Congressional Briefing and National Webinar
Defending Our Progress Against Preventable Deaths: 2026 Pain in the Nation Report
Trust for America's Health
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Live captioning Transcript by AI-Media

TIM HUGHES:

Good afternoon and welcome to our Congressional Briefing and National Webinar on the report Pain in the Nation 2026: The Epidemics of Alcohol, Drug, and Suicide Deaths hosted by Trust for America's Health, commonly known as TFAH. My name is Tim Hughes, the External Relations and Outreach Manager at TFAH. We would like to thank our speakers and audience for being with us today.

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Real-time captioning is provided today by April of AI-Media. For captions, click on more on the bottom right hand of your screen with the three dots. Next, click on closed captions. Next slide.

ASL interpretation is also being provided today by Keystone Interpreting solutions with Hannah and Kyle as our interpreters today. If you would like to use ASL interpretation, hover over your cursor over the interpretation button on the bottom of your Zoom screen. Next slide.

We encourage you all to share your thoughts and questions about today's presentation by typing them into the Q&A box. We will try to answer as many as we can as time permits. To open the Q&A, click the Q&A icon at the bottom of your screen. From there, select enter when you are ready to submit your question. Next slide, please.

And now it is my pleasure to introduce the moderator of this event, Doctor Tekisha Dwan Everette. Dr. Everette is TFAH's Executive Vice President. In this role, she works in partnership with TFAH's President and CEO to chart and implement the organization's strategic direction and priorities, provides counsel on current and emerging policy issues, and engages with key organizations, policymakers, and other partners to advance policy priorities to improve public health and promote equity.

Welcome Dr. Everette!

TEKISHA EVERETTE:

Thank you to everyone joining us today for this important discussion. My name is Doctor

Tekisha Everette and first I would like to welcome you all and thank our esteemed panelists for taking the time to attend this event today. We are truly honored that you are all here. Next slide, please.

Our agenda today is on the slide. After the presentations, we will have time for questions from the audience. Before we get into our panel, I want to start off with a brief recap of our 2026 Pain in the Nation Report.

A copy of the full report, including state specific information is available at www.tfah.org. And we will include a link in the chat. My hope for this briefing is that you will leave with a better understanding of the comprehensive policies and programs that address the underlying causes of these preventable deaths and help heal individuals and build more resilient communities. Next slide.

In 2017, TFAH began the report series to highlight the alcohol, drug and suicide deaths in the United States. An effective interventions and recommended policy action to address such deaths. The 2026 report shows improvements in the death rate for alcohol, drugs and suicide supported by investments and prevention grants and programs. Funding for vital data systems and a growing focus on early intervention.

After peaking in 2021, this year's report finds that the combined age-adjusted rate of deaths for alcohol, drug and suicide declined by 16% in 2024. Living on a decrease of 4% in 2023.

Specifically, drug overdose mortality declined 26% and alcohol-induced mortality declined by 4%, and suicide mortality by 3%. And provisional data for 2025 signals this promising trend may continue.

The recent declines are encouraging but let us be clear: this progress is fragile. Whether recent gains continue depends on public health infrastructure that makes prevention possible. Next slide.

The 2026 report includes a special feature on suicide that was the 10th leading cause of death in 2024 and the second leading cause of death people ages 10 to 35. The report exampled trends across demographic and geographic populations, including sex, age, race and ethnicity, region, suicide method, urbanization, occupation, veteran status, and sexual orientation and gender identity.

The highlight the notable variations in mortality from the report in 2024, let's start by talking about the differences between males and females.

Males had 22.3 suicide deaths per 100,000, compared to 5.6 deaths per 100,000 among females. One major difference in characteristics between sexes is suicide method. In 2024, males died at a rate 6.8% higher for firearm suicide compared to females.

Older adults had the highest suicide mortality rates of any age group, followed closely by young and middle-aged adults. Excuse me.

Over the last two decades, American Indian and Alaskan Native people consistently had the highest suicide mortality rate of any race or ethnicity with the rate of 22.5 deaths per 100,000 in 2024.

