ISSUE REPORT

Pain in the Nation:
The Epidemics of Alcohol, Drug, and Suicide Deaths 2025

SPECIAL FEATURE: Progress in Drug Overdose Deaths




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Acknowledgments

Trust for America's Health (TFAH) is a nonprofit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority.

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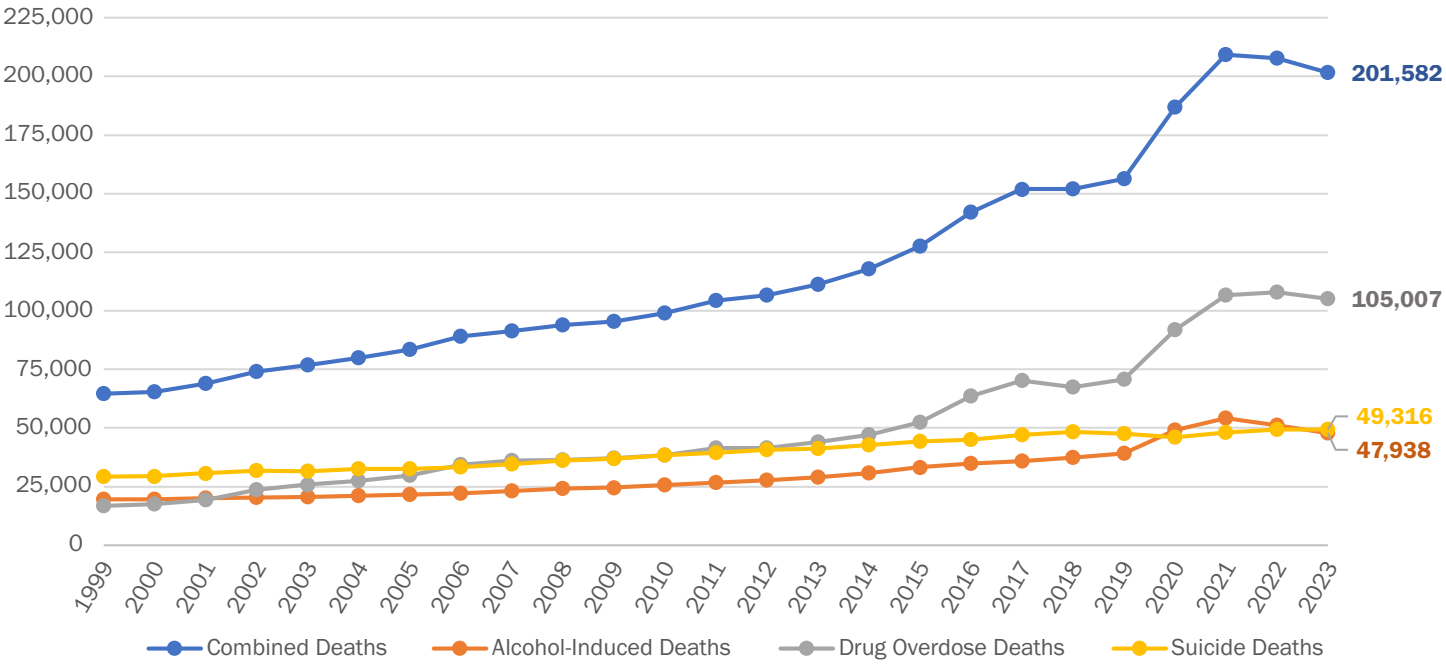
Pain in the Nation: *The Epidemics of Alcohol, Drug, and Suicide Deaths*

Introduction

After large increases in combined alcohol-induced, drug overdose, and suicide deaths in 2020 and 2021, there were finally declines in 2022 and 2023—and very positive preliminary data for 2024. Even with these declines in 2022 and 2023, more than 200,000 people died from alcohol, drugs, and suicide combined in the United States, twice the rate from 20 years ago.[1] The increases over two decades overlaps with other challenges, including higher rates of youth mental health issues, increased loneliness and reduced economic opportunity for many adults, and underinvestment in critical prevention strategies aimed at underlying drivers of poor mental health and substance use outcomes.[2,3,4,5]

Figure 1: Annual Deaths from Alcohol, Drugs, and Suicide in the United States, All Ages, 1999–2023



Source: TFAH analysis of National Center for Health Statistics data.[6]

The recent improvements in alcohol, drug, and suicide mortality in 2022 and 2023—due to decreases in alcohol-induced causes (e.g., alcohol poisoning, liver diseases, and other diseases) and fatal opioid overdoses—demonstrate that these deaths are not inevitable and can be prevented. The nation is at a critical moment to capitalize on this momentum and build on the developments and lessons from the last few years to create sustained improvements and 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. However, recent and ongoing cuts to the federal workforce and health and prevention programs across the country put this progress at risk.[7,8,9]

This report includes three sections: (1) a special feature on the recent trends in drug overdose deaths (page 7); (2) a deeper analysis into the 2023 mortality trends from alcohol, drugs, and suicide (page 21); and (3) key policy recommendations that, if implemented, could further reduce alcohol, drug, and suicide deaths in the country and promote well-being for all Americans (page 31). This year's special feature examines the trends in drug overdoses since 2020—including both overall net positive trends in 2023 and 2024, and disparate experiences for certain populations and communities. It also explores some of the successful strategies and policies that underlie the recent progress and offers considerations for future policymaking.

SUMMARY OF RECOMMENDATIONS

Trust for America's Health (TFAH) calls for a sustained commitment to primary prevention and to the workforce, programs, and systems that enable communities to reduce alcohol-induced, drug, and suicide deaths and improve mental health and well-being. These recommendations focus on actionable items in three areas and are primarily aimed at federal and state policymakers. A summary of recommendations follows; the full recommendations are on page 31.

Invest in Prevention and Conditions that Promote Health

- Protect investments in injury and violence prevention, and restore and maintain the workforce dedicated to these efforts.
- 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.
- Strengthen capacity to address the behavioral health impacts of environmental risk 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 focused 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.
- 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: Progress in Drug Overdose Deaths

Over the past 20 years, more than 1 million Americans have died from drug overdoses. While the rate of drug overdose deaths has risen in the United States for decades, there have been positive developments recently. After precipitous increases in the rate of drug overdose deaths in 2020 and 2021, the 2022 overall mortality rate was virtually unchanged, the 2023 mortality rate was 4 percent lower, and provisional mortality data suggest even greater reductions in 2024.[10] While these marked improvements point to major public health successes, trends in overdose death rates are still among the highest that the United States has experienced. In addition, steep cuts to federal programs and workforce put this progress at risk. This report section examines the recent mortality data available on drug overdoses in more depth, including differences by group; highlights current strategies that have been successful and essential to the recent progress; and considers additional policies to address the ongoing crisis and to sustain progress.

A. Recent Overdose Trends

Drug overdose mortality trends have changed drastically over the last five years, from very large increases in the drug overdose death rate in 2020 (+31 percent) and 2021 (+14 percent), stabilization in 2022 (+<1 percent), and then a decrease in 2023 (-4 percent). Provisional data suggest even greater declines in 2024—new data show a predicted 27 percent decrease.[11]

These recent improvements are encouraging, though long-term trends are still extremely poor. Even assuming a decline of 27 percent for 2024 (about 23 deaths per 100,000), the drug overdose rate would still be higher than the 2019 rate (21.6 deaths per 100,000), almost twice the rate in 2010 (12.3 deaths per 100,000), and almost four times the rate in 2000 (6.2 deaths per 100,000). (See Figure 2.)

There is concerning variation underlying these overall positive trends, including different experiences across sexes, demographic groups, geographic regions, and types of drugs. To better understand how current policies and programs are working, to identify gaps in current efforts, and to guide future work, it is necessary to have a full picture of trends across groups. Looking at 2022 and 2023 mortality

data—the most recent years with complete, final data available—shows some groups made progress, other groups saw some improved trends (i.e., smaller increases in mortality than prior years), and others are experiencing continuing, poor trends or new, worsening trends. Analysis of trends by group are below.

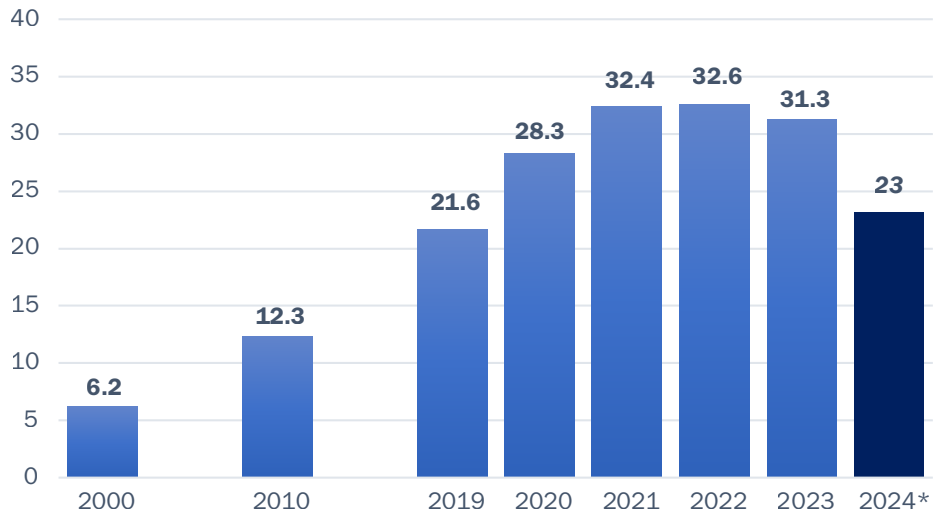
Sex

Both males and females had statistically significant decreases in drug overdose death rates in 2023 compared with 2022, though females (-6 percent) saw larger decrease than males (-3 percent).[12] (See Figure 3.)

Race/Ethnicity

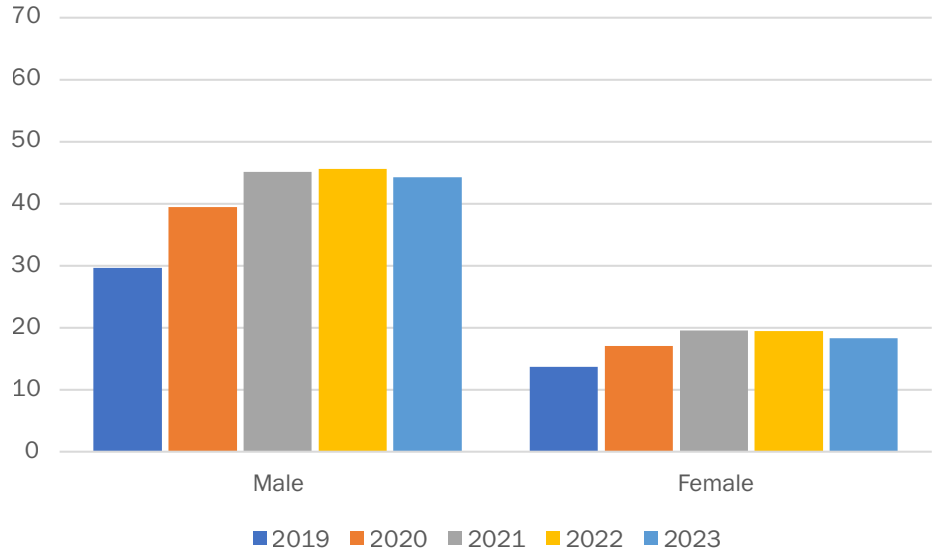
In 2023, the only racial/ethnic group with a statistically significant decrease in drug overdose mortality from the previous year was white people (-7 percent). American Indian and Alaska Native (AI/AN) (0 percent), Asian (-4 percent), and Hispanic/Latino (+1 percent) people had nonsignificant changes, and Black (+3 percent) and Native Hawaiian or Other Pacific Islander (NHOPI) (+39 percent) people had statistically significant increases.[13] It is notable that most racial/ethnic groups did see smaller increases in 2023 than previous years—for example, Black Americans had an increase of 3 percent in 2023, down from an increase of 8 percent in 2022, 24 percent in 2021, and 44 percent in 2020. The exception is NHOPI people, who experienced a large decrease in 2022 followed by a large increase in 2023. (See Figure 4.) (Note: Racial/ethnic groups in this report are non-Hispanic unless stated as Hispanic/Latino.)

Figure 2: Annual Age-Adjusted Mortality Rate from Drug Overdoses (Deaths per 100,000) in the United States, 2000, 2010, 2019–2024



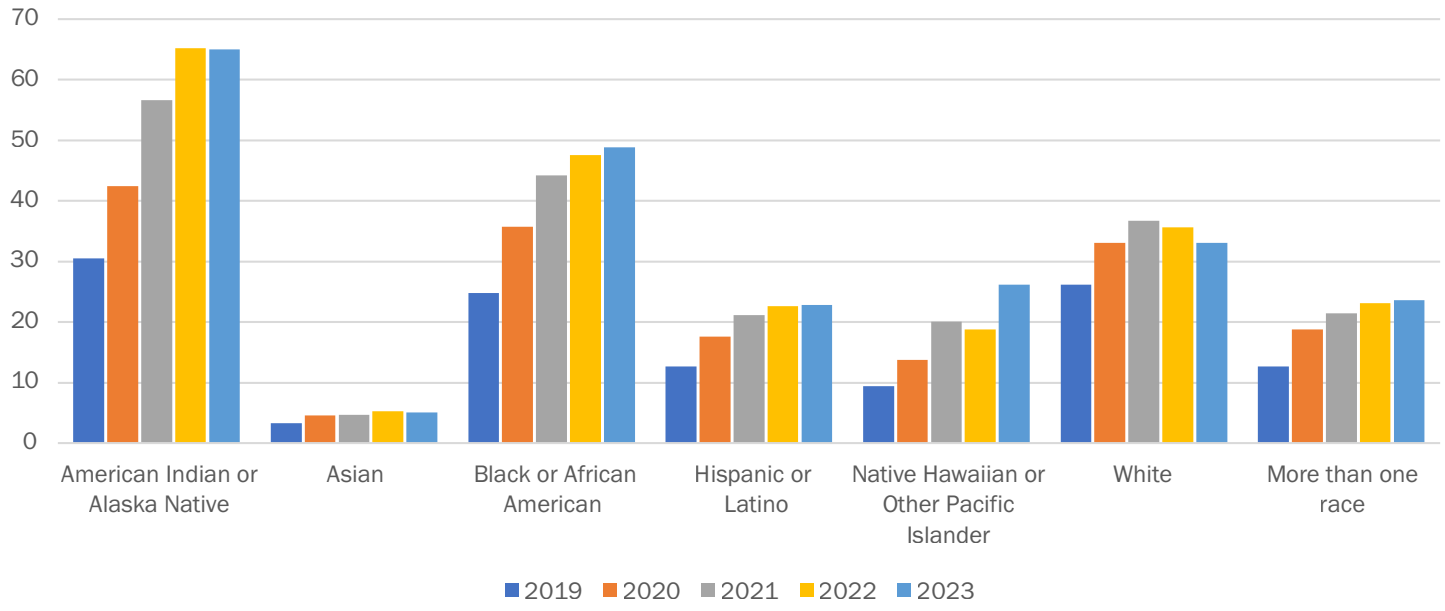
Source: TFAH analysis of National Center for Health Statistics data.
Note: 2024 data in this figure is estimated mortality rate based on provisional data.

Figure 3: Annual Age-Adjusted Rate of Drug Overdose Deaths (Deaths per 100,000 People) in the United States by Sex, 2019–2023



Source: TFAH analysis of National Center for Health Statistics data.

Figure 4: Annual Age-Adjusted Rate of Drug Overdose Deaths (Deaths per 100,000 People) in the United States by Race/ Ethnicity, 2019–2023

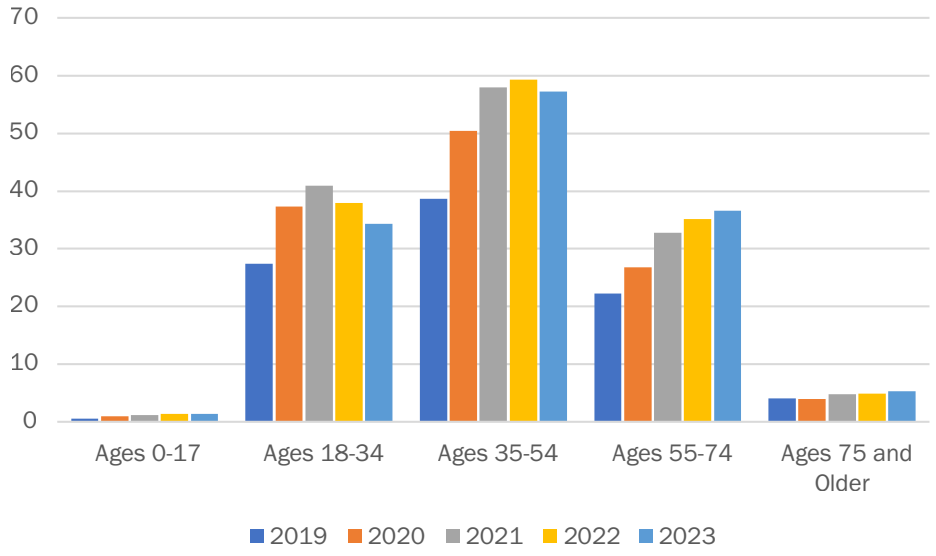


Source: TFAH analysis of National Center for Health Statistics data.

Age Group

Drug overdose mortality in younger and middle-age groups was about the same or lower in 2023 than 2022: ages 0–17 (-1 percent), ages 18–34 (-10 percent), and ages 35–54 (-4 percent). Older age groups, on the other hand, had higher mortality rates in 2023: ages 55–74 (+4 percent) and ages 75 and older (+9 percent). (See Figure 5.)

Figure 5: Annual Rate of Drug Overdose Deaths (Deaths per 100,000 People) in the United States by Age Group, 2019–2023



Source: TFAH analysis of National Center for Health Statistics data.

