ISSUE REPORT

Pain in the Nation:

The Epidemics of Alcohol, Drug, and Suicide Deaths 2024

SPECIAL FEATURE: Polysubstance Use and Emerging Drug Overdose Trends

Trust for America's Health
TFAH.ORG

JULY 2024

Acknowledgments

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Pain in the Nation: *The Epidemics of Alcohol, Drug, and Suicide Deaths*

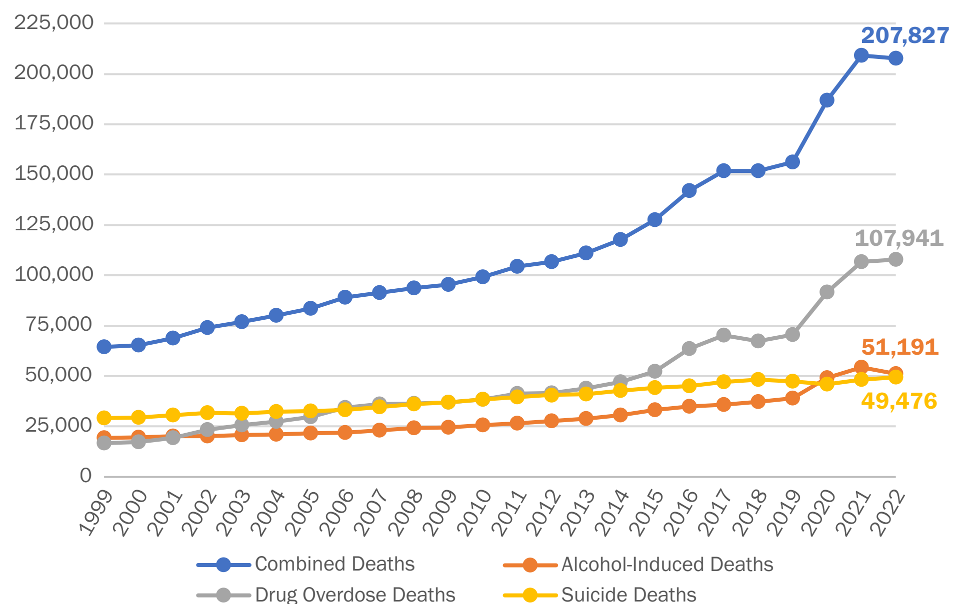
Introduction

Over the past two decades, deaths from alcohol, drugs, and suicide in the United States have all increased alarmingly. This critical public health issue intertwines with several other concerning trends: higher rates of mental health issues, particularly among youth; increased loneliness; and reduced economic opportunity; a dangerous shift in the illegal drug supply; and insufficient investment in public health and prevention policies that could reduce underlying drivers of poor mental health and substance use.[1,2,3,4,5,6,7] The COVID-19 pandemic added extensive trauma, stress, and isolation on top of these trends, and the United States saw parallel, extraordinarily large, increases in alcohol, drug, and suicide deaths in 2020 and 2021.[8,9] The most recent mortality data, from 2022, show total deaths from alcohol, drugs, and suicide in the United States was slightly lower for the first time in five years. While the long-term trends remain alarming—the 2022 rate is still more than double the rate compared with 20 years ago—this year is markedly better than an increase of 11 percent, as in 2021, or 20 percent, as in 2020.[10]

The 2022 trends include a 6 percent decline in the overall alcohol-induced mortality rate, after more than a decade of increases, and nearly identical rates for overall drug overdose and suicide mortality. Most of the underlying trends in 2022 are an improvement over 2021, too, though there is still notable variation in trendlines by demographic and geographic groups. For example, white and Native Hawaiian and other Pacific Islander populations had modest decreases in drug overdose rates while other populations of color still saw increases; and younger Americans (under age 35) had declining suicide rates, while Americans ages 35 and older had higher rates.

While the rates of alcohol, drug, and suicide deaths have each risen over the past decades, drug overdoses in particular have increased relentlessly in the past decade as synthetic opioids have become ubiquitous. More recently, stimulants, xylazine, and polysubstance use have also become more common in the drug supply and in overdoses. This year's special feature explores the latest data on substance use and drug overdoses, emerging substances and polysubstance use trends, and reflections on policy responses to evolving circumstances. The nation is at a critical moment and needs to build on the recent tentatively positive developments and lessons in order to reverse the long-term trends in alcohol, drug, and suicide deaths. In particular, additional attention is needed on strengthening primary prevention, harm reduction, early intervention, and treatment policies and programs to save lives, boost resiliency, and improve mental health and well-being for all Americans.

Figure 1: Annual Deaths from Alcohol, Drugs, and Suicide in the United States, All Ages, 1999–2022



Source: TFAH analysis of National Center for Health Statistics data

This report includes three sections: (1) a special feature on polysubstance use and emerging drug overdose trends (page 7); (2) a deeper analysis into the 2022 mortality trends from alcohol, drugs, and suicide for all groups (page 20); and (3) an outline of key policy recommendations that, if implemented, could reduce alcohol, drug, and suicide deaths in the country and promote well-being for all Americans (page 31). There are also expanded appendices in this year's report that include national and state-level alcohol, drug, and suicide mortality data; national and state-level substance use and mental health data; and state policies, programs, and other indicators (page 42).

SUMMARY OF RECOMMENDATIONS

Trust for America's Health (TFAH) calls for a multifaceted approach to reduce alcohol, drug, and suicide deaths and to improve mental health and well-being for all Americans. These recommendations focus on actionable items in three areas and are primarily aimed at federal and state governments. A summary of recommendations follows; the full recommendations start on page 31.

Invest in Prevention and Conditions that Promote Health

- Support policies and programs that reduce adverse childhood experiences and the impact of trauma and that promote positive childhood experiences.
- Increase support for substance use prevention, mental health, and resiliency programs in schools.
- Boost access to early prevention and family-support programs.
- Expand funding for comprehensive suicide prevention efforts.
- Focus prevention efforts on substance misuse among youth.
- Promote policies and programs to address social determinants of health.
- Strengthen capacity to address the behavioral health impacts of climate change and weather-related disasters.

Reduce Overdose Risk and Access to Lethal Means of Suicide

- Promote harm reduction policies to reduce overdose and blood-borne infections.
- Support efforts to limit access to lethal means of suicide.
- Reduce the availability of illegal opioids and unnecessary prescriptions through responsible opioid prescribing practices.
- Implement policies focusing on psychostimulant use that complement current opioid-focused policies.
- Lower excessive alcohol use through evidence-based policies.

Transform the Mental Health and Substance Use Prevention System

- Bolster the continuum of crisis intervention programs and supports.
- Support efforts to modernize and increase access to mental health and substance use services.
- Expand the mental health and substance use treatment workforce, and build community capacity across the continuum of prevention, treatment, and recovery.
- Promote equity in mental health, including through workforce diversity and culturally and linguistically appropriate services.
- Improve the accuracy, completeness, and timeliness of data concerning health events like overdose and suicide.
- Expand efforts to combat stigma and improve acceptance of mental healthcare and health-seeking behaviors.

SPECIAL FEATURE: Polysubstance Use and Emerging Drug Overdose Trends

Drug overdose deaths in the United States have risen considerably over the past few decades and exponentially in recent years, though there have been tentatively positive trends in the last two years.[11] The increases in overdose deaths have paired with other serious public health issues, including rising alcohol-induced and suicide mortality, mental health issues, and loneliness and social isolation—and have been further exacerbated by COVID-19.

Also underlying the overdose trends are changes to prescription opioids and the illegal drug supply. Prescription opioid drugs were the primary drivers of the opioid epidemic when it began in the late 1990s. In 2010, the crisis centered on illegal opioids: first heroin and then, starting around 2013, synthetic opioids.[12,13] In the last few years, synthetic opioid overdoses (primarily from illegal fentanyl) continued to increase along with increases in overdoses involving stimulants, like cocaine and methamphetamines, and more recently xylazine.[14] At the same time, substance use for most kinds of drugs in the United States, besides marijuana, has largely remained unchanged in recent years, though the illegal drug supply has become more dangerous.[15,16,17,18]

This section examines the latest data in substance use and drug overdoses, important trends and considerations for understanding the ongoing and evolving crisis, and key strategies and policies for tackling this crisis. To build on the current small, positive developments, careful attention to current and evolving trends; capacity building to better serve communities in need; continued improvement of access, availability, and quality of treatments for overdose and substance use; and proactive early prevention measures are needed.

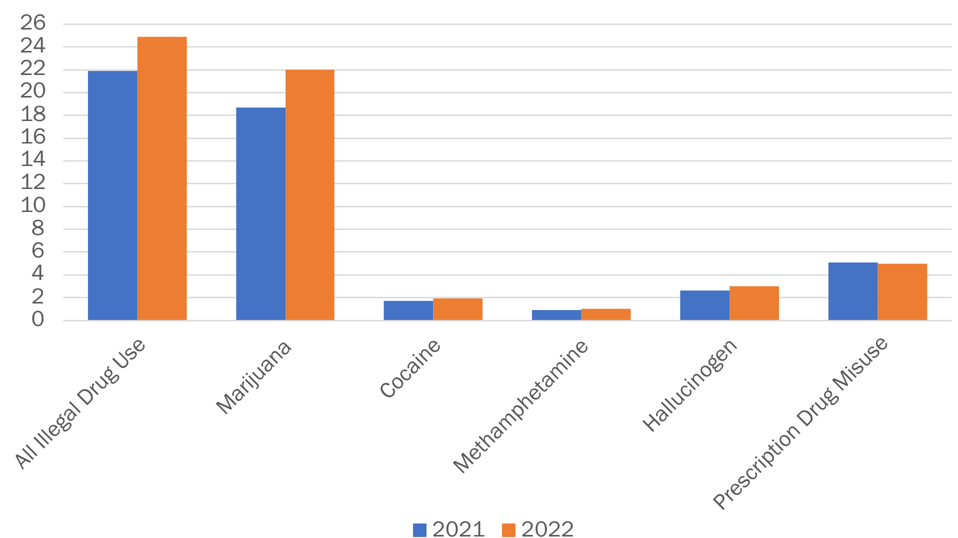
A. Substance Use and Drug Overdose Data

Examining the most recent substance use and drug overdose data available for the overall U.S. population as well as data from across time, demographic groups, geography, and drug types can further an understanding of current circumstances, reveal notable trends, and highlight population groups and communities that are disproportionately impacted in order to direct additional resources.

Substance Use Trends

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducts an annual survey on the substance use and mental health trends of Americans called the National Survey on Drug Use and Health (NSDUH).[19] The 2022 iteration found 70.3 million individuals ages 12 and older in the United States—about one-quarter of the adolescent and adult population—reported any illegal drug use in the past year.[20] Reported drug use among all adolescents and adults ages 12 and older increased by 14 percent between 2021 and 2022. The increase was primarily due to higher use of marijuana, while the reported use of most other kinds of drugs surveyed remained relatively unchanged.[21,22] Notably, 2022 was the first year that fentanyl use was surveyed. It found 0.4 percent of the population reported fentanyl misuse, including 0.2 percent of the population reporting illegally-made fentanyl use in the past year. The survey authors note, however, that other illegal drugs may contain fentanyl without the person's knowledge and the true usage figure is likely higher.[23] (See recent substance use trends for recent years in Figure 2 and by demographic data in Figure 3.)

Figure 2: Percentage of Individuals Ages 12 and Older Who Report Using Select Drugs in the Past Year, 2021–2022

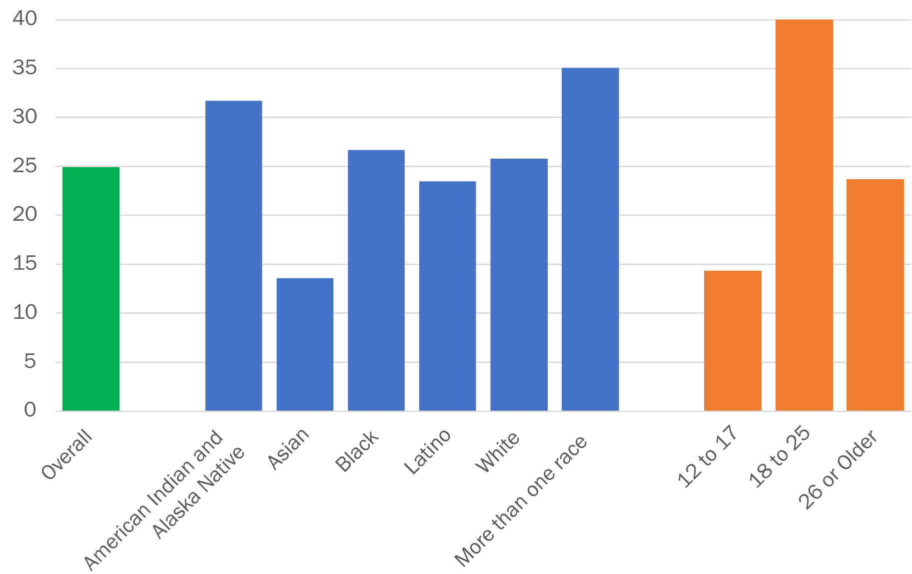


Source: National Survey on Drug Use and Health

NSDUH also includes questions about substance use disorders (including alcohol and drug use disorders) and found 9.7 percent of individuals ages 12 and older in the United States had a drug use disorder in the past year. More than half of those with drug use disorder had a mild drug use disorder (55.2 percent), while 23.5 percent had a moderate disorder and 21.3 percent had a severe disorder.[24] (See Figure 4 for more drug use disorders data by demographics.)

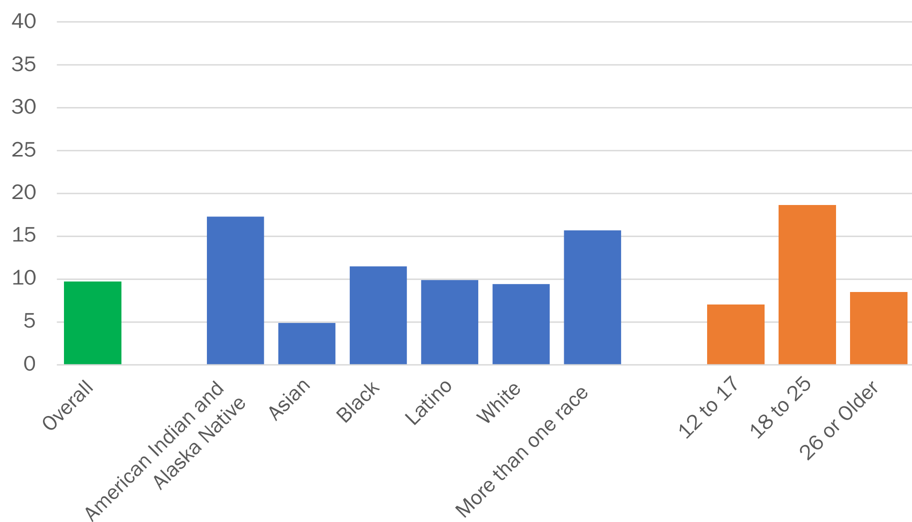
Other sources examining adolescent drug use find unchanged rates recently and declines over the past decade. The 2023 Monitoring the Future survey—funded by the National Institute on Drug Abuse and conducted by the University of Michigan's Survey Researcher Center—found that 11 percent of 8th graders, 20 percent of 10th graders, and 31 percent of 12th graders reported illegal drug use in the past year, which was the same as 2022 and below the 2020 pre-pandemic rates. This included an unchanged use rate for alcohol, marijuana, and any other illegal drug.[25] Another study—using data from the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS)–analyzed changes in substance use among high schoolers from 2009 to 2021 and found a decrease in use rates across all types of substance use surveyed. This included decreases in current use of alcohol, marijuana, binge drinking, and prescription opioid misuse; as well as decreases in lifetime use of alcohol, marijuana, inhalants, ecstasy, cocaine, methamphetamine, heroin, injection drug use, synthetic marijuana, and prescription opioid misuse.[26] (See more YRBS trends in Figure 5.)

Figure 3: Percentage of Individuals Ages 12 and Older Who Report Using Illegal Drugs in the Past Year, by Select Demographics, 2022



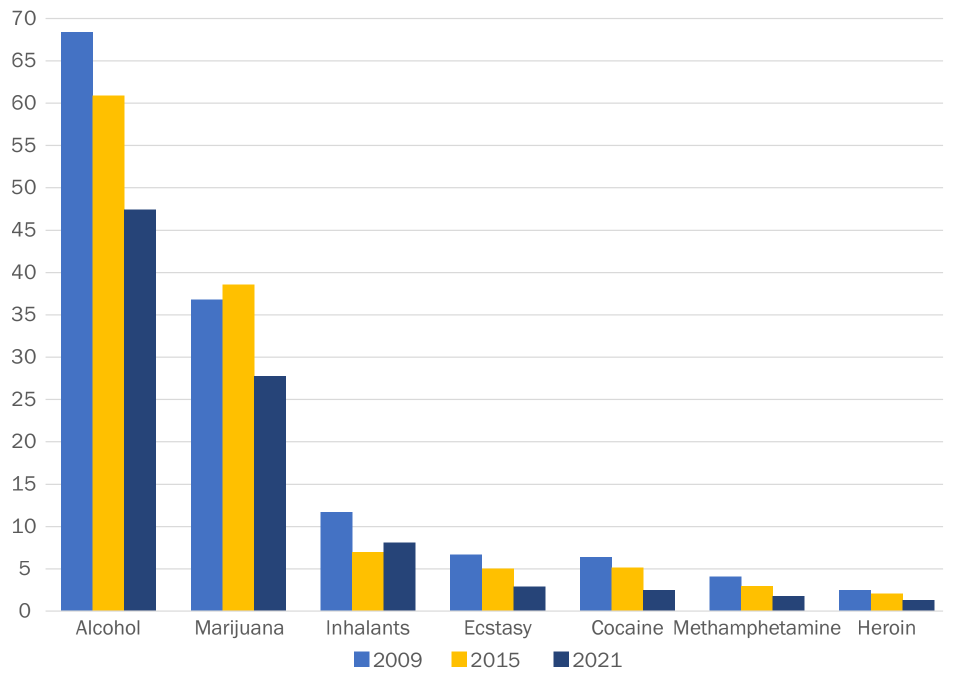
Source: National Survey on Drug Use and Health

Figure 4: Percentage of Individuals Ages 12 and Older With a Drug Use Disorder in the Past Year, 2022



Source: National Survey on Drug Use and Health

Figure 5: Percentage of High School Students Reporting Lifetime Use of Select Substances, 2009–2021



Source: Youth Risk Behavior Survey

For additional data on substance use and mental health at the national level, see Appendix D on page 46, and for additional state-level data, see Appendix E on page 47.

WHAT ARE OPIOIDS, PSYCHOSTIMULANTS, AND XYLAZINE?

Opioids are a class of drug that bind to opioid receptors and interact with nerve cells to reduce pain and produce feelings of euphoria.[27] Natural opioids are sourced from opium poppies, semisynthetic opioids are synthesized from naturally occurring opium, and synthetic opioids are made entirely in a lab.[28]

Common side effects of opioid use include sedation, dizziness, nausea, vomiting, and constipation. Regular opioid use can lead to physical dependence and tolerance, and in some people can lead to addiction and overdose.[29,30] The most common types of opioids include:

- **Natural/semisynthetic opioids:** the most common prescription opioids, like codeine, hydrocodone (including Vicodin), oxycodone (including OxyContin and Percocet), and morphine.
- **Heroin:** an illegal semisynthetic opioid that is twice as potent as morphine.
- **Synthetic opioids:** extremely potent opioids, including most commonly fentanyl, as well as carfentanil, tramadol, nitazene, and brorphine. **Fentanyl** is a medication that is 50 to 100 times as potent as morphine and most frequently used in anesthesia. **Carfentanil** is 10,000 times as potent as morphine and is used as a tranquilizer for large animals (e.g., elephants). Fentanyl and fentanyl analogs are also produced illegally for nonmedical purposes and are extremely dangerous, proving deadly in just miniscule amounts.[31,32]
- **Methadone:** a medication used for pain management and to treat individuals with opioid use disorders. It reduces withdrawal symptoms and cravings. Methadone is a type of synthetic opioid, but it is typically grouped separately from other synthetic opioids (including in this report) because it is an effective treatment for opioid use disorder.

