

State Actions in Response to the Federal Homelessness Executive Order — Tennessee

President Trump announced on July 24, 2025, a sweeping Executive Order 14321, Ending Crime and Disorder on America's Streets, to respond to homelessness, vagrancy, substance abuse, and untreated mental illness. The President's plan makes clear his priority to restore America's once-great cities after decades of mismanagement and permissiveness towards crime and disorder.

States should take the following actions to comply with the Executive Orders' (EO) requirements and build on the president's vision for a safer and cleaner America.

Restoring Civil Commitment: The EO seeks to reduce barriers toward civilly committing severely addicted and mentally ill unsheltered homeless people.

Increasing Public Safety: The EO targets endemic vagrancy, disorderly conduct, and violent attacks to improve public safety and protect American cities.

Prioritizing and Increasing Treatment: The EO encourages states to use the Certified Community Behavioral Health Clinic (CCBHC) Program to address the life-challenging threats to homeless people.

Increasing Accountability in Homelessness Programs: The EO ends the prioritization of "Housing First" homelessness programs. The state should fund accountable, results-driven programs.

Failure to implement these directives could jeopardize tens of millions of dollars in federal discretionary grants from the U.S. Department of Housing and Urban Development, Department of Justice, and Department of Transportation. Federal agencies have not yet identified which specific grants are at risk.

Governor Lee can demonstrate compliance with the Executive Order through the following executive actions:

- Replace *Disability Rights Tennessee*, Tennessee's designated Protection and Advocacy for Individuals with Mental Illness Act (PAIMI) advocate group, with a

nonprofit or state office that supports a more balanced approach to civil commitment.

- Create state grant requirements supporting the enforcement of laws prohibiting open drug use, urban squatting, camping, and loitering.
- Direct the Tennessee Attorney General to ensure homeless services providers share data with local and state law enforcement agencies.
- Require state outreach and enforcement programs directed at homeless people to include participation of CCBHC staff when appropriate.

These proposals, as well as additional executive and legislative actions compliant with the EO, are detailed further in the following pages.

Restoring Civil Commitment

Executive Order 14321 seeks to reduce barriers to civilly committing unsheltered homeless people who are unable to care for themselves due to severe mental illness and addiction. States need to review their processes and reform their laws to appropriately shift, as the EO says, “homeless individuals into long-term institutional settings for humane treatment through the appropriate use of civil commitment.”

- The rights of institutionalized patients require protection. However, the federal program created to advocate for the mentally ill, PAIMI, and its Washington, D.C.-based trade association, National Disability Rights Network, has morphed into a 50-state lawsuit machine against states’ ability to treat people who need it most. These groups take a radical view of treatment, often equating it to torture. Governors designate which organizations sit on the PAIMI board and, therefore, should designate nonprofits (or state agencies like AG offices) that support a more balanced approach to civil commitment, the administration of assisted outpatient treatment, and other efforts to treat the mentally ill.
- According to the Treatment Advocacy Center, Tennessee scores an F in providing involuntary treatment for psychiatric illness. While Tennessee does have civil commitment and outpatient treatment provisions in state law, deficiencies include narrow petitioning authority limited to professionals or enumerated relatives, burdensome multi-professional certification requirements, vague and overly restrictive grave disability standards, lack of

psychiatric deterioration criteria, absence of clear court oversight and reporting for outpatient orders, and mandatory outpatient treatment (MOT) limited as a hospital step-down rather than a community-initiated alternative.

Executive Actions:

1. Governors and attorneys general should adopt policies relating to mental illness, addiction, and homelessness in addition to legal standards that reduce barriers to civil commitments and treatment requirements. These policies and standards should provide maximum flexibility and form a basis for defending lawsuits opposing treatment and civil commitment. They should also direct agencies to prioritize treatment over non-treatment, which too often leads to tragedy. The U.S. Department of Justice (DOJ) and Health and Human Services (HHS) are charged with offering assistance to states in this effort.
2. Designate aligned nonprofits or state agencies to replace current PAIMI-designated organizations. (See Appendix A.)

