Deaths (and Diseases) of Despair: Packaging Data to Promote Policy, Systems & Environmental Change

Community Health Conference, October 11, 2018
Kari Gloppen, PhD, MPH; Jon Roesler, MS; Dana Farley, MS
Injury & Violence Prevention Section
Learning Objectives

1. Describe the basic trends in Minnesota for mortality due to excessive alcohol use, drug overdose, and suicide.

2. Identify the shared risk and protective factors influencing morbidity and mortality due to alcohol, drugs, and suicide.

3. Discuss ways we can promote policy, systems, and environmental change.
• Case & Deaton: **Deaths of Despair**

• Ruhm: **Deaths of Despair or Drug Problems**

• Dwyer-Lindgren et al.: **Trends and Patterns of Geographic Variation in Mortality**

• Woolf et al.: **Why Are Death Rates Rising in Minnesota’s White Population?**
• Case & Deaton: Deaths of Despair

• Ruhm: Deaths of Despair or Drug Problems

• Dwyer-Lindgren et al.: Trends and Patterns of Geographic Variation in Mortality

• Woolf et al.: Why Are Death Rates Rising in Minnesota’s White Population?
Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case\(^1\) and Angus Deaton\(^1\)

Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544

Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013. This change reversed decades of progress in mortality and was unique to the United States; no other rich country saw a similar turnaround. The midlife mortality reversal was confined to white non-Hispanics; black non-Hispanics and Hispanics at midlife, and those aged 65 and above in every racial and ethnic group, continued to see mortality rates fall. This increase for whites was largely accounted for by increasing death rates from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis. Although all education groups saw increases in mortality from suicide and poisonings, and an overall increase in external cause mortality, those with less education saw the most marked increases. Rising midlife mortality rates of white non-Hispanics were paralleled by increases in midlife morbidity. Self-reported declines in health, mental health, and ability to conduct activities of daily living, and increases in chronic pain and inability to work, as well as clinically measured deteriorations in liver function, all point to growing distress in this population. We comment on potential economic causes and consequences of this deterioration.

the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). The comparison is similar for other Organisation for Economic Co-operation and Development countries.

Fig. 1 shows a cessation and reversal of the decline in midlife mortality for US white non-Hispanics after 1998. From 1978 to 1998, the mortality rate for US whites aged 45–54 fell by 2% per year on average, which matched the average rate of decline in the six countries shown, and the average over all other industrialized countries. After 1998, other rich countries’ mortality rates continued to decline by 2% a year. In contrast, US white non-Hispanic mortality rose by half a percent a year. No other rich country saw a similar turnaround. The mortality reversal was confined to white non-Hispanics; Hispanic Americans had mortality declines indistinguishable from the British (1.8% per year), and black non-Hispanic mortality for ages 45–54 declined by 2.6% per year over the period.

For deaths before 1989, information on Hispanic origin is not available, but we can calculate lives lost among all whites. For those aged 45–54, if the white mortality rate had held at its 1998 value,
White Americans Are Dying From A Surge In ‘Deaths Of Despair’

This may help explain Trump, according to economists studying mortality.

By Ann Brenoff

Why ‘Despair Deaths’ Continue to Rise in the U.S.

Alcohol, drug, and suicide deaths continue to increase, with most segments of society affected. What can be done to reverse this tide?

Middle-Aged White Americans Are Dying of Despair

Even as longevity increases across the rich world, uneducated white Americans are living sicker and dying earlier. Two economists speculate on the reasons why.
U.S. SUICIDE DEATHS AMONG WHITE ADULTS 50-54

White non-Hispanic deaths per 100,000

SOURCE: CDC
U.S. SUICIDE DEATHS AMONG ADULTS 50-54

Deaths per 100,000

SOURCE: CDC
"DEATHS OF DESPAIR"