Psychostimulants or stimulants, include a wide variety of substances that stimulate the central nervous system and elevate mood and alertness. Psychostimulants can be addictive. Some have important medicinal uses (e.g., treating attention deficit hyperactivity disorder), and some have the potential for misuse and serious health effects, including overdose death.[33] The psychostimulants most often involved in overdose deaths are cocaine (which has its own category) and a combined category called other psychostimulants with abuse potential, referred to in this report as other stimulants. They include methamphetamine, ecstasy, amphetamine, cathinones (including “bath salts”), and prescription stimulants.[34]

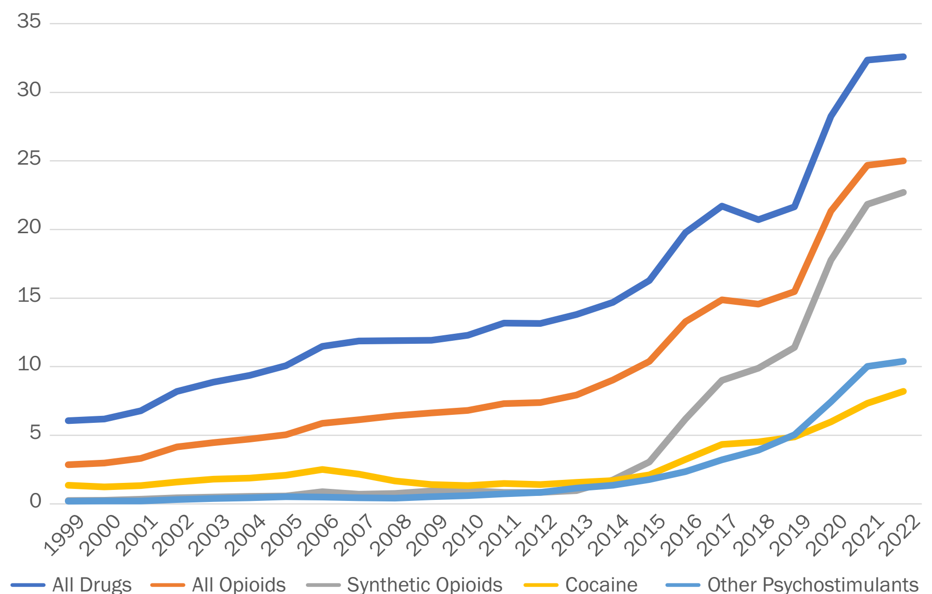
Xylazine, also called “tranq,” is an illegal drug and not approved as a medicine for humans but is used as a veterinary tranquillizer. It is a central nervous system depressant that causes sedation and decreased perception of painful stimuli. It is almost always found mixed with fentanyl in the illegal drug supply.[35] It can be deadly, though the primary risk is when it is in combination with other sedating substances like opioids, alcohol, or benzodiazepines. Regular use of xylazine has been associated with serious skin sores, ulcers, abscesses, and subsequent complications.[36]

Nonfatal and Fatal Drug Overdose Trends

Nonfatal overdose data is typically tracked through the healthcare system, though there is no comprehensive tracking across the United States. CDC's Drug Overdose Surveillance and Epidemiology System tracks emergency department visits and inpatient hospitalizations in 22 states. It showed a 10 percent increase in emergency department visits for nonfatal overdoses between 2019 and 2022, with a peak in 2021 at 141.4 visits per 100,000 people. Inpatient hospitalizations for nonfatal overdoses had a 12 percent decrease over the same time period—with a low of 49.8 hospitalizations per 100,000 people in 2022.[37] For reference, during this same 2018 to 2022 time period, fatal overdoses increased 57 percent.

Nationally, fatal drug overdoses have increased more than five-fold since 1999—when current tracking data began—rising from 6.1 deaths per 100,000 to 32.6 deaths per 100,000 in 2022. The increases were first driven by prescription opioids in the 2000s, then more potent and illegal opioids, including heroin and synthetic opioids (including fentanyl predominantly) starting around 2010, and now stimulants combined with synthetic opioids in the last few years. (See Figure 7 for fatal overdose rates by drug type.)

Figure 6: Annual Age-Adjusted Mortality Rate (Deaths per 100,000 People) from Overdoses by Drug Type, 1999–2022



Source: TFAH analysis of National Center for Health Statistics data

In contrast, the overall drug overdose mortality rate was nearly the same in 2021 and 2022 (32.4 and 32.6 deaths per 100,000, respectively). This is a notable change from previous years where annual increases have typically been very large; for example, drug overdose mortality increased 14 percent from 2020 to 2021 and 31 percent from 2019 to 2020. Furthermore, provisional data show a small decline in drug overdose mortality in 2023.[38] For additional information on drug overdose trends, see the Alcohol, Drug, and Suicide Mortality Data and Trends section on page 20.

B. Context and Complications of Emerging Trends

Xylazine and Polysubstance Overdoses

Over the past decade, overdoses from synthetic opioids, including fentanyl primarily, have increased exponentially, from 1.0 deaths per 100,000 in 2013 to 22.7 deaths per 100,000 in 2022. More recently, polysubstance overdoses—where individuals have multiple types of drugs in their system—have increased as well. Since fentanyl is inexpensive to produce and easy to transport, it has flooded the drug supply as a common drug alone, as an addition to other drugs, and for use in counterfeit pills or substances—and since it is extremely dangerous, it is often involved in overdoses.[39] As of 2022, synthetic opioids like fentanyl were connected to more than two-thirds of all fatal drug overdoses.[40] Cocaine, methamphetamines, alcohol, heroin, prescription opioids, benzodiazepines, and xylazine are common co-involved substances.[41]

Xylazine has become a prominent additive along with fentanyl more recently. Just five years ago, a study of 45,676 overdose deaths from 38 states and the District of Columbia using data from the State Unintentional Drug Overdose Reporting System (SUDORS), found xylazine in less than 2 percent of overdose deaths. All deaths involving xylazine in this study had at least one other co-involved drug—with 99 percent listing fentanyl as the cause of death. (The study authors did however note that these values may have been an underestimation as testing for xylazine was not standard during the study period.)[42] Since then, however, the illegal drug supply has increasingly contained xylazine, especially in the Northeast. For example, xylazine has become exponentially more prominent in the city of Philadelphia. The Philadelphia Department of Public Health found that 90 percent of illegal opioid samples tested contained xylazine in 2021, and another study, in 2022, again found xylazine in nearly all illegal opioid samples.[43,44] In July 2023, in response to this trend, the White House Office of National Drug Control Policy declared fentanyl mixed with xylazine an emerging threat and mobilized the federal government to use additional resources in response.[45]

Illegally manufactured fentanyl continues to be the main driver of drug overdose death. While xylazine does not pose a major overdose mortality risk alone, it is often co-involved with fentanyl and other dangerous drugs, and it may cause other serious health issues and complications. In addition to short-term effects like sedation, xylazine use is associated with serious wounds that in some cases can lead to infection, tissue death, and even limb loss.[46,47,48] Wounds are a particular problem for individuals who are unhoused or unstably housed, since it is harder for them to properly care for wounds, and many postpone needed care due to concerns about stigma, expectations of poor treatment within the healthcare system, and fears of losing their belongings. This can lead to wound progression, infection, and hospitalization. Individuals with wounds also may not be accepted in certain medical facilities, including skilled nursing facilities or residential drug treatment centers, which further complicates wound healing and substance use treatment.[49]

Xylazine can also cause difficulties during emergency treatment for overdoses. Naloxone, a rapid-acting medication that reverses opioid overdoses, does not stop the effects of any other types of drugs, including xylazine. This means that patients with xylazine in their system may remain sedated even when naloxone has reversed the respiratory depressant effects of opioids. This may lead responders and medical personnel to provide additional doses of naloxone, which can lead to severe withdrawal during recovery.[50]

Increasingly Dangerous Illegal Drug Supply

Despite largely unchanged rates for drug use of most kinds of drugs for adults and lower rates of drug use by adolescents, fatal and nonfatal overdoses have continued to increase. This is likely tied to the illegal drug supply becoming increasingly dangerous—with fentanyl becoming ubiquitous and counterfeit pills more common.

One CDC study found increases in the number of both fatal and non-fatal overdoses between 2010 and 2020—though the ratio of fatal overdoses compared with non-fatal overdoses increased over time. In other words, more people were overdosing overall, and of those who overdosed, a higher percentage were dying. Among the drug types assessed, fatal synthetic opioid overdoses and fatal opioid and stimulant overdoses had the greatest relative increases from 2010 to 2020.[51] Together this suggests a greater potency of drugs writ large and, specifically, more potent synthetic opioids and polysubstance drugs that lead to overdose and death.

Synthetic opioid use is not always intentional but can come from adulterated or misbranded drugs. One study—using SUDORS data from 29 states and the District of Columbia—analyzed fatal drug overdose trends involving counterfeit pills. It found that fatal overdoses involving counterfeit pills more than doubled between 2019 and 2021 across all states in the study (from 2.0 to 4.7 percent of deaths) and tripled among the Western states, which already had higher rates in 2019 (from 4.7 to 14.7 percent). The true figures are likely higher since it is not always obvious when substances are counterfeit and further testing is not common, but the trends are notable. The study also found that overdose deaths where counterfeit pill use was found were much more likely to include illegal fentanyl than other overdose deaths (without counterfeit pills).[52] These findings suggest that counterfeit pills are becoming more common in the drug market and/or are increasingly likely to have illegal fentanyl, which is causing more overdose deaths due to its high potency. Another study, using the same data source and time period, found evidence of counterfeit pill use in one-quarter of all fatal drug overdoses among adolescents—a proportion five times the overall population. The study notes that this figure is likely an underestimate as well.[53]

INNOVATIVE STATE AND LOCAL HARM REDUCTION POLICIES AND PROGRAMS

Many states, localities, organizations, and cross-sector partnerships have instituted innovative efforts in recent years to better align programs, policies, and practices with the principles of harm reduction. Harm reduction strategies attempt to minimize the negative health, social, and legal effects associated with drug use and drug policy using an evidence-based, comprehensive approach that directly engages people who use drugs without stigma.[54] There are some federal grants for this work, including SAMHSA's Harm Reduction Grant Program for communities seeking to increase recovery supports and community capacity to strengthen related programming, as well as many state and local efforts.[55] A few examples from across the country are below.

The California Naloxone Distribution Project (NDP) is an example of harm reduction at the state level.[56] The NDP is administered by the California Department of Health Care Services and provides free naloxone to qualified organizations, including community organizations, emergency medical services, federally qualified health centers, and schools, among others. Since its launch in 2018, the NDP has distributed almost 4 million kits of naloxone, resulting in 249,000 reversed overdoses.[57] This year, the NDP expanded to include fentanyl test strips in its distribution services. With the addition of fentanyl test strips to its distribution services, NDP will continue to reduce opioid-related overdose deaths as part of its broader prevention and harm reduction efforts.

Ohio also began a new initiative to increase access to naloxone kits by installing 130 boxes at 65 highway rest areas across the state.[58] This effort highlights collaboration across government units, led through the RecoveryOhio partnership through Governor Mike DeWine's office, the Ohio Department of Transportation, and the Ohio Department of Health's ProjectDAWN (Deaths Avoided With Naloxone).[59] This effort builds on the prior work of ProjectDAWN, which distributed naloxone kits to Ohioans and helped to reverse 18,000 overdoses from 2014 to 2022.[60]

Another example of intra-government collaboration is in Alaska. Alaska Medicaid, the Division of Public Health, the Division of Behavioral Health, and the Office of Children's Services partnered with the Rural Alaska Community Action Program (RurAL CAP).[61] This community-based organization delivers early childhood and maternal programs to underserved rural communities across the state. RurAL CAP used its established partnerships with rural communities to engage families in a journey-mapping process, with the goal of understanding how pregnant people with substance use disorders access health services throughout their pregnancy. These insights, alongside perspectives of state agency staff and medical providers, produced an enhanced understanding of opportunities for improvement in access to services and overall care coordination.[62]

Some states and communities engage sobering centers, also known as stabilization centers, to divert acutely intoxicated individuals from incarceration and emergency departments.[63] Sobering centers provide a supportive environment for those who are primarily unhoused and/or uninsured to become sober, typically over a 24-hour period. These individuals may have other co-occurring disorders, and the centers offer connections to related services and supports (e.g., housing assistance, case management) that can lead to longer-term recovery. In the District of Columbia, the city government recently opened a sobering center in response to the continuing negative impacts of the opioid epidemic in local communities.[64] The District has some of the highest opioid overdose rates in the country. In 2022 alone, there were 5,200 suspected non-fatal opioid overdoses and more than 400 deaths from opioids in the city.[65] The D.C. Stabilization Center opened in late 2023 and provides temporary care to people with substance use disorders, alongside connections to resources like medical care, peer counselors, and social workers.[66] Within three months of opening, the center surpassed 1,000 admissions.[67] Patients at the center are served regardless of immigration or insurance status, and the city government hopes to open additional locations in other parts of the District.

A final example of harm reduction, plus maternal health promotion, is in San Antonio's Casa Mía, a program supporting pregnant women and new mothers with substance addiction.[68,69] Specifically, the program offers housing, nutrition services, case management, and access to intensive outpatient services to a population that does not frequently feel safe seeking care due to fear of losing custody of their children amid experiences with homelessness and substance use.[70]

C. Responding to Evolving Circumstances

While drug overdose trends over the past decade have been alarming, the most recent data show tentatively positive developments. The most recent final data on mortality in the United States shows that the overall drug overdose death rate was unchanged in 2022 from 2021, and provisional data on mortality show a small decline in 2023 mortality rates.[71] Sustained, declining mortality is the goal, though staying the same is a marked improvement after extremely large increases in recent years.

Other signs point to progress in key prevention and treatment policies. Since 2021, both prescriptions for naloxone and buprenorphine, a medication to treat opioid use disorder, have increased—two measures of the reach of critical overdose prevention and treatment strategies.[72]

Building on these steps in the coming years is critical to moving toward sustained progress. The pervasiveness of synthetic opioids in the illegal drug market, increasing polysubstance use, and other evolving substance use patterns require continued careful attention; capacity-building to better serve communities in need; continued improvement of access, availability, and quality of treatments for overdose and substance use; and proactive early preventive measures. A few examples include:

- Bolstering the public health and behavioral health systems across the country to respond to the current needs and potential changing landscape of substance use, drug overdoses, harm reduction interventions, and substance use disorder (SUD) treatment.
- Continuing to improve data systems, like CDC's Overdose Data to Action, to track emerging trends by geographic, demographic, and drug type metrics in order to guide local, state, and national responses and to prevent overdoses and deaths in real time in communities in need.
- Maximizing harm reduction strategies to save lives now, including continuing to ensure access to naloxone, buprenorphine, and drug test strips.
- Improving treatments for drug overdoses and SUDs, including medications for stimulant overdose and stimulant use disorders, as well as increasing equitable access and eliminating barriers to the current available medications and treatments.
- Supporting and expanding the behavioral health workforce, including peer supports, to reduce barriers and increase access to SUD treatment and harm reduction measures.
- Focusing on underlying drivers of substance misuse and inequities through early prevention and intervention policies, including improving social, environmental, and economic conditions; expanding resilience programs in schools; and increasing access to social and mental health services for children and families.

For additional specifics, see the Policy Recommendations section on page 31.

Mr. Denny is a licensed clinical social worker and licensed clinical addiction counselor. The Four County Mental Health Center is a certified community behavioral health clinic (CCBHC) that provides outpatient services in five Kansas counties: Chautauqua, Cowley, Elk, Montgomery, and Wilson. Mr. Denny has worked in the behavioral health field since 2002.

The Behavioral Health Crisis in Rural Kansas: Providing Interventions that Work

Interview with Steve Denny, LSCSW, LCAC, *Deputy Director of the Four County Mental Health Center, Inc., Kansas*

TFAH: Can you describe your program and the communities it serves? What are your key challenges?

Mr. Denny: We're a level 1 program that's licensed by the state to provide substance use disorder treatment. As a certified community behavioral health clinic, we follow a whole person, integrated care model. Community-based treatment is standard practice in many areas of programming and services offered at our clinics. One of the most important things for us is to be flexible in our approach and to provide additional programs and services in addition to the more traditional facility-based services. We need a combination of both.

You can't have mental health in one place and substance misuse in another place and pretend those two things aren't connected. People often have co-occurring mental health issues and substance use issues. Our programs are community-based: we go where people are, if we can find them, and we have a team of providers, including therapists, prescribers, peer providers, nurses, and physicians. The team provides whatever is necessary to help stabilize a person.

We serve a rural community. Fentanyl hasn't quite made its way into our communities at the same level you would see in Wichita, Kansas City, or other urban areas. There's some fentanyl, but by far the number one issue we are treating now is meth and other stimulants, but meth in particular. Alcohol is second for us in terms of treatment demands; marijuana is third.

In terms of the state of Kansas, there are a few things happening that I think are important. One is the need for treatment in a lot of different areas, particularly residential treatment. Residential treatment providers face both funding gaps and challenges with workforce supply. Many of the individuals served in SUD programs are uninsured or underinsured, which makes referral and placement quite challenging, especially for rural providers like us.

TFAH: How do you approach the work to deliver both traditional substance use disorder services and other services that don't fall into the traditional services category?

Mr. Denny: As a CCBHC, we need to think about social determinants of health and create strategies that meet people's needs. We have established care coordination agreements with a variety of partners: hospitals, ERs, long-term care facilities, law enforcement, departments of children and families, schools, and a variety of other partners. For example, we have a crisis community outreach program, one branch of that program provides services in correctional facilities. The program provides transitional specialists who are available to do care coordination, for example, if someone needs assistance getting documents completed so they have employment opportunities or Medicaid services when they get out. Whatever the need is, we try to address it prior to discharge because so many individuals end up in

the same situation without a solid plan to maintain care and treatment after release from correctional facilities.

In rural areas, relationships and connection are just as important as formal agreements and structure. Who can I call when someone in our community or organization needs support? Sometimes a crisis puts us together in the same room. For example, we often receive crisis services requests involving law enforcement, EMS [emergency medical services], schools—all of which causes us to step back and say, How can we handle this or handle it better in the future?

Another example is at the state level. We have monthly collaborative calls between all the CCBHCs and the VA [Veterans Affairs]. Part of being a CCBHC is having a veterans program, and a big part of that is having someone on staff who understands the VA system and knows how to plug into it.

TFAH: What are the barriers to treatment in your communities, and what do you do to address them?

Mr. Denny: We do a needs assessment for everyone who requires services. The top three needs in our area are transportation, housing, and access to health insurance.

We have to plan for how people can get access to transportation. There's no buses, no subway, not even Uber here. We have offices in larger communities, but not everyone has reliable vehicles or gas money to access their nearest location. Transportation is a real issue here.

Housing is a complex issue. As a CCBHC, we have specialized housing coordinators. There's still transitional housing in some parts of the state and Oxford House type models where people can get support for co-occurring issues, but not enough of any of those.

In terms of access to health insurance, Kansas is not a Medicaid expansion state. Most of the people we serve in SUD programs do not have any form of insurance. They rely heavily on state-funded programs for the uninsured and funding for target populations.

TFAH: To what extent do your clients need services beyond harm reduction—that is, other types of services that address the social determinants of health (SDOH)?

Mr. Denny: Addressing SDOH and general life needs are essential to recovery. It's hard to think about changing your lifestyle and moving away from addiction if you're not sure where you are going to live tomorrow. Safe neighborhoods, which are related to housing, are another issue. A lot of the people we work with report that they don't feel safe in their current housing situation.

