ISSUE REPORT | JUNE 2026

PAIN IN THE NATION

The Epidemics of Alcohol, Drug, and Suicide Deaths

SPECIAL FEATURE: Suicide and Well-Being in the United States

Trust for America's Health 25 YEARS

Acknowledgements

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. For more information, please review TFAH's 2023–2026 Strategic Plan at tfah.org.

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Introduction

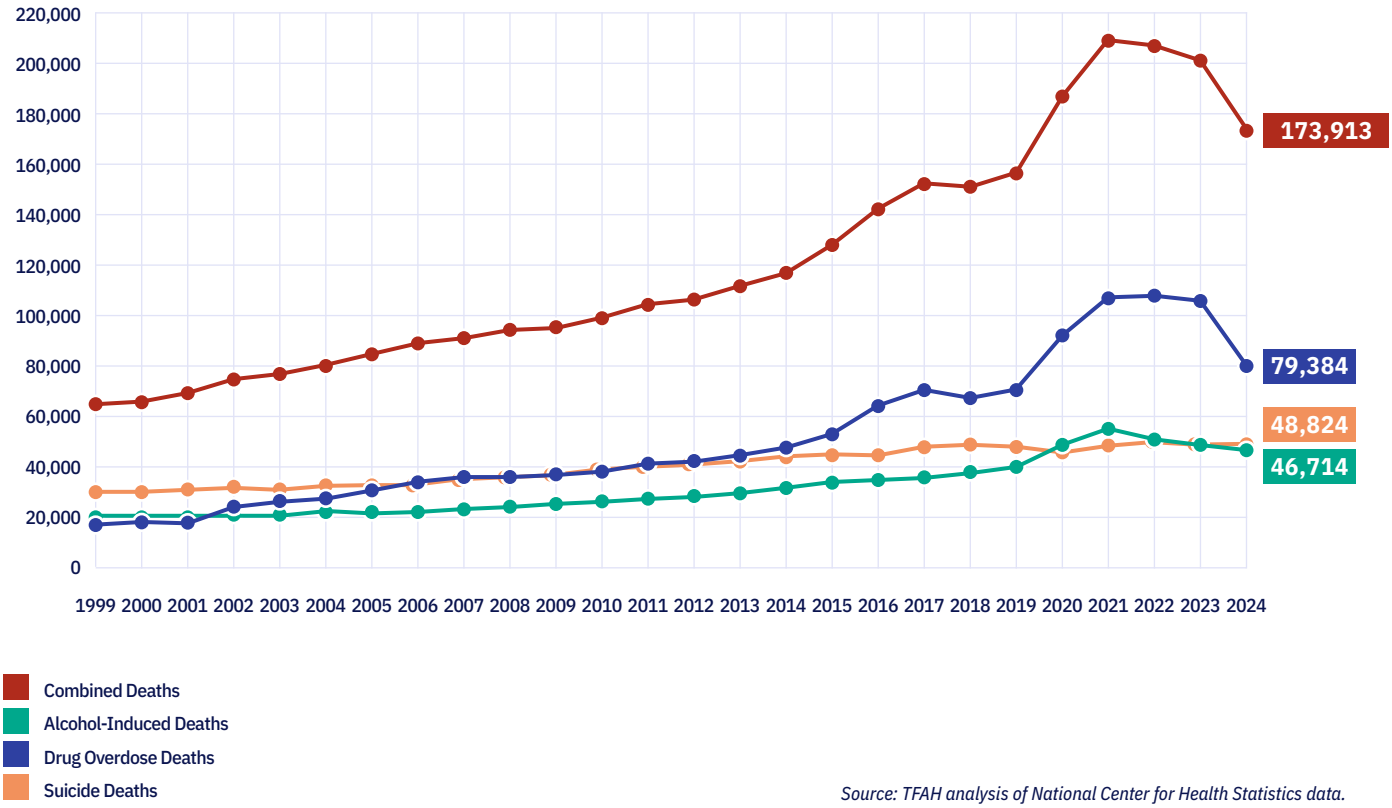
After two decades of rising deaths from alcohol, drugs, and suicide, the United States is at a turning point. Recent declines in mortality suggest meaningful progress, but that progress is fragile. Over the past year, the federal behavioral health and injury prevention systems that support prevention, surveillance, and crisis response have experienced leadership upheaval, funding disruptions, and workforce reductions. Whether recent gains continue will depend on sustained investment in the public health infrastructure that makes prevention possible.

After peaking in 2021, the combined age-adjusted mortality rate from alcohol-induced causes, drug overdoses, and suicide declined in 2022 (-1 percent), 2023 (-4 percent), and 2024 (-16 percent), and preliminary data suggest positive or stable trends in 2025.[1,2,3] Importantly, for 2024, this has included improvements across all three mortality causes: alcohol-induced mortality declined by 4 percent, drug overdose mortality by 26 percent, and suicide mortality by 3 percent. *(See Figure 1 on page 7)*

Even with these notable improvements, mortality remains historically elevated. The 2024 combined rate is still more than double what it was in 1999 and higher than at any point before 2020. Sustaining and building on recent progress will require bolstering investments in primary prevention—efforts designed to stop substance use and misuse, suicide, and related harms before they occur by strengthening protective factors, reducing risk factors, and improving the social, economic, and environmental conditions that shape health—continuing to support evidence-based programming, and strengthening policies that save lives, boost resilience, and improve mental health and well-being for all Americans.

This report includes three sections: (1) a special feature on suicide (page 12); (2) a deeper analysis into the 2024 mortality trends from alcohol, drugs, and suicide (page 42); and (3) key policy recommendations for reducing such deaths and promoting well-being for all Americans (page 60). This year's feature examines trends in suicide and well-being in the United States. It also explores some of the successful strategies and policies that underlie the recent progress and offers considerations for future policymaking.

FIGURE 1: Annual Deaths from Alcohol, Drugs, and Suicide in the United States, All Ages, 1999–2024



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

RECENT FEDERAL DEVELOPMENTS RELATED TO BEHAVIORAL HEALTH AND INJURY PREVENTION

Between February 2025 and April 2026, the federal behavioral health and injury prevention systems experienced significant organizational changes and destabilization that have touched communities across the United States. In early 2025, more than 2 million civilian federal employees were given an offer to resign by February 6, 2025, and maintain pay and benefits through September 2025.[4] In April 2025, the U.S. Department of Health and Human Services (HHS) began substantial reductions to the workforce—cutting an estimated 10,000 positions across the department.[5] This included significant cuts to the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Center for Injury Prevention and Control (Injury Center) at the Centers for Disease Control and Prevention (CDC).

As of April 2026, SAMHSA employed 534 individuals—a decline of more than 40 percent from the 916 individuals employed in fiscal year (FY) 2024.[6] Twelve of SAMHSA's 17 senior leaders departed the agency throughout 2025, with several temporarily reassigned to other federal agencies.[7] CDC's Injury Center also experienced significant staffing reductions throughout 2025.[8] While the United States grapples with ongoing mental health and substance misuse crises, the federal workforce tasked with addressing these challenges has been significantly reduced.

These staffing reductions were paired with abrupt disruptions to vital behavioral health funding streams. In March 2025, the Trump Administration clawed back approximately $1 billion in approved SAMHSA grant funding.[9] These COVID-era grants were already supporting vital mental health and substance use disorder activities across states and communities—including medication-assisted treatment, suicide prevention, and critical surveillance and data collection.[10] And on January 13, 2026, SAMHSA distributed roughly 2,000 grant termination notices to awardees across the United States, totaling nearly $2 billion in funding.[11] These terminations impacted several SAMHSA programs, including Mental Health Awareness Training and Rural Emergency Medical Services Training.[12] Following 24 hours of opposition from stakeholders and lawmakers, the terminations were reversed on January 14, 2026.[13] These actions demonstrate the fragility of federal support for the behavioral health system and raise serious concerns about future disruptions.

The FY 2026 Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act provided level funding for SAMHSA and CDC's Injury Center.[14] The appropriations bill maintained these entities and their programs, rather than approving their consolidation into a new "Administration for a Healthy America," as proposed in the president's FY 2026 and 2027 budget requests.[15,16] The bill also included provisions to ensure that HHS maintained the staffing levels necessary to carry out its congressionally authorized and appropriated programs and activities.

Summary of Recommendations

Trust for America's Health (TFAH) calls for a sustained commitment to primary prevention and to the workforce, programs, surveillance, and systems that enable communities to reduce alcohol, drug, and suicide deaths as well as 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 60.

RECOMMENDATION 1: Invest in Prevention and Conditions that Promote Health

- Spend behavioral health funds and carry out investments as directed by Congress.
- Protect investments in injury and violence prevention, and maintain the vital workforce dedicated to these efforts.
- Expand funding for comprehensive suicide prevention efforts.
- Support policies and programs that reduce adverse childhood experiences and the impact of trauma as well as those that promote positive childhood experiences.
- Increase support for substance misuse prevention, mental health, and resiliency programs in schools.
- Focus prevention efforts on substance misuse among youth.
- Implement innovative approaches to prevent substance misuse and overdose, including through the investment of opioid settlement funds.
- Strengthen the capacity to address the behavioral health impacts of environmental risk and weather-related disasters.

RECOMMENDATION 2: Reduce Overdose Risk and Access to Lethal Means of Suicide

- Support policies to reduce overdose and blood-borne infection.
- 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.

RECOMMENDATION 3: Transform the Mental Health and Substance Use Prevention System

- Protect SAMHSA's funding and programs, and maintain the critical workforce needed to fulfill the agency's activities.
- Restore Medicaid funding and eligibility to prevent losses in mental health and substance use healthcare.
- 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.

Looking Back at 25 Years of Work in the Field of Behavioral Health and Injury Prevention

In 2026, TFAH is celebrating its 25th anniversary, and we are reflecting on all that has happened in public health. The subject of this report—alcohol, drug, and suicide deaths—has been grim, driven by increasingly lethal waves of opioid overdose deaths at a scale unimaginable in 2001, as well as significant increases in stimulant overdose deaths and the rate of alcohol and suicide deaths.

Over this time, countless individuals across the public and private sectors and in communities throughout the United States have worked to combat alcohol, drug, and suicide deaths and save lives. Together, they have developed strategies, policies, and programs that underpin the recent decline in mortality. These include:

- Increasing widespread harm-reduction strategies, including access to naloxone, medications for opioid use disorder, and drug-checking tools.
- Creating new federal programs and infrastructure, including prevention grants such as Garrett Lee Smith (2004), the Comprehensive Suicide Prevention program (2020), and Preventing Adverse Childhood Experiences through Data to Action (2023); surveillance systems such as the National Violent Death Reporting System (2002) and the State Unintentional Drug Overdose Reporting System (2016); overdose response initiatives such as the Overdose Data to Action program (2019); and crisis response infrastructure such as the 988 Suicide and Crisis Lifeline (2022).
- Continuing investment and improvement in data systems, like CDC's Overdose Data to Action and the National Violent Death Reporting System, 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.
- Establishing a growing focus over the past decade on the drivers of substance misuse and poor mental health through primary prevention and early intervention policies, including improving social, environmental, and economic conditions; expanding resiliency programs in schools; and increasing access to social and mental health services for children and families.

The recent progress is real—but it is not guaranteed to continue. Protecting and building on these investments will be essential to continuing to reduce alcohol, drug, and suicide deaths in the decades ahead.

As TFAH moves toward the next 25 years, we remain committed to the evidence-based policies and sustained investments that have driven this progress—and to advocating for the public health infrastructure that makes it possible.

SINCE 2001, MORE THAN

3 MILLION

Americans have died from alcohol, drugs, and suicide combined

THE RATE OF DEATH GREW **153%**

2001	2021
24.1	**60.9**
DEATHS	**DEATHS**
per 100,000	per 100,000

SINCE 2021, THERE HAS BEEN MEANINGFUL PROGRESS

IN 2024, THE RATE OF DEATH DECLINED TO

48.6 DEATHS

PER 100,000

SPECIAL FEATURE: Suicide and Well-Being in the United States

In 2024, 48,824 Americans died by suicide, making it the 10th leading cause of death overall.[17] Among younger age groups, suicide ranks even higher: it was the second leading cause of death for individuals ages 10–14, 15–24, and 25–35, and it was among the leading causes of years of potential life lost before age 65.[18,19,20]

Suicide risk is shaped by factors at multiple levels—from individual experiences and peer/family relationships to community conditions and broader societal forces. Research has identified a range of risk and protective factors.[21] Several critical protective factors for reducing suicide risk are relevant across many populations—including coping and problem-solving skills, connections with community and social institutions, access to affordable and high-quality behavioral and physical healthcare, and reduced access to lethal means.[22]

Over the past two decades, suicide mortality increased 25 percent, and 2018 and 2022 saw the highest rates of suicide since 1941.[24] Most recently, between 2023 and 2024, age-adjusted suicide rates declined by 3 percent. At the same time, there have been important, though insufficient, developments and investment in policies and programs aimed at suicide prevention and drivers of suicide risk. It is a critical time to build on this work and further strengthen evidence-based suicide prevention. In 2025 and the first half of 2026, however, there have been significant shifts within the federal behavioral health and injury prevention systems, including leadership upheaval, funding disruptions, and workforce reductions, which has far-reaching effects on the state and local efforts that received financial, technical, and infrastructure support from federal grants, programs, and expertise. (See more on recent federal developments on page 8.)

This section examines what the data say about who is most affected and where, documents the policy and program successes that drove recent progress, and considers what is at risk if federal investment in suicide prevention continues to erode.

Note: This section contains detailed data and analysis on suicide mortality, suicidal thoughts and behaviors, and mental health trends in the United States. Readers affected by this content are encouraged to reach out for support. Free and confidential help is available 24 hours a day, seven days a week, by calling or texting 988 or by chatting at 988lifeline.org.

CHART 1: Suicide Risk and Protective Factors

	RISK FACTORS	PROTECTIVE FACTORS
INDIVIDUAL	■ Previous suicide attempt ■ History of mental health disorder ■ Serious illness or chronic pain ■ Financial/job or legal/criminal problems ■ Impulsive or aggressive tendencies ■ Substance use ■ Current or prior adverse childhood experiences ■ Sense of hopelessness ■ Violence victimization and/or perpetration	■ Effective coping and problem-solving skills ■ Reasons for living (e.g., family, friends, pets, etc.) ■ Strong sense of cultural identity
RELATIONSHIP	■ Bullying ■ Family/loved one's history of suicide ■ End of relationship ■ High conflict or violent relationships ■ Social isolation	■ Support from partners, friends, and family ■ Feeling connected to others
COMMUNITY-LEVEL	■ Lack of healthcare ■ Suicide cluster in the community ■ Stress of acculturation ■ Community violence ■ Historical trauma ■ Discrimination	■ Connections to school, community, and other social institutions ■ Availability of consistent high-quality physical and behavioral healthcare
SOCIETAL	■ Stigma associated with help-seeking and mental illness ■ Easy access to lethal means of suicide ■ Unsafe media portrayals of suicide	■ Reduced access to lethal means of suicide among people at risk ■ Cultural, religious, or moral objections to suicide

Source: CDC[23]

Suicide Mortality and Related Trends

The first step to addressing a public health problem is to understand it: Who does it affect? Where is the problem happening? What is the scope and magnitude? This section describes the characteristics and trends in suicide mortality, suicidal thoughts and behaviors, and mental health and well-being in the United States.

I. SUICIDE MORTALITY

Over the last two decades, the overall age-adjusted suicide rate in the United States has risen from 11.0 deaths per 100,000 in 2004 to 13.7 deaths per 100,000 in 2024, a 25 percent increase. Within the last decade, there has been some additional fluctuation with the highest suicide rate recorded in 2018 and 2022 at 14.2 deaths per 100,000, and then a 3 percent decrease from 2023 to 2024. *(See Figure 2 on page 15.)* Provisional mortality data through November 2025 suggest a similar number of suicide deaths in 2025 as 2024.[25]

Within demographic and geographic populations, there are often notable differences in suicide death rates and trends across time. This subsection examines variations in suicide by sex, age, race/ethnicity, region, suicide method, urbanization, occupation, veteran status, and sexual orientation and gender identity.

SEX

Males had suicide death rates about 3.5–4 times the rate of females annually over the past two decades. In 2024, males had 22.3 suicide deaths per 100,000 and females had 5.6 deaths per 100,000.

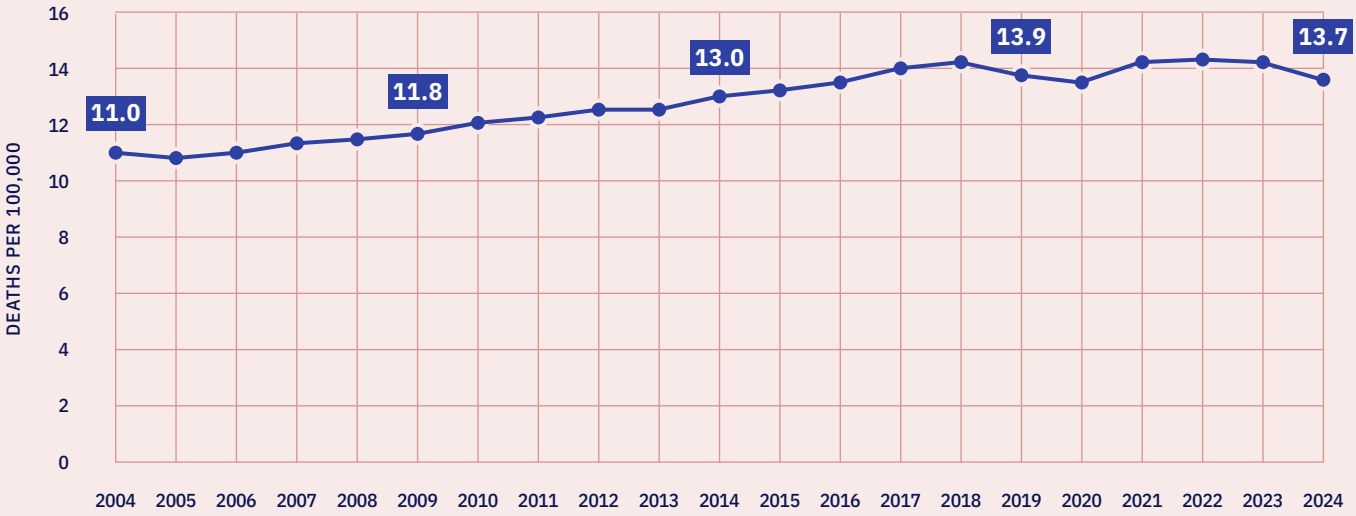
One major difference in suicide characteristics between sexes is suicide method. In 2024, males died at a rate 6.8 times higher for firearm suicide (13.5 vs. 2.0 deaths per 100,000) and 3.5 times higher for suffocation/hanging suicide (5.3 vs. 1.5 deaths per 100,000) compared with females. The rate of poisoning/overdose suicide, the third most common suicide method, was comparable across sexes (1.6 vs. 1.5 deaths per 100,000).

Research suggests women attempt suicide at a higher rate than men. One study found that in 2020, women attempted suicide at 1.8 times the rate of men—consistent with broader research on suicide attempt rates by sex.[26,27] However, since women more often choose nonlethal and less immediate methods of suicide (e.g., drug overdose), while men employ more immediate and lethal methods (e.g., firearm), more men die of suicide.[28]

AGE

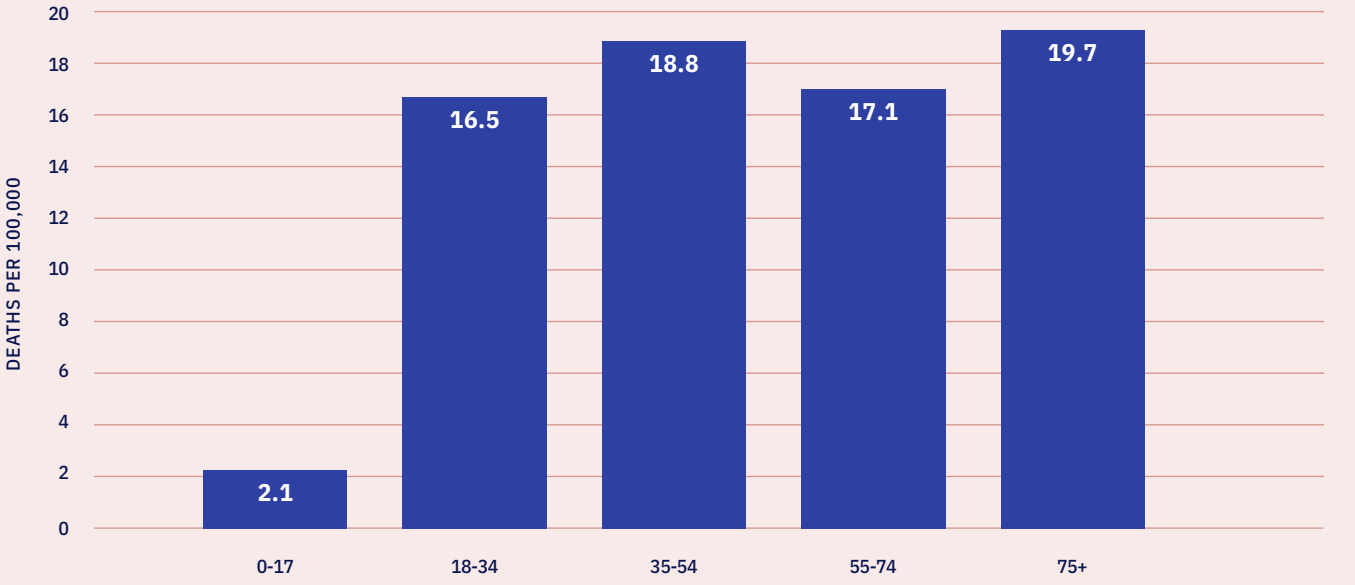
Youth have the lowest suicide rates by a substantial margin. Older adults have the highest suicide rates, followed closely by young and middle-age adults. Over the last two decades, all age groups have seen increases in suicide rates. The trend shows that age groups with lower suicide rates overall still saw increases in their suicide rates (i.e., youth increased 49 percent, young adults 31 percent, adults ages 55–74 30 percent), while age groups with higher suicide rates had smaller increases (i.e., adults ages 35–54 increased 18 percent and older adults 19 percent). These divergent rates of increase suggest a broadening of suicide risk across the lifespan, a trend with implications for prevention strategies. *(See Figure 3 on page 15.)*

FIGURE 2: Annual Age-Adjusted Suicide Mortality Rate, 2004–2024



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

FIGURE 3: Suicide Mortality Rate, by Age Group, 2024



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

Looking at suicide rates among youth, there are important differences in rates and trends by sex and race/ethnicity. Researchers examining suicide among youth under age 12 between 2010 and 2019 found suicide mortality was higher among boys, but the suicide mortality rate for girls increased faster (300 percent between 2010 and 2019).[29] Historically, Black youth have had relatively low suicide mortality rates compared with their peers. Since the 2000s, however, suicide mortality among Black youth has risen at an alarming pace: increasing 144 percent, from 1.5 deaths per 100,000 in 2007 to 3.8 deaths per 100,000 in 2020. In particular, Black boys and older Black youth ages 15–19 have seen the largest increases in suicide mortality rates.[30]

RACE/ETHNICITY

Suicide rates vary considerably by race/ethnicity. American Indian and Alaska Native (AI/AN) people consistently have the highest suicide rate of any race/ethnicity, with a rate of 22.5 deaths per 100,000 in 2024—followed by white (17.2 deaths per 100,000), Native Hawaiian or other Pacific Islander (NHOPI) (13.7 deaths per 100,000), multiracial (10.1 deaths per 100,000), Black (8.7 deaths per 100,000), Hispanic or Latino (8.0 deaths per 100,000), and Asian (6.5 deaths per 100,000) people. *(See Figure 4 on page 17.)*

Trends across race/ethnicity have diverged substantially in recent years as well—ranging from small improvements for some populations to large increases in others. Specifically, white (-5 percent) and Asian (-4 percent) people have seen improvements in their suicide rates since 2018, and the suicide rate for AI/AN people is about the same (less than 1 percent increase). On the other hand, Black (+20 percent), NHOPI (+16 percent), multiracial (+12 percent), and Hispanic or Latino (+7 percent) people have seen large increases since 2018. Notably, suicide rates across nearly all racial and ethnic groups declined in 2024, after peaks in 2022 or 2023. *(Note: The National Vital Statistics System changed the race/ethnicity categories in 2018, and earlier data are not comparable.)*

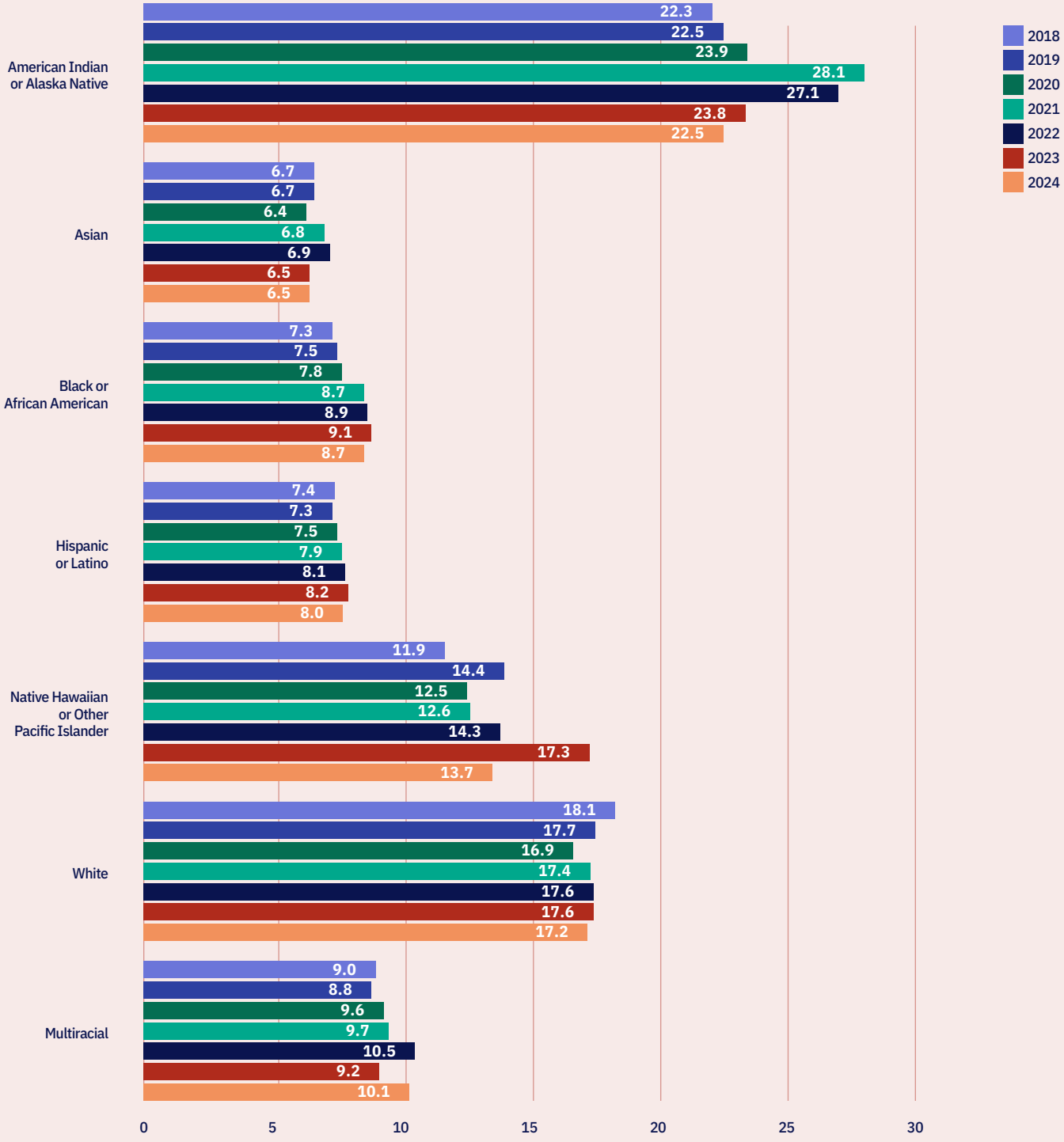
Importantly, other data sources suggest substantial differences in suicide trends among AI/AN populations. For example, studies have found that Apache and Alaska Native youth have significantly higher rates of suicide than the overall AI/AN population, and another study found different patterns in suicide attempts by gender in some Alaska Native populations compared with the overall U.S. population and overall AI/AN population.[31,32,33]

The Indian Health Service points to higher rates of mental health conditions and substance use disorders, intergenerational trauma, and community-wide issues as factors contributing to higher suicide rates among AI/AN populations. Protective factors for AI/AN youth include a "sense of belonging to one's culture, a strong tribal/spiritual bond, the opportunity to discuss problems with family or friends, feeling connected to family, and positive emotional health."[34] The National Indian Council on Aging also points to several social factors underlying high suicide rates in Native communities, including disproportionately high levels of violence that female AI/AN individuals experience, historical disenfranchisement through genocide and institutional racism, and poorer health and socioeconomic conditions in AI/AN communities.[35]

REGION

The Northeast region has substantially lower suicide death rates than the rest of the country. In 2024, the suicide rate in the Northeast was 9.8 deaths per 100,000, the Midwest was 14.7 deaths per 100,000, the South was 14.6 deaths per 100,000, and the West was 14.4 deaths per 100,000. The trend between 2004 and 2024 varied by region: The Northeast increased 24 percent, the Midwest increased 36 percent, the South increased 23 percent, and the West increased 14 percent.

FIGURE 4: Annual Age-Adjusted Suicide Mortality Rate, by Race/Ethnicity, 2018–2024



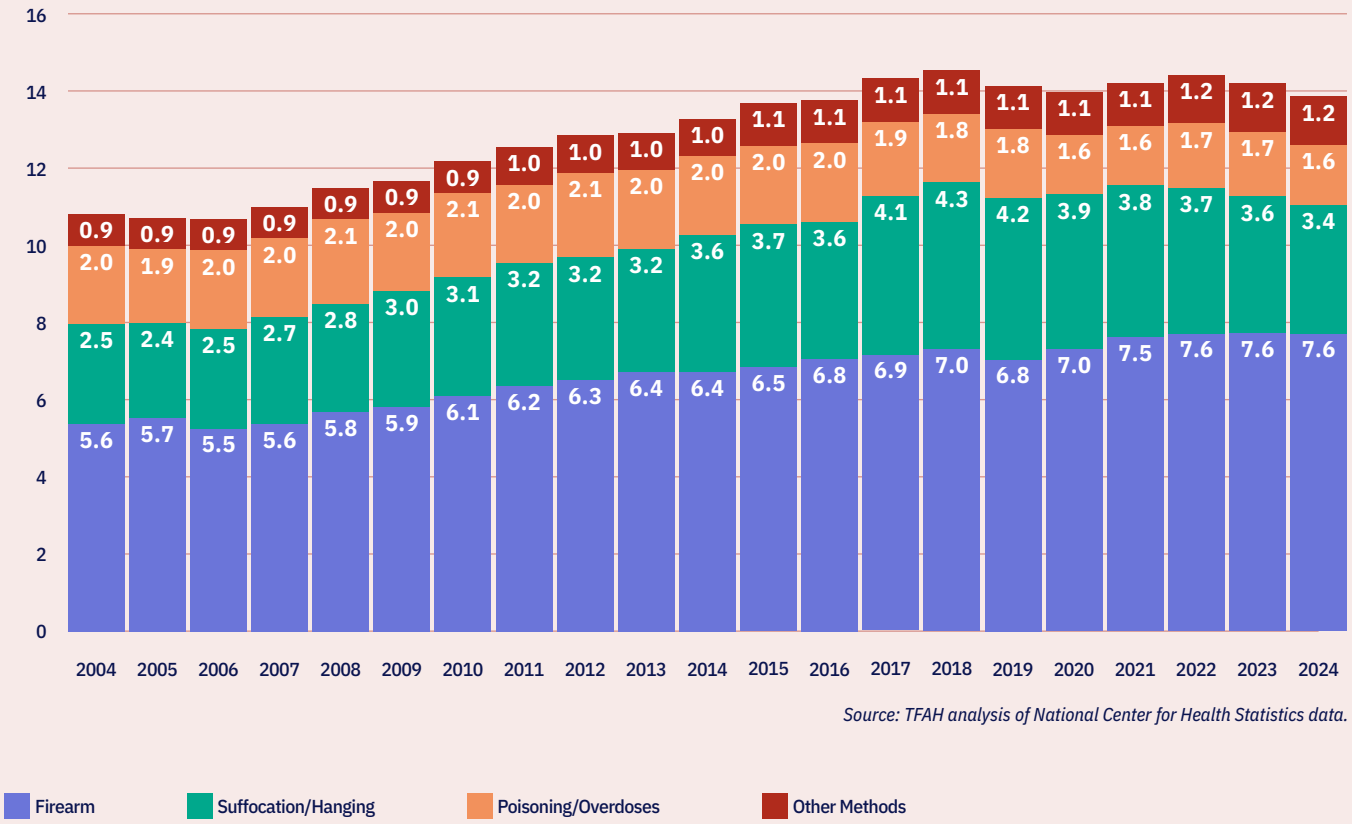
Source: TFAH analysis of National Center for Health Statistics data.

METHOD

More than half of suicides every year are by firearm, with suffocation/hanging and poisoning/overdose as the other two common methods. In 2024, firearm suicides made up 55 percent of suicides, suffocation/hanging 25 percent, poisoning/overdose 12 percent, and all other methods 9 percent. *(Note: total is greater than 100 percent due to rounding.)*

Suicide by firearm and suffocation/hanging have both increased substantially since 2004. The rate of firearm suicides increased by 35 percent, and rates of suffocation/hanging suicides increased by 36 percent. At the same time, the rate of poisoning/overdose suicide deaths decreased. *(See Figure 5.)*

FIGURE 5: Annual Age-Adjusted Suicide Rate, by Suicide Method, 2004–2024



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

URBAN AND RURAL AREAS

Suicide rates are consistently higher in rural areas compared with urban areas and have increased at a faster rate over the last two decades. The most recent data available are from 2022 and show that rural areas had a suicide rate 41 percent higher than urban areas (19.6 vs. 14.0 deaths per 100,000).

A CDC study looking at the urban-rural differences in suicide between 2000 and 2018 found rural areas' suicide rates increased by 48 percent, versus 34 percent in urban areas. It also found that, in 2018, the firearm suicide rate was 63 percent higher for males and 82 percent higher for females in rural areas compared with urban areas.