Alcohol, drugs, and suicide deaths in ages 50-54, per 100,000 people

ANNE CASE AND ANGUS DEATON OF PRINCETON UNIVERSITY
HIGHER SUICIDE RATE WITHOUT COLLEGE

Suicide rate per 100,000

SOURCE: RUTGERS UNIVERSITY STUDY ON U.S. SUICIDE RATES BY EDUCATIONAL ATTAINMENT / CDC
Mortality Rate for 45-to-54-Year-Olds, By Country

Key: U.S. White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). (PNAS)
Midlife mortality from “deaths of despair” across countries

Men and women ages 50-54, deaths by drugs, alcohol, and suicide

Midlife mortality by all causes in the U.S.
Men and women ages 50-54, death by all causes

White non-Hispanic midlife mortality from “deaths of despair” in the U.S. by education

Ages 50-54, deaths by drugs, alcohol, and suicide

Midlife ‘Deaths Of Despair’ In The U.S., 2000 and 2014

Deaths by drugs, alcohol and suicide among non-Hispanic whites, ages 45-54

Notes
The geographic units represented are a blend of county boundaries and Public Use Microdata Areas.

Source: Anne Case and Angus Deaton, Brookings Papers on Economic Activity
How Come This Is Taking So Long?

• Case & Deaton: *Deaths of Despair*

• **Ruhm: Deaths of Despair or Drug Problems**

• Dwyer-Lindgren et al.: *Trends and Patterns of Geographic Variation in Mortality*

• Woolf et al.: *Why Are Death Rates Rising in Minnesota’s White Population?*
DEATHS OF DESPAIR OR DRUG PROBLEMS?

Christopher J. Ruhm

Working Paper 24188
http://www.nber.org/papers/w24188

NATIONAL BUREAU OF ECONOMIC RESEARCH
1050 Massachusetts Avenue
Cambridge, MA 02138
January 2018
Figure 1: Drug, Nondrug Suicide and Alcohol (DSA) Mortality Rates

- All Drugs (left axis)
- Opioid Analgesics (right axis)
- Illicit Opioids (right axis)
- Nondrug Suicides (left axis)
- Alcohol (right axis)
When Do We Get There?

• Case & Deaton: *Deaths of Despair*

• Ruhm: *Deaths of Despair or Drug Problems*

• Dwyer-Lindgren et al.: *Trends and Patterns of Geographic Variation in Mortality*

• Woolf et al.: *Why Are Death Rates Rising in Minnesota’s White Population?*
Trends and Patterns of Geographic Variation in Mortality From Substance Use Disorders and Intentional Injuries Among US Counties, 1980-2014

Laura Dwyer-Lindgren, PhD; Amelia Bertozzi-Villa, MPH; Rebecca W. Stubbs, MA; et al
Chloe Morozoff, MPH; Shreya Shirude, MPH; Jürgen Unützer, MD; Mohsen Naghavi, MD, PhD;
Ali H. Mokdad, PhD; Christopher J. L. Murray, MD, DPhil

Author Affiliations Article Information
New maps reveal where Americans are dying at alarming rates from drugs, alcohol, suicide, and homicide.

These so-called deaths of despair do not affect all places equally.
Drug-related deaths have increased by 618.3% since 1980.

Appalachian states have been hit the hardest.

The opioid epidemic is likely to blame.

University of Washington / Via jamanetwork.com
Figure 1. County-Level Mortality From Alcohol Use Disorders

A  Age-standardized mortality rate from alcohol use disorders, both sexes, 2014

University of Washington / Via jamanetwork.com
Percent change in age-standardized mortality rate from alcohol use disorders between 1980 and 2014, both sexes
Figure 2. County-Level Mortality From Drug Use Disorders

A  Age-standardized mortality rate from drug use disorders, both sexes, 2014

Deaths per 100,000 population

1 to 2  8  14  21  27  33 to 58
B Percent change in age-standardized mortality rate from drug use disorders between 1980 and 2014, both sexes

% Change

8 to 249
1189
2129
3068
4008
4948 to 8370
Figure 3. County-Level Mortality From Self-harm

A Age-standardized mortality rate from self-harm, both sexes, 2014
Percent change in age-standardized mortality rate from self-harm between 1980 and 2014, both sexes
Percent change in age-standardized mortality rate from interpersonal violence between 1980 and 2014, both sexes
How Long Does This Last?