Employment services are another really important area in the SDOH conversation. It's important to not gloss over these things; it's important to have a comprehensive plan. That doesn't mean it's our system's role to do all those things for people, but we want to give people the opportunities, and we need to have those connections so we can get people plugged into whatever resources they need.

TFAH: What substances are causing the most harm in the communities you serve? Is polysubstance use a big problem?

Mr. Denny: Polysubstance and co-occurring SUDs aren't new to us; there's been that pattern for some time. What does complicate treatment is what substances people are using and the potency of the substances they're using.

If we don't know or understand what's been taken, and the person doesn't know what they've taken—what's been mixed in—it's hard to know what the long-term impact on their health will be.

The question with polysubstance treatment is often, Where do you start? We always support someone's autonomy. They may say, "I want to start by cutting back on meth, but I don't want to stop alcohol yet." One of our principles is to support someone's chosen pathway to recovery.

Our biggest issue is the widespread availability of meth in many of our local communities, which have become saturated. And meth is quite cheap at street value, based on many conversations I have had with local law enforcement. The more people who have access, the more people who potentially become addicted. That creates real challenges when you have a limited workforce. Even if we had every dollar of funding that we needed, that doesn't mean we have the workforce or the infrastructure to resolve the crisis.

TFAH: Is workforce recruitment and retention an issue for your program?

Mr. Denny: Yes, workforce is a challenge at multiple levels. We definitely need more counselors and therapists. At the medical, psychiatric level, there's a huge shortage of psychiatrists. We've done a few things in Kansas through changes in licensure and some training requirements to try to expand the workforce. We're also working on a compact that would allow us to work in partnership with other states.

Part of the solution is that we have to raise up our own—find people in our communities who are interested in going to school and getting this training. There are also some opportunities with apprenticeships. We are also working with some universities, but there's no easy solution.

TFAH: Can you talk about how you use data in your program? What data do you collect and how do you use it?

Mr. Denny: As a CCBHC, we needed to expand and grow in the area of data collection. We're required to do a community needs assessment every three years; we're actually in the middle of ours now. As part of the needs assessment, there's going to be focus groups, and we'll engage with community partners to identify concerns and gaps. The needs assessment then guides our staffing plan: what staff do we need to connect to the populations we serve, and what training do we need to provide to staff so they are competent in serving those populations?

There are also national and state-specific measures that have to be reported to SAMHSA. That includes things like, Are we providing whole person care and are we screening for health and primary care needs? The data requirements address accessibility measures, alcohol and drug screening, SDOH screening, suicide screening/referral, and depression remission measures.

As a CCBHC, we are also required to have a continuous quality improvement plan, which is going to integrate data, including key performance indicators.

Specific to SUDs, the things we are looking at are diagnostic trends and the trends specific to any community. Are we seeing more meth or alcohol in one particular community or another? So far in our communities, there's not a lot of differences right now. We also look at age, demographics, race, ethnicity, and employment status, as well as people who have a preferred language other than English, who are experiencing homelessness, and who have a record of incarceration. We look at all of these things at admission and at discharge. Ultimately, we want to know how many people we have helped recover and successfully discharged from our services.

Research and evaluation are important components of all our programs. Data is really important, but a challenge with data is that there is so much of it. You have to find a way to help the data tell a story. People need a narrative to make sense of it.

TFAH: What's the importance of collaboration to address the SUD crisis? Is collaboration happening?

Mr. Denny: Collaboration between different sectors definitely happens, and the vast majority is positive. In terms of federal entities that we report to, it's mainly SAMHSA, a little bit HRSA [Health Resources and Services Administration]. We also have connections with people in the state Department of Corrections because they have to deal with a lot of behavioral health issues.

For the most part, we've worked really positively with SAMHSA, and KDADS [Kansas Department of Aging and Disability Services] has partnered really well with SAMHSA. I had the opportunity to be part of a SAMHSA/CCBHC collaboration that ultimately authored a white paper with the National Council for Mental Wellbeing. We wrote the paper and had some recommendations around crisis services that should serve as a guide for other communities. All participants were open to hearing the rural perspective, while also addressing many of the common challenges in both rural and urban communities.

At the federal and state level, there's lots of positive partnerships. It gets inherently more complex at the local level because even within our area there are stark differences among communities. It depends who sits on your local commission, who is in your city government. But that being said, I think that community-based, community-driven intervention is so important. Many times, one of the challenges is that there will be a recommendation or guidance issued from the top down that just doesn't work here. We can't lose community-driven partnerships because there's no cookie-cutter model that's going to meet the needs of every community.

Politics aside, most people want to see our communities be healthy places. I had the opportunity to testify before the U.S. Senate HELP Committee last year. Obviously, there were partisan differences, but there was absolute agreement that this behavioral health crisis is a real thing. How to resolve it—there's some differences there. But there's no disagreement on the need to resolve it.

TFAH: Any closing thoughts?

Mr. Denny: We have to start thinking about the significant gaps in services, for both residential and outpatient services. Even with the expansion of all the community-based programs, there are still acute unaddressed needs, particularly for adults in terms of being able to access in-patient residential behavioral health services. When I started in this work, our closest in-patient psych hospital was 20 minutes away; now the closest one is two and a half hours away. That's a challenge.

This interview was edited for length and clarity.

Mortality Data and Trends

Overall deaths from alcohol, drugs, and suicide in the United States declined slightly in 2022—a marked divergence with trends over the past two decades, in which mortality rates have increased at an alarming pace. The age-adjusted rate of total deaths was marginally lower (less than 1 percent) in 2022, though trends varied by causes of deaths, demographic groups, and geography. A few overall takeaways:

1. The overall age-adjusted alcohol-induced mortality rate decreased by 6 percent from 2021 to 2022 (from 14.4 deaths to 13.5 deaths per 100,000). This is the first time since 2002 that this rate has decreased. The decreases crossed nearly all demographic and geographic groups, with rates for only a few groups showing an unchanged or increased mortality rate.

2. The overall age-adjusted drug overdose mortality rate remained virtually the same from 2021 to 2022 (32.4 and 32.6 deaths per 100,000, respectively), an important shift over recent years in which there have been double-digit increases (14 percent from 2020 to 2021, and 31 percent from 2019 to 2020). The trends, however, diverged substantially by demographics, with some groups making progress, some remaining unchanged, and some seeing continued worsening trends. For example, most populations of color continued to experience increases in drug overdose mortality from 2021 to 2022 (although the size of increases were mostly much lower than previous years). In contrast, white, Native Hawaiian, and other Pacific Islander (NHOPI) people saw lower rates.

3. The overall age-adjusted suicide mortality rate remained virtually the same from 2021 to 2022 (14.1 and 14.2 deaths per 100,000, respectively). There is some variation by demographics and geography, with the most notable differences appearing across age groups. Younger age groups saw decreases in suicide mortality (ages 0–17 by 9 percent, and ages 18–34 by 6 percent), while mortality increased for all older age groups (i.e., 35–54, 55–74, and 75 and older) from 3 to 8 percent.

Additional data and trends in deaths from alcohol, drugs, and suicide are summarized below, followed by a state-by-state analysis. Additional data (including by additional drug types, demographic groups, and states) and methodology (including sources and definitions) can be found in the appendices starting on page 42.

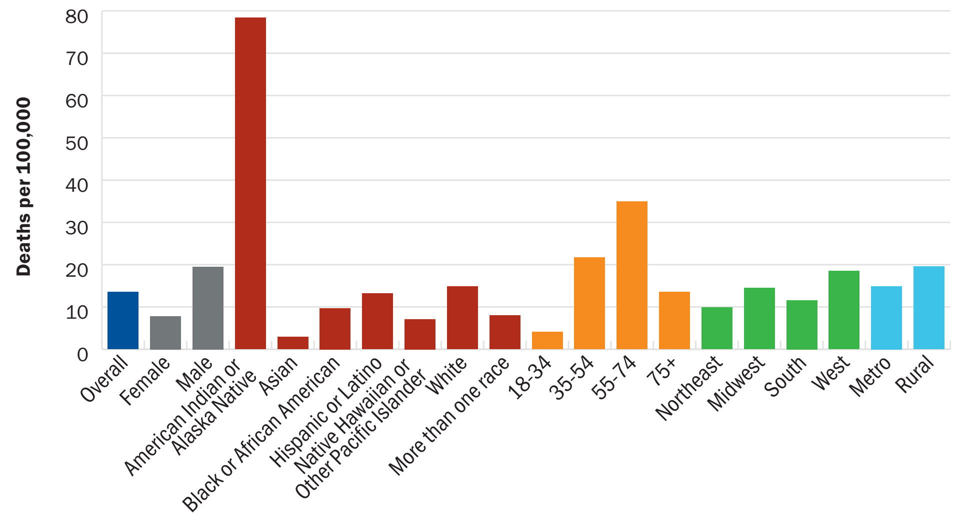
A. Overall National Data and Trends

In total, there were 207,827 alcohol-induced, drug overdose, and suicide deaths in the United States in 2022—or an age-adjusted rate of 60.1 deaths per 100,000 people. This is slightly below the 2021 rate (60.9 deaths per 100,000) and double the rate 15 years ago (29.6 deaths per 100,000 in 2007). Additional alcohol, drug, and suicide trends are described in this section, and additional data and year trends are in Appendix B on page 43.

Trends in Alcohol-Induced Deaths

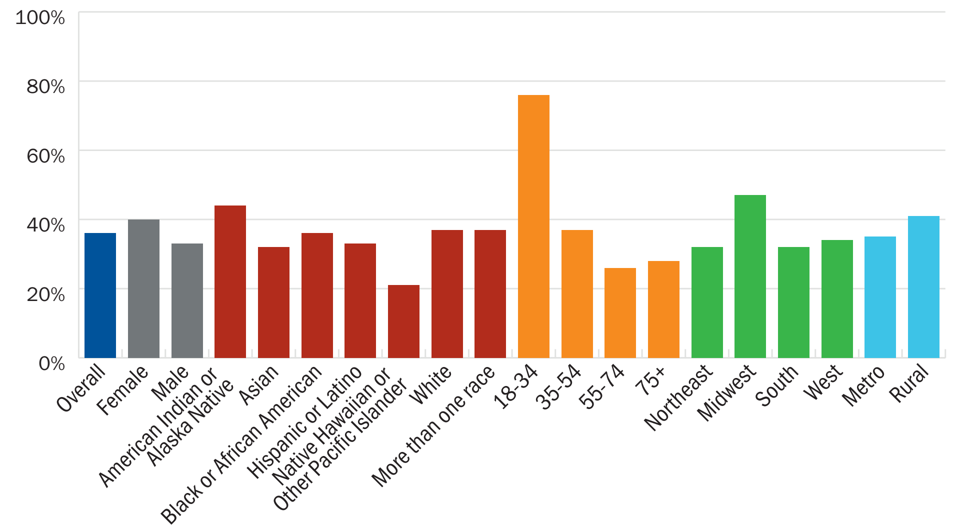
- In 2022, 51,191 Americans of all ages died from alcohol-induced causes, and 394,464 Americans died from alcohol-induced causes in the decade from 2013 to 2022. Note that alcohol-induced deaths include alcohol poisoning, liver diseases, and other diseases; it does not include alcohol-attributable deaths, such as alcohol-related violence, accidents, or vehicle fatalities. See sidebar on page 22 for more on alcohol-attributable deaths and other consequences of alcohol use.
- The age-adjusted rate of U.S. deaths from alcohol-induced causes was 6 percent lower in 2022 compared with 2021, decreasing from 14.4 to 13.5 deaths per 100,000 (age-adjusted rates). It was the first time there was a decline in two decades (since 2002), and, in total, the alcohol-induced death rate doubled in the prior 20 years.
- Alcohol-induced death rates in 2022 were highest among American Indian and Alaska Native (AI/AN) people (78.4 per 100,000), adults ages 55 to 74 (34.9 per 100,000), adults ages 35 to 54 (21.7 per 100,000), those living in rural areas (19.6 per 100,000), males (19.5 per 100,000), and those living in the West (18.5 per 100,000).
- All groups had lower rates of alcohol deaths in 2022 compared with 2021, except for Asian people, NHOPI people, and adults ages 75 and older, who had rates that remained unchanged or increased. AI/AN and Black people had particularly large decreases in 2022 in alcohol-induced deaths.

Figure 7: Age-Adjusted Alcohol-Induced Mortality Rate (Deaths per 100,000 People) Overall and by Select Demographics and Region, 2022



Source: TFAH analysis of National Center for Health Statistics data

Figure 8: Percent Change in Alcohol-Induced Mortality Rates by Select Demographics and Region, 2018–2022



Source: TFAH analysis of National Center for Health Statistics data

CONSEQUENCES OF ALCOHOL USE: ALCOHOL-INDUCED MORTALITY AND BEYOND

Alcohol-related mortality and other consequences of alcohol use are a serious public health problem that has been increasing in recent decades—along with drug overdoses and suicide mortality, mental health issues, loneliness, and social isolation—with further exacerbation by COVID-19 trauma, stress, and isolation, and relaxed alcohol policies. Since 1999, alcohol-induced mortality has more than doubled, causing the death of 51,191 people in the United States in 2022. TFAH's *Pain in the Nation* report series has tracked this alcohol-induced mortality figure over the last six years, though the harm from alcohol is much wider than alcohol-induced mortality alone. It is important to recognize the wider burden of alcohol-attributable deaths, which includes a wider range of injuries and diseases in which alcohol played a role. Alcohol use can also increase disease burden and impact individuals, families, and communities through alcohol use disorder (AUD), adverse childhood experiences (ACEs), and a decrease in economic productivity.

CDC's Alcohol-Related Disease Impact program estimates the number of deaths and other health impacts due to alcohol use in the United States.[73] For 2020 and 2021, an average of 178,307 people died from alcohol-attributable causes annually, which is more than three times the alcohol-induced mortality figure alone. This includes about 117,000 deaths due to chronic causes and 61,000 due to acute causes. Within the chronic causes, 42 percent were alcohol-induced (caused by alcohol alone), and include alcoholic liver disease, alcohol dependence syndrome, and alcohol abuse. Common chronic causes that are alcohol-attributable (not solely caused by alcohol) include hypertension, coronary heart disease, and cancer. The top acute causes of alcohol-attributable deaths were due to alcohol-related poisonings (primarily drug overdose deaths that also include alcohol), motor vehicle traffic crashes, and suicide.[74] Other recent research has estimated that of the 20,216 alcohol-attributable cancer deaths in 2020–2021 for adults over the age of 20, about 16,000 of those deaths could have been avoided by following the *Dietary Guidelines for Americans* on alcohol consumption. Liver cancer made up the largest percentage of alcohol-attributable cancer deaths that could have been prevented.[75]

In addition to research on the causes of alcohol-attributable deaths, there has been a recent focus on identifying worsening trends in alcohol mortality. A 2024 CDC study found that between the years 2016 and 2021, deaths from excessive alcohol use, including partially and fully alcohol-caused conditions, increased by 29 percent (age-adjusted death rates rose from 38.1 to 47.6 deaths per 100,000 people). This includes statistically significant increases across sexes, but there was a greater increase among females (35 percent increase).[76] CDC also found that there was a rise in alcohol-induced mortality from 2019 to 2020 (10.4 to 13.1 deaths per 100,000 people, respectively).[77] CDC suggests that increased consumption during the height of the COVID-19 pandemic—and related stress, loneliness, and social isolation—in addition to expanded and relaxed alcohol policies are potential drivers of increases in 2020 and 2021.[78]

Beyond mortality and physical disease burden, excessive alcohol use and AUD also harms individuals, families, and

communities in other ways. In 2022, 10.5 percent of people over age 12 in the United States (29.5 million Americans) had AUD in the past year, and 21.7 percent (61.2 million Americans) reported binge alcohol use in the past month.[79] Individuals with AUD and alcohol dependence are more likely to have unmet developmental needs, economic stressors, legal problems, and emotional distress; they are also more likely to commit violence against a partner or children.[80] Children who are raised by a parent with AUD are two to three times more likely to report ACEs such as verbal, sexual, and physical abuse as well as broken family systems.[81] About 11 percent of all maltreatment cases are affiliated with parental alcohol use, and individuals who are raised in a family where there is an SUD are at much higher risk of developing one themselves.[82,83]

Economic costs related to alcohol use also impact individuals and society at large. One national study conducted on AUD and workplace absenteeism found that full-time employees with AUD missed more workdays than those without AUD, and as AUD severity increased, more workdays were missed. The study found specifically that individuals with severe AUD miss about 2.5 times the workdays as their counterparts without AUD, and, in total, AUD contributes to over 232 million missed workdays annually—underscoring for employers and policymakers the need to invest in AUD treatment and prevention.[84] Excessive alcohol use also costs the U.S. economy about $249 billion annually. The majority of these costs are due to binge drinking, with the largest share of this cost (72 percent) resulting from losses in workplace productivity.[85]

There are evidence-based treatments available to individuals with AUD—including several FDA-approved medications (e.g., acamprosate, acamprosate, and naltrexone)—as well as evidence-based policies that can reduce excessive alcohol use and increase AUD screening and treatment at the population-level, including several policy recommendations below from the Community Preventive Services Task Force.[86,87]

1. **Regulate alcohol outlet density** (i.e., through licensing or zoning) to reduce or limit excessive alcohol consumption and related harms.[88]

2. **Increase alcohol taxes** to reduce excessive consumption and related harms. Often these taxes are based on the amount of beverage sold and need to be updated regularly to reflect inflation.[89]

3. **Put dram shop liability laws in place** to reduce alcohol-related harms. These laws ensure that the owner of an establishment is legally responsible for any excessive harm (i.e., injury or death) caused by a customer after excessive drinking at that location.[90]

4. **Implement electronic screening and brief intervention (e-SBI)** to reduce excessive alcohol consumption and alcohol-related problems. Although less effective than a face-to-face intervention, the e-SBI does screen and provide an intervention for those who present risky behavior.[91]

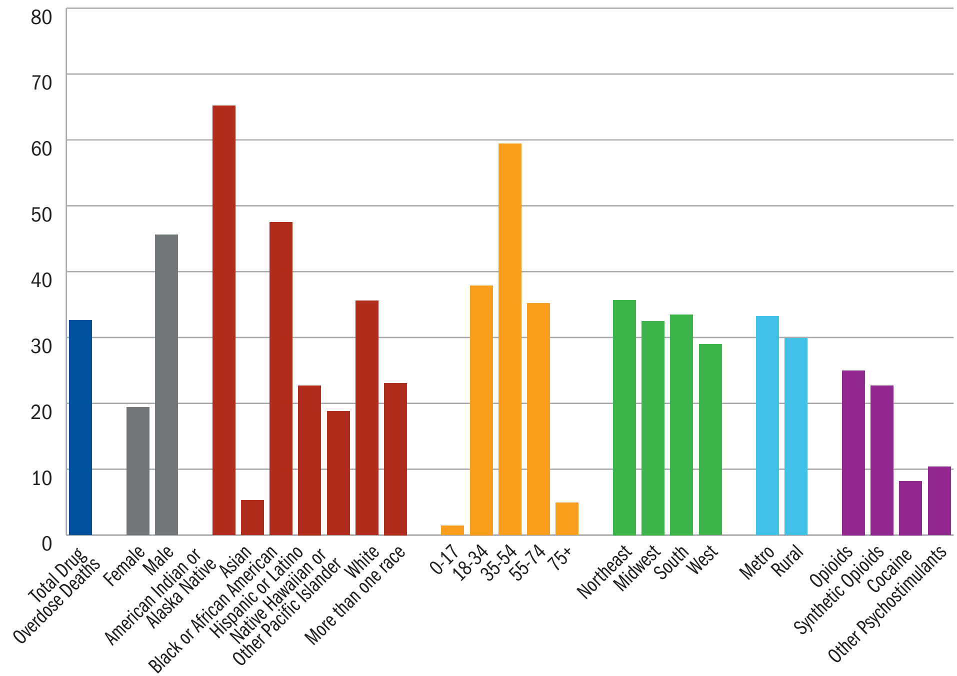
5. **Increase enforcement of laws that prohibit sales to minors** to reduce underage drinking.[92]