The Rural Health Information Hub points to several suicide risk factors that are disproportionately prevalent in rural areas, including access to firearms, higher alcohol use, lack of access to mental healthcare, stigma, and socioeconomic factors.[42] An analysis of de-identified anonymized conversations from 2019–2024 with Crisis Text Line—an organization that provides text-based mental health support and crisis intervention across the United States—found that the youngest rural texters mentioned suicide the most often, and older rural texters increasingly cited isolation and loneliness.[43]

LETHAL MEANS AND SUICIDE DEATH RATES

Most people who attempt suicide do not die by suicide, and the method of a suicide attempt is often a critical determinant of survival. Case fatality rates—that is the proportion of suicidal acts that are fatal—vary markedly among different methods. A 2019 study found that 8.5 percent of all suicide attempts requiring emergency care or hospitalization in the United States from 2007–2014 were fatal. More than half (59 percent) of all suicide attempts were due to drug poisoning or overdoses, but they made up 14 percent of deaths. On the other hand, firearms and hanging made up 9 percent of suicidal acts but 75 percent of deaths.[36]

Case Fatality Rate Varies by Method

90% FIREARMS	**56%** DROWNING	**53%** HANGING
31% TOXIC GAS	**28%** HEIGHTS	**27%** VEHICLES
<2% POISON	**<2%** CUTTING	**<2%** OPIATES

Source: Annals of Internal Medicine[37]

Because suicide attempts often occur during an emergent crisis—and 90 percent of individuals who survive a suicide attempt do not die by suicide later—reducing access to lethal means can keep more individuals in crisis alive and allow them to reach help.[38]

Prevention strategies, like lethal-means counseling and lethal-means safety, center on putting time and distance between a person at risk for suicide and any lethal means or methods of suicide and are effective at reducing suicide attempts and deaths.[39,40]

OCCUPATION

Individuals in certain occupations are more at risk of suicide than others. A CDC study of 2021 data found that industries with the highest suicide rates were mining; construction; services (e.g., automotive repair); arts and entertainment (e.g., musicians, athletes); and agriculture, forestry, fishing, and hunting. The article notes that suicide risk is associated with a number of factors, including lower educational attainment, lower socioeconomic status, work-related access to lethal means of suicide, job stress, low job control, and job insecurity.[44]

VETERANS

Military veterans are another group disproportionately affected by suicide, with veteran suicide death rates twice that of the civilian population each year. The latest data from the U.S. Department of Veterans Affairs (VA) shows the veteran suicide rate at 35.2 deaths per 100,000 in 2023 (versus 14.1 deaths per 100,000 for the overall population in 2023). After increasing between 2001 and 2018, the suicide rate for veterans fell in 2019, was steady in 2020, and then increased again from 2021–2023.[45,46]

IN 2023, VETERAN SUICIDE RATE WAS

35.2 DEATHS

PER 100,000

The overall population was **14.1 deaths per 100,000**

The 2025 National Veteran Suicide Prevention Annual Report notes that suicide risk is higher for veterans with certain characteristics: a mental health or substance use disorder diagnosis, homelessness, legal issues, low income, a history of head trauma, a history of military sexual trauma, recent separation from military service, or an unsecured firearm in the home. In 2023, 73 percent of veteran suicides were by firearm. The report also notes that many veterans who died by suicide were experiencing health, pain, or sleep issues; relationship or financial problems; feelings of hopelessness or impulsivity; or an unsecured firearm in the home.[47] Other recent research finds that moral injury—defined by the VA as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations"—is another risk factor for veterans for suicidal behaviors and death by suicide.[48,49,50]

In recent years, the VA has emphasized suicide prevention and worked to implement a new suicide prevention strategy and related initiatives. At the same time, Congress passed the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 and the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020, both of which provided additional funding for veteran programs and services. For example, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grants Program, part of the 2019 law, funds community-based early intervention and prevention services and resources. Between 2022 and 2025, the program funded 95 organizations across the country and connected 13,807 veterans, service members, and their families to mental healthcare, support services (e.g., financial counseling, legal services, employment training, temporary income support), or emergency services. Participants who completed referrals reported lower suicide risk and improved well-being related to mental health, social support, and financial stability.[51]

Some veterans struggle to get the healthcare they need, despite long-term efforts to improve quality and timeliness.[52] The VA's Office of the Inspector General found that every Veterans Health Administration medical center reported staffing shortages in FY 2025, with 94 percent reporting a severe shortage of physicians and 79 percent a severe shortage of

nurses. This is a 50 percent increase from FY 2024, and psychology staffing was the most frequently cited shortage.[53] At the same time, the VA cut 14,400 medical positions in 2025—about 5 percent of all medical staff—including more than 1,500 physician and 4,900 nurse positions, and thousands of social workers, psychologists, and support staff.[54] In addition to fewer medical staff, there have been reports of new caps on mental health treatments permitted, patients losing their longstanding mental health providers, longer waits for therapy appointments, and patient privacy concerns in 2025.[55,56,57,58]

LGBTQ POPULATIONS

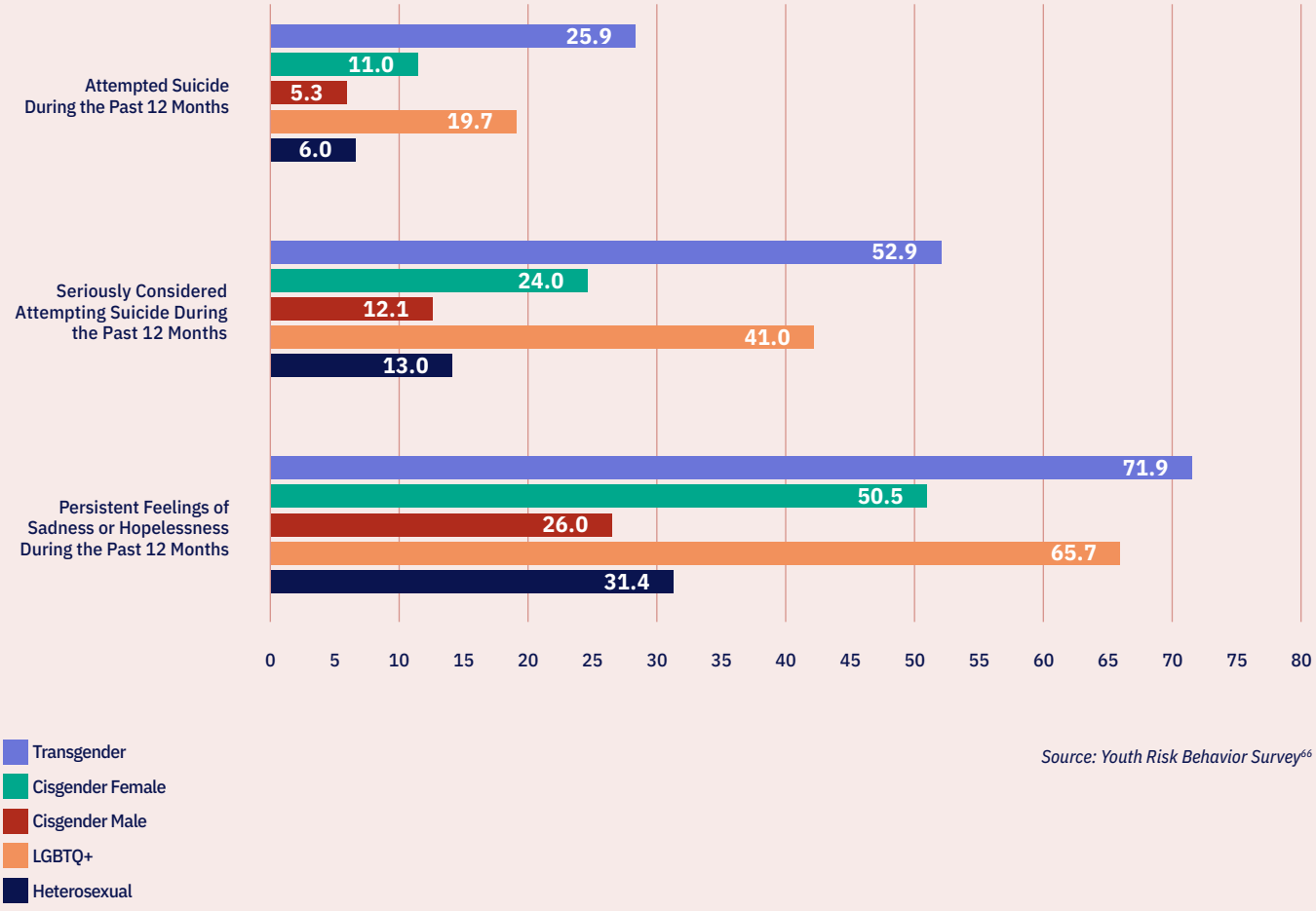
Death certificates and most mortality surveys in the United States do not include information on decedents' sexual orientation or gender identity, leaving the rate of suicide for LGBTQ individuals unknown. The National Violent Death Reporting System (NVDRS) tracked additional data for homicides and suicides, including an optional field for sexual orientation since 2013, though the data is limited because it has low completion rates and is open to misclassification and bias.[59] Transgender status was also included in 2013, but then removed in 2025 after President Trump's January 2025 Executive Order on transgender, nonbinary, and intersex identities led the federal government to remove hundreds of sexual orientation or gender identity measures from data collections.[60] (See more on NVDRS on page 32.)

While the rate of suicide deaths is unknown for LGBTQ populations, surveys and research consistently find higher rates of mental health issues, substance use, and suicidal behaviors for LGBTQ individuals compared with heterosexual individuals.[61,62,63] LGBTQ youth likewise have higher rates of mental health issues and suicidal behaviors. For example, CDC's 2023 Youth Risk Behavior Survey found that high school students who were LGBTQ+ had much worse mental health and higher rates of suicidal behaviors than their heterosexual counterparts. Rates of persistent feelings of sadness or hopelessness, seriously considering attempting suicide, and attempting suicide among LGBTQ+ high school students were about two to four times as high as rates among their heterosexual and cisgender peers.[64,65] *(See Figure 6 on page 22.)*

Research suggests that the heightened levels of suicidal thoughts and behaviors for LGBTQ individuals are related to stigma, discrimination, victimization, and family disapproval.[67,68,69,70,71] The higher risk for transgender individuals may also be linked to physical threats or harm that are perceived to be related to sexual orientation or gender identity.[72] One key protective factor for LGBTQ youth is acceptance by family.[73] The Trevor Project's 2024 annual survey found LGBTQ youth who reported living in very accepting communities attempted suicide less often, and those who reported bullying attempted suicide more often.[74]

For additional information on suicide mortality, see the Alcohol, Drug, and Suicide Mortality Data and Trends section on page 42 and additional data in Appendix B on page 74 and Appendix C on page 78.

FIGURE 6: Percent of High School Students with Mental Health and Suicide Risk Indicators, by Sexual Orientation and Gender Identity, 2023



Source: Youth Risk Behavior Survey[66]

II. SUICIDAL THOUGHTS AND BEHAVIORS

Many more individuals have suicidal thoughts and behaviors every year than die by suicide. The National Survey of Drug Use and Health (NSDUH) estimates that 2.2 million adults and 700,000 adolescents attempted suicide in the United States in 2024. There is no data system that systematically tracks all suicide attempts in the United States. The best information available is from hospital data or surveys.[75]

CDC collects information on emergency department visits for suspected suicide attempts through the National Syndromic Surveillance Program. The most recent data, for March 2026, show 154 suspected suicide attempts per 100,000 emergency visits, which is similar to the 2025 average (151 attempts per 100,000) and slightly higher than the 2024 average (147 attempts per 100,000). The visit rate for adolescents and young adults, females, and AI/AN people was higher than for other groups. [76]

The Substance Abuse and Mental Health Services Administration (SAMHSA) issues the NSDUH report on mental health, substance use, and related trends annually. The most recent survey, from 2024, found that in the past year, for adults ages 18 and older, an estimated 5.5 percent had serious thoughts of suicide, 1.8 percent made a suicide plan, and 0.8 percent attempted suicide.[77] Younger adults, AI/AN and multiracial people, unemployed individuals, and people on Medicaid or who were uninsured all reported serious thoughts of suicide, suicide planning, and attempted suicide at higher rates than other adults in 2024.[78]

For adolescents ages 12–17, NSDUH data show that an estimated 10.1 percent had serious thoughts of suicide in the past year, 4.6 percent made a suicide plan, and 2.7 percent attempted suicide in the past year. The suicidal thoughts and behaviors figures for adolescents have all declined since 2021 (declining from 12.9 percent, 6.2 percent, and 3.6 percent, respectively, in 2021).[79] In 2024, older adolescents, girls, and multiracial adolescents reported higher rates of serious thoughts of suicide, suicide planning, and attempted suicide than their peers. Additionally white adolescents reported serious thoughts of suicide at higher rates specifically, and AI/AN adolescents reported higher rates of suicide planning and attempted suicide specifically.[80]

CDC's Youth Risk Behavior Survey tracks suicidal behaviors among high school students. The last report, from 2023, found 20 percent of high schoolers seriously considered attempting suicide, 16 percent made a suicide plan, 9 percent attempted suicide, and 2 percent were injured in a suicide attempt. LGBTQ+, female, AI/AN, and Native Hawaiian and Pacific Islander students reported higher suicidal behaviors than their peers.[81]

III. MENTAL HEALTH AND WELL-BEING

Suicide risk factors span individual, relationship, community, and societal levels, some of which are tied to general mental health and well-being. These overlap with concerning national trends around mental illness, loneliness, and economic stressors. Suicide is often preceded by emergent problems that create a crisis of hopelessness and despair, and societal conditions can add to risks or limit protective factors.

Mental illness is a suicide risk factor that has also been increasing across the country in recent years.[82,83] The National Health and Nutrition Examination Survey found that the current rate of

depression in youth and adults ages 12 and older increased 60 percent between 2013–2014 and 2021–2023, from 8.2 to 13.1 percent. Rates of depression were higher among females, youth, and individuals with low family income—and showed incremental decreases with increase in age and higher family income.[84] Gallup polling found that the rate of depression among American adults remained elevated compared with pre-pandemic levels in the first quarter of 2026 (19.1 percent) compared with 12.5 percent of adults who reported depression in 2019.[85] When looking at youth experiences specifically, CDC's Youth Risk Behavior Survey found that 40 percent of high schoolers experienced persistent feelings of sadness or hopelessness in 2023—up from 30 percent in 2013—and 29 percent reported poor mental health in 2023. LGBTQ, female, and AI/AN students reported the highest rates of both persistent feelings of sadness or hopelessness and poor mental health in the survey.[86]

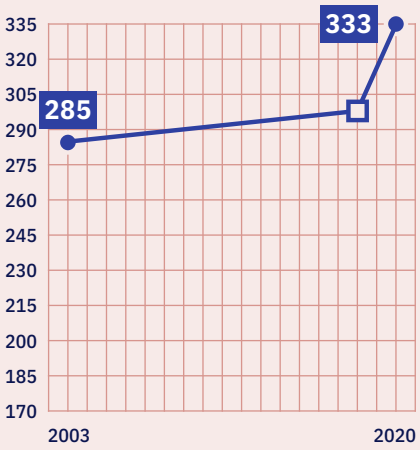
Social isolation and loneliness are other suicide risk factors that have been increasing nationally in recent years.[87,88] In 2023, the U.S. Surgeon General issued the report, "Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community," outlining the rise in loneliness and isolation in the United States, its negative effects on mental and physical health, and the protective benefits of social connection on health, educational attainment, economic productivity, and community connection.[89] More recently, the American Psychological Association's November 2025 poll found 54 percent of American adults felt isolated, 50 percent felt left out, and 50 percent felt they were lacking companionship. The survey found that Americans who reported loneliness were also more likely to report poor mental and physical health.[90]

Economic hardships represent another set of risk factors for suicide or suicidal behaviors, including financial problems, job loss, unemployment, and housing insecurity at the individual level.[92,93,94,95] Poor macroeconomic circumstances—like economic downturns and high unemployment rates—are also associated with higher suicide rates at the population level.[96,97,98,99] In the United States, in the long-term, income inequality has increased and economic opportunity has declined.[100,101] In more recent years, a period of elevated inflation between 2021 and 2023 and low consumer sentiment have added to economic stressors for many Americans.[102,103]

NATIONAL TRENDS FOR SOCIAL CONNECTION: From 2003 to 2020, time spent alone increased, while time spent on in-person social engagement decreased.

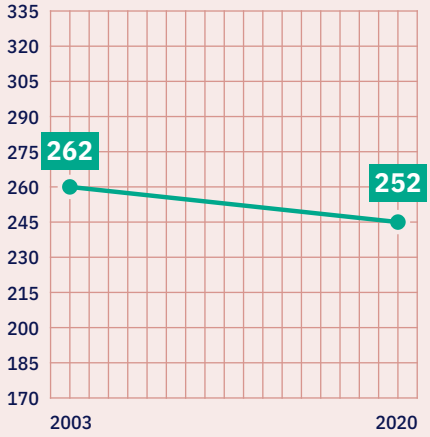
Social Isolation

An increase of **24 hours** per month



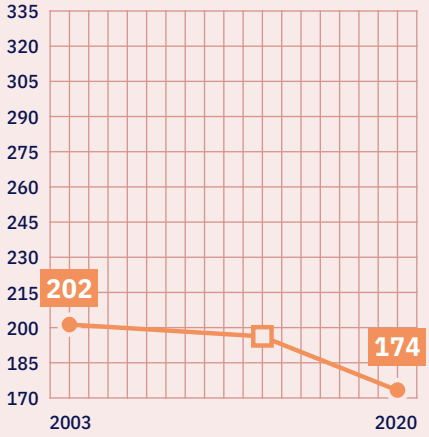
Household Family Social Engagement

A decrease of **5 hours** per month



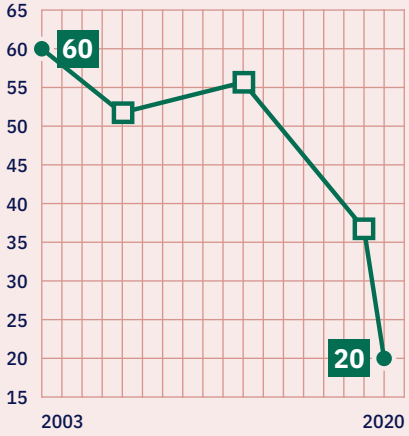
Companionship

A decrease of **14 hours** per month



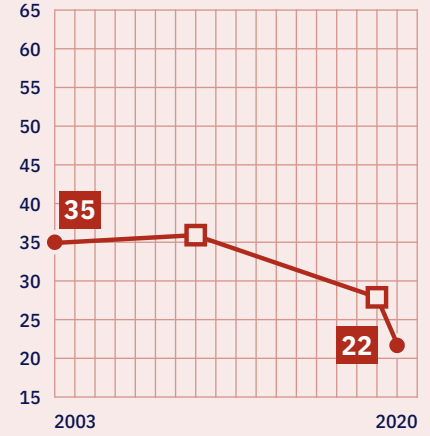
Social Engagement with Friends

A decrease of **20 hours** per month



Non-Household Family Social Engagement

A decrease of **6.5 hours** per month



Social Engagement with Others

A decrease of **14 hours** per month

Note: Y-axis shows minutes per day; subtitles convert the 2003–2020 change to hours per month.

Source: U.S. Surgeon General. [91] *Adapted from Viji Diane Kannan, Peter J. Veazie, US Trends in Social Isolation, Social Engagement, and Companionship: Nationally and by Age, Sex, Race/ethnicity, Family Income, and Work Hours, 2003-2020, SSM-Population Health, Volume 21, 2023. The joinpoints are visual approximations.*

Recent Policy and Program Successes

Over the past two decades, a focus on suicide prevention at the local, state, and national level has led to new and strengthened policies and programs across the country. This subsection highlights progress in crisis response, federal suicide prevention programs, and policies to limit lethal means of suicide.

I. CRISIS RESPONSE

Crisis response in the United States is one policy area where there have been significant developments in recent decades. This includes the creation of the national 988 Lifeline, state red flag laws, and local mobile mental health response units.

988 LIFELINE

In October 2020, President Trump signed the National Suicide Hotline Designation Act into law. The 2020 law created a new three-digit 988 National Suicide and Crisis Lifeline to replace the 10-digit 800-number suicide prevention hotline and the Veterans Crisis Line, which were administered separately. The law requires SAMHSA to support training and services for populations at high risk of suicide, including LGBTQ youth, AI/AN peoples, and individuals living in rural areas.[104]

Since its launch in July 2022, the 988 Lifeline has answered more than 21 million calls, texts, and chats, including more than 6 million in both 2024 and 2025.[105] Awareness of the 988 Lifeline has likewise increased: as of summer 2025, 74 percent of Americans had at least heard of 988, an increase of 30 percentage points since September 2022.[106] An April 2026 JAMA study found that suicide mortality rate among adolescents and young adults ages 15–34—the group most likely to use 988—was 11 percent lower than expected during the first two and a half years of the Lifeline. The study also found that states with the highest 988 uptake saw lower suicide mortality among 15–34-year-olds compared with states with lower 988 uptake, and that older adults—who were less likely to use 988—saw a smaller reduction in their suicide mortality rate over the same time period. Together, this study provides strong evidence that the Lifeline has helped lower suicide mortality for adolescents and young adults.[107]

However, this essential program is at risk. In 2025, the Trump Administration laid off more than 10 percent of SAMHSA staff—the agency that administers the 988 Lifeline—including individuals working on projects related to the Lifeline.[108,109] Additionally, SAMHSA terminated operations of the LGBTQ youth specialized-service program in July 2025.[110]

988 LIFELINE IMPROVEMENTS AND CHALLENGES

For nearly four years, the 988 Suicide and Crisis Lifeline has provided immediate support, resources, and referrals to millions of individuals in crisis. Monthly contact volume reaches roughly 500,000—nearly three times the volume of the previous "1-800" system (184,819 in June 2022).[111] Additionally, call answer rates have improved—with most states now answering 80 percent or more of in-state 988 calls.[112]

There are ongoing and new challenges with 988. Most states have not permanently funded 988 Lifeline efforts, despite a previous expectation from Congress that states would establish long-term funding mechanisms.[113,114] In fact, as of June 2025, only 12 states have enacted monthly telecommunications fees to support the Lifeline.[115]

In October 2024, the Federal Communications Commission approved rules that implemented geo-routing for the 988 Lifeline, requiring wireless providers to route calls and texts based on geographic location instead of area code, improving how users are connected with local crisis centers and resources.[116]

In December 2025, SAMHSA released guidance to help communities improve coordination between 988 and 911 services. In detailing the purpose of the guidance, SAMHSA stated, "interoperability of the 988 and 911 emergency services systems aims to provide a seamless response to individuals experiencing a behavioral health crisis."[117] Specifically, the resource provides practical guidance on defining the distinct roles of 988 and 911, strengthening partnerships between the two services, streamlining communications, and reducing legal risk and liability concerns. Liability concerns have included those related to the Health Insurance Portability and Accountability Act (HIPAA), liability for failure to act or for incorrect action, contractual risks, and fatalities. Washington state passed legislation to implement liability protections for crisis call center staff or designated 988 contact hub staff for performing dispatching responsibilities in "good faith."[118]

Despite these impacts and actions, the elimination of specialized services and staffing cuts at SAMHSA threaten to diminish access to the Lifeline's life-saving support. In June 2025, SAMHSA announced the termination of the "Press 3" option, which provided specialized services for LGBTQ+ youth. The termination came despite the significant demand—the option had received 1.5 million contacts from LGBTQ+ young people since its launch.[119] LGBTQ+ youth are more than four times as likely to attempt suicide as their cisgender and heterosexual peers, underscoring the importance of providing services tailored to this demographic.[120] Eliminating these specialized services will diminish access to targeted care and disrupt the continuum-of-crisis intervention supports and services.

Some states and localities have taken steps to protect specialized services for LGBTQ+ youth. In July 2025, the Illinois Department of Health announced that it would continue to provide the specialized services.[121] In December 2025, the Los Angeles County Board of Supervisors approved two motions to implement the "Press 3" option within the county.[122] Federal action will be needed to ensure that these services are accessible across all states and communities. The bipartisan 988 LGBTQ+ Youth Access Act of 2025 would codify these specialized services nationally.[123] The FY 2026 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill provides $534.6 million in funding for the Lifeline—a $15 million increase from the FY 2025 continuing resolution. The bill also provides $33.1 million in funding for "Specialized Services for Youth," like the "Press 3" option.

In an April 2026 hearing held by the Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, the Department of Health and Human Services Secretary Robert F. Kennedy, Jr. committed to restoring the specialized services for LGBTQ+ youth.[124]

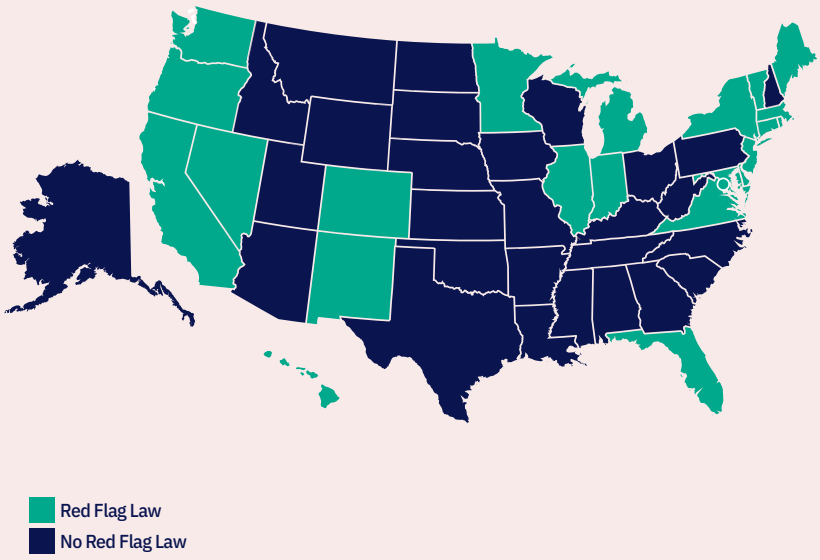
RED FLAG LAWS

Red flag laws, also called Extreme Risk Protection Orders or Gun Violence Restraining Orders, allow a judge to temporarily prevent someone at serious risk of harming themselves or others from accessing firearms. This allows law enforcement, family members, or others in a community to take action and restrict access to lethal weapons for individuals in crisis.

Connecticut was the first state to pass a red flag law, enacted in 1999, followed by Indiana in 2004. Between 2014 and 2025, another 20 states plus the District of Columbia passed red flag laws or ballot initiatives.[125,126] On the other hand, between 2020 and 2025, several states—Oklahoma, West Virginia, Wyoming, Tennessee, Montana, and Texas—enacted preemption laws that stop cities, counties, or other municipalities within the state from enacting red flag laws.[127,128,129,130,131]

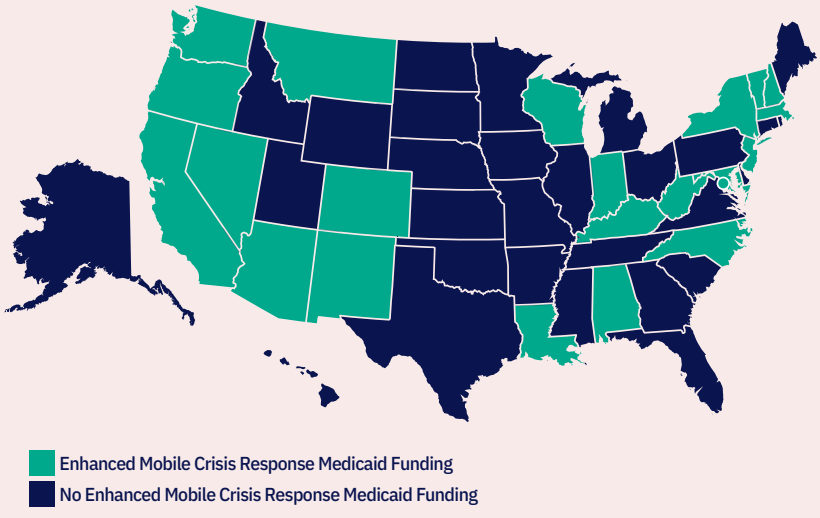
Researchers studying Connecticut's red flag law estimated that for every 10.6 removal orders, one suicide was averted.[133] A 2024 study of California's Extreme Risk Protection Order law found one suicide death was prevented for every 22 orders.[134]

MAP 1: States with Red Flag Laws, 2026



Source: Everytown for Gun Safety[132]

MAP 2: States with Enhanced Medicaid Funding for Mobile Crisis Response, as of 2024



Source: National Alliance on Mental Illness[148]

MOBILE CRISIS RESPONSE

Mobile crisis units or mobile crisis teams are behavioral health professionals who respond to mental health crises in the place of or jointly with law enforcement via 911, nonemergency police lines, or 988 calls. The teams are trained to handle nonemergency situations, de-escalate and counsel the person in crisis, administer medication where authorized, refer people to additional treatment, bring the person to the hospital for additional assistance, and provide follow-up support. The units are typically managed by local or state health departments, community mental health organizations, or hospitals.[135,136] A 2025 JAMA Network Open study found that about 20 percent of U.S. mental health treatment facilities reported offering mobile crisis services.[137]

One pioneering program—established by the White Bird Clinic in Eugene, Oregon, in 1989—was the Crisis Assistance Helping Out On The Streets (CAHOOTS) program, which paired an EMT and a crisis worker to provide crisis intervention, support, and resources to community members. In addition to crisis intervention, mobile crisis teams may also conduct grief and wellness check-ins to support individuals with nonemergency health concerns, as well as to provide basic medical care, including naloxone to reverse opioid overdose. The Eugene program largely ended in April 2025, after more than 35 years, when the White Bird Clinic stopped its support and city funding alone proved insufficient.

Research shows that crisis intervention can reduce law enforcement involvement, incarceration, emergency department visits, and inpatient admissions. For example, a study in Michigan of county-level crisis response found a reduction in arrests in counties that instituted mobile crisis response; a study of Arizona's Medicaid program found crisis response services reduced emergency department and inpatient services; and a 2013 study of mental health crisis units in Minnesota found the program saved money based on healthcare savings—providing a $2.16 return on investment for every dollar spent on the program.[140,141,142]

The 2021 American Rescue Plan Act included a provision for Medicaid programs to receive enhanced federal funding for qualified mobile crisis services for up to three years between 2022 and 2027. It also provided funding for planning grants to develop mobile crisis infrastructure.[143]

Despite improving outcomes and reducing healthcare costs, many programs struggle for sustainable funding. Medicaid, the largest provider of behavioral health services in the country, often reimburses mobile crisis units for services to some extent, though many private insurers do not, leaving programs dependent on additional state and local government funding or grant support.[144,145] The 2025 One Big Beautiful Bill Act is estimated to reduce Medicaid spending by $990 billion and will cause 7.5 million Americans to lose their Medicaid or Children's Health Insurance Program (CHIP) health coverage by 2034—creating more funding uncertainty for individuals and behavioral health programs.[146,147] (See page 71 for more on Medicaid and behavioral health treatment.)

IMPLICATIONS OF SOCIAL MEDIA AND AI ON SUICIDE AND WELL-BEING

Social media and generative artificial intelligence (AI) include a broad array of platforms and products that reach most Americans. A 2025 Pew Research survey of U.S. adults found that 84 percent have used YouTube, 71 percent have used Facebook, and 50 percent have used Instagram, and about half visit YouTube and/or Facebook daily. Young adults ages 18–29 are more likely to use YouTube, Instagram, Snapchat, and TikTok.[149]

Social media, at its best, can create social support, facilitate meaningful connections, and promote well-being.[150] It is also often linked with negative effects on mental health and well-being, including associations with higher rates of depression, anxiety, and loneliness.[151] The effects on youth have been a particular concern, including specific experiences on social media—bullying, harming self-image, and promoting and enabling unhealthy and risky behaviors (e.g., disordered eating, self-harm, and purchasing illicit drugs)—as well as addiction, excessive screen time, impact on academic performance, and reduced well-being at the population level.[152,153,154,155,156,157] Some research has found no major impact on well-being for the majority of youth, but for those who are impacted, other research connects social media use with higher rates of anxiety, depression, and self-harm.[158] A January 2026 study found that smartphone ownership, which allows continual access to social media, was associated with depression, obesity, and insufficient sleep for youth.[159] Continued research is needed to understand which youth are at risk on social media, what platforms or uses cause harm, and what steps social media companies and policymakers can take to create safe environments for all youth users.

Generative AI products (e.g., virtual assistants and chatbots) are an emerging issue. Many people turn to these products with the questions and problems in their lives, including mental health issues, personal crises, and suicidal thoughts. A March 2026 KFF poll found 16 percent of U.S. adults have used AI for mental health information or advice. The most common reasons that respondents cited for using AI for health advice are: (1) a desire for quick and immediate advice, (2) wanting to look up information before seeing a provider, (3) feeling more comfortable looking up health questions privately, and (4) difficulty in access or affordability of healthcare.[160] And, according to OpenAI, in one week, more than 1 million ChatGPT users expressed "explicit indicators of potential suicidal planning or intent."[161] While AI is immediate and accessible, research shows that it fails to identify and respond to mental distress, and it misses nuances when providing support as compared with humans.[162,163] A number of news stories and legal challenges involving suicide deaths and self-harm after seeking chatbot support underscore the potential harms of inadequate AI responses to suicidal crises.[164,165,166,167,168]

In 2022, the American Academy of Pediatrics established the Center of Excellence on Social Media and Youth Mental Health with support from SAMHSA.[169] The center is dedicated to creating a healthy digital ecosystem for children and adolescents as well as providing actionable recommendations and resources to families and pediatricians, including parental guidance, tipsheets, and toolkits geared toward different ages and concerns. The center's Youth Advisory Panel has called on policymakers to collaborate with mental health researchers on evidence-based policy design, to increase regulation and oversight of social media platforms, to mandate digital literacy education, and to promote mental health resources within social media environments—while recognizing that social media's effects on youth are neither uniform nor universally negative.[171]

II. FEDERAL PROGRAMS

Federal programs provide essential expertise and funding to states, territories, tribes, localities, and organizations to support a variety of suicide prevention activities. This includes programs like CDC's Comprehensive Suicide Prevention program, which uses population-based strategies; the National Violent Death Reporting System, which supports data collection that guides policy and program responses; and the Garrett Lee Smith program, which focuses on suicide prevention for youth. These programs and their impact are described in this subsection.

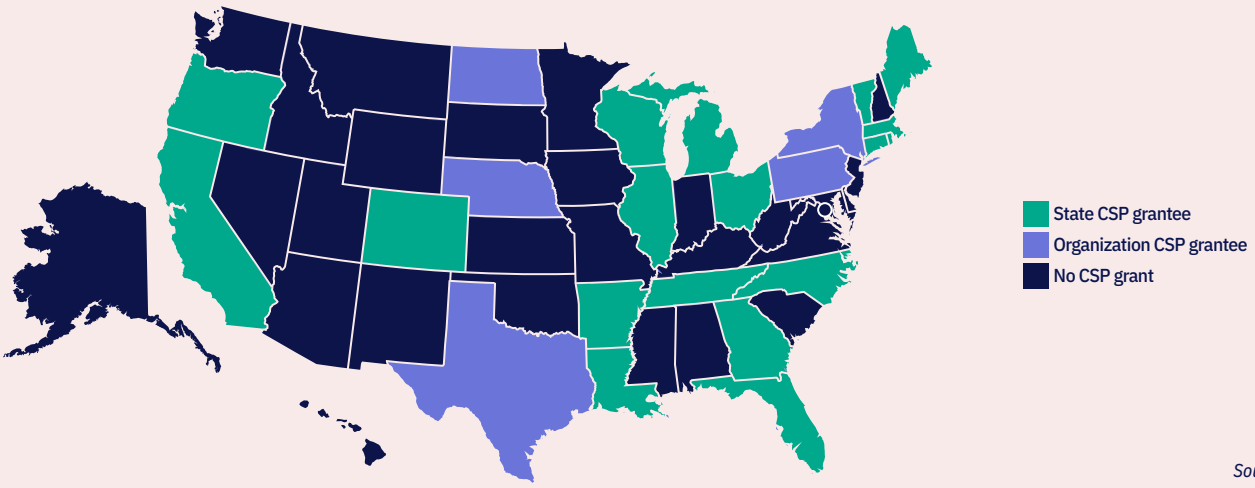
COMPREHENSIVE SUICIDE PREVENTION PROGRAM

CDC created the Comprehensive Suicide Prevention (CSP) program in 2020, and currently funds suicide prevention through 19 state or territorial health departments and five universities and nonprofit organizations. CSP grantees use data to guide implementation, use evidence-based strategies, focus on populations with high suicide rates, evaluate program efficacy, and identify service gaps.[173,174]

Examples of the current CSP grantees and their work include:

- **The Arkansas Department of Public Health** hired two dedicated personnel to focus on suicide prevention in the state, building collaborations across healthcare, behavioral health, and crisis intervention sectors; creating regular stakeholder and community meetings to identify needs; and instituting the "Question. Persuade. Refer." training program and media campaign.
- **University Health System of Bexar County, Texas** identified individuals ages 15–44 as a high-risk population in their area, and built a program focused on reducing suicide attempts and deaths for this age group. They worked with 12 partners across educational, healthcare, nonprofit, and public health sectors to implement different strategies, including mental health trainings for local universities, Zero Suicide (a prevention framework) and lethal means trainings for healthcare partners, and increasing access to mental health services for youth.
- **The Vermont Department of Health** conducted a suicide data-linkage project to better understand the risk factors, populations at risk, and interaction patterns with state or community services for

MAP 3: CDC Comprehensive Suicide Prevention Program Grantees, February 2025



Source: CDC [175]

individuals who died by suicide in Vermont. These findings were used to guide prevention strategies and inform future policymaking.[176]

- **The Florida Department of Health** focused on preventing suicide among veterans. The department collaborated with veteran and suicide prevention organizations to create a multifaceted training program for healthcare providers, social services providers, public health workers, first-responders, and veterans. The training aimed to promote conversation and reduce shame about suicide, create connections across sectors and between veterans and non-veterans, and improve veteran-specific resources in communities across the state.