Geographic Region

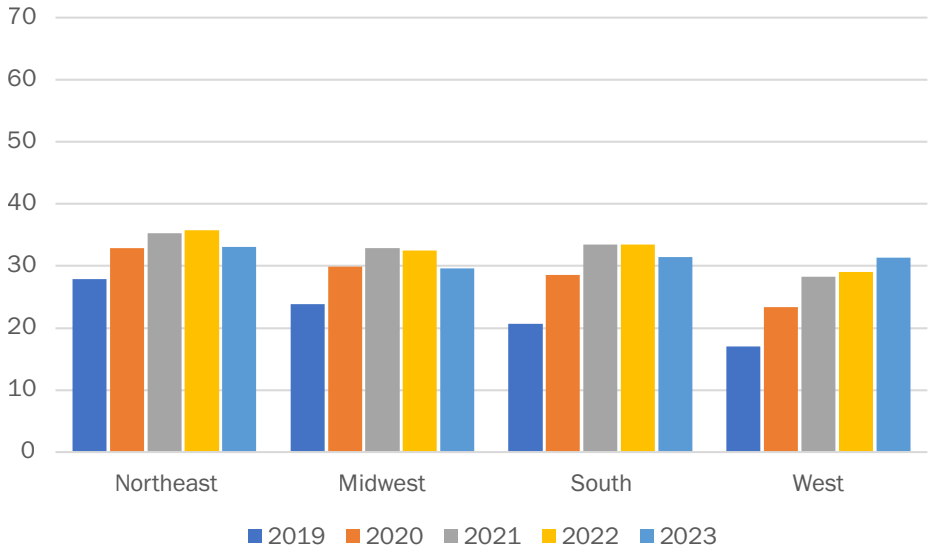
The Northeast (-7 percent), Midwest (-9 percent), and South (-6 percent) regions all saw decreases in overdose deaths in 2023, while the West had a substantial increase (+8 percent). The increase in the West includes extremely large jumps in a number of states in 2023, including in Alaska (+44 percent), Nevada (+26 percent), Oregon (+31 percent), and Washington state (+26 percent). Historically, the West has had lower drug overdose mortality, but it has had a faster pace of increases over the last few years and is now similar to other regions in the United States. (See Figure 6 for regional data and appendix C for state data.)

Drug Type

In 2023, the overall drug overdose mortality rate declines were driven by declines in opioid overdoses—including a statistically significant decline in the rate of overdose deaths involving synthetic opioids (-2 percent), natural and semisynthetic opioids (-17 percent), and heroin (-34 percent).[14] This was the first time synthetic opioid overdose mortality declined in more than a decade. However, the rate of overdose deaths involving cocaine (+5 percent) and other psychostimulants (+2 percent) both had statistically significant increases.[15] (See Figure 7.)

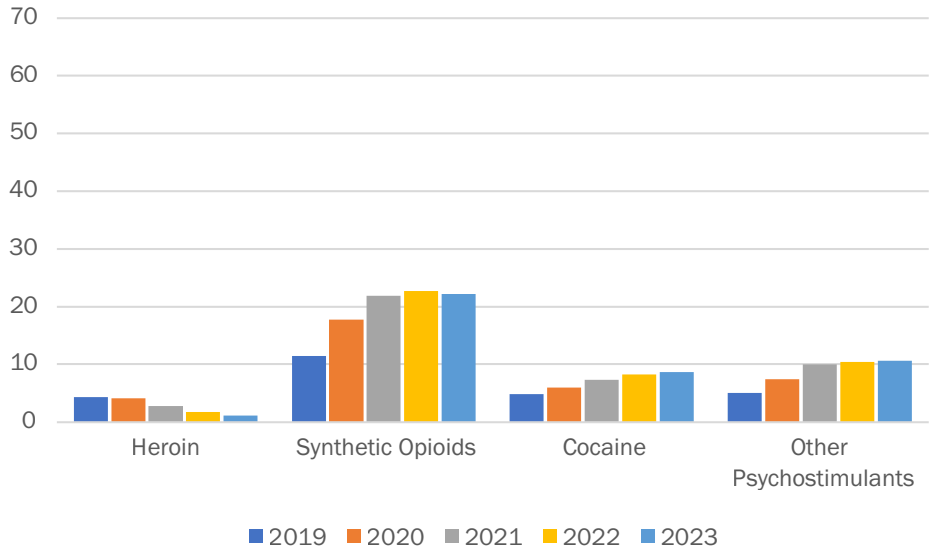
For additional information on drug overdose trends, see the Alcohol, Drug, and Suicide Mortality Data and Trends section on page 21 and additional data in Appendix B on page 41 and Appendix C on page 42.

Figure 6: Annual Age-Adjusted Rate of Drug Overdose Deaths (Deaths per 100,000 People) in the United States by Geographic Region, 2019–2023



Source: TFAH analysis of National Center for Health Statistics data.

Figure 7: Annual Age-Adjusted Mortality Rate (Deaths per 100,000 People) from Overdoses by Select Drug Type, 2019–2023



Source: TFAH analysis of National Center for Health Statistics data.

INNOVATIVE STATE, TRIBAL, AND LOCAL POLICIES AND PROGRAMS

Across the United States, state governments, tribes, and local organizations have worked in a variety of ways to reduce drug overdoses in their communities. Examples include:

- In Mississippi, federal funding and a 2024 law increased the availability of naloxone to schools and other community groups.[16,17] Prior to this law, the state's Department of Mental Health only offered naloxone access to certain first-responders and law enforcement. As a result of expanded access, the Mississippi Department of Health distributed more boxes of bulk naloxone in the first two months after the law passed than in the previous 10 months combined.
- The Recidivism Reduction Educational Program Services of Raleigh, North Carolina, launched its Mobile Recidivism Reduction Center in 2025.[18] The center serves as the state's first mobile unit dedicated to reentry populations. Services include fentanyl test strips and naloxone, in addition to wraparound supports such as connections to Medicaid, unemployment assistance, substance misuse treatment, mental health resources, legal aid, and housing supports.[19]
- Following a 2023 Illinois law, the state's Board of Education released a resource guide in 2024 to teach students about the dangers of overdoses and substance use disorder.[20,21] The guide contains age-appropriate materials, with greater complexity added to discussions as students age. Curricula are sourced from materials developed by universities, nonprofits, and federal agencies on harm reduction, drug interaction, and related topics.[22]
- Several tribes are using harm reduction strategies to reduce overdose disparities faced by Native communities. The Indian Health Service's Community Opioid Intervention Prevention Program continues to fund several pilot programs that incorporate culturally effective practices into harm reduction techniques.[23] For example, in New Mexico, the Albuquerque Area Indian Health Board uses the funds to educate partners on culturally appropriate best practices when integrating harm reduction strategies.[24] The Jamestown S'Klallam Healing Clinic in Washington state uses the funds to address both medical and nonmedical needs (e.g., housing, food security, job training) for those dealing with opioid use disorders.[25]
- In addition to state-led efforts, local organizations are also bolstering access to harm reduction services. In one example, a Tulsa, Oklahoma, nonprofit clinic, Health Outreach Prevention Education, Inc., has been able to stock and maintain the harm reduction vending machine outside its clinic and increase its availability to 24 hours a day, after previous funding ended.[26]
- Montclair State University in New Jersey experienced its first year of offering an online graduate-level certificate, titled *Harm Reduction Approaches to Substance Use*.[27] The certificate is the nation's first to certify students and professionals in the practices and principles of harm reduction strategies, including harm reduction services and programs and non-stigmatizing, social-justice-oriented, and trauma-informed engagement strategies.[28]
- Louisiana participated in the Centers for Disease Control and Prevention Overdose Data to Action in States cooperative agreement, which provides funds for surveillance activities, like tracking overdoses and emerging threats, and evidence-based prevention activities. As part of this agreement, the Louisiana Office of Public Health developed a data brief on suicide during the COVID-19 pandemic using real-time surveillance data and is now building a system to share near real-time suicide-related data to inform prevention efforts.[29]
- Since May 2024, more than 30 public health offices in New Mexico are now providing medications for opioid use disorder both in person and via telehealth through the New Mexico Pathways program.[30] With this expansion, the state is now able to provide services across all regions in the state expanding access to many more residents.[31]

B. Policy and Program Successes

As deaths from drug overdoses have risen—along with heightened harm from nonfatal overdoses, substance misuse, and substance use disorders—over the last two decades, so has the focus on prevention, harm reduction, and treatment to help those in need. In October 2017, the U.S. Department of Health and Human Services (HHS) declared the opioid overdose crisis a public health emergency, providing additional funding and programmatic flexibility to better respond.[32,33] The public health emergency has been extended every 90 days in the years since, with the most recent renewal in March 2025.[34,35] The reduction in the rate of drug overdose deaths in recent years has no singular explanation but is rooted in a number of important, long-term strategies, policies, and programs at the national, state, and local levels, including: (1) sustained investment in public health and community overdose response, (2) multisector partnerships, (3) harm reduction, (4) medication-assisted treatment, and (5) changing drug supply enforcement and awareness efforts.

Sustained Investment in Community and Public Health Overdose Response

Significant reductions in the drug overdose death rate in 2023 and 2024 have coincided with substantial federal investment in communities to address the opioid epidemic through complementary strategies: (1) boosting the continuum of prevention, treatment, and recovery services for individuals in communities; and (2) population-level prevention efforts driven by data.

For Fiscal Year (FY) 2024, for example, the Substance Abuse and Mental Health Services (SAMHSA) awarded more than $1.5 billion in State Opioid Response (SOR), Tribal Opioid Response (TOR), and SOR/TOR Technical Assistance grants.[36] These grants have focused on "evidence-based, holistic practices that address the overdose crisis through prevention; harm reduction, including naloxone and other opioid overdose-reversal medications; treatment, including use of medications for opioid use disorder; and recovery supports."[37] Sustained investments through these programs have dramatically expanded treatment for opioid use disorder and stimulant use disorder, recovery support services, and naloxone distribution, as discussed in more detail below.[38]

Parallel to these efforts, investments by the Centers for Disease Control and Prevention (CDC) in population-level overdose prevention strategies have also provided critical support to state and local public health efforts. Through the Overdose Data to Action (OD2A) program, for example, CDC supports 90 jurisdictions in tracking the evolving nature of the drug supply and using that data to tailor and implement proven prevention strategies.[39] Current state and local grantees receive $280 million in awards to track overdoses and emerging drug threats (i.e., new substances in the drug supply, such as the veterinary sedative xylazine), partner with public safety and first-responders, support peer navigators who link individuals to treatment, fund prescription drug monitoring programs, review overdose fatalities, and other efforts.[40] In addition, CDC data-collection and analysis efforts have allowed for early detection and intervention; have assisted state and local partners in responding to the rise of xylazine, carfentanil, and other substances in the drug supply; and have maximized the impact of naloxone distribution to ensure it gets to people and places it is most needed.[41] These data are also used by other partners across local, state, and national levels, including other federal agencies like SAMHSA, to inform their efforts. Emergency epidemiologic assistance from CDC's Epidemic Intelligence Service has also assisted public health departments in addressing emerging threats.[42]

THE DISTINCT AND VITAL ROLES OF CDC AND SAMHSA IN THE PREVENTION AND TREATMENT OF DRUG OVERDOSE AND SUICIDE

CDC's National Center for Injury Prevention and Control (CDC Injury Center) and SAMHSA play distinct—and equally important—roles in promoting mental health and well-being for all Americans. Rather than duplicating efforts, these federal agencies' programs inform and complement one another to enhance overdose and suicide prevention efforts, among other initiatives.

CDC's Injury Center adopts a population-level approach to reduce drug overdose and suicide—acting as a national data hub and analysis center to track trends and identify emerging issues, a technical assistance provider to states and local communities, and a funder of prevention programs across the country that address causes of suicide, violence, and overdose. The data insights and expertise from the Injury Center are essential to inform federal, state, and local actions and maximize the impact of the federal funding.

As related to overdose prevention, Injury Center experts monitor changes in overdose and near-overdose patterns, track regional utilization patterns, develop and evaluate prevention strategies, and provide practical guidance on topics ranging from safe opioid prescribing to best practices for distribution of overdose-reversal medication. CDC's laboratory expertise is critical to identifying rapidly emerging threats, like new synthetic opioids or contaminants, including xylazine and carfentanil, in the drug supply.

By integrating its efforts into the infrastructure of state and local health departments, the Injury Center helps these partners gather comprehensive data to understand the scope of public health challenges and to identify best practices.[43] For example, data in the Drug Overdose Surveillance and Epidemiology dashboard assists communities in distributing naloxone, and overdose death data in the State Unintentional Drug Overdose Reporting System dashboard helps partners identify new overdose trends within four to five months.[44] Injury Center support also assists state and local partners in translating research and prevention best practices into action,[45] and CDC supplements these efforts by providing on-the-ground support during emergencies at no cost to states.[46] Importantly, more than 80 percent of Injury Center funding flows directly to communities, supporting locally driven solutions and thousands of jobs across the United States.[47]

In contrast to CDC, SAMHSA primarily funds behavioral health state agencies to direct treatment and recovery services to individuals or to support mental health providers. SAMHSA, for example, administers the Substance Use Prevention, Treatment, and Recovery Services Block Grant, which empowers recipients to provide treatment and recovery support services with an emphasis on vulnerable populations, like people who inject drugs, pregnant women, and women with dependent children.[48] SAMHSA also operates the Harm Reduction grant program, which supports community-based overdose prevention programs, syringe services programs, and other harm reduction services.[49] Recipients have used funding to enhance overdose prevention and related activities to help control the spread of infectious diseases.[50] Recipients can also distribute overdose-reversal medication, address stigma, and connect individuals to education, counseling, and recovery services.[51]

Importantly, CDC and SAMHSA have also combined efforts to enhance their collective impact on behavioral health outcomes. The agencies, for example, collaborated to develop the 2024 National Strategy for Suicide Prevention and Federal Action Plan, a 10-year, whole-of-society approach to addressing gaps in the suicide prevention field.[52] CDC and SAMHSA also developed the National Harm Reduction Technical Assistance Center, which assists providers of harm reduction services, including services focused on opioid use disorder.[53] Among other initiatives, the center supports the integration of opioid misuse harm reduction services into medical care settings.[54] Finally, CDC overdose data also informs SAMHSA-funded recipients' efforts to distribute naloxone to the people and places it is most needed, maximizing the impact of federal investments in harm reduction.[55]

Multisector Partnerships

Communities have also sustained progress in reducing overdoses by developing and strengthening multisector partnerships with healthcare organizations, social services, community-based organizations, and other entities. CDC, for example, manages the Drug-Free Communities program, which funds efforts by 750 local coalitions—in mostly rural areas—to prevent youth substance use in partnership with schools, community organizations, and public health and public safety agencies.[56] CDC also funds state-level partnerships between public health agencies and law enforcement, first-responders, courts, and community corrections to identify emerging drug threats and increase access to substance use disorder treatment for vulnerable populations.[57,58,59] The OD2A program, in particular, engages "local health departments, community organizations, coalitions, and community members" and "capitalizes on the important and distinct prevention roles of state and local partners."[60]

In a related program beginning in 2019, the National Institutes of Health conducted the HEALing Communities Study, funding 67 communities to leverage community coalitions and data to promote naloxone distribution, medication treatment for opioid use disorder, and safer opioid prescribing.[61] Facing significant challenges from the COVID-19 pandemic and the fentanyl crisis, the program, in general, did not lead to a statistically significant reduction in opioid-related overdose death rates nationally.[62] However, officials in Lucas County, Ohio—a recipient of HEALing Communities funding—saw a 20 percent decline in fatal fentanyl overdoses between 2020 and 2022 after coordinating among health department workers, treatment providers, clergy, and law enforcement to understand overdoses and direct resources effectively.[63]

State coalitions are also important. For example, the California Overdose Prevention Network (COPN) includes 41 local coalitions that focus on community education and harm reduction strategies in 45 counties, reaching 85 percent of Californians.[64] COPN currently receives funding from SAMHSA's SOR grants via the California Department of Health Care Services.[65] COPN has distributed tens of thousands of fentanyl test strips and expanded access to naloxone, among other initiatives.[66]

Harm Reduction

Increased access to harm reduction tools also have played a key role in reducing drug overdose mortality in 2023 and 2024. Through the SOR/TOR grant programs, for example, federal agencies have worked to provide communities with large inventories of naloxone.[67] In September 2024, SAMHSA reported that SOR/TOR awards had supported the distribution of almost 2.7 million naloxone kits and 92,000 reported overdose reversals between April 2022 and March 2023.[68] In March 2024, a White House press release further stated that the SOR program had delivered nearly 10 million naloxone kits and prevented more than 600,000 overdose deaths.[69] The FY 2024 Notice of Funding Opportunity for the SOR program requires recipients to develop a "targeted distribution strategy to get the appropriate type of naloxone and other opioid overdose reversal medications into the hands of those most likely to witness an overdose and in the locations where they are most likely to occur."[70] CDC data shows that the total number of dispensed naloxone prescriptions increased from 1.68 million prescriptions in 2022 to 2.13 million in 2023.[71]

