Now you can change to the second… second slide. And now the third, and go ahead to the slide 4.

One more? Okay.

No, right there, that's fine.

All right. Um, so I'll go ahead and get started then. Um, this is just sort of our introduction to our 2025 annual report that we put out earlier this year.

Um, some of the data and stuff that is in that report.

Um, it's sort of our detailed look at all of the… to address suicide, all of our efforts, and addressing public health concern.

Sheds light on emerging trends and…. Uh… identifies populations at risk.

And then, uh, next slide.

William Thompson:

Alright, so, uh, this… this is our sort of overview of the state of Tennessee.

Um, I'm looking at suicide fatalities in Tennessee from 2019 to 2023.

Um, you can really see here…. How… so that blue line at the top is the right for Tennessee, and that red line below it is the U.S. Rate.

Per 100,000 populations. And so you can see here we're, you know, much higher here in Tennessee.

About 20% higher than the national average. And you can see that there's, you know, about 1,200.

Death to suicide a year in Tennessee. Um, we've seen an increase over the last, you know, 2 or 3 years.

Sort of in a place of fluctuation, we don't…. But, um, our numbers have gone up following, you know, increases in population here in the state of Tennessee, so that.

You know, absolute number of deaths has increased, but the rate has not changed.

If you want to go to the next slide. So here's a, you know, overview of how it breaks down statewide. You can really see here that it's that.

Eastern sort of section. It's not quite the eastern grand region, but it's close.

Um, has some of the highest rates of…. Suicide here in Tennessee, so the East Public Health Region, the Northeast in Sullivan.

Are really where you see the highest burden. Um, and overall, the rural parts of the state are about 1.2 times higher than the.

Uh, sort of metro-urban parts of the state. Uh, if you want to go to the next slide.

Uh, here we have, you know, looking at that again, that 1.2% higher.

It used to be much further apart, 1.4 times. However, we've seen.

Both the decrease in rural rates and an increase in our rates in metro areas have really brought that a lot closer together.

Over the last 2 years, but there's still an outsized burden in those rural parts of the state. They're still….

You know, quite a bit higher than…. The metro parts, despite closing that gap.

Uh, if you want to go to the next slide. Here we have the breakdown by gender. This is the biggest disparity in suicide, is the gender disparity.

Um, you know. About 4 times higher among men than it is among women. It, you know, the exact number changes, but it's around 4 times as high.

Um, but it is important here, and we…. Marked out that this is sort of the first time we've seen.

At least in the last 5 years, an increase in the rate among women between 2022 and 2023.

And then this was driven primarily by those. Age 25 to 64, so they're sort of like the….

Working adult aged. Um, women is where we've really seen an increase in the rates.

Uh, next slide, please. Um, so here's the, sort of, the second biggest disparity. Um, white.

Tennesseans see a much higher, um, suicide rate, more than twice that of non-Hispanic Black Tennesseans.

And our other racial ethnic group. Fortunately, or sort of fortunately.

There's not enough suicide in. Are other minority, um, racial ethnic groups.

For us to break them out. But, you know, in terms of statistics, it's unfortunate, because we can't see how each individual group is really.

Impacted? Um, but we could really see here how it's that white, non-Hispanic white that is suffering the highest rates of.

Suicide in Tennessee. Uh, next slide, please.

Um, here's the, sort of, the biggest thing we really were looking at in our latest report is that firearms.

Account for more than 2 out of every 3 suicides in Tennessee, and every single year.

Pretty much it increases. It's never gone down as a percentage of….

Firearm, or percentage of methods. Of death by suicide in Tennessee. That firearm is consistently taking up a bigger and bigger chunk, going back over a decade. That chunk has increased ev-.

Increased or stayed the same, I should say, every year. Um.

And so, next slide. Here we have by age.

The… the sort of adult…. Age groups, all….

Don't have really any trends in them. They've stayed. They fluctuate up and down, but they don't… they're not trending in any specific direction. However, that 10 to 17 age group.

This is where we've really seen. Changes over the last 5 years. You can see a real big increase from 2019 to 2023.

Um, really highlighting the need for specialized enhanced mental health support.

Targeting this age group, because while it is below its really trending up. It's, you know, it's below the other age groups, it's really trending up.

Uh, next 8, next slide… not next age group. Um, here you can see….

How the…. Youth Rated Tennessee has really diverged from.

