

# Pain in the Nation:

## Alcohol, Drug, and Suicide Epidemics

***SPECIAL FEATURE: COVID-19 AND TRAUMA***



## 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.

**Well Being Trust (WBT)** is a national foundation dedicated to advancing the mental, social and spiritual health of the nation. Led by clinical, community, and policy innovators, WBT brings an ecosystem approach to prevention, treatment, and recovery for mental health and substance misuse issues, while prioritizing an upstream focus on resilience and well-being in communities.

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### REPORT AUTHOR

**Molly Warren, S.M.**

*Senior Health Policy Researcher and Analyst*  
Trust for America's Health

### CONTRIBUTOR

**Jonah C. Cunningham**

*Government Relations Manager*  
Trust for America's Health

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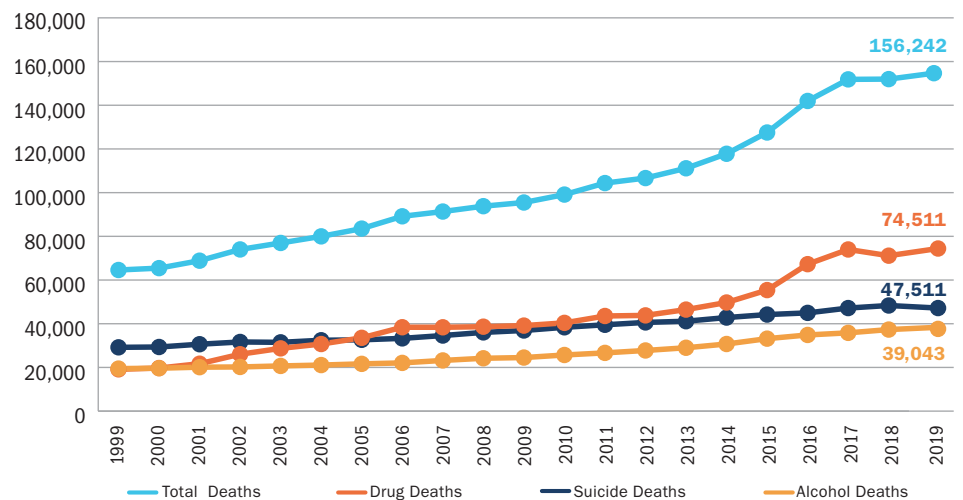
## Pain in the Nation: *Alcohol, Drug, and Suicide Epidemics*

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## Introduction

Between 2010 and 2019, more than one million Americans died from alcohol, drugs, and suicide. There were persistent increases in alcohol and suicide deaths, and exponential waves of overdose deaths from different types of drugs. Some of these trends continued in 2019, including increases in the alcohol-induced and drug-induced death rates, skyrocketing death rates from specific types of drugs, and deteriorating trends among certain demographic and geographic populations. There were also two notable and new trends in 2019. First, the age-adjusted drug-induced death rate among Blacks surpassed whites after many years of substantially lower rates. Second, while still extremely high, the overall suicide death rate was slightly lower in 2019 than in 2018—a first since 2004–2005.

**Annual Deaths from Alcohol, Drugs, and Suicide in the United States, 1999–2019**



Source: TFAH and WBT analysis of National Center for Health Statistics data

The COVID-19 pandemic that enveloped the world in 2020 has created additional stressors to the already devastating situation, and emerging data indicates that Americans are struggling with much higher rates of distress, substance use, and drug overdoses over the past year. Without urgent action, mental health and substance issues—already on a grim trajectory—may continue to rise in the coming years and lead to more deaths from alcohol, drugs, and suicide.<sup>1</sup> Americans need support coping with and healing from the pandemic’s harm now. They need help managing emergent crises, mental health conditions, and substance use disorders

with early intervention, improved medical care and treatment, and harm-reduction policies. And they need better underlying social and economic conditions that will support and bolster their health, well-being, and resilience, and prevent future alcohol, drug, and suicide deaths.

This report includes three sections that (1) examine the effect of trauma and the COVID pandemic as they relate to mental health, substance use, and Americans’ well-being; (2) review the latest mortality trends from alcohol, drugs, and suicide; and (3) outline key policy solutions and recommendations to stem and reverse these trends.

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## SUMMARY OF SOLUTIONS AND RECOMMENDATIONS

Trust for America's Health and Well Being Trust call for a multifaceted approach to reduce alcohol, drug, and suicide deaths and improve mental health and well-being, with a particular emphasis on healing from the COVID-19 pandemic. These recommendations focus on actionable items in three areas and are primarily aimed at federal and state governments. A summary of recommendations follows; the full recommendations are on page 26.

### Invest in Prevention and Conditions that Promote Health

- Reduce traumatic experiences, and promote resilience in children, families, and communities.
- Expand substance use prevention, mental health, and resiliency programs and staff in schools.
- Bolster crisis-intervention programs and supports.
- Reduce availability of illicit opioids and inappropriate prescriptions.
- Lower excessive alcohol use through evidence-based policies.
- Limit access to lethal means of suicide, including drugs and firearms.

### Address the Worsening Drug Use and Overdose Crisis

- Implement policies targeting psychostimulant use.
- Promote harm-reduction policies to reduce overdose and blood-borne infections.

- Continue pandemic-related enhanced flexibilities in access to and rules for substance-use treatment.
- Address the secondary impact of the substance use and overdoses on children.

### Transform the Mental Health and Substance Use Prevention System

- Expand efforts to combat stigma and improve social attitudes toward mental health.
- Improve data accuracy, completeness, and timeliness through innovation and additional funding.
- Modernize mental health and substance use services.
- Increase access to mental health and substance use healthcare through full enforcement of the Mental Health Parity and Addiction Equity Act.
- Expand the mental health and substance use treatment workforce.
- Build community capacity for early identification and intervention for individuals with mental health needs.
- Promote diversity and culturally appropriate care in the healthcare system.
- Adopt trauma-informed and culturally competent policies and practices for youth-serving programs and agencies.

## SPECIAL FEATURE: COVID-19 and Trauma

Traumatic events of many types can cause damage at the individual, relationship, community, and societal level in direct and indirect ways. Research shows that trauma negatively affects health and well-being in a variety of ways.<sup>2</sup> For example, natural disasters (e.g., hurricanes and earthquakes) and manmade disasters (e.g., mass violence and nuclear accidents) are consistently associated with subsequent increases in the rates of post-traumatic stress disorder (PTSD), depression, anxiety, substance use, and youth behavior problems.<sup>3</sup> Traumatic events in childhood can have lasting effects on health and well-being, including higher risks of a wide range of chronic diseases and suicide as adults.<sup>4,5</sup>

In 2020, the COVID-19 pandemic created new, almost inconceivable heights of trauma, grief, stress, and isolation for many Americans. After the first COVID deaths in the United States in February 2020, the virus swept across the country, causing widespread illness (more than 30 million Americans have been diagnosed) and death (over half million Americans have died from COVID-19).<sup>6,7</sup> The harm from this acute illness, its extended recoveries and continued morbidity, and its deaths reverberates, from survivors and the deceased to families, friends, caretakers, and colleagues.

Cases, hospitalizations, and deaths have disproportionately affected certain populations, particularly racial/ethnic minorities, including American Indians, Blacks, and Latinos; older Americans; individuals with underlying medical conditions; and those living in congregate settings (e.g., nursing homes and prisons).<sup>8,9,10</sup> (For more on racial/ethnic disparities related to COVID, see page 13.)

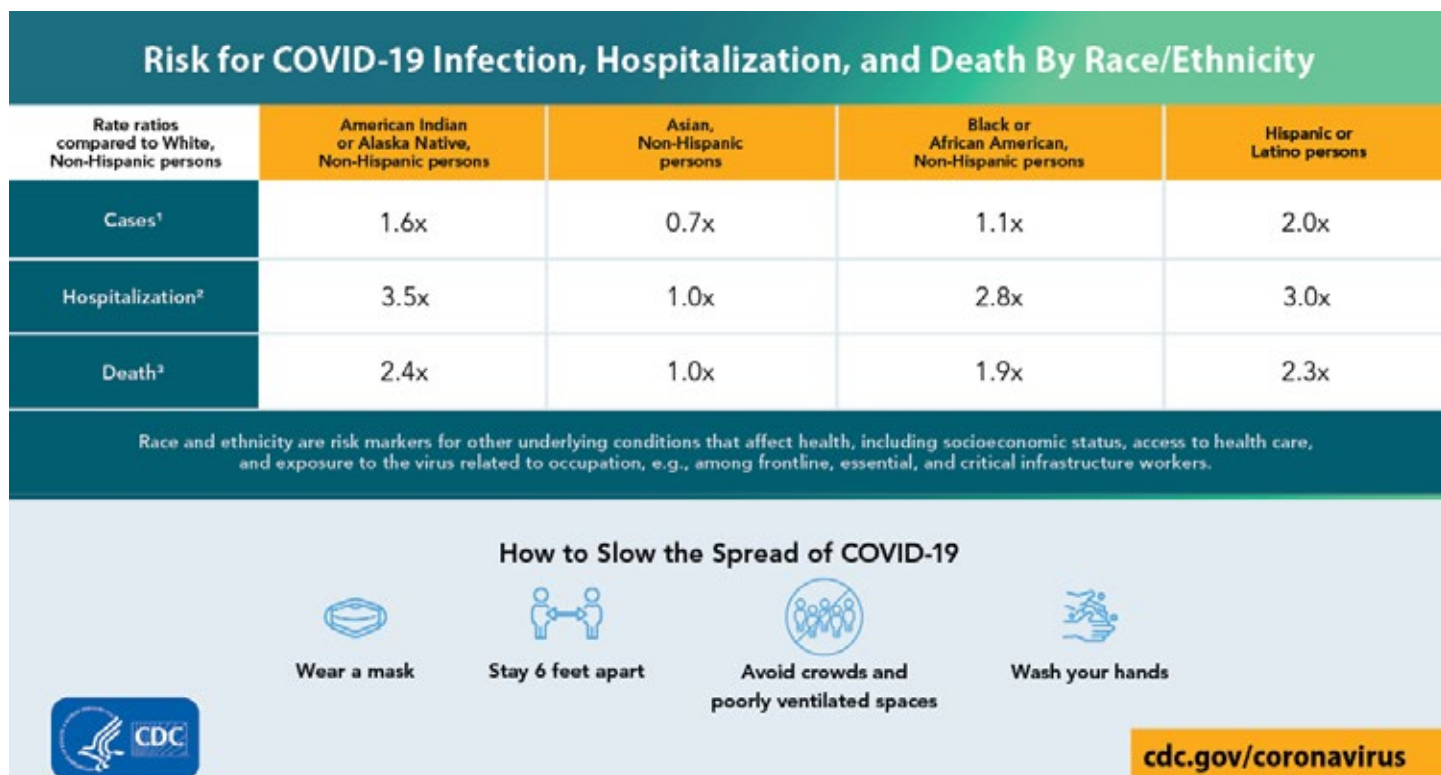
Indirect consequences have extended across the population—from general stress and anxiety about COVID and its ramifications to the downside costs of policies and norms that changed to reduce the spread of COVID and that touch different groups. Some of the changes to socializing, business, travel, and other aspects of daily life came with substantial trade-offs for certain people. Examples of indirect consequences include:

- New financial strain from business closures or modifications, or employment loss or reduction (for more on economic stress, see on page 12);
- Social isolation to maintain physical distance and reduce exposure to COVID;
- Learning loss and disruption in school-based services and supports (e.g., counseling services, lunch programs, child abuse reporting) due to school/childcare closures;

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## Risks for COVID-19 Infections, Hospitalizations, and Death By Race/Ethnicity



Source: CDC, April 15, 2021<sup>11</sup>

- Added stress and worry about health and COVID exposures, consequences of illnesses, healthcare coverage, school closures, etc.; and
- New challenges in maintaining a healthy lifestyle and managing new physical-distancing requirements, economic stress, food insecurity, gym/park closures, and inaccessible healthcare, including treatment for substance use disorders and mental healthcare.

Surveys and other data from the past year show a catastrophic situation: many Americans are struggling; they are unable to manage these new, overwhelming challenges; and they cannot maintain healthy coping strategies. The past decade, 2010–2019, already saw huge increases in alcohol,

drug, and suicide deaths; the data indicate that 2020 will be much worse regarding alcohol and drug use, mental health, and overdose deaths. Without extensive interventions, this traumatic year may continue to echo for decades to come. Furthermore, the differential impact on population groups is stark and must be considered carefully when designing policy solutions and programs. Four key trends during the COVID-19 pandemic from emerging data are:

### 1. More Americans in crisis

Available data points show extremely high call volumes to crisis lines at the beginning of the pandemic, with elevated levels continuing in subsequent months, as Americans struggled to manage with the pandemic:



- The number of March 2020 calls to the Disaster Distress Helpline at the Substance Abuse and Mental Health Services Administration (SAMHSA) was 891 percent higher than in March 2019.<sup>12</sup>
- The Crisis Text Line saw an increase in volume of 40 percent in March and April 2020.<sup>13</sup>
- Colorado's Crisis Services call and text lines saw a 33 percent increase in volume for March–October 2020 compared with the pre-pandemic volume.<sup>14</sup>

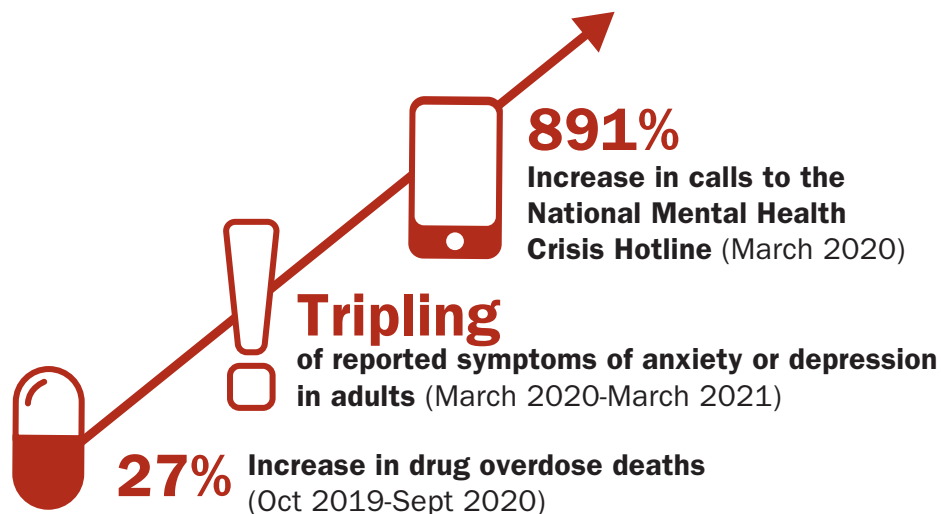
Increased distress held true for clinical settings as well. One study using data on emergency department visits from the Centers for Disease Control and Prevention (CDC) National Syndromic Surveillance Program found an increase in rates of emergency department visits for mental health conditions, suicide attempts, and drug overdoses between March–October 2019 and March–October 2020.<sup>15</sup>

On a positive note, these higher levels of crisis and distress do not appear to be translating to overall higher suicide rates immediately. Preliminary data show a decline in U.S. suicide deaths in 2020.<sup>16</sup>

## 2. Deteriorating mental health, particularly among certain populations

In 2019, CDC's National Health Interview Survey found 11 percent of adults ages 18 and older reported symptoms of anxiety disorder and/or depressive disorder.<sup>17</sup> That figure tripled by April 2020, and according to the U.S. Census Bureau and CDC's Household Pulse Survey more than one-third of adults ages 18 and older had symptoms of anxiety disorder or depressive disorder during the prior

During the COVID-19 Pandemic, there has been...