- Case & Deaton: *Deaths of Despair*
- Ruhm: *Deaths of Despair or Drug Problems*
- Dwyer-Lindgren et al.: *Trends and Patterns of Geographic Variation in Mortality*
- Woolf et al.: *Why Are Death Rates Rising in Minnesota’s White Population?*
WHY ARE DEATH RATES RISING IN MINNESOTA'S WHITE POPULATION?
The Role of Stress-Related Conditions

Steven H. Woolf, M.D., M.S.H.1
Derek A. Chapman, Ph.D.
Jeanine M. Buu-Hillon, M.D., Ph.D.1
Lauren K. Snelting, M.P.H., CHES1
Kendra J. Babby, B.S.
Larsen S. M.R., M.P.H.
Emily S. Zimmerman, Ph.D., M.S., M.P.H.1

1 Center on Society and Health, Virginia Commonwealth University
2 Department of Biostatistics, School of Public Health, University of Washington

June 2018
The rise in drug and alcohol abuse and suicides is striking—what some have called “deaths of despair”

- 770% increase in drug overdose
- 402% increase in alcohol poisoning
- 35% increase in suicides
Figure 1. Increases in deaths among whites ages 25–59 years in Minnesota, 1995–2014

<table>
<thead>
<tr>
<th>Cause</th>
<th>1995–99</th>
<th>2010–14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of deaths</td>
<td>Mortality rate (per 100,000)</td>
</tr>
<tr>
<td>Drug overdoses</td>
<td>134</td>
<td>1.3</td>
</tr>
<tr>
<td>Alcohol poisoning</td>
<td>39</td>
<td>0.4</td>
</tr>
<tr>
<td>Suicide</td>
<td>1,387</td>
<td>13.0</td>
</tr>
<tr>
<td>Alcoholic liver disease</td>
<td>356</td>
<td>3.5</td>
</tr>
<tr>
<td>Viral hepatitis</td>
<td>65</td>
<td>0.6</td>
</tr>
<tr>
<td>Liver cancer</td>
<td>111</td>
<td>1.1</td>
</tr>
<tr>
<td>Hypertensive heart disease</td>
<td>67</td>
<td>0.7</td>
</tr>
</tbody>
</table>
Figure 2. Age-adjusted all-cause mortality, non-Hispanic whites ages 25–59 years, by county, Minnesota, 2010–2014
Figure 3. Relative increase in age-adjusted mortality from stress-related conditions between 1995–1999 and 2010–2014 by (a) region and (b) county, in Minnesota
“Deaths of Despair” in Minnesota
Suicide, drug overdose, and alcohol-attributable deaths increased substantially in Minnesota between 2000 and 2017.

Death Certificate Data
Males are more likely to die of suicide or substance abuse-related causes than females.

- **Alcohol-related deaths, 2016**
  - Male: 34.5%
  - Female: 65.5%

- **Suicide deaths, 2016**
  - Male: 78.0%
  - Female: 22.0%

- **Drug overdose deaths, 2014-2016**
  - Male: 37.8%
  - Female: 62.2%
Significant disparities in death rates by race/ethnicity

<table>
<thead>
<tr>
<th>Category</th>
<th>American Indian</th>
<th>African American</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall drug overdose</td>
<td>64.6</td>
<td>24</td>
<td>11.7</td>
</tr>
<tr>
<td>Alcohol-attributable deaths</td>
<td>44.1</td>
<td>5.1</td>
<td>10.9</td>
</tr>
<tr>
<td>Suicide (2014-16)</td>
<td>21.3</td>
<td>7.1</td>
<td>13.8</td>
</tr>
</tbody>
</table>

Death Certificate Data 2016
Peak drug overdose rates have moved to **younger** age groups
Peak alcohol-attributable deaths have moved to older age groups.
Suicide deaths increased among younger adults (ages 20-34) and adults ages 55 - 64.
Drug overdoses are happening in urban and rural Minnesota.