NATIONAL VIOLENT DEATH REPORTING SYSTEM

After decades of advocacy and pilot programs by researchers, advocates, and foundations, CDC launched the National Violent Death Reporting System (NVDRS) in 2002 and began collecting data in 2003. NVDRS data was made publicly accessible through CDC's web-based Injury Statistics Query and Reporting System in 2008 and expanded nationwide in 2018. It combines information from law enforcement and public health sources to create a detailed picture of these deaths modeled after the National Highway Traffic Safety Administration's Fatality Analysis Reporting System. The details provide useful data to identify patterns and to design violence prevention strategies.[177,178] NVDRS now includes death information from suicides, homicides, law enforcement

actions, undetermined intents (when circumstances of death are unclear: could be accidents, could be suicide, etc.), and unintentional firearm deaths from all 50 states, the District of Columbia, and Puerto Rico across 600 unique data elements.[179]

NVDRS data supports researchers, practitioners, advocates, and policymakers in better understanding the scope and underlying causes of violent deaths, and in designing, implementing, and evaluating policies and programs in response. Numerous research studies drawing on NVDRS data have yielded new insights into suicide and other violent deaths. This includes academic studies linking higher suicide rates with preceding evictions and foreclosures, and finding intimate partner problems as the most common precipitating factor for suicide among active duty Army personnel.[180]

State health departments also use their states' data to identify populations at risk of suicide and to plan suicide prevention efforts. Examples include:

- **Massachusetts:** After an increase in deaths from train strikes, the Commonwealth used data to inform where to improve fencing and add signage for the national suicide prevention hotline around train lines. Preliminary data showed a decrease in train suicide after the intervention.[181]
- **Oregon:** The health department investigated suicide patterns among its state veterans and shared findings with the local Veterans Health Administration.[182]
- **Utah:** The state identified a large increase in youth suicides, which led to the creation of the Governor's Teen Suicide Prevention Task Force and eight new state laws related to improving youth mental health and preventing suicide. Since these steps, youth suicide in Utah has declined.[183]

GARRETT LEE SMITH PROGRAMS

In October 2004, President George W. Bush signed the Garrett Lee Smith Memorial Act into law, creating new grant programs to support community-based suicide prevention for youth across the country.[184] Since then, the Garrett Lee Smith programs—managed by SAMHSA—have supported hundreds of grants to promote suicide prevention and early intervention strategies on college campuses, as well as adolescent-focused efforts by states, territories, and tribes.[185]

The Garrett Lee Smith campus grants support a comprehensive, evidence-based approach to student mental health, focusing on expanding services for students at risk of suicide, depression, serious mental illness, or substance use disorders; preventing mental and substance use disorders; promoting help-seeking behavior and reducing stigma; and improving identification and treatment of at-risk students to support academic success.[186] Examples of FY 2025 campus grantees and activities include: the University of Notre Dame expanding current mental health and suicide prevention initiatives with an emphasis on early intervention, a supportive campus culture, and student well-being; Occidental College creating and implementing a data-driven strategic plan to prevent suicide on campus in partnership with the Jed Foundation; and Illinois Wesleyan University launching an awareness campaign for suicide prevention and available campus resources, as well as partnering with the county government and local hospital mental health crisis team to help students in need.[187,188,189]

Garrett Lee Smith state, territorial, and tribal grants support the implementation of youth suicide prevention and early intervention strategies across schools, juvenile justice systems, substance use and mental health programs, foster care systems, and other youth-serving organizations, with the goals of increasing organizational capacity to identify youth at risk of suicide, strengthening clinical providers' ability to assess and treat youth at risk of suicide, and improving continuity of care and follow-up for youth following discharge from emergency or inpatient settings.[190] The 21 FY 2025 grantees include a mix of states, tribes, and educational organizations, including Arizona State Department of Education, Cherokee Nation,

Generation Schools Network (Colorado), Massachusetts State Department of Public Health, Oglala Sioux Tribal Council, Johns Hopkins University (Maryland), and Texas Health and Human Services Commission.[191]

Over the years, evaluations have found the Garrett Lee Smith programs save lives. For example, a 2015 study looking at Garrett Lee Smith gatekeeper training sessions, the most common strategy among grantees, found significantly lower suicide rates (1.33 fewer deaths per 100,000) among 10–24-year-olds the next year in counties with the training compared with counties without the training.[192] Another 2015 study found significantly lower suicide attempt rates (4.9 fewer attempts per 1,000 youths) among 16–23-year-olds in areas with Garrett Lee Smith programs the year after implementation, compared with areas without those programs. The researchers estimated that the Garrett Lee Smith program may have averted 79,000 suicide attempts between 2006 and 2009.[193]

A 2019 study of the longer-term impacts found that youth suicide mortality in counties with Garrett Lee Smith programs was significantly lower both one year (-0.9 deaths per 100,000 youths) and two years (-1.1 per 100,000 youths) after program implementation compared with control counties without programs. The study found that multiple years of implementation led to larger mortality declines, but those impacts stopped after three or more years of program discontinuation. The study also looked at rural areas, finding an even greater impact: in rural counties with Garrett Lee Smith programs, suicide mortality was 2.4 deaths lower per 100,000 youths two years after program implementation compared with control counties.[194]

SAMHSA awarded the most recent round of Garrett Lee Smith grants in 2024. The campus grants included three-year awards of up to $102,000 annually, and the state/tribal grants included five-year awards up to $735,000.[195,196] In January 2026, the Trump Administration announced $2 billion in cancellations of SAMHSA's behavioral health grants, including the Garrett Lee Smith programs, which were restored following opposition from stakeholders and policymakers, including bipartisan members of Congress.[197]

III. REDUCING ACCESS TO LETHAL MEANS OF SUICIDE

Limiting lethal means of suicide saves lives.[198] These efforts include promoting safe storage of medications and firearms through public education and laws; limiting access to firearms for children and individuals in crisis or at risk of suicide; and training healthcare providers, counselors, and first-responders on lethal means counseling.

SAFE GUN STORAGE AND CHILD ACCESS PREVENTION LAWS

Firearm suicides comprised more than half of all suicides in 2024. Research consistently shows that having access to a firearm significantly increases the risk of suicide.[199,200,201] This holds true for gunowners and anyone who lives in the household, including youth.[202] One study found that at the population level, for every 10 percentage point increase in gun ownership, the total suicide rate was 27 percent higher for youth ages 14–19.[203] Safe storage of firearms—that is an unloaded firearm stored in a gun safe or secured with a firearm lock—can reduce that risk.[204] A 2025 study found that while safe gun storage did not significantly change the odds of firearm suicide for adults in the household, it did reduce the odds for youth and young adults who were 15–20 years old.[205]

To that end, several states have laws to keep firearms out of the hands of youth. Child access prevention laws impose criminal liability on adults if a child accesses an unsecured firearm or if a firearm is stored in a manner that a child could access. As of January 2025, such laws are in effect in 27 states and the District of Columbia. A 2025 study of child access prevention laws found that these laws lowered overall suicide rates for youth under age 18 by up to 14 percent. The study also determined that the most effective child access

prevention laws were those requiring firearms to be stored, unloaded, and locked in a secure device in homes with children under age 16.[206]

SAFE STORAGE COUNSELING AND PROGRAMS

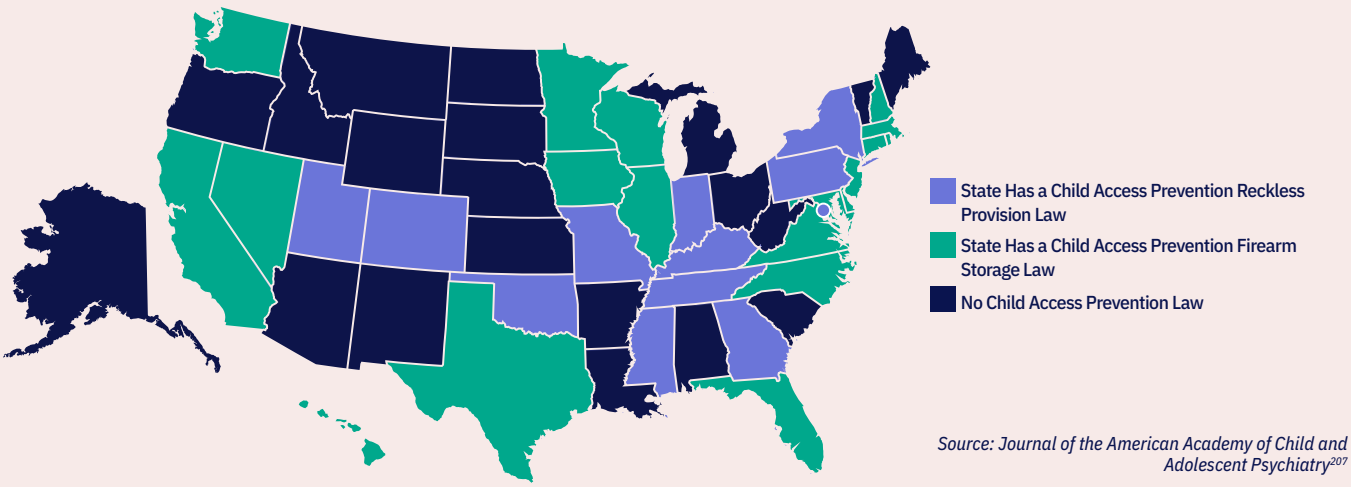
Many programs encourage safe firearm and medication storage practices through education, counseling, and provision of locks or safes.[208,209] For example, the Counseling on Access to Lethal Means (CALM) model trains healthcare providers and social-service professionals on how to identify patients at risk of suicide, ask them about access to lethal means, and counsel them and their families on reducing means access. In practice, this may mean helping families improve firearms storage behavior.[210] One study, which focused on parental counseling for suicidal youth in the emergency department, found a 100 percent safe storage compliance rate for firearms at follow-up.[211]

Many local, state, and national programs also provide free firearm locking devices along with educational materials on safe storage practices, drawing on coalitions that span public health and the firearms industry. National examples include the Suicide Awareness Voices of Education (SAVE) organization and the National Shooting Sports Foundation's Project Childsafe—reflecting the broad, cross-sector support for safe storage as a suicide prevention strategy.[212,213]

BRIDGE BARRIERS

Suicide by fall or jumping is a lethal but uncommon suicide method—making up less than 3 percent of suicides in 2024—but it is a serious problem in certain localities and can lead to suicide clusters and contagion (the spread of suicidal behavior through social exposure) due to the public nature of these deaths. Studies show that another person's suicide can increase the risk of suicidal behavior and death by suicide for family and friends—and that this effect is heightened among youth.[214,215] Installation of evidence-based suicide deterrents like barriers and nets on bridges can prevent suicide attempts and deaths, and are particularly important at places with a history of suicide deaths.[216]

MAP 4: States with Child Access Provision Laws, 2025



Source: Journal of the American Academy of Child and Adolescent Psychiatry[207]

Note: Storage laws require secure firearm storage; reckless provision laws impose liability for recklessly allowing child access.

In recent years, there have been high-profile bridge barrier projects. Since the 1937 opening, the Golden Gate Bridge in San Francisco, California, has been a locus for suicide attempts. In recent years, the bridge annually saw about 30 suicide deaths and almost 200 additional individuals in crisis intercepted by bridge officers on average—that is, until the bridge barriers were completed in 2024. The Golden Gate Bridge had eight suicide deaths in 2024 and, in 2025, the first full year with barriers, there were four suicide deaths. The number of officer interventions for suicide attempts also fell by half in 2025, suggesting many individuals were deterred by the barriers' presence.[217]

Several bridges across deep gorges near Cornell University in Ithaca, New York, were a known suicide location and during the 2009–2010 academic year, were a site of a suicide cluster of five deaths on or near campus. In response, Cornell built suicide safety barriers across eight local bridges and adjacent gorges in 2010. A 2024 doctoral dissertation evaluating the efficacy of the barriers found that there were 27 lethal and three nonlethal jumps from January 1990–March 2010 before the barriers, and three lethal and two nonlethal jumps from April 2010–December 2022 after the barriers. Despite increases in suicide ideation and attempts by Cornell undergraduate students over the time, the overall suicide rate for Cornell students fell slightly (from 7.4 deaths per 100,000 before the barrier to 6.8 deaths per 100,000 after the barriers).[218]

INNOVATIVE STATE, TERRITORIAL, TRIBAL, AND LOCAL POLICIES AND PROGRAMS

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

- In Washington state, the 988 Suicide and Crisis Lifeline provides services in multiple languages, including Spanish and American Sign Language. In addition, the line provides tailored services for some groups, including military veterans, AI/AN people, and, until July 2025, LGBTQ youth.[219,220] Notably, the Native and Strong Crisis Lifeline option is the first of its kind in the nation specifically for AI/AN individuals.[221] Those accessing the AI/AN line can call, chat, or text with trained crisis counselors who are tribal members and community descendants with strong cultural ties.[222] The lifeline is operated by Volunteers of America Western Washington and emphasizes cultural practices for healing, crisis intervention, and support.[223]
- In 2000, the Colorado legislature established the Office of Suicide Prevention (OSP) to address the high incidence of suicide in the state.[224] In 2024, Colorado observed the lowest suicide rate for the state's youth since 2007.[225] The OSP runs several suicide prevention efforts, including programs in public schools that provide follow-up for those discharged after a mental health crisis. A notable OSP program is the Colorado Gun Shop Project, which educates and raises awareness about firearm suicide prevention.[226] The office awards funds to grantees in 49 Colorado counties to work with local firearm advocates at firearm retailers, gun ranges, sportsman clubs, veterans and first-responder organizations, and other community-based organizations.[227]

- Tribal populations across the country are addressing the disparately high rates of suicide in AI/AN communities.[228] In 2024, the Indian Health Service (IHS) introduced a policy requiring all IHS facilities to screen patients using the "Ask Suicide-Screening Questions" (ASQ).[229] In July 2025, the Clinton IHS Health Center in Oklahoma was one of the first providers to implement ASQ.[230] The center also provided customized IHS train-the-trainer materials for each type of provider and locally applicable screening procedures to ensure successful implementation.[231] The new process at Clinton has had patients complete the ASQ on their own and then review their responses with the provider, allowing for a more comprehensive assessment.[232]
- In 2024, a multidisciplinary team from the North Carolina Department of Health and Human Services (NCDHHS) was selected to attend the second Black Youth Suicide Prevention Policy Institute hosted by SAMHSA.[233] The meeting goal was for each state to make a plan for preventing Black youth suicide through policy, systems, and environmental strategies.[234] In July 2025, NCDHHS released the North Carolina Black Youth Suicide Prevention Action Plan to implement evidence-based practices to prevent death by suicide, suicidal behaviors, and self-injury among Black youth and young adults in the state.[235] The plan includes the Community of Practice and Education (COPE) initiative, expanded peer-to-peer support systems, and programs created specifically for the needs of Black youth.[236] Components of the plan include educational posters for Black barbershops and training barbers to have conversations about lethal means access.[237]
- Rhode Island has taken a multipronged approach to addressing suicide rates in the state. In 2024, Rhode Island passed legislation establishing a suicide mortality review board.[238] The board—a multidisciplinary team including representatives from the Office of the Medical Examiner; the Rhode Island Department of Health Violence and Injury Prevention Program; the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals; Emergency Medical Services, law enforcement, healthcare workers, and others—is now responsible for reviewing suicide deaths with the goal of reducing its prevalence by examining trends in demographic, geographic, and community risk factors.[239] Additionally, the Samaritans of Rhode Island supplement the Rhode Island Department of Health's suicide prevention efforts by offering programs and services in every locality in the state.[240] Suicide prevention advocates have also led advocacy efforts to implement safety barriers for bridges throughout the state, but those efforts have not been successful.[241,242]
- For more than 25 years, the Puerto Rico Department of Health's Commission on Suicide Prevention (Comisión Para La Prevención Del Suicidio) has been working on reducing suicide with a data-driven approach.[243] The commission has noted an increase in suicides coinciding with natural disasters, such as the 2020 earthquake sequence and COVID-19 pandemic.[244] In response, the commission established a unique program focused on suicide prevention in disaster situations.[245]

Progress at Risk

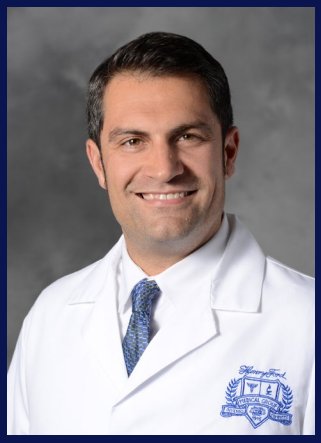
After two decades of slowly worsening trends, suicide mortality declined in 2024—a tentative turning point. Cuts to public health funding, reductions to the federal public health workforce, and uncertainty surrounding long-standing programs and grants all threaten these advancements; for example, there have been reductions in SAMHSA, CDC Injury Center, and VA healthcare staff, elimination of the 988 Lifeline LGBTQ+ youth services, and Garrett Lee Smith termination notices that were then rescinded.

Sustained progress requires building on the evidence-based strategies, policies, and programs created over decades, as well as continuously looking for areas to expand, innovate, and improve. Policymakers at the national, state, and local levels should commit to a comprehensive, long-term approach with increased program investments and evidence-based policies to reduce suicide and improve the mental health and well-being of all Americans. Key priorities include:

- Supporting individuals experiencing crises and mental distress by connecting them with available social and healthcare services through the 988 Lifeline; emergency healthcare interventions; peer supports; and grief, emergency, and crisis counseling.
- Limiting lethal means of suicide by promoting safe storage for firearms and medications, advancing red flag laws, and supporting bridge barriers.
- Providing affordable, accessible, high-quality healthcare, screenings, and early intervention services, along with complementary social supports, for individuals with behavioral health conditions.
- Improving underlying conditions that support optimal health and well-being, buffer against economic and social stressors, and promote resilience by improving youth well-being, the social safety net, and economic opportunities.
- Strengthening programs and support for populations with high suicide risk such as older adults, AI/AN people, Black youth, rural populations, occupations with high suicide rates, veterans, and the LGBTQ community.
- Increasing and sustaining investments in the spectrum of suicide prevention services, including through SAMHSA and CDC programs, and ensuring they reach every state and territory.

The policy recommendations that follow on page 60 offer a roadmap for sustaining and building on recent progress—but their value depends on sustained investment in the public health infrastructure that makes prevention possible.

INTERVIEW WITH BRIAN AHMEDANI, PH.D. ON HENRY FORD HEALTH'S ZERO SUICIDE MODEL



Brian K. Ahmedani, Ph.D., is the Director of the Center for Healthcare Improvement and the Director of Research for Behavioral Health Services at Henry Ford Health, in Detroit, Michigan. He leads research related to suicide prevention, including evaluating implementation of the Zero Suicide model.

BACKGROUND: The Zero Suicide in Health and Behavioral Health Care model (Zero Suicide) offers specific, evidence-based practices for health systems with a larger goal to make healthcare settings safer and more compassionate for people with suicidal thoughts and to normalize suicide prevention. Initially developed in 2001 within the Henry Ford Health system, Zero Suicide includes seven elements of suicide care adaptable for uptake in numerous care settings, including public health agencies.

TFAH: Reflecting on the past 25 years of the Zero Suicide Model, what do you think has been the most important opportunity or impact of the model? What has been the biggest challenge with implementation?

AHMEDANI: For a long time, there was no clear solution for how providers could help prevent suicide in healthcare systems. This approach has provided a solution, and we finally have momentum and support to make change, especially as recognition of suicide as a public health issue has grown.

As far as challenges, healthcare has so many priorities and requirements. There are constantly new initiatives and priorities to solve the latest issues of the day, so navigating, and integrating another process within a healthcare system is always challenging.

Still, health systems are beginning to understand the importance of suicide prevention. Healthcare payers are understanding it, too. Policymakers are starting to get it. There's obviously a lot of work to do, but the recognition is there, and the suicide prevention movement has momentum that I have never seen before.

TFAH: Discourse about and openness to behavioral health and suicide prevention have evolved over the past 25 years. How have these societal and structural shifts facilitated adaptation of elements in the Zero Suicide model?

AHMEDANI: Each year, over 15 million people across the country are having suicidal thoughts, which is about 5 percent of the U.S. adult population. That's a lot of people, and there's a good chance that an individual has struggled themselves or knows somebody in their life who has struggled with suicidal thoughts. We have an obligation to learn from these experiences and take action.

We've been able to reach more people as Zero Suicide approaches are integrated into healthcare systems. There's still stigma, and many people at risk fear that there isn't anything to actually help them. They've been through the system before. They've been sent to places that they feel might be harmful. There's a lot of fear.

Telehealth is one way that we're reaching more people. We've been able to set up teletherapy approaches that help people navigate issues like childcare, transportation, and taking time off work. We can support people in rural areas without extensive travel. It's been encouraging to see society come together to

understand the lived experiences of so many people in our communities, whether they have faced suicide risk themselves or know someone who has.

TFAH: What do you wish policymakers understood about our country's progress and challenges in achieving zero suicides?

AHMEDANI: There are still a lot of opportunities for people to understand the struggles of suicide. There's a lot of stigma, and there are many people who are fearful of sharing their experiences. They may not even fully understand what is happening to them. We have to promote a society where it's continually okay to get help, but also, that there's access available for people to get help when they need it. One of our biggest issues is that, for some people, it's hard to get access to mental healthcare—and it's even more difficult to get access to suicide care.

We're starting to integrate Zero Suicide approaches, but they're not yet available everywhere. It's important to really reinforce policies that expand access to care, support the behavioral health system that serves as the treatment and care pathway for so many people, and invest in behavioral healthcare and prevention approaches further upstream. Our system waits until a crisis happens and then we invest. What we really need to do is invest in prevention. While crisis care is important, investing in prevention saves a lot of bad outcomes, and I think policymakers have an opportunity to recognize and support policies that create access and support prevention so that we never get to the space where people need crisis care.

TFAH: Given that suicide disproportionately affects certain populations, how does the Zero Suicide model center equity to address health disparities in suicide risk, such as Native Americans, veterans, and increasing suicide rates among Black youth and older adults?

AHMEDANI: Zero Suicide is designed to be adaptable, allowing different approaches for different populations. That starts with identifying groups at high risk—understanding the data and recognizing the populations that are struggling. From there, we can design outreach and support programs tailored to high-risk individuals that integrate the unique, cultural factors important for people to engage in that care. If the approach is not relevant to the community, we're not going to reach people and help them get healthy.

For example, there's a high suicide risk among veterans. The Department of Veterans Affairs has one of the better suicide prevention programs in the country—using a model that identifies risk factors among veterans to proactively reach out to veterans and provide services, rather than waiting for them to seek care. The challenge is that many veterans don't receive care through the VA. That's why our model also has very clear pathways for recognizing and responding to suicide risk for those populations within the community healthcare system. By actively reaching out to people, we can connect with them sooner.

TFAH: Since it was developed at Henry Ford Health, the Zero Suicide model has been adopted by health systems across the United States. What elements of this model make it scalable across such a wide range of systems serving populations with very different needs?

AHMEDANI: One of the most important things about this approach is that it's designed to be pragmatic and fit within the healthcare system, rather than bolted on to the outside as an extra piece. For example, we conduct routine screenings during many types of healthcare visits. Integrating one question about risk of suicide within the workflow is simple because it fits within the framework that already exists. In many cases, we can format that question just like we ask about other conditions, so people can respond in the same way they're responding to other questions.

The other important point is that each of these pieces builds within structures that already exist. The treatment approaches can be done in the same format as a standard psychotherapy or psychiatry visit. We can use models that focus on suicidal ideation or thoughts in much the same way that we would provide cognitive behavioral therapy. The billing codes are the same, and the session takes the same amount of time, so the healthcare doesn't need to change to accommodate this work.

There are brief interventions that we can provide right after they screen positive, making sure they receive support immediately, rather than being screened and then waiting for an appointment. We can provide real care right away, followed by ongoing touch points, and then treatment that fits within the healthcare system. That's what makes this model so adaptable.

TFAH: Among other research, in 2025, you found that multiple health systems implementing the model experienced a reduction in suicide attempt rates. How do these robust findings inform the future direction and impact of the Zero Suicide model? How do you envision the next 25 years of evidence-informed suicide prevention strategies?

AHMEDANI: The findings from that study covered more than 10 years of data, tracking outcomes before and after implementation of Zero Suicide approaches within six big healthcare systems. Each system integrated the evidence-based tools in their unique way, and we were able to identify reductions in suicide attempts.

Prior to these findings, the data that showed this approach works came mostly from within our healthcare system at Henry Ford Health. The question was: could the model work in places that don't have the same kind of structure, providers, infrastructure, or resources? These findings show that the model can be implemented successfully and leads to reductions in suicide attempts and deaths, lending support to broad-scale approach to implementation across the country.

For the first time, we have reached a point where we have a solution and serious momentum behind making change. That has never been the case before. What I see over the next 25 years is an opportunity to make a significant difference in saving lives—not just preventing suicide but also helping people become healthy. The goal is for people to be healthy and to live happy lives. We're excited to partner with people throughout our community in Detroit, across the country, and around the world to make that happen.

SECTION II

Mortality Data and Trends

The combined rate of deaths from alcohol, drugs, and suicide in the United States declined by 16 percent in 2024, building on a decrease of 4 percent in 2023. The continued progress, after two decades of rapidly increasing mortality, is a critical step in lasting improvements and brings mortality back to pre-COVID-19 levels. The age-adjusted rate of total deaths was driven by a very large decrease in overdose deaths in 2024 but importantly included declines across all three causes of deaths. Some overall trends include:

1. The overall age-adjusted alcohol-induced mortality rate decreased by 4 percent from 2023 to 2024 (from 12.6 to 12.1 deaths per 100,000). This decline built on a 7 percent decrease in 2023 and 6 percent decrease in 2022, and crossed nearly all demographic and geographic groups.
2. The overall age-adjusted drug overdose mortality rate declined by 26 percent from 2023 to 2024 (from 31.3 to 23.1 deaths per 100,000). This change marks the second year of decrease (-4 percent in 2023) and a marked shift compared with 2021 (+14 percent) and 2020 (+31 percent). The improvements crossed all demographic and geographic groups, though with variation in the size of the improvement.
3. The overall age-adjusted suicide mortality rate decreased by 3 percent from 2023 to 2024 (from 14.1 to 13.7 deaths per 100,000). The improvements crossed nearly all demographic and geographic groups.

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 73.

WHAT ARE OPIOIDS, PSYCHOSTIMULANTS, AND XYLAZINE?

Opioids are a class of drugs that bind to opioid receptors and interact with nerve cells to reduce pain and produce feelings of euphoria. Natural opioids are sourced from opium poppies; semisynthetic opioids are synthesized from naturally occurring opium; and synthetic opioids are made entirely in a lab.[246]

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, addiction and overdose.[247,248] The most common types of opioids include:

- **Natural and semisynthetic opioids:** the most common prescription opioids, like codeine, hydrocodone (including Vicodin), oxycodone (including OxyContin and Percocet), and morphine.[249]
- **Heroin:** an illegal semisynthetic opioid that is twice as potent as morphine.[250]
- **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.[251] Fentanyl analogs include cychlorphine, which is 10 times as powerful as fentanyl, and carfentanil, which is 100 times as potent as fentanyl.[252,253] Fentanyl and fentanyl analogs are also produced illegally for nonmedical purposes and are extremely dangerous, proving deadly in just minuscule amounts.[254,255]
- **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 is typically grouped separately—including in this report—because it is an effective treatment for opioid use disorder.[256]

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.[257] The psychostimulants most often involved in overdose deaths are cocaine (which is tracked separately in this report's data) and a combined category called other psychostimulants with abuse potential, referred to in this report as other stimulants. Other stimulants include methamphetamine most commonly, as well as ecstasy, amphetamine, cathinones (including "bath salts"), and prescription stimulants (e.g., Adderall).[258]

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.[259] It can be deadly, though the primary risk arises when it is combined with other sedating substances like opioids, alcohol, or benzodiazepines. Regular use of xylazine has been associated with serious skin wounds, ulcers, and abscesses, and subsequent complications.[260] Naloxone does not reverse the effects of xylazine but will reverse any opioid it might be mixed with.

Overall National Data and Trends

In total, there were 173,913 alcohol-induced, drug overdose, and suicide deaths in the United States in 2024—or an age-adjusted rate of 48.6 deaths per 100,000 people in a standard population. This is 16 percent below the 2023 rate (57.8 deaths per 100,000) but still 80 percent higher than 20 years prior (27.0 deaths per 100,000 in 2004) and 37 percent higher than 10 years ago (35.4 deaths per 100,000 in 2014). This section includes alcohol, drug, and suicide trends by cause of death. Additional data by demographics and yearly trends on alcohol, drug, suicide, opioid, synthetic-opioid, cocaine, and other psychostimulant deaths and death rates are in Appendix B on page 74.

CHART 2: Populations with the Highest Age-Adjusted Mortality Rates for Alcohol, Drug, and Suicide in the United States, 2024

ALCOHOL-INDUCED	■ **American Indian and Alaska Native people** (57.9 deaths per 100,000) ■ **Adults ages 55–74** (31.1 deaths per 100,000) ■ **Adults ages 35–54** (19.3 deaths per 100,000) ■ **Males** (17.3 deaths per 100,000 people) ■ **West region residents** (16.6 deaths per 100,000)
DRUG OVERDOSE	■ **American Indian and Alaska Native people** (51.6 deaths per 100,000) ■ **Adults ages 35–54** (42.7 deaths per 100,000) ■ **Black or African American people** (33.8 deaths per 100,000) ■ **Males** (32.2 deaths per 100,000)
SUICIDE	■ **American Indian and Alaska Native people** (22.5 deaths per 100,000) ■ **Males** (22.3 deaths per 100,000) ■ **Older adults ages 75 and older** (19.7 deaths per 100,000) ■ **Adults ages 35–54** (18.8 deaths per 100,000)

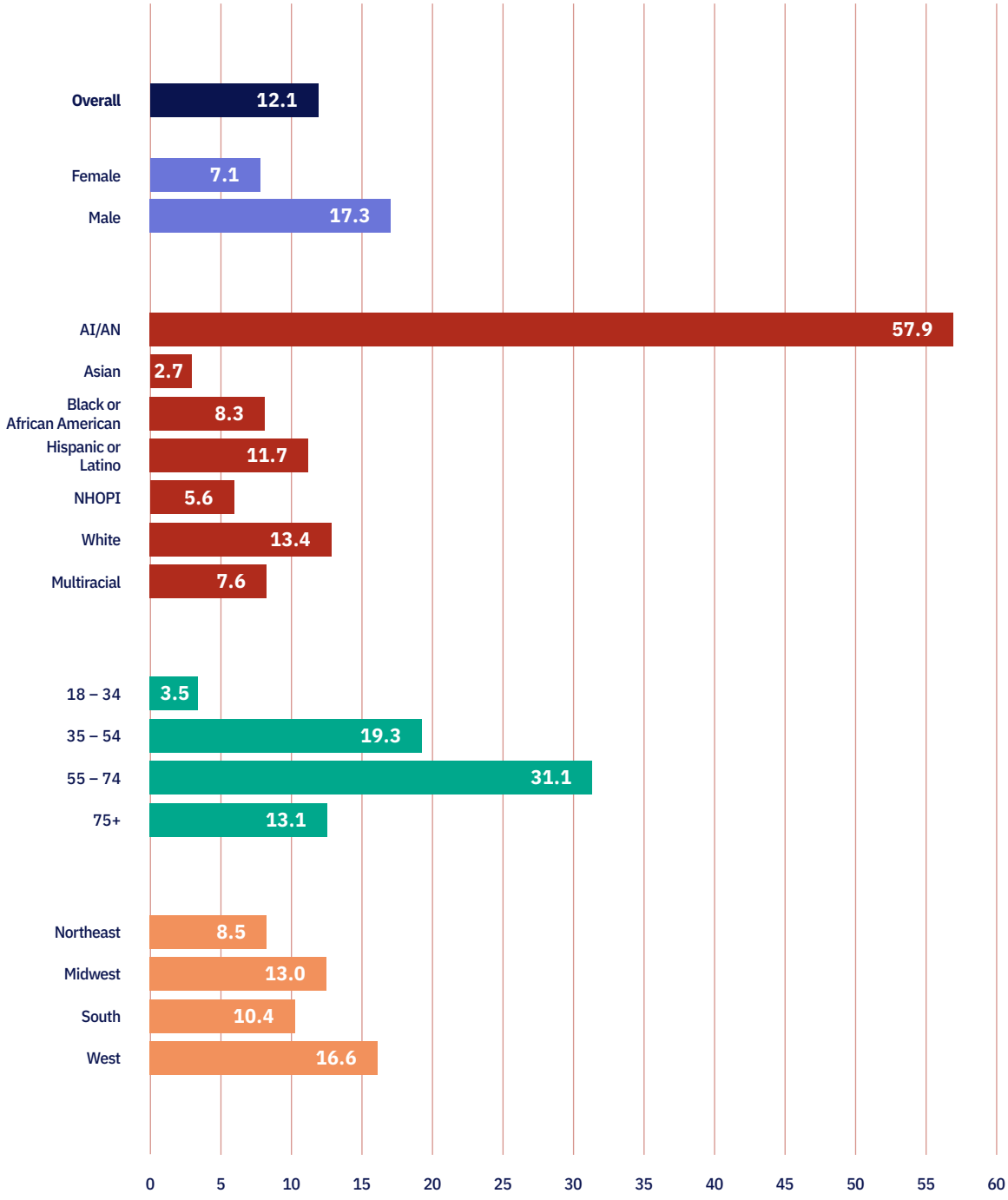
Source: TFAH analysis of National Center for Health Statistics data

I. TRENDS IN ALCOHOL-INDUCED DEATHS

In 2024, 46,714 Americans of all ages died from alcohol-induced causes. (Note: 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 overall age-adjusted rate of U.S. deaths from alcohol-induced causes was 4 percent lower in 2024 (12.1 deaths per 100,000) compared with 2023 (12.6 deaths per 100,000 people).

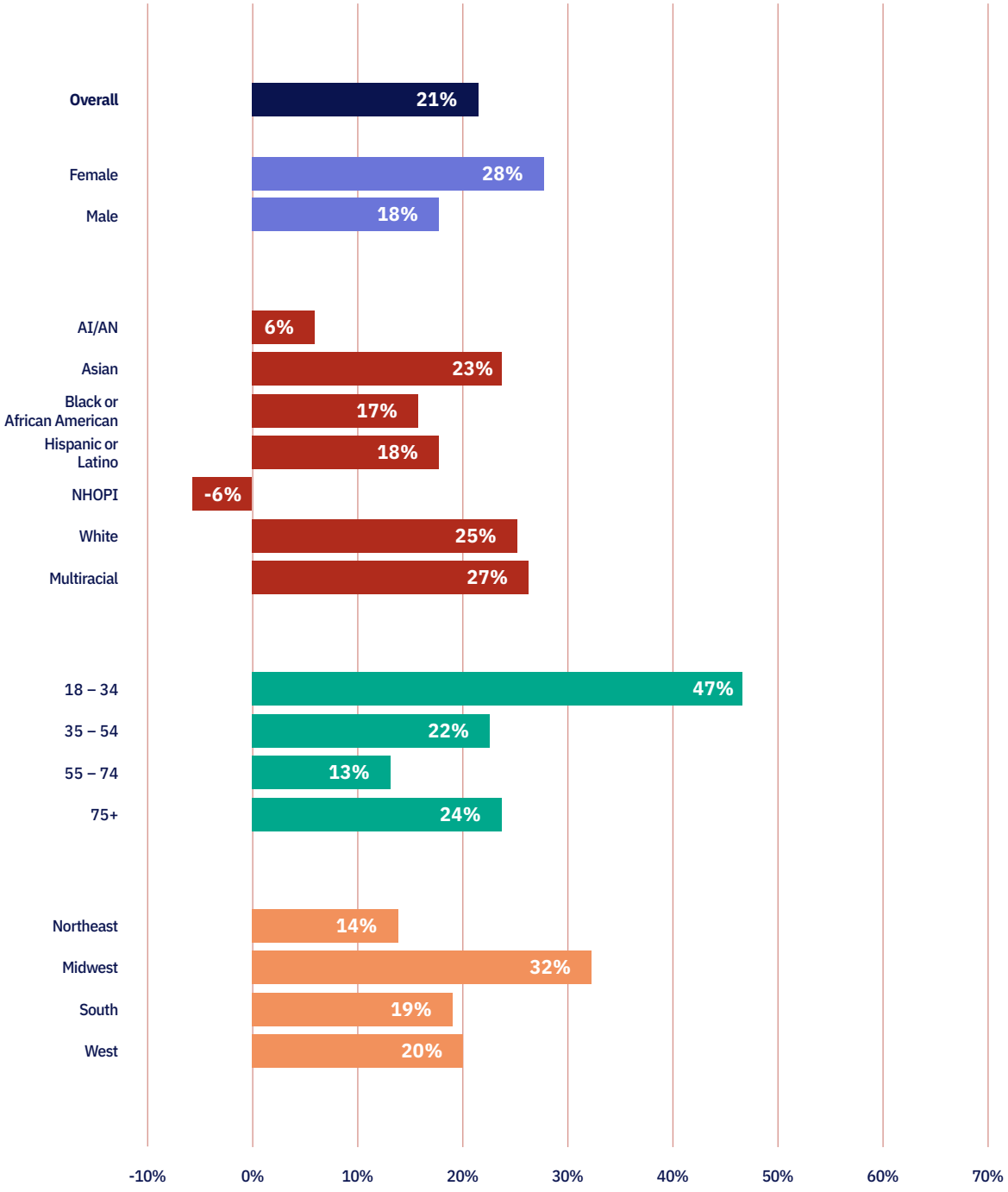
- After two decades of increases (since 2002), this was the third year in a row with a decline in the alcohol-induced death rate.
- All groups had lower rates of alcohol-induced deaths in 2024 compared with 2023, except for multiracial people.