Mortality trends across race and ethnicity have diverged substantially in recent years, ranging from small improvements for some populations, to large increases in others. Notably, suicide mortality rates across nearly all racial and ethnic groups declined in 2024 after peaks in 2022 and 2023.

Regionally, the Northeast has lower suicide rates than the rest of the country. In 2024, the suicide rate in the Northeast was 9.8 deaths per 100,000, compared to 14.7 deaths per 100,000 in the Midwest. Next slide.

Historically, Black youth have had relatively low suicide mortality rates compared to their peers. But, rates have risen at an alarming pace in recent decades, increasing 144% from 2007 until -- 2020.

Have increased at faster rates over the past two decades. In 2022, rural areas had a suicide rate 41% higher than urban areas. Military veterans are another group disproportionately affected by suicide, with veteran suicide death rates twice that of civilian populations each year.

The latest data from the US Department of veteran affairs show that veteran suicide rate at 35.2 deaths per 100,000 in 2023. Compared to 14.1 deaths per 100,000 in the overall population in the same year.

And while the rate of suicide deaths is unknown for LGBTQ populations, research consistently finds higher rates of mental health issues, substance use, and suicidal behaviors for LGBTQ individuals compared with heterosexual individuals. Youth, likewise, have higher rates of mental health issues and suicidal behaviors.

According to the 2023 youth -- risk behavior survey, rates of persistent feelings of sadness reported by LGBTQ+ high school students were roughly 2 to four times as high as rates among their heterosexual and cisgender peers. Next slide.

The 2026 Pain in the Nation report examines policies that have helped to drive crisis response and reduce suicide mortality. This includes the 988 Suicide and crisis hotline, which has answered more than 23 million calls, texts and chats since its first launch in 2022.

In April 2026, a (unknown name) study and the 2026 edition found that states with the highest 988 uptake solve lower suicide mortality among 15 to 34-year-olds, compared to states with lower 988 uptake.

In addition to 988, 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 their selves or others from using firearms. 28 districts have adopted laws allowing temporary removal

for individuals in crisis.

Researchers studying Connecticut's red flag law estimated that for every 10.6 removal orders, one suicide was averted.

Furthermore, mobile crisis response teams are providing crisis response, de-escalation and support outside of traditional law enforcement settings. Research shows that crisis intervention can reduce law enforcement involvement in incarceration, emergency department visits, and incarcerations. Next slide.

This report also highlight key programs that provide funding to states, territories, tribes, localities and organizations to find a variety of activities. Programs such as the comprehensive suicide prevention program at the Center for disease control and prevention and the Garrett Lee Smith program at the Substance Abuse and Mental Health Services Administration frequently called SAMHSA support suicide prevention and early intervention activities within community-based counties and college campus. (unknown name) have allowed health officials to track emerging trends by geographic, demographic, and drug type to guide local, state and national responses, and prevent overdoses and deaths in real time in communities in need. Next slide, please.

The Federal health and injury prevention systems, excuse me, that support prevention, surveillance and crisis response have experienced leadership upheaval and workforce reduction, with SAMHSA losing half of its workforce and the CDC's (unknown name) losing more than 200 staff throughout 2025 and 2026.

To maintain progress and ensure that it touches all communities, we must sustain primary prevention programs and investments. And ensure they maintain the staff capacity to carry out these programs. The recommendations for policymakers within the report represents TFAH research on programs and legislation that is needed to improve the nation's behavioral outcomes.

First, we must protect programs that promote health. Sustaining behavioral health funds and sustaining investments in injury and violence prevention, and restoring and maintaining the workforce dedicated to these efforts.

And finally, supporting policies and programs that reduce adverse childhood experiences, and the impact of trauma and that promote positive childhood expensive.

Second, we need to reduce overdose risk and access to meet the needs of suicide. Promoting harm reduction policies to reduce overdose and blood-borne infections, and supporting efforts to limit access to meet the needs of suicide.