The graph shows the number of deaths due to drug overdoses over the years from 2000 to 2016. The data is categorized into Twin Cities Metro and Greater MN regions. The graph indicates a significant increase in the number of deaths in both regions, with Twin Cities Metro reaching 400 deaths and Greater MN reaching 236 deaths.
Alcohol-attributable deaths are a statewide problem in Minnesota.

Number of Deaths

- Twin Cities: 350
- Greater MN: 291

Death Certificate Data
Suicide is a statewide problem, with a greater increase in deaths in rural Minnesota.
Key Takeaways

1. Males and American Indians are suffering the greatest proportions of deaths from these causes.

2. The age at death for each of the three causes is changing—
   - more young people are dying from suicide and drug overdose, and
   - more older people are dying from alcohol-attributable causes.

3. Both urban and rural areas are affected.
“Diseases of Despair” in Minnesota
The number of hospital treatments for alcohol, drug overdose, and suicide-related conditions increased among working age adults (25-64 years) Minnesota, 2001-2016.
Gender differences in hospital treatments for “diseases of despair”

- Patients treated for drug overdose and alcohol-attributable conditions were more likely to be male
- Patients treated for self-inflicted injuries were more likely to be female
Young and old suffer, but it manifests in different ways

The highest number of hospital treatments for were among these age groups:

- **Self-inflicted Injuries**
  - 15-19 year olds

- **Alcohol-attributable conditions**
  - (mostly acute causes)
  - 21-24 years

- **Drug overdose**
  - 15-34 year olds

- **Alcohol-attributable conditions**
  - (more chronic causes)
  - 45-54 year olds
Moving ‘Upstream’
How do we truly move upstream?

**Three Sisters**

*Primary Prevention & Public Health*

*Intervention & Treatment*

*Emergency Response*

**Tertiary Prevention**
- Naloxone
- Good Samaritan Laws
- Needle Exchange
- Transitions of care
- Discharge planning
- Fentanyl alerts
- Infectious disease control

**Secondary Prevention**
- Screening
- Early Identification
- SBIRT Services
- Medication Assisted Therapy
- Chemical Health Treatment
- OB and Infant Care for NAS
- Safe Storage
- Safe Disposal

**Primary Prevention**
- Prescribing practices
- Safe use of prescriptions
- Control supply
- Prevent diversion
- Reduce marketing
- Enrollment and use of PMP
- Prevention of ACEs
- Adolescent risk reduction
- Pain management
- Addressing trauma
- Integrating care
- Protective factors
- Community resiliency
- Culture as prevention

[www.health.state.mn.us/opioiddashboard](http://www.health.state.mn.us/opioiddashboard)
MDH provides funding to the eight Emergency Medical Services regions to purchase Naloxone and provide training to first responders statewide.

Minnesota allows pharmacies to dispense Naloxone for those at risk for opioid overdose. Commissioner of Health has designated Dr. Ruth Lynfield as an option for CHBs and pharmacists should they need/choose to enter the protocol.

As of May 2018, all 52 CHBs have designated a prescriber. At the county level: 81 counties designating MDH/Dr. Lynfield while 6 counties designating a local medical consultant.