FIGURE 7: Age-Adjusted Alcohol-Induced Mortality Rate, by Select Characteristics, 2024



Source: TFAH analysis of National Center for Health Statistics data

FIGURE 8: Percent Change in Annual Alcohol-Induced Mortality Rates, by Select Characteristics, 2018–2024



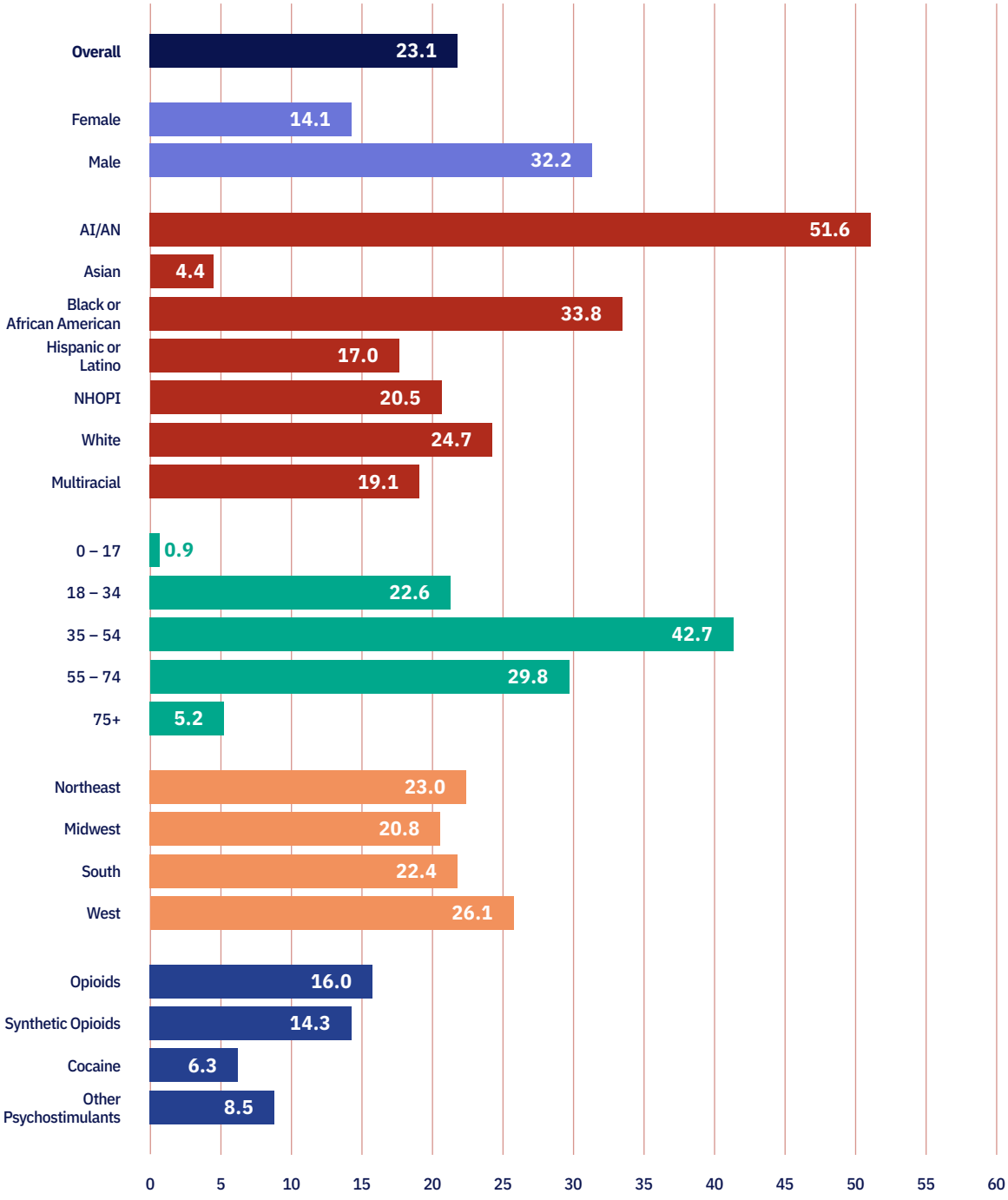
Source: TFAH analysis of National Center for Health Statistics data

II. TRENDS IN DRUG OVERDOSE DEATHS

In 2024, 79,384 Americans of all ages died from drug overdoses. The overall age-adjusted drug overdose rate was 26 percent lower in 2024 (23.1 deaths per 100,000) as compared with 2023 (31.3 deaths per 100,000).

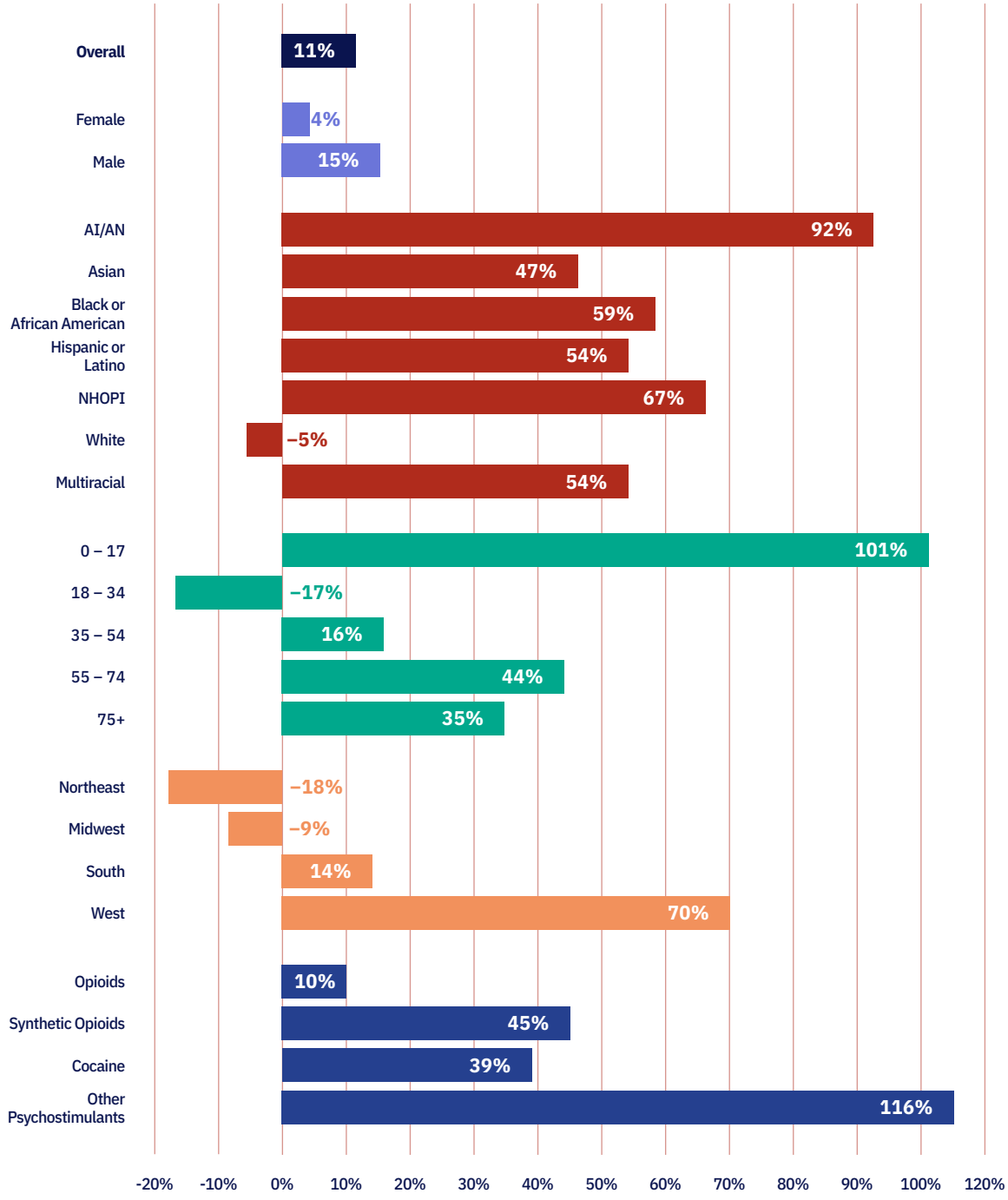
- This was the second year in a row that the drug overdose death rate declined, after a long-term rise over the last two decades and precipitous increases in 2020 and 2021.
- All groups had lower rates of drug overdose deaths in 2024 compared with 2023, with particularly large decreases among youth ages 0–17 and young adults ages 18–34 (-34 percent), Black Americans (-31 percent), and people in the Northeast (-30 percent), Midwest (-30 percent), and South (-29 percent).
- Synthetic opioids remained the subtype of drug with the highest overdose death rate (14.3 deaths per 100,000) in 2024. It also had the highest decrease in overdose rate (-36 percent) in 2024, though cocaine (-27 percent) and other psychostimulants (-20 percent) also declined markedly.

FIGURE 9: Age-Adjusted Drug Overdose Mortality Rate, by Select Characteristics, 2024



Source: TFAH analysis of National Center for Health Statistics data

FIGURE 10: Percent Change in Annual Drug Overdose Mortality Rates, by Select Characteristics, 2018–2024



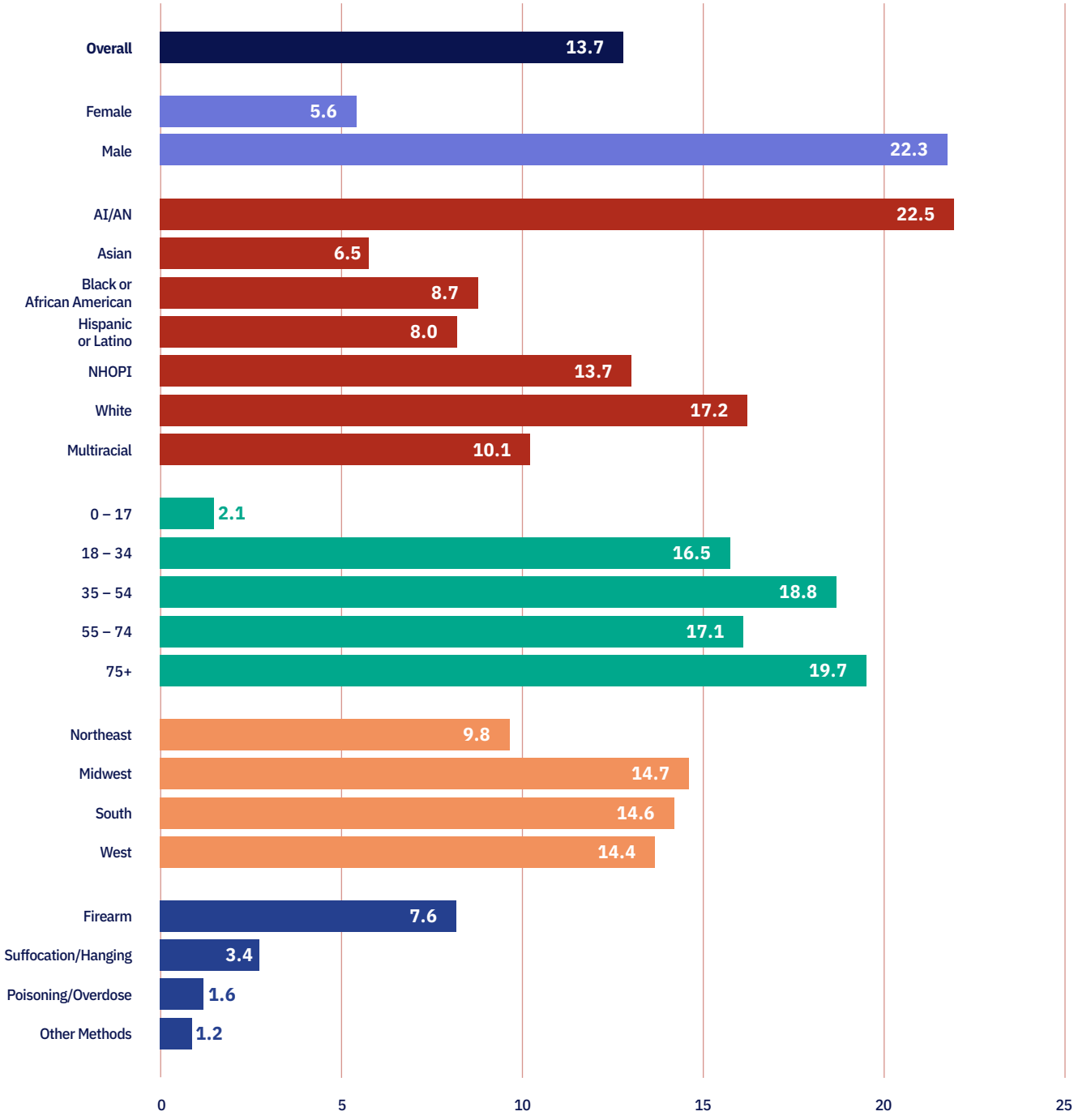
Source: TFAH analysis of National Center for Health Statistics data

III. TRENDS IN DEATHS BY SUICIDE

In 2024, 48,824 Americans of all ages died from suicide. The overall age-adjusted suicide rate was 3 percent lower in 2024 (13.7 deaths per 100,000) as compared with 2023 (14.1 deaths per 100,000).

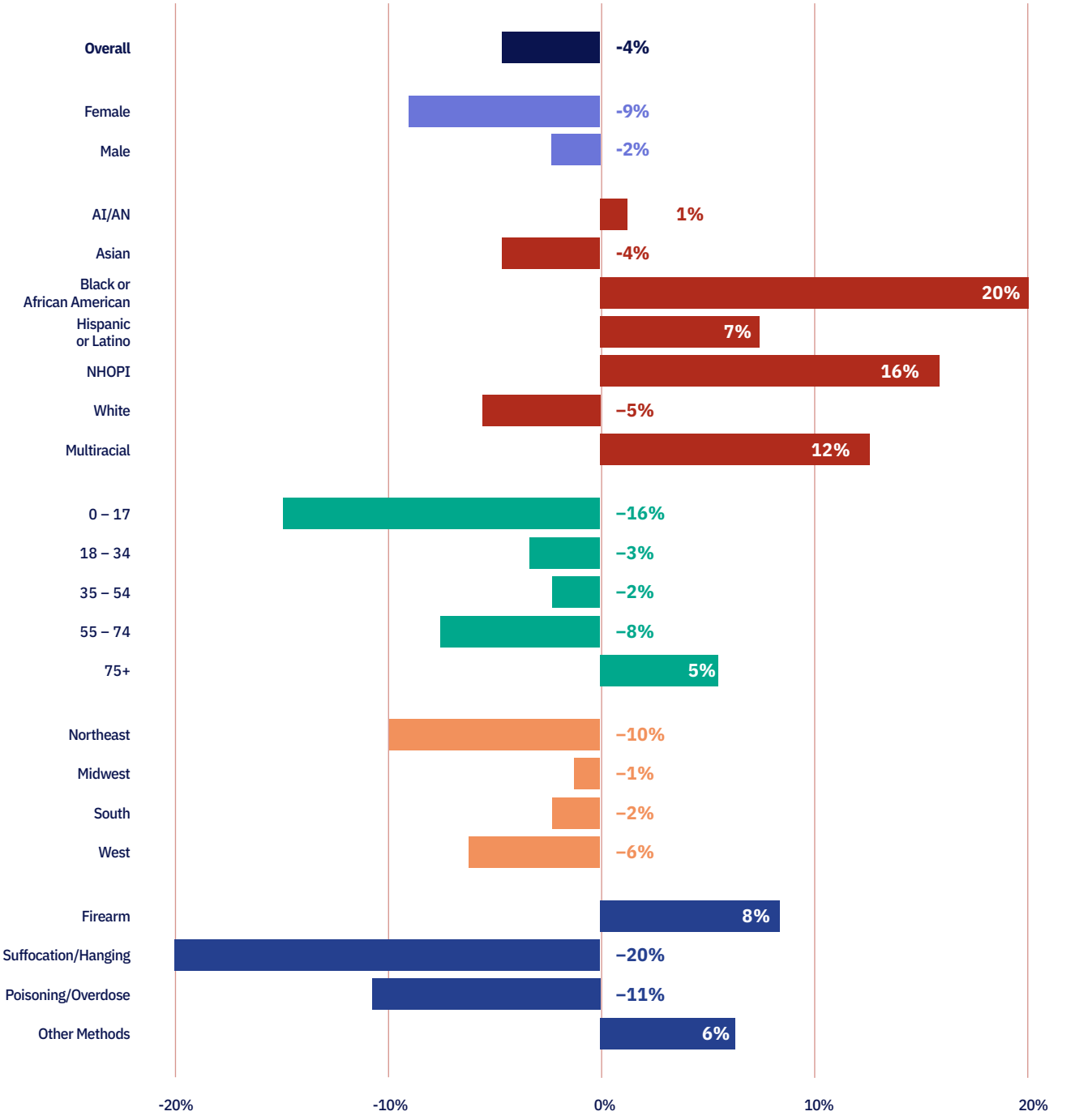
- Over the last decade, there have been fluctuations with lows in 2015/2016 and 2020 (13.3-13.5 deaths per 100,000), and peaks in 2018 and 2022 (14.2 deaths per 100,000).
- All groups had lower rates of suicide deaths in 2024 compared with 2023, except for multiracial people.
- Firearm suicides make up more than half of suicides every year and the rate (7.6 deaths per 100,000) remained the same in 2023 and 2024. Suicide rate by suffocation/hanging and poisoning/overdose methods were lower in 2024. *(See Figure 5. on page 18.)*

FIGURE 11: Age-Adjusted Suicide Mortality Rate, by Select Characteristics, 2024



Source: TFAH analysis of National Center for Health Statistics data

FIGURE 12: Percent Change in Annual Suicide Mortality Rates, by Select Characteristics, 2018–2024



Source: TFAH analysis of National Center for Health Statistics data

DATA LIMITATIONS: WHAT THIS DATA DOES NOT SAY

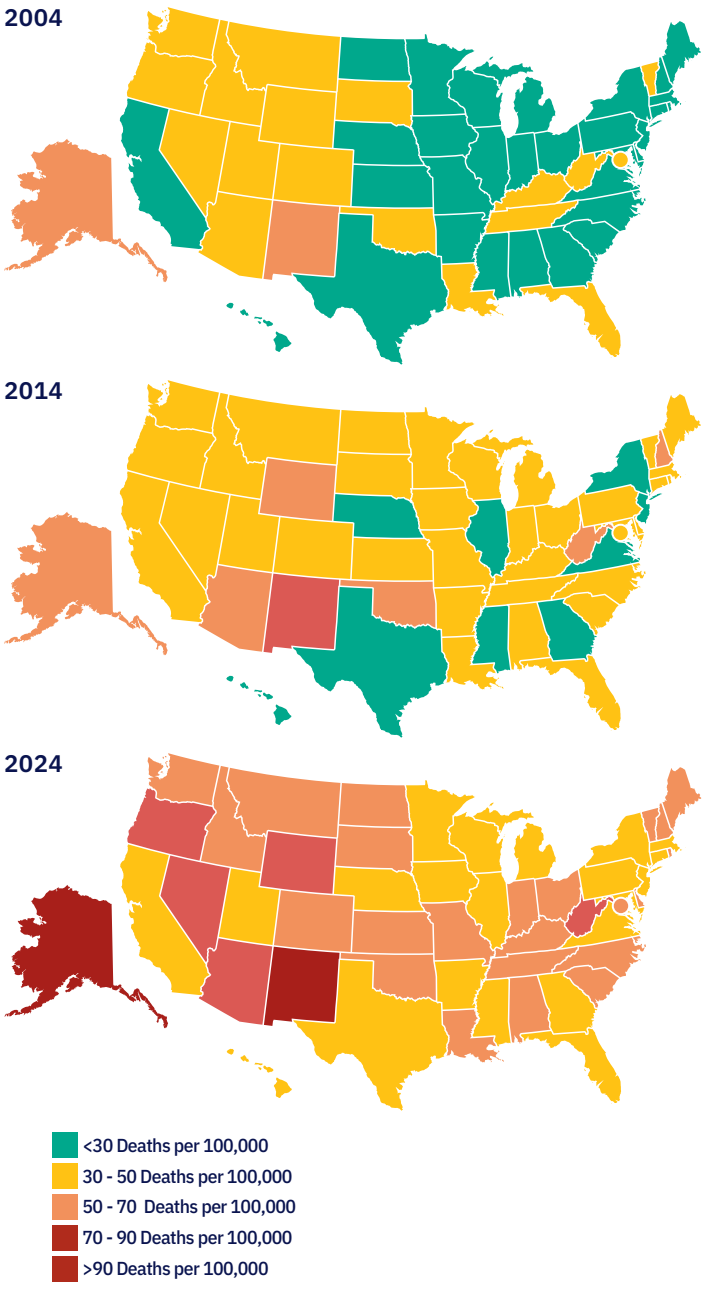
This section focuses on mortality from alcohol, drugs, and suicide in 2024 and other recent trends. It does not capture local trends, mortality data from 2025 or 2026 (as final mortality data from those years were not available at the time of the report's publication), or the full burden of these epidemics 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, territorial, tribal, and local jurisdictions and could result in an undercount of mortality rates for synthetic opioids and other specific drug types.

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 78 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 suicide**
  In 2024, most states saw improvements in their age-adjusted rates of death from combined alcohol, drugs, and suicide as compared with 2023: 45 states and the District of Columbia had lower rates, four states had higher rates (Iowa, North Dakota, South Dakota, and Wyoming), and one state stayed the same (Nebraska).
- **Alcohol-induced deaths**
  In 2024, 32 states and the District of Columbia had lower age-adjusted alcohol death mortality rates compared with 2023, 17 states had higher rates, and one state (Montana) stayed the same.
- **Drug overdose deaths**
  In 2024, 49 states and the District of Columbia had lower age-adjusted drug-overdose mortality rates compared with 2023, with only one state (South Dakota) with a higher rate. Sixteen states had decreases of 30 percent or more.
- **Deaths by suicide**
  In 2024, 32 states plus the District of Columbia had lower age-adjusted suicide mortality rates, 16 states had higher rates, and two states (Colorado and Texas) stayed the same compared with 2023.

MAPS 5-7: Annual Age-Adjusted Mortality Rate for Alcohol, Drugs, and Suicide in the United States, 2004, 2014, and 2024



Source: TFAH analysis of National Center for Health Statistics data

CHART 3: States with Highest and Lowest Age-Adjusted Mortality Rates for Alcohol, Drug, and Suicide in the United States, 2024

	STATES WITH HIGHEST MORTALITY *(Deaths per 100,000)*	STATES WITH LOWEST MORTALITY *(Deaths per 100,000)*
ALCOHOL, DRUG, AND SUICIDE COMBINED	■ Alaska (101.5) ■ New Mexico (97.0) ■ West Virginia (76.8)	■ New Jersey (32.9) ■ New York (37.0) ■ Nebraska (37.9)
ALCOHOL-INDUCED	■ New Mexico (35.9) ■ South Dakota (34.6) ■ Wyoming (29.7)	■ New Jersey (6.1) ■ Hawaii (6.2) ■ Maryland (7.6)
DRUG OVERDOSE	■ West Virginia (48.9) ■ Alaska (45.1) ■ Washington state (37.6) ■ District of Columbia (43.2)	■ Nebraska (8.1) ■ South Dakota (11.9) ■ Iowa (13.7)
SUICIDE	■ Alaska (29.7) ■ Wyoming (27.8) ■ Montana (26.8)	■ New Jersey (6.7) ■ New York (8.1) ■ Massachusetts (8.3) ■ District of Columbia (5.7)

RESEARCH ROUNDUP: NEW INSIGHTS AND ANALYSIS

Research continues to yield new insights into the causes and consequences of alcohol misuse, drug overdose, and suicide, and into effective strategies to reduce their burden. A few examples of recent studies are below.

MEDETOMIDINE IN THE U.S. ILLEGAL FENTANYL SUPPLY INCREASING RISK FOR OVERDOSE AND SEVERE WITHDRAWAL SYNDROME

***CDC Health Advisory,* April 2026**

Medetomidine, a veterinary drug not approved for human use, was first identified in the illegal drug supply in 2021. Since then, law enforcement drug seizures and sampling, along with wastewater surveillance, have increasingly detected illegal forms of medetomidine and analogs. Law enforcement drug seizure reports for medetomidine submitted to the National Forensic Laboratory Information System increased from 247 in 2023 to 2,616 in 2024, and 8,233 in 2025. More than half (52 percent) of reports were from the Northeast, followed by the Midwest (31 percent), South (17 percent), and West (<1 percent). Medetomidine intoxication causes low heart rate, low blood pressure, and profound and prolonged sedation. Regular medetomidine use can lead to severe withdrawal symptoms and require emergency care. Most medetomidine overdoses involve fentanyl.[261]

DID THE ILLICIT FENTANYL TRADE EXPERIENCE A SUPPLY SHOCK?

***Science,* January 2026**

This 2026 Science study used governmental data from the United States and Canada as well as analysis of Reddit discussion boards to investigate changes in the fentanyl drug trade since 2023, when fentanyl overdoses in the United States began a marked decline. Researchers found that law enforcement reports on drug purity and seizures showed increases in purity and seizure volume in 2022, followed by decreases in both in the second half of 2023 and 2024. Reddit posts on fentanyl shortages and Canadian overdose data also followed similar timing patterns. The researchers conclude that these findings point to a disruption in the international trade of illegal fentanyl in 2023 and 2024, possibly related to a reduction in precursor chemicals from China.[262]

EVALUATING THE EFFECTIVENESS OF FIREARM STORAGE DEVICES ON SECURE FIREARM STORAGE INTENTION AND BEHAVIORS: RESULTS FROM A RANDOMIZED PILOT STUDY

APHA Annual Meeting and Expo, **November 2025**

Safe firearm storage is important to reducing firearm injury and suicide. This pilot study tested whether firearm owners' intentions to store their unsecured firearms more securely and actual storage practices differ when they are offered a biometric lockbox versus a cable lock. Researchers provided educational information plus either a biometric lockbox or a cable lock to 40 gunowners at community events in Louisiana. They found lockbox recipients were more likely to immediately report an intention to store their unsecured firearms than cable lock recipients. At a one-week follow-up, 100 percent of lockbox recipients reported secure storage and a higher proportion of lockbox recipients than cable-lock recipients reported intending to maintain safe storage in the future. Lockbox recipients appreciated the convenience, quick access, and security of the lockbox. These findings suggest that biometric lockboxes may be more effective than cable locks at promoting immediate and sustained safe firearm storage, though the small sample size and single-site design limit generalizability. Larger, more representative studies are needed to confirm these results.

ONCE-WEEKLY SEMAGLUTIDE IN ADULTS WITH ALCOHOL USE DISORDER: A RANDOMIZED CLINICAL TRIAL

JAMA Psychiatry, **February 2025**

Researchers conducted a randomized controlled study of 48 adults with alcohol use disorder to determine whether the GLP-1 receptor agonist semaglutide medications reduce alcohol consumption and cravings. They found that low-dose semaglutide reduced alcohol consumption in laboratory assessments conducted before and after nine weeks of treatment. The participants on semaglutide also reported lower alcohol cravings and reductions in some (but not all) weekly measures of drinking outcomes compared with the placebo. Among participants who smoked, semaglutide was also associated with reduced daily cigarette consumption. While the small sample size warrants caution in interpreting these findings, the results add to growing evidence on GLP-1 medications as a potential treatment for alcohol use disorder.

SECTION III

Policy Recommendations

As the United States faces the ongoing epidemics of alcohol, drug, and suicide deaths, the federal behavioral health system has undergone substantial organizational and policy changes. Throughout 2025 and the first half of 2026, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Center for Injury Prevention and Control (Injury Center) at the Centers for Disease Control and Prevention (CDC) experienced significant workforce reductions—with SAMHSA losing roughly half of its workforce and the Injury Center reportedly losing more than 200 staff.[265,266] These staff tracked emerging trends in behavioral health, provided expertise and technical assistance to states and localities, and administered critical programs focused on mental health and well-being.

Congress provided level funding for SAMHSA and CDC's Injury Center through the FY 2026 Labor, Health and Human Services, Education, and Related Agencies Appropriations legislation. The legislation also required agencies to maintain the minimum staffing necessary to carry out the funded programs.[267] However, abrupt terminations of already-approved funding throughout 2025 and 2026 have generated uncertainty among state and local grantees surrounding the stability of these investments. These actions are paired with HHS's proposal to consolidate SAMHSA and CDC's Injury Center into a new Administration for a Healthy America—potentially resulting in the elimination of existing offices, programs, capabilities, and public health approaches.

Amid these actions and evolving federal landscape, the following recommendations for policymakers represent TFAH's research into 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.

Invest in Prevention and Conditions that Promote Health

- **Federal agencies must spend behavioral health funds as appropriated by Congress and enacted in law.** Termination of behavioral health investments already at work in states and communities puts lives at risk and undermines progress in reducing deaths from alcohol, drugs, and suicide. It is imperative that federal agencies spend these dollars as directed by Congress and maintain these critical investments.

- **Congress should provide robust funding for the National Center for Injury Prevention and Control at CDC, and the administration should maintain the vital workforce necessary to fulfill the center's activities.** The Injury Center empowers and funds public health departments and other partners to implement community-driven, evidence-based prevention strategies to reduce overdose, 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 substance misuse to better deploy limited resources. Injury Center efforts also provide a critical complement to other federal approaches focused on overdose prevention or treatment: for example, states rely on Overdose Data to Action to guide the distribution of naloxone to populations and communities most at risk of drug overdose. The reduction of Injury Center staff and proposed reorganization of its remaining work will limit state and local health departments' 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 (PCEs).** ACEs can have a long-term impact on physical and mental health, but they are preventable through multisectoral efforts and strongly mitigated through the promotion of PCEs.

- **Congress should pass the Preventing Adverse Childhood Experiences Act and provide funding for CDC's Adverse Childhood Experiences program.** The ACEs program monitors the prevalence of ACEs and researches and disseminates evidence-based strategies to prevent ACEs and their negative effects and to promote PCEs. Federal, state, and local governments should adopt these evidence-based strategies, including strengthening economic supports to families, improving access to quality childcare, and teaching parenting skills.[268]

- **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 researches, evaluates, and implements the best available evidence for suicide prevention. 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 Tribal Nations and veterans, particularly veterans returning to civilian life.

Enhanced funding for CSP can also help states understand nonfatal suicide-related outcomes and use data to inform preventive action.

- Congress should 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.[269]

- **Congress should increase funding for federal programs that support evidence-based prevention efforts in schools and that promote protective factors to reduce substance misuse and mental health issues, including CDC's Division of Adolescent and School Health (DASH).** State policymakers should also work to reduce barriers to reimbursement for school-based health centers, which can provide comprehensive mental health services for children.[270]
  - 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.[271] 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.[272]

- **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 with 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.[273,274]

- **Congress should promote safer communities by investing in CDC's Core State Violence and Injury Prevention Program and other programs focused on violence and injury 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 Initiative. This initiative recognizes the importance of cultural awareness, responsiveness, and understanding for trauma-informed school systems.

- **The juvenile justice system should adopt approaches that recognize substance misuse and serious emotional disturbance as health issues—not criminal justice issues—and ensure access to diversion and care for young people.**

- **The Centers for Medicare and Medicaid Services (CMS) and health insurers should expand coverage and training for screening of suicide risk in primary care, older adult care, maternal healthcare, and other settings.**

- **Congress and federal agencies should increase support for public health education campaigns, and 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 other healthcare systems to address the social, relational, and mental health needs of children and youth.[275] Specifically, schools need support to increase: (1) staff training in understanding and responding 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.[276]

- **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. The bill would provide increased federal Medicaid funding through the Federal Medical Assistance Percentage to cover 90 percent of related provider hiring and training expenses for schools.[277,278] 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.[279,280]

- **Congress and HHS should maintain funding, and adequate regional office and workforce capacity, for Head Start and other federal programs that provide access to social and mental health services for children and families.**[281]

- **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.**[282]
  - Congress should pass the Helping Kids Cope Act to 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.[283,284]
  - Congress should invest in an expanded maternal mental health workforce to improve perinatal prevention, intervention, and treatment. Specifically, Congress should pass the Momnibus Act, to increase access to maternal mental healthcare to reduce drivers of maternal mortality, morbidity, and disparities.[285,286]
  - 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. As part of these efforts, HHS should work with states and insurers to ensure equitable access to and uptake of evidence-based preventive interventions for family mental health.[287]

- **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 maintain robust funding for the Drug-Free Communities Support Program, managed through a partnership between ONDCP and CDC.

- **State and local governments should ensure that supporting the prevention of youth substance misuse is a priority for any opioid litigation settlement funds.** ONDCP and HHS should support this process by building on the 2021 model law concerning settlement funding and issuing guidance to states and localities on utilizing these funds for primary prevention strategies.[288]

- **Congress, CMS, and state policymakers should address the nonmedical 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 an influence on the rates of substance use disorder. Congress should ensure CDC is able to continue its research to incorporate best practices related to nonmedical drivers of health conditions. CMS and other payers and providers should support and retain efforts to address beneficiaries' health-related social needs.

- **Congress, SAMHSA, and other agencies should strengthen their capacity to address the behavioral health impacts of weather-related disasters and other environmental risks.** 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 nonmedical drivers of health that lead to poor behavioral health outcomes.

INVESTING OPIOID SETTLEMENT FUNDS IN PRIMARY PREVENTION

In 2021, states and localities reached legal settlements with the three largest pharmaceutical distributors—McKesson, Cardinal Health, and AmerisourceBergen—as well as manufacturer Janssen Pharmaceuticals, Inc. and its parent company Johnson & Johnson.[289] In 2022, agreements added two manufacturers, Allergan and Teva, and three pharmacy chains, CVS, Walgreens, and Walmart.[290] Through these agreements, states and localities across all 50 states are receiving approximately $50 billion in opioid settlement funds.[291]

The jurisdictions filed the lawsuits due to the role of these companies in exacerbating the opioid epidemic. The settlement funds are intended to remediate these harms and support state and local interventions to address the opioid crisis. Jurisdictions must use 85 percent of the settlement funds for opioid abatement and remediation.[292] However, interpretation of "abatement and remediation" remains broad, with reports showing that some states and localities are utilizing funds for indirect strategies (law enforcement expenses, non-opioid-related community events, and similar indirect uses).[293] Some jurisdictions are also using the settlement funds to supplant existing funding streams.[294] To prevent misuse and promote investment in new interventions, several states have prohibited using settlement funds to supplant other revenue sources.[295]

The opioid settlement funds present an opportunity for states and localities to bolster evidence-based primary prevention interventions. Primary prevention of substance misuse aims to reduce risk factors for substance misuse and increase protective factors. This includes school-based prevention programs, youth resilience-building, community-based education, and public awareness campaigns. In November 2025, Michigan announced its plan for investing more than $131 million in settlement funds to address the opioid epidemic. This included $13.75 million for primary prevention, intended to expand public education and community awareness and prevent initial drug use.[296] The Town of Palm Beach, Florida, is already utilizing the settlement funds to support community workshops for parents and families to increase awareness of the signs of substance misuse and learn how to discuss the risks with their children.[297] States and localities can tailor prevention activities to align with their community's distinct needs and effectively prevent addiction and overdose.

With thoughtful investment, opioid settlement funds represent a significant and time-limited opportunity to build the prevention infrastructure communities need to reduce addiction and overdose for generations to come.

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 support states and localities in expanding comprehensive syringe services programs. States and local governments should adopt model laws to ensure the effective establishment of syringe services programs.
  - ONDCP and SAMHSA should provide technical assistance and strategies to state and local governments to reduce barriers to accessing overdose reversal medications like naloxone.
  - Federal agencies should also provide technical assistance to state legislators seeking to remove legal barriers to the use of test strips for fentanyl, xylazine, 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 for diverse populations, including children and rural communities. Evidence-based research into these priorities can reduce firearm-related injuries, identify populations at risk of suicide, and evaluate new interventions.
  - Congress should pass the Kid Providing Resources for Optimal Outcomes against Fatalities Act (or "Kid PROOF Act") to 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.[298] Federal agencies like SAMHSA should also work to incorporate lethal means assessments and counseling into standard procedures for their mental health crisis lines.[299]
  - Congress should 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.[300,301]
  - 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.[302]
- **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 and based on local needs.
- **State and local governments should lower excessive alcohol use through evidence-based policies, and Congress should support these efforts.** States and communities can reduce harms from alcohol by increasing pricing, reducing sales hours, and limiting the density of alcohol outlets; enforcing underage drinking laws; and holding sellers and hosts liable for serving minors or overserving adults.[303] 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.