And lastly, we must transform the mental health and substance use prevention system. This means maintaining SAMHSA's funding and critical workforce and bolstering the continuum of crisis intervention programs and supports. Restoring Medicaid funding and eligibility to prevent losses of behavioral healthcare and promoting equity in mental health with a specialized workforce and targeted services to reduce disparities and outcomes, and access and outcomes.

Overall, we need to focus on the underlying drivers on many behavioral health outcomes through early intervention and prevention strategy.

Current and proposed cuts to prevention programs will diminish recent progress and ultimately cost lives. But that overview, as well as the policy recommendations, I now want to turn to our steam panel. Next slide.

I'm pleased to welcome Doctor Vohra who was appointed director of the Illinois Department of Public health effective August 1, 2022 second by Governor JB Pritzker. He charged him with continuing to shape a stronger Illinois for the 21st century. He is a pediatrician with degrees in medicine, law, and public policy, and is a cross disciplinary leader in state and national health policy formulation.

Since becoming Illinois top Doctor, he has led the state through the end of the COVID-19 public health emergency and is now focused on efforts to strengthen Illinois Public Health infrastructure and build a unified vision for health in every corner of the state.

Joining us also is Laurel Stine who leads the American foundation for suicide prevention, Washington DC based policy office in the development and advancement of Federal and State Policy to save lives and bring hope to those affected by suicide.

Prior to joining to AFSP, Stein has engaged in mental health and disability policy development and advocacy for over 25 years. Most recently as senior director of Congressional and Federal Affairs and partnerships for the American Psychological Association.

She now serves as the Chair of the Board of Directors for the Mental Health Liaison Group, a coalition of over 70 national Behavioral Health coalitions. And co-led the Committee for over 10 years with coalition successes, including the enactment of mental health parity, the Affordable Care Act, and comprehensive health reform.

Welcome Doctor Vohra and Ms Stein. Before we get started with the presentation, I want to give a special note to the audience. We will save questions for the end, but please remember to submit your questions in the Q&A box and not the chat. We will get to as many as possible after the presentation.

And now, it's my honor to welcome Doctor Sameer Vohra from the Illinois Department of Public Health. Doctor Vohra.

DR SAMEER VOHRA:

Thank you so much, Doctor Everette. And thank you for inviting me today. As you mentioned, I have the extended privilege to serve as the director of the Illinois Department of Public Health. It's an honor to speak with all of you today about Illinois suicide prevention efforts and how our partnerships at the local, state and Federal level are supporting that work. Next slide, please.

Part of my presentation will really discuss Illinois efforts against preventable deaths and really focus on suicide prevention as our core issue and topic this afternoon. Next slide, please.

Let me start by telling you a little bit about the Illinois Department of Public Health. The department was founded back in 1877, making us one of the oldest agencies in Illinois state government. Today, we oversee six regional offices, three public health laboratories, and over 1500 employees all working to protect and improve the health of Illinoians. Next slide, please.

First and foremost I want to emphasize that mental health and substance use disorder, moving against preventable deaths, is a core aspect of our work at the Illinois Department of Public Health. As per our healthy Illinois 2028 state health improvement plan, Mental Health and substance use disorder are one of five key priorities as we work to improve the health of our residents. Next slide, please.

A key component of this work in mental health and substance use disorder is really analyzing and thinking through suicide prevention. Now, suicide prevention is in the work that we do at the agency, is in partnership with the Centers for Disease Control and Prevention. A partner that provides our state with funding, best practices, and subject matter expertise.

And this Federal support has allowed us to build capacity. It allows partnership, with the CDC serving as a resource for best practices, and subject matter expertise on implementation, of strategies and best practices used across the nation. This has allowed Illinois to create a more robust and coordinated coalition within the state. Next slide, please.

So, as a backdrop, suicide takes enormous toll on Illinois. In 2025, more than 1400 lives were lost in Illinois to suicide. And we average about hundred 80,000 suicide related emergency department visits across Illinois. We estimate just in a four-year span from 2021 until 2025, more than 120,000 years of potential life were cumulatively lost to suicide in our state. Next slide, please.