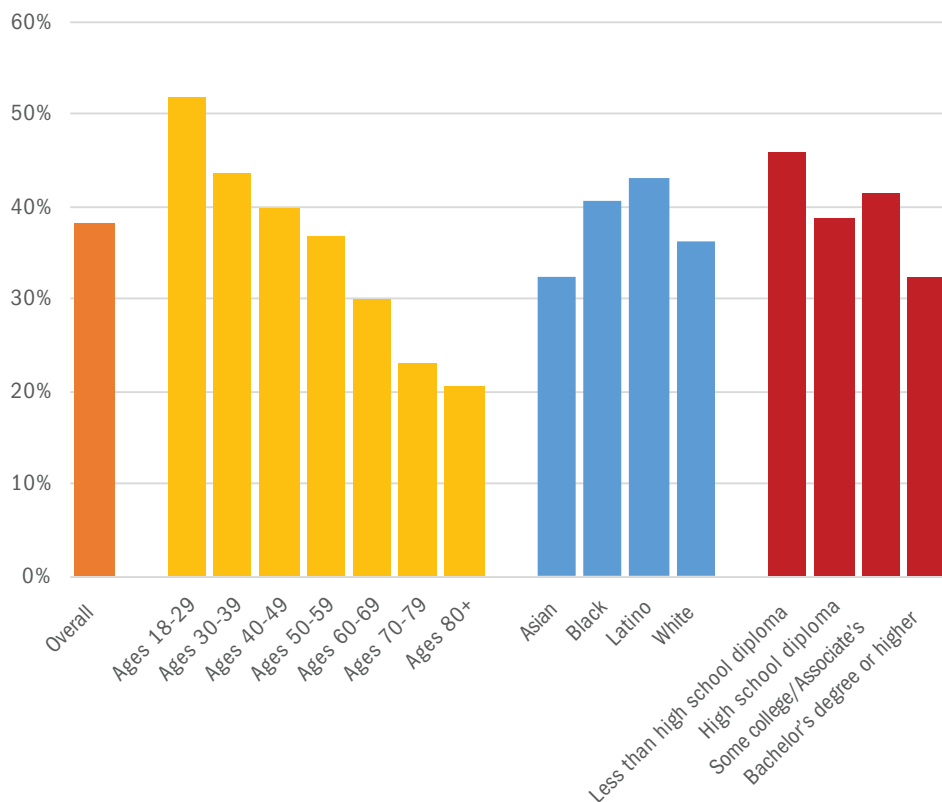
Source: ABC News; Household Pulse Survey, National Center for Health Statistics

week from April 2020 through March 2021 (the latest date available at time of analysis). This ranged from a low of 34 percent in May 14–19, 2020 to a high of 43 percent in November 11–23, 2020.<sup>18</sup>

The Household Pulse Survey shows variation in the rates of symptoms reported in different groups:

- Younger age groups have had higher rates of reported anxiety or depression symptoms between April 2020 and March 2021, with the proportion of 18- to 29-year-olds with symptoms consistently at two to two-and-a-half times that of groups ages 70 to 79 and 80 and older.<sup>19</sup> The average rates of those with symptoms of anxiety disorder or depressive disorder across the time period are: 52 percent of those ages 18 to 29, 44 percent of ages 30 to 39, 40 percent of ages 40 to 49, 37 percent of ages 50 to 59, 30 percent of ages 60 to 69, 23 percent of ages 70 to 79, and 21 percent of those ages 80 and older.

## Average Percent of Adults Reporting Anxiety or Depression Symptoms in Prior Week, by Demographic, April 2020–March 2021



Source: TFAH and WBT analysis of Household Pulse Survey data

- Latinos and Blacks have had notably higher rates of reported symptoms than whites and Asians. The average rates across the time period show 43 percent of Latinos, 41 percent of Blacks, 36 percent of whites, and 32 percent of Asians with reported symptoms of anxiety disorder or depressive disorder. Another CDC study confirmed that Latino adults had the highest levels of distress and in particular more stress from food insecurity and unstable housing compared with other racial/ethnic groups.<sup>20</sup>
- Reported symptoms of anxiety disorder or depressive disorder also vary by education levels. Individuals with a

college degree had lower average rates of symptoms (32 percent with symptoms), compared with those who did not complete high school (46 percent), those only with a high school education (39 percent), and those with some college/associate's degree (41 percent).

Likewise, Mental Health America found the number of people seeking online screening and resources for anxiety and depression on their website increased dramatically—with 93 percent more anxiety screens and 62 percent more depression screens in the first nine months of 2020 (January to September) compared with all of 2019. More people also reported moderate or severe symptoms for anxiety and depression, suicidal thoughts, and self-harm. Seven in 10 individuals with moderate/severe symptoms of anxiety and depression reported that loneliness or isolation were the top contributors to their mental health concerns.<sup>21</sup>

### 3. More substance use

Surveys consistently show increases in substance use during the COVID pandemic. One CDC study found during a June 24–30, 2020 survey, that overall 13 percent of adults “started or increased substance use [including drugs and alcohol] to cope with pandemic-related stress or emotions.” A number of groups increased substance use disproportionately: ages 18 to 24 (25 percent); ages 25 to 44 (20 percent); Blacks (18 percent); Latinos (22 percent); individuals without a high school education (22 percent); essential workers (25 percent); unpaid adult caregivers (33 percent); individuals with existing anxiety disorder (27 percent); individuals with existing depressive disorder (25 percent); and individuals with existing PTSD (44 percent).<sup>22</sup>

Another study, from the *Journal of the American Medical Association*, looked specifically at alcohol use. Comparing surveys from April 29–June 9, 2019, and May 28–June 16, 2020, the researchers found an increase in overall alcohol consumption for adults, with higher increases among women, adults ages 30 to 59 years, and whites.<sup>23</sup>

At the same time, there has also been disruption to substance use treatment. The National Association of Addiction Treatment Providers surveyed 165 organizations in August–September 2020 and found that 27 percent closed facilities or discontinued programming, 58 percent decreased new admissions since February 2020, and 66 percent saw revenue declines.<sup>24</sup>

#### **4. Higher rates of drug overdoses**

Drug deaths increased by 5 percent in 2019, driven by large increases in overdoses of synthetic opioids and psychostimulants, and the available data indicate that 2020 will be much worse. As more 2020 provisional drug overdose data from CDC's National Vital Statistics System becomes available, they show larger increases in the number of deaths from drug overdoses. The most recent data—covering October 2019 to September 2020—show a 27 percent increase in reported deaths over the prior 12 months. This is more than five times the increase seen in the official mortality data between 2018 and 2019, and the greatest rate of change in the provisional data since collection began in 2015.<sup>25</sup> It is unlikely that final 2020 data on drug overdoses will be available before December 2021.

Other studies looking at medical services further support the findings of increased fatal and nonfatal drug overdoses in 2020:

- A cross-section study using CDC's National Syndromic Surveillance Program data from emergency department visits from December 30, 2018, to October 10, 2020, found statistically significantly higher rates of all drug overdoses and opioid overdoses starting at the end of March 2020.<sup>26</sup>
- Virginia Commonwealth University's health system saw nonfatal opioid overdose visits to the emergency department more than double between March–June 2019 and March–June 2020. In contrast, visits for heart attack, another common reason for emergency visits, decreased between the two time periods.<sup>27</sup>
- Emergency medical services in Kentucky increased for opioid overdose calls after the state's March 6 emergency declaration in response to the COVID-19 pandemic. Specifically, the study found a 17 percent increase in opioid overdose calls leading to transportation to an emergency department, a 71 percent increase in runs with refused transportation, and a 50 percent increase in suspected opioid overdose deaths at the scene when comparing the 52 days after the declaration to the 52 days before it.<sup>28</sup>
- In Philadelphia, Pennsylvania, unintentional fatal and nonfatal opioid overdoses increased significantly among non-Hispanic Blacks, declined among non-Hispanic whites, and did not change for Hispanics between April–June 2019 and April–June 2020.<sup>29</sup>

## ECONOMIC STRESS FROM THE PANDEMIC

The COVID-19 pandemic has caused substantial harm and added anxiety to lives of Americans in many ways, including economic stress and uncertainty. There was a very large, immediate recession in spring 2020—more than 20 million Americans lost their jobs, and the unemployment rate reached an all-time high of 14.7 percent in April 2020.<sup>30,31</sup> Job losses disproportionately hurt women, Blacks, Latinos, and low-wage workers.<sup>32</sup>

By summer 2020, many Americans were back at work or receiving financial assistance, including unemployment insurance and economic impact payments.<sup>33</sup> However, there are still considerable, persistent effects for certain sectors and populations:

- As of March 2021, the overall unemployment rate had fallen to 6 percent, still substantially higher than 3.5 percent in February 2020.<sup>34</sup> Unemployment rates, however, have

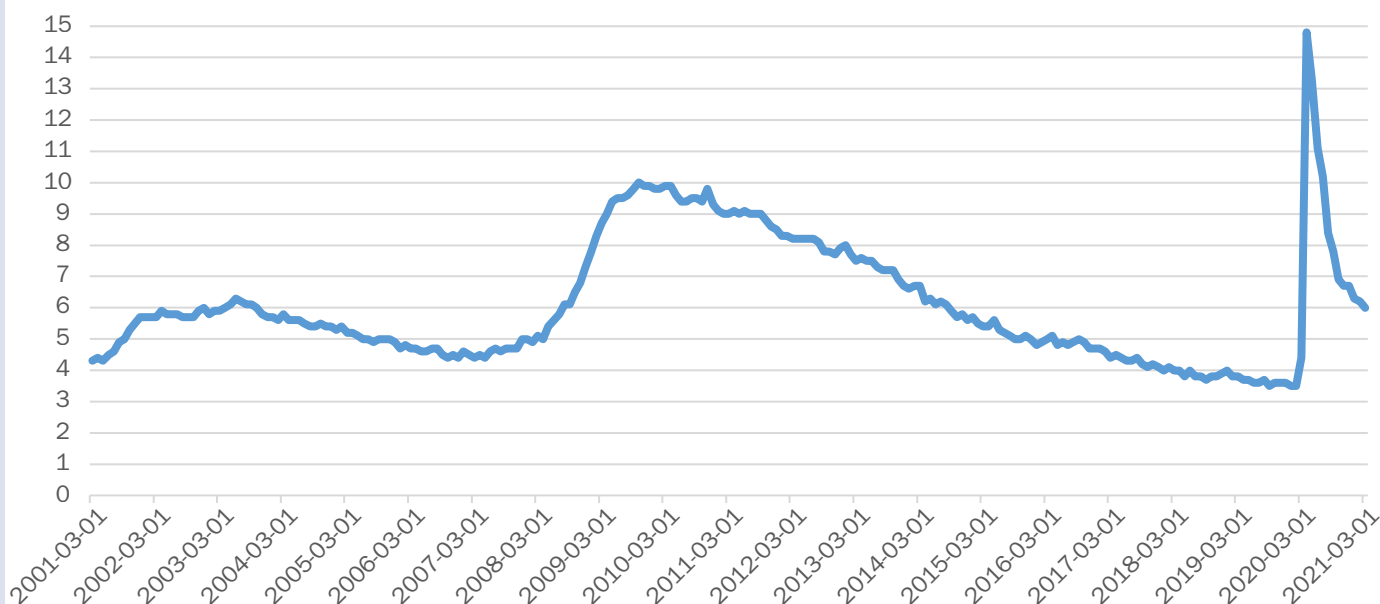
remained much higher for Blacks (9.6 percent) and Latinos (7.9 percent) as compared with whites (5.4 percent).<sup>35,36</sup>

- Small-business revenue, which could affect both owner as well as employee employment, wages, and financial and/or job security, also remained lower—down 19 percent between January 2020 and August 2020 (including a 48 percent decline in the leisure and hospitality sector's revenue), and an estimated 420,000 small businesses failed in the first half of 2020, a rate twice that of the prior year.<sup>37</sup>
- Food insecurity remained just above 20 percent of all households from April 2020 through early March 2021, twice the rate from prior years.<sup>38,39</sup> Food insecurity was even higher for Black and Latino households—with rates above 30 percent for food insecurity during the same time period.<sup>40</sup> The March 17–29, 2021 survey showed a

drop in food insecurity to 18 percent for all households—the first time below 20 percent during the pandemic—corresponding with the passage of American Rescue Plan of 2021 the prior week. The American Rescue Plan continued and expanded many social safety-net programs, including extending the emergency increase in Supplemental Nutrition Assistance Program benefits, continuing unemployment benefits, and providing a third economic-impact payment of up to \$1,400 per person (payments started March 12, 2021).<sup>41,42</sup>

Studies suggest that job loss, unemployment, and a poor economy are associated with higher rates of substance use, development or relapse of substance use disorder, and, in some studies, modestly higher suicide rates.<sup>43,44,45,46</sup> Another recent study found a link between food insecurity and suicidal behaviors.<sup>47</sup>

**Monthly Unemployment Rate in United States, March 2001–March 2021**



Source: U.S. Bureau of Labor Statistics

## COVID-19'S RACIAL/ETHNIC DISPARITIES

The COVID-19 pandemic has had a disproportionate impact on racial/ethnic minorities, with American Indian/Alaska Natives, Blacks, and Latinos having higher rates of COVID cases, hospitalizations, and death than whites. The data available on COVID and race/ethnicity is incomplete and potentially even worse than current estimates; nonetheless, different estimates come to the same conclusions: there has been a greater impact on racial/ethnic minorities.<sup>48,49</sup>

These higher rates of cases, hospitalizations, and death for American Indian/Alaska Natives, Blacks, and Latinos come both from a higher risk of exposure and infection (e.g., people of color disproportionately work in frontline and essential jobs during the pandemic or live in a multigenerational home) and worse outcomes after infection (e.g., preexisting health conditions or lack of healthcare access due to longstanding systemic inequities). These kinds of conditions, together called “social determinants of health” (SDOHs),

influence many kinds of health outcomes, including the risk of coronavirus infection and a worse disease course.