Transform the Mental Health and Substance Use Prevention System

- **The administration should maintain SAMHSA's funding and critical workforce.** SAMHSA supports behavioral health state agencies across the country, bolstering access to prevention, treatment, and recovery services that address substance use disorder and overdose prevention, among other initiatives. SAMHSA requires adequate funding and staffing levels to maintain the agency's critical programming and to continue addressing mental health and substance misuse crises in the United States.
- **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 robust SAMHSA funding and by maintaining 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.[304] The bill would also authorize funding for mobile crisis units and extend Medicare, Medicaid, and TRICARE coverage for crisis response services.
  - Congress should provide funding for the Lifeline's specialized services for LGBTQ+ youth, and SAMHSA should restore and maintain these specialized services as enacted. Congress should also codify the specialized services by passing the 988 LGBTQ+ Youth Access Act of 2025.[305]
  - Congress and states should pass legislation to protect 988 Lifeline call center staff from organizational and personal liability concerns, when conducting their roles and responsibilities in good faith.
  - 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.[306]
  - Congress should pass the Raising Awareness for Youth Suicide Prevention (RAYS) Act, which would require contact information for the 988 Lifeline, Crisis Text Line, and a state or local suicide prevention hotline selected by the school, if applicable, to be provided on the back of all student identification cards.[307]
  - Passage of the 9-8-8 Continuity in Necessary Evaluative Crisis Treatment Act (or the "9-8-8 Connect Act") would also provide resources for follow-up care for individuals receiving suicide prevention and crisis intervention services.[308]
  - SAMHSA should 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 disorder 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.
  - 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.[309]

- **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 nonmedical social needs and those that prioritize integrated delivery models.
  - Congress should pass the Connecting Our Medical Providers with Links to Expand Tailored and Effective Act (or the "COMPLETE Care Act") to encourage primary care providers to implement and expand integrated behavioral healthcare into their practices and provide related technical assistance.[310,311]
  - 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.[312]
- **Congress and the administration should protect access to mental health and substance use healthcare by restoring Medicaid funding and eligibility.** The Congressional Budget Office (CBO) estimates that roughly 11.8 million individuals will lose health coverage by 2034, due to implementation of the One Big Beautiful Bill Act.[313,314] As the single largest payer for behavioral health services in the United States, these cuts to Medicaid will diminish access to behavioral health services for families and communities across the country.[315] Other congressional initiatives to expand access to care under Medicaid should include:
  - Passage of the Medicaid Bump Act to reimburse states for 90 percent of the cost of providing new mental health and SUD treatment under Medicaid.[316,317]
  - 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.[318]
- **The administration should strengthen mental health parity** through full enforcement of the Mental Health Parity and Addiction Equity Act to ensure patients have access to essential services.[319] This includes requiring health insurers and health plans to define mental health and substance use disorder benefits based on nationally recognized standards. Congress should also 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 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 supports and services.
  - HHS should help sustain progress on capacity and workforce issues by implementing the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment ("SUPPORT") for Patients and Communities Reauthorization Act of 2025.[320] HHS should maintain the programs and activities authorized through this legislation, including those administered by SAMHSA, and carry them out as enacted.
  - Congress should pass the Providing Empathetic and Effective Recovery Support Act (or "PEER Support Act") to ensure accurate data reporting on the peer workforce, support best practices on training and supervision, and address barriers to certification and practice.[321,322]

SUPPORT ACT REAUTHORIZATION

In December 2025, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment ("SUPPORT") for Patients and Communities Reauthorization Act of 2025 was signed into law.[323] The legislation reauthorizes federal programs focused on prevention, treatment, and recovery from substance use disorder through FY 2030. The initial SUPPORT Act was enacted in 2018 and expired in September 2023.[324] The law sought to address the worsening drug overdose epidemic, with a particular focus on the opioid overdose epidemic. The original legislation included provisions to address overprescribing of opioids, expand coverage for substance use disorder treatment, train first responders in administering overdose reversal medication, and bolster the addiction treatment workforce.

The reauthorized programs are carried out across a range of HHS agencies, with several administered by SAMHSA. This includes youth-focused prevention and early intervention programs, such as the Youth Prevention and Recovery Initiative and the Donald J. Cohen National Child Traumatic Stress Initiative (NCTSI) at SAMHSA. The NCTSI supports grantees throughout the country in implementing trauma-informed interventions in child-serving systems, including juvenile justice, child protective services, and schools. Since 2000, the NCTSI has trained more than 2 million professionals in trauma-informed services to prevent long-term effects of child trauma. The NCTSI's services directly reach an estimated 50,000 individuals each quarter.[325]

Without adequate staffing levels at SAMHSA, the agency may be unable to carry out these programs as enacted. For example, the NCTSI sits within SAMHSA's Center for Mental Health Services, which reportedly lost over half of the 130 staff throughout 2025.[326] Other centers such as the Center for Behavioral Health Statistics and Quality have experienced significant staffing cuts—as the entire team that administers the National Survey on Drug Use and Health annually was reportedly laid off in April 2025.[327]

The proposed restructuring of HHS in the FY 2027 budget further complicates implementation of the SUPPORT Act reauthorization.[328] While SAMHSA had been proposed to be consolidated into the proposed Administration for a Healthy America, Congress authorized these programs and provided funding for SAMHSA to carry them out. Any restructuring efforts should be subject to congressional direction and should retain specialized behavioral health expertise.

- **Congress should promote equity in mental health, with a specialized workforce and targeted services to reduce disparities in access and outcome.** Congress should pass and fund the Pursuing Equity in Mental Health Act, which would help establish behavioral healthcare teams in areas with underserved populations, improve training and best practices to address mental health disparities, and enhance outreach to communities of color to promote mental health and reduce stigma.[329] 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.[330] 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.
  - Congress and the administration should ensure timely, complete, disaggregated demographic data collection and reporting. Federal agencies should also collect all demographic data, including racial and ethnic data, in surveillance activities, such as the National Survey on Drug Use and Health and the Youth Risk Behavior Survey.
  - Congress should protect 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.[331] 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.[332]

FUTURE MEDICAID CUTS AND BEHAVIORAL HEALTH TREATMENT

Medicaid is a major provider of behavioral health treatment in the United States—covering 29 percent of nonelderly adults with mental illness and 21 percent of nonelderly adults with substance use disorder.[333]

Several provisions in the One Big Beautiful Bill Act (OBBBA), signed into law in July 2025, will affect Medicaid across the country in the coming years. The Congressional Budget Office (CBO) estimates that OBBBA will reduce Medicaid spending by $990 billion over 10 years—the largest spending cut ever—and cause 7.5 million Americans to lose their Medicaid or CHIP health coverage by 2034.[334,335] The expected coverage losses equal about 10 percent of current Medicaid and CHIP enrollees.[336]

Policy changes include work requirements for adults who do not have disabilities or young children, stricter eligibility monitoring, new cost-sharing requirements for adults covered by Medicaid expansion, and a prohibition on states increasing provider taxes to help finance their Medicaid programs.[337]

CBO attributes 5.3 million coverage losses to the law's new work reporting requirements for adults in the expanded Medicaid program (i.e., the eligibility category created in the Affordable Care Act to cover more low-income adults); 1.2 million to new restrictions on states financing their program contributions through provider taxes; and 700,000 to a requirement for more frequent eligibility redeterminations for enrollees in the expanded Medicaid program.[338,339]

Fifty-nine percent of Medicaid enrollees with mental illness and substance use disorders are in the expanded Medicaid population—which is facing the majority of coverage losses. Experts also suggest that federal and state decisions on how the new work reporting requirements—and exemptions from the requirements—are implemented for the expanded Medicaid population could have disproportionate impacts on enrollees with mental illness and substance use disorders. Implementation questions include how to define the criteria for medical exemptions and what documentation and verification requirements should apply. Navigating complex documentation and verification requirements poses significant administrative burdens, which research suggests fall disproportionately on individuals managing chronic illness, behavioral health conditions, or undiagnosed disorders.[340]

Data Methodology

Unless otherwise referenced, data in this report are from the National Center for Health Statistics' Multiple Cause of Death Files, 1999–2024, 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 updates in racial/ethnic data reporting, comparable data is not available for racial/ethnic groups across all years (1999–2024).

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

National Alcohol, Drug, and Suicide Mortality Data

Deaths, death rates, and one-year percent change in death rate from alcohol-induced, drug overdose, and suicide causes, overall and by select demographics, 2024

	Combined Alcohol, Drug, and Suicide			Alcohol-Induced		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024
Overall	**173,913**	**48.6**	**-16%**	**46,714**	**12.1**	**-4%**
Female	46,670	26.1	-18%	13,807	7.1	-3%
Male	127,243	71.8	-16%	32,907	17.3	-5%
AI/AN	3,233	133.0	-12%	1,424	57.9	-6%
Asian	3,087	13.1	-8%	665	2.7	-9%
Black or African American	23,244	51.6	-24%	3,837	8.3	-8%
Hispanic or Latino	23,850	36.7	-15%	7,208	11.7	-3%
NHOPI	284	41.0	-21%	38	5.6	-17%
White	116,527	54.7	-14%	32,849	13.4	-3%
Multiracial	2,284	36.6	-9%	399	7.6	0%
0 – 17	2,094	2.9	-17%	<20	<0.1	—
18 – 34	32,622	41.9	-24%	2,695	3.5	-8%
35 – 54	69,557	80.6	-16%	16,674	19.3	-5%
55 – 74	60,064	77.9	-10%	23,964	31.1	-3%
75+	9,564	37.2	-3%	3,365	13.1	-2%
Northeast	25,323	41.1	-21%	5,778	8.5	-5%
Midwest	34,688	47.9	-16%	10,279	13.0	-2%
South	65,412	47.4	-17%	15,777	10.4	-5%
West	48,490	56.7	-11%	14,880	16.6	-4%

Source: TFAH analysis of National Center for Health Statistics data

	Drug Overdose			Suicide		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024
Overall	**79,384**	**23.1**	**-26%**	**48,824**	**13.7**	**-3%**
Female	24,308	14.1	-23%	9,847	5.6	-5%
Male	55,076	32.2	-27%	38,977	22.3	-2%
AI/AN	1,237	51.6	-21%	545	22.5	-6%
Asian	1,044	4.4	-12%	1,508	6.5	-1%
Black or African American	15,228	33.8	-31%	3,795	8.7	-4%
Hispanic or Latino	11,239	17.0	-25%	5,382	8.0	-2%
NHOPI	142	20.5	-22%	96	13.7	-21%
White	48,436	24.7	-25%	36,560	17.2	-2%
Multiracial	1,177	19.1	-19%	728	10.1	10%
0 – 17	664	0.9	-34%	1,530	2.1	-5%
18 – 34	17,580	22.6	-34%	12,869	16.5	-5%
35 – 54	36,851	42.7	-25%	16,191	18.8	-2%
55 – 74	22,940	29.8	-19%	13,151	17.1	-2%
75+	1,342	5.2	-2%	5,080	19.7	-3%
Northeast	13,674	23.0	-30%	6,013	9.8	-3%
Midwest	14,346	20.8	-30%	10,510	14.7	-2%
South	29,641	22.4	-29%	20,067	14.6	-2%
West	21,723	26.1	-17%	12,234	14.4	-4%

Source: TFAH analysis of National Center for Health Statistics data

NATIONAL ALCOHOL, DRUG, AND SUICIDE MORTALITY DATA (CONT.)

	Opioid Overdose			Synthetic Opioid Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024
Overall	**54,045**	**16.0**	**-33%**	**47,735**	**14.3**	**-36%**
Female	16,096	9.5	-30%	13,322	8.0	-33%
Male	37,949	22.5	-35%	34,413	20.6	-37%
AI/AN	845	35.5	-28%	767	32.3	-31%
Asian	518	2.2	-31%	465	2.0	-34%
Black or African American	10,202	22.8	-39%	9,590	21.5	-40%
Hispanic or Latino	7,899	11.8	-33%	7,276	10.9	-34%
NHOPI	70	10.2	-35%	68	9.9	-30%
White	33,105	17.5	-31%	28,301	15.3	-34%
Multiracial	824	12.8	-25%	747	11.5	-29%
0 – 17	440	0.6	-46%	399	0.5	-48%
18 – 34	13,875	17.8	-39%	12,946	16.6	-40%
35 – 54	25,933	30.0	-32%	23,322	27.0	-34%
55 – 74	13,269	17.2	-29%	10,816	14.0	-33%
75+	524	2.0	-7%	249	1.0	-20%
Northeast	10,527	18.0	-35%	9,571	16.5	-37%
Midwest	9,789	14.4	-38%	8,678	12.9	-40%
South	19,473	14.9	-36%	17,088	13.3	-38%
West	14,256	17.5	-24%	12,398	15.4	-26%

Source: TFAH analysis of National Center for Health Statistics data

	Cocaine Overdose			Other Psychostimulants Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	2023 to 2024
Overall	**21,945**	**6.3**	**-27%**	**28,722**	**8.5**	**-20%**
Female	6,082	3.6	-24%	8,043	4.8	-18%
Male	15,863	9.1	-28%	20,679	12.2	-20%
AI/AN	164	6.8	-10%	691	28.9	-13%
Asian	228	1.0	-18%	372	1.5	-12%
Black or African American	7,661	16.6	-32%	3,220	7.5	-21%
Hispanic or Latino	3,311	5.1	-25%	4,098	6.3	-15%
NHOPI	16	2.3	-25%	86	12.4	-24%
White	10,022	5.2	-24%	19,323	9.9	-21%
Multiracial	234	3.8	-25%	555	9.7	-10%
0 – 17	52	<0.1	—	90	0.1	-9%
18 – 34	4,132	5.3	-34%	5,977	7.7	-28%
35 – 54	10,222	11.8	-26%	14,688	17.0	-20%
55 – 74	7,362	9.5	-23%	7,826	10.1	-9%
75+	176	0.7	-8%	136	0.5	15%
Northeast	6,370	10.7	-28%	1,988	3.6	-20%
Midwest	4,478	6.4	-30%	4,128	6.2	-26%
South	8,235	6.1	-27%	10,220	7.9	-26%
West	2,862	3.4	-17%	12,386	14.9	-10%

Source: TFAH analysis of National Center for Health Statistics data

State Alcohol, Drug, and Suicide Mortality Data

Deaths, death rates, and one-year percent change in death rate from alcohol-induced, drug overdose, and suicide causes, overall and by select demographics, 2024

	Combined Alcohol, Drug, and Suicide		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**173,913**	**48.6**	**-16%**
Alabama	2,626	50.9	-17%
Alaska	769	101.5	-8%
Arizona	5,512	70.4	-4%
Arkansas	1,379	43.6	-11%
California	19,187	45.1	-14%
Colorado	4,266	66.9	-9%
Connecticut	1,861	47.0	-15%
Delaware	588	55.7	-26%
District of Columbia	443	60.1	-24%
Florida	11,528	45.4	-20%
Georgia	4,917	42.3	-13%
Hawaii	640	41.2	-3%
Idaho	1,136	54.8	-9%
Illinois	5,383	40.0	-18%
Indiana	3,841	54.6	-13%
Iowa	1,500	45.6	3%
Kansas	1,537	50.9	-10%
Kentucky	2,967	63.3	-19%
Louisiana	2,592	56.8	-24%
Maine	1,024	68.8	-13%
Maryland	2,940	44.2	-23%
Massachusetts	3,091	40.3	-24%
Michigan	4,792	44.8	-21%
Minnesota	2,881	46.9	-14%
Mississippi	1,407	46.8	-12%

	Combined Alcohol, Drug, and Suicide		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	3,379	52.8	-15%
Montana	765	63.7	-4%
Nebraska	769	37.9	0%
Nevada	2,524	71.3	-8%
New Hampshire	761	50.1	-17%
New Jersey	3,325	32.9	-22%
New Mexico	2,092	97.0	-12%
New York	7,862	37.0	-22%
North Carolina	5,746	50.5	-15%
North Dakota	449	57.8	2%
Ohio	6,447	52.6	-23%
Oklahoma	2,594	62.1	-14%
Oregon	3,663	76.7	-9%
Pennsylvania	6,325	46.0	-22%
Rhode Island	625	52.2	-13%
South Carolina	3,207	56.0	-19%
South Dakota	614	67.4	12%
Tennessee	4,927	66.5	-21%
Texas	12,608	39.4	-8%
Utah	1,632	48.6	-8%
Vermont	449	64.9	-15%
Virginia	5,198	38.4	-24%
Washington	3,408	67.9	-9%
West Virginia	2,166	76.8	-33%
Wisconsin	3,096	48.3	-20%
Wyoming	475	75.8	1%

Source: TFAH analysis of National Center for Health Statistics data

	Alcohol-Induced		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**46,714**	**12.1**	**-4%**
Alabama	505	8.6	-3%
Alaska	206	26.6	-20%
Arizona	1,609	19.7	8%
Arkansas	368	10.6	-9%
California	6,150	13.9	-5%
Colorado	1,451	22.0	-8%
Connecticut	485	11.1	-1%
Delaware	129	11.0	6%
District of Columbia	76	10.1	-17%
Florida	3,061	10.6	-5%
Georgia	1,204	9.6	-4%
Hawaii	103	6.2	13%
Idaho	384	17.3	1%
Illinois	1,503	10.5	3%
Indiana	998	12.9	4%
Iowa	552	15.8	3%
Kansas	452	13.7	-13%
Kentucky	628	11.9	-1%
Louisiana	437	8.5	6%
Maine	274	15.5	-9%
Maryland	536	7.6	-12%
Massachusetts	819	9.7	-9%
Michigan	1,488	12.8	-6%
Minnesota	1,073	16.1	-2%
Mississippi	415	12.6	9%

	Alcohol-Induced		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	821	12.0	8%
Montana	294	23.4	0%
Nebraska	325	15.4	3%
Nevada	671	17.5	-14%
New Hampshire	243	13.5	-1%
New Jersey	663	6.1	-5%
New Mexico	798	35.9	-5%
New York	1,745	7.7	-7%
North Carolina	1,361	10.8	-3%
North Dakota	190	23.3	2%
Ohio	1,476	10.6	-13%
Oklahoma	680	15.3	-15%
Oregon	1,163	22.1	-2%
Pennsylvania	1,215	7.7	-4%
Rhode Island	201	15.6	11%
South Carolina	839	12.7	-4%
South Dakota	325	34.6	16%
Tennessee	1,191	14.7	3%
Texas	3,256	9.8	-4%
Utah	362	10.9	-10%
Vermont	133	16.2	3%
Virginia	851	8.4	-8%
Washington	1,494	16.2	-4%
West Virginia	240	10.9	-17%
Wisconsin	1,076	14.9	-6%
Wyoming	195	29.7	14%

Source: TFAH analysis of National Center for Health Statistics data

STATE ALCOHOL, DRUG, AND SUICIDE MORTALITY DATA (CONT.)

	Drug Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**79,384**	**23.1**	**-26%**
Alabama	1,211	25.0	-26%
Alaska	340	45.1	-9%
Arizona	2,453	32.6	-10%
Arkansas	416	13.9	-21%
California	9,028	21.7	-22%
Colorado	1,610	25.7	-16%
Connecticut	995	26.2	-26%
Delaware	338	33.4	-37%
District of Columbia	315	43.2	-29%
Florida	4,958	21.3	-33%
Georgia	2,029	18.1	-23%
Hawaii	333	21.0	-2%
Idaho	338	17.3	-15%
Illinois	2,531	19.3	-29%
Indiana	1,717	25.7	-25%
Iowa	427	13.7	-8%
Kansas	570	19.7	-13%
Kentucky	1,492	33.5	-30%
Louisiana	1,467	33.5	-34%
Maine	483	35.2	-22%
Maryland	1,772	26.9	-32%
Massachusetts	1,590	21.8	-35%
Michigan	1,944	19.1	-34%
Minnesota	995	17.3	-27%
Mississippi	525	18.6	-26%

	Drug Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	1,461	23.7	-29%
Montana	170	15.3	-10%
Nebraska	155	8.1	-10%
Nevada	1,237	35.9	-6%
New Hampshire	293	21.6	-34%
New Jersey	1,992	20.2	-29%
New Mexico	775	37.1	-24%
New York	4,449	21.3	-31%
North Carolina	2,780	25.7	-23%
North Dakota	108	14.8	-10%
Ohio	3,165	27.2	-35%
Oklahoma	1,019	25.5	-21%
Oregon	1,500	33.5	-18%
Pennsylvania	3,341	25.6	-31%
Rhode Island	323	28.0	-25%
South Carolina	1,467	27.5	-33%
South Dakota	98	11.9	6%
Tennessee	2,499	35.2	-33%
Texas	4,980	15.8	-15%
Utah	674	20.3	-5%
Vermont	208	33.6	-21%
Virginia	1,552	17.6	-38%
Washington	3,145	37.6	-11%
West Virginia	821	48.9	-40%
Wisconsin	1,175	19.8	-35%
Wyoming	120	20.1	-15%

Source: TFAH analysis of National Center for Health Statistics data

	Suicide		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**48,824**	**13.7**	**-3%**
Alabama	837	15.9	-5%
Alaska	222	29.7	5%
Arizona	1,516	18.9	-2%
Arkansas	592	19.0	-6%
California	4,022	9.6	-6%
Colorado	1,313	20.8	0%
Connecticut	394	10.0	9%
Delaware	125	11.8	-8%
District of Columbia	44	5.7	-2%
Florida	3,633	13.9	-4%
Georgia	1,648	14.3	-3%
Hawaii	200	13.7	-10%
Idaho	437	21.2	-9%
Illinois	1,426	10.8	-9%
Indiana	1,175	16.8	-1%
Iowa	548	17.1	10%
Kansas	527	17.9	-9%
Kentucky	844	17.9	2%
Louisiana	654	14.1	-10%
Maine	285	19.2	4%
Maryland	630	9.7	4%
Massachusetts	648	8.3	-3%
Michigan	1,448	13.7	-8%
Minnesota	818	13.7	-1%
Mississippi	450	15.1	-3%

	Suicide		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	1,152	17.8	-1%
Montana	320	26.8	1%
Nebraska	297	14.9	3%
Nevada	676	19.6	-3%
New Hampshire	248	16.4	12%
New Jersey	682	6.7	-7%
New Mexico	532	24.6	8%
New York	1,701	8.1	-2%
North Carolina	1,620	14.1	-1%
North Dakota	145	19.2	8%
Ohio	1,856	15.2	3%
Oklahoma	868	20.9	-4%
Oregon	941	20.0	3%
Pennsylvania	1,845	13.3	-7%
Rhode Island	105	8.9	-6%
South Carolina	904	16.0	9%
South Dakota	198	21.9	6%
Tennessee	1,229	16.4	-6%
Texas	4,490	14.2	0%
Utah	665	19.5	-9%
Vermont	105	14.7	-18%
Virginia	1,196	12.9	-5%
Washington	1,221	14.5	-8%
West Virginia	303	16.4	-12%
Wisconsin	920	14.8	-1%
Wyoming	169	27.8	6%

Source: TFAH analysis of National Center for Health Statistics data

STATE ALCOHOL, DRUG, AND SUICIDE MORTALITY DATA (CONT.)

	Opioid Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**54,045**	**16.0**	**-33%**
Alabama	822	17.3	-33%
Alaska	277	37.0	-8%
Arizona	1,684	23.0	-16%
Arkansas	181	6.2	-43%
California	5,492	13.5	-31%
Colorado	993	16.0	-26%
Connecticut	858	22.9	-28%
Delaware	290	28.9	-38%
District of Columbia	249	34.1	-31%
Florida	3,281	14.6	-38%
Georgia	1,285	11.7	-33%
Hawaii	123	8.2	-13%
Idaho	207	11.0	-24%
Illinois	1,873	14.3	-36%
Indiana	1,170	17.8	-33%
Iowa	172	5.8	-31%
Kansas	355	12.5	-16%
Kentucky	1,024	23.4	-39%
Louisiana	725	16.8	-36%
Maine	386	28.6	-27%
Maryland	1,468	22.4	-34%
Massachusetts	1,336	18.5	-38%
Michigan	1,350	13.5	-42%
Minnesota	676	11.9	-34%
Mississippi	301	11.0	-39%

	Opioid Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	918	15.3	-39%
Montana	101	9.3	-22%
Nebraska	63	3.3	-22%
Nevada	801	23.9	-10%
New Hampshire	252	18.7	-38%
New Jersey	1,620	16.5	-34%
New Mexico	490	24.1	-33%
New York	3,394	16.5	-37%
North Carolina	2,140	20.2	-29%
North Dakota	68	9.4	-19%
Ohio	2,289	20.1	-41%
Oklahoma	599	15.3	-29%
Oregon	1,083	24.8	-23%
Pennsylvania	2,280	18.0	-37%
Rhode Island	224	20.1	-37%
South Carolina	1,049	20.2	-39%
South Dakota	44	5.4	-4%
Tennessee	1,818	26.1	-39%
Texas	2,438	7.8	-25%
Utah	452	13.6	-12%
Vermont	177	29.0	-24%
Virginia	1,170	13.5	-44%
Washington	2,491	30.2	-14%
West Virginia	633	38.6	-46%
Wisconsin	811	14.0	-44%
Wyoming	62	10.4	-31%

Source: TFAH analysis of National Center for Health Statistics data

	Synthetic Opioid Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**47,735**	**14.3**	**-36%**
Alabama	737	15.7	-34%
Alaska	255	33.9	-11%
Arizona	1,482	20.4	-19%
Arkansas	143	5.1	-46%
California	4,837	12.0	-34%
Colorado	797	13.0	-32%
Connecticut	765	20.6	-32%
Delaware	262	26.3	-41%
District of Columbia	239	32.7	-33%
Florida	2,875	13.0	-40%
Georgia	1,096	10.1	-35%
Hawaii	105	7.2	-12%
Idaho	138	7.5	-36%
Illinois	1,670	12.8	-38%
Indiana	1,061	16.3	-34%
Iowa	125	4.3	-39%
Kansas	293	10.4	-18%
Kentucky	891	20.7	-41%
Louisiana	642	15.0	-38%
Maine	349	26.1	-31%
Maryland	1,321	20.1	-37%
Massachusetts	1,251	17.5	-39%
Michigan	1,175	11.9	-46%
Minnesota	606	10.7	-37%
Mississippi	261	9.5	-42%

	Synthetic Opioid Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	823	13.9	-41%
Montana	78	7.2	-24%
Nebraska	49	2.6	-21%
Nevada	675	20.5	-8%
New Hampshire	228	17.3	-40%
New Jersey	1,501	15.4	-34%
New Mexico	420	20.8	-37%
New York	3,049	14.9	-39%
North Carolina	1,961	18.5	-31%
North Dakota	41	5.7	-44%
Ohio	2,094	18.5	-42%
Oklahoma	516	13.4	-32%
Oregon	975	22.7	-24%
Pennsylvania	2,066	16.4	-38%
Rhode Island	195	17.8	-40%
South Carolina	930	18.2	-41%
South Dakota	30	3.8	-26%
Tennessee	1,666	24.1	-41%
Texas	1,902	6.2	-29%
Utah	304	9.1	-12%
Vermont	167	27.7	-24%
Virginia	1,059	12.3	-46%
Washington	2,296	27.9	-15%
West Virginia	587	36.1	-48%
Wisconsin	711	12.5	-46%
Wyoming	36	6.3	-39%

Source: TFAH analysis of National Center for Health Statistics data

STATE ALCOHOL, DRUG, AND SUICIDE MORTALITY DATA (CONT.)

	Cocaine Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**21,945**	**6.3**	**-27%**
Alabama	221	4.4	-30%
Alaska	31	4.0	-2%
Arizona	255	3.4	-1%
Arkansas	38	1.2	-29%
California	1,255	3.0	-23%
Colorado	263	4.2	-11%
Connecticut	511	13.7	-19%
Delaware	158	15.4	-42%
District of Columbia	171	23.7	-26%
Florida	1,449	6.0	-32%
Georgia	542	4.7	-11%
Hawaii	30	1.9	-10%
Idaho	21	1.1	-4%
Illinois	1,060	8.0	-28%
Indiana	362	5.3	-26%
Iowa	34	1.1	-11%
Kansas	78	2.6	5%
Kentucky	197	4.4	-35%
Louisiana	244	5.3	-23%
Maine	206	15.2	-14%
Maryland	697	10.5	-37%
Massachusetts	843	11.7	-33%
Michigan	759	7.4	-36%
Minnesota	198	3.4	-20%
Mississippi	93	3.1	-25%

	Cocaine Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	270	4.3	-17%
Montana	<20	—	—
Nebraska	<20	—	—
Nevada	166	4.6	8%
New Hampshire	49	3.7	-33%
New Jersey	923	9.3	-25%
New Mexico	126	5.9	-28%
New York	2,318	11.1	-29%
North Carolina	1,104	10.0	-18%
North Dakota	<20	—	—
Ohio	1,163	9.8	-35%
Oklahoma	108	2.6	-13%
Oregon	156	3.5	-2%
Pennsylvania	1,228	9.3	-32%
Rhode Island	179	15.7	-23%
South Carolina	409	7.3	-33%
South Dakota	<20	—	—
Tennessee	611	8.4	-32%
Texas	1,460	4.5	-10%
Utah	62	1.8	-13%
Vermont	113	19.3	-10%
Virginia	589	6.7	-40%
Washington	480	5.6	-21%
West Virginia	144	8.7	-30%
Wisconsin	529	8.8	-32%
Wyoming	<20	—	—

Source: TFAH analysis of National Center for Health Statistics data

	Other Psychostimulants Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Overall	**28,722**	**8.5**	**-20%**
Alabama	504	10.6	-20%
Alaska	206	27.8	3%
Arizona	1,479	19.7	4%
Arkansas	207	7.0	3%
California	5,155	12.3	-18%
Colorado	805	13.0	-3%
Connecticut	65	1.9	-24%
Delaware	46	4.8	-25%
District of Columbia	28	3.8	16%
Florida	1,360	6.0	-29%
Georgia	787	7.2	-21%
Hawaii	238	14.9	16%
Idaho	138	7.1	-16%
Illinois	403	3.2	-30%
Indiana	646	9.9	-21%
Iowa	241	7.7	5%
Kansas	255	9.0	-8%
Kentucky	671	15.3	-28%
Louisiana	402	9.4	-36%
Maine	187	14.1	-6%
Maryland	114	1.9	-23%
Massachusetts	166	2.4	-23%
Michigan	371	3.9	-29%
Minnesota	397	7.0	-29%
Mississippi	257	9.2	-16%

	Other Psychostimulants Overdose		
	2024 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2023 to 2024
Missouri	568	9.4	-24%
Montana	83	7.3	-14%
Nebraska	52	2.8	-12%
Nevada	714	20.8	-2%
New Hampshire	47	3.4	-37%
New Jersey	230	2.5	-20%
New Mexico	450	21.7	-13%
New York	577	3.1	-16%
North Carolina	843	8.1	-25%
North Dakota	29	3.9	-28%
Ohio	869	7.8	-35%
Oklahoma	589	14.8	-11%
Oregon	913	20.5	-16%
Pennsylvania	652	5.2	-27%
Rhode Island	39	3.6	-15%
South Carolina	490	9.5	-37%
South Dakota	41	5.1	30%
Tennessee	983	14.1	-37%
Texas	2,084	6.6	-14%
Utah	300	9.1	-2%
Vermont	25	4.3	22%
Virginia	387	4.5	-32%
Washington	1,854	22.1	-5%
West Virginia	468	28.0	-40%
Wisconsin	256	4.6	-36%
Wyoming	51	8.4	-10%

Source: TFAH analysis of National Center for Health Statistics data

National Substance Use and Mental Health Data

	Illicit Drug Use Among 12+ Population (2024)	Binge Drinking Among 12+ Population (2024)	Substance Use Disorder Among 12+ Population (2024)	Serious Mental Illness Among 18+ Population (2024)	Serious Thoughts About Suicide Among 18+ Population (2024)
	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 (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?
Overall	**25.5**	**20.1**	**16.8**	**23.4**	**5.5**
Female	23.2	17.4	13.7	26.7	5.5
Male	28.0	22.8	19.9	20.0	5.5
AI/AN	29.6	19.1	21.3	25.9	7.3
Asian	12.0	10.7	8.7	17.0	4.4
Black or African American	27.1	20.3	17.2	20.9	5.5
Hispanic or Latino	22.0	22.1	15.5	20.7	5.4
NHOPI	18.8	13.7	12.0	12.2	2.6
White	27.5	20.5	17.8	25.1	5.4
Multiracial	36.2	18.4	22.6	35.5	10.7
12 – 17	15.1	3.5	7.8	–	–
18 – 25	38.1	6.7	25.9	33.2	12.6
26 or Older	24.8	21.0	16.4	–	–
26 – 49	–	–	–	29.7	6.1
50 or Older	–	–	–	15.2	2.9

Source: National Survey on Drug Use and Health

	Poor Mental Health Among High Schoolers (2023)	Seriously Considered Suicide Among High Schoolers (2023)	ACEs Among Children 0-17 (2023–2024)
	What percentage of high schoolers reported their mental health was most of the time or always not good?	What percentage of high schoolers seriously considered attempting suicide?	What percentage of children ages 0-17 have ever experienced two or more ACEs?
Overall	**28.5**	**20.4**	**17.1**
Female	38.8	27.1	16.9
Male	18.8	14.1	17.4
AI/AN	42.3	24.5	–
Asian	23.0	14.4	4.0
Black or African American	26.5	19.6	24.1
Hispanic or Latino	26.1	18.2	17.6
NHOPI	14.9	16.1	–
White	31.4	22.1	15.6
Multiracial	28.9	21.6	–
12 – 17	–	–	–
18 – 25	–	–	–
26 or Older	–	–	–
26 – 49	–	–	–
50 or Older	–	–	–
	Source: Youth Risk Behavior Survey		*Source: National Survey of Children's Health*

State Substance Use and Mental Health Data

	Illicit Drug Use Among 12+ Population (2023 – 2024)	Binge Drinking Among 12+ Population (2023 – 2024)	Substance Use Disorder Among 12+ Population (2023 – 2024)	Serious Mental Illness Among 18+ Population (2023 – 2024)	Serious Thoughts About Suicide Among 18+ Population (2023 – 2024)
	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 (drugs or alcohol) in the past year?	What percentage of people ages 18+ had serious mental illness in the past year?	What percentage of people ages 18+ had serious thoughts about suicide in the past year?
Overall	**17%**	**21%**	**17%**	**6%**	**5%**
Alabama	12%	21%	16%	6%	6%
Alaska	22%	18%	18%	7%	6%
Arizona	18%	20%	18%	6%	6%
Arkansas	18%	18%	17%	7%	5%
California	17%	21%	17%	5%	5%
Colorado	25%	22%	22%	7%	6%
Connecticut	20%	21%	18%	6%	5%
Delaware	18%	22%	18%	6%	5%
District of Columbia	24%	30%	24%	7%	6%
Florida	15%	20%	16%	5%	4%
Georgia	17%	21%	18%	6%	6%
Hawaii	13%	19%	14%	4%	5%
Idaho	14%	19%	16%	6%	6%
Illinois	19%	24%	18%	5%	5%
Indiana	17%	19%	17%	7%	6%
Iowa	14%	24%	18%	7%	7%
Kansas	15%	22%	17%	6%	6%
Kentucky	15%	18%	17%	7%	5%
Louisiana	18%	23%	17%	6%	5%
Maine	28%	20%	22%	6%	6%
Maryland	16%	20%	16%	5%	5%
Massachusetts	23%	21%	20%	6%	6%
Michigan	22%	23%	17%	5%	5%
Minnesota	19%	22%	16%	6%	5%
Mississippi	13%	20%	16%	5%	5%
	NOTES: Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.	**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.	**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.	**NOTES:** Serious mental illness (SMI) 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 SMI rather than direct measures of diagnostic criteria.	

Source: National Survey on Drug Use and Health

Substance Abuse and Mental Health Services Administration. "NSDUH State Releases." https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases#nsduh-state-result-data-tables. Accessed March 25, 2026.

	Illicit Drug Use Among 12+ Population (2023 – 2024)	Binge Drinking Among 12+ Population (2023 – 2024)	Substance Use Disorder Among 12+ Population (2023 – 2024)	Serious Mental Illness Among 18+ Population (2023 – 2024)	Serious Thoughts About Suicide Among 18+ Population (2023 – 2024)
	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 (drugs or alcohol) in the past year?	What percentage of people ages 18+ had serious mental illness in the past year?	What percentage of people ages 18+ had serious thoughts about suicide in the past year?
Missouri	22%	23%	19%	7%	6%
Montana	25%	23%	22%	7%	6%
Nebraska	13%	24%	16%	7%	6%
Nevada	21%	23%	22%	7%	6%
New Hampshire	19%	21%	18%	8%	6%
New Jersey	15%	21%	15%	4%	5%
New Mexico	24%	20%	20%	6%	6%
New York	18%	20%	17%	5%	5%
North Carolina	13%	19%	15%	5%	5%
North Dakota	15%	25%	17%	6%	5%
Ohio	17%	23%	18%	6%	6%
Oklahoma	22%	19%	18%	6%	5%
Oregon	25%	20%	21%	8%	7%
Pennsylvania	16%	23%	17%	6%	6%
Rhode Island	22%	22%	19%	6%	6%
South Carolina	14%	24%	18%	5%	4%
South Dakota	13%	22%	17%	7%	6%
Tennessee	15%	19%	16%	7%	6%
Texas	12%	20%	15%	5%	5%
Utah	11%	13%	13%	8%	7%
Vermont	27%	23%	21%	8%	7%
Virginia	15%	19%	16%	6%	5%
Washington	19%	18%	17%	7%	5%
West Virginia	13%	19%	17%	8%	6%
Wisconsin	15%	25%	19%	6%	5%
Wyoming	13%	22%	18%	7%	6%
	NOTES: Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.	**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.	**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.	**NOTES:** Serious mental illness (SMI) 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 SMI rather than direct measures of diagnostic criteria.	

Source: National Survey on Drug Use and Health

Substance Abuse and Mental Health Services Administration. "NSDUH State Releases." https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases#nsduh-state-result-data-tables. Accessed March 25, 2026.

STATE SUBSTANCE USE AND MENTAL HEALTH DATA (CONT.)