Over 300 pharmacies are using the MDH option.
ASTHO Presidential 2017 Challenge: Public Health Approaches to Preventing Substance Misuse and Addictions

1º Prevention

- Reduce the need to self-medicate
- Control access to addictive substances
- Promote protective factors

Foundation:

Effective, Evidence-Based Education and Communication

2º Prevention

- Diagnose and treat addictions and substance use disorders
- Remove Stigma
- Understand Addiction as a Chronic Condition of the Brain
- Withdrawal Management and MAT

3º Prevention

- Prevent life-threatening adverse outcomes
- Acute health event control and prevention

Public Health Practice Paradigms

- Environmental controls and social determinants
- Chronic disease screening and management

Effective PDMPs and Use of Data
- Rational Pain Management
- Integrated Behavioral Health Services
- Prevent and Mitigate ACEs
- Adolescent Risk Reduction
- Personal and Community Resiliency

Screening and Treatment
- Naloxone
- Syringe/Needle Exchange
- Drug Take-Back

Jay C. Butler, MD
Chief Medical Officer, Alaska Dept of Health & Social Services
President, ASTHO
In this “epidemic” are we focusing on the right issues and solutions?

The “Streetlight Effect” or Google effect
What is the underlying pattern?
Root causes of Deaths of Despair

- Social exclusion
- Poverty
- Poor housing
- Substance use
- Violent neighborhoods
- Red lining
- Environmental contamination
- Climate vulnerability
- Physical abuse
- Sexual abuse
- Emotional abuse
- Disrupted families
- Homicide
- Homeless
- Food insecurity
- Racism
- Unemployment
- School suspensions
- Incarceration
- Social exclusion
- Lack of wealth
- Land use
- Lack of hope
- Crime
- Education disparities
Health Disparities
Adverse Outcomes
Consequences

Determinants
Social/Economic/Environmental
Risk/Protective Factors

Substance Abuse
(e.g. opioids overdose, neonatal abstinence syndrome, alcohol)

Mental Health
(e.g. depression, suicide)

Health Issues
(e.g. access, cultural competence)

Historical Trauma
Discrimination
Health Care
Inequities, cultural competence, access
Poverty
Education
Employment

Are we measuring symptoms or causes?
if **Health** is on a continuum and created in communities
Communities of Opportunity

- Parks & trails
- Healthy food options
- Thriving small businesses and entrepreneurs
- Financial institutions
- Better performing schools
- Good transportation options and infrastructure
- Sufficient healthy and affordable housing
- Home ownership
- Social inclusion
- IT connectivity
- Strong local governance
- Access to medical care

Low-Opportunity Communities

- Unsafe/limited parks
- Fast food restaurants
- Payday lenders
- Few small businesses
- Poor performing schools
- Increased pollution and contaminated drinking water
- Few transportation options
- Poor and limited housing stock
- Rental housing/foreclosure
- Social exclusion
- Limited IT connections
- Weak local governance

Contributes to health disparities:
- Suicide
- Diabetes
- Cancer
- AOD abuse
- Obesity
- Injury
...communities can create a
These problems share risk factors

Excessive alcohol use

Suicidality

Drug abuse

- Physical health problems
- Behavioral health problems
- Trauma/Adverse Childhood Experiences
- Social Isolation
Caregiver incarceration was the most frequently reported ACE among Minnesota students.

- Caregiver incarceration: 17%
- Verbal abuse: 14%
- Physical abuse: 12%
- Household alcohol problems: 10%
- Domestic violence: 7%
- Household drug use: 5%
- Sexual abuse: 5%

8th, 9th, and 11th grade students. Minnesota Student Survey, 2016
Percent of students, by county, who reported 1 or more ACEs.

8th, 9th, and 11th grade students. Minnesota Student Survey, 2016
ACEs + Past Month Substance Use
MSS 2016

- ACE Score 0: 9% for alcohol, 4% for marijuana, 2% for tobacco
- ACE Score 1: 17% for alcohol, 11% for marijuana, 6% for tobacco
- ACE Score 2: 23% for alcohol, 17% for marijuana, 9% for tobacco
- ACE Score 3: 31% for alcohol, 22% for marijuana, 13% for tobacco
- ACE Score 4+: 44% for alcohol, 34% for marijuana, 24% for tobacco

10/12/2018
These problems share Protective Factors

- Community
  - Adults in community care
  - Neighborhood is safe
  - Participation in pro-social community activities

- School
  - Educational engagement
  - Teacher-student relationships
  - Participation in school activities