Legislative Actions:

- 1) Reforms to state civil commitment laws should reduce barriers to civil commitment and mandatory treatment. Such legislation should include:
 - a. Expanding civil commitment processes to include substance abuse and expanding involuntary psychiatric holds beyond 72 hours for a maximum of 60 days for certain substance abuse cases.
 - b. Redefining and standardizing the definition of “dangerousness” for civil commitments to include repeated and continuous violations of the social order. This reform uses repeated and continuous violations of social order as a demonstration of a deteriorated mental state. It provides the state the authority to intervene before someone becomes a threat to physical harm to themselves or others, which is often the current standard.

Increasing Public Safety

Executive Order 14321 seeks to increase the public safety of American cities. To do this, it is necessary to take steps to end “endemic vagrancy, disorderly behavior,

sudden confrontations, and violent attacks.” The EO instructs the U.S. Attorney General and the U.S. Secretaries of HHS, Housing and Urban Development, and the Department of Transportation to utilize their authority to award discretionary grants to prioritize funding based on enforcing prohibitions of:

- Open illicit drug use,
- Urban camping and loitering, and
- Urban squatting.

Awarding of grants will also be prioritized based on:

- Utilizing mandatory outpatient treatment (MOT) and moving the unwell into treatment via civil commitment and other means, and

Federal discretionary housing and homelessness grants alone accounted for \$30 million for Tennessee’s agencies and nonprofit organizations in fiscal year 2025.

Tennessee Homelessness Executive Order Implementation Score Card	
<i>Open Illicit Drug Use</i>	<i>Insufficient</i> Enforcement is uneven and data is limited
<i>Urban Camping and Loitering</i>	<i>Insufficient</i> Enforcement, data collection, and reporting lacking
<i>Urban Squatting</i>	<i>Sufficient</i>
<i>Use of MOT to Remove SMI from Street</i>	<i>Insufficient</i> Additional action required to connect MOT with unsheltered and untreated individuals with mental illness
<i>SORNA Compliance</i>	<i>Sufficient</i>

Executive Actions to Increase Public Safety:

1. Create state grant requirements supporting the enforcement of laws prohibiting open drug use, urban squatting, camping, and loitering. Utilize MOT and move the seriously mentally ill and addicted off the streets and into treatment. Grant requirements should also include that homeless services and outreach providers keep data on the effectiveness of programs intended to reduce the number of people living on the streets.

Tennessee Housing Development Agency (THDA) announces funding opportunities, and those opportunities should be aligned with the EO. There are other similar opportunities with appropriate grants through Tennessee HHS, such as addiction services, HIV/STD programs, and drug abuse intervention programs.

2. Direct the Tennessee Attorney General and law enforcement agencies to identify homeless criminals and cross-reference with Homeless Management Information System (HMIS) records. Require homeless service organizations to share HMIS with law enforcement.
3. Require mental health hospitals and state mental facilities to collect data on forensic bed monitoring and occupancy and report these findings to the state. Currently, because there is a shortage of beds, forensic or criminal cases occupy most state mental health beds. Should occupancy rates for non-forensic cases fall below a certain standard, transfer state funds from forensic detention to community programs like group homes so that non-forensic cases are placed in supportive and clinically appropriate facilities.
4. The EO promotes expanded MOT utilization as a mechanism to transition individuals with serious mental illness (SMI) or drug and alcohol addictions from street homelessness into structured treatment programs. Effective implementation requires comprehensive data collection and reporting systems at the state and county levels. This enables mental health outreach services and homelessness service providers to monitor and document MOT's effectiveness in reducing unsheltered populations among individuals with SMI.

Legislative Action to Increase Public Safety:

1. Pass Cicero model legislation creating Drug Free Homeless Service Zones. Institute a state crack house statute that would prohibit the operation, management, or control of properties for manufacturing, distributing, or using controlled substances and forbid property owners from making a property available for the unlawful use of controlled substances.