The national rate in the last, really, 2 years, you can see there. You know, it did increase between 2019 and 2020.

You know, 2022, but really, 2022 to 2023, we saw a big increase.

That is very different from an actual averages. Really overall seeing a decrease in the rate of youth suicide.

Um, and this was paired…. To….

Paired with an 80% rise in the use of firearms in youth.

Suicides during that same 5-year time period. Um, there… males were more affected than females, but not….

Not really any differently than the, you know, whole population average difference between men and.

Women, and then there are no significant differences observed by race.

Um, which is different than our…. Overall age group, so overall.

Not Hispanic, whites are much higher, whereas here, there's no significant.

Differences observed by race. In our rates.

Uh, so next slide. And then sort of expanding it out beyond that, we, you know, we talked about the $1,279 deaths by.

Suicide in Tennessee. However, it's also important that we focus on the over 9,000 self-injury ED or hospital visits.

The over 40,000 suicidal ideation ED visits. Um, and then, of course, all the people who've never received medical care.

Uh, next slide, please. Uh, intentional self-injury has decreased by about 9% for all Tennesseans, which is….

You know, great to see, while…. You know, some of… this is, you know, it's different, obviously, than what we were seeing in death.

We are seeing pretty significant decreases in self-injury hospitalizations. However, the rate of hospital visits for Black Tennesseans.

Non-hispanic Black Tennesseans surpassed the rate of non-Hispanic white Tennesseans for the first time.

So they were very close together, you know. Different from death, where white was much higher. They were very close together for self-harm, but for the first time, that non-Hispanic Black Tennessean group.

Surpassed the non-Hispanic white Tennessean group. And while more men die by suicide annually, the rate of hospital visits for injury are 1.5 times….

For… among women are 1.5 times that among men. And our… and while we saw that overall decrease.

Mirroring our increase in death by suicide among our youngest age group. We also saw an increase in non-fatal self-injury among that age group.

Um, so this is the only age group that experienced an increase during this 5-year period.

Uh, next slide, please. Suicidal ideation, hospitalization has remained relatively stable in Tennessee, some minor fluctuations, decreasing about 3 point….

3%, um…. So that's relatively stable, and while not Hispanic white tee Indusians die by suicide annually, non-Hispanic Black Tennesseans.

Are the racial ethnic group with the highest rate of suicidal ideation.

So that is much higher among this age group. And, um, yeah, the highest age group we actually see. So while the youth age group was the lowest death by suicide, they have the highest rate.

Of suicidal ideation hospitalization, and they have increased by 25%. Over the past 5 years. Once again, sort of the one age group that's really increasing.

Among all three of these outcomes. And so, that's just sort of a brief overview of all the data of suicide in Tennessee, some of our data.

And now I want to pass it over to LaDonna. On the recommendations, uh, next slide.

Hi, friends!

Thank you, William, and thank you… thank you for the, um, great presentation of that data. Uh, go ahead to the next slide, please.

This is Paula. Ladonna and William, can I hop in? Did you want to hold.

Any questions you may have? We have a couple in the chat.

Sure. We could go over… I guess it would be good… we can go over the data questions real quick and get them out of the way.

Sure.

Okay. Thank you.

Um, so, sort of the first question is…. Is there a way to ferret out those who are dying already?

Poor quality of life, chronic, painful health conditions. So, we don't have a great way to separate those out.

Um, you know…. There's… and then there's a lot of, just sort of….

Difference in terms of, you know. There are a lot of people who do….

Um, have self-harm or suicidal ideation because, you know, chronic pain or anything.

Obviously, we do see that more at the, you know, the higher age group of the spectrum.

Um, but there's not a great way to set… other than….

At scale, there's not a great way to separate those people from.

Is this from all… all other reasons, um, and of course.

You know, we're still concerned about those people. We don't really want to separate them out because.

All of those reasons. You know, maybe they….

Need just better treatment. Better healthcare treatment or other reasons, and we sort of like to keep all of those different groups together.

And then, I think the other one is, do you think the decrease was coming out of the pandemic?

Um, it's possible, you know, we…. There was a lot of talk, um, in the, you know, especially in 2022, 2023 here at Tennessee.

Looking at… or even last year, 2024, we were looking at.

The impacts of the…. Of the pandemic on some of our numbers.

And… yeah, I mean, hospice is definitely very different, but we don't currently sort of separate those out. You know, hospice versus people who are just in chronic pain and living at home.