	Poor Mental Health Among High Schoolers (2023)	Seriously Considered Suicide Among High Schoolers (2023)	ACEs Among Children (2023 – 2024)	Loneliness Among Adults (2024)
	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?	What percentage of U.S. adults reported feeling lonely at least sometimes?
Overall	**29%**	**20%**	**14%**	**40%**
Alabama	Not Available	Not Available	18%	41%
Alaska	Not Available	23%	21%	46%
Arizona	Not Available	Not Available	13%	40%
Arkansas	28%	24%	21%	43%
California	Not Available	Not Available	11%	41%
Colorado	Not Available	Not Available	16%	38%
Connecticut	28%	16%	12%	39%
Delaware	Not Available	17%	16%	37%
District of Columbia	21%	Not Available	14%	N/A
Florida	Not Available	Not Available	14%	38%
Georgia	Not Available	Not Available	16%	42%
Hawaii	24%	16%	13%	39%
Idaho	Not Available	Not Available	18%	40%
Illinois	26%	19%	13%	41%
Indiana	34%	25%	18%	42%
Iowa	Not Available	Not Available	16%	36%
Kansas	Not Available	Not Available	16%	39%
Kentucky	30%	19%	21%	39%
Louisiana	Not Available	Not Available	18%	41%
Maine	34%	19%	17%	42%
Maryland	28%	18%	12%	39%
Massachusetts	31%	16%	10%	40%
Michigan	31%	22%	17%	41%
Minnesota	Not Available	Not Available	14%	38%
Mississippi	22%	20%	16%	41%
	NOTES: Poor mental health includes stress, anxiety, and depression during the 30 days before the survey.		**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.	
	Source: Youth Risk Behavior Survey		*Source: National Survey of Children's Health*	*Source: Household Pulse Survey*
	Centers for Disease Control and Prevention. "Youth Risk Behavior Survey Data Explorer." https://yrbs-explorer.services.cdc.gov/#/. Accessed March 25, 2026.		*America's Health Rankings. "Adverse Childhood Experiences." United Health Foundation. https://www.americashealthrankings.org/explore/measures/ACEs_8_overall. Accessed March 25, 2026.*	*U.S. Census Bureau Household Pulse Survey. "Phase 4.2 Cycle 08 Household Pulse Survey: July 23–August 19: Table 6a. Social and Emotional Support and Feelings of Loneliness." https://www.census.gov/data/tables/2024/demo/hhp/cycle08.html. Accessed April 24, 2026.*

	Poor Mental Health Among High Schoolers (2023)	Seriously Considered Suicide Among High Schoolers (2023)	ACEs Among Children (2023 – 2024)	Loneliness Among Adults (2024)
	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?	What percentage of U.S. adults reported feeling lonely at least sometimes?
Missouri	31%	26%	18%	40%
Montana	32%	26%	23%	40%
Nebraska	23%	14%	13%	41%
Nevada	Not Available	21%	15%	41%
New Hampshire	33%	21%	15%	38%
New Jersey	27%	14%	11%	38%
New Mexico	25%	15%	19%	41%
New York	25%	19%	12%	38%
North Carolina	30%	18%	14%	41%
North Dakota	31%	18%	17%	42%
Ohio	33%	18%	15%	38%
Oklahoma	30%	23%	18%	42%
Oregon	Not Available	Not Available	15%	45%
Pennsylvania	30%	18%	15%	42%
Rhode Island	27%	16%	12%	38%
South Carolina	Not Available	Not Available	15%	41%
South Dakota	Not Available	17%	19%	39%
Tennessee	28%	24%	18%	37%
Texas	30%	21%	13%	42%
Utah	29%	23%	13%	43%
Vermont	34%	Not Available	15%	41%
Virginia	27%	17%	13%	43%
Washington	Not Available	Not Available	12%	43%
West Virginia	34%	25%	23%	43%
Wisconsin	Not Available	19%	14%	37%
Wyoming	Not Available	Not Available	23%	41%
	NOTES: Poor mental health includes stress, anxiety, and depression during the 30 days before the survey.		**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.	
	Source: Youth Risk Behavior Survey		*Source: National Survey of Children's Health*	*Source: Household Pulse Survey*
	Centers for Disease Control and Prevention. "Youth Risk Behavior Survey Data Explorer." https://yrbs-explorer.services.cdc.gov/#/. Accessed March 25, 2026.		*America's Health Rankings. "Adverse Childhood Experiences." United Health Foundation. https://www.americashealthrankings.org/explore/measures/ACEs_8_overall. Accessed March 25, 2026.*	*U.S. Census Bureau Household Pulse Survey. "Phase 4.2 Cycle 08 Household Pulse Survey: July 23–August 19: Table 6a. Social and Emotional Support and Feelings of Loneliness." https://www.census.gov/data/tables/2024/demo/hhp/cycle08.html. Accessed April 24, 2026.*

State Policies, Programs, and Other Indicators

	Suicide Prevention				
	CDC-Funded Comprehensive Suicide Prevention Programs (2024)	State Suicide Prevention Office (2025)	K-12 Suicide Prevention Training (2025)	Safe Gun Storage Laws (2026)	Red Flag/Extreme Risk Laws (2025)
	Which states have CDC-funded comprehensive suicide prevention programs?	Does jurisdictional law establish a suicide prevention office or coordinator?	Is suicide prevention and/or mental health training required annually for certain school personnel?	Does the state have child-access or secure storage laws for guns?	Which states have enacted Red Flag laws?
Alabama	No	No	No	No	No
Alaska	No	No	No	No	No
Arizona	No	No	No	No	No
Arkansas	Yes	Yes	No	No	No
California	Yes	Yes	No	Yes	Yes
Colorado	Yes	Yes	No	Yes	Yes
Connecticut	Yes	No	No	Yes	Yes
Delaware	No	No	Yes	Yes	Yes
District of Columbia	No	No	No	N/A	N/A
Florida	Yes	Yes	No	Yes	Yes
Georgia	Yes	No	Yes	No	No
Hawaii	No	No	Yes	Yes	Yes
Idaho	No	No	Yes	No	No
Illinois	Yes	No	No	Yes	Yes
Indiana	No	Yes	No	No	Yes
Iowa	No	No	Yes	Yes	No
Kansas	No	Yes	Yes	No	No
Kentucky	No	No	No	No	No
Louisiana	Yes	No	No	No	No
Maine	Yes	No	No	Yes	Yes
Maryland	No	No	Yes	Yes	Yes
Massachusetts	Yes	No	No	Yes	Yes
Michigan	Yes	No	No	Yes	Yes
Minnesota	No	No	No	Yes	Yes
Mississippi	No	No	No	No	No
Missouri	No	No	No	No	No
Montana	No	Yes	No	No	No
	Source: CDC	*Source: Association of State and Territorial Health Officials*	*Source: American Foundation for Suicide Prevention*	*Source: Everytown for Gun Safety*	*Source: Everytown for Gun Safety*
	Centers for Disease Control and Prevention. "Comprehensive Suicide Prevention: Program Profiles." https://www.cdc.gov/suicide/csp-profiles/index.html. Accessed March 25, 2026.	*Association of State and Territorial Health Officials. "Public Health Legal Mapping Center: Suicide Prevention." https://www.astho.org/advocacy/state-health-policy/public-health-legal-mapping-center/suicide-prevention/. Accessed March 25, 2026.*	*American Foundation for Suicide Prevention. "State Facts." https://afsp.org/state-facts/. Accessed March 25, 2026.*	*Everytown for Gun Safety. "Secure Storage or Child Access Prevention Required." https://everytownresearch.org/rankings/law/secure-storage-or-child-access-prevention-required/. Accessed March 25, 2026.*	*Everytown for Gun Safety. "Extreme Risk Law." https://everytownresearch.org/rankings/law/extreme-risk-law/. Accessed March 25, 2026.*

	Suicide Prevention				
	CDC-Funded Comprehensive Suicide Prevention Programs (2024)	State Suicide Prevention Office (2025)	K-12 Suicide Prevention Training (2025)	Safe Gun Storage Laws (2026)	Red Flag/Extreme Risk Laws (2025)
	Which states have CDC-funded comprehensive suicide prevention programs?	Does jurisdictional law establish a suicide prevention office or coordinator?	Is suicide prevention and/or mental health training required annually for certain school personnel?	Does the state have child-access or secure storage laws for guns?	Which states have enacted Red Flag laws?
Nebraska	No	No	Yes	No	No
Nevada	No	Yes	No	Yes	Yes
New Hampshire	No	No	Yes	Yes	No
New Jersey	No	No	No	Yes	Yes
New Mexico	No	No	No	Yes	Yes
New York	No	No	No	Yes	Yes
North Carolina	Yes	No	Yes	Yes	No
North Dakota	No	No	No	No	No
Ohio	Yes	No	No	No	No
Oklahoma	No	No	No	No	No
Oregon	Yes	Yes	No	Yes	Yes
Pennsylvania	No	No	No	No	No
Rhode Island	Yes	No	Yes	Yes	Yes
South Carolina	No	No	No	No	No
South Dakota	No	No	No	No	No
Tennessee	Yes	No	Yes	No	No
Texas	No	No	No	Yes	No
Utah	No	Yes	No	No	No
Vermont	Yes	Yes	No	Yes	Yes
Virginia	No	Yes	No	Yes	Yes
Washington	No	No	No	Yes	Yes
West Virginia	No	No	No	No	No
Wisconsin	Yes	No	No	Yes	No
Wyoming	No	No	No	No	No
Overall	**18 states***	**12 states**	**13 states**	**26 states**	**22 states**
	Source: CDC	*Source: Association of State and Territorial Health Officials*	*Source: American Foundation for Suicide Prevention*	*Source: Everytown for Gun Safety*	*Source: Everytown for Gun Safety*
	Centers for Disease Control and Prevention. "Comprehensive Suicide Prevention: Program Profiles." https://www.cdc.gov/suicide/csp-profiles/index.html. Accessed March 25, 2026.	*Association of State and Territorial Health Officials. "Public Health Legal Mapping Center: Suicide Prevention." https://www.astho.org/advocacy/state-health-policy/public-health-legal-mapping-center/suicide-prevention/. Accessed March 25, 2026.*	*American Foundation for Suicide Prevention. "State Facts." https://afsp.org/state-facts/. Accessed March 25, 2026.*	*Everytown for Gun Safety. "Secure Storage or Child Access Prevention Required." https://everytownresearch.org/rankings/law/secure-storage-or-child-access-prevention-required/. Accessed March 25, 2026.*	*Everytown for Gun Safety. "Extreme Risk Law." https://everytownresearch.org/rankings/law/extreme-risk-law/. Accessed March 25, 2026.*

*CDC's Comprehensive Suicide Prevention Program includes the 18 state programs noted above, as well as programs in Puerto Rico and five healthcare or research entities: Bexar County Hospital District (TX), Research Foundation for Mental Hygiene (NY), University of Nebraska, University of North Dakota, and University of Pittsburgh.

STATE POLICIES, PROGRAMS, AND OTHER INDICATORS (CONT.)

	Crisis Response			
	988 Lifeline Funding (2025)	988 In-State Answer Rates (2025)	Number of Mobile Crisis Teams (2024)	Medicaid Reimbursement for Mobile Crisis (2025)
	Has the state enacted a dedicated fee or recurring state appropriations to fund 988?	What is the in-state answer rate for 988 calls?	How many mobile crisis teams are operating in each state?	Has the state received approval for enhanced Medicaid funding for mobile crisis response?
Alabama	No	90%	11-20	Yes; also received planning grant
Alaska	Legislation Pending	77%	6-10	No
Arizona	State Appropriations	91%	100+	Yes
Arkansas	No	58%	One	No
California	Dedicated Fee	86%	100+	Yes; also received planning grant
Colorado	Dedicated Fee	93%	11-20	Yes; also received planning grant
Connecticut	No	93%	21-50	No
Delaware	Dedicated Fee	77%	2-5	Received planning grant
District of Columbia	Legislation Pending	74%	N/A	Yes
Florida	State Appropriations	78%	51-100	No
Georgia	State Appropriations	63%	100+	No
Hawaii	No	85%	11-20	No
Idaho	No	88%	6-10	No
Illinois	Dedicated Fee	91%	100+	No
Indiana	No	94%	21-50	Yes
Iowa	No	86%	11-20	No
Kansas	State Appropriations	91%	21-50	No
Kentucky	No	90%	21-50	Yes; also received planning grant
Louisiana	No	87%	11-20	Yes
Maine	No	89%	6-10	Received planning grant
Maryland	Dedicated Fee	92%	21-50	Yes; also received planning grant
Massachusetts	Legislation Pending	88%	21-50	Yes; also received planning grant
Michigan	No	89%	51-100	No
Minnesota	Dedicated Fee	87%	21-50	No
Mississippi	No	98%	11-20	No
Missouri	Legislation Pending	96%	11-20	Received planning grant
Montana	No	98%	2-5	Yes; also received planning grant
Nebraska	No	85%	11-20	No
	NOTES: Public policy extends beyond legislation; however, this resource is limited to 988 state legislation efforts.	**NOTES:** Data are from the May 2025 in-state answer rate. Detailed data from the Veterans Crisis Line are not publicly available, so they are not included in the analysis.		
	Source: National Alliance on Mental Illness	*Source: KFF*	*Source: National Association of State Mental Health Program Directors Research Institute*	*Source: National Alliance on Mental Illness*
	National Alliance on Mental Illness. "988 Crisis Response State Legislation Map." Reimagine Crisis. https://reimaginecrisis.org/map/. Accessed March 25, 2026.	*KFF. "Demand for 988 Continues to Grow at Third Anniversary." July 14, 2025. https://www.kff.org/mental-health/demand-for-988-continues-to-grow-at-third-anniversary/. Accessed March 25, 2026.*	*National Association of State Mental Health Program Directors Research Institute. "Profiles." https://nri-inc.org/profiles. Accessed March 25, 2026.*	*National Alliance on Mental Illness. "Enhanced Medicaid Mobile Crisis Map." Reimagine Crisis. https://reimaginecrisis.org/mobilecrisis/. Accessed March 25, 2026.*

	Crisis Response			
	988 Lifeline Funding (2025)	**988 In-State Answer Rates (2025)**	**Number of Mobile Crisis Teams (2024)**	**Medicaid Reimbursement for Mobile Crisis (2025)**
	Has the state enacted a dedicated fee or recurring state appropriations to fund 988?	What is the in-state answer rate for 988 calls?	How many mobile crisis teams are operating in each state?	Has the state received approval for enhanced Medicaid funding for mobile crisis response?
Nevada	Dedicated Fee	77%	6-10	Yes; also received planning grant
New Hampshire	No	88%	6-10	Yes
New Jersey	Legislation Pending	77%	11-20	Yes
New Mexico	Dedicated Fee	90%	2-5	Yes; also received planning grant
New York	Legislation Pending	91%	51-100	Yes
North Carolina	No	84%	100+	Yes; also received planning grant
North Dakota	No	84%	6-10	No
Ohio	No	92%	51-100	No
Oklahoma	No	91%	51-100	Received planning grant
Oregon	Dedicated Fee	88%	21-50	Yes; also received planning grant
Pennsylvania	No	91%	51-100	Received planning grant
Rhode Island	Legislation Pending	99%	11-20	No
South Carolina	No	88%	11-20	No
South Dakota	No	84%	2-5	No
Tennessee	No	89%	11-20	No
Texas	No	82%	21-50	No
Utah	State Appropriations	88%	21-50	Received planning grant
Vermont	Dedicated Fee	89%	6-10	Yes; also received planning grant
Virginia	Dedicated Fee	86%	100+	No
Washington	Dedicated Fee	93%	51-100	Yes
West Virginia	No	91%	11-20	Yes; also received planning grant
Wisconsin	No	78%	51-100	Yes; also received planning grant
Wyoming	No	92%	None	No
Overall	**State appropriations: 5 states Dedicated fee: 12 states Pending legislation: 6 states + DC**	**N/A**	**N/A**	**Yes: 7 states + DC Yes and planning grant: 14 states received planning grant: 6 states**
	NOTES: Public policy extends beyond legislation; however, this resource is limited to 988 state legislation efforts.	**NOTES:** Data are from the May 2025 in-state answer rate. Detailed data from the Veterans Crisis Line are not publicly available, so they are not included in the analysis.		
	Source: National Alliance on Mental Illness	*Source: KFF*	*Source: National Association of State Mental Health Program Directors Research Institute*	*Source: National Alliance on Mental Illness*
	National Alliance on Mental Illness. "988 Crisis Response State Legislation Map." Reimagine Crisis. https://reimaginecrisis.org/map/. Accessed March 25, 2026.	*KFF. "Demand for 988 Continues to Grow at Third Anniversary." July 14, 2025. https://www.kff.org/mental-health/demand-for-988-continues-to-grow-at-third-anniversary/. Accessed March 25, 2026.*	*National Association of State Mental Health Program Directors Research Institute. "Profiles." https://nri-inc.org/profiles. Accessed March 25, 2026.*	*National Alliance on Mental Illness. "Enhanced Medicaid Mobile Crisis Map." Reimagine Crisis. https://reimaginecrisis.org/mobilecrisis/. Accessed March 25, 2026.*

STATE POLICIES, PROGRAMS, AND OTHER INDICATORS (CONT.)

	Mental Health			
	Mental Health Access Ranking (2025)	**Mental Health Professional Shortage Areas (2025)**	**Medicaid Rate Increases for Behavioral Health Providers (2024-2025)**	**School-Linked Mental Health Services Program (2025)**
	What is the state's Mental Health Access ranking?	What percentage of a state's mental healthcare professional needs are being met?	Has the state increased its Medicaid reimbursement rate for outpatient behavioral health clinicians in FY 2024 or 2025?	Has the state established a program or policy to increase access to community providers in schools?
Alabama	51	28%	Yes	Yes
Alaska	34	12%	Yes	No
Arizona	45	10%	No	Yes
Arkansas	40	26%	No	No
California	37	24%	Yes	Yes
Colorado	14	41%	Yes	Yes
Connecticut	9	24%	Yes	No
Delaware	26	7%	Yes	Yes
District of Columbia	6	0%	Yes	Partial
Florida	44	25%	N/A	Yes
Georgia	46	45%	N/A	Partial
Hawaii	18	33%	Yes	Partial
Idaho	41	30%	Yes	No
Illinois	13	23%	Yes	No
Indiana	25	40%	Yes	Partial
Iowa	11	20%	Yes	No
Kansas	31	19%	No	No
Kentucky	16	20%	Yes	Partial
Louisiana	32	28%	No	No
Maine	2	14%	Yes	No
Maryland	30	22%	Yes	Yes
Massachusetts	3	25%	Yes	No
Michigan	15	39%	Yes	No
Minnesota	29	25%	Yes	Yes
Mississippi	48	35%	Yes	Partial
Missouri	24	15%	No	No
Montana	28	37%	Yes	Yes
	NOTES: The Mental Health Access ranking measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and mental health workforce availability. States are ranked from 1 (best) to 51 (worst) in terms of access to mental healthcare.	**NOTES:** Healthcare Professional Shortage Areas are determined by the ratio of healthcare professionals to population within a geographic area, population group, or facility type. For mental health, the population to provider ratio must be at least 30,000:1 and 20,000: 1 if there are high needs in the community.	**NOTES:** States were asked to indicate whether fee-for-services provider rates increased (+), decreased (-), or did not change in FY 2024 and FY 2025 by provider type.	**NOTES:** Yes: if state statute establishes a program or policy to increase access to community providers in schools; Partial: for pilots, programs, partnerships, or other agency efforts that are not in statute; No: if no policy or program
	Source: Mental Health America	*Source: KFF*		*Source: Inseparable*
	Mental Health America. "The State of Mental Health in America." https://mhanational.org/the-state-of-mental-health-in-america/. Accessed March 25, 2026.	*KFF. "Mental Health Care Health Professional Shortage Areas (HPSAs)." https://www.kff.org/other-health/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/. Accessed March 25, 2026.*	*Hinton, Elizabeth, Elizabeth Williams, Julia Raphael, et al. "As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities Amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025." KFF, October 23, 2024. https://www.kff.org/medicaid/50-state-medicaid-budget-survey-fy-2024-2025/. Accessed March 25, 2026.*	*Inseparable. "School Mental Health: State Score Cards." https://www.inseparable.us/school-mental-health/#stateScoreCards. Accessed March 25, 2026.*

	Mental Health			
	Mental Health Access Ranking (2025)	**Mental Health Professional Shortage Areas (2025)**	**Medicaid Rate Increases for Behavioral Health Providers (2024-2025)**	**School-Linked Mental Health Services Program (2025)**
	What is the state's Mental Health Access ranking?	What percentage of a state's mental healthcare professional needs are being met?	Has the state increased its Medicaid reimbursement rate for outpatient behavioral health clinicians in FY 2024 or 2025?	Has the state established a program or policy to increase access to community providers in schools?
Nebraska	35	45%	Yes	No
Nevada	47	21%	Yes	No
New Hampshire	4	48%	Yes	No
New Jersey	27	52%	Yes	Yes
New Mexico	17	30%	Yes	Partial
New York	8	15%	Yes	Yes
North Carolina	38	13%	Yes	No
North Dakota	36	35%	Yes	No
Ohio	12	34%	Yes	Partial
Oklahoma	23	21%	No	Partial
Oregon	7	30%	Yes	Yes
Pennsylvania	5	32%	No	No
Rhode Island	10	50%	Yes	No
South Carolina	49	31%	Yes	Yes
South Dakota	39	18%	Yes	No
Tennessee	42	13%	N/A	Partial
Texas	50	32%	No	No
Utah	33	51%	Yes	Partial
Vermont	1	N/A	Yes	No
Virginia	19	22%	No	Partial
Washington	20	21%	Yes	Yes
West Virginia	22	6%	Yes	Yes
Wisconsin	21	42%	Yes	Partial
Wyoming	43	32%	No	No
Overall	**N/A**	**27%**	**37 States + DC**	**Yes: 15 States Partial: 12 states + DC**
	NOTES: The Mental Health Access ranking measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and mental health workforce availability. States are ranked from 1 (best) to 51 (worst) in terms of access to mental healthcare.	**NOTES:** Healthcare Professional Shortage Areas are determined by the ratio of healthcare professionals to population within a geographic area, population group, or facility type. For mental health, the population to provider ratio must be at least 30,000:1 and 20,000: 1 if there are high needs in the community.	**NOTES:** States were asked to indicate whether fee-for-services provider rates increased (+), decreased (-), or did not change in FY 2024 and FY 2025 by provider type.	**NOTES:** Yes: if state statute establishes a program or policy to increase access to community providers in schools; Partial: for pilots, programs, partnerships, or other agency efforts that are not in statute; No: if no policy or program
	Source: Mental Health America	*Source: KFF*		*Source: Inseparable*
	Mental Health America. "The State of Mental Health in America." https://mhanational.org/the-state-of-mental-health-in-america/. Accessed March 25, 2026.	*KFF. "Mental Health Care Health Professional Shortage Areas (HPSAs)." https://www.kff.org/other-health/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/. Accessed March 25, 2026.*	*Hinton, Elizabeth, Elizabeth Williams, Julia Raphael, et al. "As Pandemic-Era Policies End, Medicaid Programs Focus on Enrollee Access and Reducing Health Disparities Amid Future Uncertainties: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025." KFF, October 23, 2024. https://www.kff.org/medicaid/50-state-medicaid-budget-survey-fy-2024-2025/. Accessed March 25, 2026.*	*Inseparable. "School Mental Health: State Score Cards." https://www.inseparable.us/school-mental-health/#stateScoreCards. Accessed March 25, 2026.*

STATE POLICIES, PROGRAMS, AND OTHER INDICATORS (CONT.)

	Substance Use	
	Substance Use Treatment Access (2023 – 2024)	**Opioid Litigation Proceeds Requirements (2025)**
	What percentage of people age 12+ in the state needed but did not receive substance use treatment in the past year?	What states require opioid litigation settlement funds to be spent on opioid remediation?
Alabama	75%	General parameters for expenditures
Alaska	73%	General parameters for expenditures
Arizona	84%	Specific expenditures
Arkansas	81%	Specific expenditures
California	82%	General parameters for expenditures
Colorado	83%	General parameters for expenditures
Connecticut	85%	Specific expenditures
Delaware	84%	General parameters for expenditures
District of Columbia	85%	Specific expenditures
Florida	82%	General parameters for expenditures
Georgia	80%	Specific expenditures
Hawaii	81%	Specific expenditures
Idaho	82%	General parameters for expenditures
Illinois	82%	General parameters for expenditures
Indiana	80%	General parameters for expenditures
Iowa	81%	General parameters for expenditures
Kansas	82%	General parameters for expenditures
Kentucky	75%	Specific expenditures
Louisiana	76%	Specific expenditures
Maine	82%	General parameters for expenditures
Maryland	81%	Specific expenditures
Massachusetts	84%	General parameters for expenditures
Michigan	83%	General parameters for expenditures
Minnesota	83%	Specific expenditures
Mississippi	76%	General parameters for expenditures
Missouri	79%	General parameters for expenditures
Montana	83%	Specific expenditures
	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/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.	The specific examples of permissible expenditures for opioid litigation settlement funds "include things like expanding the availability of medication for addiction treatment, providing counseling and peer support services, and addressing the needs of pregnant and postpartum women with substance use disorder." General parameters for permissible expenditures include noting that the funds must be used for opioid remediation.
	Source: National Survey on Drug Use and Health	*Source: Legislative Analysis and Public Policy Association*
	Substance Abuse and Mental Health Services Administration. "NSDUH State Releases." https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases#nsduh-state-result-data-tables. Accessed March 25, 2026.	*Legislative Analysis and Public Policy Association. "Opioid Litigation Proceeds: Summary of State Laws." https://legislativeanalysis.org/opioid-litigation-proceeds-summary-of-state-lawsary-of-state-laws/. Accessed March 25, 2026.*

	Substance Use	
	Substance Use Treatment Access (2023 – 2024)	**Opioid Litigation Proceeds Requirements (2025)**
	What percentage of people age 12+ in the state needed but did not receive substance use treatment in the past year?	What states require opioid litigation settlement funds to be spent on opioid remediation?
Nebraska	81%	General parameters for expenditures
Nevada	83%	Specific expenditures
New Hampshire	82%	Specific expenditures
New Jersey	84%	Specific expenditures
New Mexico	79%	Specific expenditures
New York	81%	Specific expenditures
North Carolina	76%	Specific expenditures
North Dakota	81%	General parameters for expenditures
Ohio	76%	Specific expenditures
Oklahoma	82%	Specific expenditures
Oregon	81%	Specific expenditures
Pennsylvania	79%	No set permissible expenditures
Rhode Island	81%	General parameters for expenditures
South Carolina	81%	General parameters for expenditures
South Dakota	81%	General parameters for expenditures
Tennessee	74%	General parameters for expenditures
Texas	79%	Specific expenditures
Utah	79%	General parameters for expenditures
Vermont	79%	Specific expenditures
Virginia	83%	Specific expenditures
Washington	81%	General parameters for expenditures
West Virginia	75%	No set permissible expenditures
Wisconsin	83%	General parameters for expenditures
Wyoming	81%	Specific expenditures
Overall	**81%**	**Specific parameters: 23 states + DC General parameters: 25 states**
	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/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.	The specific examples of permissible expenditures for opioid litigation settlement funds "include things like expanding the availability of medication for addiction treatment, providing counseling and peer support services, and addressing the needs of pregnant and postpartum women with substance use disorder." General parameters for permissible expenditures include noting that the funds must be used for opioid remediation.
	Source: National Survey on Drug Use and Health	*Source: Legislative Analysis and Public Policy Association*
	Substance Abuse and Mental Health Services Administration. "NSDUH State Releases." https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases#nsduh-state-result-data-tables. Accessed March 25, 2026.	*Legislative Analysis and Public Policy Association. "Opioid Litigation Proceeds: Summary of State Laws." https://legislativeanalysis.org/opioid-litigation-proceeds-summary-of-state-lawsary-of-state-laws/. Accessed March 25, 2026.*

Endnotes

1. Unless otherwise specified, all mortality data in this report is from CDC's National Center for Health Statistics' National Vital Statistics System, via CDC WONDER Online Database, and analyzed by Trust for America's Health. For more information on the analysis, see Appendix A on page 73.
2. National Vital Statistics System. "Provisional Drug Overdose Death Counts." https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Accessed April 10, 2026.
3. Centers for Disease Control and Prevention. "Mapping Injury, Overdose, and Violence Dashboard." CDC Injury Center, updated April 15, 2026. https://www.cdc.gov/injury-violence-data/data-vis/index.html. Accessed April 20, 2026.
4. Hsu, Andrea. Trump administration adds fine print to 'Fork' resignation offer, deepening confusion." NPR, February 4, 2025. https://www.npr.org/2025/02/04/nx-s1-5286238/federal-employees-fork-musk-trump-deferred-resignation. Accessed April 24, 2026.
5. Stein, Rob, Sydney Lupkin, Selena Simmons-Duffin, et al. "Widespread Firings Start at Federal Health Agencies Including Many in Leadership." NPR, April 1, 2025. https://www.npr.org/sections/shots-health-news/2025/04/01/g-s1-57485/hhs-fda-layoffs-doge-cdc-nih. Accessed April 20, 2026.
6. Office of Personnel Management. "Workforce Size & Composition." February 5, 2026. https://data.opm.gov/explore-data/analytics/workforce-size-and-composition. Accessed April 20, 2026.
7. Broderick, O. Rose, and Lev Facher. "Trump Cuts Have Decimated the Federal Addiction and Mental Health Agency." STAT News, October 30, 2025. https://www.statnews.com/2025/10/30/samhsa-grant-cuts-staff-reductions-impact-analyzed/. Accessed April 20, 2026.
8. Stone, Will. "With CDC injury prevention team gutted, 'we will not know what it killing us.'" NPR, April 21, 2025. https://www.npr.org/sections/shots-health-news/2025/04/21/nx-s1-5371519/cdc-hhs-injury-prevention-federal-layoffs. Accessed April 24, 2026.
9. Goldman, Maya, and Sabrina Moreno. "Trump Admin Cancels Over $12B in Health Care Grants." Axios, March 27, 2026. https://www.axios.com/2025/03/27/trump-admin-cancels-state-health-care-grants. Accessed April 20, 2026.
10. Tong, Noah, and Dave Muoio. "States Win Injunction Against HHS' $11B Clawback of COVID-19, Public Health Grants." Fierce Healthcare, May 19, 2025. https://www.fiercehealthcare.com/regulatory/cdc-doge-claws-back-covid-19-grants-headed-states. Accessed April 20, 2026.
11. Mann, Brian. "24 Hours of Chaos as Mental Health Grants Are Slashed Then Restored." NPR, January 15, 2026. https://www.npr.org/2026/01/15/nx-s1-5677711/mental-health-addiction-grants-cut-then-restored. Accessed April 20, 2026.
12. Grant Witness. "Grant Witness is Tracking SAMHSA Grant Terminations." January 21, 2026. https://grant-witness.us/posts/2026-01-16_samhsa-jan-terminations/. Accessed April 20, 2026.
13. Ibid.
14. Departments of Labor, Health and Human Services, Education, and Related Agencies. "Joint Explanatory Statement." https://www.appropriations.senate.gov/imo/media/doc/fy26_lhhs_jes.pdf. Accessed April 20, 2026.
15. White House. "The President's FY 2026 Discretionary Budget Request." https://www.whitehouse.gov/omb/information-resources/budget/the-presidents-fy-2026-discretionary-budget-request/. Accessed April 20, 2026.
16. Office of Management of Budget. "Budget of the U.S. Government: Fiscal Year 2027." https://www.whitehouse.gov/wp-content/uploads/2026/04/budget_fy2027.pdf. Accessed April 20, 2026.
17. Xu, Jiaquan, Sherry L. Murphy, Kenneth D. Kochanek, and Elizabeth Arias. "Mortality in the United States, 2024." NCHS Data Brief, No. 548, January 2026. https://www.cdc.gov/nchs/products/databriefs/db548.htm. Accessed April 20, 2026.
18. Centers for Disease Control and Prevention. "10 Leading Causes of Death, United States 2024, All Deaths with Drilldown to ICD Codes, All Sexes, All Races, All Ethnicities." WISQARS Leading Causes of Death Visualization Tool, 2024. https://wisqars.cdc.gov/lcd/?o=LCD&y1=2024&y2=2024&ct=10&cc=ALL&g=00&s=0&r=0&ry=2&e=0&ar=lcd1age&at=groups&ag=lcd1age&a1=0&a2=199. Accessed April 20, 2026.
19. Years of potential life lost is a measure of premature mortality calculated by subtracting the age at death from a standard lifespan and summing those years across all individuals who died prematurely.
20. Centers for Disease Control and Prevention. "Explore Years of Potential Life Lost: Years of Potential Life Lost (YPLL) Before age 65 for 10 All Deaths with Drilldown to ICD Codes." WISQARS Leading Causes of Death Visualization Tool, 2023. https://wisqars.cdc.gov/lcd/?o=YPLL&y1=2023&y2=2023&ct=10&cc=ALL&g=00&s=0&r=0&ry=2&e=0&ypll=65. Accessed April 20, 2026.
21. Centers for Disease Control and Prevention. "Risks and Protective Factors." April 25, 2024. https://www.cdc.gov/suicide/factors/index.html. Accessed April 20, 2026.
22. Ibid.

23. Ibid.

24. Curtin, Sally C., Matthew F. Garnett, and Farida B. Ahmad. "Provisional Estimates of Suicide by Demographic Characteristics: United States, 2022." Vital Statistics Rapid Release, 34, November 2023. https://www.cdc.gov/nchs/data/vsrr/vsrr034.pdf. Accessed April 20, 2026.

25. Centers for Disease Control and Prevention. "Mapping Injury, Overdose, and Violence Dashboard." Updated April 20, 2026. https://www.cdc.gov/injury-violence-data/data-vis/index.html. Accessed April 20, 2026.

26. National Institute for Health Care Management Foundation. "The Launch of 988 & More." Press release: July 7, 2022. https://nihcm.org/newsletter/the-launch-of-988-more. Accessed April 20, 2026.

27. Cai, Ziyi, Alvin Junus, Qingsong Chang, and Paul S.F. Yip. "The Lethality of Suicide Methods: A Systematic Review and Meta-Analysis." Journal of Affective Disorders, 300: 121-129, March 1, 2022. https://www.sciencedirect.com/science/article/abs/pii/S0165032721013732. Accessed April 20, 2026

28. Berardelli, Isabella et al. "Is Lethality Different between Males and Females? Clinical and Gender Differences in Inpatient Suicide Attempters." International Journal of Environmental Research and Public Health, 19(20): 13309, 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC9602518/. Accessed April 20, 2026.

29. Carretta, Rachel F., Sherry A. McKee, and Taeho Greg Rhee. "Gender Differences in Risks of Suicide and Suicidal Behaviors in the USA: A Narrative Review." Current Psychiatry Reports, 25(12): 809-824, 2023. https://pmc.ncbi.nlm.nih.gov/articles/PMC11225381/#T1. Accessed April 20, 2026.

30. Cubbage, Janel, and Leslie Adams. "Still Ringing the Alarm: An Enduring Call to Action for Black Youth Suicide Prevention." Johns Hopkins Center for Gun Violence Solutions and Johns Hopkins Bloomberg School of Public Health, Department of Mental Health, August 23, 2023. https://publichealth.jhu.edu/sites/default/files/2023-08/2023-august-still-ringing-alarm.pdf. Accessed April 20, 2026.

31. Mullany, Britta, Allison Barlow, Novalene Goklish, et al. "Toward Understanding Suicide Among Youths: Results From the White Mountain Apache Tribally Mandated Suicide Surveillance System, 2001–2006." American Journal of Public Health, 99(10): 1840-1848. https://pubmed.ncbi.nlm.nih.gov/19696377/. Accessed April 20, 2026.

32. Wexler L., Lisa, Marushka L. Silveira, and Elizabeth Bertone-Johnson. "Factors Associated with Alaska Native Fatal and Nonfatal Suicidal Behaviors 2001-2009: Trends and Implications for Prevention." Archives of Suicide Research, 16(4): 273-286, 2012. https://pubmed.ncbi.nlm.nih.gov/23137218/. Accessed April 20, 2026.

33. Substance Abuse and Mental Health Services Administration. "Suicide Clusters Within American Indian and Alaska Native Communities: A Review of Literature and Recommendations." U.S. Department of Health and Human Services, HHS Publication No. SMA17-5050, 2017. https://store.samhsa.gov/sites/default/files/d7/priv/sma17-5050.pdf. Accessed April 20, 2026.

34. Indian Health Service. "Suicide Prevention and Care Program." https://www.ihs.gov/suicideprevention/. Accessed April 20, 2026.

35. Ramirez, Alan. "American Indian Suicide Rate Increase." National Indian Council on Aging, Inc. September 9, 2019. https://www.nicoa.org/national-american-indian-and-alaska-native-hope-for-life-day/. Accessed April 20, 2026.

36. Conner, Andrew, Deborah Azrael, and Matthew Miller. "Suicide Case-Fatality Rates in the United States, 2007 to 2014: A Nationwide Population-Based Study." Annals of Internal Medicine, 171(12): 885-895, December 3, 2019. https://pubmed.ncbi.nlm.nih.gov/31791066/. Accessed April 20, 2026.

37. Ibid.

38. Harvard T.H. Chan School of Public Health. "Attempters' Longterm Survival." Means Matter. https://hsph.harvard.edu/research/means-matter/means-matter-basics/attempters-longterm-survival/. Accessed April 20, 2026.

39. American Foundation for Suicide Prevention. "Policy Priority: Lethal Means Safety." https://afsp.org/policy-priority-lethal-means-safety/#medications,-toxic-chemicals,-and-other-substances. Accessed April 20, 2026.

40. Marcus, Steven C., Sara W. Cullen, Ming Xie, et al. "Evaluating the Effect of Routine Lethal Means Counseling in the Emergency Department on Suicide Mortality Among Mental Health Patients." AJPM Focus, 4(4): 100336, August 2025. https://www.sciencedirect.com/science/article/pii/S2773065425000240. Accessed April 20, 2026.