To counter this, Illinois has embarked on creating a unified coordinated coalition that aims to create intervention strategies that can be scaled and adjusted to the needs of a particular community or region.

As you see from this side, the Illinois suicide prevention alliance focuses on developing and updating a statewide partnership plan and expanding stakeholder engagement across sectors, and ensuring partnerships and partners are involved in decision-making, data review, and strategy selection.

The CDC comprehensive suicide prevention Grant is the engine that makes this grant, makes this work and strategy possible. Funding, really the real-time surveillance system that targets work with disproportionately affected populations and allows us to deliver interventions in high need communities. Next slide, please.

So, let's talk about this really critical grant in more detail. It's a five-year grant that the state of Illinois gets -- $950,000 per year and it's funded through September 2028. Three primary

objectives of this grant: first, it establishes a data-driven suicide prevention framework, allowing the state and our partners to get the kind of information that allows us to understand and address the problem in real time.

Second, it identifies and formally designates two disproportionately affected populations as high burdened groups. For example, males aged 50 and above in small urban counties, and females aged 10 to 19.

Third, it expands multisector partnerships within Illinois suicide prevention alliance from 15, two as we will show you, more than 160. Next slide, please.

Now, this funding has been invaluable as we look to increase the scope and reach of our suicide prevention efforts. We have grown from initially 15, two as I just mentioned, hundred and 60 statewide partners actively engaged through the Illinois suicide prevention alliance, and collaborations aligned with this grant. We've also been able to identify 96 organizations as implementing suicide prevention or related behavioral health programming.

And finally, 47 current local coalitions are built statewide to address suicide prevention just this year, that's up 42% from last year. This creates the kind of partnerships and coalitions that have real-time information to address and move community-based efforts to improve suicide prevention and reduce those suicide rates. Next slide, please.

This funding has allowed us to take on a number of internal projects that are bolstering the statewide push to prevent suicides. Now, we have created and maintained a statewide inventory of suicide prevention programs and coalitions, mapping prevention assets and documenting gaps in service. We have built and refined our surveillance tools to identify suicide clusters, enhancing local response. Third, we have strengthened monitoring of youth self-harm ED visits, improving alignment between public health, schools, pediatric care, and behavioral health systems. And finally, we haven't had statewide communication and public engagement on suicide prevention.

Next slide, please.

And partly, we wanted to highlight one grantee spotlight. (unknown name) Behavioral Health Foundation. For those that know Illinois, we know that (Place name) is an hour southwest of the city of Chicago and we know our state agency alone cannot carry out its vital public health mission. That's why these partnerships with local health departments, hospitals, clinics, community-based organizations are so essential.

With support from our IDPH comprehensive suicide prevention funding, the behavioral health -- foundation has made a frameworks date wide to address suicide risk among high-risk adults. They have established oversight councils, updated clinical protocols, implemented safety planning models, and distribute more than 150 suicide prevention coping kits that included mental health support materials, wellness items, and a first aid kit. They are one of the example of things that have been bolstered by funding to make a real difference in communities and address suicides, and implement action steps to enhance suicide prevention.

Thank you everybody, that's my last slide. I will pass it on back to Doctor Everette to introduce our next speaker, and get us started moving along with -- webinar. Thank you all for your time this afternoon.

TEKISHA EVERETTE:

Thank you, Doctor Vohra. I'm now going to turn to Laurel Stine from the American Foundation for Suicide Prevention. I think she's joining us only through audio and not visually. I turn it over to you.

LAUREL STINE:

Thank you for the opportunity to join you today. Again, apologies for not being able to join on camera due to technical difficulties. But once again, I think the Trust for America's Health for highlighting the findings of this important report.

My name is Laurel Stine and I'm Executive Vice President and key Policy and Advocacy Officer at the American Foundation for Suicide Prevention. AFSP is dedicated for saving lives and bringing hope to those that are affected by suicide. And we carry out this mission through research, advocacy, community-based education and programming, with more than 70 chapters in all 50 states, the District of Columbia, and Puerto Rico.