Um. We don't have a good way to separate those out, um, currently, at least.

And then, pandemic, we really haven't been able to…. Find any, sort of.

Concrete evidence of…. Real impacts from the pandemic on our rates.

If anything, our numbers in 2020 were lower than they were in 2019.

So, you know, there are a lot of…. People concerned, and obviously, you know, the hospital visits are going to be impacted during COVID because it's harder to get into the hospital, people don't want to go to the hospital.

But even deaths decreased during that 2020 period and 2021 period.

Which were really the most… when most people were most severely impacted directly by, you know.

Staying at home. And we didn't see an increase in that going into those periods, so….

Also have a hard time, sort of. Assigning anything….

On the back end as well. So, I think that's the last end of the question.

Is there anything else?

That's all I see. Oh, wait, there's new ones.

Yes, I would… I was seeing the increases correlate to overdose, um, doses.

Okay.

And then…. Looks like a comment on, yes, the topic.

Is crucial and very common in this industry, unfortunately.

Are we ready to proceed?

Hello? Okay, sorry. So, um….

Yep, yep, go ahead.

LaDonna Merville:

I was going to talk a little bit about our recommendations from our annual report, and I'm going to try to go through this pretty quickly, because I know we've got some of the presentations. So, uh….

First of all, we have some recommendations for healthcare providers and healthcare systems relative to screening patients.

Promoting the 98 Suicide Crisis Line, making sure patients understand their, uh, rights under mental health parity. Also, ensuring that, uh, pediatricians and other people who work with children are aware of the.

Tinsi Child and Adolescent Psychiatric Education and Support, uh, consult line.

And then, um, obviously, uh, screening and treating pregnant and postpartum patients.

Uh, next slide. Please.

Uh, our county health councils, um. We have recently released some Essence Rapid Response Plans. We always want to share suicide data with our local partners.

And we encourage you to join our Tennessee Suicide Prevention Advisory Group to stay informed.

Next slide, please. With our community faith-based organizations and schools, uh, we encourage people to take, um, gatekeeper, uh, training, such as, um.

Assist or QPR, make sure clergy are, um, taking advantage of programs like Livingworth Banks.

Faith, or Living Works Faith, um, as I said, talking about our essence rapid response plans, uh, incorporating sources of strength in middle and high schools, uh, if your organization can host a Be Smart webinar that promotes.

5 firearm, uh, safe firearm storage, and then partnering with other, uh, coalitions like Voices for a Safer Tennessee.

Next slide, please. For those organizations that serve service members, be sure to encourage them to complete some.

The free suicide prevention trainings that are provided through the VA, and also promote the VA's.

Keep a secure campaign for firearm safety. Next slide. And then for all Tennesseans, uh, we encourage everyone to learn to recognize and respond to suicide warning systems. Be sure you safely store your medications and adopt safe firearm storage practices. Anyone can take an assist or QPR training. Be sure you know about the 988 crisis line.

And provide, um, that information to others, and then go to our website at www.presentsuicitn for more resources. Next slide.

Uh, for the next couple minutes, we're going to talk about just some of the links between TBI and suicide.

Uh, traumatic brain injury is, uh, is known to, uh, increase the risk of suicide. Studies show that individuals with TBI.

Are 2 to 4 times more likely to die by suicide than the general population. And this is especially true for those with moderate severe TBI.

And for vulnerable groups such as veterans, young athletes, and individuals living in rural areas.

Tb often affects brain regions responsible for impulse control and emotional regulation.

Which can lead to suicide behavior even without prior mental illness. This intersection is critical to prevent, uh, in addressing prevention.

Next slide. The mental health effects of TBI are profound. Depression alone affects about half of those with brain injury, often within the first year post-injury. Depression is also the strongest predictor of suicide in this group.

Anxiety, PTSD, impulsivity, and substance misuse are also common. These symptoms, combined with the stigma of mental illness and disability, may prevent individuals from seeking help.

Further increasing suicide risk. Next slide.

Also, other factors such as difficulty returning work to work, and a change in one's role at home can create financial and social impacts.

That decreased quality of life. And lead to increased sense of hopelessness. Other factors include difficulties associated with brain functioning, shifts in relationships.

In changes in sleep, energy levels, and mood. Next slide. Also, individuals with TBI may exhibit other factors associated with higher risk for suicide.

Such as substance misuse, stressful life events, a history of prior suicide attempts, and lower levels of social support.