- Family/Friends
  - Other adult relatives care
  - Can talk to at least one parent about problems

- Individual
  - Hope for future
  - Ability to make good decisions
  - Feeling valued and appreciated
  - Having useful roles
Educational Engagement

Among those with 2+ ACEs, students with greater educational engagement are less likely to report:

- Past month alcohol use: 23% vs. 40%
- Past month Rx misuse: 10% vs. 19%
- Past year suicidal ideation: 27% vs. 38%
Among those with 2+ ACEs, students with stronger teacher-student relationships are less likely to report:

- Past month alcohol use: 25% vs. 36%
- Past month Rx misuse: 9% vs. 16%
- Past year suicidal ideation: 21% vs. 35%
Caring Adults in Community

Among those with 2+ ACEs, students who feel adults in their community care about them are less likely to report:

• Past month alcohol use: 22% vs. 32%
• Past month Rx misuse: 9% vs. 14%
• Past year suicidal ideation: 19% vs. 35%
Promoting Policy, Systems, and Environmental Change
Identification of underlying causes “Deaths of Despair”

Fatality Review Teams
Analyze deaths, help us understand the community & context of a death

Emergency Incident Coordination
Organizational model for effective emergency management—coordinating multidisciplinary teams

Community Action Teams
Engage sectors of community to contribute qualitative experience from the community to understand and prevent root causes
Strengthen behavioral health services

- Affordable health care and insurance coverage, and strategies to address shortages in clinicians and facilities
- Resources to address expanding caseloads among clinicians, practices, hospitals, emergency medical services for care at the scene, intensive care in the hospital, long-term care in rehabilitation facilities, and psychological counseling for mental illness and addiction
- Prevention, detection, and early treatment of drug and alcohol abuse—including the opioid epidemic
- Strategies for suicide prevention, including better access to treatment for depression and other risk factors for suicide
Preventing suicide involves everyone in the community.

- **Provide financial support to individuals in need.**
  
  States can help ease unemployment and housing stress by providing temporary help.

- **Strengthen access to and delivery of care.**
  
  Health care systems can offer treatment options by phone or online where services are not widely available.

- **Create protective environments.**
  
  Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

- **Connect people within their communities.**
  
  Communities can offer programs and events to increase a sense of belonging among residents.

- **Teach coping and problem-solving skills.**
  
  Schools can teach students skills to manage challenges like relationship and school problems.

- **Prevent future risk.**
  
  Media can describe helping resources and avoid headlines or details that increase risk.

- **Identify and support people at risk.**
  
  Everyone can learn the warning signs for suicide, how to respond, and where to get help.

www.cdc.gov/vitalsigns/suicide
Address root causes by improving economic and social conditions

• Investments by government and the private sector to improve job opportunities, increase wages, reduce poverty, and promote economic mobility

• Reforms and investments to improve the quality of education—from preschool through high school to improve the affordability of college, vocational training, and professional education

• Economic development by business, investors, and philanthropy, and the promotion of new industry in marginalized and resource-poor rural counties

• Civic engagement and cross-sector partnerships to leverage and target resources and expand opportunities to break the cycle of poverty
Pain in the Nation:
The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy
“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

-Institute of Medicine (1988), *Future of Public Health*
Voices of the African American Community
Sam Simmons & Rashida Fischer

Fridays 6pm to 7pm

May 11, 2018
Everyone does drugs, but only minorities are punished for it

By German Lopez
germanrlopezgerman.lopez@vox.com

Jul 1, 2014
Percent of population who used a drug in the past year

- Marijuana: 12% (White), 12% (Black)
- Cocaine: 2% (White), 2% (Black)
- Crack: 1% (White), 1% (Black)
- Heroin: 0.5% (White), 0.5% (Black)
- Hallucinogen: 1% (White), 1% (Black)

Source: SAMHSA, 2011 data
US drug arrest rates, per 100,000 residents of each race

Source: Human Rights Watch, 2009 analysis of government data
Incarcerated Americans
1920 - 2008

Sources: Justice Policy Institute
Report: The Punishing Decade, &
U.S. Bureau of Justice Statistics

In 1971 President Richard Nixon declared a “War On Drugs”

1984: Sentencing Reform Act (SRA)
"Alcohol (abuse) is going up, suicide is going up, drug overdose is going up," said Jon Roesler, epidemiological supervisor with the Minnesota Department of Health.

