Tennessee's Opioid Settlements

The United States is in the **midst of a crisis** on its streets and in its communities as **overdoses, homelessness, and disorder reach record levels**. Yet settlement proceeds secured by the State of Tennessee present an **unprecedented opportunity for generational investment** in treatment capacity for chronic substance abuse (CSA) and severe mental illness (SMI).

Tennessee is set to receive **over $1.3 billion** (*$1,388,484,302.98*) in opioid settlement funds—equal to over one-third of the state's share of the monumental Tobacco Master Settlement Agreement.[1] With twenty-two separate settlements and with payments spread out over decades, the funds are **at risk of being squandered** through ad-hoc allocations to **diffuse and disorganized efforts**.

The state must ensure that this opportunity for treatment investment does not go underutilized. **Tennessee can make targeted investments in treatment capacity** that will **honor those who suffered** in the opioid crisis and **ensure accessible care** for decades to come.

Tennessee reserves 15 percent of opioid funds for the state's use, 45.5 percent for the abatement fund (combined: *$881,072,318.76)*, and the remainder is allocated to subdivisions.[2] [3] [i] The 15 percent state share is directed to the state's general fund.[4] The abatement share is directed by the Tennessee Opioid Abatement Council, comprised of 15 members, and tasked with creating a list of approved programs for the state, the Council, and subdivisions.[5] [6] Unfortunately, the list of approved uses is the same as the list of recommended uses found in each settlement.[7] **The Council could amend this list of approved uses and provide for a more targeted set of priorities.** Additionally, the state's dashboard does not provide information on the actual uses of funds.[8] This negates any possibility of oversight on use of funds by the Council. **The legislature should amend the allocation statute to streamline funding by directing the abatement funds into a separate account allocable by the legislature.**

The state must rein in the potential misallocation of these funds and prioritize investments in comprehensive treatment networks. **Three priorities** (Certified Community Behavioral Health Clinics, secure psychiatric beds, and community SMI/CSA response) **will ensure these funds have the largest impact** on the state.

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[i] Except the McKinsey and Publicis settlements, of which the state controls 100 percent of funds.

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care and are stably-funded and supported by all recent presidential administrations. CCBHCs are a key response to the crisis and can augment other services such as police crisis response teams, homelessness outreach and services, and outpatient psychiatric commitment services.

- **Solution: Fund the development and expansion of CCBHCs.**
    - Expand the CCBHC footprint with an emphasis on a team-based approach to co-occurring disorders.
    - Create a stepped approach to SMI/CSA treatment with services provided by the CCBHCs.
    - Require CCBHCs to offer specific care pathways to meet the needs of individuals with co-occurring disorders.

State Psychiatric Hospitals

Inpatient beds in secure facilities are critical for serving the highest-acuity psychiatric patients. Tennessee currently has only **6.6 state psychiatric beds** per 100,000 people available for civil patients.[9] [10] Treatment Advocacy Center recommends a rate of 30-60 beds per 100k. Even counting non-public secure psychiatric beds, Tennessee still falls short of the minimum.[11] Secure beds are costly, but a necessary expenditure to protect patients with severe psychiatric disorders and the public at large.

- **Solution: Fund the expansion of civil psychiatric beds.**
    - Invest in expanding state hospital capacity.
    - Move forensic (criminal) commitments to a jail-based restoration facility.
    - Apply for one of several Section 1115(a) waivers to expand Medicaid reimbursement for institutions for mental diseases (IMDs).

Inpatient Stabilization Centers and Mobile Crisis Teams

Emergency departments (EDs) are supposed to be a last-resort for times of true emergencies, but are increasingly used for all types of immediate-need medical care, especially true for low- to medium-acuity mental health crises. In order for the other two priorities to have the largest impact, there must be an immediate triage of low-acuity patients from higher-need patients, or else these investments will be drowned out, overburdened, and underutilized by those that need them most, just like emergency departments.

- **Fund community-based mental health response resources.**
    - Build out community-based recovery centers, including voluntary short-term respite housing, especially for young adults.
    - Leverage CCBHC resources to develop comprehensive mobile crisis response teams in conjunction with police crisis intervention teams (CIT).

- Support integration with crisis networks such as the Lifeline to support those in need or provide guidance for concerned loved ones.

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[1] KFF. "Actual Tobacco Settlement Payments Received by the States (in millions)." Accessed 8 September 2025. https://www.kff.org/health-costs/state-indicator/tobacco-settlement-payments.
[2] The allocation split as stated in the Agreement provides 15 percent to the state, 70 percent to the abatement fund, and 15 percent to subdivisions. However, *see Note 3* for subsequent reallocation. "Tennessee State-Subdivision Opioid Abatement Agreement." https://drive.google.com/file/d/1U7eXgNB2HZm7LtuvGH5sBiiB1rqGwzAw/view?usp=sharing. For further amendments to the Agreement, *see* Cicero Institute, "Opioid Lawsuit Documents: Tennessee." https://drive.google.com/drive/folders/1Zs5Wh-nxoTQ0QTsvSCbhRDrwU83YscBY?usp=sharing.
[3] Tenn. Code Ann. § 33-11-103(p) redistributes 35 percent of funds from the abatement fund to counties that join the settlements (with the [likely accidental] exceptions of Apotex, Alvogen, and Zydus). https://advance.lexis.com/api/document/collection/statutes-legislation/id/62Y0-DRV0-R03M-D0K2-00008-00?cite=Tenn.%20Code%20Ann.%20§%2033-11-103&context=1000516.
[4] "Tennessee State-Subdivision Opioid Abatement Agreement," Section III.D. https://drive.google.com/file/d/1U7eXgNB2HZm7LtuvGH5sBiiB1rqGwzAw/view?usp=sharing.
[5] Tenn. Code Ann. § 9-4-1302(c). https://advance.lexis.com/api/document/collection/statutes-legislation/id/62XY-W6K0-R03M-S0KS-00008-00?cite=Tenn.%20Code%20Ann.%20§%209-4-1302&context=1000516.
[6] Tenn. Code Ann. § 33-11-103. https://advance.lexis.com/api/document/collection/statutes-legislation/id/62Y0-DRV0-R03M-D0K2-00008-00?cite=Tenn.%20Code%20Ann.%20§%2033-11-103&context=1000516.
[7] Tennessee Opioid Abatement Council, "Tennessee's Opioid Abatement & Remediation Uses." 30 September 2022. https://www.tn.gov/content/dam/tn/mentalhealth/documents/OAC_Remediation_List_Revised_10-10-22.pdf.
[8] Opioid Abatement Council, "Community Grants Dashboard." https://cloudmh.tn.gov/TNFundRpt/.
[9] Treatment Advocacy Center, "Tennessee Psychiatric Beds Report." 2023. https://www.tac.org/wp-content/uploads/2023/10/Tennesseebedsinformation.pdf.
[10] United States Census Bureau, "2023 American Community Survey – Total Population." https://data.census.gov/table/ACSDT1Y2023.B01003?q=population&t=Population+Total&g=010XX00US$0400000.
[11] Silver, Shanti, "Estimating Psychiatric Bed Need in the United States," p. 2-4. Treatment Advocacy Center Office of Research and Public Affairs. January 2024. https://www.tac.org/wp-content/uploads/2024/03/TAC_ORPA_ResearchSummary1.24.pdf.