Next slide. And then our data from our annual report shows that over 2.

1,000 moderate to severe TBIs. Often occur in rural communities where suicide rates are already elevated. Unfortunately, access to brain injury services may be limited outside of metro areas, so we need to think about how we can integrate suicide prevention into TBI care.

From trauma centers to primary care. So, having stronger referral partnerships between TBI programs and suicide prevention services are something that's an actionable first step.

So, sharing training and cross-system alerts and resource integration can help make a difference.

Next slide. And there's a growing body of research that connects concussions and other mild TBIs to elevated suicide risk in youth.

Those, uh, studies have found that adolescents who experience one or more concussions are more likely.

To report suicidal thoughts, plans, and even attempts in their peers who haven't had a concussion. Therefore, there's some mental health overlap.

Uh, with bullying, depression, substance use, poor sleep, um, males often, uh, tend to be more impacted by repeat concussions.

Uh, and females have, uh, are more impacted by related stressors. And therefore, there's a lasting impact, even mild TBIs can have long-term psychiatric effects, like anxiety.

And depression. Next slide. Uh, now I want to cover some of the suicide prevention resources that we offer. First of all, our program is a layered, multifaceted.

Comprehensive approach to suicide prevention across the state. You can visit our website for, um, information and resources.

Next slide. Our prevention program has, um, several notable, um, initiatives. First of all, it's important to, uh, train and empower gatekeepers.

Who can help, uh, help you learn to recognize suicide warning signs and respond. We are focusing on implementing in healthcare systems the suicide.

Zero Suicide framework. And then, uh, expanding our tele-mental health best practices so that we can, uh, help providers improve their delivery of telemental health services, particularly in rural and underserved areas.

Next slide. Uh, we've also, uh, conduct public service campaigns to reduce stigma and promote health-seeking behavior.

And we, uh, leverage real-time data from emergency rooms, uh, through our Essence Alert system to monitor spikes in suicide-related emergency visits, and, um, to initiate a timely coordinated response when necessary.

Next slide. As, um…. William, uh, pointed out earlier, um, we analyze and share suicide-related data, like, uh, our annual report.

Uh, with our partners across the state to help inform suicide prevention initiatives, and we work to empower youth through programs like Sources of Strength, which is an evidence-based youth-led suicide prevention model.

Uh, that's being implemented in middle and high schools, faith-based organizations.

And community-based organizations across the state in rural communities. Next slide. Uh, for those, um, who are interested in a gatekeeper suicide prevention training, our, uh, partner Tennessee Suicide Prevention Network provides.

Many different types of trainings, and you can go to their website and learn more about the trainings.

And request one for your organization. Next slide. Uh, if you're interested in the Zero Suicide, um, uh, system and implementing that in your organization.

There's some contact information there. Lisa Kling at TSPN. Would be happy to, uh, provide that information for you. Next slide.

Uh, as I mentioned before, we're, uh, doing a series of trainings for implementing best practices in telehealth.

Partnering with Centerstone for those trainings. Uh, they have a website where you… or, um.

Web page, excuse me, where you can sign up for the trainings, uh, and includes a calendar of upcoming trainings. These are hour-long trainings.

And they offer, uh, one hour of continuing education cred… uh, credit.

Next slide. Um, as I mentioned before, we, uh, conduct some, um, uh.

Statewide PSA campaigns. Um, those include, um, broadcast and social media, uh, presence, uh, to, um, promote, uh, suicide.

Resources and, uh, the 988 crisis line. We also run the ads in English and Spanish.

Uh, next slide. Uh, as I mentioned before, the ESSENCE program is what we use to monitor, uh, suicide-related behavior across the state. This is a subscriber-based program. You can sign up to receive.

Alerts for your county, your region, or the whole states, and those subscribers get a weekly email bulletin that includes.

County health region, age, and risk factors, and there's also, as I said, the rapid response, um, plan that is shared with our subscribers so that they can implement, um.

Prevention activities in their communities when they are alerted or, um, an increase in suicide-related behavior.

Next slide. Uh, this is a little more information about sources of strength, and, um, the contact person there, I'm sorry I didn't put his name on the slide, is Chiari Jackson.

He's with TSPN's Youth Programs, and he's the liaison across the state for implementation of Sources of Strength.

Next slide. Uh, we also produce a statewide directory and information resource guide that lists, um.