AFSP is also the largest private funder of suicide prevention globally. So, the 2026 Pain in the Nation Report gives us reason for cautious optimism. After years of rising suicide rates, we've begun to see encouraging declines. Every life saved matters. Every life saved matters and these improvements remind us that suicide can be prevented.

At the same time, suicide remains a public health issue and is a shared responsibility that demands national priority.

The national strategy for suicide prevention, I want to make sure I put the slide here, it was released in 2024 and was led by this disease control and prevention (audio issues). And the national alliance for suicide prevention.

This reflects this priority, essentially serving as our nation's roadmap for suicide prevention. It recognizes that suicide prevention is a public health responsibility at every level of government.

Today, I will highlight just a few Federal investments that support this competence of approach that is outlined in the national suicide strategy for suicide prevention. Next slide, please.

SAMHSA and the CDC support many suicide prevention initiatives. SAMHSA has extended crisis response capacity, strengthen the behavioral health workforce, and essentially supporting communities in implementing evidence-based suicide prevention programs.

And the CDC has advanced surveillance efforts and help translate research into practical public

health, so many things that these leading organizations do to help promote and advance suicide prevention.

I'm highlighting just a few in a few minutes, just a few examples, because together they illustrate different parts of a comprehensive health approach from upstream prevention, crisis response, to surveillance and data.

These examples demonstrate how different investments work together to strengthen the overall suicide prevention system. Next slide, please.

988. The launch of the 988 Suicide and Crisis Lifeline transformed Access to crisis care by creating an easy to remember three digit number that connects people to trained two crisis counselors free of charge. It includes local call centers, mobile crisis teams, and crisis stabilizations, and it is essential. I repeat: local funding for local call centers, mobile crisis teams, crisis stabilization is essential so that every person that reaches out receives timely, effective and potentially life-saving care.

What's also perhaps just as important, it's just important to normalize reaching out for help. I've outlined here on the slide some data just recently on call volume, from calls, chats and texts. Next slide, please.

The evidence that these investments can make a measurable difference. This is really significant. A recent study as outlined and shared on the screen published in JAMA found an estimated 11% reduction in suicide deaths among adolescents and young adults aged 15 to 34 after the launch of 988. This began in 2022. It just celebrated its four year anniversary at July 16 of this year.

These studies strengthen the evidence that expanding access to 988 crisis care can save lives. Next slide, please.

And for young individuals, the Garrett Lee Smith Suicide Prevention Programs, SAMHSA also supports upstream preventions through the Garrett Lee Smith Suicide Prevention Programs. These help support tribal communities, states, school, college campuses in implementing evidence-based youth suicide prevention strategies, identifying young people at risk earlier and connecting them to the care that they need to help improve the follow-up.

In fiscal year 2024 alone, more than 113,000 youth were screened for suicide risk and over 30,000 were referred for services, and nearly 80% receive care following referral.

It's programs like this, the Garrett Lee Smith Suicide Prevention Programs that strengthen systems within schools and communities so that young people receive help before a crisis escalates. Next slide, please.

While 988 response during a crisis, the CDC's comprehensive suicide prevention program, as you heard already from Doctor Vohra, it works upstream to help prevent crises from occurring in the first place. That's ultimately what we want to do for suicide prevention, to help support so

that we are not getting to a crisis in the first place.

These grants supports states, communities in implementing and evaluating prevention strategies with a particular attention to populations disproportionately affected by suicide, and Doctor Everette at the outset mentioned individuals, the LGBTQ plus individuals and communities, Alaska natives, and Native Americans, and many others, veterans, young individuals, young individuals and rural areas and individuals with disabilities that are disproportionally affected by suicide.

With this comprehensive suicide prevention program, what's especially valuable is that communities tailor the evidence-based strategies to their own needs. The encouraging results showed here on the slides with these participating states that I outlined here, it reports reduction in suicide rates among several high rate populations, which demonstrates how comprehensive community-based approaches can reduce suicide among populations at increased risk. Next slide, please.