With respect to COVID, CDC suggests five SDOH risk factors that contribute to the racial/ethnic disparities:<sup>50</sup>

- 1. Discrimination:** chronic and toxic stress, as well as the influence of critical social and economic factors that shapes health and well-being.
- 2. Healthcare access and utilization:** higher uninsured rates, barriers to accessing healthcare, and distrust of the healthcare system.
- 3. Occupation:** higher rates of employment in essential work settings, less likely to work from home or have paid sick leave.
- 4. Education, income, and wealth gaps:** barriers to higher education, as well as lower paying and less flexible job opportunities.
- 5. Housing:** Crowded conditions and multigenerational households.

### Social Determinants of Health



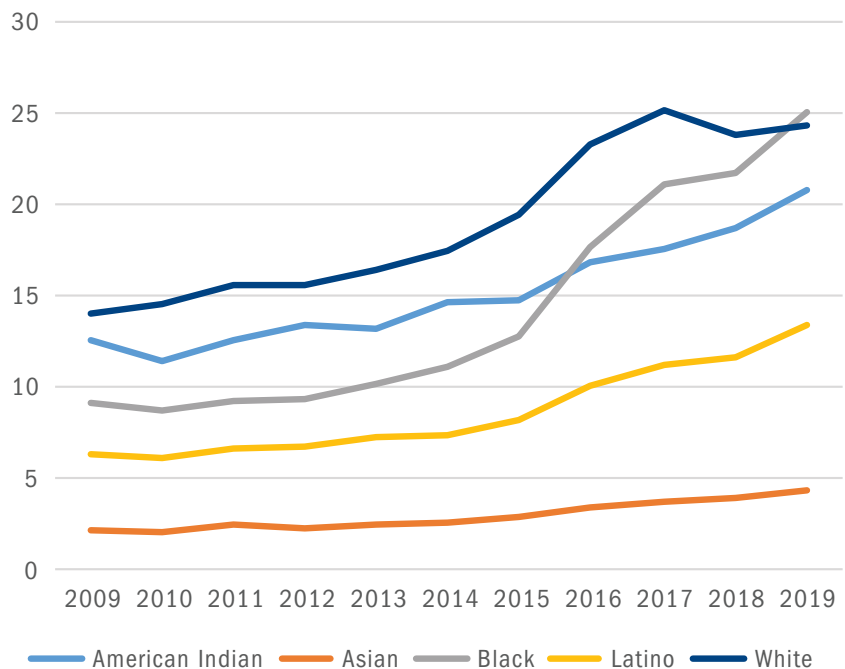
Source: CDC<sup>51</sup>

Beyond direct infection, the indirect consequences of the COVID-19 pandemic may adversely impact racial/ethnic minority communities in a number of ways. As discussed earlier in this section, Black and Latino households were more likely to experience job loss during the pandemic's resulting recession, have higher food insecurity, and were likely to have symptoms of anxiety or depression.<sup>52,53</sup>

Considering the disproportionate direct and indirect effects of COVID-19 on racial/ethnic minorities and the implications for mental health and substance use, policymakers should prioritize policies, programs, and funding on the populations most affected. This is particularly true

around substance use treatment and prevention. In the years before 2020 and the COVID-19 pandemic, racial/ethnic minorities had seen large increases in the rate of drug-induced deaths compared with the nearly stable rates among whites. Between 2016 and 2019, Blacks saw increases of 42 percent; Latinos: 33 percent; Asians: 30 percent; American Indians: 23 percent; and whites: 5 percent. In contrast to the decade between 2006 and 2015, Blacks had substantially lower rates of drug-induced deaths than whites; as of 2019, Blacks have a higher age-adjusted drug-induced death rate than any other race/ethnicity. (See Section 2, page 17, for more on mortality trends.)

**Annual Age-Adjusted Drug Induced Death Rate (Deaths Per 100,000) By Race/Ethnicity, 2009–2019**



Source: TFAH and WBT analysis of Household Pulse Survey data



## Q&A with Dr. John Rich: The Impact of Racial Trauma and Substance Use in Communities of Color

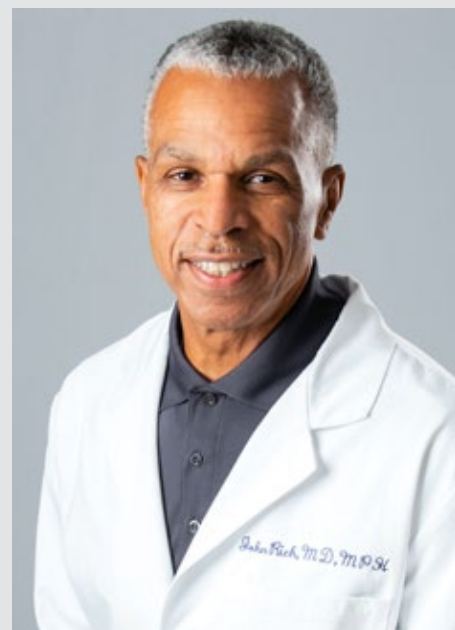
John A. Rich, M.D., MPH, is the Co-Director of the Center for Nonviolence and Social Justice and Professor at Drexel University School of Public Health

**TFAH:** You started your career as a primary care physician and you saw the impact of drug and alcohol misuse every day. How did that work lead you to your current focus on community health and the impact of trauma?

**Dr. Rich:** Yes, in my work in inner-city Boston and now in urban Philadelphia, we see that alcohol abuse and substance use are very much linked to the trauma and adversity people have experienced throughout their lives. But it is not only urban environments, or among people of color, in which we see this connection. The CDC's Adverse Childhood Experiences Study has shown that childhood trauma is almost ubiquitous, with two-thirds of people, regardless of their social class, reporting childhood adversity.<sup>54</sup> But in urban contexts, and in Black and Brown communities, there is the added effect of racial trauma. Racial trauma embodies both small acts of racism, such as being ignored when walking through a store or potentially followed, to overt racism, such as the police violence. We know that these experiences affect the mind and body in ways that can worsen chronic diseases. And these experiences can create emotional stresses that lead to self-damaging behaviors, such as excessive alcohol use. As we focus on the health of communities, we not only need to take a trauma-informed perspective—I prefer the term “healing informed”—we must also take account of the impact of racial trauma and ensure that our approaches to healing are racially just and culturally responsive.

**TFAH:** Tell us more about your work to design new models of healthcare and criminal justice that recognize and treat trauma.

**Dr. Rich:** My work is centered on creating opportunities for healing, particularly for young people, in the healthcare system—whether through primary care or as victims of violence. In each of these interventions—the first being the Young Men's Health Clinic, which I started in Boston; and more recently, Healing Hurt People, founded by my colleague and partner Dr. Ted Corbin—our goal has been to orient young people to the existence of physical, psychological, and racial trauma so they understand what is happening to them in the aftermath of these significant traumatic events. This orientation is critical so they do not turn to substances or other self-destructive behaviors as a result of the very intrusive symptoms of trauma. We then engage them in support to meet their concrete social needs, such as education, jobs, intervention with the legal system, or navigation through the healthcare and behavioral health systems in order to address the very real social determinants of health. As we meet these identified needs, we then engage them in culturally responsive healing. Such healing programs could be traditional evidence-based therapy delivered by a diverse staff. But they could also be engagement with music, movement arts, or yoga, because we know that the wounds of trauma are not physical and psychological alone; they are also spiritual.





**TFAH:** Some of your programs train young Black men to be peer health educators to other members of their community. Can such programs help change the trajectory of boys and young men within those communities? Can they play a role in addressing the deaths of despair crisis?

**Dr. Rich:** We believe that young people who have experienced trauma and have undertaken a healing journey are the real experts in fashioning new systems and in helping other young people heal. We know that young men of color are often stigmatized and judged, almost as though they are blamed for the traumas that have befallen them. Sometimes this happens at the hands of the very people who are supposed to be helping, such as therapists who have not done their own work to understand their implicit racial biases. We have launched a Community Health Worker Peer Training Academy to equip these amazingly talented young people of color with the skills and the certification to be able to support other young people who are embarking on a healing journey. Their role is to engage young people to help them navigate often unfriendly systems and to come away with a sense of normalcy, understanding that the effects of trauma can be felt by anyone. We've also worked to ensure that these young people, when they are hired by health centers or behavioral health organizations or youth organizations, have the certifications that will allow their services to be reimbursed under behavioral health Medicaid. This is critical for allowing these young people to have a viable and promising trajectory within healthcare and behavioral health.

**TFAH:** Recently released data showed a striking decline in mental health and suggest an increase in overdose deaths nationwide during the current pandemic. Are you concerned that COVID-19 will add to race-based trauma in the United States?

**Dr. Rich:** Already COVID has taken a devastating toll on the physical and behavioral health of communities of color. Not only are communities and individuals in those communities in a deep state of grief over the loss of family, friends, and trusted elders in the community, COVID has laid bare the reality that Black and Brown people suffer a disproportionate toll of pain from any and all health and public health problems. For example, the lack of healthcare providers who are Black and Brown is a direct result of the historical legacy of policies of exclusion in health professions' education. It is also true that the vaccine hesitancy we are seeing and hearing about among people of color is entirely understandable given what people have observed about the lack of equity in care for COVID and the lack of access to vaccines that is occurring across the country. The only way to address this is to take an aggressive stance to improve health equity not only for COVID but for all of the health and public health problems that are exacerbated by racism and inequity. Empowering communities through community health workers is one such strategy, but we must build that infrastructure before we are facing a crisis.

**TFAH:** As a member of the TFAH Board of Directors, you know a focus of TFAH's work is recommending policy actions to improve Americans' health and address health inequities. What are your top priorities for policies that should be implemented to advance health and well-being, particularly around mental health and substance misuse, in communities of color?

**Dr. Rich:** First, we must aggressively rebuild public health infrastructure across the country in both urban and rural settings. We must acknowledge that this public health infrastructure is critical not only for chronic diseases but also to stem the tide of the diseases of despair that come from disproportionate suffering, deaths, and racial trauma. We must promote place-based approaches focusing on those communities that have been most affected and devastated.

It has been quite disheartening to watch the evolution of the COVID-19 pandemic. When Black and Brown people were suffering and dying disproportionately from this infection, there was little concern about these unfair inequities from white communities. But when the vaccine appeared and we began as public health leaders to advocate for directing vaccinations first to those who are most at-risk, including Black and Brown communities, suddenly there were cries of "unfair" and public health leaders were accused of bias against white people. This argument was ludicrous. We must always focus on the most affected communities, whether we know all of the underlying reasons or not. Our policies must reflect a desire for health equity, which means meeting the needs of communities and focusing resources on those communities that are most in need of those resources. Finally, we must focus on greater diversity among healthcare providers and healthcare institution leadership, including boards of trustees and certainly leadership of public health institutions. This leadership is critical to ensuring that the issues that affect Black and Brown people are squarely placed in the high priorities and missions of these institutions.

# Mortality Data and Trends

Even before the pandemic, there was little progress in the nation's prevention of alcohol, drug, and suicide deaths. The most recent alcohol, drug, and suicide mortality data, from 2019, mostly show continuing trends, with small increases in alcohol-induced deaths and larger increases for drug deaths. On a positive note, suicide deaths declined, and certain groups saw declines in drug overdoses. More on these two notable trends:

**1. The age-adjusted suicide rate declined from 14.2 to 13.9 deaths per 100,000 from 2018 to 2019.** The decline was statistically significant and the first decrease of any kind since 2005.<sup>55</sup> Also promising is that the decreases were widespread, reaching across many demographic and geographic groups—the exceptions were slightly higher rates among adults ages 75 and older, Asians, and Blacks, and a stable rate for those living in the West. Even better, preliminary data show a further decrease in suicides in 2020, despite the COVID pandemic.<sup>56</sup>

**2. Drug-induced mortality trends continued to diverge in 2019—with small increases and even improvement in certain groups, areas, and types of drugs, and much worse trends elsewhere.**

- **Race/ethnicity:** Whites saw a small increase in drug-induced death rates, while all other race/

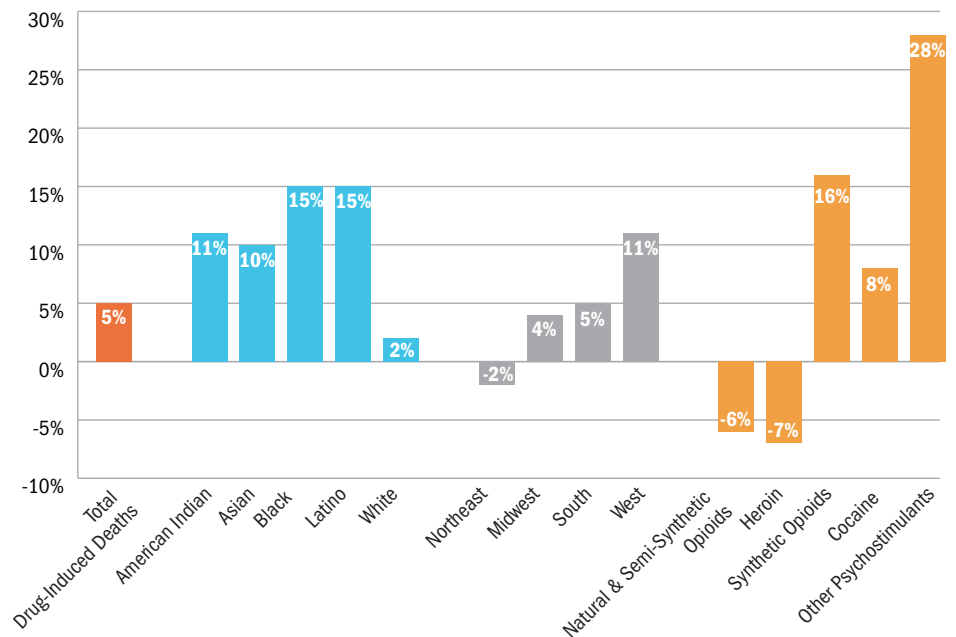
ethnicities saw four to six times the size of increase. Blacks, as of 2019, have a higher age-adjusted drug-induced death rate than any other race/ethnicity. This is a big change from most of the decade in which Black drug deaths were substantially lower than whites.