6. **Eliminate further privatization of retail alcohol sales** in places where there is currently government control of retail sales. Evidence shows that privatization increases per capita consumption, which can lead to excessive consumption.[93]

Trends in Drug Overdose Deaths

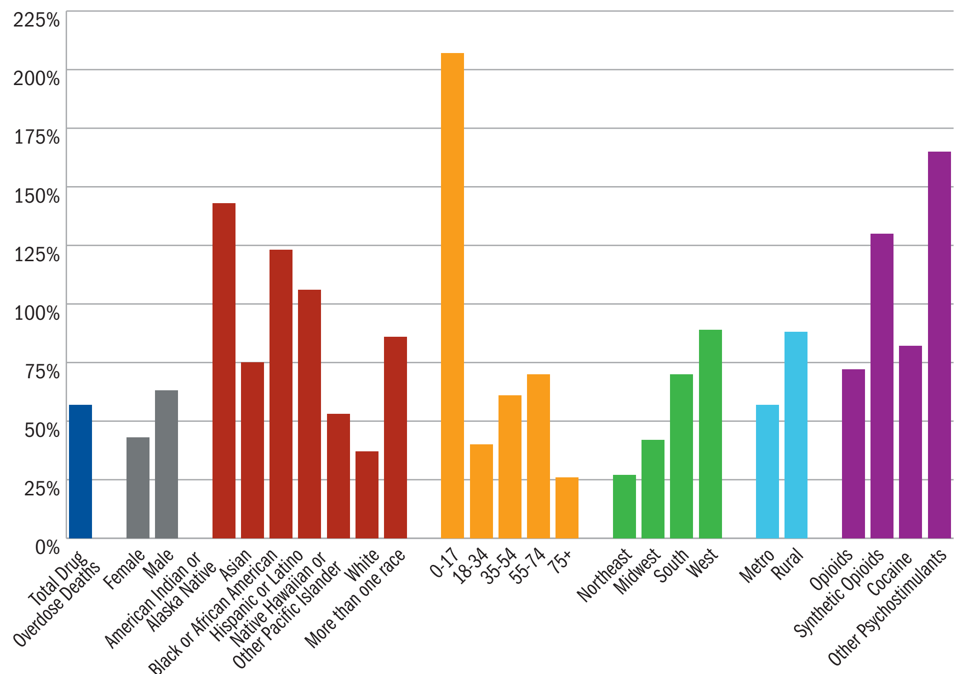
- In 2022, 107,941 Americans of all ages died from drug overdoses, and 721,746 Americans died from drug overdoses during the decade from 2013 to 2022.
- The age-adjusted rate at which Americans died from drug overdoses in 2022 was nearly identical to 2021, shifting by less than 1 percent from 32.4 deaths per 100,000 in 2021 to 32.6 deaths per 100,000 (age-adjusted rates). This is a big change from recent years: the last two years saw 14 and 31 percent rate increases, and over the last 20 years, the rate has quadrupled.
- Drug overdose death rates in 2022 were highest among AI/AN people (65.2 per 100,000), adults ages 35 to 54 (59.4 per 100,000), Black Americans (47.5 per 100,000), and males (45.6 per 100,000).
- Mortality trends varied substantially by group in 2022. Notably, young adults ages 18–34 were the only age group that saw declines in mortality, and NHOPI and white people were the only racial/ethnic groups with declines in mortality. All other populations of color saw increases in mortality in 2022, with the largest increases for AI/AN and Asian people.

Figure 9: Age-Adjusted Drug Overdose Mortality Rate (Deaths per 100,000 People) Overall and by Select Demographics and Region, 2022



Source: TFAH analysis of National Center for Health Statistics data

Figure 10: Percent Change in Drug Overdose Mortality Rates by Select Demographics and Region, 2018–2022

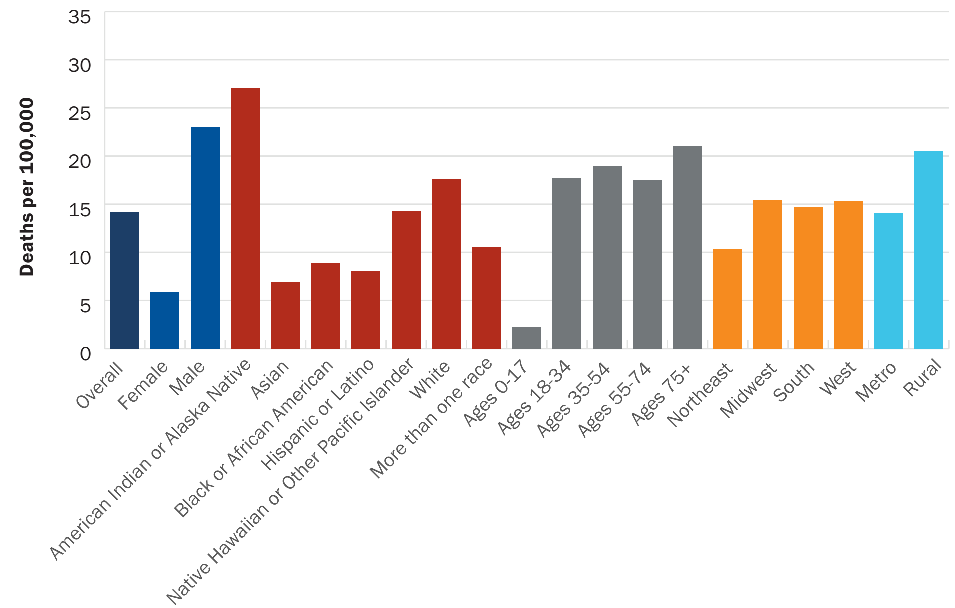


Source: TFAH analysis of National Center for Health Statistics data

Trends in Deaths by Suicide

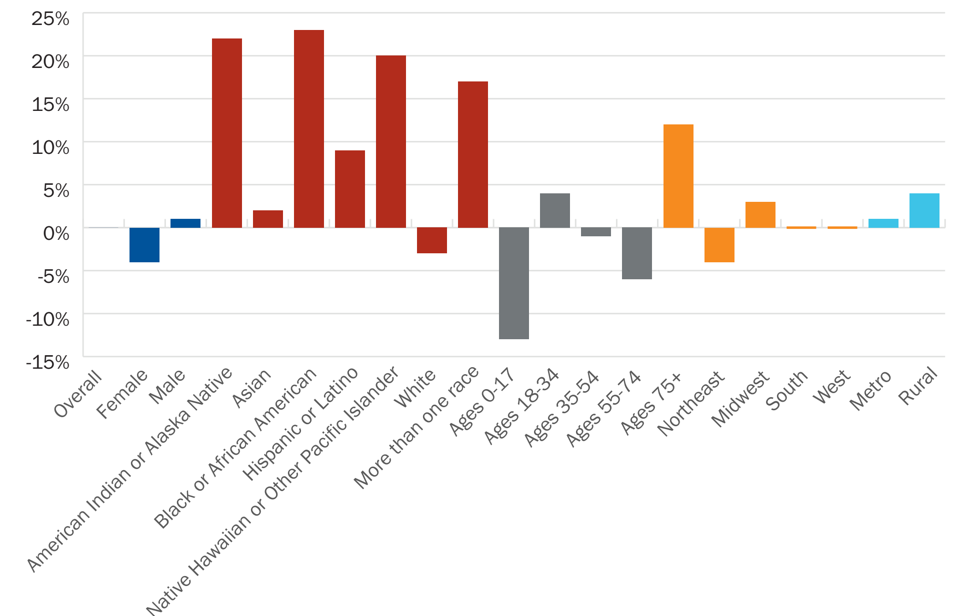
- In 2022, 49,476 Americans of all ages died from suicide, and 459,799 Americans died from suicide during the decade from 2013 to 2022.
- The overall age-adjusted suicide rate remained unchanged in 2022, shifting from 14.1 per 100,000 in 2021 to 14.2 per 100,000 in 2022. In the past 10 years, deaths from suicide increased from 2012 through 2018, decreased in 2019 and 2020, and then increased again in 2021 and 2022 to match the previous peak in 2018.
- Age-adjusted suicide rates in 2022 were highest among AI/AN people (27.1 deaths per 100,000), males (23.0 per 100,000), adults ages 75 and older (21.0 per 100,000), and residents in rural areas (20.5 per 100,000).
- Mortality trends varied by group in 2022. Most racial/ethnic groups remained unchanged or had small increases, except for AI/AN people who saw a 4 percent decrease and NHOPI and multiracial people who saw larger increases. Also notably, younger Americans (youth ages 0–17 and young adults ages 18–34) experienced decreases in suicide rates, while all other age groups (ages 35–54, 55–74, and 75 and older) experienced increases.
- Suicide by firearm and suffocation/hanging have both increased substantially over the last 10 years. Between 2012 and 2022, rates of firearm suicides increased by more than 20 percent and rates of suffocation/hanging suicides increased by 15 percent. All other methods, including poisoning/overdose, decreased by 4 percent over the same time.

Figure 11: Age-Adjusted Suicide Mortality Rate (Deaths per 100,000 People) Overall and by Select Demographics and Region, 2022



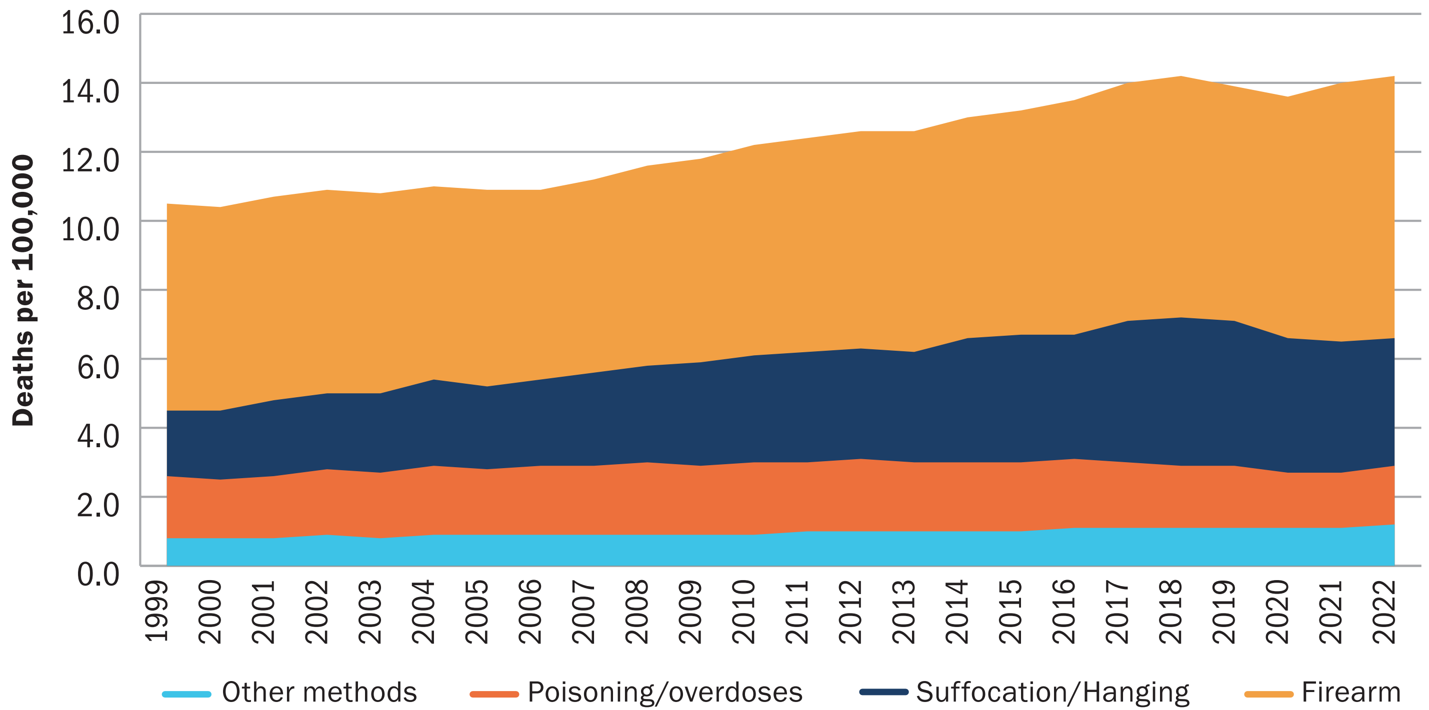
Source: TFAH analysis of National Center for Health Statistics data

Figure 12: Percent Change in Suicide Mortality Rates by Select Demographics and Region, 2018–2022



Source: TFAH analysis of National Center for Health Statistics data

Figure 13: Annual Age-Adjusted Suicide Rate (Deaths Per 100,000) By Suicide Method, 1999–2022



Source: TFAH analysis of National Center for Health Statistics data

RESEARCH ROUNDUP: NEW INSIGHTS AND ANALYSIS

This section highlights selected examples of new research that increases an understanding of current trends, causes, and solutions related to the alcohol, drug, and suicide epidemic.

The Projected Costs and Economic Impact of Mental Health Inequities in the United States

Meharry Medical College School of Global Health and Deloitte Health Equity Institute, May 2024

The School of Global Health at Meharry Medical College and Deloitte Health Equity Institute estimates in a May 2024 report that excess costs arising from mental health inequities will total $477.5 billion in 2024. The report also estimates that costs will continue to grow between now and 2040, when excess spending will exceed $1.3 trillion and cumulative costs will total nearly $14 trillion. This cost equals roughly $42,000 per person living in the United States. Importantly, the report notes that although the white population shows the highest prevalence of mental health diagnosis, non-white populations tend to experience more of the costs associated with mental health conditions. The report points to long-standing structural racism, the legacy of policies that disadvantage certain populations, and social and economic conditions as factors leading to this outcome.[94]

Recent Trends in Mental Health and Substance Use Concerns Among Adolescents

KFF, February 2024

This KFF brief reviews trends in adolescent mental health and substance use since the COVID-19 pandemic. Data for the brief comes from the National Health Interview Survey (NHIS), which surveyed adolescents ages 12–17 about their mental health. According to NHIS data, about one in five adolescents report experiencing symptoms of depression or anxiety. Additionally, LGBTQ+ adolescents are more than three times as likely as their non-LGBTQ+ peers to report feelings of anxiety and depression, as well as suicide attempts. Fatal drug overdoses in this age group have also rapidly increased since the pandemic; this is generally attributed to synthetic opioids such as fentanyl. The brief also notes that the suicide death rate for AI/AN adolescents is three times higher than their white counterparts and that the suicide death rate for adolescent males is more than double the rate for adolescent females. KFF concludes that these disparities are in part due to a lack of accessibility, affordability, and availability of mental healthcare, and recommends policy changes such as expanding school-based mental health services and promoting Medicaid behavioral health services to improve adolescent mental health.[95]

Gun Violence Exposure and Suicide Among Black Adults

Journal of the American Medical Association, February 2024

Gun violence and the resulting collective trauma to communities is a pressing public health concern that disproportionately affects Black Americans. This research study focuses on gun violence exposure (GVE) as a risk factor for suicidal ideation and suicide attempts among Black adults. In the study, four types of GVE are examined: an individual being shot, being threatened with a gun, knowing someone who has been shot, and witnessing or hearing about a shooting. The researchers find that (1) being threatened with a gun or having a friend or family member who had been shot are associated with higher lifetime suicidal ideation among Black adults; (2) being shot is associated with higher rates of planning a suicide; and (3) being threatened or knowing someone who has been shot is associated with higher lifetime suicide attempts. Additionally, having multiple types of GVE is associated with higher rates of all three suicidal behaviors measured. The authors conclude that future prevention efforts and policies should focus on preventing gun violence, as well as ensuring culturally appropriate support and resources for communities with GVE.[96]

New Research Characterizes Alcohol Use Disorder Profiles to Predict Treatment Outcomes

National Institute on Alcohol Abuse and Alcoholism, March 2023

The National Institutes of Health's National Institute on Alcohol Abuse and Alcoholism created the Addictions Neuroclinical Assessment, a framework to guide treatment based on new research into the biological and psychological factors that contribute to AUD. The research finds that assessing patients based on three key addiction cycle domains—binge/intoxication, negative affect, and preoccupation/anticipation—can predict treatment outcomes accurately. For example, individuals with higher negative emotionality (i.e., more anxiety, fear, and other negative emotions) and incentive salience (i.e., strong feelings of wanting) before treatment tend to have more intense and frequent drinking post-treatment, with those high in negative emotionality showing the lowest overall functioning at three years post-treatment. These findings suggest that personalized profiles based on these domains could pave the way for tailored treatment of AUD.[97]

RESEARCH ROUNDUP: NEW INSIGHTS AND ANALYSIS

Estimating the Effects of Hypothetical Alcohol Minimum Unit Pricing Policies on Alcohol Use and Deaths: A State Example

Journal of Studies on Alcohol and Drugs, January 2024

Excessive alcohol consumption is one of the leading causes of preventable death in the United States, causing about 140,000 deaths annually. A common strategy to reduce these deaths is to increase the price of alcohol to reduce its consumption. This quantitative study, using Michigan liquor sales as a baseline, is the first of its kind to estimate the potential effectiveness of a minimum unit pricing (MUP) strategy on reducing alcohol-attributable deaths. The study investigates MUP policies of 40 and 45 cents per standard drink (defined as 0.6 fluid ounces of pure alcohol). It finds that an MUP of 40 cents would increase the average price per drink by 6 cents, and an MUP of 45 cents would increase the price by 13 cents, which would reduce alcohol-attributable deaths by 5 and 8 percent, respectively. Additionally, the study concludes that MUP policies would be particularly effective in reducing deaths among males ages 35 to 64 and people who drink alcohol at above-average levels. This research shows that alcohol pricing is one important strategy to reduce alcohol-related deaths.[98]

Telemedicine Buprenorphine Initiation and Retention in Opioid Use Disorder Treatment for Medicaid Enrollees

Journal of the American Medical Association, October 2023

The COVID-19 pandemic changed the frequency and availability of in-person healthcare delivery in the United States, and consequently, there was a large shift toward telemedicine. Although previous regulations restricted telemedicine appointments for opioid use disorder (OUD), the federal government waived these to continue to provide care during the pandemic, including for patients taking medication-assisted treatment, like buprenorphine, methadone, and naltrexone. In Kentucky and Ohio, the states examined, the study finds that starting buprenorphine for OUD treatment via telemedicine corresponds with higher rates of buprenorphine retention compared with in-person appointments. However, racial disparities continue among those who initiate and sustain treatment, with Black patients having lower odds of buprenorphine initiation and retention than their white counterparts. Overall, the study finds that telemedicine is associated with increased access to OUD treatment and better retention rates, and future policies should support the continued use of telemedicine to treat OUD.[99]

State Approaches to Addressing the Opioid Epidemic: Findings from a Survey of State Medicaid Programs

KFF, February 2024

State Medicaid programs cover nearly 40 percent of people with OUD and play a critical role in helping their members get treatment and recovery services. To address OUD and overdoses, state Medicaid programs have implemented some strategies, including removing prior authorization requirements for buprenorphine treatment, reimbursing buprenorphine treatment prescribed via telehealth, and adding Narcan (an opioid overdose reversal drug) to the fee-for-service and Medicaid over-the-counter (OTC) formularies. Although these changes are positive, barriers to receiving care still exist. For example, some states have not included OTC Narcan within the Medicaid formulary, making treatment harder to access and more unaffordable for people with OUD in these states. However, more general changes to state Medicaid systems such as expanding access to services, lowering or removing copays, and adjusting reimbursement may help remove some barriers to OUD care.[100]