And these are the reductions that I said. There's been a 1.45% reduction in the suicide rates overall and the 23 recipients. And I have illustrated here, Connecticut and Oregon, and including Doctor Vohra who has information on Illinois, but Connecticut received a reported 21.5% reduction in suicide rates. Whereas in Oregon, among rural veterans and other disproportionately impacted populations, 28.3% reduction. These are success stories and successful data indicators of the value and merit of the comprehensive suicide prevention. It's now up to us to advocate for scaling up these programs so that more states and programs can be implemented and have the essential funding for that.

Next slide, please.

So, then national violent death reporting system is just another one of the CDC's essential programming. It state-based but an essential advancement in the CDC's national violent death NVDRS—one of the most important tools and public health. This is the data. We cannot prevent what we don't understand.

It combines information from death certificates, medical examiners, corners, and law enforcement to better understand the circumstances surrounding suicide. Those insights help identify the trends and recognize the disparities that we are talking about, and guide preventive strategies where they can have the greatest impact. Next slide, please.

So, conference of approach. I said that many times, but taken together, the examples illustrate an important point. This is captured on the slide. The suicide prevention requires sustained investments across prevention, data and surveillance, crisis response, treatment and recovery, and community-based -- support. This leads to better crisis response and prevention programs, better surveillance, and more awareness, improved treatments and community partnerships.

All of this, it comes down to public health progress that really comes from one intervention. It comes from many evidence-based efforts working together over time. Next slide, please.

However, we know that progress is real, but it is fragile and this is highlighted in the 2026 Pain in the Nation Report.

The encouraging trends we are seeing should give us hope, right? But they should also really remind us that progress is not guaranteed. Suicide is still the 10th leading cause of death in the United States in 2024. There were more than 48,824 suicide related deaths and while this is a decrease from 2023, suicide is also still the second leading cause of death among young people and young adults aged 15 to 34. However, we do know rates decreased by 8% from 2023 to 2024. Once again, it gives us hope, but also reminds us that progress is not guaranteed. And also reminding us that many communities continue to experience disproportionately high rates of suicide.

So, essentially effective suicide prevention programs requires stable funding. I say that again: stable funding. We know that public health programs can be quickly reversed. Funding and stability and reductions in prevention capacity can enter up programs just as they began to demonstrate results. Funding that is delayed, reduce funding or interrupting programs that have been shown to work, may not be able to continue operating as intended.

Workforce reductions can mean fewer individuals to oversee those grants and to support the communities. Delays and data collection and analysis, reduce training and to the, and implementation of evidence-based strategies become more difficult.

So, protecting the recent gains means maintaining that infrastructure that allows the communities to continue implementing and improving effective suicide prevention strategies. Next slide, please.

So, protect, scale and invest. So, that is what is key here. Protecting the evidence-based suicide prevention programs and infrastructure of that saving lives. Scaling those proven strategies to reach more communities and populations that benefit from them and continuing to invest in suicide prevention programs, research, surveillance, and infrastructure so we can build on what we know works.

Again, the encouraging trends highlighted in the 2026 Pain in the Nation Report demonstrate something very important. Evidence-based suicide prevention works and now the responsibility is to continue investing in proven strategies, supporting the agencies and the programs that make this possible, so that even more lives can be saved. Next slide, please.

And lastly, I leave with you some resources. This is just some snapshot of some advocacy partners. If you want to become an AFSP advocate, we would love to have you. We have a listing of our priorities and a Federal funding page. We also have a link to the CDC resources, and a valuable guide. As well as SAMHSA's 2025 national guidance for Behavioral Health and coordinate systems of Chris's care. Also Trust for America's Health, and Mental Health lies in group, and keep America safe coalition, our partners in this road to progress.

Thank you once again! Look forward to the questions.

TEKISHA EVERETTE:

Thank you so much! This actually concludes the formal part of the presentation and panel today. We now want to open it up for questions and answers.