Programs and services related to, um, mental health and suicide prevention. This is posted on our website.

And can be downloaded and shared with your organization. Next slide. We have a monthly newsletter. Our Prevent Suicide TN newsletter. It includes information about.

What we're doing in our program, uh, we highlight some of our partners, provide information about trainings and resources, and generally, um, any other data that might be, um, helpful to share.

Next slide. Uh, the North Tennessee Suicide Prevention Advisory Group, um, we, um, represent, uh, broad sectors across the state. We meet quarterly in a virtual setting.

To share statewide data, to update our partners on programs and services, and then get their input on how to do, um, implement, uh, more effective suicide prevention.

Programming across the state. Currently, we have about 117 people on the advisory group, but we welcome more.

Next slide. And this is for, um, Terry Love, who, um, is, uh, responsible for this. We encourage everybody to, uh, take a counseling on access to lethal Means program, or it's called Calm.

Uh, this is a program that, um, teaches participants how to identify, uh, anyone who, um, needs, uh, lethal means counseling.

Uh, it, uh, gives them information about how to raise the topic, and makes them more comfortable with discussing it.

And how to, uh, advise those people about to, um, how to store their firearms in a secure location. It may be, um, and gives them, uh.

Strategies that they can work with their patients or clients and families to develop a plan to, uh, reduce access to lethal means.

Next slide. Um…. This is also a program that our Injury Prevention Division does for youth sports. It's a Safe Stars program. It's a partnership between the Tennessee Department of Health and Vanderbilt Youth Sports Center. Um, it awards awards, uh, silver, gold, silver, and bronze.

Levels for excellence in athletic safety, or athlete safety. Uh, they provide concussion education, weather safety, and injury prevention.

And, uh, it's all about enforce… uh, enhancing safety and developing, uh, safer sports practices to reduce.

Youth sports-related injuries. So, that is, uh, all we have in terms of our presentation, and we're welcome to take questions, or please go to our website and, um.

There may be more resources that may be helpful for you, but we appreciate your time today. Thanks.

Thank you so much, LaDonna, and Brittany. Are you up next?

Well, Brittany is on vacation this week, so you've got Andy this week. That's….

Great!

She did offer to join, um, from the beach, and I told her absolutely not, so I told her to enjoy some time at the beach.

Um, first off, LaDonna, William, thank you. Thank you, thank you. Um, we are so grateful.

For our partners and our friends over at Department of Health.

Um, the data that they so expertly pull together, uh, really does help kind of drive.

Um, what resources we… we try to make available across the state, so….

Um, Wendy, am I okay to jump in and go ahead and present?

All right, I'm gonna keep this relatively short, um, because I have got… oh.

Absolutely.

Let's see here… share sound….

Let's see if I can do this. Alright, can you see that?

Okay.

We've got the same view again, not that it's a big deal, but if you want to go down and… yeah.

How about that? All right, all right. Well.

Perfect. There you go.

Andy Lawrence:

Listen, um, I… my name is Andy Lawrence, I'm the Assistant Director, uh, in the Tennessee Department of Mental Health and Substance Abuse Services Office of Crisis Services and Suicide Prevention.

Um, thank you. Thank you for inviting me today. Um, normally I would have Brittany here. Um, like I said, she is enjoying a much-deserved vacation, so I am going to, uh, get through this material.

Uh, on my own. Um, you know, when I… when I hear the….

The statistics that, uh, Department of Health was able to present on.

Um, we're… we're losing too many, right? As long as we're losing anyone to suicide, we know that we've got a lot of work to do still.

Um, so, I was… I was trying to make some notes while I was… while I was listening to the presentation as well.

Um, it did alarm me, you know, certainly seeing the increase in suicide deaths for, uh, ages 10 to 17.

Um, and it really just reminded me of why we do what we do in the Office of Crisis Services and Suicide Prevention. And this title seems appropriate. Meeting Tennesseans Where They Are.

Um, you know, we really try to, um, make. The step from reaching out for assistance.

To getting connected with that assistance, as simple as possible. And, uh, just gonna go through some of the resources that we do have, uh, available, and some of the things that we do have coming soon.

Um, so I'm gonna jump in here. Alright, I'm gonna give kind of an overview of Crisis Continuum Services.

Uh, talk some about 988, um, and then some of the outcomes that we are… we are seeing, um, with, with these services.

Um, let's see… let me see if I can move that… there we go! Alright.