B. State Analysis

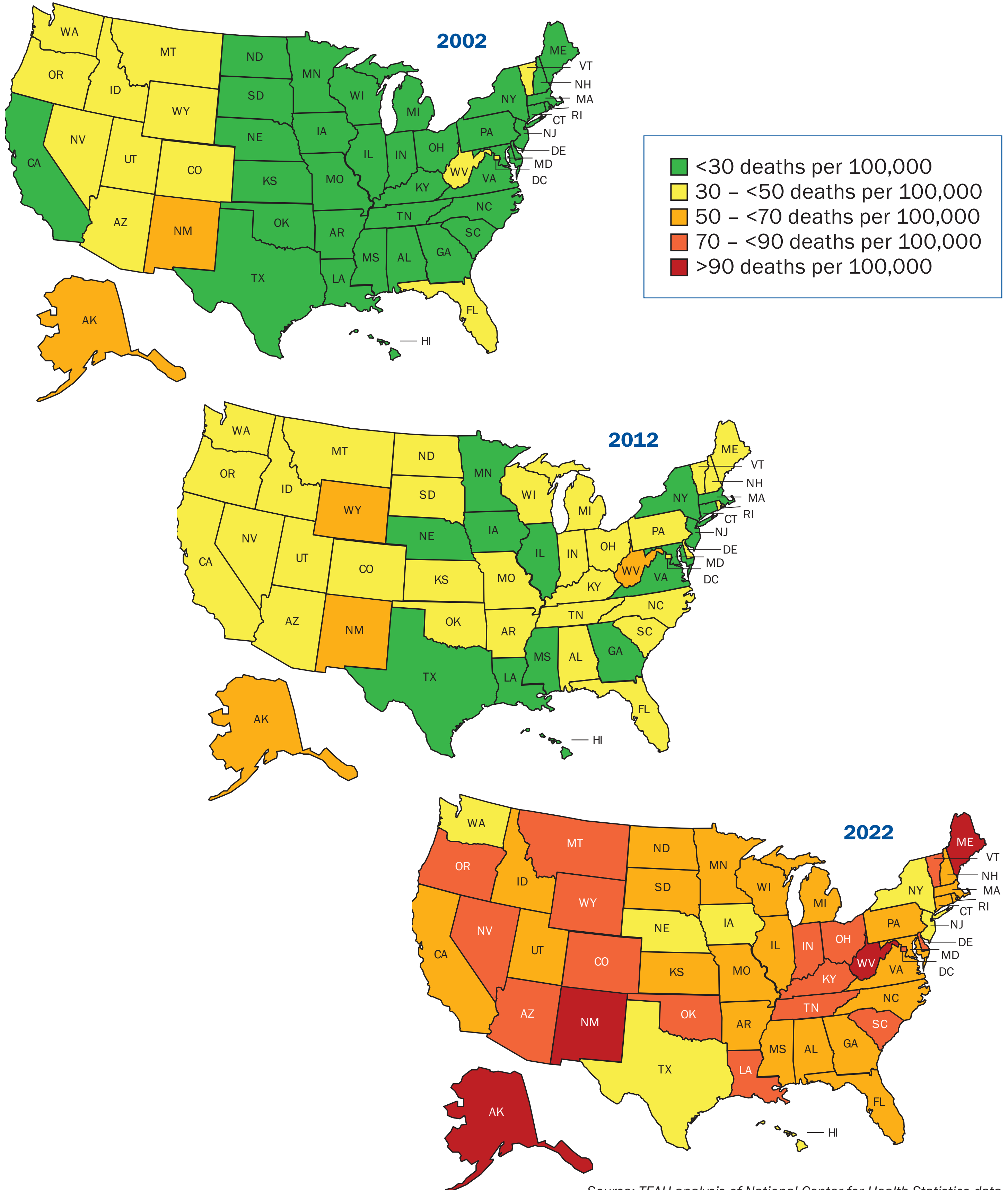
The rates and trends for total U.S. deaths caused by alcohol, drugs, and suicide vary across regions and states. A state-level analysis follows, and charts on page 44 in Appendix C have state-level data and year trends on alcohol, drug, suicide, opioid, synthetic-opioid, cocaine, and other psychostimulant deaths and death rates.

- **Deaths from alcohol, drugs, and suicides.** In 2022, state trends for age-adjusted rates of death from combined alcohol, drugs, and suicide were split: 24 states and the District of Columbia had higher rates compared with 2021, 24 states had lower rates, and two states (Iowa and Utah) stayed the same.
  - States with the highest age-adjusted death rates from alcohol, drugs, and suicide combined in 2022 were New Mexico (117.1 per 100,000), West Virginia (114.8 per 100,000), and Alaska (99.7 per 100,000).
  - States with the lowest age-adjusted death rates from alcohol, drugs, and suicide combined in 2022 were Hawaii (42.7 per 100,000), Texas (42.8 per 100,000), and Nebraska (45.5 per 100,000).
- **Alcohol-induced deaths.** In 2022, 40 states and the District of Columbia had lower age-adjusted alcohol death rates compared with 2021, seven states (Delaware, Indiana, Missouri, Nebraska, New Hampshire, New York, and North Dakota) had higher rates, and three states (Illinois, Oregon, and Wisconsin) stayed the same.
  - States with the highest age-adjusted alcohol death rates in 2022 were New Mexico (42.7 per 100,000), Alaska (36.6 per 100,000), and South Dakota (34.5 per 100,000).
  - States with the lowest age-adjusted alcohol death rates in 2022 were Hawaii (7.1 per 100,000), New Jersey (7.3 per 100,000), and Maryland (8.6 per 100,000).
- **Drug overdose deaths.** In 2022, state trends for age-adjusted drug-overdose rates compared with 2021, were split: 24 states had lower rates compared with 2021, and 26 states and the District of Columbia had higher rates.
  - States with the highest age-adjusted drug overdose death rates in 2022 were West Virginia (80.9 per 100,000) and Tennessee (56.0 per 100,000) plus the District of Columbia (64.3 per 100,000).
  - States with the lowest age-adjusted drug overdose death rates in 2022 were South Dakota (11.3 per 100,000), Nebraska (11.8 per 100,000), and Iowa (15.3 per 100,000).
- **Deaths by suicide.** In 2022, 29 states had higher age-adjusted suicide death rates compared with 2021, 19 states plus the District of Columbia had lower rates, and two states (Florida and Indiana) stayed the same.
  - States with the highest age-adjusted suicide rates in 2022 were Montana (28.7 per 100,000), Alaska (27.6 per 100,000), and Wyoming (25.6 per 100,000).
  - States with the lowest age-adjusted suicide rates in 2022 were New Jersey (7.7 per 100,000) and Massachusetts (8.3 per 100,000) plus the District of Columbia (6.1 per 100,000).

DATA LIMITATIONS: WHAT THIS DATA *DOES NOT* SAY

This section focuses on mortality from alcohol, drugs, and suicide in 2022 and other recent trends. It does not capture local trends, events in 2023 or 2024 (as final mortality data from those years were not available at the time of the report's publication), or the full burden of these epidemics beyond mortality, such as nonfatal overdoses, suicide attempts, or SUDs. It is also important to consider that mortality-reporting policies and capacity, particularly regarding identifying drug type in overdoses, vary by state, tribal, or local geographic areas and could artificially lower mortality rates for synthetic opioids and other specific drug types.

Annual Age-Adjusted Deaths per 100,000 People from Alcohol, Drugs, and Suicide in the United States, 2002, 2012, and 2022



Source: TFAH analysis of National Center for Health Statistics data

Policy Recommendations

Reversing trends in alcohol, drug, and suicide deaths will require a significant focus on primary prevention and the upstream drivers of behavioral health concerns. The impact of newly prominent substances like xylazine and the rising rates of overdose from polysubstance use also require public health approaches independent of the evolving drug supply. Accordingly, TFAH continues to call for strategies to bolster prevention and resilience programs in early childhood and in schools. This work must include efforts to identify and address the connections between adverse childhood experiences (ACEs)—potentially traumatic events occurring in childhood—and multiple negative health outcomes like substance use disorders (SUDs) across the lifespan. The promotion of positive childhood experiences (PCEs) in homes, schools, and communities can also help minimize the risk of SUDs, suicide, and other mental health challenges among all children and youth. Integrating behavioral healthcare and physical healthcare and expanding and diversifying the healthcare workforce can also help meet the needs of underserved populations and address social determinants of health. More immediately, effective harm reduction measures can combat the deadly impact of fentanyl in U.S. communities and reduce deaths from suicide. Taken together, the following actionable recommendations will save lives, boost resiliency, and improve mental health and well-being. Many of the recommendations discussed in this report focus primarily on prevention and early intervention around mental health and substance misuse concerns, although treatment, crisis services, and data collection are critical components as well.

A. Invest in Prevention and Conditions that Promote Health

Congress and the U.S. Department of Health and Human Services (HHS) should support policies and programs that reduce ACEs and the impact of trauma and promote PCEs. ACEs can have a long-term impact on physical and mental health, but they are preventable through multisectoral efforts and strongly mitigated through the promotion of PCEs.

- Congress should increase funding for Adverse Childhood Experiences program at the Centers for Disease Control and Prevention (CDC), which monitors the prevalence of ACEs and researches and disseminates evidence-based strategies to prevent ACEs and their negative effects and to promote PCEs. Federal, state, and local governments should adopt these evidence-based strategies, including strengthening economic supports to families, improving access to quality childcare, and teaching parenting skills.[101] Congress should pass and CDC should implement the Preventing Adverse Childhood Experiences Act, which would authorize ACEs research with a strong focus on equity and community factors.[102]
- Congress should pass the Resilience Investment, Support, and Expansion from Trauma Act (or RISE from Trauma Act), which authorizes programs to mitigate the impact of trauma, including in schools; hospital interventions to improve outcomes for patients who experience drug overdoses, suicide attempts, or violent injury; and clinical training in infant and early childhood mental health.[103,104]
- Congress should also promote safer communities by investing in CDC's Core State Violence and Injury Prevention Program and other programs focused on community violence prevention. These successful state programs create the infrastructure to reduce domestic violence, child trauma, ACEs, and suicide.
- Congress should support youth-serving programs that adopt trauma-informed and culturally and linguistically appropriate policies and practices. Congress should support programs that disseminate technical assistance and training for trauma, including by providing funding to the Substance Abuse and Mental Health Services Administration (SAMHSA) for the National Child Traumatic Stress Network. Importantly, this network recognizes the importance of cultural awareness, responsiveness, and understanding for trauma-informed school systems.
- The juvenile justice system should also adopt approaches that recognize substance misuse and serious emotional disturbances as health issues—not criminal justice issues—and ensure access to diversion and care for young people.
- The Centers for Medicare & Medicaid Services (CMS) and health insurers should expand coverage and training for screening of suicide risk in primary care, pregnancy care, and other settings.

Congress and federal agencies should increase support for substance use prevention, mental health, and resiliency programs in schools. Schools are an ideal location for prevention and early intervention, but they need the resources to perform these functions and effectively partner with other healthcare systems to address the social, relational, and mental health needs of children and youth.[105] Specifically, schools need support to increase: (1) staff training in understanding and responding to childhood trauma, promoting PCEs and family resilience and connection, and recognizing the emotional and mental health needs of children; (2) social and emotional learning programs that yield a robust return on investment and promote lifelong health; and (3) culturally and linguistically appropriate mental health services and screenings.[106]

- Congress should pass the Mental Health Services for Students Act, which would authorize increased funding through SAMHSA for public schools to partner with local mental health professionals to establish on-site mental health services for students.[107,108] Similarly, passage of the Advancing Student Services in Schools Today Act (or the ASSIST Act) would fund the hiring and retention of mental health providers in schools and would implement a 90 percent increase in federal matching funds to pay for these services.[109,110]

- Congress should increase funding for federal programs that support evidence-based prevention efforts in schools and that promote protective factors to reduce high-risk substance use and mental health issues, including CDC's Division of Adolescent and School Health (DASH) and initiatives through the U.S. Department of Education. (See additional information on DASH initiatives below.)
- State policymakers should also work to reduce barriers to reimbursement for school-based health centers, which can provide comprehensive mental health services for children.[111]
- Congress should also support comprehensive mental health programs for college-age young people, such as those proposed in the Campus Prevention and Recovery Services for Students Act to prevent alcohol and substance misuse and to integrate campus health services.[112] Congress should also pass the Student Mental Health Rights Act to help improve an understanding of mental health conditions on campuses and to establish related best practices.[113]

CDC'S MENTAL HEALTH AND WELL-BEING ACTION GUIDE FOR SCHOOLS AND RELATED INITIATIVES

On December 6, 2023, CDC's DASH released a school mental health action guide titled "Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders."[114] The guide provides six evidence-based strategies to promote mental health and well-being in K–12 students:

- Increase students' mental health literacy by delivering classroom-based mental health education curricula and implementing peer-led modeling programs.
- Promote mindfulness by delivering classroom-based mindfulness education, dedicating time for students to independently practice mindfulness, and offering small group mindfulness activities.
- Promote social-emotional learning by providing classroom instruction focused on building skills related to social-emotional learning and offering education focused on teaching social and emotional skills.
- Enhance connectedness among students, staff, and families by providing relationship-building programs.
- Provide psychosocial skills training and cognitive behavioral interventions by engaging students in coping-skills training groups and promoting acceptance and commitment to change.
- Support school staff well-being by offering mindfulness-based training programs and providing therapeutic resources.

The guide also provides details on how schools can implement these strategies, which DASH has tied to specific mental health outcomes, and includes recommendations for focusing on equity. DASH intends for schools to choose strategies based on their capacity and existing systems of support.

DASH also administers the Youth Risk Behavior Survey (YRBS), a system of school-based national and local surveys that monitor six categories of health-related behaviors, including alcohol and other drug use and behaviors contributing to unintentional injuries and violence. In February 2023, DASH released the "Youth Risk Behavior Survey: Data Summary and Trends Report, 2011-2021," which showed increasing suicidal thoughts and behaviors and other negative mental health conditions for nearly all groups of youth.[115] Importantly, the survey showed that teen girls have experienced record high levels of violence, sadness, and suicide risk, and LGBQ+ teens continue to face extremely high levels of violence and mental health challenges.[116]

In 2023, the Biden-Harris Administration proposed an increase of $52 million for the DASH program to expand the reach of CDC's What Works in Schools program, which includes strategies to improve mental health and decrease substance use, to up to 75 of the largest U.S. local education agencies.[117] Congress, however, did not provide an increase in funding in FY 2023 or FY 2024 sufficient to support a nationwide approach for DASH initiatives.

SIX KEY RESOURCES TO SUPPORT YOUTH MENTAL HEALTH

Mental illness and suicide rates among young people have substantially increased since 2010. In 2022, nearly 5 million adolescents in the United States experienced depression compared with 2 million in 2010.[118] Data from CDC's 2021 Youth Risk Behavior Survey found that among high school students, girls and LGBTQ+ youth in particular were more likely to experience persistent sadness and have suicidal thoughts, plans, and attempts.[119,120]

Crisis Text Line, a nonprofit organization that offers free, confidential, 24/7 mental health services and crisis intervention across the United States, and Common Good Labs, a data science and research organization with the mission of finding solutions that improve people's lives and communities, analyzed 87,000 conversations between Crisis Text Line counselors and adolescents from 2019 to 2022 for insights into how to support youth mental health. The researchers found six common resources that young people said they needed from their communities to help them cope. The desired resources, in order of importance to youth, are: (1) opportunities for social connection; (2) engagement in the arts (music, writing, visual, and performance); (3) mental health services; (4) exercise and sports programs; (5) books and audiobooks; and (6) outdoor spaces and nature.[121]

Separate peer-reviewed research studies have measured how some of these key resources, such as social support,[122] participation in creative arts,[123] physical activity,[124] and interacting with nature,[125] can help build connections, increase self-esteem, reduce loneliness,[126] and offer ways to process difficult events. CDC has explained, for example, that after-school programs can connect youth to caring adults and activities, which can serve as key buffers against the impact of ACEs.[127] Unfortunately, many schools have lowered funding for these resources, especially for the arts and after-school activities.[128] Additionally, data from CDC and the U.S. Census Bureau shows a decline in after-school activity involvement for adolescents, even though the youth population has increased.[129,130] The Crisis Text Line and Common Good Labs researchers hypothesize that a reduction of, and reduced funding for, these essential resources is worsening youth mental health outcomes. Reinvesting in these resources are actionable ways communities can support youth.

Congress and HHS should boost access to early prevention and family-support programs. Congress should increase funding and reimbursement for Head Start and other federal programs that provide access to and coordination of social and mental health services for children and families.[131]

- Congress should expand guidance and funding for mental health screening and interventions for children in Head Start programs, including through grants proposed in the Early Childhood Mental Health Support Act.[132,133] As part of these efforts, HHS should continue to work with states and insurers to ensure equitable access to and uptake of evidence-based preventive interventions for family mental health.[134]
- Passage of the Helping Kids Cope Act would also expand the availability of community-based pediatric mental healthcare, bolster the pediatric mental and behavioral health workforce, and strengthen pediatric mental health infrastructure to support a full continuum of care.[135,136]
- Congress should increase access to behavioral healthcare for youth by raising Medicaid reimbursement rates for pediatric mental health and supportive services, including through passage of the Strengthen Kids' Mental Health Now Act.[137]
- Congress should invest in an expanded and diverse maternal mental health workforce to improve perinatal prevention, intervention, and treatment. Specifically, Congress should pass the Black Maternal Health Momnibus Act, which would increase access to maternal mental healthcare to reduce drivers of maternal mortality, morbidity, and disparities.[138,139]
- Congress can also support upstream approaches to behavioral health by establishing a set-aside for prevention and early intervention services within SAMHSA's Community Mental Health Services Block Grant.

IMPROVING MATERNAL MENTAL HEALTH

Throughout 2023, federal policymakers acted to address a growing maternal health crisis: mental health conditions, including SUDs, became the leading underlying cause of pregnancy-related deaths according to 2017–2019 survey data.[140] A 2022 study, moreover, found that drug overdose mortality among pregnant and postpartum individuals increased more than 80 percent from 2017 to 2020,[141] and a February 2023 analysis found a significant increase in maternal fentanyl use during the COVID-19 pandemic.[142] In September 2022, CDC data also showed that mental health–related deaths accounted for 23 percent of deaths during pregnancy or in the year following pregnancy.[143]

Maternal mental health challenges can arise from a combination of biological, psychological, and social factors, including a lack of social resources, according to the Policy Center for Maternal Mental Health.[144] Women living in poverty, for example, suffer postpartum depression at double the rate of those not living in poverty.[145] Gender-based violence is also associated with a variety of mental health consequences during pregnancy and postpartum, and studies support a connection between ACEs and the prevalence of depression during pregnancy.[146]

In response to concerning maternal mental health trends, the Biden-Harris Administration designated a Maternal Health Day of Action in September 2023, announcing several initiatives to implement the 2022 White House Blueprint for Addressing the Maternal Health Crisis:[147,148]

- HHS created the Task Force on Maternal Mental Health, co-chaired by Assistant Secretary for Health Admiral Rachel Levine, M.D., and Assistant Secretary for Mental Health and Substance Use Miriam E. Delphin-Rittmon, Ph.D., to identify recommendations, best practices, and communications to support maternal mental health.[149]
- The Health Resources and Services Administration (HRSA) announced $90 million in awards to expand treatment and screening for maternal mental health and SUDs, support maternal health in rural areas, and improve access to basic social and health services, among other initiatives.[150]
- The Office on Women's Health launched a national campaign to raise awareness regarding postpartum depression, highlight reliable resources, and share information on opportunities to access care.[151]

Earlier in the year, HRSA also announced more than $65 million in awards to health centers to improve maternal health outcomes and reduce disparities by developing innovative models of care delivery for patients with the highest levels of maternal health risk.[152] In addition, CMS continued to expand comprehensive coverage through Medicaid and the Children's Health Insurance Program for postpartum individuals for 12 months after pregnancy on a state-by-state basis.[153]

Federal officials and other experts have also highlighted ongoing obstacles to reducing stigma and expanding access to maternal care. National Institute on Drug Abuse Director Dr. Nora Volkow, for example, has described the ways in which punitive policies related to substance use in pregnancy can deter individuals from seeking help and can also worsen racial health disparities.[154] Relatedly, a 2019 RAND study found that state-level punitive action against pregnant people who used illegal substances was associated with higher rates of infants born with opioid withdrawal; the study authors suggested policymakers should focus on prevention and expanding access to treatment instead of punishment.[155] Even without punitive policies, individuals may not access treatment due to a lack of facilities with specialized programs for pregnant and postpartum women or a lack of buprenorphine prescribers, especially in rural areas.[156]

Racial discrimination in healthcare and income inequality also contribute to higher rates of maternal mental health conditions for women of color. The Maternal Mental Health Leadership Alliance, for example, has explained that Black women are twice as likely to experience maternal mental health conditions compared with white women and half as likely to receive care.[157] Women of color also have an increased risk of being uninsured prior to pregnancy and face limited access to providers and culturally appropriate care.[158] A 2019 study also found higher rates of mistreatment by maternity care providers for this population.[159] To help address these disparities, TFAH has endorsed the Black Maternal Health Momnibus Act, reintroduced in the 118th Congress, which seeks to reduce drivers of maternal mortality, morbidity, and disparities.[160]

Congress should expand funding for comprehensive suicide prevention efforts that employ specialized approaches for populations at risk of suicide, support data collection, and improve local understanding of suicide attempts.