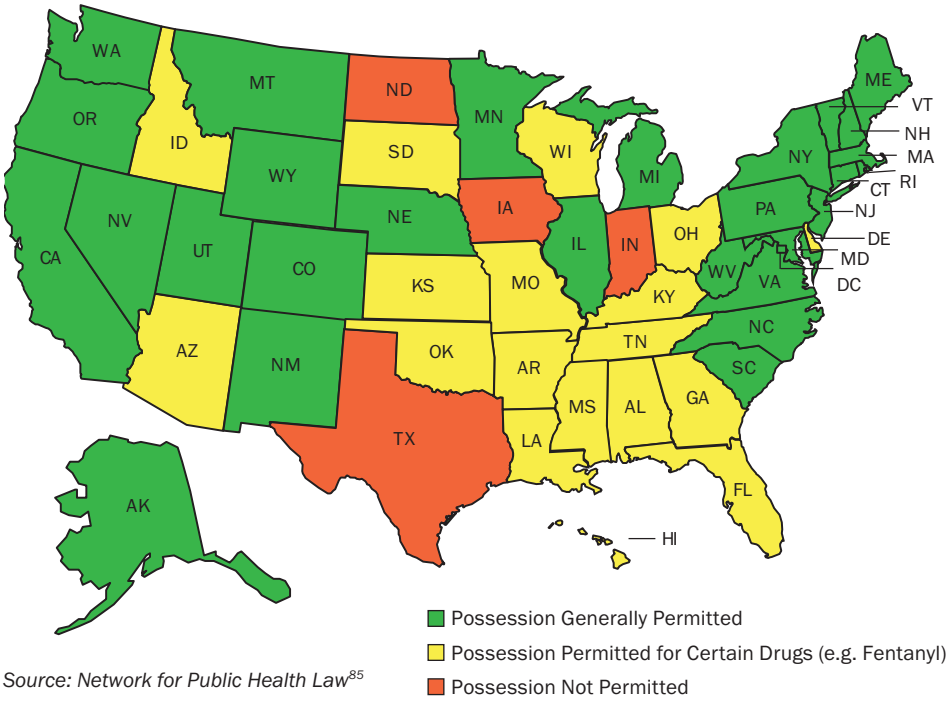
Assisting this effort, in March 2023, the Food and Drug Administration (FDA) approved the first naloxone nasal spray for over-the-counter (OTC) nonprescription use, explaining that the approval "paves the way for the life-saving medication to reverse an opioid overdose to be sold directly to consumers in places like drug stores, convenience stores, grocery stores and gas stations, as well as online."[72] In July 2023, FDA approved a second OTC naloxone nasal spray product.[73] OTC naloxone is an important step in increasing public access, though cost is a remaining barrier as a two-pack of naloxone nasal spray costs between $35 and $45.[74] Research shows many people who receive naloxone get it free of charge from community-based organizations and opioid overdose education programs.[75]

In response to the rising threat of xylazine in the fentanyl supply, as identified by CDC data collection and surveillance efforts and Drug Enforcement Administration (DEA) reports, the Office of National Drug

Control Policy (ONDCP) designated this drug combination as an "emerging drug threat" to the United States in April 2023 and later released a national response plan focused on testing, data collection, and harm reduction strategies.[76,77,78] Relatedly, in February 2024, HHS announced that certain grant recipients could use specific funds to purchase xylazine test strips, which it described as "a useful tool to help people detect and avoid xylazine in illicit drugs and serve as a much-needed addition to the wider array of harm reduction supports and services available to help keep people safe."[79] State and federal policies also decriminalized or enhanced access to xylazine and fentanyl test strips, particularly in states where fentanyl test strips were previously considered illegal drug paraphernalia.[80,81]

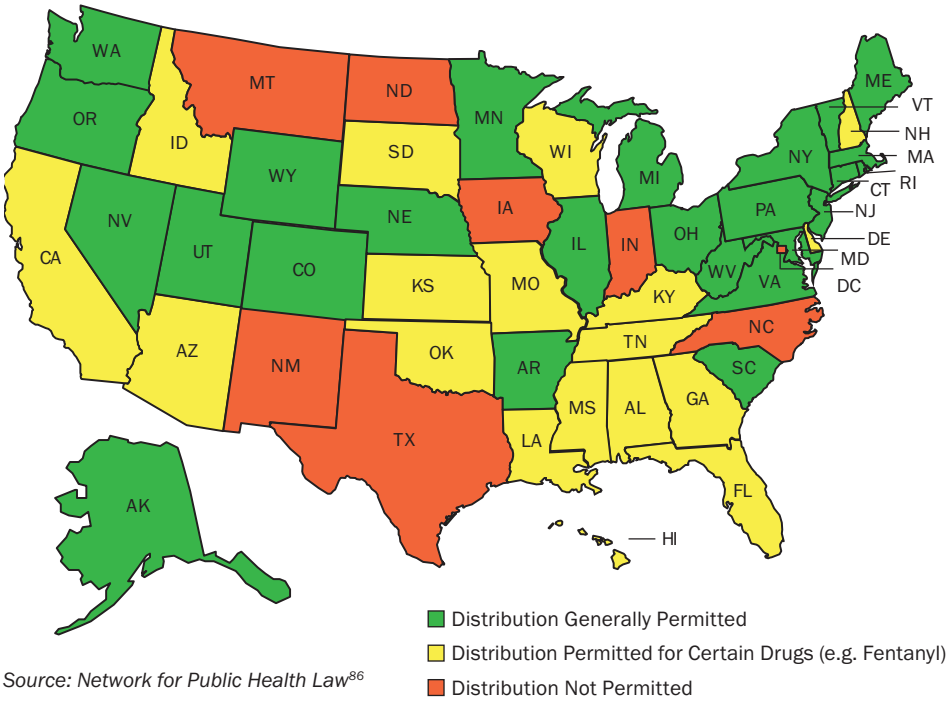
Earlier, in 2021, CDC and SAMHSA announced that recipients in federal grant programs could use funding to purchase fentanyl test strips (when consistent with the purpose of the specific program).[82] This change has allowed recipients in CDC's OD2A program and the SOR program to purchase test strips with federal funds.[83] Alongside lifting this funding restriction, an increasing number of states modified their laws concerning drug-checking equipment, which can include fentanyl test strips. According to an analysis from the Network for Public Health Law, 37 states implemented laws to permit the possession and/or distribution of drug-checking equipment between August 2021 and August 2024.[84] (See Maps 1 and 2, and Appendix F.)

Map 1: State Laws Related to Possession of Drug Checking Equipment, as of August 2024



Source: Network for Public Health Law[85]

Map 2: State Laws Related to Distribution of Drug Checking Equipment, as of August 2024



Source: Network for Public Health Law[86]

Medication-Assisted Treatment

Access to medication-assisted treatment for opioid use disorder (i.e., buprenorphine, methadone, naltrexone) has also expanded at the federal level. In December 2022, for example, Congress eliminated the special licensing requirement to prescribe buprenorphine, known as the "X waiver," dramatically expanding the number of potential prescribers.[87] In March 2023, then–ONDCP Director Dr. Rahul Gupta reported that 2 million prescribers were registered with the DEA to prescribe buprenorphine, a large increase from the 130,000 providers with an X waiver at the end of 2022.[88] A study published in April 2024, however, found that while the elimination of the waiver "may have reduced barriers to prescribing, [it] was insufficient to meaningfully increase buprenorphine use through the end of 2023."[89] In fact, CDC data shows that the total number of dispensed buprenorphine prescriptions declined a bit from 16.0 million prescriptions in 2022 to 15.7 million in 2023.[90] A 2022 survey of clinicians with waivers found that "lack of patient demand" and "still setting up practice" were the most common reasons for not prescribing buprenorphine.[91] Some anecdotal evidence suggests the lifting of the X waiver has begun to change medical prescribing culture surrounding buprenorphine.[92]

In February 2024, HHS also revised federal regulations for opioid treatment programs (OTPs) for the first time since 2001 to update language, standardize new best practices, and make certain COVID-19-era flexibilities permanent.[93,94] These changes expanded patients' eligibility to receive take-home doses of methadone; allowed the initiation of treatment with methadone and buprenorphine via telehealth; allowed nurse practitioners and physician assistants to order medications in OTPs; and reduced barriers to treatment by altering admission criteria and allowing for access to interim treatment.[95] Previously, OTP restrictions—required daily reporting, for example—often posed significant logistical barriers to individuals seeking methadone treatment.[96] Research into the impact of new flexibilities suggest they improved program retention, decreased patient opioid usage, and resulted in minimal misuse of doses.[97,98] A separate study also found that more flexibility did not increase overdose deaths involving buprenorphine in the months after implementation.[99]

Other federal actions to expand access to medication-assisted treatment include lifting a moratorium on mobile methadone vans—a critical service for rural areas—and permitting the use of Medicaid and SOR grants for substance use treatment and reentry coverage for incarcerated individuals.[100,101,102]

Changing Drug Supply Enforcement and Awareness Efforts

Federal officials have also addressed the supply side of the overdose crisis through increased enforcement efforts against fentanyl trafficking activity. For example, federal officials increased seizures of fentanyl at ports of entry, added inspections systems to improve detection of fentanyl, imposed sanctions on at least 300 persons and entities involved in the global illicit drug trade, and arrested and prosecuted drug cartel leaders.[103] In July 2023, ONDCP also designated nine new countries for the High Intensity Drug Trafficking Areas Program, which "coordinates and assists federal, state, local, and tribal law enforcement agencies to address regional drug threats with the purpose of reducing drug production and drug trafficking in the United States."[104]

Research published in May 2024 found that "[b]oth the number and size of drug seizures containing fentanyl have increased in the US between 2017 and 2023."[105] A National Security Council official also noted in October 2024 that the amount of fentanyl seized along the Southwest border between August 2022 and August 2024—70,000 pounds—was greater than the amount seized in the previous five years combined.[106] Recent reporting also suggests increased enforcement efforts have reduced the availability and purity of fentanyl supplies.[107] Then–DEA Administrator Anne Milgram stated in November 2024 that DEA laboratory testing indicated 5 out of 10 fentanyl pills tested in 2024 contained a potentially deadly dose of fentanyl—down from 7 out of 10 pills in 2023 and 6 out of 10 pills in 2022.[108]

CDC programs have also contributed to broader efforts to understand and disrupt the illegal drug supply. For example, the Overdose Response Strategy—a partnership between the High Intensity Drug Trafficking Areas Program and CDC—operates a network of public health and public safety officers in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to share information, disrupt the illicit drug supply, and protect people from overdose.[109] In addition, CDC's Injury Center provides emergency, on-the-ground expertise to address local overdose surges; in one example, CDC assisted the city of Chicago with an investigation into the contamination of the illegal fentanyl supply with medetomidine, a potent sedative.[110]

C. Progress At Risk

After two decades of worsening trends, there have been some positive developments in drug overdose mortality. However, the recently announced restructuring of HHS, cuts in public health funding, and layoffs of the federal public health workforce threaten these advancements.[111,112] The next step is to ensure sustained progress by restoring and continuing the important strategies, policies, and programs that have been built up over decades—and underpin the recent improvement—and continuously look for areas of improvement.

To do this, policymakers at the national, state, and local levels need to carefully follow evolving trends in the drug supply and gaps in prevention and treatment resources; sustain current and commit additional investments and build capacity to better serve communities with disproportionate overdose rates; continue to improve access, availability, and quality of treatments for overdose and substance use; and be proactive with early prevention measures. A few examples include:

- Protecting and 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 treatment.
- Continuing to improve data systems, like CDC's Overdose Data to Action, to track emerging trends by geographic, demographic, and drug type metrics 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-checking tools.
- Improving treatments for drug overdoses and substance use disorders, including medications for stimulant overdose and stimulant use disorders, as well as increasing equitable access and eliminating barriers to currently available medications and treatments.
- Supporting and expanding the behavioral health workforce, including peer supports and community health workers, to reduce barriers and increase access to substance use disorder treatment and harm reduction.
- Focusing on the underlying drivers of substance misuse and disparities 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.

Stephen Williams was the mayor of Huntington, West Virginia, from 2012 to 2024. During his tenure, he created the Mayor's Office of Public Health and Drug Control Policy and served on a joint task force of the National League of Cities and the National Association of Counties addressing the opioid epidemic. He currently is a member of the Stanford University Network on Addiction Policy.

Interview with Stephen Williams

Q: Let's start by talking about your focus on addressing drug overdose and substance misuse during your tenure as mayor. What led to prioritizing that work?

Williams: What was happening, and it was perplexing to me at the time, was that no matter where I'd go, I could be going to the grocery store, or sitting in church, or just walking down the street, people would come up to me and say, "Mayor, you've got to do something, we don't feel safe." I was hearing admonitions of, "You've got to do something."

I knew we had a strong police department with the resources they needed. I felt like we had the situation under control. Shortly after that I accompanied our police on a raid; the police had intelligence about a major drug shipment coming into the community. I was only an observer, but it was a frightening experience. I saw the degree to which our police officers were at risk, and I saw firsthand the magnitude of the problem. The experience showed me that this is more than a policing problem. We were not going to be able to arrest ourselves out of this problem.

As I made my way back to my office after witnessing the raid, I happened to see a bunch of young children who were on a little field trip walking down the street, a precious sight. It hit me, that's the next target (for the drug trade). We've got to protect them. I realized that I had to take ownership of this problem. From that point on, everything changed in my administration.

Q: What were your next steps?

Williams: I created the Mayor's Office of Drug Control Policy in 2014. At that time, we were the only city in the country with one. I realized that there were resources available—we had a lot of people doing things within the community and the region—but we needed a more fundamental strategy. We needed communication and collaboration.

I put together a three-person team. They went around the community talking to the experts, learning from what they were observing. We had the good sense to start listening to the experts. The team sat down with business leaders, they sat down with folks at the state's medical schools and people who were active in recovery programs, and with pastors. Based on these meetings, we created a strategic plan.

We recognized that we needed naloxone. We also came up with a plan for a syringe exchange program. It was the first in the state of West Virginia. By the way, once the syringe exchange program was in place, we started to see in the data a decrease in HIV and Hepatitis B and C infections. So instead of talking about the program as related to the heroin epidemic, we talked about it as an important step to prevent the proliferation of disease.

Where we became known as a city of innovation and doing things on the cutting edge, it was simply because we brought the experts together to discuss, "What if we tried this or tried that?" That always led to something innovative.

Q: As the drug overdose problem has evolved, how did the city's strategies change?

Williams: Yes, the epidemic of addiction has evolved, and we've had to keep adjusting and working with partners. It's not just a heroin problem, it's a fentanyl problem, and other issues are involved, homelessness for example.

When I met with community groups to talk about the community's drug overdose problem, I'd also talk about what they can do to help. I'd ask, "What's your assignment?" We recognized that the whole idea of a harm reduction program is to build connection, build trust with the people you are looking to help. We had a local church volunteer to help with the syringe exchange program. They offered to host lunches so people could a get a meal and clean syringes.

Q: The availability of naloxone has helped save lives. What should happen next for someone who has experienced an overdose? Can you say more about West Virginia's Quick Response Team program and how it creates pathways to treatment?

Williams: When fentanyl arrived in our community, this was the summer of 2016, in one afternoon there were 28 overdoses. Two people died due to overdose, 26 did not because we had naloxone. Having naloxone in the hands of our first-responders was an early win for us. In the spring of 2015, a product donation grant from Kaléo, a Richmond, Virginia based pharmaceutical company, allowed us to ensure that every first responder carried naloxone.

You'll notice I won't say that we saved their life. What we did was prevent them from dying. The problem was not a single person was referred to treatment. What we found was that the 26 people who did not die were still at risk. When someone is saying, "I need help," we can't wait six days or six weeks to help.

The city's Quick Response Team program launched in 2017 with initial funding from CDC and the U.S. Department of Justice (see editor's note). It worked this way: whoever was the first-responder on the scene, the EMS officer, they would be a part of the response team, plus a behavioral health specialist, a police officer, and a pastor would also be on the response team. Within no more than 48 hours after the overdose, the team would go calling on that person.

If we had to drive someone to get treatment, we would do that. We'd reach out to facilities across the state to ensure that people could get into treatment. And, importantly, we worked to make sure we had certification programs for training facilities within the city. We also worked to make sure that treatment programs are located strategically around the state, particularly in rural areas, so the support mechanisms that are needed are there.

The opportunity that we now have, as the opioid lawsuit settlement dollars make their way into communities, is we can develop more treatment programs. At the local level, we want to have state partners, we want to have federal partners, we need those (state and federal) funds, but the settlement monies will also allow us to have stability to be able to provide treatment on an ongoing basis.

Q: How did the city use data when you created your overdose response strategies?

Williams: CDC has been a wonderful partner for us. What's important for CDC and for us is timely data. If you don't have real-time data locally, it's like a batter who swings at a pitch too late. When we have real-time data, we can respond right now. Particularly in smaller communities, we can identify sooner what works, what doesn't work, and be faster to fix it. If you are working with old data, you find yourself reacting to something that has already moved.

We've often said to CDC and others, let us be your pilot project. The things that we were dealing with in Huntington were the same issues that larger communities were dealing with. Small towns, particularly

in rural America, have the ability to be the pilot projects for the much larger communities. We'll be able to bring things together, and if they work, they can be replicated around the country. We've had so many cities come to us to learn from us because we learned early on how important real-time data is.

Q: As I'm sure you know, we've recently had some good news about overdose deaths going down nationally the last two years. We seem to be moving in the right direction, is the progress going to hold?

Williams: Yes, overdoses are starting to go down. The problem is, my greatest concern is, the generational problems that we have. Even if we had the miracle of miracles that came in and there was no heroin, no opioids, no fentanyl, the problem we would still have is the generational impact. We are going to have three to four decades of issues that we will need to overcome.

An analogy is the rebuilding that has to take place after a natural disaster—the recent hurricanes and the wildfires in California. We have to come back and rebuild. Communities will need to come together to build themselves back from the addiction crisis. We need partners in the federal government, we need partners in the state government. But the reality is: it's not going to be someone coming in from Washington and saying, "Here's what you do." The foundation has to be at the local level, the community and county level.

I'm not saying do exactly what Huntington did. Don't copy us. Look for the talent and assistance in your community and put your local experts to work. You have resources that are available to you that are unique to your own community.

Q: If you have the opportunity to advise other elected officials about how to address the addiction crisis what would you say?

Williams: Local officials need to understand that they have an assignment, everyone has an assignment. Whether it's a big city or a small city. Officials should focus on the three Cs: communication, cooperation, and collaboration. If you start talking to one another, you'll realize there are ways to cooperate and that will lead to collaboration. We brought everyone to the table—healthcare leaders, schools officials, the business community, faith leaders of all denominations, and people from neighborhood associations. It's what I said earlier, all sectors of the community have an assignment.