So, one of the first goals of crisis services is really to help stabilize that mental health crisis, really helping that person kind of regain their emotional stability in a way that feels safe.

Um, and really looking to minimize further deterioration in the mental illness or emotional crisis.

Um, planning and connection, that is a lot of what Crisis Services does, um, really helping, uh, individuals cope, uh, develop coping skills.

Uh, utilizing those natural supports where appropriate, and connecting people with, with, uh, treatment resources.

Um, I… I was glad to hear LaDonna mention, uh, the CALM training. One of the things that we have that is… well, a couple of things that we have that are some of the most effective tools.

In suicide prevention is really that kind of means restriction education.

Um, in forming individuals and their natural supports. What does a safe home look like?

Um, what are… what are some, uh, common things that can be done, uh, to really safeguard that home? So I'm a big supporter of the CALM training.

Um, and then also, another thing that we have that has proven to be very effective in a reduction of suicidal ideation.

Is kind of the follow-up care. You know, what happens after the crisis intervention?

You know, are we… are we connecting with that individual? Are we support… continuing to wrap that support, uh, around that individual, making sure that they are reminded of maybe upcoming appointments, uh, reminded of what services are available should a crisis situation arise again?

Um, and then community-based. Crisis services encourages services and supports. In the least restrictive setting. You know, we do recognize there are times that maybe someone does need to be placed in a hospital.

Um, maybe even on an involuntary basis. Uh, but really recognizing.

That there are a variety of services that often meet the needs of individuals, um.

That are less restrictive than that. So really working with that individual to figure out, uh, exactly what service would be most clinically appropriate.

Alright, I am going to attempt to play a quick video here. Somebody give me a thumbs up if you can hear this once I hit play.

In a mental health emergency, where do you go? If a loved one is threatening suicide.

Who do you call? For many, the first reaction is to call 911.

While more and more police officers are trained in mental health topics, what if there was another option?

While hospitals deliver excellent emergency medical care, what if there was an option focused on mental health emergencies?

What if there was one statewide number that unlocked a door to mental health care in a crisis?

In Tennessee, there is. And that number is 988. Tennessee has a continuum of crisis services available to you any day, anytime. It starts with a call or text to 988, or a chat through 988Lifeline.org. Crisis counselors act as an air traffic control of sorts, providing triage, support.

And consultation to make sure that whatever they need, the caller is met with resources or referrals necessary to assist them. If there's a need for a higher level of care, the individual is connected with a local.

Mobile Crisis Team for completion of a face-to-face assessment. Tennessee has a statewide network of mobile crisis providers for both adults and children. In some situations, people may need real-time, in-person access, or short-term stabilization. These state-funded walk-in centers and crisis stabilization units, managed by community mental health centers.

Are an alternative to jail for police, and an alternative to the emergency room for families.

Together, in this unbroken continuum of care, we can meet people at the moment of crisis.

And connect them with the correct level of care to support their resiliency, recovery.

And independence.

I'm trying to get to the next slide here. Let's see.

We'll just skip past it.

All right, there we go. All right, so when we talk about the crisis continuum, um, you know, we talk about those walk-in centers and crisis stabilization units.

Uh, really offering kind of an alternative to inpatient psychiatric care.

Um, and what we have seen happen, we have been fortunate to receive funding to work with providers in areas of the state that maybe have not had as easy of an access point.

Uh, to those services as needed. So, uh, we do have several new ones coming on board.

Um, we, uh, I've been to, um, uh, I think I'm getting pretty good at this, uh, ribbon-cutting thing. I've been to several of them over the past few months. Uh, but, uh, do have the newest one that has opened.

Is, uh, in Henry County, um, that is operated by Cary Counseling, and, uh, that is, uh, again, an adult site that is available 24-7.

Um, we have a brand new facility over in Memphis, Alliance Health Services is operating that one.

Uh, Centerstone is opening a new adult site, uh, probably within the next month, up in the Clarksville area, so serving that Montgomery County area.

Um, and then, um, kind of going back to meeting individuals where they are, meeting those needs that we can see through the data, uh, for the first time.

Um, we… we have one, uh, operational kids, uh, CSU, and that is in the Knoxville area.

Operated by McNabb. Um, and we have two more coming on board, one in Davidson County, operated, uh, by Mental Health Cooperative. That will be opening.

Uh, probably in September. And then we have a kid's CSU that will be coming on board.