- Congress should provide funding for the nationwide implementation of CDC's suicide prevention program, which advances strategies to deter suicide risk by promoting connectedness, creating protective environments, and teaching coping skills, among other measures. These primary prevention efforts include the Comprehensive Suicide Prevention (CSP) program, which helps communities implement a multisectoral, public health approach to suicide prevention, as well as focused prevention efforts among veterans and tribal nations. Enhanced funding for CSP can also help states understand nonfatal suicide-related outcomes and use data to inform preventive action. CDC is implementing and evaluating the best available evidence for suicide prevention, but the current funding level for CSP can only support recipients in 24 states.[161]

- Congress should also provide funding, including through the passage of the Suicide Prevention Act, to enhance the timeliness and effectiveness of health department prevention efforts by improving their understanding of suicide attempts and other instances of self-harm.[162]

- The Community Preventive Services Task Force should also consider issuing recommendations regarding suicide prevention interventions focused on LGBTQ+ populations, youth suicide clusters and contagion, perinatal risks, and promoting connectedness in schools.

Congress, the Office of National Drug Control Policy (ONDCP), and state and local governments should focus prevention efforts on substance misuse among youth. Congress should increase funding for the Drug-Free Communities Support Program, managed through a partnership between ONDCP and CDC. State and local governments should also ensure that any opioid litigation settlement funds go toward supporting the primary prevention of youth substance misuse, and ONDCP should support this process by building on its 2021 model law concerning settlement funding.

Congress should promote policies and programs to address social determinants of health (SDOH). Social and economic conditions—such as housing instability, limited employment opportunities, food insecurity, community violence, and lack of transportation options—have a major influence on health, including rates of substance use disorder. To build on the 2023 U.S. Playbook to Address Social Determinants of Health, Congress should approve increased funding for CDC programs to address these determinants.[163] These programs should include grants to states, localities, and tribes to plan, coordinate, and measure activities to improve community drivers of poor health. A public health approach is necessary to ensure implementation of evidence-based and cost-effective changes at a community and population level.

Congress, SAMHSA, and other agencies should strengthen capacity to address the behavioral health impacts of climate change and weather-related disasters. Community preparation and responses can help prevent or reduce the mental health impacts of accelerating climate change. SAMHSA should strengthen its support for population-level approaches for mental health resilience; increase research, surveillance, and monitoring of the impact of climate emergencies and extreme weather on behavioral health; and research the most effective post-disaster interventions. SAMHSA and other federal agencies should also ensure climate-related programming accounts for the needs of underserved areas, including the interaction between climate change and existing SDOH that lead to poor behavioral health outcomes.

- In addition, federal efforts should address the impact of structural racism and discrimination on these outcomes, particularly among communities of color. Throughout their climate planning and grantmaking processes, federal agencies should also prioritize engaging with and funding organizations led by and serving people of color and other frontline recipients to ensure individuals with lived experiences have sufficient capacity and resources. Additional federal data collection and research concerning climate-related mental health impacts and interventions would assist efforts to build climate resiliency in populations of color.

B. Reduce Overdose Risk and Access to Lethal Means of Suicide

Congress, federal agencies, and states should promote harm reduction policies to reduce overdose and blood-borne infections. Congress should increase funding for comprehensive syringe services programs and remove barriers to purchasing harm reduction supplies with federal funds. States should adopt model laws to ensure the effective establishment of syringe services programs, as outlined by ONDCP.[164]

- ONDCP and SAMHSA should continue to provide technical assistance and strategies to state and local governments to reduce barriers to accessing overdose prevention medications like naloxone.[165]
- Federal agencies should also provide technical assistance to state legislators seeking to remove legal barriers to the use of test strips for fentanyl and other illegal substances.

Congress and states should support efforts to limit access to lethal means of suicide. This includes promoting safe storage of medications and firearms through public education and laws; limiting access to firearms for children and individuals in crisis or at risk of suicide; and providing education and creating protocols for healthcare providers, counselors, and first-responders on counseling patients and families to create safe environments.

- Passage of the Kid Providing Resources for Optimal Outcomes against Fatalities Act (or Kid PROOF Act) would provide funding through SAMHSA to help healthcare providers equip parents, with their consent, with lethal means safety supplies, like gun safes and lockboxes, when a child is at risk of suicide or overdose.[166,167] Federal agencies like SAMHSA should also work to incorporate lethal means assessments and counseling into standard procedures for their mental health crisis lines.[168]
- Congress should provide additional funding for foundational research at CDC, the National Institutes of Health, and the National Institute of Justice related to lethal means use and suicide prevention efforts suited to diverse populations.[169] Evidence-based research into these priorities can reduce firearm-related injuries, identify populations at risk of suicide, and evaluate new forms of interventions.
- Congress should also pass the Barriers to Suicide Act to establish a grant program for states and localities to fund the installation of evidence-based suicide deterrents like barriers and nets on bridges.[170,171]
- Congress should consider legislation to allow for extreme risk protection orders or other methods for preventing individuals who pose a risk to themselves or others from obtaining firearms on a temporary basis.
- Healthcare providers should be trained in lethal means counseling. The Counseling on Access to Lethal Means model improves medication and firearms storage behavior: one study, which focused on parental counseling for suicidal youth in the emergency department, found 100 percent of parents reported securely stored firearms at follow-up.[172]

State and federal officials should reduce the availability of illegal opioids and unnecessary prescriptions through responsible opioid prescribing practices, informed by the Clinical Practice Guideline for Prescribing Opioids for Pain, and support for high-functioning prescription drug monitoring programs. ONDCP, the U.S. Department of Justice, and the U.S. Department of Homeland Security should maintain support for hotspot monitoring, like the Overdose Detection Mapping Application Program, as well as interventions and anti-trafficking strategies focused on heroin, fentanyl, and other illegal drugs. Finally, federal efforts should also focus on improving access to evidence-based alternatives to opioids for pain treatment, including through expanding coverage for interdisciplinary care and funding chronic pain research.

State and federal officials should implement policies focusing on psychostimulant use that complement current opioid-focused policies. Congress and/or federal agencies should enable additional flexibility in federal overdose prevention grants to allow states to address substances other than opioids and based on local needs.

State and local governments should lower excessive alcohol use through evidence-based policies, and Congress should support these efforts. States and communities can reduce harms from alcohol by increasing pricing, reducing sales hours, and limiting the density of alcohol outlets; enforcing underage drinking laws; and holding sellers and hosts liable for serving minors or overserving adults.[173] Congress should support efforts to provide technical assistance and training on strategies to reduce excessive alcohol use with continued funding for CDC's Alcohol Program, which focuses on improving epidemiology and prevention in this area.

988 SUICIDE AND CRISIS LIFELINE: A FIRST STEP AND CHALLENGES AHEAD

July 2024 marks the two-year anniversary of the 988 Suicide and Crisis Lifeline, which replaced the previous National Suicide Prevention Lifeline with a single three-digit number for mental health, substance misuse, and crisis services. With oversight and funding from SAMHSA and assistance from partners like Crisis Text Line and The Trevor Project, 988 consists of independently operated and funded call, text, and chat centers across the country. When individuals in crisis contact 988, trained crisis counselors at these centers listen, provide support, and share resources if necessary. Access to 988 can play a critical role in improving depressed, suicidal, or overwhelming feelings—in fact, SAMHSA estimates that 98 percent of individuals contacting 988 receive the crisis support they need in the moment.[174] SAMHSA has identified the current 988 system as a first step toward evolving crisis care to include mobile crisis units, which provide in-person responses, and stabilization centers, which provide a safe place to stay for individuals in crisis.

Even in its current form, 988 represents a momentous advancement in the effort to connect more Americans with crisis services. In May 2023, for example, 988 answered 45 percent more calls, 52 percent more chats, and 938 percent texts compared with the previous lifeline in May 2022.[175] In total, 988 answered nearly 160,000 more contacts in May 2023 compared with May 2022.[176] The 988 lifeline has also launched specialized services for the LGBTQ+ population, and SAMHSA announced the addition of Spanish-language text and chat services in July 2023.[177,178] Other specialized services have followed for hearing-impaired individuals.[179] Contacts have also continued to grow in 2024; in March 2024, for example, 988 answered almost 440,000 contacts compared with roughly 341,000 answered contacts in March 2023.[180]

Despite this notable progress, significant challenges remain in the effort to strengthen 988 and connect individuals in crisis to behavioral health services. A May 2023 survey by the Pew Charitable Trusts, for example, found that only 13 percent of American adults knew about the existence and purpose of 988; awareness was higher among white adults and individuals with a college education compared with Black adults and individuals with a high school degree or less.[181] An October 2023 study also found that only one-third of respondents with serious distress who had used 988 were likely to use it in the future.[182]

On the federal level, 988 received a modest increase in appropriations for FY 2024—a concerning prospect given that SAMHSA estimates outreach to the lifeline will increase by up to 50 percent (to a total of around 9 million contacts) during this period.[183] At the same time, although state governments share the responsibility for funding and operating 988 call centers, only a handful of states have passed legislation to secure long-term financial support for the lifeline through telecommunications fees.[184] A June 2023 study, moreover, found that only around half of states have earmarked sufficient funding to meet increased 988 center costs.[185] Due in part to insufficient and short-term funding, call centers can also struggle to provide job security and competitive wages for qualified staff, and answer rates can vary significantly by state.[186,187,188,189]

Improved data collection and analysis concerning 988 services will help improve lifeline implementation and identify gaps in crisis care.[190] A proposal from the Federal Communications Commission to route 988 callers based on their real-time location—not their area code—may also improve access to lifesaving support.[191] States will also require additional federal support to develop and implement mobile responses and stabilization units and publicize the full range of 988 services.

C. Transform the Mental Health and Substance Use Prevention System

Congress and SAMHSA should bolster the continuum of crisis intervention programs and supports. Congress should continue to strengthen the 988 Suicide and Crisis Lifeline through increased SAMHSA funding and through passage of the 9-8-8 Implementation Act, which would provide funding for crisis call centers to purchase or upgrade call center technology, hire and train call center staff, and improve call center operations.[192] The bill would also authorize funding for mobile crisis units and extend Medicare, Medicaid, and TRICARE coverage for crisis response services.[193]

- The Federal Communications Commission should finalize its proposed rule to require wireless carriers to implement a geo-routing solution for 988 while maintaining necessary privacy safeguards.

- Passage of the Continuity in Necessary Evaluative Crisis Treatment Act (or the CONNECT Act) would also provide resources for follow-up care for individuals receiving suicide prevention and crisis intervention services.[194]

- SAMHSA should expand on efforts to ensure that crisis services provide culturally and linguistically appropriate care and address individual and collective trauma resulting from discrimination and stigma. SAMHSA and ONDCP can also assist with analyzing data from 988 calls to help direct resources and support to indicated populations at higher risk of SUD and related issues.

- SAMHSA, ONDCP, and other entities should also increase opportunities for youth and young adults to serve in 988 call centers as support staff or mobile-response team members, with an emphasis on representatives from communities of color.

- Congress should also pass the Crisis Counseling Act to streamline the process of providing crisis counseling to states after disaster declarations. CMS and other agencies can also assist by considering in advance the necessary waivers to ensure continuity of care for individuals in treatment.[195]

Congress should support efforts to modernize mental health and substance use services by aligning healthcare provider payment, quality measures, service delivery, and training toward clinical models that focus on the whole health of individuals, including individual non-medical social needs, and that prioritize integrated delivery models.

- Congress should pass provisions of the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act to expand mental healthcare and SUD services under Medicaid and Medicare, support access to telehealth services, and incentivize behavioral health integration.[196,197] Similarly, passage of the Connecting Our Medical Providers with Links to Expand Tailored and Effective Act (or the COMPLETE Care Act) would encourage primary care providers to implement and expand integrated behavioral healthcare into their practices and provide related technical assistance.[198,199]

- To aid in these efforts, HHS should define the key elements of mental health integration and develop measures to simplify related metrics and reporting, especially those focused on disparities in health outcomes.[200]

- Congress should also support programs to aid emergency departments in identifying and treating patients at risk of suicide, including through passage of the Effective Suicide Screening and Assessment in the Emergency Department Act, as well as efforts to increase access to follow-up services for individuals receiving crisis care.[201]

Congress should increase access to mental health and substance use healthcare, including through full enforcement of the Mental Health Parity and Addiction Equity Act to ensure patient access to essential services. Congress should strengthen enforcement efforts by providing the U.S. Department of Labor the authority to levy monetary penalties against health insurers and health plan sponsors who violate the Parity Act; expand the scope of entities subject to enforcement to include Medicare, Medicaid fee-for-service, and TRICARE; and allow participants and beneficiaries to recover amounts lost through wrongfully denied claims. Congress should also define mental health and SUD benefits based on nationally recognized standards. Other congressional initiatives to expand access to care should include:

- Passage of the Reentry Act to allow incarcerated individuals to receive medical services supported by Medicaid—including SUD treatment—30 days before the end of their incarceration to reduce overdose risk.[202]

- Passage of the Medicaid Bump Act to increase the federal reimbursement rate for state Medicaid spending on mental health and SUD treatment greater than 2019 levels.[203,204]

Congress and federal agencies should expand the mental health and substance use treatment workforce and build community capacity across the continuum of prevention, treatment, and recovery. SAMHSA, CDC, and other federal agencies should identify trends and gaps in mental health utilization to better determine local needs and the populations requiring care, including needs in community-based or nontraditional settings. CDC should provide guidance to assist in training community health workers on suicide prevention and other evidence-based treatment, and experts should establish uniform standards and definitions for recovery support and other services.

- Passage of the Providing Empathetic and Effective Recovery Support Act (or PEER Support Act) could aid these efforts by ensuring accurate data reporting on the peer workforce, supporting best practices on training and supervision, and addressing barriers to certification and practice.[205,206]

- Congress should also help sustain progress on capacity and workforce issues by reauthorizing provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (or SUPPORT for Patients and Communities Act).[207]

Congress should promote equity in mental health, including through workforce diversity and culturally and linguistically appropriate services in order to reduce disparities in access and outcome. Congress should pass and fund the Pursuing Equity in Mental Health Act, which would help establish behavioral healthcare teams in areas with underserved populations, improve training and best practices to address mental health disparities, and enhance outreach to communities of color to promote mental health and reduce stigma.[208] Passage of the Health Equity and Accountability Act would also help reduce health disparities by improving data reporting, supporting workforce diversity, and increasing access to culturally and linguistically appropriate care.[209] In addition, continued congressional support for SAMHSA's Minority Fellowship Program will help increase the diversity of mental health and substance use treatment practitioners.

Federal agencies should improve data accuracy, completeness, and timeliness, and Congress should increase funding for these efforts. Gaps in data, including information regarding nonfatal suicide and overdose incidents, mask the extent of these crises. Near real-time data can provide public health officials with a system for detecting, understanding, and monitoring health events like overdoses and suicide, serve as an early warning system for emerging issues, identify inequities, and guide government and nongovernmental responses. Additional funding for updated data infrastructure could also enable integration and quicker analysis and comparison across datasets.

- SAMHSA should continue to improve data collection, analysis, sharing, and reporting, including through the 988 lifeline, to enhance behavioral health crisis responses and to ensure individuals of all races, ethnicities, sexual orientation, disability status, and gender have access to care.[210,211]
- HHS should promote standardized categories and collection of racial, ethnic, and other demographic data to help identify disparities and improve death investigation systems.
- Congress should increase CDC's Surveillance, Epidemiology, and Informatics budget to expand programs like the National Syndromic Surveillance Program, which currently covers 78 percent of the nation's emergency departments. Additional support for these efforts will help develop a comprehensive national view of the overdose epidemic and enable effective responses.

Federal officials should expand efforts to combat stigma and improve social acceptance of mental healthcare and health-seeking behaviors. The federal government should promote culturally and linguistically appropriate messaging around mental health screening and treatment in order to reach underserved populations to increase screening, reduce stigma for those seeking help, and provide naloxone-related education. These messages should come from trusted, salient messengers and should educate a range of stakeholders, including educators, healthcare professionals, justice system officials, and the media.[212]

Appendix A: Data Methodology

Unless otherwise referenced, data in this report are from the National Center for Health Statistics' Multiple Cause of Death Files, 1999–2022, accessed via the CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER) Database (wonder.cdc.gov/mcd.html).

For alcohol-induced deaths, TFAH used "alcohol-induced" from CDC's underlying cause-of-death category "Drug/Alcohol Induced Causes."

For deaths related to drug overdose, TFAH used International Classification of Diseases, Tenth Revision (ICD-10) codes as follows:

- All drug overdose: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes.
- All opioid overdose deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.0–40.4 and T40.6 "multiple causes of death" codes.
- Synthetic opioid overdose deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.4 "multiple causes of death" code.
- Heroin overdose deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.1 "multiple causes of death" code.
- Common prescription opioid overdose deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.2 "multiple causes of death" code.
- Cocaine overdose deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.5 "multiple causes of death" code.
- Other psychostimulant overdose deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T43.6 "multiple causes of death" code.

For deaths by suicide, TFAH used "suicide" from CDC's "underlying causes of death" category "Injury Intent and Mechanisms."

To calculate combined deaths from alcohol, drugs, and suicide, TFAH added alcohol-induced deaths, drug-induced deaths (from the "Drug/Alcohol Induced Causes" category), and suicide deaths. Because a small number of deaths are categorized as both alcohol- or drug-induced and as suicide, TFAH then removed duplicates (ICD-10 "underlying causes of death" codes X60–65) when determining the combined death totals.

Age-adjusted death rates (deaths per 100,000) are used when available, which includes all categories except by age group and urbanization level.

Due to recent updates in racial/ethnic data reporting, analogous data is not available for racial/ethnic groups across all years with data (1999–2022).

TFAH uses slightly different terminology than CDC when describing racial/ethnic groups. TFAH uses "Latino" to include individuals of Hispanic or Latino ethnicity, and, unless noted, AI/AN, Asian, Black or African American, NHOPI, white, and more-than-one-race individuals are non-Hispanic.