Leaders also need to understand that there are two sides to this coin. One side is dealing with addiction. The other side is the need to create dynamic and innovative economic revitalization. We don't only need recovery programs, we need programs to help people develop job skills so they can be active in the workforce. We need to create economic opportunity. It's not just about creating treatment programs, we also need to create economic opportunities for individuals to be able step forward and take care of themselves and their families.

Editor's note: In March 2024, Kaiser Health News reported that the number of EMT calls due to an overdose were down 40 percent since the Huntington Quick Response Team program was established.[113] You can read more about post-overdose outreach programs, supported by CDC's OD2A cooperative agreements, here: https://www.cdc.gov/overdose-prevention/php/od2a/public-safety.html.

This interview was edited for length and clarity.

Mortality Data and Trends

Overall deaths from alcohol, drugs, and suicide in the United States declined in 2023—the second year in a row with lower death rates after two decades in which mortality rates increased at an alarming pace. The age-adjusted rate of total deaths was 4 percent lower in 2023 as compared with 2022, though trends varied by causes of death, demographic groups, and geography. Some overall trends include:

1. The overall age-adjusted alcohol-induced mortality rate decreased by 7 percent from 2022 to 2023 (from 13.5 to 12.6 deaths per 100,000 people). This decrease built on a 6 percent decrease the year prior and crossed nearly all demographic and geographic groups.

2. The overall age-adjusted drug overdose mortality rate was 4 percent lower in 2023 compared with 2022 (31.3 and 32.6 deaths per 100,000 people, respectively). This change marks the first decline in five years and an important shift compared with 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, the Northeast, Midwest, and South regions saw substantial decreases in overdose deaths, while the West had an 8 percent increase.

3. The overall age-adjusted suicide mortality rate was virtually identical from 2022 to 2023 (14.2 and 14.1 deaths per 100,000, respectively). Trends vary by demographics and geography, with the most notable differences appearing across racial/ethnic groups. The difference ranges from a 13 percent decrease among multiracial individuals to an increase of 21 percent among NHOPI individuals.

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 40.

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.[114] Natural opioids are sourced from opium poppies, semisynthetic opioids are synthesized from naturally occurring opium, and synthetic opioids are made entirely in a lab.[115]

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.[116,117] 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.[118,119]
- **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.[120] 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 (e.g., Adderall).[121]

Xylazine, also called "tranq," is a non-opioid veterinary tranquilizer that is not approved for human use. 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.[122] 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.[123] Naloxone does not reverse the effects of xylazine but will reverse any opioid it might be mixed with.

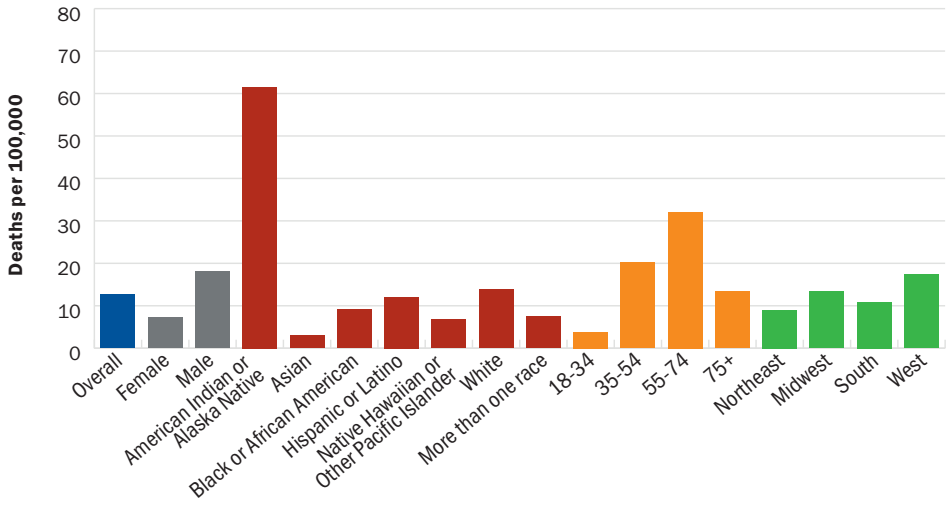
A. National Data and Trends

In total, there were 201,582 alcohol-induced, drug overdose, and suicide deaths in the United States in 2023—or an age-adjusted rate of 57.8 deaths per 100,000 people in a standard population. This is 4 percent below the 2022 rate (60.1 deaths per 100,000 people) but still more than twice the rate of 20 years ago (26.3 deaths per 100,000 people in 2003). This section includes alcohol, drug, and suicide trends by cause of death. Additional data by demographics and year trends on alcohol, drug, suicide, opioid, synthetic-opioid, cocaine, and other psychostimulant deaths and death rates are in Appendix B on page 41.

Trends in Alcohol-Induced Deaths

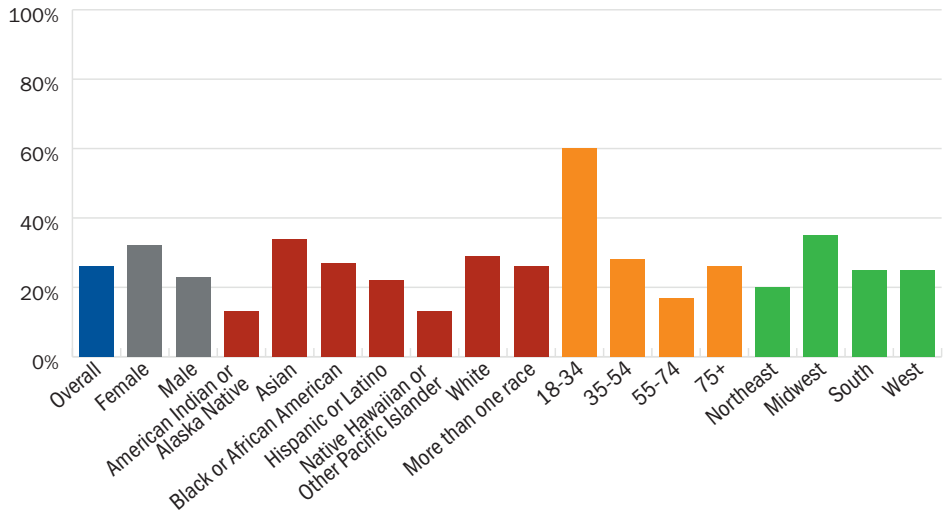
- In 2023, 47,938 Americans of all ages died from alcohol-induced causes, and 413,401 Americans died from alcohol-induced causes in the decade from 2014 to 2023. Note that alcohol-induced deaths include alcohol poisoning, liver diseases, and other diseases; it does not include alcohol-attributable deaths, such as alcohol-related violence, accidents, or vehicle fatalities.
- The age-adjusted rate of U.S. deaths from alcohol-induced causes was 7 percent lower in 2023 compared with 2022, decreasing from 13.5 to 12.6 deaths per 100,000 people. After two decades of increases (since 2002), this was the second year in a row with a decline.
- Alcohol-induced death rates in 2023 were highest among AI/AN people (61.5 deaths per 100,000 people), adults ages 55 to 74 (32.1 deaths per 100,000 people), adults ages 35 to 54 (20.2 deaths per 100,000 people), males (18.1 deaths per 100,000 people), and those living in the West (17.3 deaths per 100,000 people).
- All groups had lower rates of alcohol deaths in 2023 compared with 2022, except for Asian Americans. AI/AN people experienced particularly large decreases in 2023.

Figure 8: Age-Adjusted Alcohol-Induced Mortality Rate (Deaths per 100,000 People) Overall and by Select Demographics and Region, 2023



Source: TFAH analysis of National Center for Health Statistics data.

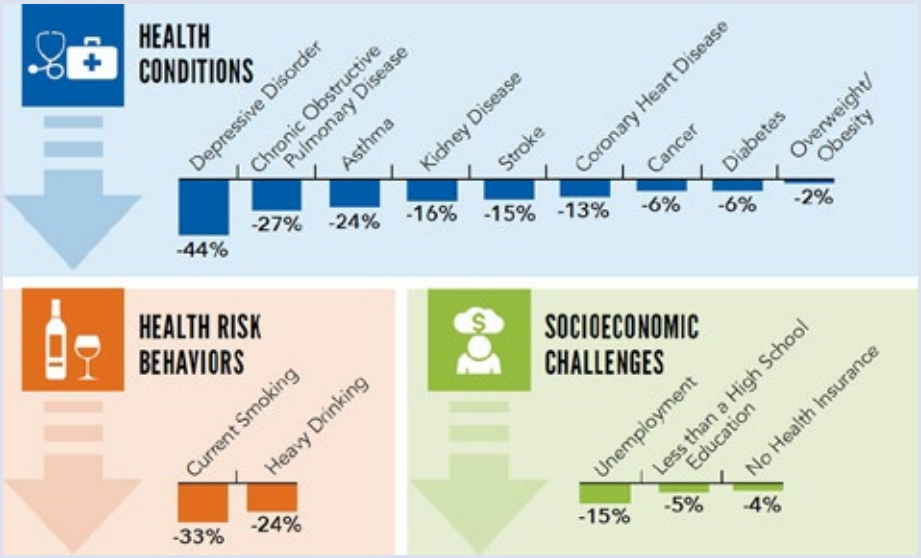
Figure 9: Percent Change in Alcohol-Induced Mortality Rates by Select Demographics and Region, 2018–2023



Source: TFAH analysis of National Center for Health Statistics data.

HEALTH AND ECONOMIC CONSEQUENCES OF ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences (ACEs) are defined by CDC as a range of events occurring in childhood (ages 0–17) that are potentially traumatic. Examples include experiencing or witnessing violence, abuse, neglect, mental health or substance use problems, suicide of a family member, discrimination, and food insecurity.[124] The long-term health effects of ACEs vary widely, and experiencing one or more ACEs during childhood is linked to worse health outcomes and more risk behaviors later in life.[125]



Source: BRFSS 2015-2017, 25 states,[132] CDC Vital Signs, November 2019[133]

Research shows that 64 percent of adults in the United States reported experiencing at least one type of ACE, and 17 percent reported experiencing four or more ACEs as children.[126] These kind of experiences can lead to long-term activation of a stress response, sometimes called toxic stress, that impacts the brain, immune, cardiovascular, and metabolic regulator systems long after the experiences occur, causing increased risk for a variety of negative health effects, ranging from cancer and respiratory disease to self-directed violence.[127] CDC estimates that preventing ACEs could reduce up to 21 million cases of depression, 1.9 million cases of heart disease, and 2.5 million cases of overweight or obesity.[128] Children who experience more ACEs also were more likely to engage in health risk behaviors later in life. This includes a higher association with substance misuse, and young adults with higher ACE counts have also been found to report higher consumption of alcohol, tobacco, and illicit or prescription drugs.[129,130] Despite these somber statistics, studies also show that many individuals who experience ACEs demonstrate positive adaptation or resilience and lead productive lives.[131]

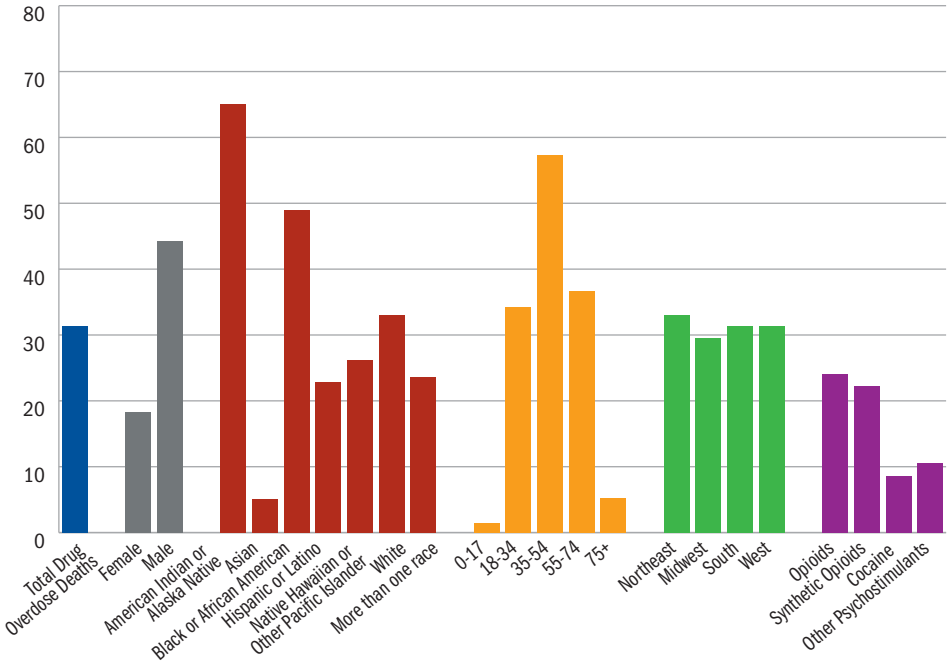
The health problems associated with ACEs have serious economic consequences. A recent estimate cites the economic costs associated with ACEs at $14.1 trillion annually in the United States. This includes $183 billion due to direct medical spending and $13.9 trillion for lost healthy life years (that is the reduced economic productivity of individuals who are unhealthy over years due to chronic disease).[134] Other estimates surrounding the direct costs of ACEs in European countries are similar, with ACE-attributable costs estimated to be 1–6 percent of a country's gross domestic product. For example, Germany's ACE-attributable costs are $129 billion.[135] Evidence from a systematic review and meta-analysis demonstrates that reducing ACE prevalence by 10 percent could save $105 billion in both Europe and North America.[136] These consistent estimates of direct and total costs demonstrate a strong economic argument for ACE prevention in addition to expected health benefits.

ACEs and the associated negative consequences are preventable. At an individual, family, and community level, there are important protective factors. Examples include supportive and loving parents and access to safe, engaging after-school programs and activities within the community.[10] State and national policies also have a critical role in supporting families and creating healthy communities. This includes reducing stressors in families, such as ensuring access to basic needs (e.g., food, housing, and economic security) and tackling issues such as substance misuse and suicide.[137] Public health plays an important role by analyzing data to create a more comprehensive understanding of the burden of ACEs, implementing strategies to strengthen protective factors, evaluating programs and policies, disseminating best practices, and coordinating cross-sector partnerships.

Trends in Drug Overdose Deaths

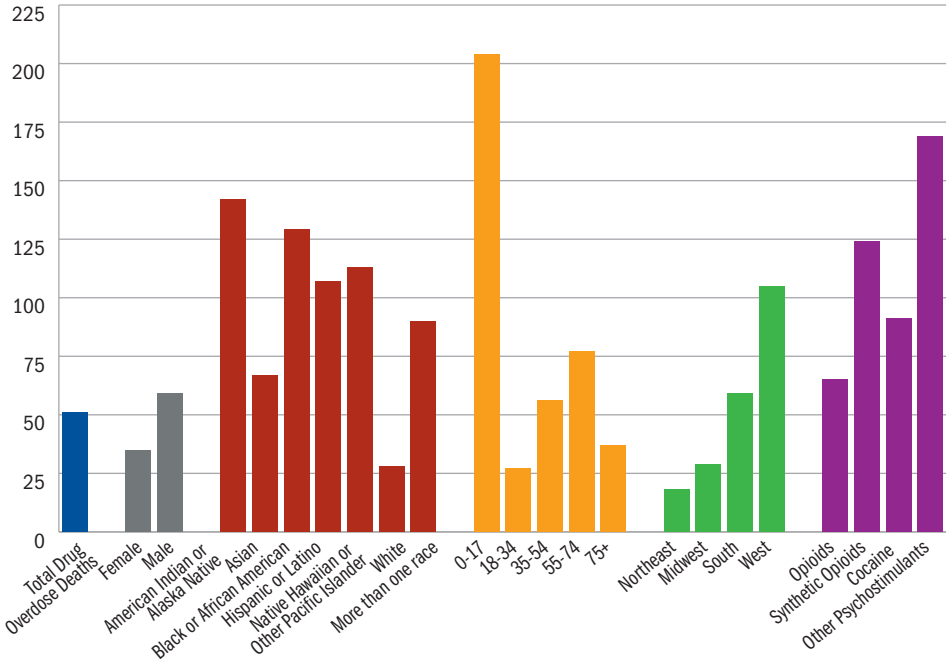
- In 2023, 105,007 Americans of all ages died from drug overdoses (an age-adjusted rate of 31.3 deaths per 100,000 people) and 782,771 Americans died from drug overdoses from 2014 to 2023.
- Drug overdose death rates in 2023 were highest among AI/AN people (65.0 deaths per 100,000 people), adults ages 35 to 54 (57.3 deaths per 100,000 people), Black Americans (48.9 deaths per 100,000 people), and males (44.3 deaths per 100,000 people).
- Mortality trends varied by group in 2023, including differences across race/ethnicity, age group, and region. For more analysis of drug overdose mortality trends across populations, see the Feature section on page 7.

Figure 10: Age-Adjusted Drug Overdose Mortality Rate (Deaths per 100,000 People) Overall and by Select Demographics and Region, 2023



Source: TFAH analysis of National Center for Health Statistics data.

Figure 11: Percent Change in Drug Overdose Mortality Rates by Select Demographics and Region, 2018–2023

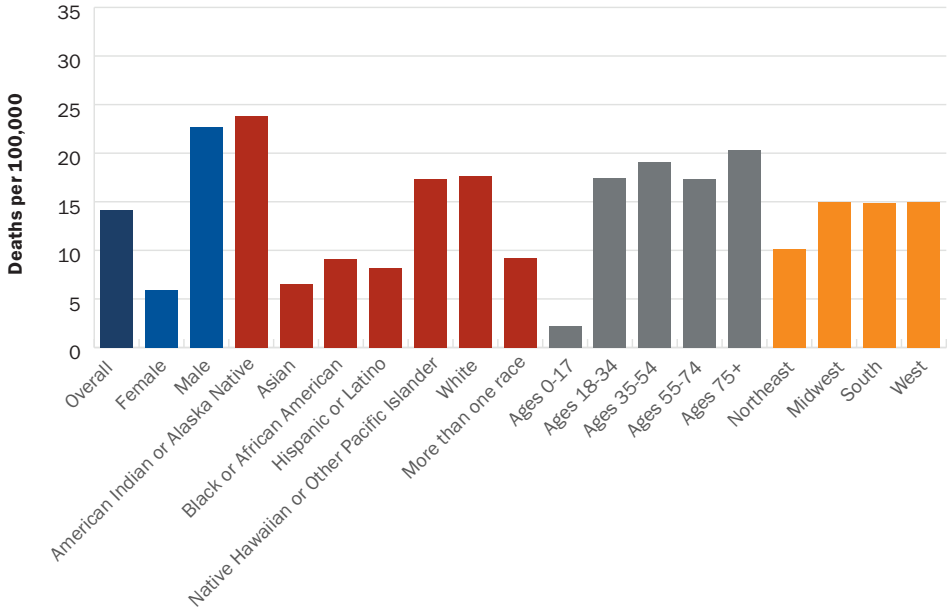


Source: TFAH analysis of National Center for Health Statistics data.

