse</td><td>Need: Establish Bridge Treatment / SUD Respite Options for Pre-Treatment and Post-Treatment.

Data:

• Lag Time for Treatment Access: Some SUD providers report challenges related to the time it takes individuals to access treatment services, particularly those who are unhoused and have nowhere to stay while waiting for a treatment bed.
• Irregular Discharges: Some clients are discharged from treatment services for irregular reasons and this creates a safety concern. A program offering a temporary, safe environment would ensure clients are supported until a bed can be found, which maintains the therapeutic environment.
• Transition and Recovery Housing: Some SUD providers have reported challenges with lag time in providing clients with a "warm handoff" to transitional and/or recovery housing, especially when such housing is not immediately available. This transition period can take up to a week which could hinder a client’s recovery process.

Data from Buffalo Valley’s EHR system highlights the number of prescreens, admissions, homelessness rates, and average wait times for treatment. This data underscores concerns about where individuals stay while waiting for treatment, especially in terms of preventing life loss and offering a safe place away from the “using environment.”

<table>
<tr><th>Year</th><th>Prescreens</th><th>Admissions</th><th>% of Admissions</th><th>Homeless</th><th>Overall Wait List (days)</th></tr>
<tr><td>2021-22</td><td>4,125</td><td>1,577</td><td>38%</td><td>92%</td><td>7.15</td></tr>
<tr><td>2022-23</td><td>2,500</td><td>1,053</td><td>42%</td><td>82%</td><td>8.7</td></tr>
<tr><td>2023-24</td><td>9,388</td><td>4,350</td><td>46%</td><td>45%</td><td>6.5</td></tr>
<tr><td>2024-Current (as of 2-28-25)</td><td>6,623</td><td>2,656</td><td>40%</td><td>46%</td><td>6.0</td></tr>
</table>
Prescreens: The number of prescreens has increased significantly from 4,125 in 2021-22 to 9,388 in 2023-24, with a decrease to 6,623 by 2024.
Admissions: The percentage of admissions has varied between 38% in 2021-22, peaking at 46% in 2023-24, and then dropping to 40% in 2024-25.
Homelessness: The percentage of individuals self-identifying as homeless decreased from 92% in 2021-22 to 45% in 2023-24, with a slight increase to 46% in 2024-25.
Wait Times: The overall wait list time has improved, decreasing from 7.15 days in 2021-22 to 6.0 days in 2024-25.</td></tr>
</table>

Committee	Priority	Category	Adult Committee Needs Assessment (continued)
Adult Committee	3	Substance Abuse	**Data: Conclusion:** The data shows a growing number of prescreens and admissions for treatment services, although the number of individuals identified as homeless remains significant. The decrease in wait times is a positive trend, but there is still a notable gap in the ability to provide immediate respite options or bridge treatment for clients in need of a safe environment while waiting for a treatment bed or transitional housing. This indicates a clear need for bridge treatment and SUD respite services to improve access to care and provide stability for clients before and after treatment. **Available Resources to Address Need:** None at this time.

Tennessee Department of Mental Health and Substance Abuse Services Planning and Policy Council
2025 Needs Assessment Summary

Committee	Priority	Category	Children's Committee Needs Assessment
Children's Committee	1	Mental Health	**Need:** Enhance mental health support and intervention strategies for adolescents, specifically around suicide prevention/intervention, to further develop a comprehensive statewide youth mental health crisis response system. **Data:** • Between 2019 and 2022, Tennessee reported 146 suicide deaths among children aged 9 to 17. The suicide rate in this age group rose from 4.1 to 4.9 per 100,000 population during this period, while national rates remained steady. • High School Students' Suicidal Ideation and Attempts: In 2021, nearly 1 in 4 Tennessee high school students seriously considered attempting suicide, and more than 1 in 10 attempted suicide. Specifically, 29% reported experiencing poor mental health in the past month, and over 40% had symptoms of depression in the prior year (Sycamore Institute). • Female high school students are significantly more likely to report poor mental health, depressive symptoms, and suicidal thoughts and actions. However, males aged 12-17 had a suicide death rate six times higher than that of females in 2021 (Sycamore Institute). • Methods of Suicide: Among the 146 suicide deaths from 2019 to 2022 in children aged 9-17, 51% resulted from firearms, 40% from suffocation (including hanging), and 7% from poisoning. Notably, Tennessee's firearm suicide rate in this age group was higher than the national average (2.4 vs. 1.9 deaths per 100,000) (TSPN). • Suicide Attempts and Help-Seeking Behavior: In 2022, 1 in 3 high school students who had attempted suicide in the previous 12 months reported seeking help from a doctor, counselor, or hotline prior to their attempt, indicating a critical window for intervention (TSPN). Tennessee is experiencing a rise in suicide rates among youth. These statistics underscore the critical need to strengthen Tennessee's mental health infrastructure, focusing on early intervention, access to care, and targeted support for at-risk youth populations to mitigate the rising trend in youth suicides. **Available Resources to Address Need:** Crisis Hotline & Mobile Crisis Services (988); School-Based Mental Health Programs; the Trevor Project, TSPN, the Jason Foundation, etc.
	2	Mental Health	**Need:** Strengthen and grow the workforce of outpatient clinical mental health providers in the public behavioral healthcare system to address critical workforce shortages.