Appendix B: National Alcohol, Drug, and Suicide Mortality Data

Deaths, death rates, and one-year percent change in death rate from alcohol, drug, and suicide, overall and by select demographics, 2022

	Combined Alcohol, Drug, and Suicide			Alcohol-Induced			Drug Overdose			Suicide		
	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022
Overall	**207,827**	**60.1**	**-1%**	**51,191**	**13.5**	**-6%**	**107,941**	**32.6**	**<1%**	**49,476**	**14.2**	**1%**
Female	55,730	32.4	-2%	14,765	7.8	-5%	32,127	19.4	-1%	10,203	5.9	3%
Male	152,097	88.4	-1%	36,426	19.5	-6%	75,814	45.6	1%	39,273	23.0	1%
American Indian and Alaska Native	4,159	173.6	-3%	1,904	78.4	-14%	1,543	65.2	15%	650	27.1	-4%
Asian	3,149	14.5	5%	660	2.9	0%	1,142	5.3	13%	1,459	6.9	1%
Black	29,342	67.1	3%	4,339	9.7	-13%	20,725	47.5	8%	3,826	8.9	3%
Latino	26,774	44.1	3%	7,467	13.2	-3%	14,131	22.7	7%	5,122	8.1	2%
Native Hawaiian and Pacific Islander	269	41.0	2%	44	7.1	11%	125	18.8	-7%	95	14.3	13%
White	140,323	67.4	-3%	36,099	14.8	-5%	67,974	35.6	-3%	37,481	17.6	1%
More than one race	2,474	41.5	4%	397	8.0	-9%	1,411	23.1	8%	682	10.5	8%
0-17	2,479	3.4	-1%	<20	--	--	1,005	1.4	18%	1,582	2.2	-9%
18-34	45,550	59.3	-7%	3,180	4.1	-3%	29,133	37.9	-7%	13,623	17.7	-6%
35-54	84,095	100.0	0%	18,281	21.7	-9%	49,935	59.4	2%	15,966	19.0	5%
55-74	66,416	87.5	2%	26,463	34.9	-5%	26,686	35.2	7%	13,260	17.5	8%
75+	9,267	38.6	2%	3,248	13.5	1%	1,171	4.9	2%	5,042	21.0	3%
Northeast	33,254	55.7	1%	6,626	9.9	-1%	20,529	35.7	1%	6,282	10.3	4%
Midwest	43,501	61.9	-1%	11,267	14.5	-3%	21,731	32.5	-1%	10,842	15.4	3%
South	79,025	59.9	-2%	17,077	11.6	-8%	42,255	33.5	0%	19,703	14.7	0%
West	52,047	62.5	-2%	16,221	18.5	-9%	23,426	29.0	3%	12,649	15.3	1%
Metro	175,549	61.9	0%	42,170	14.9	-5%	94,217	33.2	2%	40,044	14.1	4%
Non-Metro	32,278	70.3	-2%	9,021	19.6	-7%	13,724	29.9	2%	9,432	20.5	2%

	Opioid Overdose			Synthetic Opioid Overdose			Cocaine Overdose			Other Psychostimulants Overdose		
	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-Adjusted)	2021 to 2022
Overall	**81,806**	**25.0**	**1%**	**73,838**	**22.7**	**4%**	**27,569**	**8.2**	**12%**	**34,022**	**10.4**	**4%**
Female	23,421	14.4	-1%	19,880	12.4	2%	7,530	4.6	11%	9,435	5.9	2%
Male	58,385	35.5	2%	53,958	32.9	5%	20,039	11.8	12%	24,587	15.0	5%
American Indian and Alaska Native	1,109	46.9	21%	1,031	43.6	30%	183	7.7	10%	764	32.7	19%
Asian	683	3.2	24%	608	2.8	27%	251	1.1	24%	376	1.7	12%
Black	15,917	36.6	9%	15,114	34.7	11%	9,932	22.5	14%	3,385	8.1	12%
Latino	10,919	17.3	9%	10,116	16.0	13%	4,033	6.5	20%	4,227	6.9	8%
Native Hawaiian and Pacific Islander	55	8.3	-14%	51	7.7	-14%	<20	--	--	90	13.7	16%
White	51,457	27.6	-3%	45,387	24.7	0%	12,621	6.7	7%	24,268	12.9	2%
More than one race	1,029	16.2	8%	950	14.6	12%	251	4.3	22%	569	10.0	9%
0-17	781	1.1	17%	730	1.0	19%	70	0.1	34%	113	0.2	23%
18-34	24,711	32.2	-7%	23,278	30.3	-5%	6,233	8.1	4%	8,549	11.1	-6%
35-54	38,109	45.3	4%	34,660	41.2	7%	13,140	15.6	12%	17,666	21.0	7%
55-74	17,725	23.4	8%	14,940	19.7	14%	8,023	10.6	21%	7,626	10.1	11%
75+	472	2.0	11%	223	0.9	23%	101	0.4	11%	61	0.3	-21%
Northeast	17,255	30.3	2%	16,124	28.5	3%	8,203	14.2	16%	2,666	4.9	4%
Midwest	16,966	25.0	-1%	15,632	23.8	1%	6,050	8.9	15%	5,731	8.9	1%
South	31,527	25.3	1%	28,283	22.8	3%	10,529	8.2	9%	13,735	11.2	5%
West	16,058	20.2	5%	13,799	17.5	13%	2,787	3.4	10%	11,890	14.7	5%
Metro	72,204	25.4	2%	65,437	23.1	5%	25,692	9.1	13%	28,300	10.0	5%
Non-Metro	9,602	20.9	0%	8,401	18.3	4%	1,877	4.1	15%	5,722	12.5	5%

Source: TFAH analysis of National Center for Health Statistics data

Appendix C: State Alcohol, Drug, and Suicide Mortality Data

Deaths, death rates, and one-year change in death rate from alcohol, drug, and suicide, overall and by select demographics, 2022

	Combined Alcohol, Drug, and Suicide			Alcohol-Induced			Drug Overdose			Suicide		
	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022
Overall	**207,827**	**60.1**	**-1%**	**51,191**	**13.5**	**-6%**	**107,941**	**32.6**	**1%**	**49,476**	**14.2**	**1%**
Alabama	2,924	58.5	-1%	502	8.9	-19%	1,492	31.5	5%	840	16.3	3%
Alaska	750	99.7	-8%	286	36.6	-11%	254	34.3	-4%	200	27.6	-10%
Arizona	5,846	77.5	-6%	1,623	20.2	-17%	2,664	37.2	-4%	1,603	20.6	6%
Arkansas	1,543	50.9	-8%	386	11.4	-6%	617	21.7	-3%	547	18.0	-13%
California	21,904	52.7	-2%	6,708	15.5	-8%	10,952	26.9	1%	4,312	10.4	3%
Colorado	4,585	73.7	-7%	1,581	24.5	-8%	1,811	29.8	-5%	1,293	21.1	-7%
Connecticut	2,373	62.4	-3%	509	12.0	-5%	1,482	40.3	-5%	398	10.6	6%
Delaware	852	80.8	-1%	174	14.1	7%	549	55.3	2%	130	11.4	-17%
DC	602	86.3	0%	96	14.5	-2%	451	64.3	1%	44	6.1	-3%
Florida	14,093	60.4	-6%	3,262	11.7	-11%	7,551	35.2	-6%	3,446	14.1	0%
Georgia	5,588	50.2	0%	1,273	10.6	-6%	2,687	24.9	6%	1,624	14.6	-4%
Hawaii	653	42.7	8%	120	7.1	-13%	284	18.6	7%	246	16.6	22%
Idaho	1,183	58.7	-1%	375	17.0	-14%	385	20.7	9%	444	22.2	8%
Illinois	6,921	52.6	3%	1,601	11.4	0%	3,849	30.0	3%	1,533	11.7	5%
Indiana	4,933	71.8	-3%	1,151	15.1	2%	2,682	41.0	-5%	1,152	16.4	0%
Iowa	1,604	49.0	-1%	591	16.8	-2%	469	15.3	-1%	590	18.5	6%
Kansas	1,807	61.5	3%	487	15.6	-9%	754	26.5	9%	596	20.5	6%
Kentucky	3,783	84.7	-5%	646	12.6	-5%	2,271	53.2	-4%	823	18.0	1%
Louisiana	3,624	80.1	-1%	491	9.3	-5%	2,376	54.5	-2%	726	15.6	5%
Maine	1,283	90.1	6%	317	18.5	-2%	707	54.3	15%	268	17.7	-9%
Maryland	3,771	58.1	-5%	601	8.6	-4%	2,573	40.3	-6%	608	9.5	-3%
Massachusetts	4,261	57.9	1%	959	11.8	-5%	2,642	37.4	2%	626	8.3	4%
Michigan	6,020	58.5	-3%	1,598	13.9	-8%	2,997	30.7	-2%	1,503	14.7	3%
Minnesota	3,442	57.7	1%	1,171	17.8	-1%	1,384	24.8	1%	860	14.8	6%
Mississippi	1,622	54.8	-10%	442	13.0	-16%	758	27.6	-3%	417	14.0	-14%
Missouri	4,288	68.8	1%	911	13.3	1%	2,192	36.9	1%	1,219	19.1	2%
Montana	873	74.8	-9%	343	27.3	-11%	208	19.4	-1%	329	28.7	-10%
Nebraska	902	45.5	5%	371	18.1	3%	225	11.8	4%	306	15.6	4%
Nevada	2,429	71.0	-2%	759	20.7	-7%	1,003	30.3	4%	698	21.0	-2%
New Hampshire	1,014	68.6	10%	295	17.1	9%	486	36.0	11%	247	16.6	10%
New Jersey	4,507	46.3	-2%	777	7.3	-7%	2,985	31.6	-2%	769	7.7	8%
New Mexico	2,455	117.1	-7%	925	42.7	-14%	1,024	50.3	-2%	525	24.7	-1%
New York	10,092	48.6	8%	2,003	8.8	6%	6,358	31.4	9%	1,765	8.5	7%
North Carolina	7,425	68.3	3%	1,532	12.4	-7%	4,310	41.8	7%	1,614	14.4	9%
North Dakota	505	66.5	5%	195	25.0	1%	148	19.8	15%	169	22.5	8%
Ohio	8,660	73.1	-4%	1,707	12.4	-4%	5,144	45.6	-5%	1,798	15.0	2%
Oklahoma	2,899	71.8	8%	836	19.3	-1%	1,196	30.7	25%	857	21.4	-3%
Oregon	3,593	76.4	4%	1,264	24.5	0%	1,363	31.1	16%	883	19.3	-1%
Pennsylvania	8,461	63.6	-4%	1,420	9.1	-3%	5,169	40.9	-5%	1,955	14.2	2%
Rhode Island	727	62.0	-8%	202	15.3	-8%	424	38.1	-9%	126	10.6	2%
South Carolina	4,101	75.7	2%	954	15.3	-7%	2,279	44.7	5%	853	15.4	1%
South Dakota	594	67.3	-13%	307	34.5	-19%	95	11.3	-10%	192	21.6	-7%
Tennessee	6,432	89.6	-2%	1,328	16.4	-2%	3,825	56.0	-1%	1,245	16.7	-2%
Texas	13,058	42.8	1%	3,285	10.4	-9%	5,489	18.2	9%	4,368	14.4	2%
Utah	1,666	52.1	-3%	373	11.8	-14%	627	19.8	-6%	718	22.1	10%
Vermont	536	79.2	1%	144	16.8	-4%	276	45.9	9%	128	18.0	-11%
Virginia	4,682	51.9	-3%	965	9.6	-6%	2,496	28.8	-5%	1,208	13.3	1%
Washington	5,632	67.0	4%	1,658	18.4	-7%	2,725	33.7	20%	1,243	14.9	-3%
West Virginia	2,026	114.8	-11%	304	13.7	-6%	1,335	80.9	-11%	353	18.3	-11%
Wisconsin	3,825	62.4	1%	1,177	16.6	0%	1,792	31.8	1%	924	15.1	1%
Wyoming	478	77.0	-11%	206	31.1	-9%	126	21.9	16%	155	25.6	-21%

Source: TFAH analysis of National Center for Health Statistics data

Deaths, death rates, and one-year change in death rate from alcohol, drug, and suicide, overall and by select demographics, 2022												
	Opioid Overdose			Synthetic Opioid Overdose			Cocaine Overdose			Other Psychostimulants Overdose		
	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022	2022 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2021 to 2022
Overall	**81,806**	**25.0**	**1%**	**73,838**	**22.7**	**4%**	**27,569**	**8.2**	**12%**	**34,022**	**10.4**	**4%**
Alabama	1,097	23.4	10%	989	21.1	14%	255	5.2	7%	591	13.0	21%
Alaska	188	25.1	-9%	161	21.5	1%	21	2.9	--	144	19.6	-14%
Arizona	1,930	27.4	-5%	1,735	24.9	-2%	234	3.3	10%	1,343	18.8	6%
Arkansas	388	13.8	0%	315	11.4	2%	76	2.6	17%	259	9.4	5%
California	7,347	18.4	3%	6,473	16.4	7%	1,393	3.3	0%	5,808	14.2	2%
Colorado	1,177	19.4	-10%	971	16.1	-2%	261	4.3	-6%	712	11.8	-5%
Connecticut	1,349	36.8	-4%	1,254	34.3	-4%	575	15.9	7%	79	2.3	-9%
Delaware	490	50.2	4%	457	47.1	7%	223	22.0	9%	71	7.6	22%
DC	345	48.9	0%	327	46.4	0%	226	32.0	0%	<20	--	--
Florida	5,581	26.5	-8%	5,083	24.3	-8%	2,124	9.8	-6%	1,912	9.2	-3%
Georgia	1,983	18.7	9%	1,726	16.4	18%	593	5.3	13%	967	9.2	-1%
Hawaii	103	7.1	16%	76	5.4	46%	29	2.1	--	183	11.8	3%
Idaho	270	14.7	15%	200	11.2	29%	<20	--	--	139	7.5	6%
Illinois	3,189	24.9	5%	2,917	22.8	8%	1,487	11.4	16%	544	4.5	0%
Indiana	2,072	32.0	-6%	1,923	29.9	-5%	480	7.1	11%	959	14.9	-5%
Iowa	236	7.9	-8%	203	6.9	-2%	45	1.5	36%	208	6.9	5%
Kansas	506	18.2	16%	420	15.4	20%	85	2.9	17%	334	12.1	17%
Kentucky	1,767	41.8	-7%	1,613	38.5	-6%	243	5.7	2%	1,014	24.2	-3%
Louisiana	1,367	31.6	4%	1,202	28.1	4%	337	7.5	21%	647	15.3	8%
Maine	619	48.2	14%	568	44.7	15%	212	16.7	42%	228	18.0	18%
Maryland	2,247	35.3	-8%	2,081	32.7	-9%	984	15.5	9%	141	2.4	3%
Massachusetts	2,326	33.1	2%	2,223	31.8	1%	1,226	17.4	5%	220	3.3	-3%
Michigan	2,418	24.9	-4%	2,223	23.0	-2%	1,077	10.9	15%	497	5.4	-7%
Minnesota	1,031	18.7	5%	949	17.3	7%	219	3.7	29%	516	9.4	8%
Mississippi	543	20.0	-2%	484	18.0	2%	107	3.8	12%	319	12.0	-2%
Missouri	1,586	27.1	0%	1,470	25.3	1%	319	5.2	25%	731	12.7	2%
Montana	130	12.3	11%	101	9.6	34%	<20	--	--	91	8.6	-3%
Nebraska	122	6.6	9%	101	5.5	14%	<20	--	--	75	4.1	21%
Nevada	639	20.0	6%	455	14.4	22%	104	3.1	14%	523	15.6	15%
New Hampshire	431	32.1	13%	415	31.1	20%	69	4.8	39%	106	8.1	50%
New Jersey	2,637	28.1	-2%	2,489	26.5	-1%	1,168	12.4	8%	353	4.0	16%
New Mexico	733	36.5	-2%	646	32.4	8%	195	9.4	38%	503	24.7	-6%
New York	5,361	26.7	9%	4,950	24.7	10%	2,869	14.1	29%	658	3.5	12%
North Carolina	3,639	35.7	7%	3,371	33.2	8%	1,532	14.6	8%	1,294	12.9	33%
North Dakota	97	13.4	32%	86	11.9	52%	<20	--	--	45	5.8	-16%
Ohio	4,230	38.0	-5%	3,989	35.9	-5%	1,648	14.2	8%	1,387	12.8	1%
Oklahoma	761	19.8	63%	648	17.0	93%	86	2.2	56%	614	15.8	20%
Oregon	968	22.4	24%	843	19.8	55%	116	2.7	20%	746	17.1	24%
Pennsylvania	3,960	31.8	-3%	3,692	29.9	-2%	1,780	13.8	16%	957	7.9	-4%
Rhode Island	333	30.7	-14%	307	28.5	-11%	201	18.2	-10%	39	3.6	-41%
South Carolina	1,831	36.6	5%	1,642	33.2	7%	552	10.5	21%	796	16.4	4%
South Dakota	46	5.5	-2%	38	4.6	12%	<20	--	--	43	5.1	-20%
Tennessee	3,062	45.3	0%	2,836	42.2	0%	727	10.3	12%	1,547	23.2	-1%
Texas	3,172	10.6	14%	2,452	8.2	30%	1,396	4.6	16%	2,248	7.5	15%
Utah	427	13.5	-4%	214	6.7	8%	40	1.2	-18%	271	8.6	-15%
Vermont	239	40.9	9%	226	38.8	11%	103	17.6	1%	26	5	-17%
Virginia	2,108	24.6	-5%	1,973	23.1	-4%	892	10.2	18%	577	6.8	1%
Washington	2,063	25.9	26%	1,863	23.5	50%	363	4.4	51%	1,377	17.0	21%
West Virginia	1,146	70.5	-9%	1,084	67.0	-9%	176	10.2	6%	724	44.3	-11%
Wisconsin	1,433	25.9	0%	1,313	23.9	1%	670	11.7	22%	392	7.3	2%
Wyoming	83	14.4	16%	61	10.9	38%	<20	--	--	50	8.8	20%

Note: Some data unavailable for privacy reasons.

Appendix D: National Substance Use and Mental Health Data

	Ilicit Drug Use Among 12+ Population (2022)	Binge Drinking Among 12+ Population (2022)	Substance Use Disorder Among 12+ Population (2022)	Serious Mental Illness Among 18+ Population (2022)	Serious Thoughts About Suicide Among 18+ Population (2022)	Poor Mental Health Among High Schoolers (2021)	Seriously Considered Suicide Among High Schoolers (2021)	ACEs Among Children 0-17 (2020-2021)
	What percentage of people ages 12+ used illicit drugs in the past month?	What percentage of people ages 12+ engaged in binge drinking in the past month?	What percentage of people ages 12+ had a substance use disorder (includes drugs or alcohol) in the past year ?	What percentage of people ages 12+ had a substance use disorder (includes drugs or alcohol) in the past year ?	What percentage of people 18+ had serious thoughts about suicide in the past year?	What percentage of high schoolers reported their mental health was most of the time or always not good?	What percentage of high schoolers seriously considered attempting suicide?	What percentage of children ages 0-17 have ever experienced two or more ACEs?
Overall	**24.9**	**21.7**	**17.3**	**23.1**	**5.2**	**29.3**	**22.2**	**17.8**
Female	--	--	--	--	--	18	14	18
Male	--	--	--	--	--	41	30	18
American Indian and Alaska Native	31.7	25.5	24.0	19.6	7.0	31.1	27.3	--
Asian	13.6	10.3	9.0	16.8	3.4	22.8	17.7	4.6
Black	26.7	20.9	18.4	19.7	5.5	26.5	21.6	25.0
Latino	23.5	23.3	17.4	21.4	4.6	29.7	22.0	18.1
Native Hawaiian and Pacific Islander	n/a	n/a	n/a	n/a	n/a	20.1	21.4	--
White	25.8	22.5	17.6	24.6	5.2	30.2	22.7	16.1
More than one race	35.1	20.5	21.8	35.2	9.3	33.0	24.1	n/a
12 to 17	14.3	3.2	8.7	--	--	--	--	--
18 to 25	40.9	29.5	27.8	36.2	13.6	--	--	--
26 or Older	23.7	22.6	16.6	--	--	--	--	--
26 to 49	--	--	--	29.4	5.5	--	--	--
50 or Older	--	--	--	13.9	2.4	--	--	--
	2022 National Survey on Drug Use and Health					2021 Youth Risk Behavior Survey		2022 National Survey of Children's Health

Notes and Sources for Appendix D and E

Ilicit Drug Use Among 12+ Population

Notes: Illicit Drug Use includes the misuse of prescription medications or the use of marijuana, cocaine, heroin, hallucinogens, inhalants, or methamphetamine.

