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Emergency Department Visits for Suspected Suicide Attempts — United States, 2021–2025

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Abstract

Suicide is a substantial public health problem. In 2024, approximately 49,000 persons died by suicide in the United States, and an estimated 2.9 million persons aged ≥12 years reported having attempted suicide. Emergency department (ED) visits for suspected suicide attempts among adolescents increased during 2020–2021, then decreased in 2022; reports based on more recent data, including ED visits for suicide attempts among older age groups, are lacking. National Syndromic Surveillance Program data were examined overall and by sex and age group to identify changes in ED visits for suspected suicide attempts. During 2021–2025, numbers of ED visits for suspected suicide attempts and proportions of those visits among all ED visits for any reason (visit proportions) were highest among adolescents aged 12–17 years compared with other age groups and were higher among females than among males. Compared with 2021, overall visit proportions in 2025 declined 7.0%, with the largest decreases occurring among adolescents aged 12–17 years (20.8% decline) and females (10.7% decline). Visit proportions increased among adults in age groups ≥26 years (range = 1.4%–15.2%). These findings highlight the need for suicide prevention in all groups, particularly in those with high or increasing proportions of suicide attempts. Timely monitoring of suicide-related data and a comprehensive approach that both prevents suicidal behavior by addressing multiple risk and protective factors and also supports those who have attempted suicide are critical for saving lives.

[*] These authors contributed equally to this report.

Introduction

During 2024, a total of 48,824 persons in the United States died by suicide (*1*). These deaths are only one part of a larger public health problem; an estimated 2.9 million persons in the United States aged ≥12 years reported attempting suicide in 2024[†] (*2*). Emergency departments (EDs) are an important setting for tracking trends in suicidal behavior in near real-time.

During 2019–2022, notable changes in ED visits for suspected suicide attempts among adolescents and young adults occurred (*3*,*4*). Although ED visit numbers for suspected suicide attempts initially decreased during spring 2020 compared with spring 2019, the number of such visits increased in adolescents by summer 2020; proportions of all ED visits for suspected suicide attempts among adolescents and young adults were elevated through spring 2021 (*3*). A second study of suicide attempts among adolescents found decreases from 2021 to 2022, particularly among girls (*4*). Reports based on recent data on suicide attempts, including those among adults aged ≥26 years, are lacking. To understand whether decreasing

[†] Based on age-specific estimates (age groups 12–17 and >18 years); summed to produce total population estimate.

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trends have persisted and to guide suicide prevention activities, this report evaluated January 2021–December 2025 data from the National Syndromic Surveillance Program (NSSP) on ED visits for suspected suicide attempts, by sex and age group.

Methods

Data Source

NSSP receives deidentified ED data from state and local health departments, usually within 24 hours of a patient's visit to a medical facility. Approximately 83% of U.S. EDs contribute to NSSP. Data filters were applied to ensure that only facilities with rigorous and consistent reporting to NSSP across the study period were included. Among 5,398 facilities that shared data with CDC during 2021–2025, a total of 3,184 (59.0%) met the inclusion criteria after applying data quality filters. These facilities account for 80.6% of ED visits sent to NSSP during the analysis period.

Data Analysis

For this analysis, a validated definition that excludes visits for nonsuicidal self-harm was used to identify ED visits for suspected suicide attempts (Suicide Attempt Definition Factsheet and Technical Brief | CDC). NSSP was queried for ED visits for suspected suicide attempts and total ED visits during January 1, 2021–December 31, 2025. To account for fluctuations in ED visit volume during the study period, proportions of suspected suicide attempts per 10,000 ED visits for any reason (visit proportions) were calculated overall, by sex, and by age group (≤11, 12–17, 18–25, 26–34, 35–44, 45–54, 55–64, and ≥65 years). Visits with no reported patient age (0.6% of visits) and those with no reported patient sex (0.2% of visits) were excluded from respective age or sex stratifications. Consistent with previously published methods (*3*,*4*), comparisons were made using visit ratios (VRs)[§] with 95% CIs and percent changes in visit proportions.[¶] All analyses were completed in R (version 4.4.0; R Foundation). This activity was reviewed by CDC, deemed not research, and conducted consistent with applicable federal law and CDC policy.[**]