- **Region:** Drug-induced death rates declined among individuals in the Northeast, increased moderately in Midwest and South, and increased substantially in the West.
- **Drug types:** Natural and semi-synthetic opioids and heroin overdoses declined markedly while synthetic opioids, cocaine, and other psychostimulants saw very large increases.

Other trends in deaths from alcohol, drugs, and suicide are summarized below, followed by a state-by-state analysis. Additional data can be found in the appendices starting on page 36.

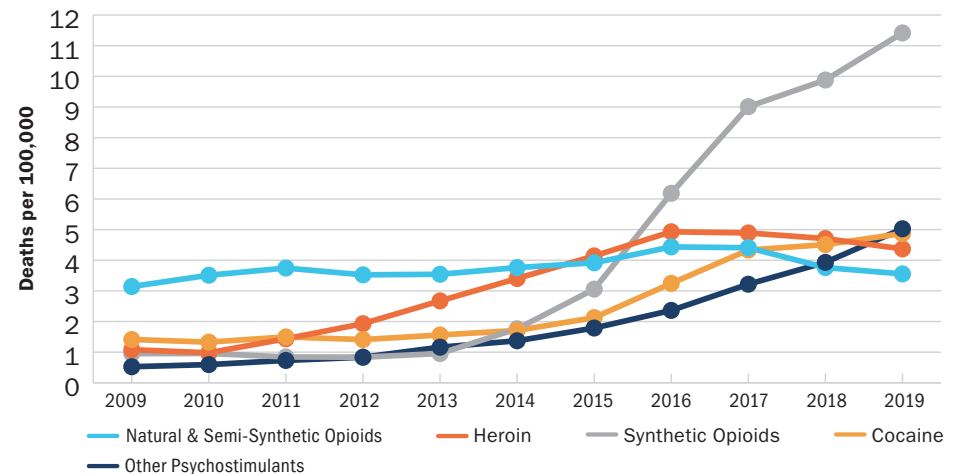
## Pain in the Nation: *Alcohol, Drug, and Suicide Epidemics*

### Percent Change in Age-Adjusted Rates of Drug-Induced and Drug-Specific Overdose Mortality, 2018-2019



Source: TFAH and WBT analysis of National Center for Health Statistics data

### Annual Age-Adjusted Mortality Rate (Deaths per 100,000) from Overdoses by Drug Type, 2009–2019



Source: TFAH and WBT analysis of National Center for Health Statistics data

## WHAT ARE OPIOIDS AND PSYCHOSTIMULANTS?

**Opioids** are a class of drug that have chemical structures similar to opium poppies and that interact with nerve cells to reduce pain and produce feelings of euphoria.<sup>57</sup> Natural opioids are sourced from opium poppies, semisynthetic opioids are synthesized from naturally occurring opium, and synthetic opioids are made entirely in a lab.<sup>58</sup>

Common side effects of opioid use include sedation, dizziness, nausea, vomiting, and constipation, and regular opioid use can lead to physical dependence, and misuse can lead to addiction and overdose.<sup>59,60</sup> Common prescription opioid drugs, due to increased prescribing, were the primary drivers of the opioid epidemic when it began in the late 1990s. In 2010, the crisis moved toward more potent and illicit opioids: first heroin and then, starting around 2013, synthetic opioids.<sup>61</sup>

The most common types of opioids include:

- **Natural/semisynthetic opioids.** The most common prescription opioids, like codeine, hydrocodone (including Vicodin), oxycodone (including OxyContin and Percocet), and morphine.
- **Heroin.** An illicit semisynthetic opioid that is twice as potent as morphine.
- **Synthetic opioids.** Extremely potent opioids, including fentanyl and carfentanil. Fentanyl is a medication that is 50 to 100 times as potent as morphine and most frequently used in anesthesia. Carfentanil is 10,000

times as potent as morphine and is used as a tranquilizer for large animals (e.g., elephants). Fentanyl and carfentanil, as well as their analogs, are also produced illicitly for nonmedical purposes and are extremely dangerous, proving deadly in just miniscule amounts.<sup>62,63</sup>

- **Methadone.** A medication used for pain management and to treat individuals with opioid use disorders; it reduces withdrawal symptoms and cravings, and blocks highs from other opioids. Methadone is a type of synthetic opioid, but it is typically grouped separately from other synthetic opioids (including in this report) because it is an effective treatment for opioid use disorder.

**Psychostimulants** 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., for attention deficit hyperactivity disorder), and some have the potential for misuse and serious health effects, including overdose death.<sup>64</sup> The psychostimulants most often involved in overdose deaths are **cocaine** (which has its own category) and a combined category called *other psychostimulants with abuse potential*, referred to in this report as **other psychostimulants**. They include methamphetamine, ecstasy, amphetamine, and prescription stimulants.<sup>65</sup>

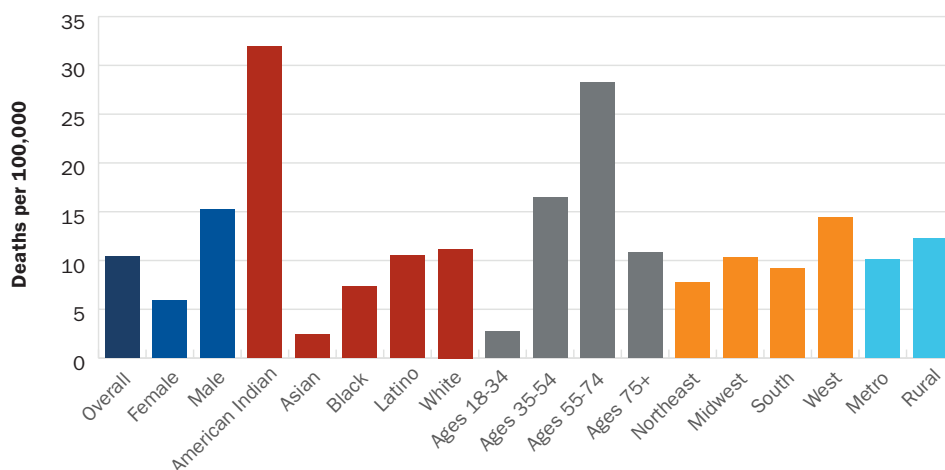
## Overall National Data and Trends

In total, there were 156,242 alcohol-induced, drug-induced, and suicide deaths—an age-adjusted rate of 45.7 deaths per 100,000—in the United States in 2019; this is slightly higher than 2018 and a 52 percent increase over 2009. Additional alcohol, drug, and suicide trends are below.

### Trends in Alcohol-Induced Deaths

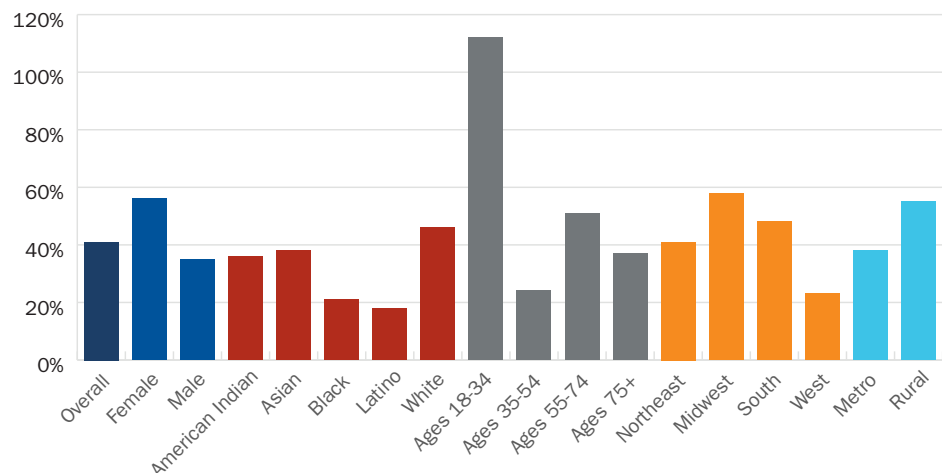
- In 2019, 39,043 Americans died from alcohol-induced causes, and 320,062 Americans died from alcohol-induced causes from 2010 to 2019. *Note:* Alcohol-induced deaths include alcohol poisoning, liver diseases, and other diseases; it does not include alcohol-attributable deaths, such as alcohol-related violence, accidental, or vehicle fatalities. In this report, alcohol deaths include alcohol-induced causes only.
- The rate of American deaths from alcohol-induced causes was 4 percent higher in 2019 compared with 2018, increasing from 9.9 to 10.4 deaths per 100,000 (age-adjusted rates). It was the 10th year of growth, and, in total, the alcohol death rate increased by 41 percent since 2009.
- Alcohol death rates in 2019 were highest among American Indians (31.9 per 100,000), adults ages 55 to 74 (28.3 per 100,000), males (15.2 per 100,000), and those living in the West (14.4 per 100,000).
- All groups had higher rates of alcohol deaths in 2019 compared with 2018, except for youth ages 0 to 17, who held steady.

### Age-Adjusted Alcohol-Induced Mortality Rate (Deaths per 100,000) Overall and by Select Demographics and Region, 2019



Source: TFAH and WBT analysis of National Center for Health Statistics Data

### Percent Change in Alcohol-Induced Mortality Rates by Select Demographics and Region, 2009–2019



Source: TFAH and WBT analysis of National Center for Health Statistics Data

## Trends in Drug-Induced Deaths

- In 2019, 74,511 Americans died from drug-induced causes, and 566,257 Americans died from drug-induced causes from 2010 to 2019. *Note:* Drug-induced deaths is a slightly wider category than drug overdose deaths, and is used because it allows for combining total alcohol, drug, and suicide deaths.
- The rate that Americans died from drug-induced causes was 5 percent higher in 2019 compared with

2018, up from 21.8 to 22.8 deaths per 100,000 (age-adjusted rates). Since 2009, the drug death rate has increased by 80 percent.

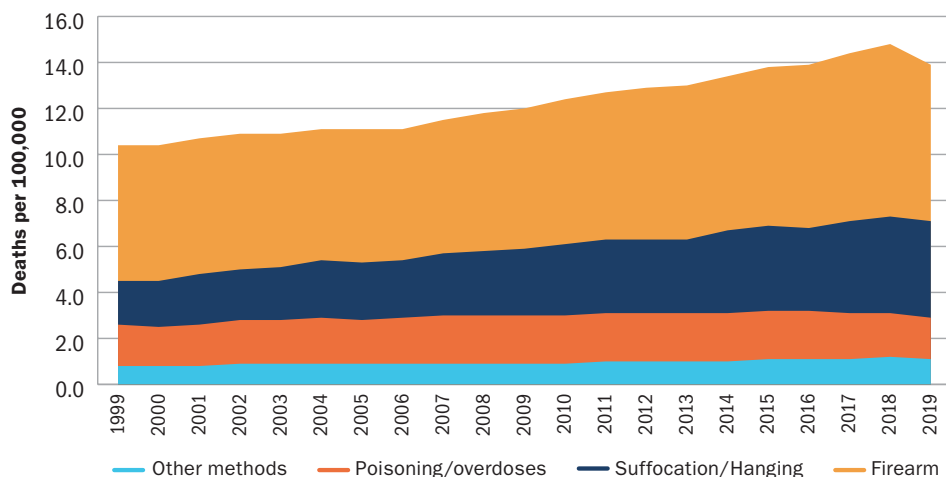
- Drug death rates in 2019 were highest among adults ages 35 to 54 (40.6 per 100,000), males (31.1 per 100,000), those living in the Northeast (28.8 per 100,000), young adults ages 18 to 34 (28.4 per 100,000), Blacks (25.1 per 100,000), and whites (24.3 per 100,000).