Trends in Deaths by Suicide

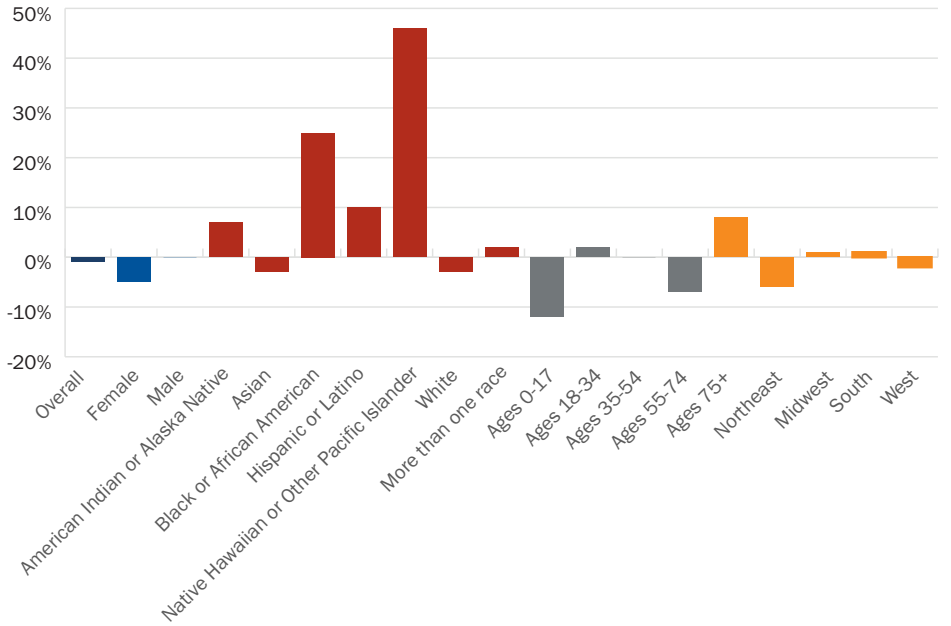
- In 2023, 49,316 Americans of all ages died from suicide, and 467,966 Americans died from suicide during the decade from 2014 to 2023.
- The overall age-adjusted suicide rate remained unchanged in 2023, shifting from 14.2 deaths per 100,000 people in 2022—the highest rate since 1941—to 14.1 deaths per 100,000 people in 2023.[138] In the past 10 years, deaths from suicide increased from 2012 through 2018, decreased in 2019 and 2020, then increased again in 2021 to match the previous peak in 2018, and stayed the same in 2022 and 2023.
- Age-adjusted suicide rates in 2023 were highest among AI/AN people (23.8 deaths per 100,000 people), males (22.7 deaths per 100,000 people), and adults ages 75 and older (20.3 deaths per 100,000 people).
- Mortality trends from 2022 to 2023 varied by populations. In particular, the experiences across racial/ethnic groups ranged from large decreases among AI/AN and multiracial people to large increases among NHOPI people; Black, Hispanic/Latino, and white people had little or no change in suicide mortality.
- Suicide by firearm and suffocation/hanging have both increased substantially over the last 15 years. Between 2008 and 2023, rates of firearm suicides increased by 31 percent and rates of suffocation/hanging suicides increased by 28 percent. At the same time, the rate of poisoning/overdose mortality decreased.

Figure 12: Age-Adjusted Suicide Mortality Rate (Deaths per 100,000 People) Overall and by Select Demographics and Region, 2023



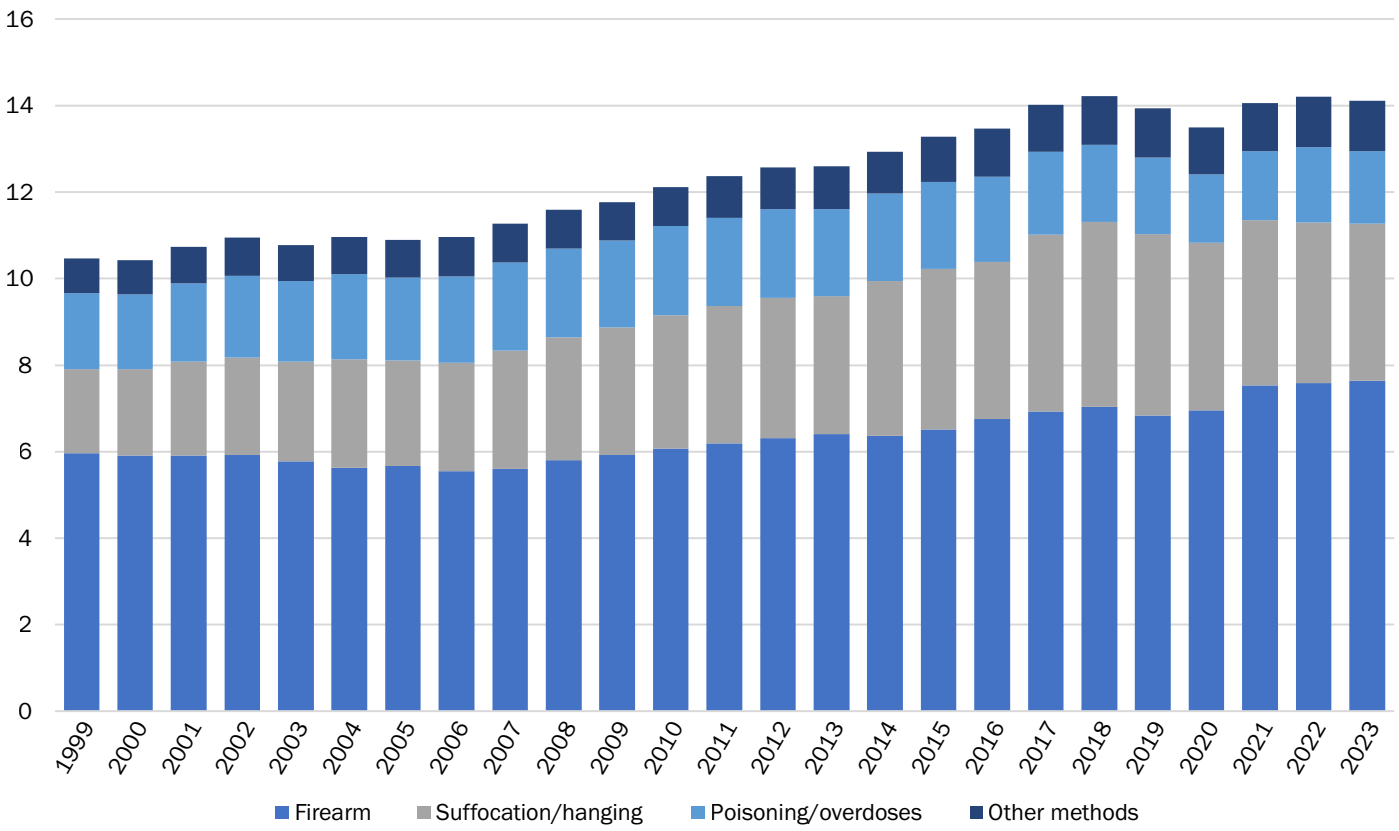
Source: TFAH analysis of National Center for Health Statistics data.

Figure 13: Percent Change in Suicide Mortality Rates by Select Demographics and Region, 2018–2023



Source: TFAH analysis of National Center for Health Statistics data.

Figure 14: Annual Age-Adjusted Suicide Rate (Deaths Per 100,000 People) By Suicide Method, 1999–2023



Source: TFAH analysis of National Center for Health Statistics data.

HEALTH BEHAVIORS AND WELL-BEING OF AMERICAN HIGH SCHOOL STUDENTS

In August 2024, CDC released the 2013–2023 Youth Risk Behavior Survey Data Summary and Trends Report that tracks high-level trends of health behaviors—including substance use, mental health, and suicidal behaviors—among high school students in the United States. Youth Risk Behavior Survey (YRBS) is a long-standing survey that has been conducted every other year since 1991.[139]

The most recent YRBS report found 22 percent of high school students reported drinking alcohol over the prior 30 days, 29 percent of high school students reported their mental health was not good most of the time or always, and 20 percent of high school students reported seriously considering attempting suicide in 2023.[140] The trends varied by demographic group; for example, there were increases in the percentage of Black students who currently drank alcohol and decreases in poor mental health and suicidal thoughts and behaviors among Hispanic students. Across all substance use behaviors (alcohol and drug use) in 2023, broad trends emerged among female and lesbian, gay, bisexual, transgender, queer (LGBTQ+) students who were more likely to engage in substance use behaviors. Compared with their cisgender and heterosexual classmates, LGBTQ+ students were twice as likely to have ever used illegal drugs and misused prescription opioids.[141]

Over the last 10 years, YRBS data shows that many important markers of substance use are improving among high school students, while mental health and suicide behavior indicators have worsened. In the past 10 years, the percentage of high school students who have ever used select illicit drugs has declined from 16 percent and 17 percent for males and females, respectively, to 10 percent for both. This includes decreases in the percentage of Black, Hispanic, and white students who are currently misusing prescription opioids and who have ever used select illicit drugs.[142] On the other hand, almost all indicators involving suicidal thoughts or behaviors have shown increases in 10-year trends across nearly every demographic—including 40 percent of high school students reporting that they felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing their usual activities. Worse, 9 percent of high school students attempted suicide one or more times in the past year with a continuing pattern of higher rates among female and LGBTQ+ youth. Some of these changes seen in the 10-year trends are likely tied to large increases during the COVID-19 pandemic.[143]

In the last two years (2021 to 2023), YRBS data shows more mixed, and in some cases, tentatively positive trends. For example, there were small decreases for female students who experienced persistent feelings of sadness or hopelessness in the past year (57 percent in 2021 to 53 percent in 2023) and seriously considered attempting suicide (30 percent in 2021 to 27 percent in 2023). Other positive signs include lower rates of Hispanic students reporting experiencing persistent feelings of sadness or hopelessness, making a suicide plan, and seriously considering suicide; and lower rates of Black students reporting attempting suicide and being injured in a suicide attempt.[144]

The YRBS report also includes information on high school students' experiences with education, family, and social environment, including items like unstable housing, racism in school, unfair discipline in school, and high levels of social media use. The report found 11 percent of NHOPI students reported experiencing unstable housing during the prior 30 days, and 77 percent of all high school students reported using social media several times a day. Across all demographic groups, 32 percent of students reported experiencing racism or bad/unfair treatment due to their race in school, with higher rates among Asian students. These kinds of student experiences have an important connection to mental health and well-being. One study using YRBS data found that students who are unfairly disciplined are associated with more health risk behaviors and mental health issues.[145] School-based capacity-building programs to reduce student stress and increase the mental health workforce are all part of a larger solution to the barriers young people are facing as part of the country's mental health crisis.[146]

B. State Analysis

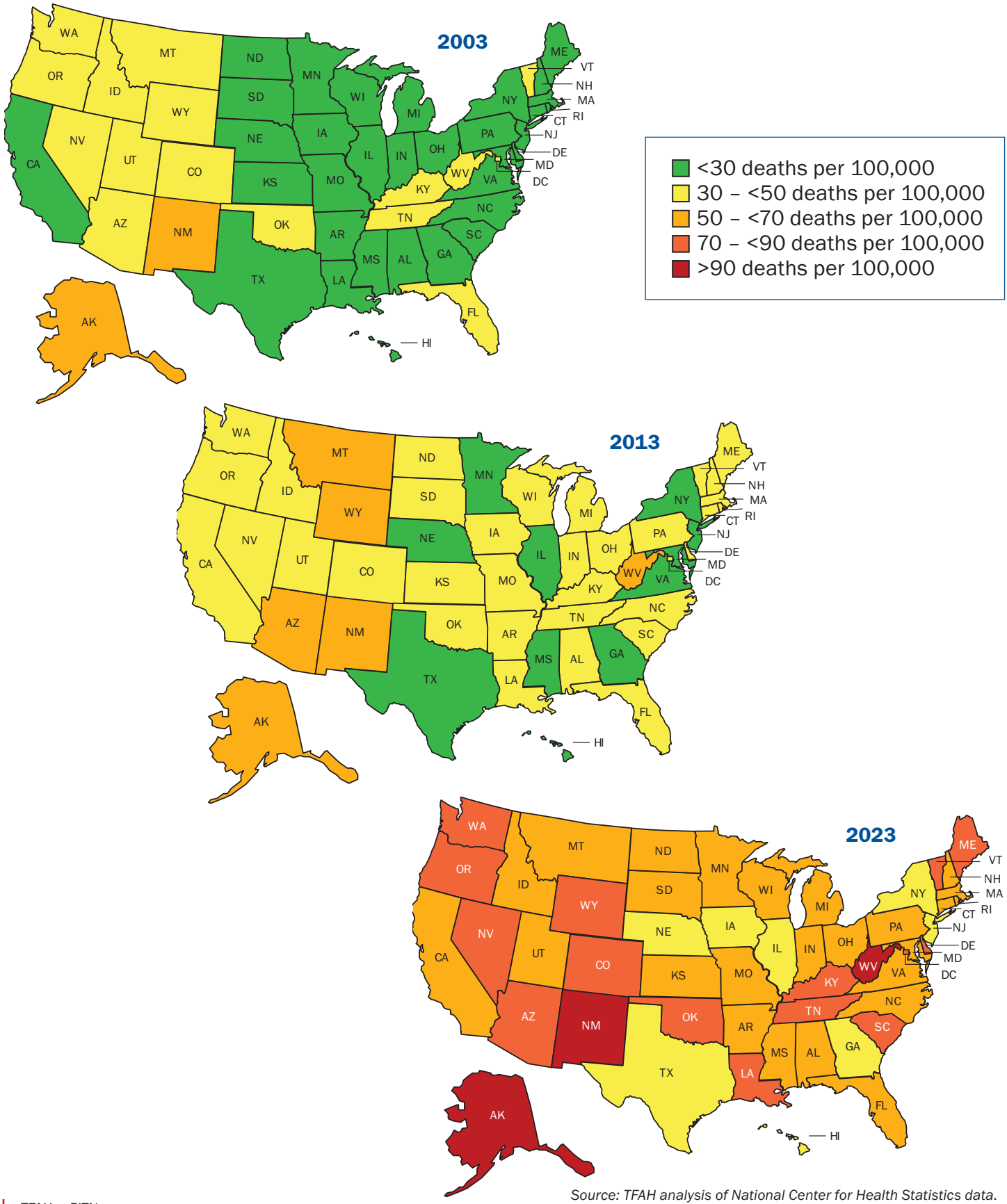
The rates and trends for total U.S. deaths caused by alcohol, drugs, and suicide vary across regions and states. This section includes state-level analysis. Charts on page 42 in Appendix C have state-level data and yearly trends on combined and separate alcohol, drug, and suicide deaths and death rates, as well as overdoses by certain drug types (opioids, synthetic-opioids, cocaine, and other psychostimulants).

- **Deaths from alcohol, drugs, and suicides.** In 2023, most states saw improvements in their rates of age-adjusted rates of death from combined alcohol, drugs, and suicide as compared with 2022: 43 states and the District of Columbia had lower rates, five states had higher rates (Alabama, Alaska, Nevada, Utah, and Washington state), and two states stayed the same (Oklahoma and West Virginia).
  - States with the highest age-adjusted death rates from alcohol, drugs, and suicide combined in 2023 were West Virginia (114.3 deaths per 100,000 people), Alaska (110.7 deaths per 100,000 people), and New Mexico (109.7 deaths per 100,000 people).
  - States with the lowest age-adjusted death rates from alcohol, drugs, and suicide combined in 2023 were Nebraska (37.8 deaths per 100,000 people), New Jersey (42.4 deaths per 100,000 people), Hawaii (42.6 deaths per 100,000 people), and Texas (42.7 deaths per 100,000 people).
- **Alcohol-induced deaths.** In 2023, 45 states and the District of Columbia had lower age-adjusted alcohol death rates compared with 2022, and five states (Arkansas, Idaho, Kansas, Maryland, and Utah) had higher rates.
  - States with the highest age-adjusted alcohol death rates in 2023 were New Mexico (37.6 deaths per 100,000 people), Alaska (33.2 deaths per 100,000 people), and South Dakota (29.7 deaths per 100,000 people).
  - States with the lowest age-adjusted alcohol death rates in 2023 were Hawaii (5.5 deaths per 100,000 people), New Jersey (6.5 deaths per 100,000 people), Louisiana (8.0 deaths per 100,000 people), and Pennsylvania (8.0 deaths per 100,000 people).
- **Drug overdose deaths.** In 2023, 37 states and the District of Columbia had lower age-adjusted drug-overdose mortality rates compared with 2022, and 13 states had higher rates. Notably, many states in the West had very large increases, including Alaska, Nevada, Oregon, and Washington, which all increased by more than 25 percent from 2022 to 2023.
  - States with the highest age-adjusted drug overdose death rates in 2023 were West Virginia (81.9 deaths per 100,000 people), Delaware (53.0 deaths per 100,000 people), and Tennessee (52.3 deaths per 100,000 people) plus the District of Columbia (60.7 deaths per 100,000 people).
  - States with the lowest age-adjusted drug overdose death rates in 2023 were Nebraska (9.0 deaths per 100,000 people), South Dakota (11.2 deaths per 100,000 people), and Iowa (14.9 deaths per 100,000 people).
- **Deaths by suicide.** In 2023, the age-adjusted suicide mortality rate by state was mixed compared with 2022: 28 states plus the District of Columbia had lower rates, 21 states had higher rates, and one state (Louisiana) stayed the same.
  - States with the highest age-adjusted suicide rates in 2023 were Alaska (28.2 deaths per 100,000 people), Montana (26.6 deaths per 100,000 people), and Wyoming (26.3 per 100,000).
  - States with the lowest age-adjusted suicide rates in 2023 were New Jersey (7.2 deaths per 100,000 people), New York (8.3 deaths per 100,000 people) and Massachusetts (8.6 deaths per 100,000 people) plus the District of Columbia (5.7 deaths per 100,000 people).