Uh, in the Shelby County area, operated by Alliance, uh, that will probably be in, I believe, February.

Of 2026. So, really expanding those stabilization services to individuals that we are seeing through data are at a heightened risk for suicide.

Uh, we do have, uh, 12 mobile crisis teams operating across 95 counties, um, 4 that serve.

Um, uh, youth as well. Um, crisis services are community-based, offered 24 hours a day, 7 days a week.

Um, and really, uh, we do work with individuals to kind of define their crisis.

Um, really, um, reaching out, uh, to, um, 988. That is the easiest access point.

To access crisis services, and uh, really, uh, determine what level of response is most appropriate.

Um, for FY24, the number of crisis assessments completed by mobile crisis was a little over 54,000.

Uh, that number in FY25, uh, completed by Mobile Crisis, uh, from July to, uh, March 25th… March of 25, was $39,000.

Um, so we probably will increase that number. Um, again, just ensuring that individuals are getting to care, uh, in a more timely manner.

So what happens at the Crisis Walk-In Centers? Um, you know, they… individuals do have access to, uh, crisis assessment, as well as 23-hour observation. Um, these are embedded within the Crisis Stabilization units. Um, you know, sometimes individuals come in and they just need some short-term stabilization.

In kind of that supervised treatment setting, um, you know, medical needs can be managed safely. Services must include, but are not limited to, crisis assessment, nursing assessment, observation.

Uh, really helping connect those individuals with outpatient services, and working with discharge planning. You know, we talk a lot in discharge planning about kind of softening that landing.

Uh, not just taking someone from a treatment resource and putting them right back in the exact same environment, but really wrapping those support services around them to really, um, kind of soften, um.

What that post-crisis period feels like. And again, those crisis stabilization units, a total of 146 beds across the state available.

24-7, 365, uh, intensive short-term stabilization, up to 120 hours. Um, if an individual is not quite ready for discharge, um, at the end of that 120 hours, uh, very often they are stepped down to respite services.

Uh, to really ensure kind of robust discharge planning. Again, making sure they have the level of support needed to successfully navigate that post-crisis period.

Um, again, you know, these individuals who are admitted to the Crisis Stabilization units.

Are able to, you know, receive crisis assessment, um, you know, nursing assessment, uh, they do have nursing care kind of around the clock. Uh, they do have access to medication providers, um, such as a psychiatrist or a nurse practitioner.

Um, they do have individual group, um, services, family support, a lot of psychoeducational groups, uh, to really, uh, explore what does.

What does that crisis feel like? What does it feel like when that kind of impending storm is coming, um, and really talking through how to navigate that, how to access services?

Um, before getting to the point of maybe making a suicide attempt.

And then again, those respite services do offer an additional 72 hours. Typically, this is done to, um, to assist an individual who is not quite ready for discharge from a crisis stabilization unit, uh, maybe needing some additional time for discharge planning, or just some additional observation.

This is a map of the adult crisis services available in Tennessee. Again, the easiest way to access these services is to call.

Text or chat with 988, press 0 for a crisis counselor, and you are connected, um.

Pretty much immediately, I'm gonna go over here in just a minute, uh, kind of some of the stats that we've seen around, uh, individuals reaching out to 988.

Uh, these are all available on our website, uh, and there is a link to that at the end of this presentation.

Okay, these are child and youth crisis services? Yes. Uh-huh.

Andy…. Oh, I'm sorry, if I may, this is Paula. Uh, we have a question about who does respite?

Sure. Um, so the respite services, uh, that I was referring to, they are offered within our crisis stabilization units.

So whoever is operating that crisis stabilization unit, uh, respite would be just a slightly less restrictive level of care.

Um, but provided by the same team.

Okay, thank you. I'll read the full question. It says, who does respite? I've worked respite in Arizona.

At La Frontera. When Nelva Chavez, I think that's….

My screen… yes, ran it.

Okay, yeah, um, it is a… it is a service kind of offered within that… that overall crisis continuum.

Um, and again, if there are any additional questions on it, there is more information on our website, and certainly, I did put my email in the chat, you'll see it again at the end of this presentation. If you do have a question, please reach out.

Thank you.

Alright, these are just some stats from fiscal year 24. Um, over 117,000 calls came into our crisis line.

Uh, more than 42,000 calls came into 988, with more than 9,200 chats and texts coming into 988.