## Trends in Deaths by Suicide

- In 2019, 47,511 Americans died from suicide, and 434,643 Americans died from suicide between 2010 and 2019.
- Suicide rates decreased by 2 percent in 2019 compared with 2018, though rates are still 19 percent higher than in 2009. (See beginning of section for more demographic analysis).
- Trends over time differ based on method of suicide. Suicide by gun and suffocation/hanging have both increased substantially over the last decade. Between 2009 and 2019, gun suicides increased 16 percent and suffocation/hanging suicides increased 42 percent. All other methods, including poisoning/overdose, increased by 4 percent over the same time period.
- Deaths by suicide in 2019 were highest among males (22.4 per 100,000), those living in non-metro areas (18.9 per 100,000), whites (15.7 per 100,000),

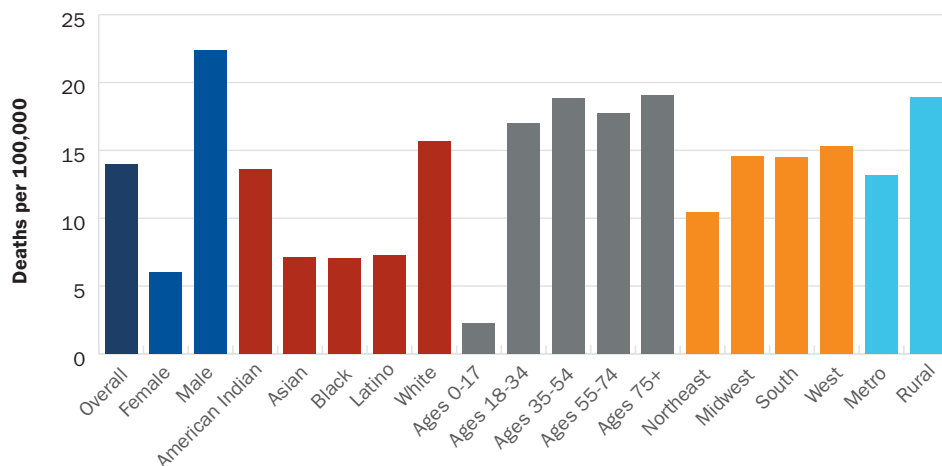
## Annual Age-Adjusted Suicide Rate (Deaths Per 100,000) By Suicide Method, 1999–2019



Source: TFAH and WBT analysis of National Center for Health Statistics data

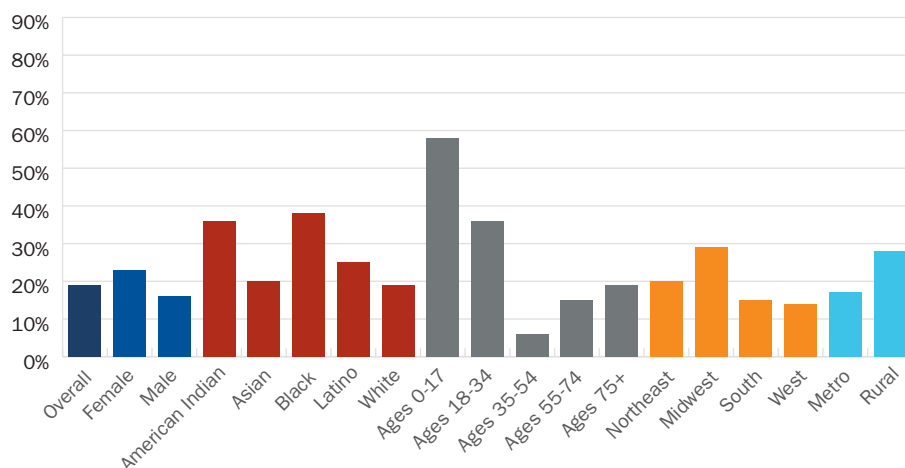
and American Indians/Alaska Natives (13.5 per 100,000). In 2019, half of suicides were by firearm, 29 percent were by suffocation/hanging, 13 percent were by poisoning/overdose, and 8 percent were by other methods.

## Age-Adjusted Suicide Mortality Rate (Deaths per 100,000) Overall and by Select Demographics and Region, 2019



TFAH and WBT analysis of National Center for Health Statistics data

## Percent Change in Suicide Mortality Rates by Select Demographics and Region, 2009–2019



TFAH and WBT analysis of National Center for Health Statistics data

## DATA LIMITATIONS: WHAT THIS DATA DOES NOT SAY ABOUT DRUG OVERDOSES?

This section focuses on mortality from alcohol, drugs, and suicide in 2019 and other recent trends. It doesn't capture local trends, what has happened in 2020 or 2021 (as mortality data from those years were not available at the time of the report issuance), nor the full burden of these epidemics beyond mortality, such as nonfatal overdoses and substance use disorders. Other factors to consider when looking at overdose data are:

- A reduction in fatal overdoses may indicate a successful harm-reduction strategy (e.g., naloxone is reversing more overdoses) but not an improvement in underlying issues.
- Mortality reporting policies and capacity, particularly regarding identifying drug type in overdoses, vary by state and could artificially lower mortality rates for synthetic opioids and other specific drug types.
- A particularly lethal or adulterated batch of illicit drugs may cause a cluster of deaths and drive overdose rates in low-population states. For example, roughly half of the synthetic-opioid overdose deaths in Alaska in 2017 occurred in Anchorage over a three-week period.<sup>66</sup>



## MENTAL HEALTH, SUBSTANCE USE, AND TREATMENT IN 2019

In addition to the thousands of Americans who die from alcohol, drug, and suicide annually, many more Americans struggle with suicidal crises, substance use, mental illness, and poor well-being. Below are related indicators from two 2019 surveys. Notably, suicidal behaviors and mental illness have increased over the past decade, particularly among younger Americans.

### Youth Risk Behavior Survey

- **Substance use among high schoolers:** In 2019, 22 percent of high schoolers reported using marijuana and 29 percent reported using alcohol in the past 30 days.<sup>67</sup> Over the past decade, most types of substance use among high schoolers has declined significantly, including lifetime alcohol, cocaine, methamphetamine, and heroin use. Lifetime marijuana use between 2009 and 2013 and decreased between 2013 and 2019.
- **Suicidal ideation and attempts among high schoolers:** Overall, 19 percent of high schoolers reported seriously considering a suicide attempt, 16 percent made a suicide plan, and 9 percent attempted suicide in 2019. High schoolers who identify as lesbian, gay, or bisexual (LGB) or who reported having sex with same-sex partners had significantly higher rates of suicide ideation and attempts than their classmates who identified as heterosexual and reported only opposite-sex partners. Almost half (47 percent) of LGB high schoolers and more than half (54 percent) of high schoolers who reported having sex with same-sex partners reported seriously considering attempting suicide compared with 15 percent of heterosexual high schoolers and 19 percent of high schoolers who reported only opposite-sex sexual partners.<sup>68</sup>

### National Survey on Drug Use and Health

- **Alcohol use among Americans ages 12 and older:** In 2019, half of all Americans reported drinking alcohol in the past month, 24 percent reported binge drinking (five or more drinks on the same occasion for males and four or more for females) in the past month, and 6 percent reported heavy alcohol use (binge drinking five or more days in the past month). Both binge drinking and heavy alcohol use has declined since 2015. Over the past two decades, alcohol use among adolescents ages 12 to 17 and young adults ages 18 to 25 has declined substantially (from 18 percent of adolescents in 2002 to 9 percent in 2019, and from 61 percent of young adults in 2003 to 54 percent in 2019).
- **Drug use among Americans ages 12 and older:** In the past year, 21 percent of Americans reported using illicit drugs

(which includes marijuana most frequently plus drugs like cocaine, heroin, and methamphetamines, as well as the misuse of prescriptions drugs). Illicit drug use has increased since 2015, when 18 percent of Americans reported illicit drug use, and that increase appears to be driven by higher marijuana use among adults ages 26 and older.

- **Alcohol and substance use disorders among Americans age 12 and older:** In 2019, 5 percent of Americans met the criteria for alcohol use disorder and 3 percent for substance use disorder. Alcohol use disorders have declined by 8 percent in 2002, while substance use disorders have been stable since 2015 (comparative data before 2015 is unavailable).
- **Substance use treatment among Americans ages 12 and older:** In 2019, 8 percent of Americans met the criteria of needing substance use treatment and only 2 percent of them received substance use treatment, leaving a gap of 6 percent of Americans in need of treatment. These numbers have been stable for since 2015. Self-help groups and outpatient rehabilitation were the most common types of treatment in 2019.
- **Mental illness among adults:** In 2019, 21 percent of adults ages 18 and older met criteria for a mental, behavioral, or emotional disorder in the past year, including 9 percent with a serious mental illness. The prevalence of mental illness and serious mental illness has increased since 2008 (when 18 percent of adults had any mental illness and 4 percent had a serious mental illness). Young adults ages 18 to 25 had particularly large increases in both any mental illness (increased from 19 percent in 2008 to 29 percent in 2019) and serious mental illness (increased from 4 percent in 2008 to 9 percent in 2019), while adults ages 50 and older had stable rates over the time period.
- **Mental health services among adults:** In 2019, 16 percent of adults ages 18 or older received mental health services in the past year (up from 13 percent in 2002). Less than half of (45 percent) with a mental illness received mental health services—although this is higher than in 2008 (when it was 41 percent).
- **Suicidal thoughts and behaviors among adults:** In 2019, 5 percent of adults ages 18 or older seriously considered suicide in the past year, 1 percent made a suicide plan, and less than 1 percent made a nonfatal suicide attempt. The number of adults with suicidal thoughts and plans has increased since 2008; nonfatal attempts have been flat.<sup>69</sup>

## State Analysis

The rates and trends for deaths caused by alcohol, drugs, and suicide vary across regions and states. A state-level analysis follows, and charts on page 38 in Appendix C have state-level data on alcohol, drug, suicide, opioid, and synthetic-opioid deaths and death rates.

- **Deaths from alcohol, drugs, and**

- suicides.** In 2019, 31 states and the District of Columbia saw higher rates of death from alcohol, drugs, and suicide compared with 2018. Between 2009 and 2019, all states' alcohol, drug, and suicide mortality rates increased by double digits, and six states and the District of Columbia more than doubled.

- States with the highest age-adjusted death rates from alcohol, drugs, and suicide in 2019 were New Mexico (88.0 per 100,000) and West Virginia (85.1 per 100,000).
- States with the lowest age-adjusted death rates from alcohol, drugs, and suicide in 2019 were Texas (32.7 per 100,000) and New York (33.5 per 100,000).

- **Alcohol-induced deaths.** In 2019, 41 states had higher alcohol death rates compared with 2018.

- States with the highest age-adjusted alcohol death rates in 2019 were New Mexico (34.3 per 100,000) and Wyoming (28.5 per 100,000).

- States with the lowest age-adjusted alcohol death rates in 2019 were Hawaii (5.9 per 100,000) and Maryland (6.2 per 100,000).

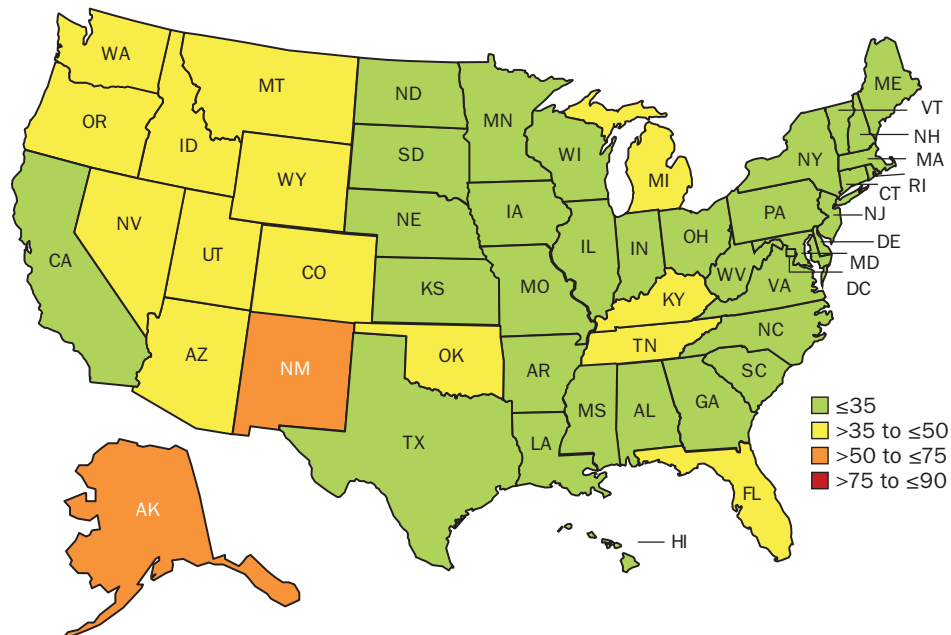
- **Drug-induced deaths.** In 2019, 33 states plus the District of Columbia had higher drug-induced drug rates compared with 2018.

- States with the highest age-adjusted drug death rates in 2019 were West Virginia (56.6 per 100,000) and Delaware (48.7 per 100,000).
- States with the lowest age-adjusted drug death rates in 2019 were Nebraska (9.5 per 100,000) and South Dakota (11.0 per 100,000).

- **Deaths by suicide.** In 2019, 19 states had higher suicide death rates compared with 2018.

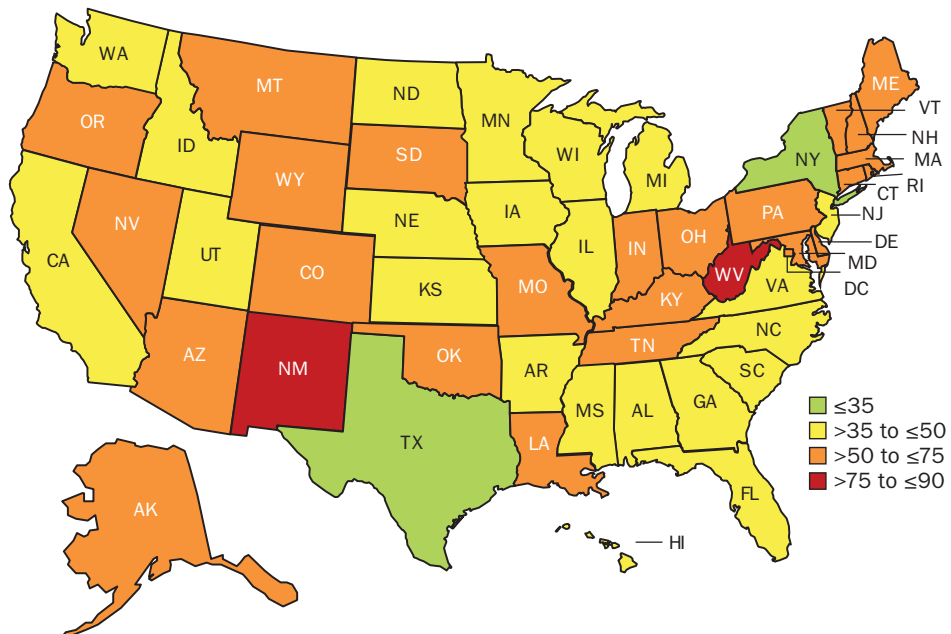
- States with the highest age-adjusted suicide rates in 2019 were Wyoming (29.3 per 100,000) and Alaska (28.5 per 100,000).
- States with the lowest age-adjusted suicide rates in 2019 were New Jersey (8.0 per 100,000) and New York (8.3 per 100,000), plus the District of Columbia (6.2 per 100,000).