DATA LIMITATIONS: WHAT THIS DATA *DOES NOT* SAY

This section focuses on mortality from alcohol, drugs, and suicide in 2023 and other recent trends. It does not capture local trends, events in 2024 or 2025 (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 substance use disorders. 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, 2003, 2013, and 2023



Source: TFAH analysis of National Center for Health Statistics data.

Policy Recommendations

On March 27, 2025, the U.S. Department of Health and Human Services (HHS) announced a widespread restructuring across the agency. This restructuring included a substantial reduction in workforce and elimination of programs devoted to injury and suicide prevention, and behavioral health. The reduction in force was estimated to decrease the HHS workforce from 82,000 full-time employees to 62,000 thus far, and includes significant cuts to the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Center for Injury Prevention at the Centers for Disease Control and Prevention (CDC).[147] The restructuring also consolidates several HHS agencies, including some programs from SAMHSA and CDC, into a new Administration for a Healthy America. Additionally, the Injury Center was proposed for elimination in the Administration's topline Budget request for fiscal year 2026 to Congress. These actions followed the Administration's claw-back of roughly $11.4 billion in public health funding already at work in states and communities across the country, including for suicide prevention.[148]

Amid these significant changes, the following recommendations for policymakers represent TFAH's research on the programs and policies that are needed to improve the nation's behavioral health outcomes. Reducing deaths from alcohol, drugs, and suicide requires a sustained commitment to primary prevention and to the workforce, programs, and systems that enable communities to address these epidemics.

Editor's note: These recommendations were finalized in April 2025.

A. Invest in Prevention and Conditions that Promote Health

Congress should provide robust funding for CDC's National Center for Injury Prevention and Control, and the Administration should fully restore the center's workforce. The Injury Center empowers and funds public health departments to implement community-driven, evidence-based prevention strategies to reduce overdoses, suicide, and adverse childhood experiences. Unique among federal agencies, CDC adopts a population-level approach to the underlying causes of negative behavioral health outcomes to maximize the impact of federal funding. The Injury Center's innovative data and surveillance systems also help communities detect and forecast changes in suicide and overdoses to better deploy limited resources. Injury Center efforts also provide a critical complement to other federal approaches focused on harm reduction or treatment: for example, states rely on Overdose Data to Action support to use data best practices to guide the distribution of naloxone to the most vulnerable populations and communities. The reduction of Injury Center staff due to the HHS restructuring and proposed reorganization of its remaining work will limit state and local health department capacity to prevent injuries in communities across the United States.

- Congress and HHS should support policies and programs that reduce adverse childhood experiences (ACEs) and the impact of trauma, and promote positive childhood experiences. 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 positive childhood experiences.
- Congress should pass the Preventing Adverse Childhood Experiences Act to authorize funding for CDC's Adverse Childhood Experiences program, which monitors the prevalence of ACEs and researches and disseminates evidence-based strategies to prevent ACEs and their negative effects and to promote positive childhood experiences. 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.[149]
- 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 school-based programs; 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.[150,151]
- 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 SAMHSA for the National Child Traumatic Stress Network. Importantly, this network recognizes the value 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 and health insurers should expand coverage and training for screening of suicide risk in primary care, pregnancy care, and other settings.

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.[152]

- 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.[153]
- The Community Preventive Services Task Force should also consider issuing recommendations regarding suicide prevention interventions focused on populations at disproportionate risk, youth suicide clusters and contagion, and perinatal risks, as well as connectedness promotion in schools.

Congress and federal agencies should increase support for substance use prevention, mental health, and resiliency programs in all schools. Schools are an ideal location for prevention and early intervention, but they need the resources to perform these functions and effectively partner with healthcare systems to address the social, relational, and mental health needs of children and youth.[154] Specifically, schools need support to increase: (1) training for staff in their understanding and responses to childhood trauma, promoting positive childhood experiences 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.[155]

- Congress should pass the Advancing Student Services in Schools Today Act (or the "ASSIST Act"), which would establish a grant program to increase the number of mental health providers in schools and implement a 90 percent increase in federal matching funds to pay for these services.[156,157] Similarly, passage of the Mental Health Services for Students Act 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.[158,159]
- 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. State policymakers should also work to reduce barriers to reimbursement for school-based health centers, which can provide comprehensive mental health services for children.[160]
- 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.[161] 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.[162]

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.[163]

- Congress can support upstream approaches to behavioral health by passing the Early Action and Responsiveness Lifts Youth Minds Act (or "EARLY Minds Act") to allocate funding for prevention and early intervention services within SAMHSA's Community Mental Health Services Block Grant.[164]
- Passage of the Helping Kids Cope Act would also expand the availability of community-based pediatric mental healthcare, bolster the pediatric behavioral health workforce, and strengthen pediatric mental health infrastructure to support a full continuum of care.[165,166]
- Congress should increase access to behavioral healthcare for youth by supporting pediatric behavioral healthcare integration and workforce training and by improving related infrastructure, including through passage of the Strengthen Kids' Mental Health Now Act.[167]

- Congress should invest in an expanded 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.[168,169]
- Congress should also 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.[170,171] 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.[172]

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 supporting the primary prevention of youth substance misuse functions as a priority for any opioid litigation settlement funds. ONDCP should support this process by building on its 2021 model law concerning settlement funding.

Congress should invest in capacity to address the non-medical drivers of health. Challenging 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 physical and mental health across the lifespan, including rates of substance use disorder. Congress should ensure that CDC is able to continue its research to incorporate best practices related to nonmedical drivers of health conditions. The Centers for Medicare and Medicaid Services should also continue to support state efforts to address beneficiaries' health-related social needs.

Congress, SAMHSA, and other agencies should strengthen capacity to address the behavioral health impacts of weather-related disasters and other environmental risk. 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 social determinants of health that lead to poor behavioral health outcomes.

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.[173]

- 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.[174]
- 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, including veterans; and providing education and creating protocols for healthcare providers, counselors, and first-responders on counseling patients and families to create safe environments.

- Congress should maintain 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, including rural communities.[175] Evidence-based research into these priorities can reduce firearm-related injuries, identify populations at risk of suicide, and evaluate new forms of interventions.
- 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.[176,177] Federal agencies like SAMHSA should also work to incorporate lethal means assessments and counseling into standard procedures for their mental health crisis lines.[178]
- 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.[179,180]
- 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.[181]

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 and best-practice treatment options. Congress and/or federal agencies should enable additional flexibility in federal overdose and substance use disorder prevention grants to allow states to address substances other than opioids 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.[182] 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 LIFELINE IMPROVEMENTS AND CHALLENGES

The 988 Suicide and Crisis Lifeline has answered more than 14 million calls, texts, and chats from individuals in need of support since its launch in July 2022.[183] In October 2024, the Federal Communications Commission (FCC) approved rules that implemented georouting for the 988 Lifeline, requiring wireless providers to route calls and texts to local crisis centers based on geographic location instead of area code.[184] FCC explained that experts had "expressed that connecting callers in crisis with local crisis centers is important to connect those in need with life-saving public health and safety resources and enable them to speak with local counselors who may be more familiar with cultural issues or community stressors in the caller's area."[185] FCC also noted that the majority of calls to the 988 Lifeline came from wireless phones.[186]

Since its launch, the 988 Lifeline has seen increasing call volume and improved answer and wait times. For example, more than half a million contacts to the Lifeline—including calls, texts, and chats—occurred in May 2024, an increase of 80 percent since May 2022.[187] Overall answer rates also increased from 70 percent in May 2022 to 89 percent in May 2024, and wait times fell by almost one minute during the same period.[188] In terms of specialized support, contacts to the LGBTQI+ service rose from 40,423 contacts at the time the full service launched to 59,350 contacts in December 2024.[189] Contacts to the Spanish-language service also rose from 6,757 contacts in July 2023—the month when Spanish chat and text services started—to 11,568 contacts in December 2024.[190]

Despite these improvements, the Lifeline continues to face challenges as it approaches its three-year anniversary in July 2025. According to a National Alliance on Mental Illness–Ipsos poll from May 2025, for example, only 67 percent of respondents said they were aware of the Lifeline, and only 23 percent said they were "at least somewhat familiar" with it.[191] Concerningly, slightly more than half of Americans were not certain about the situations that would warrant contacting the Lifeline.[192]

Beyond public awareness, most states and other jurisdictions have not permanently funded Lifeline efforts, despite a previous expectation from Congress that states would establish long-term funding mechanisms.[193,194] In fact, only 10 states have enacted monthly telecommunications fees to support the Lifeline as of a June 2024 report from Inseparable.[195]

In February 2025, more than 10 percent of staff working for SAMHSA (the agency that administers the Lifeline) were laid off.[196] These staffing cuts included individuals working on projects related to the Lifeline. Evidence also suggests that 988 call centers have suffered from high rates of employee burnout and staff turnover. According to reporting in February 2024, for example, staff attrition rates in Washington state jumped from 19 percent in 2022 to 30 percent in 2023, more than one-third of Oklahoma staff has left since July 2022, and turnover rates in Colorado reached 40 percent for call center employees on the job for more than three months and 60 percent for those working less than three months.[197] Additional SAMHSA staff were cut in April 2025.[198]

More broadly, a January 2025 study found a significant decrease in emergency psychiatric walk-in services at mental health treatment facilities following the July 2022 launch of the Lifeline.[199] The study authors noted that the "launch of 988 did not coincide with significant and equitable growth in the availability of most crisis services," which highlights the need for strategies to "boost the financing and availability of crisis services to reduce disparities."[200]

C. Transform the Mental Health and Substance Use Prevention System

Congress and SAMHSA should bolster the continuum of crisis intervention programs and supports. Congress and the Administration should strengthen the 988 Suicide and Crisis Lifeline through increased SAMHSA funding and by restoring the workforce devoted to these services. Congress should also pass 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.[201] The bill would also authorize funding for mobile crisis units and extend Medicare, Medicaid, and TRICARE coverage for crisis-response services.[202]

- In addition, Congress should pass the Stabilization to Prevent Suicide Act (or "STOP Suicide Act"), which would create a SAMHSA grant program to expand the use of evidence-based models for stabilizing individuals with serious thoughts of suicide virtually or in outpatient settings.[203]
- 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.[204]
- Congress should also pass the Crisis Counseling Act to streamline the process of providing crisis counseling to states after disaster declarations. Centers for Medicare & Medicaid Services and other agencies can also assist by considering in advance the necessary waivers to ensure continuity of care for individuals in treatment.[205]
- 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 substance use disorders 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 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 substance use disorder services under Medicaid and Medicare, support access to telehealth services, and incentivize behavioral health integration.[206,207] 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.[208,209]

- 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.[210]
- 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.[211]

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 substance use disorder benefits based on nationally recognized standards. Other congressional initiatives to expand access to care should include:

- Passage of the Medicaid Bump Act to increase the federal reimbursement rate for state Medicaid spending on mental health and substance use disorder treatment greater than 2019 levels.[212,213]
- Passage of the Reentry Act to allow incarcerated individuals to receive medical services supported by Medicaid—including substance use disorder treatment—30 days before the end of their incarceration to reduce overdose risk.[214]

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.

- 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").[215] This reauthorization should also provide prevention resources to address upstream factors like ACEs that can increase the risk of substance use disorder.

- 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.[216,217]

Congress should promote equity in mental health with a specialized workforce and targeted services to reduce disparities in access and outcomes. 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.[218] Passage of the Health Equity and Accountability Act would also help reduce health disparities by improving data reporting, supporting a strong and specialized workforce, and increasing access to targeted care.[219] In addition, continued congressional support for SAMHSA's Minority Fellowship Program will help increase the diversity of mental health and substance use 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.[220,221]
- Congress and the Administration should ensure timely, complete, disaggregated demographic data collection and reporting, including during public health emergencies.
- Congress should increase CDC's Surveillance, Epidemiology, and Informatics budget to expand programs like the National Syndromic Surveillance Program, which currently covers 80 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 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 community members, including educators, healthcare professionals, justice system officials, and the media.[222]

Appendix A: Data Methodology

Unless otherwise referenced, data in this report are from the National Center for Health Statistics' Multiple Cause of Death Files, 1999–2023, accessed via CDC's 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.

Due to recent updates in racial/ethnic data reporting, analogous data is not available for racial/ethnic groups across all years with data (1999–2023).

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, 2023

	Combined Alcohol, Drug, and Suicide			Alcohol-Induced			Drug Overdose			Suicide		
	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023
Overall	**201,582**	**57.8**	**-4%**	**47,938**	**12.6**	**-7%**	**105,007**	**31.3**	**-4%**	**49,316**	**14.1**	**- < 1%**
Female	53,604	31.9	-1%	13,933	7.3	-6%	30,818	18.3	-6%	10,270	5.9	-1%
Male	147,978	85.5	-3%	34,005	18.1	-7%	74,189	44.3	-3%	39,046	22.7	-1%
American Indian and Alaska Native	3,669	151.6	-12%	1,512	61.5	-22%	1,548	65.0	0%	577	23.8	-12%
Asian	3,124	14.2	-2%	684	3.0	2%	1,110	5.1	-4%	1,407	6.5	-5%
Black	30,009	68.0	1%	4,101	9.1	-6%	21,547	48.9	3%	3,911	9.1	2%
Hispanic or Latino	26,949	43.1	-2%	7,118	12.1	-8%	14,520	22.8	1%	5,281	8.2	1%
Native Hawaiian and Pacific Islander	346	52.0	27%	44	6.7	-6%	174	26.2	39%	116	17.3	21%
White	133,582	63.9	-5%	33,855	13.8	-6%	63,659	33.1	-7%	37,217	17.6	0%
More than one race	2,451	40.4	-3%	386	7.5	-6%	1,443	23.6	2%	628	9.2	-13%
0-17	2,503	3.4	0%	< 20	< 0.1	--	1,001	1.4	-1%	1,604	2.2	1%
18-34	41,760	54.9	-7%	2,871	3.8	-9%	26,095	34.3	-10%	13,272	17.4	-2%
35-54	81,857	96.4	-4%	17,181	20.2	-7%	48,598	57.3	-4%	16,186	19.1	0%
55-74	66,033	86.3	-1%	24,606	32.1	-8%	27,995	36.6	4%	13,278	17.3	-1%
75+	9,414	38.3	-1%	3,267	13.3	-2%	1,305	5.3	9%	4,975	20.3	-4%
Northeast	31,240	52.0	-7%	5,986	9.0	-9%	19,190	33.1	-7%	6,148	10.1	-2%
Midwest	40,607	57.4	-7%	10,369	13.3	-8%	19,984	29.6	-9%	10,630	15.0	-2%
South	76,707	57.3	-4%	16,286	10.9	-6%	40,344	31.4	-6%	20,119	14.9	1%
West	53,028	63.4	1%	15,297	17.3	-7%	25,489	31.4	8%	12,419	15.0	-2%

	Opioid Overdose			Synthetic Opioid Overdose			Cocaine Overdose			Other Psychostimulants Overdose		
	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-Adjusted)	2022 to 2023
Overall	**79,358**	**24.0**	**-4%**	**72,776**	**22.2**	**-2%**	**29,449**	**8.6**	**5%**	**34,855**	**10.6**	**1%**
Female	22,390	13.6	-6%	19,420	11.9	-4%	7,845	4.7	1%	9,559	5.9	0%
Male	56,968	34.5	-3%	53,356	32.4	-2%	21,604	12.6	7%	25,296	15.3	2%
American Indian and Alaska Native	1,170	49.4	5%	1,099	46.5	7%	189	7.6	-2%	785	33.3	2%
Asian	695	3.2	1%	647	3.0	5%	259	1.2	2%	394	1.8	3%
Black	16,481	37.6	3%	15,798	36.1	4%	10,936	24.3	8%	4,000	9.4	17%
Hispanic or Latino	11,310	17.6	2%	10,630	16.5	3%	4,230	6.7	3%	4,659	7.4	7%
Native Hawaiian and Pacific Islander	104	15.6	88%	94	14.1	83%	21	3.0	n/a	108	16.4	20%
White	47,754	25.5	-8%	42,776	23.2	-6%	13,165	6.9	3%	23,916	12.5	-3%
More than one race	1,082	17.1	6%	1,024	16.1	10%	302	5.0	16%	611	10.8	8%
0-17	807	1.1	3%	765	1.1	4%	51	< 0.1	--	98	0.1	-14%
18-34	22,073	29.0	-10%	21,005	27.6	-9%	6,129	8.1	-1%	8,113	10.7	-4%
35-54	37,492	44.2	-2%	34,733	40.9	-1%	13,639	16.1	3%	17,986	21.2	1%
55-74	18,437	24.1	3%	15,966	20.9	6%	9,441	12.3	17%	8,540	11.2	11%
75+	539	2.2	12%	297	1.2	30%	182	0.7	76%	113	0.5	81%
Northeast	16,022	27.9	-8%	14,994	26.3	-8%	8,712	14.9	5%	2,666	4.9	9%
Midwest	15,464	23.2	-9%	14,317	21.6	-9%	6,363	9.2	4%	5,731	8.9	5%
South	29,533	23.4	-8%	26,959	21.4	-6%	10,977	8.3	2%	13,735	11.2	5%
West	18,339	22.9	14%	16,506	20.8	19%	3,397	4.1	19%	11,890	14.7	-11%