Um, 49% of those were resolved on the phone, so those are individuals calling for things other than requiring that immediate intervention. Maybe they are calling for an additional resource, some, uh, um.

De-escalation over the phone. Um, but of those calls that came in, 50% were referred to mobile crisis.

Um, 72,000 crisis assessments completed, with 63% of those being diverted from hospitalization.

So really, um, and we anticipate that number going even higher as we do kind of expand the access, um, to, um.

To those, uh, less restrictive alternatives, you know, increasing the availability of things like the walk-in centers and the crisis stabilization units as well.

Alright, for the sake of time, this video is available on our website. This one and a couple of others. You can certainly check that out, go to the website.

Um, but I am going to move on past this one. It just kind of goes over, um, what is available with 988.

Last possession….

I say that. Let's see. Alright.

All right, so, um, every county in the state is assigned a primary 988 provider.

Uh, this is a map of those primary providers. In addition to the primary provider, if something should happen.

And this primary provider is not able to, um, to respond to that call.

Uh, within… within a specified time. There is a secondary, a backup coverage.

Um, if… if the primary is not able to answer, it will then roll to these providers for backup coverage.

Um, in the event, and this is a very small number, um, in the event that both primary and backup centers were not able to, uh, to respond to that call, it does roll to a national backup center.

Uh, so we do ensure that all calls are responded to.

And then again, 988 text and chat. Um, you know, contact care in the Knoxville area provides most of the text and chat.

Text and chat support, uh, statewide. Centerstone Family and Children's Services, as well as now Volunteer.

Uh, behavioral health, uh, also provide additional capacity during kind of those peak demand times.

Uh, these numbers are, uh, increasing rapidly. Uh, we do recognize that that is becoming an increasingly.

Um, popular way for individuals to reach out to 988.

And again, the main goal is ensuring just efficient access to services. We're really wanting to make sure that individuals.

Um, you know, I think one of the hardest things to give someone who is experiencing a mental health crisis.

Is, you know, lengthy instructions, and that can include a phone number. A 3-digit number is much easier to remember, and easier to access in the time of crisis.

Um, some of the call volume that we have seen, uh, over, um, the past year.

Uh, numbers are staying fairly steady when it comes to call volume. Uh, there was a….

Spike, um, in March of 25. That elevated number has maintained over the last couple of months.

Um, so we're finalizing that data now. Uh, the in-state answer rate, uh, national benchmark is 90% are answered within the state. As you can see, we're hovering.

The last few months, right around 89%. Um, so we're really, really close to that benchmark. That means 90% of those calls that come in, uh, really are being responded to by an agency within Tennessee.

And then the time to answer, um, when an individual calls 988, uh, national benchmark, again, is 30, uh, 30 seconds or less. Uh, we have been able to stay below that. Some months are just below.

Uh, but we… we really are able to, um, stay below, um, and answer those calls as quickly as possible when they come in.

So, some of the… some of the outcomes that we're seeing, you know, um, I think that initially when 988 kind of rolled out, there was some concern that maybe.

You know, law enforcement was dispatched on a regular basis. Uh, what we are finding within Tennessee is that simply not the case. Not that it never happens.

Uh, but the vast majority of calls are able to be de-escalated over the phone. Community referrals, non-emergency mental health referral.

Very small percentage are directed to the emergency room or mobile crisis, um, and an even smaller percentage are kind of that active rescue.

Where emergency services are dispatched.

Uh, some…. Some outcomes that we are seeing, and while we can't directly attribute this to 988, this is kind of where the data is.

Uh, for FY24 to 25. We have seen an 8% decrease.

Uh, in crisis assessments completed in the emergency room. Um, 4% decrease in law enforcement involvement.

A 9% decrease in the number of certificates of need, and certificate of need is completed when someone is placed in a hospital on an involuntary basis.

Um, so what we're seeing is a 9% decrease in that, meaning that individuals, uh, have been much more active participants in their selection of care.

And then, uh, 3% decrease in number of clients admitted for inpatient hospitalization overall.

All right, that was the quick version. So, that is, uh, that is kind of what we do. Um, you know, we do have a variety of resources available on our website. We do partner as well with, uh.

Organizations like TSPN, Jason Foundation do a lot of work with, um, you know, individuals of all ages in really, uh, increasing that gatekeeper training that LaDonna was talking about. But those are… those are the resources that I wanted to present today.

If you have any questions, this is my email address. Please don't hesitate to reach out.