41. Pettrone, Kristen, and Sally C. Curtin. "Urban–Rural Differences in Suicide Rates, By Sex and Three Leading Methods: United States, 2000–2018." National Center on Health Statistics, NCHS Data Brief, no 373, August 2002. https://www.cdc.gov/nchs/data/databriefs/db373-H.pdf. Accessed April 20, 2026.

42. Rural Health Information Hub. "Risk Factors for Suicide." https://www.ruralhealthinfo.org/toolkits/suicide/1/risk-factors. Accessed April 20, 2026.

43. Upton, C. Z., Tracy Costigan, K. Tran, et al. "Listening to Rural America: Insights from Anonymized Conversations with Texters Seeking Mental Health Support." Crisis Text Line, forthcoming in August 2026. https://www.crisistextline.org/blog/category/research/. Accessed April 20, 2026.

44. Sussell, Aaron, Cora Peterson, Jia Li, et al. "Suicide Rates by Industry and Occupation—National Vital Statistics System, United States, 2021." Morbidity and Mortality Weekly Report, 72(50): 1346-1350, December 15, 2023. https://www.cdc.gov/mmwr/volumes/72/wr/mm7250a2.htm. Accessed April 20, 2026.

45. Burnett, Todd. "2025 National Veteran Suicide Prevention Annual Report: Part 1: Overview." U.S. Department of Veterans Affairs, March 8, 2026. https://news.va.gov/145433/2025-national-veteran-suicide-prevention-report/. Accessed April 20, 2026.

46. Burnett, Todd. "2025 National Veteran Suicide Prevention Annual Report: Part 2: Report Findings." U.S. Department of Veterans Affairs, March 8, 2026. https://news.va.gov/145433/2025-national-veteran-suicide-prevention-report/. Accessed April 20, 2026.

47. Burnett, Todd. "2025 National Veteran Suicide Prevention Annual Report: Part 1: Overview." U.S. Department of Veterans Affairs, March 8, 2026. https://news.va.gov/145433/2025-national-veteran-suicide-prevention-report/. Accessed April 20, 2026.

48. U.S. Department of Veterans Affairs. "Address Moral Injury to Reduce Veteran Suicide Risk." May 2025. https://www.mentalhealth.va.gov/suicide_prevention/docs/FSTP-Address-Moral-Injury-to-Reduce-Veteran-Suicide-Risk.pdf. Accessed April 20, 2026.

49. Maguen, Shira, Brandon J. Griffin, Dawne Vogt, et al. "Moral Injury and Peri- and Post-Military Suicide Attempts Among Post-9/11 Veterans." Psychological Medicine, 53(7), 3200-3209, January 17, 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC10235653/. Accessed April 20, 2026.

50. Griffin, Brandon J., Shira Maguen, Matthew L. McCue, et al. "Moral Injury is Independently Associated with Suicidal Ideation and Suicide Attempt in High-Stress, Service-Oriented Occupations." npj Mental Health Research, 4(1): 32, 2025. https://pubmed.ncbi.nlm.nih.gov/40751003/. Accessed April 20, 2026.

51. Burnett, Todd. "2025 National Veteran Suicide Prevention Annual Report: Part 1: Overview." U.S. Department of Veterans Affairs, March 8, 2026. https://news.va.gov/145433/2025-national-veteran-suicide-prevention-report/. Accessed April 20, 2026.

52. U.S. Department of Veterans Affairs. "VA Improves Access to Care, Reduces Wait Times for New Patient Appointments in Primary and Mental Health Care." Press release: May 24, 2024. https://news.va.gov/press-room/va-improves-access-to-care-reduces-wait-times-for-new-patient-appointments-in-primary-and-mental-health-care/. Accessed April 20, 2026.

53. U.S. Department of Veterans Affairs. "OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2025." August 12, 2025. https://www.vaoig.gov/sites/default/files/reports/2025-08/vaoig-25-01135-196-final.pdf. Accessed April 20, 2026.

54. Nehamas, Nicholas, Andrea Fuller, Danielle Ivory, and Ellen Barry. "Despite Promises, Veterans Affairs Department Cut Thousands of Roles for Doctors and Nurses." The New York Times, March 3, 2026. https://www.nytimes.com/2026/03/03/us/politics/veterans-affairs-nurses-doctors-cut.html. Accessed April 20, 2026.

55. Rosenbaum, Leah. "'We Need to Terminate Treatment': VA Mental Health Providers Say They Are Under Pressure to Limit Care." The War Horse, August 26, 2025. https://thewarhorse.org/va-mental-health-limits/. Accessed April 20, 2026.

56. Coleman, Vernal, Topher Sanders, Joel Jacobs, and Eric Umansky. "Veterans Who Depend on Mental Health Care Keep Losing Their Therapists Under Trump." ProPublica, March 12, 2026. https://www.propublica.org/article/veterans-affairs-mental-health-therapists-quit-trump. Accessed April 20, 2026.

57. Nehamas, Nicholas, Andrea Fuller, Danielle Ivory, and Ellen Barry. "Despite Promises, Veterans Affairs Department Cut Thousands of Roles for Doctors and Nurses." The New York Times, March 3, 2026. https://www.nytimes.com/2026/03/03/us/politics/veterans-affairs-nurses-doctors-cut.html. Accessed April 20, 2026.

58. Berry, Ellen, and Nicholas Nehamas. "V.A. Mental Health Care Staff, Crowded into Federal Buildings, Raise Patient Privacy Alarms." The New York Times, May 4, 2025. https://www.nytimes.com/2025/05/04/us/politics/veterans-affairs-mental-health-privacy.html. Accessed April 20, 2026.

59. Clark, Kirsty A., and John R. Blosnich. "Limitations of Sexual Orientation and Gender Identity Information as Reported in the National Violent Death Reporting System." LGBT Health, 11(3): 173-177, April 2024. https://pmc.ncbi.nlm.nih.gov/articles/PMC11001946/. Accessed April 20, 2026.

60. Bouton, Lauren and Elana Redfield. "Removal of Sexual Orientation and Gender Identity from Federal Data Collections: January 2025 to January 2026." UCLA School of Law Williams Institute, February 2026. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Federal-SOGI-Data-Collection-Feb-2026.pdf. Accessed April 24, 2026.

61. Hottes, Travis Salway, Laura Bogaert, Anne E. Rhodes, et al. "Lifetime Prevalence of Suicide Attempts Among Sexual Minority Adults by Study Sampling Strategies: A Systematic Review and Meta-Analysis," American Journal of Public Health 106: e1_e12, May 2016. https://ajph.aphapublications.org/doi/10.2105/AJPH.2016.303088. Accessed April 24, 2026.

62. Haas, Ann P., Mickey Eliason, Vickie M. Mays, et al. "Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations." Journal of Homosexuality, 58(1): 10-51, January 4, 2011. https://pmc.ncbi.nlm.nih.gov/articles/PMC3662085/. Accessed April 20, 2026.

63. King, Michael, Joanna Semlyen, Sharon See Tai, et al. "A Systematic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Bisexual People." BMC Psychiatry, 18(8): 70, August 2008. https://pubmed.ncbi.nlm.nih.gov/18706118/. Accessed April 20, 2026.

64. Verlenden, Jorge V., Ari Fodeman, Natalie Wilkins, et al. “Mental Health and Suicide Risk Among High School Students and Protective Factors — Youth Risk Behavior Survey, United States, 2023.” Morbidity and Mortality Weekly Report, 73(Suppl-4): 79-86, 2024. https://www.cdc.gov/mmwr/volumes/73/su/su7304a9.htm. Accessed April 20, 2026.

65. Suarez, Nicolas A., Lindsay Trujillo, Izraelle I. McKinnon, et al. “Disparities in School Connectedness, Unstable Housing, Experiences of Violence, Mental Health, and Suicidal Thoughts and Behaviors Among Transgender and Cisgender High School Students — Youth Risk Behavior Survey, United States, 2023.” Morbidity and Mortality Weekly Report, 73(Suppl-4): 50-58, 2024. https://www.cdc.gov/mmwr/volumes/73/su/su7304a6.htm. Accessed April 10, 2026.

66. Centers for Disease Control and Prevention. “Youth Risk Behavior Survey: Data Summary & Trends Report, 2013-2023.” August 2024. https://www.cdc.gov/yrbs/dstr/index.html. Accessed April 10, 2026.

67. Mental Health America. “LGBTQ+ Communities and Mental Health.” https://mhanational.org/issues/lgbtq-communities-and-mental-health. Accessed April 20, 2026.

68. Office of Disease Prevention and Health Promotion. “Lesbian, Gay, Bisexual, and Transgender Health.” HealthyPeople.gov, February 2022. https://wayback.archive-it.org/5774/20220413203148/https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health#one. Accessed April 20, 2026.

69. Meyer, Ilan H. “Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence.” Psychological Bulletin, 129(5): 674-697, September 2003. https://pubmed.ncbi.nlm.nih.gov/12956539/. Accessed April 20, 2026.

70. Hatzenbuehler, Mark L., Anna Bellatorre, Yeonjin Lee, et al. “Structural Stigma and All-Cause Mortality in Sexual Minority Populations.” Social Science & Medicine, 103: 33-41, February 2014. https://pubmed.ncbi.nlm.nih.gov/23830012/. Accessed April 20, 2026.

71. Perez-Brumer, Amaya, Mark L. Hatzenbuehler, Catherine E. Oldenburg, and Walter Bockting. “Individual-and Structural Level Risk Factors for Suicide Attempts Among Transgender Adults.” Behavioral Medicine, 41(3): 164-171, August 2015. https://pubmed.ncbi.nlm.nih.gov/26287284/. Accessed April 20, 2026.

72. Price-Feeney, Myeshia, Amy E. Green, and Samuel Dorison. “Understanding the Mental Health of Transgender and Nonbinary Youth.” Journal of Adolescent Health, 66: 684-690, November 2019. https://www.jahonline.org/action/showPdf?pii=S1054-139X%2819%2930922-X. Accessed April 20, 2026.

73. Ryan, Caitlin, Stephen T. Russell, David Huebner, et al. “Family Acceptance in Adolescence and the Health of LGBT Young Adults.” Journal of Child and Adolescent Psychiatric Nursing, 23(4): 205-213, November 2010. https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1744-6171.2010.00246.x. Accessed April 20, 2026.

74. The Trevor Project. “2024 U.S. National Survey on the Mental Health of LGBTQ+ Young People.” https://www.thetrevorproject.org/. Accessed April 20, 2026.

75. Substance Abuse and Mental Health Services Administration. “Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health.” U.S. Department of Health and Human Services, HHS Publication PEP25-07-007, H-60, 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf. Accessed April 20, 2026.

76. Centers for Disease Control and Prevention. “Suicidal Thoughts & Behavior.” March 25, 2026. https://www.cdc.gov/mental-health/about-data/suicidal-thoughts-and-behavior.html. Accessed April 10, 2026.

77. Substance Abuse and Mental Health Services Administration. “Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health.” U.S. Department of Health and Human Services, HHS Publication PEP25-07-007, H-60, 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf. Accessed April 20, 2026.

78. Substance Abuse and Mental Health Services Administration. “NSDUH Detailed Tables 2024.” https://www.samhsa.gov/data/sites/default/files/reports/rpt56484/NSDUHDetailedTabs2024/NSDUHDetailedTabs2024/2024-nsduh-detailed-tables-sect6pe.htm#tab6.71a. Accessed April 10, 2026.

79. Substance Abuse and Mental Health Services Administration. “Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health.” U.S. Department of Health and Human Services, HHS Publication PEP25-07-007, H-60, 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf. Accessed April 20, 2026.

80. Substance Abuse and Mental Health Services Administration. “NSDUH Detailed Tables 2024.” https://www.samhsa.gov/data/sites/default/files/reports/rpt56484/NSDUHDetailedTabs2024/NSDUHDetailedTabs2024/2024-nsduh-detailed-tables-sect7pe.htm#tab7.35a. Accessed April 20, 2026.

81. Centers for Disease Control and Prevention. “Youth Risk Behavior Survey: Data Summary & Trends Report, 2013-2023.” August 2024. https://www.cdc.gov/yrbs/dstr/index.html. Accessed April 20, 2026.

82. Brådvik, Louise. “Suicide Risk and Mental Disorders.” International Journal of Environmental Research and Public Health, 15(9): 2028, September 17, 2018. https://pmc.ncbi.nlm.nih.gov/articles/PMC6165520/. Accessed April 20, 2026.

83. Centers for Disease Control and Prevention. “Risks and Protective Factors.” April 2024. https://www.cdc.gov/suicide/risk-factors/index.html. Accessed April 20, 2026.

84. Brody, Debra J., and Jeffery P. Hughes. "Depression Prevalence in Adolescents and Adults: United States, August 2021–August 2023." National Center for Health Statistics, NCHS Data Brief No. 527, April 2025. https://www.cdc.gov/nchs/products/databriefs/db527.htm. Accessed April 20, 2026.

85. Gallup. "U.S. Depression Rate Remains Elevated." April 2026. https://news.gallup.com/poll/708221/depression-rate-remains-elevated.aspx. Accessed April 24, 2026.

86. Centers for Disease Control and Prevention. "Youth Risk Behavior Survey: Data Summary & Trends Report, 2013-2023." August 6, 2024. https://www.cdc.gov/yrbs/dstr/index.html. Accessed April 20, 2026.

87. Motillon-Toudic, Chloé, Michel Walter, Monique Séguin, et al. "Social Isolation and Suicide Risk: Literature Review and Perspectives." European Psychiatry, 65(1): e65, October 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC9641655/. Accessed April 10, 2026.

88. Centers for Disease Control and Prevention. "Risks and Protective Factors." April 2024. https://www.cdc.gov/suicide/risk-factors/index.html. Accessed April 20, 2026.

89. U.S. Surgeon General. "Our Epidemic of Loneliness and Isolation." The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community, 2023. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf. Accessed April 20, 2026.

90. American Psychological Association. "Stress in America 2025: A Crisis of Connection." November 2025. https://www.apa.org/pubs/reports/stress-in-america/2025. Accessed April 20, 2026.

91. U.S. Surgeon General. "Our Epidemic of Loneliness and Isolation." The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community, 2023. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf. Accessed April 20, 2026.

92. Elbogen, Eric, Megan Lanier, Ann Elizabeth Montgomery, et al. "Financial Strain and Suicide Attempts in a Nationally Representative Sample of US Adults." American Journal of Epidemiology, 189(11), July 2020. https://www.researchgate.net/publication/343163515_Financial_Strain_and_Suicide_Attempts_in_a_Nationally_Representative_Sample_of_US_Adults. Accessed April 20, 2026.

93. Hempstead, Katherine A., and Julie A Phillips. "Rising Suicide Among Adults Aged 40–64 Years: The Role of Job and Financial Circumstances." American Journal of Preventive Medicine, 48(5): 491-500, May 2015. https://pubmed.ncbi.nlm.nih.gov/25736978/. Accessed April 20, 2026.

94. Centers for Disease Control and Prevention. "Risks and Protective Factors." April 2024. https://www.cdc.gov/suicide/risk-factors/index.html. Accessed April 20, 2026.

95. American Foundation for Suicide Prevention. "Risk Factors, Protective Factors, and Warning Signs." https://afsp.org/risk-factors-protective-factors-and-warning-signs/. Accessed April 20, 2026.

96. Harper, Sam, Thomas J. Charters, Erin C. Strumpf, et al. "Economic Downturns and Suicide Mortality in the USA, 1980-2010: Observational Study." International Journal of Epidemiology, 44(3): 956-966, June 2015. https://academic.oup.com/ije/article/44/3/956/630705. Accessed April 20, 2026.

97. Sinyor, Mark, Morton Silverman, Jane Pirkis, et al. "The Effect of Economic Downturn, Financial Hardship, Unemployment, and Relevant Government Responses on Suicide." The Lancet Public Health, 9(10): e802-e806, October 2024. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(24)00152-X/fulltext. Accessed April 20, 2026.

98. Philips, Julie A., and Colleen N. Nugent. "Suicide and the Great Recession of 2007–2009: The role of economic factors in the 50 U.S. states." Social Science & Medicine, 116: 22-31, September 2014. https://www.sciencedirect.com/science/article/abs/pii/S0277953614003748. Accessed April 20, 2026.

99. Luo, Feijun, Curtis S. Florence, Myriam Quispe-Agnoli, et al. "Impact of Business Cycles on US Suicide Rates, 1928–2007." American Journal of Public Health, 1(6): 1139-1146, June 2011. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2010.300010. Accessed April 20, 2026.

100. Horowitz, Juliana Menasce, Ruth Igielnik, and Rakesh Kochhar. "Trends in Income and Wealth Inequality." Pew Research Center, January 2020. https://www.pewresearch.org/social-trends/2020/01/09/trends-in-income-and-wealth-inequality/. Accessed June 24, 2024.

101. Chetty, Raj, David Grusky, Maximilian Hell, et al. "The Fading American Dream: Trends in Absolute Mobility Since 1940." National Bureau of Economic Research, NBER Working Paper 22910, December 2016. http://www.equality-of-opportunity.org/papers/abs_mobility_paper.pdf. Accessed April 20, 2026.

102. U.S. Bureau of Labor Statistics. "Consumer Prices Up 2.4 Percent Over the Year Ended January 2026." TED: The Economics Daily, February 18, 2026. https://www.bls.gov/opub/ted/2026/consumer-prices-up-2-4-percent-over-the-year-ended-january-2026.htm. Accessed April 20, 2026.

103. University of Michigan Survey of Consumers. "Charts: Index of Consumer Sentiment." https://www.sca.isr.umich.edu/charts.html. Accessed April 20, 2026.

104. National Suicide Hotline Designation Act of 2020: Public Law No: 116-172. https://www.congress.gov/bill/116th-congress/senate-bill/2661/actions. Accessed April 20, 2026.

105. Substance Abuse and Mental Health Services Administration. "988 Lifeline Performance Metrics." Updated March 18, 2026. https://www.samhsa.gov/mental-health/988/performance-metrics. Accessed April 20, 2026.

106. National Alliance on Mental Illness. “Poll of Public Perspectives on 988 & Crisis Response (2025).” https://www.nami.org/research/publications-reports/survey-reports/poll-of-public-perspectives-on-988-crisis-response-2025/. Accessed April 20, 2026.

107. Patel, Vishal R., Michael Liu, and Anupam B. Jena. “Suicide Mortality Among Adolescents and Young Adults After Launch of a Suicide and Crisis Lifeline.” JAMA, April 2026. https://jamanetwork.com/journals/jama/fullarticle/2848066. Accessed April 27, 2026.

108. Tin, Alexander. “Mental Health Agency Loses 1 in 10 Staffers to DOGE Cuts, 988 Hotline Impacted.” CBS News, February 2025. https://www.cbsnews.com/news/samhsa-mental-health-agency-doge-job-cuts-988-hotline/. Accessed April 20, 2026.

109. U.S. Department of Health and Human Services. “HHS Announces Transformation to Make America Healthy Again.” Press release: March 27, 2025. https://www.hhs.gov/press-room/hhs-restructuring-doge.html. Accessed April 20, 2026.

110. Substance Abuse and Mental Health Services Administration. “SAMHSA Statement on 988 Press 3 Option.” Press release: June 17, 2025. https://www.samhsa.gov/about/news-announcements/statements/2025/samhsa-statement-988-press-3-option. Accessed April 20, 2026.

111. Substance Abuse and Mental Health Services Administration. “988 Lifeline Performance Metrics.” https://www.samhsa.gov/mental-health/988/performance-metrics. Accessed April 20, 2026.

112. Saunders, Heather. “Demand for 988 Continues to Grow at Third Anniversary.” KKF, July 14, 2025. https://www.kff.org/mental-health/demand-for-988-continues-to-grow-at-third-anniversary/. Accessed April 20, 2026.

113. Weinstock, Cheryl Platzman. “Decades of National Suicide Prevention Policies Haven’t Slowed the Deaths.” KFF Health News, September 16, 2024. https://kffhealthnews.org/news/article/national-suicide-prevention-strategy-action-plan-rising-rates-deaths/. Accessed April 20, 2026.

114. Goldman, Maya. “The 988 Rollout Remains Uneven Two Years Later.” Axios, June 12, 2024. https://www.axios.com/2024/06/12/988-national-suicide-hotline-response-times. Accessed April 20, 2026.

115. Inseparable. “A Better Response: Improving America’s Mental Health Crisis System.” June 2024. https://www.inseparable.us/wp-content/uploads/2024/06/Inseparable-2024CrisisReport-Final.pdf. Accessed April 20, 2026.

116. Federal Communications Commission. “FCC Adopts Rules Requiring Georouting for All Wireless Calls to 988.” Press release: October 17, 2024. https://docs.fcc.gov/public/attachments/DOC-406700A1.pdf. Accessed April 20, 2026.

117. Substance Abuse and Mental Health Services Administration. “988 & 911: Strengthening Crisis Response While Managing Risk and Liability.” December 2025. https://library.samhsa.gov/sites/default/files/988-911-strengthening-crisis-response-pep26-04-001.pdf. Accessed April 20, 2026.

118. Washington State Legislature. “National 988 System – Limitation of Liability.” https://app.leg.wa.gov/RCW/default.aspx?cite=71.24.907. Accessed April 20, 2026.

119. Substance Abuse and Mental Health Services Administration. “988 Lifeline Performance Metrics.” https://www.samhsa.gov/mental-health/988/performance-metrics. Accessed April 20, 2026.

120. The Trevor Project. “Facts About Suicide Among LGBTQ+ Young People.” https://www.thetrevorproject.org/resources/article/facts-about-lgbtq-youth-suicide/. Accessed April 20, 2026.

121. Illinois Department of Human Services. “IDHS Preserves LGBTQIA+ Youth Support on 988 Lifeline Amid Federal Cuts.” Press release: July 17, 2025. https://idhs.prezly.com/idhs-preserves-lgbtqia-youth-support-on-988-lifeline-amid-federal-cuts. Accessed April 20, 2026.

122. County of Los Angeles Supervisor Fourth District. “Supervisors Push Forward on Effort to Reinstate Specialized LGBTQ+ Support Through 988 Crisis Hotline.” December 9, 2025. https://hahn.lacounty.gov/supervisors-push-forward-on-effort-to-reinstate-specialized-lgbtq-support-through-988-crisis-hotline/. Accessed April 20, 2026.

123. Congress.gov. “S.2826 – 988 LGBTQ+ Youth Access Act of 2025.” https://www.congress.gov/bill/119th-congress/senate-bill/2826/text. Accessed April 20, 2026.

124. Modan, Naaz. “HHS working to restore LGBTQ+ youth suicide prevention hotline.” K-12 Dive. April 28, 2026. https://www.k12dive.com/news/hhs-working-to-restore-lgbtq-youth-suicide-prevention-hotline/818720/. Accessed May 15, 2026.

125. Ballotpedia. “Extreme Risk Protection Order Laws by State.” https://ballotpedia.org/Extreme_risk_protection_order_laws_by_state. Accessed April 20, 2026. Everytown for Gun Safety. “Extreme Risk Laws.” https://www.everytown.org/solutions/extreme-risk-laws/. Accessed April 20, 2026.

126. District of Columbia Office of the Attorney General. “Public Safety Advisory: DC’s ‘Red Flag’ Law Helps Keep Communities Safe.” Press Release: August 22, 2023. https://oag.dc.gov/blog/public-safety-advisory-dcs-red-flag-law-helps-keep. Accessed April 20, 2026.

127. LegiScan. “Oklahoma Senate Bill 1081.” 2020. https://legiscan.com/OK/bill/SB1081/2020. Accessed April 20, 2026.

128. West Virginia Legislature. House Bill 2694: 2nd Amendment Preservation Act. July 9, 2021. https://www.wvlegislature.gov/bill_status/bills_history.cfm?input=2694&year=2021&sessiontype=rs&btype=bill. Accessed April 20, 2026.

129. Mackenthun, Paige. "Tennessee and Wyoming Passed Anti-Red Flag Law Legislation in 2024." Ballotpedia News, July 16, 2024. https://news.ballotpedia.org/2024/07/16/tennessee-and-wyoming-passed-anti-red-flag-law-legislation-in-2024/. Accessed April 20, 2026.

130. Montana Legislature. "HB 809: Prohibit Local Governments from Enacting Red Flag Gun Laws." April 12, 2025. https://bills.legmt.gov/#/laws/bill/2/LC2325?open_tab=sum. Accessed April 20, 2026.

131. Texas Legislature. "SB 1362: Prohibiting the Recognition, Service, and Enforcement of Extreme Risk Protective Orders; Creating a Criminal Offense." June 22, 2025. https://capitol.texas.gov/BillLookup/History.aspx?LegSess=89R&Bill=SB1362. Accessed April 20, 2026.

132. Everytown for Gun Safety. "Extreme Risk Laws." https://www.everytown.org/solutions/extreme-risk-laws/. Accessed April 20, 2026.

133. Swanson, Jeffrey W., Michael A. Norko, Hsiu-Ju Lin, et al. "Implementation and Effectiveness of Connecticut's Risk-Based Gun Removal Law: Does It Prevent Suicides?" Law and Contemporary Problems, 80: 179-208, 2017. https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=4830&context=lcp. Accessed April 20, 2026.

134. Miller, Matthew, Yifan Zhang, David M. Studdert, et al. "Updated Estimate of the Number of Extreme Risk Protection Orders Needed to Prevent 1 Suicide." JAMA Network Open, 7(6): e2414864, June 2024. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2819913. Accessed April 20, 2026.

135. Wesolowski, Hannah. "Mobile Crisis Teams: Providing an Alternative to Law Enforcement for Mental Health Crises." National Alliance on Mental Illness, July 13, 2022. https://www.nami.org/blog/mobile-crisis-teams-providing-an-alternative-to-law-enforcement-for-mental-health-crises/. Accessed April 20, 2026.

136. Justice Center. "How to Successfully Implement a Mobile Crisis Team." Field Notes, Law Enforcement, April 2021. https://csgjusticecenter.org/wp-content/uploads/2021/04/Field-Notes_Mobile-Crisis-Team_508FINAL34.pdf. Accessed April 20, 2026.

137. Anderson, Andrew, Stas Spivak, and Alene Kennedy Hendricks. "Availability of Mobile Crisis Services in Mental Health Facilities." JAMA Network Open, 8(2): e2461321, February 2025. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2830554. Accessed April 20, 2026.

138. Wesolowski, Hannah. "Mobile Crisis Teams: Providing an Alternative to Law Enforcement for Mental Health Crises." National Alliance on Mental Illness, July 13, 2022. https://www.nami.org/blog/mobile-crisis-teams-providing-an-alternative-to-law-enforcement-for-mental-health-crises/. Accessed April 20, 2026.

139. Wilk, Nathan. "Eugene after CAHOOTS: The End of the Crisis Response Program, and the Efforts to Bring it Back." OPB, June 4, 2025. https://www.opb.org/article/2025/06/04/eugene-after-cahoots-the-end-of-the-crisis-response-program-and-the-efforts-to-bring-it-back/. Accessed April 20, 2026.

140. Swanson, Leonard, Catherine Zettner, Amy Watson, et al. "Eleven-Month Arrest Outcomes Among Three Crisis Response Models in Michigan." Psychiatric Research and Clinical Practice, 7(3):182-190, May 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC12418740/. Accessed April 20, 2026.

141. Tomovic, Milos, Margaret E. Balfour, Ted Cho, et al. "Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System." Psychiatric Services, 75(7), February 2024. https://psychiatryonline.org/doi/10.1176/appi.ps.20230232. Accessed April 20, 2026.

142. Substance Abuse and Mental Health Services Administration. "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies." 2014. https://library.samhsa.gov/sites/default/files/sma14-4848.pdf. Accessed April 20, 2026.

143. Centers for Medicare and Medicaid. "Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services." December 28, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf. Accessed April 20, 2026.

144. Bolton, Aaron. "They Help Police with Mental Health Calls. So Why Are 'Mobile Crisis' Teams in Crisis?" NPR, February 5, 2026. https://www.npr.org/2026/02/05/nx-s1-5693908/police-mental-health-calls-988-911-mobile-crisis-teams. Accessed April 20, 2026.

145. Scott, Roger L. "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction." Psychiatric Services, 51(9), September 2000. https://psychiatryonline.org/doi/10.1176/appi.ps.51.9.1153. Accessed April 20, 2026.

146. Park, Edwin. "New CBO Health Coverage Estimates of Budget Reconciliation Law." Georgetown University McCourt School of Public Policy, Center for Children and Families. August 14, 2025. https://ccf.georgetown.edu/2025/08/14/new-cbo-health-coverage-estimates-of-budget-reconciliation-law/. Accessed April 20, 2026.

147. Congressional Budget Office. "Distributional Effects of Public Law 119-21." August 2025. https://www.cbo.gov/publication/61367. Accessed April 20, 2026.

148. National Alliance on Mental Illness. "Enhanced Medicaid Mobile Crisis Map." https://reimaginecrisis.org/mobilecrisis/. Accessed April 20, 2026.

149. Gottfried, Jeffrey, and Eugenie Park. "Americans' Social Media Use 2025." Pew Research Center, November 2025. https://www.pewresearch.org/internet/2025/11/20/americans-social-media-use-2025/. Accessed April 20, 2026.

150. Koh, Ghee Kian, Jenna Qing Yun Ow Yong, Ainsley Ryan Yan Bin Lee, et al. "Social Media Use and its Impact on Adults' Mental Health and Well-Being: A Scoping Review." Worldviews on Evidence-Based Nursing, 21(4): 345-394, August 2024. https://pubmed.ncbi.nlm.nih.gov/38736207/. Accessed April 20, 2026.

151. Ibid.

152. Centers for Disease Control and Prevention. "Youth Risk Behavior Survey: Data Summary and Trends Report 2011-2021." Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, February 2023. https://stacks.cdc.gov/view/cdc/124928. Accessed April 20, 2026.

153. Young, Emily, Jessica L. McCain, PhD2; Melissa C. Mercado, et al. "Frequent Social Media Use and Experiences with Bullying Victimization, Persistent Feelings of Sadness or Hopelessness, and Suicide Risk Among High School Students — Youth Risk Behavior Survey, United States, 2023." Morbidity and Mortality Weekly Report, Suppl. 73(4): 23-30, October 10, 2024. https://www.cdc.gov/mmwr/volumes/73/su/su7304a3.htm. Accessed April 20, 2026.

154. Tanz, Lauren J., Amanda T. Dinwiddie, Christine L. Mattson, et al. "Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021." Morbidity and Mortality Weekly Report, 71(50): 1576-1582, 2022. https://www.cdc.gov/mmwr/volumes/71/wr/mm7150a2.htm?s_cid=mm7150a2_w. Accessed April 20, 2026.

155. Nagata, Jason M., Jennifer H. Wong, Kristen E. Kim, et al. "Social Media Use Trajectories and Cognitive Performance in Adolescents." JAMA, 334(21): 1948-1950, October 2025. https://jamanetwork.com/journals/jama/fullarticle/2839941?guestAccessKey=c8bce59a-f799-4c36-817e-dd2c05cf6ae4. Accessed April 20, 2026.

156. Amirthalingam, Jashvini, and Anika Khera. "Understanding Social Media Addiction: A Deep Dive." Cureus, 16(10): e72499, October 2024. https://pmc.ncbi.nlm.nih.gov/articles/PMC11594359/. Accesses April 20, 2026.

157. The U.S. Surgeon General's Advisory. "Protecting Youth Mental Health." U.S. Department of Health and Human Services, 2021. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf. Accessed April 20, 2026.

158. Ibid.

159. Barzilay, Ran, Samuel D. Pimentel, Kate T. Tran, et al. "Smartphone Ownership, Age of Smartphone Acquisition, and Health Outcomes in Early Adolescence." Pediatrics, 157(1): e2025072941, January 2026. https://publications.aap.org/pediatrics/article-abstract/157/1/e2025072941/205716/Smartphone-Ownership-Age-of-Smartphone-Acquisition. Accessed April 20, 2026.

160. Montero, Alex, Julian Montalvo III, Audrey Kearney, et al. "KFF Tracking Poll on Health Information and Trust: Use of AI For Health Information and Advice." KFF, March 2026. https://www.kff.org/public-opinion/kff-tracking-poll-on-health-information-and-trust-use-of-ai-for-health-information-and-advice/. Accessed April 20, 2026.

161. Public Health Communications Collaborative. "New Data on Suicide Risks Among ChatGPT Users Sparks Online Debate." October 27, 2025. https://publichealthcollaborative.org/alerts/new-data-on-suicide-risks-among-chatgpt-users-sparks-online-debate/. Accessed April 20, 2026.

162. Shehab, Ali. "When Your Therapist Is an Algorithm: Risks of AI Counseling." Psychology Today, March 2, 2025. https://www.psychologytoday.com/us/blog/the-human-algorithm/202503/when-your-therapist-is-an-algorithm-risks-of-ai-counseling. Accessed April 20, 2026.

163. OpenAI. "Strengthening ChatGPT's responses in sensitive conversations." 2025. https://openai.com/index/strengthening-chatgpt-responses-in-sensitive-conversations/. Accessed April 27, 2026.

164. Chatterjee, Rhitu. "Their Teenage Sons Died by Suicide. Now, They Are Sounding an Alarm About AI Chatbots." NPR, September 19, 2025. https://www.npr.org/sections/shots-health-news/2025/09/19/nx-s1-5545749/ai-chatbots-safety-openai-meta-characterai-teens-suicide. Accessed April 20, 2026.

165. Agence France-Presse. "Google and AI Startup to Settle Lawsuits Alleging Chatbots Led to Teen Suicide." The Guardian, January 8, 2026. https://www.theguardian.com/technology/2026/jan/08/google-character-ai-settlement-teen-suicide. Accessed April 20, 2026.

166. Titheradge, Noel, and Olga Malchevska. "I Wanted ChatGPT to Help Me. So Why Did it Advise Me How to Kill Myself?" BBC, November 6, 2025. https://www.bbc.com/news/articles/cp3x71pv1qno. Accessed April 20, 2026.

167. Cunningham, Mary. "ChatGPT Served as 'Suicide Coach' in Man's Death, Lawsuit Alleges." CBS News, January 15, 2026. https://www.cbsnews.com/news/chatgpt-lawsuit-colordo-man-suicide-openai-sam-altman/. Accessed April 20, 2026.

168. O'Brien, Matt, and Barbara Ortutay. "Study Says ChatGPT Giving Teens Dangerous Advice on Drugs, Alcohol and Suicide." Associated Press, August 6, 2025. https://www.pbs.org/newshour/nation/study-says-chatgpt-giving-teens-dangerous-advice-on-drugs-alcohol-and-suicide. Accessed April 20, 2026.

169. American Academy of Pediatrics. "AAP to Launch New Center of Excellence on Social Media and Youth Mental Health." Press release: September 13, 2022. https://www.aap.org/en/news-room/news-releases/aap/2022/aap-to-launch-new-center-of-excellence-on-social-media-and-youth-mental-health/. Accessed April 20, 2026.

170. American Academy of Pediatrics. "Center of Excellence on Social Media and Youth Mental Health." https://www.aap.org/en/patient-care/media-and-children/center-of-excellence-on-social-media-and-youth-mental-health/. Accessed April 20, 2026.

171. American Academy of Pediatrics. "Youth Advisory Panel Feedback To Policymakers." https://www.aap.org/en/patient-care/media-and-children/center-of-excellence-on-social-media-and-youth-mental-health/youth-advisory-panel/youth-advisory-panel-feedback-to-policymakers/. Accessed April 20, 2026.

172. Centers for Disease Control and Prevention. “Comprehensive Suicide Prevention: Program Profiles.” August 2024. https://www.cdc.gov/suicide/csp-profiles/index.html, Accessed April 27, 2026.

173. Centers for Disease Control and Prevention. “Comprehensive Suicide Prevention Grant Notice.” Grants.gov, March 27, 2020. https://www.grants.gov/search-results-detail/324377. Accessed April 20, 2026.

174. Centers for Disease Control and Prevention. “Comprehensive Suicide Prevention.” September 10, 2024. https://www.cdc.gov/suicide/programs/csp.html. Accessed April 20, 2026.

175. Centers for Disease Control and Prevention. “Comprehensive Suicide Prevention Program: CDC’s Injury Center Uses Data and Research to Save Lives.” February 2025. https://www.cdc.gov/suicide/pdf/CDC-DIP_At-a-Glance_ComprehensiveSuicide.pdf. Accessed April 20, 2026.

176. Centers for Disease Control and Prevention. “Comprehensive Suicide Prevention: Success Stories.” January 30, 2025. https://www.cdc.gov/suicide/csp-profiles/success-stories.html. Accessed April 20, 2026.

177. Hemenway, David, Catherine W. Barber, Susan S. Gallagher, and Deborah R. Azrael. “Creating a National Violent Death Reporting System: A Successful Beginning.” American Journal of Preventive Medicine, 37(1): 68-71, July 2009. https://www.sciencedirect.com/science/article/abs/pii/S074937970900169X. Accessed April 20, 2026.

178. Centers for Disease Control and Prevention. “About NVDRS Data”. https://wisqars.cdc.gov/about/nvdrs-data/. Accessed April 27, 2026.

179. Centers for Disease Control and Prevention. “National Violent Death Reporting System.” August 25, 2025. https://www.cdc.gov/nvdrs/about/index.html#cdc_survey_profile_how_the_information_is_used-how-the-data-is-used. Accessed April 20, 2026.