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, 2023

	Combined Alcohol, Drug, and Suicide			Alcohol-Induced			Drug Overdose			Suicide		
	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023
Overall	**201,582**	**57.8**	**-4%**	**47,938**	**12.6**	**-7%**	**105,007**	**31.3**	**-4%**	**49,316**	**14.1**	**- < 1%**
Alabama	3,086	61.0	6%	529	8.8	-1%	1,608	33.9	7%	869	16.8	3%
Alaska	825	110.7	8%	260	33.2	-9%	359	49.4	44%	206	28.2	2%
Arizona	5,591	73.1	-8%	1,483	18.2	-10%	2,624	36.1	-3%	1,506	19.2	-7%
Arkansas	1,527	49.3	-3%	394	11.7	3%	516	17.7	-18%	626	20.2	12%
California	21,980	52.7	-6%	6,410	14.7	-5%	11,378	27.9	4%	4,200	10.2	-3%
Colorado	4,609	73.6	-6%	1,557	24.0	-2%	1,872	30.6	3%	1,297	20.9	-1%
Connecticut	2,149	55.5	-15%	479	11.2	-7%	1,318	35.2	-13%	356	9.1	-14%
Delaware	790	75.3	-10%	129	10.4	-26%	525	53.0	-4%	144	12.8	13%
DC	556	79.5	-11%	82	12.2	-16%	427	60.7	-6%	41	5.7	-5%
Florida	13,626	56.7	-11%	3,168	11.2	-4%	7,010	31.7	-10%	3,620	14.4	2%
Georgia	5,508	48.5	-5%	1,237	10.0	-6%	2,570	23.6	-6%	1,670	14.8	1%
Hawaii	647	42.6	-6%	93	5.5	-23%	320	21.4	15%	223	15.3	-8%
Idaho	1,207	60.3	-1%	373	17.1	1%	386	20.5	-1%	460	23.3	5%
Illinois	6,445	48.8	-11%	1,426	10.2	-11%	3,525	27.3	-9%	1,567	11.9	1%
Indiana	4,337	62.8	-13%	957	12.4	-18%	2,244	34.2	-17%	1,187	17.0	4%
Iowa	1,454	44.4	-11%	530	15.3	-9%	462	14.9	-2%	504	15.5	-16%
Kansas	1,682	56.7	-8%	499	15.7	1%	653	22.8	-14%	569	19.6	-5%
Kentucky	3,552	78.1	-7%	632	12.0	-4%	2,077	48.0	-10%	813	17.5	-3%
Louisiana	3,400	74.8	-5%	426	8.0	-14%	2,224	50.6	-7%	719	15.6	0%
Maine	1,150	78.9	-15%	297	17.0	-8%	598	44.9	-17%	274	18.5	4%
Maryland	3,745	57.2	-7%	600	8.7	1%	2,550	39.3	-2%	599	9.3	-2%
Massachusetts	3,957	53.2	-13%	882	10.7	-10%	2,387	33.6	-10%	658	8.6	4%
Michigan	5,896	56.9	-5%	1,563	13.7	-1%	2,882	28.9	-6%	1,529	14.9	2%
Minnesota	3,295	54.7	-9%	1,075	16.5	-8%	1,331	23.6	-5%	812	13.8	-7%
Mississippi	1,563	52.9	-4%	388	11.5	-11%	702	25.3	-8%	457	15.5	11%
Missouri	3,892	62.4	-10%	778	11.2	-16%	1,986	33.5	-9%	1,143	18.0	-6%
Montana	791	66.3	-15%	304	23.5	-14%	188	17.1	-12%	310	26.6	-7%
Nebraska	759	37.8	-18%	312	14.9	-17%	172	9.0	-24%	284	14.5	-7%
Nevada	2,700	77.7	2%	760	20.2	-2%	1,282	38.1	26%	690	20.3	-3%
New Hampshire	905	60.7	-17%	246	13.6	-20%	440	32.7	-9%	221	14.6	-12%
New Jersey	4,093	42.2	-13%	681	6.5	-11%	2,688	28.3	-11%	709	7.2	-6%
New Mexico	2,320	109.7	-6%	829	37.6	-12%	993	48.9	-3%	489	22.8	-8%
New York	9,868	47.6	-7%	1,829	8.3	-6%	6,330	31.1	-1%	1,717	8.3	-2%
North Carolina	6,561	59.3	-14%	1,407	11.1	-10%	3,520	33.7	-19%	1,597	14.3	-1%
North Dakota	447	56.4	-13%	187	22.8	-9%	122	16.4	-17%	142	17.8	-21%
Ohio	8,150	68.0	-8%	1,662	12.1	-3%	4,745	41.6	-9%	1,792	14.7	-2%
Oklahoma	2,949	72.1	0%	781	18.0	-7%	1,278	32.4	6%	893	21.8	2%
Oregon	3,910	84.1	-1%	1,167	22.5	-8%	1,782	40.8	31%	888	19.4	1%
Pennsylvania	7,914	58.7	-10%	1,266	8.0	-11%	4,757	37.1	-9%	1,976	14.3	1%
Rhode Island	689	60.0	-10%	177	14.0	-8%	413	37.5	-2%	112	9.4	-11%
South Carolina	3,863	69.5	-11%	854	13.3	-13%	2,177	41.3	-8%	818	14.7	-4%
South Dakota	533	60.3	-8%	268	29.7	-14%	95	11.2	-1%	181	20.7	-4%
Tennessee	6,085	84.3	-8%	1,164	14.3	-13%	3,616	52.3	-7%	1,279	17.3	4%
Texas	13,272	42.7	-2%	3,305	10.3	-1%	5,687	18.5	1%	4,382	14.2	-1%
Utah	1,718	52.9	7%	385	12.0	2%	693	21.4	8%	706	21.5	-3%
Vermont	515	76.5	-8%	129	15.7	-6%	259	42.3	-8%	125	17.8	-1%
Virginia	4,602	50.8	-6%	906	9.1	-5%	2,480	28.5	-1%	1,243	13.6	2%
Washington	6,282	75.0	4%	1,515	16.9	-8%	3,477	42.4	26%	1,287	15.7	5%
West Virginia	2,022	114.3	0%	284	13.0	-5%	1,377	81.9	1%	349	18.6	1%
Wisconsin	3,717	60.0	-7%	1,112	15.8	-5%	1,767	30.6	-4%	920	15.0	-1%
Wyoming	448	74.9	-9%	161	25.9	-17%	135	23.7	8%	157	26.3	3%

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, 2023

	Opioid Overdose			Synthetic Opioid Overdose			Cocaine Overdose			Other Psychostimulants Overdose		
	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023	2023 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2022 to 2023
Overall	**79,358**	**24.0**	**-4%**	**72,776**	**22.2**	**-2%**	**29,449**	**8.6**	**5%**	**34,855**	**10.6**	**1%**
Alabama	1,202	25.7	10%	1,100	23.8	13%	309	6.2	20%	611	13.2	2%
Alaska	290	40.1	60%	274	38.2	77%	31	4.1	44%	199	27.0	38%
Arizona	1,950	27.3	-1%	1,774	25.1	1%	246	3.4	3%	1,378	19.0	1%
Arkansas	314	10.9	-21%	268	9.4	-18%	48	1.7	-34%	198	6.8	-28%
California	7,888	19.7	7%	7,203	18.1	11%	1,621	3.8	15%	6,151	15.0	6%
Colorado	1,304	21.6	11%	1,146	19.0	18%	295	4.7	11%	813	13.3	13%
Connecticut	1,187	31.9	-13%	1,108	30.1	-12%	627	16.8	6%	84	2.5	8%
Delaware	457	47.0	-6%	431	44.6	-5%	265	26.5	20%	60	6.5	-15%
DC	350	49.6	1%	343	48.7	5%	225	31.9	0%	24	3.3	n/a
Florida	5,049	23.3	-12%	4,593	21.5	-12%	2,004	8.9	-9%	1,827	8.5	-8%
Georgia	1,881	17.5	-6%	1,678	15.7	-4%	592	5.3	0%	971	9.1	-1%
Hawaii	133	9.4	33%	113	8.1	50%	31	2.1	2%	197	12.9	9%
Idaho	265	14.4	-2%	215	11.8	5%	22	1.2	n/a	157	8.4	12%
Illinois	2,893	22.5	-10%	2,651	20.6	-10%	1,452	11.1	-3%	553	4.6	2%
Indiana	1,699	26.4	-18%	1,587	24.7	-17%	475	7.1	0%	802	12.5	-16%
Iowa	253	8.4	6%	208	7.0	1%	40	1.2	-18%	221	7.3	6%
Kansas	423	14.9	-18%	355	12.8	-17%	75	2.5	-14%	269	9.8	-19%
Kentucky	1,625	38.1	-9%	1,475	35.0	-9%	297	6.8	19%	902	21.2	-12%
Louisiana	1,118	26.0	-18%	1,026	24.1	-14%	316	6.9	-9%	622	14.5	-5%
Maine	514	39.3	-19%	489	37.7	-16%	232	17.6	6%	194	15.0	-17%
Maryland	2,203	34.1	-4%	2,060	31.8	-3%	1,101	16.7	8%	145	2.4	1%
Massachusetts	2,109	30.0	-9%	2,012	28.7	-10%	1,231	17.5	0%	213	3.1	-5%
Michigan	2,305	23.4	-6%	2,145	22.0	-5%	1,183	11.6	7%	508	5.5	1%
Minnesota	994	18.1	-4%	935	17.0	-2%	252	4.2	13%	558	9.9	6%
Mississippi	493	18.1	-10%	449	16.6	-8%	121	4.1	9%	296	11.0	-8%
Missouri	1,458	25.0	-8%	1,358	23.4	-7%	321	5.1	-1%	729	12.5	-1%
Montana	129	12.0	-3%	99	9.5	0%	<20	--	--	93	8.5	0%
Nebraska	78	4.3	-35%	61	3.3	-40%	<20	--	--	62	3.2	-22%
Nevada	862	26.5	33%	710	22.2	54%	144	4.3	36%	719	21.2	35%
New Hampshire	399	30.2	-6%	380	29.0	-7%	74	5.6	15%	73	5.4	-33%
New Jersey	2,350	25.0	-11%	2,196	23.4	-12%	1,199	12.5	1%	274	3.1	-23%
New Mexico	714	35.9	-1%	651	33.0	2%	171	8.2	-12%	504	25.1	2%
New York	5,308	26.2	-2%	4,936	24.5	-1%	3,230	15.7	11%	693	3.7	4%
North Carolina	2,915	28.4	-20%	2,745	26.8	-19%	1,320	12.3	-16%	1,083	10.8	-16%
North Dakota	87	11.7	-13%	76	10.2	-14%	<20	--	--	38	5.4	-8%
Ohio	3,805	34.0	-10%	3,590	32.2	-10%	1,777	15.1	7%	1,318	12.0	-6%
Oklahoma	836	21.7	10%	753	19.7	16%	123	3.0	37%	655	16.6	5%
Oregon	1,384	32.1	43%	1,272	29.8	50%	158	3.5	33%	1,072	24.4	43%
Pennsylvania	3,576	28.4	-11%	3,336	26.7	-11%	1,772	13.6	-2%	865	7.1	-10%
Rhode Island	347	32.2	5%	317	29.5	3%	219	20.5	13%	44	4.2	17%
South Carolina	1,717	33.4	-9%	1,563	30.7	-7%	609	11.0	4%	762	15.1	-8%
South Dakota	48	5.7	3%	42	5.1	11%	<20	--	--	32	3.9	-24%
Tennessee	2,930	42.9	-5%	2,771	40.8	-3%	876	12.4	20%	1,532	22.5	-3%
Texas	3,181	10.5	-1%	2,613	8.7	5%	1,567	5.0	9%	2,348	7.7	3%
Utah	499	15.4	14%	337	10.3	53%	69	2.1	69%	298	9.2	8%
Vermont	232	38.2	-7%	220	36.4	-6%	128	21.4	22%	21	4	-23%
Virginia	2,078	24.1	-2%	1,954	22.8	-2%	993	11.2	10%	560	6.6	-3%
Washington	2,835	35.0	36%	2,655	33.0	40%	597	7.1	61%	1,917	23.3	37%
West Virginia	1,184	71.6	2%	1,137	69.2	3%	211	12.3	21%	772	46.2	4%
Wisconsin	1,421	25.1	-3%	1,309	23.3	-3%	759	12.9	10%	387	7.2	-2%
Wyoming	86	15.0	4%	57	10.3	-5%	<20	--	--	51	9.3	5%

Note: Some data unavailable for privacy reasons.

Appendix D: National Substance Use and Mental Health Data

	Percentage of people 12+ using illicit drug in past year (2023)	Percentage of people 12+ report binge drinking in past month (2023)	Percentage of people 12+ who have a substance use disorder in past year (drug or alcohol) (2023)	Percentage of people 18+ who had any mental illness (2023)	Percentage of people 18+ Had Serious Thoughts of Suicide in the Past Year (2023)	Percent of high schoolers who reported mental health not good most of the time or always (2023)	Percent of high schoolers who seriously considered attempting suicide (2023)	What percentage of children ages 0-17 have ever experienced two or more ACES? (2022–2023)
Overall	**24.9**	**21.7**	**17.1**	**22.8**	**5.0**	**28.5**	**20.4**	**11.9**
Male	–	–	–	–	–	18.8	14.1	11.7
Female	–	–	–	–	–	38.8	27.1	12.1
American Indian and Alaska Native	36.7	19.1	25.3	23.5	4.7	42.3	24.5	–
Asian	12.4	10.7	9.2	18.1	4.2	23.0	14.4	2.0
Black	27.7	21.6	17.6	19.4	4.0	26.5	19.6	14.5
Hispanic or Latino	21.6	22.9	15.7	20.6	5.0	26.1	18.2	11.7
Native Hawaiian and Pacific Islander	n/a	n/a	n/a	n/a	2.6	14.9	16.1	–
White	26.1	22.4	17.8	24.0	5.0	31.4	22.1	11.8
More than one race	36.2	22.2	21.8	36.7	12.0	28.9	21.6	–
12 to 17	14.7	3.9	8.5	–	–	–	–	–
18 to 25	39.0	28.7	27.1	33.8	12.2	–	–	–
26 or Older	23.9	22.7	16.6	–	–	–	–	–
26 to 49	–	–	–	29.2	5.9	–	–	–
50 or Older	–	–	–	14.1	2.1	–	–	–

Notes and Sources for Appendix D and E

Illicit Drug Use Among 12+ Population

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

Source: Substance Abuse and Mental Health Service Administration. "2022-2023 NSDUH: Model-Based Estimated Prevalence For States." February 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.pdf . Accessed March 20, 2025.

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.

Source: NSDUH: Model-Based Estimated Prevalence For States." Februrary 2025. https://www. samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables- percents/2023-nsduh-sae-tables-percent.pdf . Accessed March 20, 2025.

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.

Source: Substance Abuse and Mental Health Service Administration. "2022-2023 NSDUH: Model-Based Estimated Prevalence For States." February 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.pdf . Accessed March 20, 2025.

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.

Source: NSDUH: Model-Based Estimated Prevalence For States." Februrary 2025. https://www. samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.pdf . Accessed March 20, 2025.

Serious Thoughts About Suicide Among 18+

Source: NSDUH: Model-Based Estimated Prevalence For States." Februrary 2025. https://www. samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables- percents/2023-nsduh-sae-tables-percent.pdf . Accessed March 20, 2025.

Poor Mental Health Among High Schoolers

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

Source: Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance System (YRBSS) Explorer." 2024. https://yrbs-explorer.services.cdc.gov/#/. Accessed March 26, 2024.

Seriously Considered Suicide Among High Schoolers

Source: Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance System (YRBSS) Explorer." 2024. https://yrbs-explorer.services.cdc.gov/#/. Accessed March 26, 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 in United States.” 2024. https://www.americashealthrankings.org/explore/measures/ACEs_8_overall . Accessed March 20, 2025.