2. Outlaw urban squatting and expedite eviction processes. Oppose and make onerous circumstances for adverse possession whereby squatters can claim legal ownership of a property.
3. Instead of relying on the inaccurate and untimely Point-In-Time Count to determine the efficacy of homelessness programs, require homeless individuals to register with the state to qualify for homelessness assistance.
4. Require taxpayer-funded housing and homelessness services to report quarterly data and outcomes on their unsheltered homelessness efforts.
5. Reroute homeless individuals arrested for lower-level, nonviolent crimes to pre-arrest/post-booking/pre-trial diversion programs instead of jail.
6. Pass sex offender reforms that include passive and active electronic monitoring of transient sex offenders and ensure state compliance with the federal Sex Offender Registration and Notification Act (SORNA).
7. Dedicate state funding to assist cities in removing encampments. Include strict definitions, activities, partnerships with CCBHCs and other mental and behavioral health programs, data collection and reporting, and claw-backs of state funds for repopulation of encampments.
8. Provide grants to support reentry centers for prisoners released from incarceration and reduce funding for prisons that fail to create re-entry plans or require compliance with plans.

Prioritizing and Integrating Treatment

Executive Order 14321 squarely addresses the life-threatening challenge of homeless individuals who are seriously mentally ill and addicted. Emphasizing treatment will save lives and reduce disorder. It directs states to take advantage of the Certified Community Behavioral Health Clinic (CCBHC) program, which integrates mental health, substance abuse, and physical health treatment in a single setting. These programs provide 24/7 crisis intervention services, reducing emergency department and hospital utilization.

States can create CCBHCs and receive Medicaid reimbursement for treatment by amending their Medicaid plan. By applying to Substance Abuse and Mental Health

Services Administration (SAMHSA) for a demonstration grant and completing the demonstration period, states can increase Medicaid reimbursement by up to 10 percent.

Tennessee does not have state-supported CCHBCs. Only five clinic grants have been awarded to community-based organizations by SAMHSA. Tennessee should invest in treatment and incentivize the pairing of clinics with homelessness housing and shelter programs. Tennessee will receive more than \$881 million in Opioid Settlement dollars over the next two decades. Rather than allocating the funds in a diffuse and low-impact manner, the state should direct its share of settlement proceeds to centralized projects such as CCBHCs. Doing so will provide reduced costs in emergency department services, homelessness, and incarceration.

The EO also seeks to prioritize treatment instead of harm reduction and safe consumption of illicit drugs. It directs SAMHSA to end federal support for harm reduction and safe consumption programs. Tennessee should replicate this action at the state level.

Executive Actions for Treatment:

1. Require state outreach and enforcement programs directed at homeless individuals (Homeless Outreach Teams) to include participation of CCBHC staff when appropriate and service request protocols when individuals with severe mental illness and/or substance abuse are encountered.
2. Connect and analyze data on unsheltered homelessness to the provision of MOT, civil commitment, and other efforts intended to remove homeless people from the street. Require data collection and reporting of county and state mental health departments' outreach programs. Include the reporting of referrals and interventions of MOT and civil commitments to unsheltered homeless individuals in data collection efforts.
3. Encourage the expansion of CCBHCs by submitting a state Medicaid plan amendment to the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services.

4. Require state inmates who qualify for parole and have a history of mental illness to be evaluated for MOT and, if indicated, require such evaluation as a condition of parole.

Legislative Actions for Treatment:

1. Prohibit the distribution of harm reduction and safe consumption paraphernalia such as hypodermic needles, glass pipes used to smoke drugs, and other items.
2. Fund CCBHCs specifically focused on homelessness, street outreach, and crisis intervention. Provide funding bonuses to nonprofits and healthcare providers that operate CCBHCs and report the number of homeless served and that achieve long-term clinical milestones such as three-month, six-month, and 12-month milestones in treatment and recovery.
3. Provide bonuses for homeless service providers to co-locate shelters and housing facilities with CCBHCs.
4. Dedicate and expand state funding for drug and mental health courts, or fund and promote combined therapeutic models that reduce duplication of effort and funding, and consider all potential treatment needs under one probation officer.