180. Crosby, Alex E., James A. Mercy, and Debra Houry. “The National Violent Death Reporting System.” American Journal of Preventive Medicine, 51(5, Supp.3): S169-S17, November 2016. https://www.ajpmonline.org/article/S0749-3797(16)30293-8/fulltext. Accessed April 20, 2026.

181. Centers for Disease Control and Prevention. “National Violent Death Reporting System: Impact Examples.” May 16, 2024. https://www.cdc.gov/nvdrs/stories/index.html. Accessed April 20, 2026.

182. Crosby, Alex E., James A. Mercy, and Debra Houry. “The National Violent Death Reporting System.” American Journal of Preventive Medicine, 51(5, Supp.3): S169-S17, November 2016. https://www.ajpmonline.org/article/S0749-3797(16)30293-8/fulltext. Accessed April 20, 2026.

183. Centers for Disease Control and Prevention. “National Violent Death Reporting System: Impact Examples.” May 16, 2024. https://www.cdc.gov/nvdrs/stories/index.html. Accessed April 20, 2026.

184. U.S. Congress. “Garrett Lee Smith Memorial Act.” Public Law No: 108-355, October 2004. https://www.congress.gov/bill/108th-congress/senate-bill/2634. Accessed April 20, 2026.

185. Goldston, David B., and Christine Walrath. “The Garrett Lee Smith Memorial Act: A Description and Review of the Suicide Prevention Initiative.” Annual Review Clinical Psychology, 19: 261-275, May 2023. https://www.annualreviews.org/content/journals/10.1146/annurev-clinpsy-080921-082634. Accessed April 20, 2026.

186. Substance Abuse and Mental Health Services Administration. “Garrett Lee Smith (GLS) Campus Suicide Prevention Grant.” Updated: January 28, 2026. https://www.samhsa.gov/grants/grant-announcements/sm-18-003. Accessed April 20, 2026.

187. Green, Lari’onna. “University Counseling Center awarded grant to bolster mental health and suicide prevention initiatives.” ND Works Weekly, February 10, 2025. https://ndworks.nd.edu/news/university-counseling-center-awarded-grant-to-bolster-mental-health-and-suicide-prevention-initiatives/. Accessed April 20, 2026.

188. OXY Occidental College. “Strategic Planning for Student Well-Being.” https://www.oxy.edu/student-life/resources-support/emmons-wellness-center/well-being-oxy/strategic-planning-student-well-being. Accessed April 20, 2026.

189. Woodard, Jeffery. “Titan HEART Project Made Project Made Possible Through Mental Health Grant.” Digital Commons at IWU, Indiana Wesleyan University. Press release: November 1, 2024. https://digitalcommons.iwu.edu/cgi/viewcontent.cgi?article=8404&context=news. Accessed April 20, 2026. Accessed April 20, 2026.

190. Substance Abuse and Mental Health Services Administration. “Cooperative Agreements for the Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Program.” April 2024. https://www.samhsa.gov/grants/grant-announcements/sm-24-005. Accessed April 20, 2026.

191. Substance Abuse and Mental Health Services Administration. “SAMHSA Grants Dashboard: Cooperative Agreements for the Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Program.” https://www.samhsa.gov/grants/grants-dashboard?f%5B0%5D=by_award_fy%3A2025&f%5B1%5D=by_nofo_number%3ASM-24-005&grants_dashboard__search=&order=field_award_number&sort=asc&page=. Accessed April 20, 2026.

192. Walrath, Christine, Lucas Godoy Garraza, Hailey Reid, et al. “Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality.” American Journal of Public Health, 105(5): 986-993, May 2015. https://pmc.ncbi.nlm.nih.gov/articles/PMC4386522/. Accessed April 20, 2026.

193. Garraza, Lucas Godoy, Christine Walrath, David B. Goldston, et al. “Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on Suicide Attempts Among Youths.” JAMA Psychiatry, 72(11): 1143-1149, November 2015. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2461739. Accessed April 20, 2026.

194. Garraza, Lucas Godoy, Nora Kuiper, David Goldston, et al. “Long-Term Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Youth Suicide Mortality, 2006–2015.” Journal of Child Psychology and Psychiatry, 60(10): 1142-1147, May 8, 2019. https://acamh.onlinelibrary.wiley.com/doi/abs/10.1111/jcpp.13058. Accessed April 20, 2026.

195. Substance Abuse and Mental Health Services Administration. “GLS Campus Suicide Prevention Grant Program: Notice of Funding Opportunity.” Updated January 28, 2026. https://www.samhsa.gov/grants/grant-announcements/sm-24-004. Accessed April 20, 2026.

196. Substance Abuse and Mental Health Services Administration. “Cooperative Agreements for the Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Program: Notice of Funding Opportunity.” Updated January 28, 2026. https://www.samhsa.gov/grants/grant-announcements/sm-24-005. Accessed April 20, 2026.

197. Mann, Brian. “Trump Administration Rolls Back $2 Billion Mental Health, Addiction Grant Cuts.” NPR, January 14, 2026. https://www.npr.org/2026/01/14/nx-s1-5677714/trump-administration-mental-health-addiction-grant-cuts-restored. Accessed April 20, 2026.

198. Johns Hopkins Bloomberg School of Public Health, Center for Gun Violence Solutions. “Safe Storage Saves Lives.” https://publichealth.jhu.edu/center-for-gun-violence-solutions/safe-storage-saves-lives. Accessed April 20, 2026.

199. Miller, Matthew, and David Hemenway. “The Relationship Between Firearms and Suicide: A Review of the Literature.” Aggression and Violent Behavior, 4(1): 59-75, Spring 1999. https://www.sciencedirect.com/science/article/abs/pii/S1359178997000578?via%3Dihub. Accessed April 20, 2026.

200. Duff-Brown, Beth. “Handgun Ownership Associated With Much Higher Suicide Risk.” Stanford Medicine News Center, June 3, 2020. https://med.stanford.edu/news/all-news/2020/06/handgun-ownership-associated-with-much-higher-suicide-risk.html. Accessed April 20, 2026.

201. Siegel, Michael, and Emily F. Rothman. “Firearm Ownership and Suicide Rates Among US Men and Women, 1981–2013.” American Journal of Public Health, 106(7): 1316-1322, July 2016. https://ajph.aphapublications.org/doi/10.2105/AJPH.2016.303182. Accessed April 20, 2026.

202. Brent, D.A., J.A. Perper, C.J. Allman, et al. “The Presence and Accessibility of Firearms in the Homes of Adolescent Suicides. A Case-Control Study.” JAMA, 266(21): 2989-2995, December 1991. https://pubmed.ncbi.nlm.nih.gov/1820470/. Accessed April 20, 2026.

203. Knopov, Anita et al. “Household Gun Ownership and Youth Suicide Rates at the State Level, 2005-2015.” American Journal of Preventive Medicine, 56,3: 335-342, January 2019. https://pmc.ncbi.nlm.nih.gov/articles/PMC6380939/. Accessed April 27, 2026.

204. Grossman, David C., Beth A. Mueller, Christine Riedy, et al. “Gun Storage Practices and Risk of Youth Suicide and Unintentional Firearm Injuries.” JAMA, 293(6): 707–714, February 2005. https://jamanetwork.com/journals/jama/fullarticle/200330. Accessed April 20, 2026.

205. Miller, Matthew, Joeseph Wertz, Sonja A. Swanson, et al. “Firearm Storage and Firearm Suicide.” JAMA, 8(7): e2519266, July 2025. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2836043. Accessed April 20, 2026.

206. Johns Hopkins Bloomberg School of Public Health, Center for Gun Violence Solutions. “Findings Show Child Access Prevention (CAP) Firearm Storage Policies Reduce Youth Gun Suicide Rates.” January 23, 2025. https://publichealth.jhu.edu/center-for-gun-violence-solutions/2025/child-access-prevention-laws-reduce-youth-gun-suicide-rates. Accessed April 20, 2026

207. Athey, Alison, Paul S. Nestadt, Megan L. Rogers, et al. “A National Evaluation of the Impact of Child Access Prevention Laws on Rates of Youth Suicide and Other Youth Firearm Deaths.” Journal of the American Academy of Child & Adolescent Psychiatry, 64(8): 897-905, August 2025. https://www.jaacap.org/article/S0890-8567(24)01991-9/fulltext. Accessed April 20, 2026.

208. Johns Hopkins Bloomberg School of Public Health, Center for Gun Violence Solutions. “Safe Storage Saves Lives.” https://publichealth.jhu.edu/center-for-gun-violence-solutions/safe-storage-saves-lives. Accessed April 20, 2026.

209. Seattle Children’s. “Safe Medicine Storage and Disposal to Prevent Misuse.” https://www.seattlechildrens.org/health-safety/injury-prevention/safe-medicine-storage-and-disposal/. Accessed April 27, 2026.

210. Suicide Prevention Resource Center. “CALM: Counseling on Access to Lethal Means.” 2018. https://sprc.org/resources/calm-counseling-on-access-to-lethal-means/. Accessed April 20, 2026.

211. Runyan, Carol W., Amy Becker, Sara Brandspigel, et al. “Lethal Means Counseling for Parents of Youth Seeking Emergency Care for Suicidality.” Western Journal of Emergency Medicine, 17(1): 8-14, 2016. https://escholarship.org/uc/item/0td33354. Accessed April 20, 2026.

212. Suicide Awareness Voices of Education. “Keep Your Home Suicide-Safe: Request Free Cable Gun Locks.” https://www.save.org/programs/lethal-means-safety/request-gun-locks-and-lock-boxes/. Accessed April 20, 2026.

213. Project ChildSafe. “Who We Are.” https://projectchildsafe.org/about/. Accessed April 20, 2026.

214. Gould, M.S., S. Wallenstein, M.H. Kleinman, et al. “Suicide Clusters: An Examination of Age-Specific Effects.” American Journal of Public Health, 80(2): 211-212, February 1990. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1404629/. Accessed April 20, 2026.

215. Mueller, Anna. S., Seth Abrutyn, and Cynthia Stockton. "Can Social Ties Be Harmful? Examining the Spread of Suicide in Early Adulthood." Sociological Perspectives, 58(2): 204-222, November 2014. https://journals.sagepub.com/doi/full/10.1177/0731121414556544. Accessed April 20, 2026.

216. Annette L. Beautrais, Madelyn S. Gould, and Eric D. Caine. "Preventing Suicide by Jumping From Bridges Owned by the City of Ithaca and by Cornell University." Consultation To Cornell University, July 2010. https://legislature.vermont.gov/Documents/2016/WorkGroups/House%20Transportation/Bills/H.593/Public%20Testimony/H.593~Eric%20D.%20Caine,%20M.D.~Preventing%20Suicide%20by%20Jumping%20from%20Bridges%20Owned%20by%20the%20City%20of%20Ithaca%20and%20by%20Cornell%20University~3-8-2016.pdf. Accessed April 20, 2026.

217. Branch, John. "Suicides Were Frequent at the Golden Gate Bridge. Not Anymore." The New York Times, updated January 21, 2026. https://www.nytimes.com/2026/01/20/us/golden-gate-bridge-suicides.html. Accessed April 20, 2026.

218. Santacrose, Laura Beth. "An Evaluation of Means Restriction on Preventing Jumping Suicides: A Case Study at Cornell University." Milken Institute School of Public Health, The George Washington University Dissertation, May 2024. https://scholarspace.library.gwu.edu/concern/gw_etds/th83m019x. Accessed April 20, 2026.

219. Washington State Department of Health. "988 Suicide & Crisis Lifeline." https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/988-suicide-crisis-lifeline. Accessed April 20, 2026.

220. Fitzgerald, Emily. "Washington Prepares for End of 988 Crisis Line Support Tailored to LGBTQ+ Youth." Washington State Standard, July 17, 2025. https://washingtonstatestandard.com/briefs/washington-prepares-for-end-of-988-crisis-line-support-tailored-to-lgbtq-youth/. Accessed April 20, 2026.

221. Suicide Prevention Resource Center. "Native and Strong Lifeline: The Nation's First 988 Crisis Line for Indigenous People." https://sprc.org/resources/native-and-strong-lifeline-the-nations-first-988-crisis-line-for-indigenous-people/. Accessed April 20, 2026.

222. Ibid.

223. Ibid.

224. Breitzman, Shannon A., Jillian Jacobellis, Holly Hedegaard. "Suicide Prevention Programs in Colorado: Programs and Activities Office of Suicide Prevention Annual Legislative Report." Colorado Department of Public Health and Environment, November 1, 2024. https://spl.cde.state.co.us/artemis/heserials/he192801internet/he1928012004internet.pdf. Accessed April 20, 2026.

225. Colorado Department of Public Health and Environment. "Office of Suicide Prevention 2025 Legislative Report". November 2026. https://drive.google.com/file/d/1MqjGTpTg7k7D_TfERx8-n6J7jca76Kga/view. Accessed February 12, 2026.

226. Colorado Department of Public and Environment. "Colorado Gun Shop Project." https://cdphe.colorado.gov/suicide-prevention/gun-shop-project. Accessed April 20, 2026.

227. Ibid.

228. Stone, Deborah, Eva Trinh, Hong Zhou, et al. "Suicides Among American Indian or Alaska Native Persons — National Violent Death Reporting System, United States, 2015–2020." Morbidity and Mortality Weekly Report, 71(37): 1161-1168, September 2022. https://www.cdc.gov/mmwr/volumes/71/wr/mm7137a1.htm. Accessed April 20, 2026.

229. Indian Health Service. "Indian Health Manual: Chapter 34 – Suicide Prevention and Care." https://www.ihs.gov/ihm/pc/part-3/p3c34/. Accessed April 20, 2026.

230. Perry, Rebecca J., Pamela Sparks, and Ivette Rodriguez Borja. "Initial Lessons from Ask Suicide-Screening Questions Implementation in Indian Country." RTI International, December 15, 2025. https://www.rti.org/insights/asq-implementation-suicide-risk-screening. Accessed April 20, 2026.

231. Ibid.

232. Ibid.

233. Substance Abuse and Mental Health Services Administration. "SAMHSA's Black Youth Suicide Prevention Initiative." Updated August 27, 2024. https://www.samhsa.gov/mental-health/suicidal-behavior/prevention-initiatives/black-youth-suicide. Accessed April 20, 2026.

234. Ibid.

235. North Carolina Department of Health and Human Services. "NCDHHS Releases Black Youth Suicide Action Plan to Tackle Rising Number of Suicides Among Black Youth, Young Adults." Press release: July 18, 2025. https://www.ncdhhs.gov/news/press-releases/2025/07/18/ncdhhs-releases-black-youth-suicide-action-plan-tackle-rising-number-suicides-among-black-youth. Accessed April 20, 2026.

236. North Carolina Department of Health and Human Services. "NC Black Youth Suicide Prevention Action Plan." 2025. https://www.ncdhhs.gov/nc-black-youth-suicide-prevention-action-plan/open. Accessed April 20, 2026.

237. Substance Abuse and Mental Health Services Administration. “Answering the Call: Policy Academies as a Tool for Black Youth Suicide Prevention.” Suicide Prevention Resource Center, 2025. https://sprc.org/wp-content/uploads/Answering-The-Call.pdf . Accessed April 20, 2026.

238. Act Relating to Health and Safety – Office of State Medical Examiners, Rhode Island Senate Bill 2817. https://legiscan.com/RI/bill/S2817/2024. Accessed April 20, 2026.

239. Ibid.

240. The Samaritans of Rhode Island. “About Us.” https://www.samaritansri.org/about-us. Accessed April 20, 2026.

241. Adeleye, Temi-Tope. “RI Suicide Prevention Advocates Angry State Bridges Will Not Get Safety Netting.” WJAR, NBC, June 7, 2024. https://turnto10.com/news/local/ri-suicide-prevention-advocates-angry-state-bridges-will-not-get-safety-netting. Accessed April 20, 2026.

242. An Act Relating To Highways – Rhode Island Turnpike and Bridge Authority, House Bill 7858. https://webserver.rilegislature.gov/BillText24/HouseText24/H7858.pdf. Accessed April 20, 2026.

243. Comisión para la Prevención del suicidio. “Sobre la Comisión para la Prevención del Suicidio.” https://prevencionsuicidio.salud.pr.gov/. Accessed April 20, 2026.

244. Gobierno de Puerto Rico. “Comisión para la Prevención del suicidio Departamento de Salud.” December 2023. https://www.cdc.gov/nchs/video/puerto-rico/Webinar-CDC-National-Center-for-Health-Statistics-15-December-2023.pdf. Accessed April 20, 2026.

245. Ibid.

246. National Institute on Drug Abuse. “Opioids.” https://nida.nih.gov/research-topics/opioids Accessed April 27, 2026.

247. Benyamin, Ramsin, Andrea M. Trescot, Sukdeb Datta, et al. “Opioid Complications and Side Effects.” Pain Physician, 11(2 Suppl): S105-120, March 2008. https://pubmed.ncbi.nlm.nih.gov/18443635/. Accessed April 20, 2026.

248. National Institute on Drug Abuse. “Opioids.” https://nida.nih.gov/research-topics/opioids Accessed April 27, 2026.

249. Ibid.

250. Kaiko, Robert F., et al. “Analgesic and Mood Effects of Heroin and Morphine in Cancer Patients with Postoperative Pain.” New England Journal of Medicine, 304:1501-1505, June 1981. https://www.nejm.org/doi/pdf/10.1056/NEJM198106183042501. Accessed April 27, 2026.

251. National Institute on Drug Abuse. “Opioids.” https://nida.nih.gov/research-topics/opioids Accessed April 27, 2026.

252. Choi, Joseph. “What to Know About Cychlorphine, The Synthetic Opioid 10 Times Stronger Than Fentanyl.” The Hill, March 12, 2026. https://thehill.com/policy/healthcare/5779927-potent-opioid-cychlorphine-alarm/. Accessed April 20, 2026.

253. Drug Enforcement Administration. “Carfentanil: A Dangerous New Factor in the U.S. Opioid Crisis.” Officer Safety Alert, 2018. https://www.dea.gov/sites/default/files/2018-07/hq092216_attach.pdf. Accessed April 20, 2026.

254. Drug Enforcement Administration. “DEA Issues Carfentanil Warning to Police and Public.” Press release: September 22, 2016. https://www.dea.gov/press-releases/2016/09/22/dea-issues-carfentanil-warning-police-and-public. Accessed April 20, 2026.

255. Sanburn, Josh. “Heroin Is Being Laced With a Terrifying New Substance: What to Know About Carfentanil.” Time, September 12, 2016, updated December 12, 2023. http://time.com/4485792/heroin-carfentanil-drugs-ohio/. Accessed April 20, 2026.

256. Substance Abuse and Mental Health Services Administration. “Methadone.” December 2025. Accessed April 27, 2026.

257. Favrod-Coune, Theirry, and Barbara Broers. “The Health Effect of Psychostimulants: A Literature Review.” Pharmaceuticals, 3(7): 2333-2361, July 2010. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4036656. Accessed April 20, 2026.

258. Centers for Disease Control and Prevention. “Stimulants.” July 2025. https://www.cdc.gov/overdose-prevention/about/stimulant-overdose.html. Accessed April 20, 2026.

259. Philadelphia Department of Public Health. “Health Update: Xylazine (Tranq) Exposure Among People Who Use Substances in Philadelphia.” Substance Use Prevention and Harm Reduction, December 8, 2022. https://hip.phila.gov/document/3154/PDPH-HAN_Update_13_Xylazine_12.08.2022.pdf/. Accessed April 20, 2026.

260. National Institute on Drug Abuse. “Xylazine.” Updated September 2024. https://nida.nih.gov/research-topics/xylazine#Reference. Accessed April 20, 2026.

261. Centers for Disease Control and Prevention. “Medetomidine in the U.S. Illegal Fentanyl Supply Increasing Risk for Overdose and Severe Withdrawal Syndrome.” April 2, 2026. https://www.cdc.gov/han/php/notices/han00527.html. Accessed April 20, 2026.

262. Vangelov, Kasey, Keith Humphreys, Jonathan P. Caulkins, et al. “Did the Illicit Fentanyl Trade Experience a Supply Shock? A Synthesis of Government and Social Media Data Suggests a Disruption, Possibly Tied to Events in China.” Science, 391(6781): 134-136, January 8, 2026. https://www.science.org/doi/10.1126/science.aea6130. Accessed April 20, 2026.

263. MacWilliams, Katherine, Claire Houtsma, Gabriela Khazanov, et al. "Evaluating the Effectiveness of Firearm Storage Devices on Secure Firearm Storage Intention and Behaviors: Results from a Randomized Pilot Study." APHA 2025 Annual Meeting and Expo, 2025. https://apha.confex.com/apha/2025/meetingapi.cgi/Paper/571643?filename=2025_Abstract571643.html&template=Word. Accessed April 20, 2026.

264. Hendershot, Christian S., Michael P. Bremmer, Michael B. Paladino, et al. "Once-Weekly Semaglutide in Adults With Alcohol Use Disorder: A Randomized Clinical Trial." JAMA Psychiatry, 82(4): 395-405, February 12, 2025. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2829811. Accessed April 20, 2026.

265. Office of Personnel Management. "Workforce Size & Composition." Updated February 2026. https://data.opm.gov/explore-data/analytics/workforce-size-and-composition. Accessed April 20, 2026.

266. Stone, Will. "With CDC Injury Prevention Team Gutted, 'We Will Not Know What is Killing Us." NPR, April 21, 2025. https://www.npr.org/sections/shots-health-news/2025/04/21/nx-s1-5371519/cdc-hhs-injury-prevention-federal-layoffs. Accessed April 20, 2026.

267. Ibid.

268. Centers for Disease Control and Prevention. "Adverse Childhood Experiences Prevention Resource for Action: A Compilation of the Best Available Evidence." National Center for Injury Prevention and Control, 2019. https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf. Accessed April 20, 2026.

269. Suicide Prevention Act, S.1062, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/senate-bill/1062. Accessed April 24, 2026.

270. Lustig, Adam, and Marilyn Cabrera. "Leveraging Evidence-Based Policies to Improve Health, Control Costs, and Create Health Equity." Trust for America's Health, July 2021. https://www.tfah.org/report-details/leveraging-evidence-based-policies/. Accessed April 20, 2026.

271. Campus Prevention and Recovery Services for Students Act of 2024, H.R.8214, 118th Congress, 2023-2024. https://www.congress.gov/bill/118th-congress/house-bill/9214 . Accessed April 24, 2026.

272. Student Mental Health Rights Act, H.R.3726, 118th Congress, 2023-2024. https://www.congress.gov/bill/118th-congress/house-bill/3726. Accessed April 20, 2026.

273. RISE from Trauma Act, H.R.6625, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/6625. Accessed April 24, 2026.

274. Office of Senator Shelley Moore Capito. "Capito, Durbin, Introduce Bipartisan RISE from Trauma Act to Address Childhood Trauma." Press release: December 11, 2025. https://www.capito.senate.gov/news/press-releases/capito-durbin-introduce-bipartisan-rise-from-trauma-act-to-address-childhood-trauma. Accessed April 24, 2026.

275. The U.S. Surgeon General's Advisory. "Protecting Youth Mental Health." Office of the Surgeon General, 2021. https://pubmed.ncbi.nlm.nih.gov/34982518/. Accessed April 20, 2026.

276. Centers for Disease Control and Prevention. "Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders." December 2023. https://www.cdc.gov/mental-health-action-guide/media/pdfs/DASH_MH_Action_Guide_508.pdf. Accessed April 24, 2026.

277. Office of Senator Raphael Warnock. "Warnock Pushes New Effort to Strengthen Mental Health Resources in Schools." Press release: June 12, 2025. https://www.warnock.senate.gov/newsroom/press-releases/warnock-pushes-new-effort-to-strengthen-mental-health-resources-in-schools/. Accessed April 24, 2026.

278. Advancing Student Services in Schools Today (ASSIST) Act, S.2050, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/senate-bill/2050. Accessed April 24, 2026.

279. Office of Representative Andrea Salinas. "Rep. Salinas Reintroduces Bipartisan Legislation to Expand Mental Health Services for Students Nationwide." Press release: September 23, 2025. https://salinas.house.gov/media/press-releases/rep-salinas-reintroduces-bipartisan-legislation-expand-mental-health-services. Accessed April 24, 2025.

280. Mental Health Services for Students Act of 2025, H.R.5557, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/5557/text. Accessed April 24, 2026.

281. Counts, Nathaniel Z., Leslie R. Walker-Harding, and Benjamin F. Miller. "Enforcing Legal Compliance for Covering of Services Promoting Family Mental Health." American Journal of Preventive Medicine, 62(5): P795-798, May 2022. https://www.ajpmonline.org/article/S0749-3797(21)00598-5/fulltext. Accessed April 20, 2026.

282. EARLY Minds Act, S.779, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/senate-bill/779. Accessed April 24, 2026.

283. Office of Representative Dan Goldman. "Congressman Dan Goldman Fights to Protect Children's Mental Health." Press release: November 27, 2023. https://goldman.house.gov/media/press-releases/congressman-dan-goldman-fights-protect-childrens-mental-health. Accessed April 20, 2026.

284. Helping Kids Cope Act, H.R.2412, 118th Congress, 2023-2024. https://www.congress.gov/bill/118th-congress/house-bill/2412. Accessed April 20, 2026.

285. Representative Underwood. "Underwood, Adams, Booker Reintroduce Momnibus Bills to End America's Maternal Health Crisis." Press release: March 18, 2026. https://underwood.house.gov/media/press-releases/underwood-adams-booker-reintroduce-momnibus-bills-end-americas-maternal-health. Accessed April 24, 2026.

286. Momnibus Act, H.R.7973, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/7973. Accessed April 24, 2026.

287. Early Childhood Mental Health Support Act, H.R.9366, 118th Congress, 2023-2024. https://www.congress.gov/bill/118th-congress/house-bill/9366/text. Accessed April 24, 2026.

288. Weizman, Shelly, Sonia L. Canzater, and Taleed El-Sabawi. "Model Opioid Litigation Proceeds Act" O'Neill Institute Georgetown Law, October 2021. https://oneill.law.georgetown.edu/publications/model-opioid-litigation-proceeds-act/. Accessed April 24, 2026.

289. National Opioids Settlement. "Executive Summary of National Opioid Settlements." https://nationalopioidsettlement.com/executive-summary/. Accessed April 20, 2026.

290. Ibid.

291. National Association of County & City Health Officials. "A Quick 'How-To' Guide for Understanding Opioid Settlements State-to-State." https://www.naccho.org/uploads/downloadable-resources/OpioidSettlementsPDFFinal.pdf. Accessed April 20, 2026.

292. Ibid.

293. Pattani, Aneri. "Sock Hops and Concerts: How Some Places Spent Opioid Settlement Cash." KFF Health News, November 3, 2025. https://kffhealthnews.org/news/article/opioid-settlements-addiction-sock-hops-concerts-mma-local-spending/. Accessed April 20, 2026.

294. Ibid.

295. Vital Strategies. "Guides for Community Advocates on the Opioid Settlements." 2025. https://www.opioidsettlementguides.com/links-to-state-guides?q=which+states+restrict+supplantation. Accessed April 20, 2026.

296. Michigan Department of Health and Human Services. "Michigan Makes Historic Investment in Opioid and Substance Use Response With More Than $131 Million Included in FY2026 Budget." Press release: November 6, 2025. https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2025/11/06/opioids-budget. Accessed April 20, 2026.

297. Partnership to End Addiction. "Guidance for Investing the Opioid Settlement Funds in Primary Prevention." October 2025. https://cdn-01.drugfree.org/web/prod/wp-content/uploads/2025/10/16112400/GuidanceForInvestingTheOpoidSettlementFunds.pdf Accessed April 20, 2026.

298. Kid PROOF Act of 2025, H.R.6396, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/6396. Accessed April 24, 2026.

299. Department of Health and Human Services. "2024 National Strategy for Suicide Prevention." https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-use-disorder/national-strategy-suicide-prevention/index.html. Accessed April 24, 2026.

300. Office of Congressman Beyer. "Beyer, Fitzpatrick Introduce Barriers to Suicide." Press release: May 20, 2025. https://beyer.house.gov/news/documentsingle.aspx?DocumentID=7552. Accessed April 24, 2026.

301. Barriers to Suicide Act of 2025, H.R.3505, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/3505. Accessed April 24, 2025.

302. Runyan, Carol W., Amy Becker, Sara Brandspigel, et al. "Lethal Means Counseling for Parents of Youth Seeking Emergency Care for Suicidality." Western Journal of Emergency Medicine, 17(1): 8-14, 2016. https://escholarship.org/uc/item/0td33354. Accessed April 20, 2026.

303. Trust for America's Health. "Promoting Health and Cost Control in States: How States Can Improve Community Health and Well-Being Through Policy Change." Trust for America's Health, February 2019. https://www.tfah.org/report-details/promoting-health-and-cost-control-in-states/. Accessed April 20, 2026.

304. 9–8–8 Implementation Act of 2023, H.R.4851, 118th Congress, 2023-2024. https://www.congress.gov/bill/118th-congress/house-bill/4851. Accessed April 20, 2026.

305. Congress.gov. "S.2826 - 988 LGBTQ+ Youth Access Act of 2025." https://www.congress.gov/bill/119th-congress/senate-bill/2826/text. Accessed April 20, 2026.

306. Office of Congressman Don Bacon. "Bacon, Raskin Introduce Bipartisan Legislation to Tackle America's Mental Health Crisis. Press release: March 26, 2026. https://bacon.house.gov/news/documentsingle.aspx?DocumentID=2880. Accessed April 24, 2026.

307. Congress.gov. "H.R.7092 - RAYS Act." https://www.congress.gov/bill/119th-congress/house-bill/7092?s=1&r=1. Accessed February 20, 2026.

308. 9-8-8 CONNECT Act, H.R.8122, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/8122/text?s=1&r=3&hl=%22Connect+Act%22. Accessed April 24, 2026.

309. Bipartisan Policy Center. "Answering the Call: 988: A New Vision for Crisis Response." Bipartisan Policy Center, June 2022. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/06/BPC-Behavioral-Crisis-Intervention-Rprt_FINAL-1.pdf. Accessed April 20, 2026.

310. Office of Senator Catherine Cortez-Masto. “Cortez Masto, Cornyn Work to Improve Behavioral Health Care Access.” Press release: March 11, 2025. https://www.cortezmasto.senate.gov/news/press-releases/cortez-masto-cornyn-work-to-improve-behavioral-health-care-access/. Accessed April 24, 2026.

311. Connecting Our Medical Providers with Links to Expand Tailored and Effective Care. S.931, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/senate-bill/931/text. Accessed April 24, 2026.

312. Bipartisan Policy Center. “Tackling America’s Mental Health and Addiction Crisis Through Primary Care Integration: Task Force Recommendations.” Bipartisan Policy Center, March 2021. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf. Accessed April 20, 2026.

313. Congressional Budget Office. “Information Concerning the Budgetary Effects of H.R.1, as Passed by the Senate on July 1, 2025.” July 1, 2025. https://www.cbo.gov/publication/61537. Accessed April 20, 2026.

314. Sanger-Katz, Margot. “GOP Bill Has $1.1 Trillion in Health Cuts and 11.8 Billion Losing Care, CBO Says” New York Times, June 29, 2025. https://www.nytimes.com/2025/06/29/us/politics/trump-policy-bill-health-insurance-cuts.html. Accessed April 24, 2026.

315. Centers of Medicare and Medicaid Services. “Behavioral Health Services.” https://www.medicaid.gov/medicaid/benefits/behavioral-health-services. Accessed April 20, 2026.

316. Office of Representative Paul Tonko. Tonko, Fitzpatrick, Smith Introduce Bill to Expand Access to Mental Health Services. Press release: July 23, 2025. https://tonko.house.gov/news/documentsingle.aspx?DocumentID=4428. Accessed April 24, 2026.

317. Medicaid Bump Act, H.R.4745, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/4745. Accessed April 24, 2026.

318. Reentry Act of 2025, H.R.2586, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/2586. Accessed April 24, 2026.

319. Centers for Medicare and Medicaid Services. “The Mental Health Parity and Addiction Equity Act.” https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity, Accessed April 24, 2026.

320. SUPPORT for Patients and Communities Reauthorization Act of 2025, H.R.2483, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/house-bill/2483. Accessed April 20, 2026.

321. Office of Senator Tim Kaine. “Kaine and Banks Introduce Bipartisan Bill to Support Mental Health Care and Substance Use Disorder Recovery.” Press release: April 8, 2025. https://www.kaine.senate.gov/press-releases/kaine-and-banks-introduce-bipartisan-bill-to-support-mental-health-care-and-substance-use-disorder-recovery. Accessed April 24, 2026.

322. PEER Support Act. S.1329, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/senate-bill/1329. Accessed April 24, 2026.

323. Congress.gov. “H.R.2483 - SUPPORT for Patients and Communities Reauthorization Act of 2025.” https://www.congress.gov/bill/119th-congress/house-bill/2483. Accessed, April 20, 2026.

324. U.S. Senate HELP Committee. “Senate Passes Cassidy’s SUPPORT Act to Address Nation’s Opioid & Mental Health Crisis, Now Heads to President’s Desk.” September 18, 2025. https://www.help.senate.gov/rep/newsroom/press/senate-passes-cassidys-support-act-to-address-nations-opioid-and-mental-health-crisis-now-heads-to-presidents-desk. Accessed April 20, 2026.

325. National Child Traumatic Stress Network. “Who We Are.” https://www.nctsn.org/about-us/who-we-are. Accessed April 20, 2026.

326. Broderick, O. Rose, and Lev Facher. “Trump Cuts Have Decimated the Federal Addiction and Mental Health Agency.” STAT, October 30, 2025. https://www.statnews.com/2025/10/30/samhsa-grant-cuts-staff-reductions-impact-analyzed/. Accessed April 20, 2026.

327. Chatterjee, Rhitu. “They’ve Tracked Americans’ Drug Use for Decades. Trump and RFK Jr. Fired Them.” NPR, May 29, 2025. https://www.npr.org/sections/shots-health-news/2025/05/29/nx-s1-5407849/samhsa-nsduh-trump-rfk-jr-hhs-cuts. Accessed April 20, 2026.

328. Office of Management and Budget. “Budget of the U.S. Government.” FY 2027. https://www.whitehouse.gov/wp-content/uploads/2026/04/budget_fy2027.pdf. Accessed April 20, 2026.

329. Pursuing Equity in Mental Health Act, S.1448, 119th Congress, 2025-2026. https://www.congress.gov/bill/119th-congress/senate-bill/1448/text. Accessed April 24, 2026.

330. Health Equity and Accountability Act of 2024, S.4773, 118th Congress, 2025-2026. https://www.congress.gov/bill/118th-congress/senate-bill/4773. Accessed April 24, 2026.

331. Centers for Disease Control and Prevention. “How CDC Uses Emergency Department Data to Watch for Unusual Patterns of Flu Amid Concerns Over H5N1 Bird Flu.” August 2024. https://www.cdc.gov/bird-flu/spotlights/emergency-unusual-patterns.html#:~:text=Purpose,allowing%20further%20investigation%20and%20action. Accessed April 24, 2026.

332. The U.S. Surgeon General’s Advisory. “Protecting Youth Mental Health.” Office of the Surgeon General, 2021. https://pubmed.ncbi.nlm.nih.gov/34982518/. Accessed April 20, 2026.

333. Saunders, Heather, Amaya Diana, Elizabeth Hinton, and Robin Rudowitz. “Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders.” KFF, June 2025. https://www.kff.org/medicaid/implications-of-medicaid-work-and-reporting-requirements-for-adults-with-mental-health-or-substance-use-disorders/. Accessed April 20, 2026.

334. Park, Edwin. “New CBO Health Coverage Estimates of Budget Reconciliation Law.” Georgetown University McCourt School of Public Policy, Center for Children and Families. August 14, 2025. https://ccf.georgetown.edu/2025/08/14/new-cbo-health-coverage-estimates-of-budget-reconciliation-law/. Accessed April 20, 2026.

335. Congressional Budget Office. “Distributional Effects of Public Law 119-21.” August 2025. https://www.cbo.gov/publication/61367. Accessed April 20, 2026.

336. Centers for Medicare & Medicaid Services. “December 2025 Medicaid & CHIP Enrollment Data Highlights.” https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/october-2025-medicaid-chip-enrollment-data-highlights. Accessed April 20, 2026.

337. Association of State and Territorial Health Officials. “One Big Beautiful Bill Law Summary.” July 9, 2025. https://www.astho.org/advocacy/federal-government-affairs/leg-alerts/2025/one-big-beautiful-bill-law-summary/. Accessed April 20, 2026

338. Park, Edwin. “New CBO Health Coverage Estimates of Budget Reconciliation Law.” Georgetown University McCourt School of Public Policy, Center for Children and Families. August 14, 2025. https://ccf.georgetown.edu/2025/08/14/new-cbo-health-coverage-estimates-of-budget-reconciliation-law/. Accessed April 20, 2026.

339. Congressional Budget Office. “Distributional Effects of Public Law 119-21.” August 2025. https://www.cbo.gov/publication/61367. Accessed April 20, 2026.

340. Saunders, Heather, Amaya Diana, Elizabeth Hinton, and Robin Rudowitz. “Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders.” KFF, June 2025. https://www.kff.org/medicaid/implications-of-medicaid-work-and-reporting-requirements-for-adults-with-mental-health-or-substance-use-disorders/. Accessed April 20, 2026.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