You can submit your questions through the Q&A panel at the bottom of your screen. You can type your question to all of our panelists. I'm going to be joined right now by my wonderful colleague, Lauren Battle, who is the government relations manager at TFAH who will help moderate.

I will start with one of my own questions and we will turn to the audience questions. I think I will ask my first question to Doctor Vohra. In your presentation, you actually focused on, you mentioned the CDC comprehensive suicide prevention grant, which has nearly invested a million dollars in Illinois over a four year period. Can you talk to our audience on how Federal investments such as this really support suicide and broader Behavioral Health activities in Illinois. And not just the funding itself, but the technical assistance and the other aspects that come with it.

DR SAMEER VOHRA:

Thanks, Doctor Everette. I think partly what many of us in the public health world know is that for us, how important it is to have partnerships across local, state and Federal. Part of it is funding. State budgets are often limited, and especially public health budgets. Our state, like many, really depend on Federal funding to enhance our programs. Knowing that we have these opportunities to take Federal money and invest in our local programs, it's absolutely critical and essential.

As Ms Stein said, the stability of that funding over many years allows us to have partnership that is sustainable and allows us to learn and kinda grow on those investments.

But to your point even more, is that we need all kinds of different experts, both those local experts in community that know, but also the benefit of having the nation's leading experts at the CDC help identify linkages across other states or nations that could be applied to our work in Illinois. This really expands the strategy and partnership in our agency with Federal colleagues to really make an impact. I think that something that's highly valued by myself as the director of the Illinois Department of Public Health, but really the staff that I have the privilege to work with.

Knowing that you have those ties to the Federal agency to really make impactful things happen all across our communities here in Illinois.

TEKISHA EVERETTE:

Thank you! I love this point that you are making. It's not just about the resources. The resources are critical in terms of financial support was a a lot of people don't realize the bulk on how states

actually work on these mental health and behavioral health interventions come from Federal dollars, but it's also the expertise across, the Federal agencies that have expertise across the state level. Thank you so much for that answer!

I will go to Lauren because I want to make sure that audiences have the opportunity to have their questions answered. I will ask my first question to Lauren. I will see if you have any questions from the audience for us.

LAUREN BATTLE:

We will now take some questions from the audience. The first question that I would like to pose and this could be posed to either Doctor Vohra or to Laurel Stine, what do we do to help people better understand how those calls to the lifeline, i.e. the 988 Crisis Lifeline, where they will ultimately go?

For people that have been spoken to, they oftentimes do not want to call the lifeline because they are scared the police may come, or that they will eventually be hospitalized. I don't feel like they know it actually works enough to trust it. I posed that question to Doctor Vohra or Ms Stein on how we can better help individuals understand how those calls will go.

LAUREL STINE:

Thank you so much, Lauren. I will be happy to jump in on this. As I said, we celebrated the four year anniversary of 988, the suicide Crisis Lifeline just in July. I do appreciate this question.

There's many resources out there. And SAMHSA, as well as (Place name) the administrator of the lifeline, they are continuing to put out information on this through technical assistance webinars, that are really sharing the word that 988 is not only just a easy three digit number, but you are linking to some calls, texts, and chats to trained counselors.

The individuals do not have to share. This is free and it's voluntary. But you are giving us as much information as you want to. You can either call or text and chat on behalf of a loved one. It's not just for the person experiencing mental distress or substance use distress.

I think greater education is sorely needed and we look at it in three different components: not only the calls, texts, and chats, but we also want to make sure about 90% of those calls, texts and chats, are actually resolved at that level. They don't need an mobile crisis team to come for someone who needs additional support, or to be taken to a crisis stabilization. But all three of those components are component parts of the crisis care continuum, as well as follow-up care, which I think is embedded in all three of those.

I appreciate the question! It describes just how much more awareness, not only the number, but what the number does as well.

LAUREN BATTLE:

Thank you so much for that response, Ms Stein. I'm happy to move to another question from the audience. This can be posed to either Ms Stein or Doctor Vohra in terms of the work occurring in Illinois. We have a question that says (Reads chat), "could you discuss how you all are discussing this aspect in your work?"