### Age-Adjusted Rate of Alcohol, Drug, and Suicide Deaths (per 100,000), 2009



Source: TFAH and WBT analysis of National Center for Health Statistics Data

### Age-Adjusted Rate of Alcohol, Drug, and Suicide Deaths (per 100,000), 2019



Source: TFAH and WBT analysis of National Center for Health Statistics Data

# Pain in the Nation: *Alcohol, Drug, and Suicide Epidemics*

## Solutions and Recommendations

Policymakers looking to reduce alcohol, drug, and suicide deaths and improve mental health and well-being must now also work on healing the country from the pandemic and its ripple effects, all while continuing to address ongoing trends that existed prior to the pandemic. Trust for America's Health and Well Being Trust continue to call for a multipronged policy approach to stem the alcohol, drug, and suicide epidemics, including implementation of the following actionable solutions and recommendations. The solutions and recommendations fall into three buckets and most focus on federal and state governments.

### 1: Invest in Prevention and Conditions that Promote Health

- **Reduce traumatic experiences and promote resilience in children, families, and communities** by supporting policies and programs that reduce violence, unstable housing, and racial and ethnic discrimination—which have a long-term impact on preventing substance use, promote better mental health, and reduce economic hardship. Congress should increase funding for CDC research on and implementation of effective strategies to reduce and mitigate Adverse Childhood Experiences (ACEs). Resources should go to communities with an elevated risk of ACEs and personnel should reflect community composition.
- **Expand substance use prevention, mental health, and resiliency programs in schools.** Specifically, schools need support to increase:

  - (1) staff training in screening and responding to childhood trauma;
  - (2) social and emotional learning programs including evidence-based life- and coping-skills curriculum like the Good Behavior Game; and
  - (3) culturally appropriate mental health and other services including additional counselors, mental health professionals, mental health literacy programs for students and teachers, and regular mental health screenings. Congress should increase funding for federal programs that support evidence-based prevention programs in schools, promote protective factors, and reduce risk behaviors, including CDC's Division of Adolescent and School Health. Low-income communities where school-district funding is lower than average should receive priority.
- **Bolster crisis intervention programs and supports.** Increase federal funding of crisis-intervention services and supports for at-risk populations, such as crisis hotlines—including the forthcoming 988 hotline—with ready linkages to services, and support comprehensive crisis-intervention programs that include connectedness, reducing access to lethal means, teaching coping and problem-solving skills, providing

evidence-based treatments, and strengthening delivery and access to care. Government should support boosting of funding for state and local health departments to implement suicide-prevention programs, such as mobile crisis intervention services and comprehensive suicide-prevention planning. Congress should also ensure sustainable funding through braiding and blending of grants and reimbursement from Medicaid.



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## PREVENTING ADVERSE CHILDHOOD EXPERIENCE

Adverse childhood experiences (ACEs) are potentially traumatic events that happen between ages 0 and 17 like abuse or neglect, witnessing violence at home or in the community, having a family member attempt or die by suicide, and having household members with substance use or mental health problems. Research shows that these experiences can have lasting effects on health and well-being throughout life from an increased risk of injury, chronic illness, and suicide.<sup>70,71,72</sup>

COVID-19 has had a substantial impact on children. Many children in the United States have experienced disruptions in school and childcare, leading to potential loss of learning and separation from school supports; isolation from friends, school, and social settings; food insecurity and familial economic concerns; general fear and uncertainty; and potentially heightened abuse and substance use in the household.<sup>73,74</sup> Focusing on reducing the harm from COVID and preventing additional ACEs among children through proven policies and interventions is especially important given the compound stress and potential trauma COVID has introduced. Otherwise, the lasting impact on health and social outcomes may be felt for decades to come.

Preventing ACEs is a CDC Injury Center priority, and in 2020, CDC awarded a number of grants in this area, including four to states to boost state surveillance capacity (Georgia, Connecticut, Massachusetts, and Michigan) and three to researchers evaluating prevention strategies at Research Triangle Institute, University of Nebraska, Lincoln, and Prevent Child Abuse America.<sup>76</sup> Additional grants are expected in 2021. The Social-Emotional Learning Initiative in the U.S. Department of Education also funds grants for evidence-based, field-initiated innovations that address student social, emotional, and cognitive needs.<sup>77</sup>

CDC Framework for Preventing ACEs	
Strategy	Approach
<b>Strengthen economic supports to families</b>	<ul style="list-style-type: none"> <li>• Strengthening household financial security</li> <li>• Family-friendly work policies</li> </ul>
<b>Promote social norms that protect against violence and adversity</b>	<ul style="list-style-type: none"> <li>• Public education campaigns</li> <li>• Legislative approaches to reduce corporal punishment</li> <li>• Bystander approaches</li> <li>• Men and boys as allies in prevention</li> </ul>
<b>Ensure a strong start for children</b>	<ul style="list-style-type: none"> <li>• Early childhood home visitation</li> <li>• High-quality child care</li> <li>• Preschool enrichment with family engagement</li> </ul>
<b>Teach skills</b>	<ul style="list-style-type: none"> <li>• Social-emotional learning</li> <li>• Safe dating and healthy relationship skill programs</li> <li>• Parenting skills and family relationship approaches</li> </ul>
<b>Connect youth to caring adults and activities</b>	<ul style="list-style-type: none"> <li>• Mentoring programs</li> <li>• After-school programs</li> </ul>
<b>Intervene to lessen immediate and long-term harms</b>	<ul style="list-style-type: none"> <li>• Enhanced primary care</li> <li>• Victim-centered services</li> <li>• Treatment to lessen the harms of ACEs</li> <li>• Treatment to prevent problem behavior and future involvement in violence</li> <li>• Family-centered treatment for substance use disorder</li> </ul>

Source: CDC<sup>75</sup>

## 988: THE NEW NATIONAL CRISIS HOTLINE

The Senate passed the National Suicide Hotline Designation Act in May 2020, the House of Representatives passed it in September 2020, and former President Donald Trump signed it into law in October 2020. The Act requires the Federal Communications Commission to designate 988 as the new phone number for a national suicide-prevention and mental health crisis hotline, in the same vein as the emergency 911 hotline. The 988 crisis line will take the place of the national suicide-prevention hotlines, a 10-



digit 800-number administered by SAMSHA, and a Veterans Crisis Line administered by the U.S. Department of Veterans Affairs. The act requires SAMSHA to support training and services for high-risk populations, including LGBTQ youth, American Indians/Alaska Natives, and individuals living in rural areas.<sup>78</sup> In July 2020, the Federal Communications Commission adopted rules requiring that all service providers route 988 calls to the National Suicide Prevention Line by July 16, 2022.<sup>79</sup>

- **Reduce availability of illicit opioids and unnecessary prescriptions** through responsible opioid prescribing practices, including compliance with the CDC Guideline for Prescribing Opioids and support for high-functioning Prescription Drug Monitoring Programs. Expand public education about misuse and safe disposal of unused drugs, including through support for Drug Enforcement Administration's National Prescription Drug Take Back Day. Federal officials should maintain support for "hotspot" monitoring, like the Overdose Detection Mapping Application Program as well as interventions and antitrafficking strategies focused on heroin, fentanyl, and other illicit drugs. After multifaceted initiatives to promote appropriate prescribing, the rate of opioid prescriptions declined each

year from 2012 to 2019—and in 2019, the prescribing rate fell to the lowest in 14 years.<sup>80</sup>

- **Lower excessive alcohol use through evidence-based policies**, such as by increasing pricing, reducing sales hours, and limiting density of alcohol outlets; enforcing underage drinking laws; and holding sellers and hosts liable for serving minors. CDC has recently awarded grants to expand technical assistance and training on strategies to reduce excessive alcohol use.<sup>81</sup> The federal government should support these efforts with continued funding.
- **Limit access to lethal means of suicide** by promoting safe storage of medications and firearms through public education and laws; restricting access to firearms for children and individuals in crisis or at-risk of

suicide; and providing education and creating protocols for healthcare providers, counselors, and first responders on how to interact with and counsel patients and families to create safe environments. For example, universal background checks for gun purchases and extreme risk protection orders should be implemented nationwide, and programs to engage stakeholders—like the gun shop project which educates gun stores on suicide prevention—should be expanded; and healthcare providers should be trained in lethal mean counseling. The Counseling on Access to Lethal Means model improves medication and firearms storage behavior—with one study, focusing on parental counseling for suicidal youth in the emergency department, finding 100 percent firearms lockup at follow-up.<sup>82</sup>



## Q&A with Dr. Kelly Clark: Treating Substance Use Disorders in 2021

Kelly J. Clark, MD, MBA, DFAPA, DFASAM, is the founder and President of Addiction Crisis Solutions, a company focused on transforming addiction care into an evidence-based, cost-effective practice.

**TFAH:** What are the biggest barriers for individuals with substance use disorders to getting care? What about barriers to recovery?

**Dr. Clark:** The biggest barrier to people getting care is a lack of an appropriate addiction treatment infrastructure in the United States. The addiction treatment industry developed outside of both medical and mental health treatment systems. This separate addiction treatment industry means that evidence-based and quality driven care, as used in medical settings, has never been required. Most mental health programs and individual providers do not address addiction issues. Even we psychiatrists rarely choose to treat addiction, perhaps because during four years of post-medical school training we have just one month of addiction training. Most treatment programs don't even provide the baseline quality of care service of access to FDA approved medications to treat addiction, and because of the lack of independent oversight and certification, there is no way for individuals with substance use disorders, their families, referring physicians, or even their health plans to know whether a specific program gives appropriate care—or whether the care is likely to be harmful.

In addition, discrimination and stigma against people with addiction is a clear barrier, as well as a need for the country to immediately invest in training a more robust addictions treatment workforce.

**TFAH:** Recently data showed a striking decline in mental health and an increase in drug overdose deaths nationwide during the COVID-19 pandemic. How has the pandemic affected patients and their healthcare?

**Dr. Clark:** Significant numbers of people have had worsening of their anxiety and depressive symptoms during the pandemic, although suicides have decreased. Additional stress has been felt, particularly by people with children in the home, with lower income levels, and essential workers.

There has also been a significant increase in alcohol consumption and hospitalizations for alcohol related liver disease, particularly in the unusual demographic of women in their 20s and 30s. People identify boredom, increase availability, and increased stress as reasons for their increased alcohol use during COVID.

As for changes in healthcare: access to in-person care has decreased. Many psychiatric and addiction treatment programs closed during the beginning of the pandemic, and many of the dedicated beds were converted to treat COVID-19. Many of those have not been returned to the less profitable psychiatric or addiction beds. However, there has been an explosion of the use of telemedicine for mental health and addiction services, made possible by relaxation of federal and state constraints. Both patients and providers are happy with this change, and we can expect it to continue.





**TFAH: How has drug overdose and substance use disorder treatment evolved over the past two decades? What aspects still need improvement?**

**Dr. Clark:** Addiction medicine is now recognized subspecialty, a large body of research and information has been developed, and there have been tremendous advances.

We now have three FDA approved medications to treat opioid addiction with clear evidence that these medications save lives, and three FDA approved medications to treat Alcohol Use Disorder. Recent evidence shows a combination of two medications is effective in treating about one in seven people with methamphetamine use problems. We also have rescue medication (naloxone) for opioid overdoses that's widely available. And there are specific types of talk therapies, as well as behavioral therapies like contingency management, which have been shown to be effective. Having federal and state parity laws that require a range of healthcare plans to cover mental health and addiction conditions is also a huge step.

However, we have many areas that need improvement. Most providers are not utilizing these medications and patients do not demand them. There is no FDA approved medication for stimulant addiction, and the best behavioral program includes several months of intensive outpatient treatment with contingency management approaches outlawed by some federal health plans. State certification for treatment programs is variable with little true requirement that evidence-based approaches must be used by trained clinicians. Furthermore, we are without enforcement of the federal parity laws. We do not require physicians, nurses, social workers,

psychologists to become even minimally competent in the appropriate treatment of persons with addiction.

**TFAH: How can the healthcare system improve patient care and better support families as related to drug overdoses and substance use disorders?**

**Dr. Clark:** The healthcare system and providers can do a lot better. Healthcare systems can start by hiring physicians who specialize in addiction medicine and building evidence-based treatment programs. They should also demand parity payments from healthcare plans, including Medicaid and commercial plans, so these programs can become self-sustaining.

Healthcare providers need to stop referring people to programs which do not provide appropriate care. We must treat addiction as the chronic brain disorder that it is, and people suffering from addiction with the same respect, compassion, and quality of care as when that same person is suffering from any other disease.

We all tend to be uncomfortable with brain diseases. But the stigma around addiction and the lack of training permeates our health system. Many healthcare providers feel lost in dealing with patient's addiction—they just don't know what proper care is. They send patients to local legacy programs which might not provide quality care or trained clinicians. If the patient does not benefit from the insufficient care, then the referring provider, the patient, and the patient's family too often think "treatment does not work" or blame the patient for "not trying hard enough."

The healthcare system should treat this as any other condition, which require investment in infrastructure building and quality control but will dramatically save money and lives.

**TFAH:** What can non-health sectors (e.g. schools, private workplaces) and local communities contribute to reducing substance misuse?

**Dr. Clark:** Different programs are useful depending on the setting. For example, employers can demand appropriate benefit design and network adequacy to cover evidence-based care and not cover poor-quality programs. All health care providers and communities can promote safe disposal to help ensure every home free of unused medications. Families can decide that, as a rule, children and young adults should almost never take an opioid for pain. (Even a short-term use for dental pain in children actually increases their risk of developing a substance misuse problem. Brains younger than 25 are still developing and are at higher risk to develop addictive disease when exposed to addicting drugs.)

I believe the best type of prevention programs are community engaging resiliency programs which train parents, employees, and students to develop the skills to deal with life stresses in healthy ways. And end outdated programs where law enforcement or people in recovery come into schools to tell kids that drugs are dangerous – these are not helpful and even increase the chance that kids will use drugs. We must use prevention science to guide the way and stop doing what we know doesn't work.

**TFAH:** If you could recommend to national policymakers one or two actions that would make a real difference, what would they be?

**Dr. Clark:** We have to build a real addiction treatment system, and train people to live more resiliently with the stresses of modern life. Hundreds of millions of dollars that Congress allocated in the past few years for the opioid epidemic have not been spent, because we don't have the infrastructure to use it.