Increasing Accountability and Safety in Homelessness Programs

The Federal Government and the states have spent tens of billions of dollars on programs that have failed to address homelessness because they have ignored its root causes, leaving other citizens vulnerable to public safety threats. Issues of accountability, integrating homelessness assistance efforts with treatment, and pursuing ideologically driven approaches instead of those that effectively reduce the number of people living and dying on the street must be addressed.

This EO ends the federal prioritization of the “Housing First” approach that provides government-subsidized and government-provided housing with no preconditions or requirements for participation. Housing First creates a situation in which a mentally ill person gets sicker; They don’t stop being psychotic or using drugs or alcohol just

because they have a roof over their heads. These conditions wreak havoc on others trying to live safe and productive lives in these housing facilities as well as the surrounding communities.

States should build on the actions in the EO to increase accountability and create more effective programs to end homelessness.

Executive Actions for Homelessness:

1. Require data on public safety impacts of homelessness as part of conditional use permits and annual reporting. Impacts include calls for service, arrests, crime reports, and overdose deaths.
2. Support CCBHC operations in homelessness assistance programs and integrate CCBHCs as the preferred behavioral health provider for homeless persons in housing, shelters, domestic violence programs, and on the street.
3. Require the state to provide homeless facilities with lists of homeless sex offenders, or require homeless facilities to run background checks on participants and report to the state if hits occur.
4. Require homeless service providers who receive state funds or have been incorporated in the state as organizations housing or serving the homeless to share homelessness and HMIS data they collect with the state.

Legislative Action for Homelessness:

1. Ensure that state funding streams (e.g., the Tennessee Housing Trust Fund and the Creating Homes Initiative (CHI)) prioritize programs that include structured wrap-around services such as treatment linkage, workforce readiness, and coordinated case management, while allowing collaborative nonprofits to maintain flexibility based on local needs.
2. Regulate and discourage the practice of so-called “mixed-hoteling,” in which homeless individuals are placed in hotels that are open to the general public. Require that regular hotel patrons be notified during the booking process that the hotel participates in these programs and require hotels to prominently display signage to the same. Hotels must also be compelled to comply fully with other regulations for homeless shelters, such as staffing requirements and laws pertaining to Drug Free Homeless Service Zones.
3. Tennessee housing and shelter programs should be based on performance. Grantees that demonstrate a reduced proportion of unsheltered homelessness

should receive priority for bonus funding or contract renewals. All grantees must collect and report utilization data as a requirement of continued funding.

4. Provide funding for innovative shelter programs such as sprung structures, utilization of vacant public properties, unused sports facilities, and vacant buildings that can provide shelter and treatment for large numbers of people.
5. Require individuals qualifying for federal and state benefits due to homelessness, SMI, or substance abuse combined with homelessness, to receive treatment provided by CCBHC. Those who qualify should be automatically referred to clinics that address the conditions for which they qualified.
6. Prohibit the housing of sex offenders in facilities that also accommodate households with children.

Conclusion:

President Trump, through Executive Order 14321, has signaled that revitalizing American streets will be a priority for his administration. Addressing untreated mental illness and expanding civil commitment, improving public safety, integrating treatment into homelessness programs, and holding homelessness programs accountable can provide that revitalization. States have an important role to play. By implementing the above executive and legislative actions, essential aid will be provided to the drug-addicted and severely mentally ill, Tennessee will avoid risking tens of millions in federal funding, and Tennessee cities will become safer and more prosperous.

Appendix A: Tennessee PAIMI

The Substance Abuse and Mental Health Services Administration and Protection and Advocacy for Individuals with Mental Illness Act programs were created to safeguard the rights and improve the quality of care for those with the most serious of mental illnesses. Operated by state protection and advocacy or disability rights organizations, PAIMI programs have unique federal authority to investigate abuse, neglect, and civil rights violations in psychiatric hospitals, residential treatment programs, and carceral settings.