DR SAMEER VOHRA:

I'm happy to start with this one.

(Multiple speakers)

LAUREL STINE:
I will take it after you.

DR SAMEER VOHRA:

I think it's an absolutely great question and nice to see this question sort of amplified by our colleague here, with partners such as Brady United. I think we are really proud of making people aware of the laws and tools that are at their disposal in Illinois. Ms Everette did sort of speak to red flag laws or in Illinois as we call them, fire and restraining orders.

And we have had the unique pleasure to partner with Brady United and with the Council on a really elevated marketing campaign called Pause to Heal. Anyone in the audience can access from the Department of Health website. That really gives individuals an opportunity to know and understand how a law like this, when an individual is in crisis, it can give them that because and allow them to heal so that they are not using a firearm that can create a really unfortunate tragedy.

We know that firearms play a role in this and we know, as Doctor Everette showed, there are a number of states across the country that are moving forward on these firearms restraining order type of laws. But, our public health campaign in partnership with the Council and Brady United was really to help people understand that it is about that Pause to Heal so that we can give people an opportunity to help protect themselves and their loved ones.

And similar to, as Ms Stein said about 988, I think much of it is we have a lot of great tools that are at our disposal and a lot of it is trying to get the right communication so that people are aware of those tools and they can use them to protect themselves and their loved ones.

LAUREL STINE:

Thank you so much, Doctor Vohra. This is Laurel Stine from AFSP. Legal firearm safety has a lot of (indiscernible) and an individual who is in crisis. It's also one of our policy priorities. We not only work to help prevent suicide by firearms, through our education, awareness and programming, but also through our policies. And the 2026 Pain in the Nation Report discusses some of these recommendations on safely securing safe storage of firearms. And there is

Federal Legislation that we hope everyone will take a look at and advocate for its passage.

There's also a lot of work being done at the state level as well. Once again, lethal means safety, not only firearms, but also bridge barriers and safety nets. It also creates that time and distance from an individual at a point of attachment crisis, and creating those safety net and barriers. Really appreciate that question!

LAUREN BATTLE:

Thank you so much for your insight on the question. We will take one final question from the audience. This is in regards to the role of social media. How can social media companies support suicide prevention campaigns? Again, I think it's a question that can be posed to either Ms Stein or Doctor Vohra. Whoever is interested.

LAUREL STINE:

I will take this. Probably, I think Social Media can support suicide prevention campaigns. AFSP utilizes Social Media all the time. We also have the advocacy Social Media ambassadors who take our research and policies, they take our programming and amplify it through that. I encourage others to use this as a platform.

I'm not too sure if the question is getting into Social Media and some of the harms being cause, but I think it was more about suicide prevention campaigns. And even with that, we take a very balanced approach on that. We know that Social Media, there's opportunities for social connecting youth, as well as some potential harms that are cause. But with suicide prevention campaigns, social media is a really good avenue to get out the word, the research, and the programming that many organizations such as AFSP implements. To the public.

TEKISHA EVERETTE:

Great! I think, Lauren, do we have any other questions? That was it?

LAUREN BATTLE:

That was our last question.

TEKISHA EVERETTE:

Thank you so much! I will say this: if we did not get to your question, we will take a look and see what we can offer, but we do encourage you to visit our website to see the report at www.tfah.org. We greatly appreciate any comments and feedback that you have.

In closing, I really want to thank our panelists today, Doctor Vohra and Laurel Stine. Thank you so much for all that you did in putting your presentations together and joining us today, particularly going through some technical difficulties, we really appreciate you!

I also want to think AI-Media captioning and our behind the scene staffs who are here today who have done a tremendous amount of work to help us do this webinar today. And to each of you, the participants.

Clearly, this is an issue that is important for us to continue to pay attention to and to address the policymakers to make sure that we can reduce these crises.

A recording, along with the slides and additional resources, will be available on TFAH.org in the coming days. Thank you so much for joining us and have an amazing rest of your afternoon!

(Recording stopped)

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