The next step we should take in reimagining addiction treatment is to utilize the opioid settlement monies to build a new system that's based on trained individuals following best medical practices with adequate oversight and licensing requirements. We need to develop curriculum for doctors, nurses, social workers, psychologists, and program-based counselors (including peer support specialists) and train a new workforce focused on addiction treatment. It is insufficient to add a few hours of training to our current healthcare workforce and expect this to suddenly provide addiction treatment, nor can we simply pay for more treatment because there is no one to provide that additional treatment, and since the current systemic quality of care is insufficient the outcomes are understandably poor. Building the appropriate infrastructure can become a self-sustaining system through health insurance payments, which now far too often are being spent on wasteful care.

For more recommendations, I suggest policymakers read our article "Guide for Future Directions for the Addiction and OUD Treatment Ecosystem" recently published by the *National Academy of Medicine*.<sup>87</sup>

## 2: Address the Worsening Drug Use and Overdose Crisis

- **Implement policies targeting psychostimulant use** that complement current opioid-focused policies. This includes actions such as additional flexibility in federal grants to states to address substances besides opioids based on local needs, and congressional support for promising clinical trials for medications to treat psychostimulant-use disorder, including the Accelerated Development of Addictive Pharmacotherapy Treatment trial at the National Institute on Drug Abuse. The trials should include participants who match the racial/ethnic diversity of the populations with psychostimulants-use disorders.
- **Promote harm-reduction policies to reduce overdose and blood-borne infections.** Important harm-reduction policies include: reducing barriers to access of overdose-prevention medications, such as naloxone, for first responders and those at high risk for overdose; providing fentanyl test strips for those who use drugs; and increasing syringe-services programs. Such efforts should reflect the culture and language of those affected and should be equitably accessible.
- **Continue enhanced flexibilities in access to and rules for substance-use treatment.** In response to the COVID-19 pandemic, the U.S. Department of Justice and U.S. Department of Health and Human Services allowed physicians to prescribe buprenorphine, a medicine used to treat opioid-use disorder, to new patients via



telemedicine, provide certain patients 28 days of at-home medication, and allow alternative methods for methadone delivery, another medication for opioid use disorder.

- **Address the secondary impact of the substance use and overdoses on children** through wrap-around services for children and families, school-based supports, and school-climate programs to promote safe and supportive environments. Congress

should expand grant programs, like SAMHSA's Project AWARE or the U.S. Department of Education's Project SERV, to enable the hiring of school-based mental health providers and referrals to local mental health providers for students who would benefit from such care. Ratios between on-site mental health providers and students should ensure that any student who needs services can access them in a timely manner.

## SPRINGBOARD FOR EQUITABLE RECOVERY AND RESILIENCE IN COMMUNITIES ACROSS AMERICA

In July 2020, the CDC Foundation and Well Being Trust, along with input from more than 100 other organizations released a framework to guide the nation's recovery from COVID-19 and improving well-being and resilience. Called the *Springboard for Equitable Recovery and Resilience in Communities Across America*, it offers dozens of solutions and recommendations that meet four guiding principles: (1) affirm human dignity by establishing racial justice and full inclusion for all people as a daily, living reality; (2) strengthen belonging and civic muscle by working across differences for the well-being of people and places, which in turn, unlocks abundant assets of people and places; (3) expand all of the interconnected vital conditions with local stewards taking the lead, beginning with people and places that are struggling and suffering; and (4) solidify new legacies for living together by renewing civic life, economic life, and social, emotional, and spiritual life.

### Key recommendations from the Springboard include:

- 1. Emergency funding for access to healthcare**—We must be dedicated to community-based organizations and clinicians treating individuals with mental health and substance use disorders. With demand for services soaring in the pandemic, it is essential to keep the doors open, lights on, and providers paid, to save lives.
- 2. Organize Local Recovery and Resilience Accountability Councils**—These Councils assure local control and coordination over the direction, actions, and accountabilities of federal, state, philanthropy, and business partners. These Councils can incorporate insights from similar, successful efforts, like Accountable Communities for Health and Ryan White Planning Councils.
- 3. Uphold civil and human rights**—History shows substantial benefits when we enforce established civil rights with respect to healthcare, education, employment, housing, transportation, voting, environmental protection, and other vital conditions—all of which still have significant room to improve.
- 4. Focus on early childhood development**—To attract and retain talented teachers, salaries should be increased and there should be more funding for high-quality home visiting programs. Forty years of research shows that these kinds of programs yield significant reductions in child abuse and neglect, reduction in emergency visits, fewer behavioral and intellectual problems in children, and a healthier population.
- 5. Make housing affordable**—The cost of building affordable housing should be reduced by having state and local governments purchase and hold land with federal assistance. Policymakers should create renters' insurance through payroll taxes, and create Rent Resilience Funds to cover rent for those who require assistance during economic downturns. We can prevent housing instability in the first place by encouraging corporations to provide subsidized housing for low-income employees.
- 6. Boost household wealth**—We should establish a standard for fair pay that is tied to the local cost of living; direct first-time homebuyer credits and match savings initiatives to households of color and low-income communities; and offer a debt bail-out for working families that matches the relief given to banks in 2008.
- 7. Create Outdoor Classrooms**—Schools that create outdoor classrooms can maintain physical distance to keep kids and teachers safe and, over the long term, studies show that exploring, playing, and learning in nature improves academic achievement.
- 8. Assure equitable access to parks and open spaces**—Cities can adopt a transparent, data-driven, community-led approach to improve the equitable allocation of public resources as part of park and urban open-space development. Parks can contribute to higher land values. The positive aspects of open space can only be created if their development is just, equitable, and inclusive in both process and outcome.<sup>83</sup>

## DRUG POLICY PRIORITIES IN THE BIDEN ADMINISTRATION

In April 2021, the Biden-Harris administration released its “Statement of Drug Policies Priorities for Year One,” outlining the White House’s approach to addressing the nation’s overdose and addiction epidemic.<sup>84</sup> The statute requires the Office of National Drug Control Policy to develop and submit a plan to Congress annually.<sup>85</sup> In announcing the plan, the administration said that while focusing on recovery from the COVID-19 pandemic, the nation needs to simultaneously address the addiction crisis.

The Biden plan includes a whole-of-government approach with the Office of National Drug Control Policy in the lead, and it works across federal sectors and with Congress and other stakeholders within the following priority areas:

- Expanding access to evidence-based treatment;
- Advancing racial equity in the U.S. approach to drug policy;
- Enhancing evidence-based harm reduction efforts;
- Supporting evidence-based prevention efforts to reduce youth substance use;
- Reducing the supply of illicit substances;
- Advancing recovery-ready workplaces and expanding the addiction workforce; and
- Expanding access to recovery support services.

The American Rescue Plan Act of 2021, signed into law in March 2021, includes approximately \$4 billion in support for and an expansion of access to behavioral health services and programs nationwide.<sup>86</sup>





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

- **Expand efforts to combat stigma and improve social attitudes toward mental healthcare.** The federal government should incorporate positive messaging around mental health screening and treatment across a variety of federal funding programs that reach underserved populations in order to increase screening and reduce stigma for those seeking help. These messages should come from salient messengers, including potentially from private organizations and high-profile individuals.
- **Improve data accuracy, completeness, and timeliness** through innovation and additional funding. This includes promotion of standardized categories and collection of racial/ethnic and other demographic data that aid in identification of disparities and improvements to death investigation systems. 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, and guide government responses. Additional investments are necessary to expand current programs like CDC's National Syndromic Surveillance program (currently covering 71 percent of the nation's emergency departments) and its Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes program (which allows states to turn syndromic data into preventive action). Investment is also needed in innovative data-science methods that can provide forecasting of mortality data and bridges the gap in availability of official mortality data.
- **Modernize mental health and substance use services** by aligning healthcare provider payment, quality measures, and training toward clinical models focused on the whole health of individuals, including individual determinants of health and prioritizing integrated delivery models. Expanding comprehensive health insurance to all Americans and ensuring parity in covered mental health and substance use services and provider networks should be a priority for Congress.
- **Increase access to mental health and substance use healthcare** through full enforcement of the Mental Health Parity and Addiction Equity Act. Congress should have the U.S. Department of Labor investigate and levy monetary penalties against health insurers and health plan sponsors who violate the Parity Act. Parity should also expand to Medicare, Medicaid fee-for-service, and TRICARE.
- **Expand the mental health and substance use treatment workforce** through increased investments in mental health workforce development programs, such as the Graduate Medical Education and Graduate Psychology Education programs. Training and continuing education curricula for all mental health providers and primary care practitioners should include suicide-prevention and evidence-based services. Experts should establish uniform standards for peer support specialists and community health workers, and health insurers should cover and adequate pay for these services.
- **Build community capacity for early identification and intervention for individuals with mental health needs** by training community members and employing some mental health providers into local settings where people most commonly interact and may first present mental health needs. Creating a multilayered, community-forward approach to mental health and addiction care is a cost-effective way to connect people with early access to necessary mental health support and services, while reserving limited specialty care for individuals with more complex needs.
- **Promote diversity and culturally appropriate care in the healthcare system.** Congress should increase the number of mental health and substance use practitioners from communities of color by increasing support for programs like SAMHSA's Minority Fellowship and the Health Resources and Services Administration's Behavioral Health Workforce Education and Training grants. Medical education should include curricula on providing culturally and linguistically appropriate care throughout the continuum of care.
- **Adopt trauma-informed and culturally competent policies and practices for youth-serving programs and agencies.** Congress should maintain federal support for programs that disseminate technical assistance and training for trauma, like the National Child Traumatic Stress Network. The juvenile justice system should adopt approaches that recognize that substance abuse and serious emotional disturbances are health issues not criminal justice issues.

# Pain in the Nation: *Alcohol, Drug, and Suicide Epidemics*

## Appendix A: Data Methodology

Unless otherwise referenced, data in this report are from the National Center for Health Statistics' Multiple Cause of Death Files, 1999–2019, accessed via the CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER) Database (*wonder.cdc.gov/mcd-icd10.html*).

For alcohol and drug deaths, TFAH used CDC's underlying cause-of-death categories, "Drug/Alcohol Induced Causes," and, for deaths by suicide, the "Injury Intent and Mechanisms" category. Because a small number of deaths are categorized as both alcohol- or drug-induced and as suicide, *TFAH* removed duplicates (ICD-10 underlying causes of death codes X60–65) when determining combined death totals. Age-adjusted death rates (deaths per 100,000) are used for all categories save age categories.

For deaths related to specific drugs, TFAH used ICD-10 codes as follows:

- All opioid 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 deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.4 "multiple causes of death" code.

- Heroin 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 deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.2 "multiple causes of death" code.
- Cocaine deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T40.5 "multiple causes of death" code.
- Other psychostimulant deaths: X40–44, X60–64, X85, and Y10–14 "underlying causes of death" codes plus T43.6 "multiple causes of death" code.

*Note:* CDC and other analyses of drug deaths may use a slightly narrower drug-overdose category compared with the "drug-induced cause" category used in this brief.



# Appendix B: Demographic Data

DEATHS, DEATH RATES, AND ONE-YEAR PERCENT CHANGE IN DEATH RATE BY SELECT DEMOGRAPHICS, 2019												
	Combined Alcohol, Drug, and Suicide			Alcohol-Induced			Drug-Induced			Suicide		
	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019
Overall	156,242	45.7	3%	39,043	10.4	4%	74,511	22.8	5%	47,511	13.9	-2%
Female	42,743	24.9	1%	11,122	5.9	6%	24,118	14.5	1%	10,255	6.0	-3%
Male	113,499	67.5	3%	27,921	15.2	4%	50,393	31.1	6%	37,256	22.4	-2%
American Indian	3,028	65.2	2%	1,450	31.9	-2%	969	20.8	11%	669	13.6	-1%
Asian	3,048	13.3	4%	562	2.4	-2%	1,016	4.4	10%	1,609	7.1	2%
Black	18,235	38.8	11%	3,494	7.3	7%	11,698	25.1	15%	3,309	7.1	1%
Latino	17,270	30.6	8%	5,458	10.6	7%	7,837	13.4	15%	4,331	7.3	-2%
White	131,931	49.6	1%	33,537	11.2	5%	60,828	24.3	2%	41,935	15.7	-2%
0-17	1,967	2.7	-6%	n/a	<0.1	-	406	0.6	23%	1,646	2.3	-10%
18-34	35,745	46.9	1%	2,073	2.7	15%	21,601	28.4	1%	12,913	17.0	-1%
35-54	60,848	73.7	3%	13,618	16.5	4%	33,515	40.6	5%	15,537	18.8	-2%
55-74	50,148	67.8	3%	20,891	28.3	2%	17,855	24.2	8%	13,105	17.7	-5%
75+	7,513	33.3	1%	2,441	10.8	2%	1,126	5.0	2%	4,306	19.1	1%
Northeast	26,597	45.7	-1%	5,148	7.7	3%	15,996	28.8	-2%	6,209	10.4	-3%
Midwest	33,714	48.3	2%	8,036	10.3	4%	16,537	24.9	4%	10,183	14.6	-3%
South	57,474	44.2	3%	13,268	9.2	4%	27,134	21.8	5%	18,716	14.4	-2%
West	38,457	46.4	5%	12,591	14.4	4%	14,844	18.4	11%	12,403	15.3	0%
Metro	132,366	45.0	3%	32,373	10.1	4%	65,485	23.1	5%	38,718	13.2	-2%
Rural	23,876	50.8	2%	6,670	12.2	4%	9,026	21.0	4%	8,793	18.9	-2%