Committee	Priority	Category	Children's Committee Needs Assessment (continued)
Children's Committee	2	Mental Health	**Data**: • Prevalence of Youth Mental Health Disorders: Approximately 20% of children in Tennessee have a mental health disorder, and 5% of teens have an SUD (The University of Memphis) • Shortage of Mental Health Professionals: A 2019 study estimated that Tennessee needs an additional 17,000 mental health professionals across 20 occupations to eliminate the provider shortage. The HRSA reports that at least 95% of counties in Tennessee have Health Professional Shortage Area designations for mental health. Only 11% of the need for mental health professionals in Tennessee is currently being met, compared to 27% nationally. The report also mentions that the state is ranked 50th in access to care for youth. Shockingly, more than two-thirds of Tennessee youth with clinical depression go untreated, while only 12% of youth with severe depression receive consistent treatment (TAMHO) • Low Percentage of Psychiatric Needs Met: As of September 2020, only 13.2% of the need for psychiatrists in Tennessee was being met, indicating a substantial gap in psychiatric care availability (Tennessee State Government - TN.gov) **Available Resources to Address Need:** Using funds appropriated during the TGA's extraordinary session on public safety, the Tennessee Behavioral Health Pathways Scholarship provides tuition assistance for eligible students to pursue a graduate degree in a behavioral health field. In turn, they must work for a community mental health agency for the same length of time that they received a scholarship. Funding has also been approved to provide incentives such as sign-on bonuses, retention bonuses, and rate increases, all of which aim to increase and retain qualified mental health professionals in Tennessee. Additionally, funding has been allocated to provide licensure supervision to workers who are seeking clinical licensure.
	1	Substance Abuse	**Need:** Expand upon and increase access to IOP substance use treatment programs for youth, particularly in rural communities. **Data:** Recent data underscores the critical need for IOP substance use treatment programs for youth in Tennessee: • According to the 2023 National Survey on Drug Use and Health, 6.76% of Tennessee youths aged 12-17 reported using illicit drugs in the past month (SAMHSA) • Marijuana Use: The same survey indicates that 11.73% of adolescents aged 12-17 in Tennessee used marijuana in the past year (SAMHSA) • Prescription Drug Misuse: The 2023 Tennessee Youth Risk Behavior Survey revealed that 23.7% of high school students reported having ever taken prescription drugs without a doctor's prescription (Tennessee State Government - TN.gov) These statistics highlight the significant prevalence of substance use among Tennessee's youth, emphasizing the urgent need for accessible and effective IOP substance use treatment programs tailored to adolescents. **Available Resources to Address Need:** Yes, eight IOP programs and five residential programs statewide.

Committee	Priority	Category	Children's Committee Needs Assessment (continued)
Children's Committee	2	Substance Abuse	**Need:** Increase access to detox for adolescents.
			Data: According to the 2024 State of the Child Report, 4.1 percent of Tennessee students reported having injected an illegal drug, compared to 1.2 percent nationally. Compared to the national average, Tennessee ranks higher, pointing to a need for increased treatment options for adolescents. According to the 2022-2023 TN Together Student Survey, 2.9% of students reported misusing prescription drugs in the past 30 days, 42% of which reported high-frequency use on six or more days. Similarly, 11% of TN students reported consuming alcohol in the past 30 days, 24.2% of which reported high-frequency consumption on six or more days.
			Available Resources to Address Need: Currently, there is one medically managed detox program for adolescents at Lakeside in Memphis. Some hospitals are starting to offer detox, but most are sent to the ED to detox.