Binge Drinking Among 12+ Population

Notes: Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Substance Use Disorder Among 12+ Population

Notes: Substance Use Disorder (SUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 National Survey on Drug Use and Health, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs.

Serious Mental Illness Among 18+ Population

Notes: Any Mental Illness (AMI) aligns with Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. These estimates are based on indicators of AMI rather than direct measures of diagnostic status

Serious Thoughts About Suicide Among 18+

Source: Substance Abuse and Mental Health Service Administration. "2021-2022 NSDUH: Model-Based Estimated Prevalence For States." Februrary 2024. https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates . Accessed March 22, 2024.

Poor Mental Health Among High Schoolers

Notes: Poor mental health includes stress, anxiety, and depression during the 30 days before the survey.

Seriously Considered Suicide Among High Schoolers

Source: Centers for Disease Control and Prevention. "United States, High School Youth Risk Behavior Survey, 2021." 2023. https://nccd.cdc.gov/Youthonline/App/Results.aspx. Accessed March 24, 2024.

ACEs Among Children 0-17

Notes: The percentage of children ages 0-17 who have ever experienced two or more of the following: parental divorce or separation; living with someone who had an alcohol or drug problem; neighborhood violence victim or witness; living with someone who was mentally ill, suicidal or severely depressed; domestic violence witness; parent served jail time; being treated or judged unfairly due to race/ethnicity; or death of a parent.

Data are from National Survey of Children's Health, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), 2020-2021 (2-year estimate).

Source: United Health Foundation. "America's Health Rankings: Adverse Childhood Experiences." 2023. https://www.americashealthrankings.org/explore/measures/ACEs_8 . Accessed March 22, 2024.

Appendix E: State Substance Use and Mental Health Data

	Illicit Drug Use Among 12+ Population (2021-2022)	Binge Drinking Among 12+ Population (2021-2022)	Substance Use Disorder Among 12+ Population (2021-2022)	Serious Mental Illness Among 18+ Population (2021-2022)	Serious Thoughts About Suicide Among 18+ Population (2021-2022)	Poor Mental Health Among High Schoolers (2021)	Seriously Considered Suicide Among High Schoolers (2021)	ACEs Among Children 0-17 (2020-2021)
	What percentage of people ages 12+ used illicit drugs in the past month?	What percentage of people ages 12+ engaged in binge drinking in the past month?	What percentage of people ages 12+ had a substance use disorder (includes drugs or alcohol) in the past year ?	What percentage of people ages 12+ had a substance use disorder (includes drugs or alcohol) in the past year ?	What percentage of people 18+ had serious thoughts about suicide in the past year?	What percentage of high schoolers reported their mental health was most of the time or always not good?	What percentage of high schoolers seriously considered attempting suicide?	What percentage of children ages 0-17 have ever experienced two or more ACEs?
Alabama	11%	19%	15%	6%	5%	28%	22%	18%
Alaska	23%	21%	23%	7%	6%	n/a	Not Available	17%
Arizona	20%	22%	17%	6%	5%	36%	24%	16%
Arkansas	13%	19%	15%	6%	5%	32%	22%	19%
California	17%	21%	17%	6%	5%	n/a	Not Available	12%
Colorado	21%	25%	22%	7%	6%	33%	22%	16%
Connecticut	16%	22%	17%	5%	4%	29%	14%	12%
Delaware	16%	21%	18%	5%	5%	n/a	18%	14%
DC	22%	33%	23%	6%	5%	25%	18%	13%
Florida	13%	20%	15%	6%	5%	n/a	18%	13%
Georgia	13%	19%	16%	6%	5%	n/a	27%	15%
Hawaii	15%	21%	16%	6%	5%	n/a	17%	13%
Idaho	13%	21%	17%	7%	7%	n/a	21%	16%
Illinois	17%	23%	17%	5%	5%	30%	20%	13%
Indiana	13%	21%	18%	6%	6%	31%	28%	18%
Iowa	13%	24%	19%	7%	6%	35%	23%	15%
Kansas	14%	23%	17%	7%	5%	n/a	20%	18%
Kentucky	12%	19%	17%	7%	5%	29%	19%	20%
Louisiana	15%	24%	20%	6%	6%	30%	27%	19%
Maine	22%	20%	18%	6%	5%	33%	20%	18%
Maryland	16%	20%	17%	5%	4%	29%	21%	12%
Massachusetts	21%	23%	18%	6%	4%	32%	18%	10%
Michigan	19%	22%	18%	6%	5%	32%	19%	14%
Minnesota	17%	24%	19%	6%	5%	n/a	Not Available	13%
Mississippi	13%	19%	16%	5%	5%	26%	22%	17%
Missouri	17%	21%	18%	6%	6%	n/a	20%	17%
Montana	20%	26%	20%	6%	6%	32%	22%	22%
Nebraska	12%	25%	17%	8%	6%	29%	19%	13%
Nevada	22%	23%	21%	7%	6%	n/a	22%	16%
New Hampshire	16%	23%	17%	6%	5%	36%	25%	16%
New Jersey	14%	23%	16%	5%	4%	33%	20%	11%
New Mexico	24%	23%	23%	6%	6%	32%	19%	25%
New York	17%	24%	17%	5%	4%	n/a	17%	10%
North Carolina	12%	19%	15%	6%	5%	34%	22%	15%
North Dakota	12%	27%	20%	7%	6%	29%	19%	14%
Ohio	16%	24%	18%	6%	5%	31%	22%	16%
Oklahoma	19%	20%	19%	7%	6%	31%	23%	18%
Oregon	24%	22%	22%	7%	6%	n/a	Not Available	15%
Pennsylvania	16%	21%	17%	6%	5%	32%	23%	12%
Rhode Island	20%	26%	22%	6%	5%	29%	17%	12%
South Carolina	12%	21%	15%	5%	5%	27%	Not Available	17%
South Dakota	12%	23%	17%	7%	6%	n/a	22%	18%
Tennessee	12%	20%	16%	7%	5%	29%	23%	19%
Texas	10%	22%	15%	5%	5%	31%	22%	12%
Utah	11%	14%	13%	8%	7%	29%	23%	12%
Vermont	26%	27%	22%	7%	5%	35%	Not Available	20%
Virginia	15%	21%	17%	6%	5%	32%	21%	14%
Washington	23%	20%	19%	7%	6%	n/a	Not Available	15%
West Virginia	16%	17%	18%	7%	6%	38%	28%	19%
Wisconsin	14%	29%	18%	6%	5%	n/a	18%	16%
Wyoming	11%	22%	19%	6%	6%	n/a	Not Available	23%
TOTAL	**16%**	**22%**	**17%**	**6%**	**5%**	**29%**	**22%**	**14%**

Appendix F: State Policies, Programs, and Other Indicators

	Mental Health Access Ranking (2023)	Mental Healthcare Shortage Areas (2023)	Psychotherapy Out-of-Pocket Costs (2023)	Mental Healthcare Parity Laws (2022)	School Mental Health Report Card Ranking (2022)	Needing But Not Receiving Substance Use Treatment (2021)
	What is the state's Mental Health Access ranking?	What percentage of the state's population lives in counties that are entirely designated as mental health professional shortage areas?	What are the out-of-pocket costs for psychotherapy in the state?	Does the state have a law in place requiring public and/or private health plans to regularly submit parity compliance analyses to state regulators?	What is the state's School Mental Health Report Card ranking?	What percentage of people 12+ in the state needed but did not receive treatment at a specialty facility for substance use in the past year?
Alabama	50	93%	$158	No	20	12%
Alaska	28	91%	$209	No	46	18%
Arizona	47	7%	$195	Yes - public only	49	15%
Arkansas	45	76%	$201	No	48	12%
California	31	7%	$235	No	36	15%
Colorado	26	85%	$169	Yes - both	13	18%
Connecticut	8	5%	$173	Yes - public only	8	15%
Delaware	15	43%	$157	Yes - both	18	16%
DC	5	0%	n/a	Yes - both	3	23%
Florida	46	36%	$179	No	30	13%
Georgia	49	58%	$181	Yes - both	17	14%
Hawaii	32	0%	$205	No	23	13%
Idaho	35	100%	$147	No	50	14%
Illinois	3	39%	$176	Yes - both	12	15%
Indiana	43	94%	$158	Yes - public only	26	17%
Iowa	17	59%	$180	No	31	16%
Kansas	48	64%	$171	No	33	15%
Kentucky	24	92%	$154	Yes - public only	24	12%
Louisiana	37	92%	$287	Yes - public only	25	16%
Maine	11	18%	$160	Yes - both	2	14%
Maryland	25	51%	$164	Yes - public only	10	15%
Massachusetts	2	1%	$169	No	5	17%
Michigan	20	52%	$186	No	27	15%
Minnesota	14	42%	$207	No	14	15%
Mississippi	42	82%	$201	No	18	14%
Missouri	36	86%	$155	No	22	15%
Montana	4	100%	$164	Yes - public only	38	16%
Nebraska	29	84%	$193	No	37	13%
Nevada	38	78%	$214	Yes - both	51	17%
New Hampshire	7	30%	$165	No	6	15%
New Jersey	23	33%	$198	Yes - public only	7	14%
New Mexico	16	67%	$165	No	47	19%
New York	19	42%	$218	Yes - public only	9	16%
North Carolina	39	70%	$165	No	42	13%
North Dakota	18	81%	$240	No	34	18%
Ohio	21	73%	$164	No	19	15%
Oklahoma	27	94%	$148	Yes - public only	28	16%
Oregon	30	84%	$183	Yes - both	45	17%
Pennsylvania	6	40%	$154	Yes - public only	1	14%
Rhode Island	10	35%	$126	No	15	17%
South Carolina	44	66%	$94	No	35	13%
South Dakota	12	98%	$192	No	35	13%
Tennessee	40	87%	$145	Yes - both	40	14%
Texas	51	88%	$166	Yes - public only	41	13%
Utah	22	100%	$157	No	32	11%
Vermont	1	36%	$142	No	4	20%
Virginia	34	51%	$196	No	21	14%
Washington	13	37%	$168	No	39	16%
West Virginia	33	88%	$193	Yes - public only	44	13%
Wisconsin	9	49%	$218	No	11	14%
Wyoming	41	92%	$169	No	43	15%
TOTAL	**n/a**	**53%**	**$174**	**21 states and DC (9 states require both)**	**N/A**	**15%**

	Syringe Service Programs (2023)	Fentanyl Test Strips (2023)	Community Distribution of Naloxone (2023)	988 Implementation and Funding (2023)	Safe Gun Storage Laws (2024)	Health Professional Suicide Prevention Training (2022)
	Does the state have an operational syringe service program?	Are fentanyl strips legally authorized in the state?	Does the state have a law facilitating community distribution of naloxone?	Has the state enacted legislation to implement and fund the 988 Suicide and Crisis Lifeline?	Does the state have child-access and/or secure storage laws for guns?	Does the state have a law in place related to health professional training for suicide assesment, treatment, and management?
Alabama	Yes	Yes	No	Yes	No	No
Alaska	Yes	Yes	Yes	No	No	No
Arizona	Yes	Yes	Yes	No	No	No
Arkansas	Yes	No	Yes	No	No	No
California	Yes	Yes	Yes	Yes	Yes	Yes - b*
Colorado	Yes	Yes	Yes, supports bulk purchasing	Yes	Yes	No
Connecticut	Yes	No	Yes	Yes	Yes	Yes - a*, c*
Delaware	Yes	Yes	Yes	No	Yes	No
DC	Yes	Yes	Yes	No	N/A	No
Florida	Yes	No	Yes	No	Yes	No
Georgia	Yes	No	Yes	No	No	No
Hawaii	Yes	No	Yes	No	Yes	No
Idaho	Yes	No	No	Yes	No	No
Illinois	Yes	No	Yes, suppports bulk purchasing	Yes	Yes	No
Indiana	Yes	No	Yes	Yes	No	Yes - b, d*
Iowa	Yes	No	No	No	Yes	No
Kansas	No	No	No	Yes	No	No
Kentucky	Yes	No	Yes	Yes	No	Yes - a*
Louisiana	Yes	Yes	Yes	Yes	No	Yes - a, c
Maine	Yes	Yes	Yes	No	Yes	No
Maryland	Yes	Yes	Yes, supports bulk purchasing	Yes	Yes	No
Massachusetts	Yes	No	Yes, supports bulk purchasing	Yes	Yes	No
Michigan	Yes	Yes	Yes	Yes	Yes	No
Minnesota	Yes	Yes	No	Yes	Yes	Yes - b, d
Mississippi	No	No	No	Yes	No	No
Missouri	Yes	No	Yes	No	No	No
Montana	Yes	No	Yes	No	No	Yes - b, d
Nebraska	No	Yes	No	Yes	No	No
Nevada	Yes	Yes	Yes	Yes	Yes	Yes - a*, c
New Hampshire	Yes	No	Yes	No	Yes	Yes - a*
New Jersey	Yes	Yes	Yes	Yes	Yes	No
New Mexico	Yes	Yes	Yes	No	Yes	No
New York	Yes	Yes	Yes	Yes	Yes	No
North Carolina	Yes	Yes	Yes	No	Yes	No
North Dakota	Yes	No	Yes	No	No	No
Ohio	Yes	No	Yes	No	No	No
Oklahoma	Yes	No	Yes	No	No	No
Oregon	Yes	No	Yes	Yes	Yes	Yes - a, c
Pennsylvania	Yes	No	Yes	No	No	Yes - a*
Rhode Island	Yes	Yes	Yes	No	Yes	No
South Carolina	Yes	Yes	Yes	No	No	No
South Dakota	No	No	Yes	No	No	No
Tennessee	Yes	Yes	Yes	No	No	Yes - a*
Texas	Yes	No	Yes, supports bulk purchasing	Yes	Yes	No
Utah	Yes	No	No	Yes	No	Yes - b*, d
Vermont	Yes	Yes	Yes, supports bulk purchasing	No	Yes	No
Virginia	Yes	Yes	Yes	Yes	Yes	No
Washington	Yes	No	Yes, supports bulk purchasing	Yes	Yes	Yes - a*, d*
West Virginia	Yes	Yes	Yes	Yes	No	No
Wisconsin	Yes	Yes	No	No	Yes	No
Wyoming	No	Yes	No	Yes	No	No
TOTAL	**45 states and D.C.**	**25 states and D.C.**	**40 states and D.C.**	**26 states**	**26 states**	**14 states**

Notes and Sources for Appendix F

Mental Health Access Ranking (2023)

Notes: The Access Ranking measures access to mental healthcare within a state across nine domains, including access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. A high Access Ranking (1-13) indicates that a state provides relatively more access to insurance and mental health treatment.

Source: Mental Health America. "Access to Care Ranking 2023." October 2022. https://mhanational.org/issues/2023/mental-health-america-access-care-data . Accessed March 22, 2024.

Mental Healthcare Shortage Areas (2023)

Notes: Mental Health Provider Shortage Areas are a designation used by the Health Resources and Services Administration (HRSA) to identify geographic areas, population groups, or facilities with a shortage of mental health providers. HRSA uses the ratio of mental health providers to population, the population's need for mental health services, and accessibility of services to determine designations.

Source: Davenport, Stoddard, et al. "Access across America: State-by-state insights into the accessibility of care for mental health and substance use disorders." December 2023. https://www.milliman.com/en/insight/access-across-america-state-insights-accessibility-mental-health-substance-use . Accessed March 22, 2024.

Psychotherapy Out-of-Pocket Costs (2023)

Notes: Average undiscounted billed charge for self-pay patients for a 60-minute psychotherapy visit.

Source: Davenport, Stoddard, et al. "Access across America: State-by-state insights into the accessibility of care for mental health and substance use disorders." December 2023. https://www.milliman.com/en/insight/access-across-america-state-insights-accessibility-mental-health-substance-use . Accessed March 22, 2024.

Mental Healthcare Parity Laws (2022)

Source: American Foundation for Suicide Prevention. "State Facts." Februrary 4, 2022. https://afsp.org/state-facts/. Accessed March 22, 2024.

School Mental Health Report Card Ranking (2022)

Notes: The Hopeful Futures Campaign school mental health report cards score each state in eight policy areas that support comprehensive school mental health services. For each policy area, the scoring guide has a policy goal and specific types of policies, as well as a score reflecting progress toward the policy goal.

Source: Hopeful Futures Campaign. "America's School Mental Health Report Card." February 2022. https://www.inseparable.us/SchoolMentalHealthReportCard.pdf . Accessed March 22, 2024.

Needing But Not Receiving Substance Use Treatment (2021)

Notes: Respondents were classified as needing substance use treatment if they met the Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria for an illicit drug or alcohol use disorder or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).

Source: Substance Abuse and Mental Health Services Administration. "2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates." 2021. https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf . Accessed March 22, 2024.

Syringe Service Programs (2023)

Notes: Syringe services programs (SSP) are harm reduction programs that provide a wide range of services including, but not typically limited to, the provision of new, unused hypodermic needles and syringes and other injection drug use supplies, such as cookers, tourniquets, alcohol wipes, and sharps waste disposal containers, to people who inject drugs.

Source: Legislative Analysis and Public Policy Association. "Syringe Services Programs: Summary of State Laws." August 2023. https://legislativeanalysis.org/syringe-services-programs-summary-of-state-laws/ . Accessed March 22, 2024.

Fentanyl Test Strips (2023)

Source: Association of State and Territorial Health Officials. "ASTHO's Public Health Legend Mapping Center." July 31, 2023. https://www.astho.org/advocacy/state-health-policy/public-health-legal-mapping-center/ . Accessed March 22, 2024.

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Notes: "Supports bulk purchasing" indicates the law supports bulk purchasing of naloxone for lower costs to community organizations and non-profits to distribute it.

Source: Association of State and Territorial Health Officials. "ASTHO's Public Health Legend Mapping Center." July 31, 2023. https://www.astho.org/advocacy/state-health-policy/public-health-legal-mapping-center/ . Accessed March 22, 2024.

988 Implementation and Funding (2023)

Notes: The new Congressionally mandated three-digit calling code for the 988 Suicide and Crisis Lifeline launched in July 2022. States continue to address necessary components for implementation, such as funding, workgroups to drive 988 policy, and integrating 988 into existing crisis call systems.

Source: National Academy for State Health Policy. "State Legislation to Fund and Implement the 988 Suicide and Crisis Lifeline." June 6, 2023. https://nashp.org/state-tracker/state-legislation-to-fund-and-implement-988-for-the-national-suicide-prevention-lifeline/ . Accessed March 22, 2024.

Safe Gun Storage Laws (2024)

Notes: Secure storage laws prevent unauthorized access by children by requiring gun owners to lock up their firearms. The strongest systems have consequences for any failure to secure a gun. Weaker policies, sometimes called "Child-Access Prevention (CAP) laws," penalize gun owners only if a child actually gains access to a firearm. While some state laws are concerned only with the threat of child access, others also include consequences if an unsecure gun is likely to be obtained by an adult who is legally prohibited from possession.

Source: Everytown Research and Policy. "Which states have child-access and/or secure storage laws?." 2024. https://everytownresearch.org/rankings/law/secure-storage-or-child-access-prevention-required/ . Accessed March 22, 2024.

Health Professional Suicide Prevention Training (2022)

Notes: If the state has a law in place related to health professional training for suicide assessment, treatment, and management, the specific type of law is denoted as follows: a) mental health professionals receive regular training; b) mental health professionals receive one time training; c) medical/surgical professionals recieve regular training; and d) medical/surgical professionals receive one time training. If the policy is required by law it is denoted with an asterisk (*). If the policy is only encouraged then it does not have a symbol next to the letter.

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