	Opioid Overdose			Synthetic Opioid Overdose			Cocaine Overdose			Other Psychostimulants Overdose		
	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-Adjusted)	Change 2018 to 2019
Overall	49,860	15.5	6%	36,359	11.4	16%	15,883	4.9	8%	16,167	5.0	28%
Female	15,225	9.3	3%	10,076	6.3	13%	4,336	2.7	2%	4,733	2.9	23%
Male	34,635	21.7	8%	26,283	16.6	16%	11,547	7.1	10%	11,434	7.1	28%
American Indian	527	11.1	21%	321	6.7	44%	112	2.4	9%	381	8.3	22%
Asian	428	1.8	13%	291	1.2	27%	177	0.8	24%	377	1.6	18%
Black	7,750	16.6	23%	6,433	13.8	29%	4,873	10.4	19%	1,312	2.9	39%
Latino	5,264	8.8	18%	3,802	6.3	34%	2,006	3.4	15%	1,796	3.1	25%
White	41,155	16.8	4%	29,314	12.2	13%	10,721	4.4	3%	14,097	5.7	27%
0-17	237	0.3	25%	171	0.2	70%	31	<0.1	-	61	<0.1	-
18-34	16,886	22.2	3%	13,474	17.7	11%	4,456	5.9	1%	4,565	6.0	19%
35-54	22,440	27.2	7%	16,488	20.0	17%	7,615	9.2	9%	8,027	9.7	30%
55-74	9,955	13.5	9%	6,136	8.3	26%	3,740	5.1	15%	3,481	4.7	33%
75+	337	1.5	16%	85	0.4	3%	38	0.2	27%	33	0.1	34%
Northeast	12,586	22.9	1%	10,960	20.1	5%	4,916	8.9	8%	1,224	2.3	45%
Midwest	11,661	17.8	3%	9,273	14.3	11%	3,627	5.5	6%	3,127	4.9	38%
South	17,744	14.5	8%	12,502	10.3	19%	5,784	4.6	6%	5,845	4.9	30%
West	7,869	9.9	19%	3,624	4.7	65%	1,556	1.9	22%	5,971	7.4	17%
Metro	44,762	16.0	6%	33,024	11.9	15%	14,872	5.3	8%	13,400	4.8	28%
Rural	5,098	12.3	6%	3,335	8.3	16%	1,011	2.4	4%	2,767	6.7	27%

Source: TFAH and WBT analysis of NCHS data

# Appendix C: State Data

## DEATHS, DEATH RATES, AND ONE-YEAR CHANGE IN DEATH RATE FROM ALCOHOL, DRUG, AND SUICIDE, OVERALL AND BY DRUG TYPE, 2019

	Combined Alcohol, Drug, and Suicide			Alcohol-Induced			Drug-Induced			Suicide		
	2019 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019	2018 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019	2018 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019
<b>Overall</b>	156,242	45.7	3%	39,043	10.4	4%	74,511	22.8	5%	47,511	13.9	-2%
Alabama	2,089	41.5	0%	425	7.5	4%	906	18.7	0%	804	16.3	-2%
Alaska	529	70.3	6%	185	23.9	-10%	149	19.9	26%	210	28.5	16%
Arizona	4,569	61.1	6%	1,286	16.1	7%	2,016	28.2	11%	1,419	18.7	-3%
Arkansas	1,260	41.1	-4%	342	10.3	5%	404	14.0	-16%	548	18.0	-2%
California	15,942	37.7	7%	5,345	12.2	3%	6,668	16.1	16%	4,436	10.7	-2%
Colorado	3,465	56.8	6%	1,198	18.8	13%	1,118	18.7	7%	1,312	22.1	1%
Connecticut	2,024	54.4	13%	409	9.2	21%	1,263	36.0	14%	435	11.4	7%
Delaware	647	67.6	7%	106	8.9	16%	442	48.7	9%	111	11.3	-1%
DC	426	59.2	8%	70	9.6	-13%	319	44.4	20%	44	6.2	-18%
Florida	11,307	49.8	4%	2,722	10.2	-5%	5,538	26.8	12%	3,465	14.5	-4%
Georgia	3,911	35.3	0%	940	7.8	2%	1,502	13.9	-1%	1,585	14.6	1%
Hawaii	561	37.3	15%	96	5.9	4%	266	17.5	11%	224	15.5	30%
Idaho	900	48.9	-5%	290	14.5	4%	280	15.9	0%	365	20.4	-15%
Illinois	5,251	39.8	1%	1,137	7.9	2%	2,846	22.3	3%	1,439	10.9	-4%
Indiana	3,439	50.9	-2%	791	10.4	-2%	1,756	27.4	4%	972	14.2	-11%
Iowa	1,247	38.5	11%	408	11.7	7%	374	12.1	20%	528	16.7	8%
Kansas	1,259	42.8	3%	353	11.1	1%	430	15.2	15%	523	18.2	-6%
Kentucky	2,727	60.7	3%	553	10.7	14%	1,487	35.0	6%	756	16.5	-5%
Louisiana	2,336	50.2	7%	368	6.9	3%	1,316	29.3	11%	704	15.0	-1%
Maine	843	60.0	4%	208	11.2	-7%	391	31.5	7%	276	19.4	5%
Maryland	3,427	54.2	2%	430	6.2	5%	2,421	39.0	2%	657	10.3	1%
Massachusetts	3,612	50.3	-4%	738	9.1	2%	2,312	33.6	-4%	647	8.7	-12%
Michigan	5,070	49.3	-6%	1,193	10.2	10%	2,565	26.3	-10%	1,472	14.3	-5%
Minnesota	2,416	40.7	11%	828	12.9	10%	886	15.6	20%	830	14.4	10%
Mississippi	1,091	35.8	17%	240	7.0	19%	431	14.9	28%	436	14.4	5%
Missouri	3,299	53.4	-2%	608	8.8	2%	1,649	27.9	-1%	1,141	18.2	-7%
Montana	662	59.2	17%	246	20.3	38%	153	15.0	13%	289	26.2	5%
Nebraska	728	36.9	7%	271	13.0	0%	180	9.5	5%	309	16.1	21%
Nevada	1,799	53.9	-4%	546	15.1	-4%	690	21.4	-3%	642	19.8	-5%
New Hampshire	853	61.0	-9%	203	12.2	5%	420	33.0	-12%	255	17.5	-10%
New Jersey	4,235	46.2	-3%	698	6.7	4%	2,867	32.4	-4%	762	8.0	-3%
New Mexico	1,827	88.0	7%	729	34.3	5%	632	31.8	14%	513	24.0	-4%
New York	6,887	33.5	-2%	1,581	7.0	-4%	3,814	19.2	-1%	1,705	8.3	0%
North Carolina	4,760	44.1	-1%	1,176	9.6	5%	2,378	23.3	1%	1,358	12.5	-9%
North Dakota	371	49.7	10%	149	19.7	14%	95	13.1	21%	136	18.1	-5%
Ohio	7,331	62.7	4%	1,242	9.0	1%	4,440	39.9	7%	1,806	15.1	-1%
Oklahoma	2,096	51.6	-1%	659	15.1	6%	680	17.5	-8%	816	20.5	2%
Oregon	2,503	53.4	6%	938	18.3	1%	761	16.9	12%	906	20.4	7%
Pennsylvania	7,224	54.8	-2%	1,047	6.7	12%	4,475	36.3	-2%	1,896	14.1	-5%
Rhode Island	552	50.6	-2%	139	11.5	-7%	312	30.2	-3%	123	10.7	12%
South Carolina	2,589	48.6	2%	620	9.9	6%	1,181	23.6	-1%	852	16.2	5%
South Dakota	453	51.9	10%	191	21.2	-4%	90	11.0	56%	182	20.9	8%
Tennessee	4,282	60.7	9%	936	11.7	3%	2,219	33.1	13%	1,219	17.2	4%
Texas	9,615	32.7	4%	2,656	8.7	12%	3,355	11.5	5%	3,891	13.4	-2%
Utah	1,482	49.0	-8%	290	9.8	-10%	614	20.4	-11%	654	21.2	-5%
Vermont	367	54.9	-5%	125	15.0	23%	142	25.3	-10%	110	16.0	-15%
Virginia	3,424	38.5	4%	773	7.8	12%	1,621	19.1	8%	1,140	12.8	-8%
Washington	3,800	46.2	4%	1,264	14.3	5%	1,416	17.7	6%	1,263	15.9	0%
West Virginia	1,487	85.1	-1%	252	11.6	10%	934	56.6	2%	330	18.5	-13%
Wisconsin	2,850	46.6	6%	865	12.5	10%	1,226	21.6	10%	845	14.0	-6%
Wyoming	418	70.4	16%	178	28.5	22%	81	14.5	28%	170	29.3	16%

# DEATHS, DEATH RATES, AND ONE-YEAR CHANGE IN DEATH RATE FROM ALCOHOL, DRUG, AND SUICIDE, OVERALL AND BY DRUG TYPE, 2019

	Opioid Overdose			Synthetic Opioid Overdose			Cocaine Overdose			Other Psychostimulants Overdose		
	2019 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019	2019 Deaths	Deaths per 100,000 (Age-adjusted)	Change 2018 to 2019
<b>Overall</b>	49,860	15.5	6%	36,359	11.4	16%	15,883	4.9	8%	16,167	5.0	28%
Alabama	414	8.9	8%	213	4.7	43%	97	2.1	9%	230	5.1	46%
Alaska	83	10.9	24%	24	3.2	n/a	n/a	n/a	n/a	64	8.5	20%
Arizona	1,290	18.4	16%	796	11.6	51%	159	2.3	-3%	717	10.1	20%
Arkansas	198	7.0	-5%	115	4.1	25%	21	0.8	-12%	126	4.5	6%
California	3,235	7.9	36%	1,675	4.2	93%	850	2.1	42%	2,862	6.9	19%
Colorado	633	10.6	12%	255	4.3	95%	139	2.3	3%	353	5.9	5%
Connecticut	1,100	31.7	15%	950	27.7	23%	369	10.6	17%	70	2.3	3%
Delaware	387	43.0	9%	343	38.4	16%	169	18.8	18%	28	3.1	n/a
DC	243	33.7	26%	216	30.2	34%	124	17.3	22%	n/a	n/a	n/a
Florida	3,771	18.7	18%	2,837	14.4	34%	1,408	6.8	14%	825	4.2	39%
Georgia	862	8.2	-1%	419	4.0	19%	305	2.8	6%	439	4.2	10%
Hawaii	55	3.5	-15%	20	1.3	n/a	n/a	n/a	n/a	170	10.9	10%
Idaho	133	7.6	8%	32	1.9	8%	n/a	n/a	n/a	86	5.0	27%
Illinois	2,219	17.5	3%	1,706	13.6	9%	877	6.9	14%	257	2.1	1%
Indiana	1,254	19.9	14%	899	14.5	26%	268	4.2	4%	512	8.3	34%
Iowa	161	5.4	11%	102	3.5	25%	20	0.7	n/a	159	5.1	56%
Kansas	184	6.7	18%	75	2.8	60%	34	1.1	10%	162	5.8	108%
Kentucky	1,036	24.6	5%	825	19.9	11%	124	2.9	-6%	459	11.1	27%
Louisiana	558	12.6	26%	324	7.4	49%	104	2.3	-11%	214	4.9	62%
Maine	323	26.4	13%	283	23.3	18%	105	8.9	12%	65	5.5	82%
Maryland	2,104	34.0	1%	1,917	31.1	5%	707	11.5	1%	79	1.4	24%
Massachusetts	1,969	28.9	-1%	1,861	27.5	3%	782	11.5	8%	104	1.6	35%
Michigan	1,789	18.5	-11%	1,458	15.2	-5%	682	7.1	-11%	225	2.5	33%
Minnesota	428	7.8	24%	309	5.7	53%	60	1.1	13%	242	4.3	42%
Mississippi	245	8.5	41%	141	5.0	92%	45	1.6	36%	130	4.6	35%
Missouri	1,096	18.8	-4%	886	15.4	1%	147	2.4	6%	452	7.9	23%
Montana	70	7.2	15%	n/a	n/a	n/a	n/a	n/a	n/a	58	5.9	67%
Nebraska	68	3.6	7%	27	1.4	2%	n/a	n/a	n/a	51	2.7	61%
Nevada	373	11.7	2%	114	3.7	33%	53	1.7	11%	303	9.5	-1%
New Hampshire	365	29.1	-12%	343	27.6	-12%	76	6.4	21%	59	4.7	70%
New Jersey	2,502	28.4	-4%	2,221	25.4	-1%	878	10.0	1%	203	2.4	43%
New Mexico	394	20.0	20%	149	7.7	42%	79	3.8	32%	277	14.4	32%
New York	2,939	14.9	-1%	2,338	12.0	7%	1,320	6.6	4%	240	1.3	34%
North Carolina	1,817	18.1	1%	1,363	13.8	6%	780	7.7	9%	338	3.4	30%
North Dakota	43	5.9	13%	n/a	n/a	n/a	n/a	n/a	n/a	20	3.1	n/a
Ohio	3,452	31.5	6%	3,117	28.6	11%	1,223	10.8	10%	846	8.0	46%
Oklahoma	268	6.9	-11%	81	2.1	2%	44	1.2	1%	327	8.5	0%
Oregon	332	7.6	-4%	95	2.3	-6%	64	1.5	37%	288	6.5	28%
Pennsylvania	3,034	25.1	6%	2,661	22.2	9%	1,188	9.6	13%	454	3.8	53%
Rhode Island	240	23.3	-10%	203	20.0	-5%	143	14.1	7%	22	2.3	n/a
South Carolina	862	17.6	3%	568	11.7	9%	227	4.6	-15%	332	7.0	34%
South Dakota	39	4.5	29%	24	2.8	n/a	n/a	n/a	n/a	31	4.0	n/a
Tennessee	1,543	23.4	17%	1,152	17.8	38%	334	4.9	28%	651	10.0	36%
Texas	1,497	5.1	6%	423	1.5	19%	753	2.5	1%	1,055	3.7	31%
Utah	397	13.3	-10%	94	3.1	9%	43	1.4	-16%	224	7.5	-5%
Vermont	114	20.7	-9%	100	18.6	-4%	55	9.8	5%	n/a	n/a	n/a
Virginia	1,266	15.1	6%	993	11.9	16%	411	4.9	0%	207	2.5	53%
Washington	827	10.5	11%	337	4.4	52%	132	1.7	6%	544	6.9	15%
West Virginia	673	41.4	-2%	572	35.9	5%	131	7.9	-6%	393	24.4	27%
Wisconsin	928	16.6	9%	660	12.0	28%	302	5.4	9%	170	3.3	48%
Wyoming	47	8.3	22%	n/a	n/a	n/a	n/a	n/a	n/a	25	4.5	16%

Note: Some data unavailable due to insufficient reporting of type of drug involved in overdose or for privacy reasons.

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1730 M Street, NW, Suite 900  
Washington, DC 20036  
(t) 202-223-9870  
[www.tfah.org](http://www.tfah.org)



[wellbeingtrust.org](http://wellbeingtrust.org)  
[info@wellbeingtrust.org](mailto:info@wellbeingtrust.org)