2022–2023 National Survey of Children's Health

Appendix E: State Substance Use and Mental Health Data

	Illicit Drug Use Among 12+ Population (2022–2023)	Binge Drinking Among 12+ Population (2022–2023)	Substance Use Disorder Among 12+ Population (2022–2023)	Serious Mental Illness Among 18+ Population (2022–2023)	Serious Thoughts About Suicide Among 18+ Population (2022–2023)	Poor Mental Health Among High Schoolers (2023)	Seriously Considered Suicide Among High Schoolers (2023)	ACEs Among Children 0-17 (2022–2023)
	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 18+ had serious mental illness 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	12%	21%	16%	6%	5%	Not Available	Not Available	16%
Alaska	23%	19%	21%	7%	5%	Not Available	23%	21%
Arizona	19%	22%	19%	7%	6%	Not Available	Not Available	16%
Arkansas	16%	19%	18%	7%	5%	28%	24%	21%
California	17%	21%	17%	5%	5%	Not Available	Not Available	12%
Colorado	22%	23%	22%	7%	6%	Not Available	Not Available	17%
Connecticut	20%	24%	19%	5%	5%	28%	16%	14%
Delaware	17%	23%	18%	6%	5%	Not Available	17%	17%
DC	25%	31%	24%	6%	6%	21%	Not Available	11%
Florida	15%	21%	16%	5%	4%	Not Available	Not Available	13%
Georgia	15%	21%	17%	6%	5%	Not Available	Not Available	16%
Hawaii	16%	21%	17%	5%	5%	24%	16%	13%
Idaho	15%	20%	17%	7%	6%	Not Available	Not Available	17%
Illinois	18%	26%	17%	5%	5%	26%	19%	12%
Indiana	15%	20%	15%	6%	5%	34%	25%	17%
Iowa	12%	24%	16%	7%	6%	Not Available	Not Available	16%
Kansas	14%	24%	16%	6%	6%	Not Available	Not Available	17%
Kentucky	14%	19%	18%	8%	5%	30%	19%	18%
Louisiana	17%	25%	20%	6%	5%	Not Available	Not Available	19%
Maine	25%	20%	20%	6%	5%	34%	19%	17%
Maryland	16%	20%	15%	6%	5%	28%	18%	11%
Massachusetts	23%	23%	20%	6%	6%	31%	16%	12%
Michigan	21%	22%	18%	6%	5%	31%	22%	18%
Minnesota	19%	23%	18%	6%	5%	Not Available	Not Available	13%
Mississippi	13%	20%	16%	5%	4%	22%	20%	20%
Missouri	20%	22%	20%	7%	6%	31%	26%	18%
Montana	23%	23%	20%	6%	5%	32%	26%	23%
Nebraska	13%	24%	16%	7%	6%	23%	14%	14%
Nevada	22%	23%	21%	6%	6%	Not Available	21%	16%
New Hampshire	19%	24%	19%	7%	6%	33%	21%	15%
New Jersey	14%	22%	15%	5%	5%	27%	14%	10%
New Mexico	26%	21%	21%	6%	5%	25%	15%	21%
New York	18%	23%	17%	5%	5%	25%	19%	11%
North Carolina	13%	21%	15%	5%	4%	30%	18%	15%
North Dakota	14%	25%	17%	7%	5%	31%	18%	18%
Ohio	18%	24%	18%	6%	5%	33%	18%	16%
Oklahoma	21%	19%	18%	7%	5%	30%	23%	21%
Oregon	24%	20%	22%	8%	7%	Not Available	Not Available	18%
Pennsylvania	16%	22%	17%	6%	5%	30%	18%	14%
Rhode Island	21%	26%	22%	6%	5%	27%	16%	13%
South Carolina	14%	21%	17%	5%	4%	Not Available	Not Available	15%
South Dakota	13%	23%	18%	7%	6%	Not Available	17%	18%
Tennessee	14%	20%	16%	8%	6%	28%	24%	18%
Texas	12%	21%	15%	5%	4%	30%	21%	15%
Utah	11%	13%	13%	9%	8%	29%	23%	11%
Vermont	27%	25%	21%	7%	6%	34%	Not Available	17%
Virginia	15%	21%	16%	5%	5%	27%	17%	13%
Washington	23%	19%	18%	7%	6%	Not Available	Not Available	14%
West Virginia	15%	19%	18%	8%	7%	34%	25%	20%
Wisconsin	16%	28%	19%	7%	6%	Not Available	19%	14%
Wyoming	12%	23%	18%	8%	6%	Not Available	Not Available	21%
TOTAL	**17%**	**22%**	**17%**	**6%**	**5%**	**29%**	**20%**	**15%**

Appendix F: State Policies, Programs, and Other Indicators

	Mental Health Access Ranking (2024)	Average Therapy Session Cost (2023–2024)	Mental Health Care Parity Laws (2024)	Increases in Medicaid Reimbursement for Behavioral Health (2022–2023)	Enhanced Medicaid Reimbursement For Mobile Crisis (2025)
	What is the state's Mental Health Access ranking?	What is the average therapy session rate in the state?	Does the state have a law in place requiring public health plans (e.g., Medicaid) and/or private health plans to regularly submit parity compliance analyses to state regulators?	Has the state increased its Medicaid reimbursement rate for behavioral health providers?	Has the state received approval for enhanced Medicaid funding for mobile crisis response?
Alabama	46	$134	No	No	Yes; also recieved planning grant
Alaska	31	$212	No	No	No
Arizona	48	$158	Yes - public only	Yes	Yes
Arkansas	41	$184	No	No	No
California	34	$162	No	No	Yes; also recieved planning grant
Colorado	17	$136	Yes - both	No	Yes; also recieved planning grant
Connecticut	9	$157	Yes - public only	Yes	No
Delaware	28	$157	Yes - both	N/A	Recieved planning grant
DC	4	$189	Yes - both	Yes	Yes
Florida	40	$134	No	Yes	No
Georgia	47	$139	Yes - both	N/A	No
Hawaii	27	$167	No	N/A	No
Idaho	23	$144	No	Yes	No
Illinois	25	$163	Yes - both	N/A	No
Indiana	18	$132	Yes - public only	No	Yes
Iowa	13	$160	No	Yes	No
Kansas	35	$147	No	Yes	No
Kentucky	20	$135	Yes - public only	Yes	Yes; also recieved planning grant
Louisiana	29	$123	Yes - public only	Yes	Yes
Maine	2	$136	Yes - both	Yes	Recieved planning grant
Maryland	25	$153	Yes - public only	Yes	Yes; also recieved planning grant
Massachusetts	3	$158	No	Yes	Yes; also recieved planning grant
Michigan	22	$154	No	No	No
Minnesota	14	$176	No	N/A	No
Mississippi	50	$179	No	No	No
Missouri	32	$122	No	Yes	Recieved planning grant
Montana	30	$158	Yes - public only	No	Yes; also recieved planning grant
Nebraska	37	$180	No	No	No
Nevada	45	$134	Yes - both	Yes	Yes; also recieved planning grant
New Hampshire	8	$141	No	N/A	Yes
New Jersey	21	$165	Yes - public only	Yes	Yes
New Mexico	16	$157	No	No	Yes; also recieved planning grant
New York	7	$176	Yes - public only	Yes	Yes
North Carolina	44	$148	No	Yes	Yes; also recieved planning grant
North Dakota	38	$227	No	No	No
Ohio	12	$139	No	Yes	No
Oklahoma	39	$129	Yes - public only	Yes	Recieved planning grant
Oregon	6	$182	Yes - both	Yes	Yes; also recieved planning grant
Pennsylvania	10	$137	Yes - public only	No	Recieved planning grant
Rhode Island	5	$154	No	Yes	No
South Carolina	49	$123	No	Yes	No
South Dakota	36	$193	No	No	No
Tennessee	43	$126	Yes - both	Yes	No
Texas	51	$131	Yes - public only	Yes	No
Utah	26	$153	No	N/A	Recieved planning grant
Vermont	1	$126	No	No	Yes; also recieved planning grant
Virginia	19	$152	No	Yes	No
Washington	15	$152	No	Yes	Yes
West Virginia	42	$166	Yes - public only	Yes	Yes; also recieved planning grant
Wisconsin	11	$164	No	Yes	Yes; also recieved planning grant
Wyoming	33	$172	No	No	No
TOTAL	**N/A**	**$139 (in 2024)**	**Requires Public Plans Only: 13 States Require Both: 8 States and DC**	**27 States and D.C.**	**Yes: 7 states and D.C Yes; also recieved planning grant: 14 states Recieved planning grant: 6 states**

	School-Linked Mental Health Services Program Access (2025)	State Funding for 988 Lifeline (2025)	988 Lifeline In-State Answer Rates (2024)	Safe Gun Storage Laws (2024)
	Has the state established a program or policy to increase access to community providers in schools?	Has the state enacted a fee or recurring state funding for 988?	What is the in-state answer rate for 988 calls?	Does the state have child-access and/or secure storage laws for guns?
Alabama	Yes	No	75%	No
Alaska	No	Fee Legislation Pending	66%	No
Arizona	Yes	Recurring State Funding	90%	No
Arkansas	No	No	72%	No
California	Yes	Permanent Funding with Fee	84%	Yes
Colorado	Yes	Permanent Funding with Fee	73%	Yes
Connecticut	No	No	91%	Yes
Delaware	No	Permanent Funding with Fee	86%	Yes
DC	Partial	No	N/A	N/A
Florida	Yes	Recurring State Funding	78%	Yes
Georgia	Partial	Recurring State Funding	84%	No
Hawaii	Partial	No	78%	Yes
Idaho	No	No	90%	No
Illinois	No	Fee Legislation Pending	66%	Yes
Indiana	Partial	No	94%	No
Iowa	No	No	87%	Yes
Kansas	No	Recurring State Funding	85%	No
Kentucky	No	No	84%	No
Louisiana	No	No	89%	No
Maine	No	No	89%	Yes
Maryland	Yes	Permanent Funding with Fee	90%	Yes
Massachusetts	No	No	86%	Yes
Michigan	No	No	90%	Yes
Minnesota	Yes	Permanent Funding with Fee	85%	Yes
Mississippi	Partial	No	97%	No
Missouri	No	No	94%	No
Montana	Yes	No	97%	No
Nebraska	No	No	87%	No
Nevada	No	Permanent Funding with Fee	64%	Yes
New Hampshire	No	Fee Legislation Pending	81%	Yes
New Jersey	Yes	Fee Legislation Pending	73%	Yes
New Mexico	Partial	Fee Legislation Pending	89%	Yes
New York	No	Fee Legislation Pending	86%	Yes
North Carolina	No	No	81%	Yes
North Dakota	No	No	91%	No
Ohio	Partial	No	90%	No
Oklahoma	Partial	No	89%	No
Oregon	Yes	Permanent Funding with Fee	79%	Yes
Pennsylvania	No	No	90%	No
Rhode Island	No	Fee Legislation Pending	97%	Yes
South Carolina	Yes	No	77%	No
South Dakota	No	No	84%	No
Tennessee	Partial	No	87%	No
Texas	No	Fee Legislation Pending	84%	Yes
Utah	Partial	Recurring State Funding	93%	No
Vermont	No	Permanent Funding with Fee	86%	Yes
Virginia	Partial	Permanent Funding with Fee	83%	Yes
Washington	Yes	Permanent Funding with Fee	91%	Yes
West Virginia	Yes	No	90%	No
Wisconsin	Partial	No	74%	Yes
Wyoming	No	No	89%	No
TOTAL	**Yes: 13 States Partial: 11 states and D.C.**	**Recurring State Funding: 5 states Permanent Funding with Fee: 10 states Fee Legislation Pending: 8 states**	**N/A**	**26 States**

Appendix F: State Policies, Programs, and Other Indicators

	Percent of Individuals with SUD Not Receiving Treatment in the Past Year (2022–2023)	Drug Checking Equipment Possession And Distribution Laws		Community Distribution of Naloxone (2023)	Syringe Service Programs (2023)
	What percentage of people 12+ in the state needed but did not receive substance use treatment in the past year?	Does the state have laws permitting possession of DCE?	Does the state have laws permitting free distribution of DCE?	Does the state have a law facilitating community distribution of naloxone?	Does the state have an operational syringe service program?
Alabama	74%	Permitted for Certain Drugs	Permitted for Certain Drugs	No	Yes
Alaska	79%	Generally Permitted	Generally Permitted	Yes	Yes
Arizona	74%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Arkansas	75%	Permitted for Certain Drugs	Generally Permitted	Yes	Yes
California	81%	Generally Permitted	Permitted for Certain Drugs	Yes	Yes
Colorado	77%	Generally Permitted	Generally Permitted	Yes, supports bulk purchasing	Yes
Connecticut	76%	Generally Permitted	Generally Permitted	Yes	Yes
Delaware	78%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
DC	80%	Generally Permitted	Not Permitted	Yes	Yes
Florida	75%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Georgia	80%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Hawaii	74%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Idaho	74%	Permitted for Certain Drugs	Permitted for Certain Drugs	No	Yes
Illinois	80%	Generally Permitted	Generally Permitted	Yes, suppports bulk purchasing	Yes
Indiana	73%	Not Permitted	Not Permitted	Yes	Yes
Iowa	74%	Not Permitted	Not Permitted	No	Yes
Kansas	76%	Permitted for Certain Drugs	Permitted for Certain Drugs	No	No
Kentucky	70%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Louisiana	76%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Maine	76%	Generally Permitted	Generally Permitted	Yes	Yes
Maryland	77%	Generally Permitted	Generally Permitted	Yes, supports bulk purchasing	Yes
Massachusetts	77%	Generally Permitted	Generally Permitted	Yes, supports bulk purchasing	Yes
Michigan	75%	Generally Permitted	Generally Permitted	Yes	Yes
Minnesota	78%	Generally Permitted	Generally Permitted	No	Yes
Mississippi	72%	Permitted for Certain Drugs	Permitted for Certain Drugs	No	No
Missouri	76%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Montana	74%	Generally Permitted	Not Permitted	Yes	Yes
Nebraska	75%	Generally Permitted	Generally Permitted	No	No
Nevada	77%	Generally Permitted	Generally Permitted	Yes	Yes
New Hampshire	74%	Generally Permitted	Permitted for Certain Drugs	Yes	Yes
New Jersey	77%	Generally Permitted	Generally Permitted	Yes	Yes
New Mexico	75%	Generally Permitted	Not Permitted	Yes	Yes
New York	75%	Generally Permitted	Generally Permitted	Yes	Yes
North Carolina	77%	Generally Permitted	Not Permitted	Yes	Yes
North Dakota	77%	Not Permitted	Not Permitted	Yes	Yes
Ohio	75%	Permitted for Certain Drugs	Generally Permitted	Yes	Yes
Oklahoma	76%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Oregon	74%	Generally Permitted	Generally Permitted	Yes	Yes
Pennsylvania	71%	Generally Permitted	Generally Permitted	Yes	Yes
Rhode Island	79%	Generally Permitted	Generally Permitted	Yes	Yes
South Carolina	76%	Generally Permitted	Generally Permitted	Yes	Yes
South Dakota	76%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	No
Tennessee	72%	Permitted for Certain Drugs	Permitted for Certain Drugs	Yes	Yes
Texas	76%	Not Permitted	Not Permitted	Yes, supports bulk purchasing	Yes
Utah	70%	Generally Permitted	Generally Permitted	No	Yes
Vermont	75%	Generally Permitted	Generally Permitted	Yes, supports bulk purchasing	Yes
Virginia	78%	Generally Permitted	Generally Permitted	Yes	Yes
Washington	75%	Generally Permitted	Generally Permitted	Yes, supports bulk purchasing	Yes
West Virginia	70%	Generally Permitted	Generally Permitted	Yes	Yes
Wisconsin	78%	Permitted for Certain Drugs	Permitted for Certain Drugs	No	Yes
Wyoming	72%	Generally Permitted	Generally Permitted	No	No
TOTAL	**76%**	**Generally Permitted: 28 States and D.C. Permitted for Certain Drugs: 18 States**	**Generally Permitted: 25 states Permitted for Certain Drugs: 18 states**	**40 states and D.C. (7 states also support bulk purchasing)**	**45 states and D.C.**

Notes and Sources for Appendix F

Mental Health Access Ranking (2024)

Notes: The Access Ranking indicates how much access to mental health care exists within a state. States are ranked from 1 (best) to 51 (worst) in terms of access to mental health care. The access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and mental health workforce availability.

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.

Average Therapy Session Cost (2023–2024)

Source: SimplePractice. "Average Therapy Session Rate by State." 2024. https://www.simplepractice.com/blog/average-therapy-session-rate-by-state/. Accessed March 25, 2025.

Mental Health Care Parity Laws (2024)

Source: American Foundation for Suicide Prevention. "State Facts." May 2024. https://afsp.org/state-facts/. Accessed March 25, 2025.

Increases in Medicaid Reimbursement for Behavioral Health (2022–2023)

Notes: Rate increases include states with at least one temporary or permanent FFS rate increase to one or more behavioral health provider types in FY22 and/or planned for FY23. TN does not set FFS rates, but indicated an increase in direct payments.

Source: Kaiser Family Foundation. "A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs." 2024. https://www.kff.org/mental-health/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/. Accessed March 25, 2025.

Enhanced Medicaid Reimbursement For Mobile Crisis (2025)

Source: Reimagine Crisis. "Mobile Crisis." 2024. https://reimaginecrisis.org/mobilecrisis/. Accessed March 25, 2025.

School-Linked Mental Health Services Program Access (2025)

Notes: Yes means that state statute establishes a program or policy to increase access to community providers in schools. Partial means there are pilots, programs, partnerships, or other agency efforts that are not in statute. No means no policy or program

Source: Inseparable. "School Mental Health: State Scorecards." 2024. https://www.inseparable.us/school-mental-health/#stateScoreCards. Accessed March 25, 2025.

State Funding for 988 Lifeline (2025)

Notes: Public policy extends beyond legislation; however, this resource is limited to 988 state legislation efforts.

Source: Reimagine Crisis. "Crisis Systems Mapping." 2024. https://reimaginecrisis.org/map/. Accessed March 25, 2025.

988 Lifeline In-State Answer Rates (2024)

Notes: 988 launched in July 2022, and available metrics reflect data recorded two years post-launch. Metrics are only available for calls at a state level. Detailed data from the Veterans Crisis Line are not publicly available, so they are not included in the analysis. Lifeline performance metrics are publicly available and posted online by Vibrant.

Source: Kaiser Family Foundation. "988 Suicide & Crisis Lifeline: Two Years After Launch." 2025. https://www.kff.org/mental-health/issue-brief/988-suicide-crisis-lifeline-two-years-after-launch/. Accessed March 26, 2025.

Safe Gun Storage Laws (2024)

Source: Everytown Research. "Secure Storage or Child Access Prevention Required: State Rankings." 2025. https://everytownresearch.org/rankings/law/secure-storage-or-child-access-prevention-required/. Accessed March 20, 2025.

Percent of Individuals with SUD Not Receiving Treatment in the Past Year (2022–2023)

Notes: Respondents were classified as needing substance use treatment if they met Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria for a drug or alcohol use disorder or received treatment for drug or alcohol use through inpatient treatment; outpatient treatment; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Source: Substance Abuse and Mental Health Service Administration. "2022-2023 NSDUH: Model-Based Estimated Prevalence For States." Februrary 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.pdf . Accessed March 20, 2025.

Drug Checking Equipment Possession And Distribution Laws (2024)

Notes: State laws on the possession and free distribution of drug checking equipment (DCE) were categorized into three buckets: generally permitted, permitted for certain drugs, and not permitted. States that allow broad possession or distribution of DCE are classified as generally permitted. Some states permit possession or distribution only for specific substances, such as fentanyl, xylazine, and other synthetic opioids. States without clear legal authorization or that prohibit DCE possession or distribution are considered not permitted.

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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.

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Syringe Service Programs (2023)

Notes: Syringe services programs 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.

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