"We're changing as a society. Something is going on, which is bigger than I can wrap my head around."

"Whatever this despair is, what we're despairing of, it's there," Roesler said. "It's happening."
Loneliness has the same impact on mortality as smoking 15 cigarettes a day making it even more dangerous than obesity.
Most Americans are Considered Lonely

as measured by a score of 43 or higher on the UCLA Loneliness Scale

Study of 20,000+ U.S. Adults

THE STATE OF LONELINESS IN AMERICA

NEARLY HALF of Americans report sometimes or always feeling alone (46%) or left out (47%).

ONE IN FOUR Americans (27%) rarely or never feel as though there are people who really understand them.

TWO IN FIVE Americans sometimes or always feel that their relationships are not meaningful (43%) and that they are isolated from others (43%).

ONE IN FIVE people report they rarely or never feel close to people (20%) or feel like there are people they can talk to (18%).

ONLY AROUND HALF OF AMERICANS (53%) have meaningful in-person social interactions, such as having an extended conversation with a friend or spending quality time with family, on a daily basis.
YOUNGER GENERATIONS ARE LONELIER THAN OLDER GENERATIONS

48.3
Gen Z

45.3
Millennials

45.1
Gen X

42.4
Boomers

38.6
Greatest
PEOPLE WHO REPORT BEING LESS LONELY ARE MORE LIKELY TO:

• Have regular, meaningful, in-person interactions;
• Be in good overall physical and mental health;
• Be employed and have good relationships with their coworkers; and
• Have found a balance in their daily activities, including getting the right amount of sleep, socialization and work/life balance.
SLEEP

- Those who say they sleep the right amount have loneliness scores 4 points lower than those who sleep less than desired and 7.3 points lower than those who sleep more than desired.
- They are significantly less likely to feel they lack companionship (37% vs. 62% of those who oversleep) and are significantly more likely to feel they have someone they can turn to (85% vs. 71%).

TIME WITH FAMILY

- Those who say they spend more time than desired with family and those who spend less time than desired are on par when it comes to feelings of loneliness.
- Those who report spending too much time with family stand out as being more likely than those who don’t to say that they feel as though they are part of a group of friends (73% vs. 64%) and they can find companionship when they need it (74% vs. 67%).

PHYSICAL ACTIVITY

- People who say they get just the right amount of exercise are considerably less likely to be lonely. The loneliness score of those who exercise more than desired increases by 3.5 points, while a similar uptick is seen for those who exercise less than desired (3.7 points).
- Those who exercise more than desired and those exercising for just the right amount are on par when it comes to feeling as though they are part of a group of friends (79%, each), have a lot in common with others (75% of those who exercise more vs. 62% who exercise just right) and can find companionship when they want it (76% vs. 80%).

THE WORKPLACE

- Those who say they work just the right amount are least likely to be lonely. The loneliness score of those who work more than desired increases by just over 3 points, while those who work less than desired showed a 6-point increase in loneliness.
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• Ruhm: Deaths of Despair or Drug Problems

• Dwyer-Lindgren et al.: Trends and Patterns of Geographic Variation in Mortality

• Woolf et al.: Why Are Death Rates Rising in Minnesota’s White Population?

• Gloppen: “Deaths of Despair” in Minnesota

• Gloppen & Roesler: Alcohol-Related Mortality & Mortality in Minnesota

• MDH: Now What?

• Two Stories: Historical Trauma & In The Media
Reflection
“With whom do you share your feelings?”

- Harvey Zarren, MD