Issue

Over time, PAIMI resources have shifted away from oversight of inpatient, residential facilities and carceral settings toward a broader focus on community-based services. While community care is essential, this shift has weakened PAIMI's ability to ensure that individuals with SMI, particularly those with psychosis-related disorders, receive safe, timely, and medically necessary inpatient or residential treatment when required. Frivolous lawsuits filed by protection and advocacy organizations often impede a state's ability to effectively and efficiently provide life-saving involuntary treatment.

Why It Matters

- **Unmet needs:** Individuals with untreated or undertreated SMI often continuously cycle through emergency rooms, homelessness, and incarceration.
- **Inpatient stabilization:** Hospital and residential care provide a critical foundation for stabilization, which makes community care more effective.
- **Oversight gap:** Without robust PAIMI oversight in facilities, individuals with SMI remain vulnerable to abuse, neglect, preventable harm, and death.
- **Support the EO:** Strengthening PAIMI through state protection and advocacy organizations supports the White House EO on crime and homelessness.

Recommendation

Governors play a critical role in ensuring state protection and advocacy organizations support the re-centering of care and oversight for those with SMI. Governors should initiate a process to change a protection and advocacy designee to an entity that supports a more balanced approach to civil commitment and the appropriate actions of the state to provide treatment of severe mental illness.

The process includes a finding of cause, public notice, and other steps necessary to change the current protection and advocacy designee. To create a transparent process, a task force should be formed, comprised of stakeholders that reflect a “treatment before tragedy” approach, such as the National Alliance on Mental Health and Treatment Advocacy Center representatives. This provides an opportunity to address the complexities of expanding civil commitment, involuntary treatment, the dangerousness standard, and the link between insufficient treatment and increased unsheltered homelessness.

Tennessee PAIMI Advisory Council Members:

Caitlin Wright, Chair
Jan Cagle, Vice-Chair
Claudia Avila-Lopez, Secretary
Willa Felder-Boyd
Julia Johnson
Mark Liverman
Carey Menefee
Eve Nite
Halima Perry-Thurmon
Irena Stjepic

Appendix B: Select Tennessee Grant Programs

[Creating Homes Initiative \(CHI\)](#)

The Creating Homes Initiative (CHI) is Tennessee’s long-running, statewide affordable housing effort targeted to people with mental illness, those with co-occurring addictions, people leaving incarceration, and other vulnerable groups. CHI operates through regional housing facilitators, local task forces, and one-time grant awards to local nonprofits and providers. In April 2025, TDMHSAS announced a \$5.2 million CHI grant round that awarded funding to 12 nonprofit agencies.

[Creating Homes Initiative 2.0 \(CHI-2\)](#)

An extension of CHI focused specifically on recovery housing for individuals with drug or alcohol addiction. One-time state funds are administered through TDMHSAS with regional housing facilitators.

[Tennessee Department of Mental Health and Substance Abuse Services Criminal-Justice & Reentry Grants](#)

TDMHSAS administers multiple grant streams and programs aimed at justice-involved individuals, including pre-arrest diversion capital grants, funding for treatment of justice-involved people (ADAT, SPOT, CTC—see TDMHSAS Criminal Justice Services), and programs that fund jail diversion infrastructure and reentry housing/supports. These funds are used to expand diversion, reduce recidivism, and connect people to community treatment.

[Project Rural Recovery](#)

A multi-year, federal grant-funded initiative administered by TDMHSAS to expand treatment and recovery infrastructure in rural counties (capital and service grants awarded competitively).

[State Opioid Response \(SOR\)](#)

Tennessee receives State Opioid Response (SOR) funding (and related federal opioid response grants) used to expand medication-assisted addiction treatment, overdose prevention, and to build treatment capacity. TDMHSAS coordinates many SOR-funded initiatives at the state and regional levels