Results

Overall Number of Visits and Visit Proportions

During January 1, 2021–December 31, 2025, among 527,183,306 ED visits for any reason, 833,335 ED visits for suspected suicide attempts were identified (15.8 per 10,000 visits); 502,452 (60.3%) of such visits were by females (17.4 per 10,000 visits); and 328,962 (39.5%) were by males

[§] VR = (ED visits for suspected suicide attempts [comparison group] / All ED visits [comparison group]) / (ED visits for suspected suicide attempts [Reference] / All ED visits [Reference]). A 95% CI for a VR that excludes 1 indicates that the VR is statistically significant.

[¶] Percent change was calculated using the following equation: ([Comparison visit proportion for 2022, 2023, 2024, or 2025 – Reference visit proportion for 2021] / [Reference visit proportion for 2021]) x 100. Changes were calculated with unrounded visit proportions.

[**] 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. Sect. 241(d); 5 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq.

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(13.8 per 10,000 visits). By age group, the highest number of visits for suspected suicide attempts were by adolescents aged 12–17 years (207,028 visits; 24.8%); this group also had the highest visit proportion of ED visits for suspected attempted suicide (82.2 per 10,000 visits), particularly among girls (120.0 per 10,000 visits). Adolescents aged 12–17 years also consistently had the highest proportions of such visits each month, although visit numbers and especially visit proportions declined during the study period (Figure).

Annual Comparisons

Overall, whereas monthly average numbers of ED visits for suspected suicide attempts were similar in 2021 (monthly average = 13,668) and 2025 (monthly average = 13,889), visit proportions for suspected suicide attempts decreased by 7.0%, from 16.6 to 15.5 per 10,000 visits (VR = 0.93) (Table). Compared with 2021, the largest decreases in 2025 occurred in females (VR = 0.89; percent change = 10.7%) and adolescents aged 12–17 years (VR = 0.79; percent change = 20.8%). Among adolescents aged 12–17 years, decreases were larger for females (VR = 0.78; percent change = 22.3%) than for males (VR = 0.91; percent change = 8.9%) (Supplementary Table). In addition, the decrease from 2021 to 2025 in this age group was smaller than the decrease from 2021 to 2024 (VR = 0.74; percent change = 26.5%), indicating a small increase from 2024 to 2025; increases from 2024 to 2025 were also observed for children aged ≤11 years (Table). Visit proportions for suspected suicide attempts by adults aged ≥26 years increased significantly for most age groups during 2022–2025 compared with 2021. In 2025 compared with 2021, increases were observed among adults aged 55–64 years (VR = 1.15; percent change = 15.2%) and ≥65 years (VR = 1.12; percent change = 12.3%). Similar patterns of decreases among adolescents aged 12–17 years and females, and increases in numbers of ED visits for suspected suicide attempts among adults aged ≥26 years were observed.

Discussion

After reports of increases in U.S. ED visit numbers and visit proportions for suspected suicide attempts during 2020 and 2021 (*3*,*5*), this analysis of current data found an overall decrease in the proportion of suspected suicide attempt–related ED visits during 2021–2025. In addition to substantial decreases in visit proportions, decreases in visit numbers among adolescents aged 12–17 years also occurred during this period. Although these declines are encouraging, adolescents, particularly girls, continue to be disproportionately represented among ED visits for suspected suicide attempts. This report also noted that adults aged ≥26 years experienced small yet significant increases in proportions of ED visits for suspected suicide attempts from 2021 to 2025. Suicide attempts are more likely to be lethal with increasing age, especially among adults aged ≥65 years (*6*).

Summary

What is already known about this topic?

In 2024, approximately 49,000 persons died by suicide in the United States, and an estimated 2.9 million persons aged ≥12 years reported attempting suicide.

What is added by this report?

During 2021–2025, numbers of emergency department (ED) visits for suspected suicide attempts and the proportions of those visits among all ED visits for any reason (visit proportions) were highest among adolescents aged 12–17 years compared with other age groups. Overall visit proportions decreased, with the largest decreases occurring among adolescents aged 12–17 years and among females; however, visit proportions increased among adults aged ≥26 years.

What are the implications for public health practice?

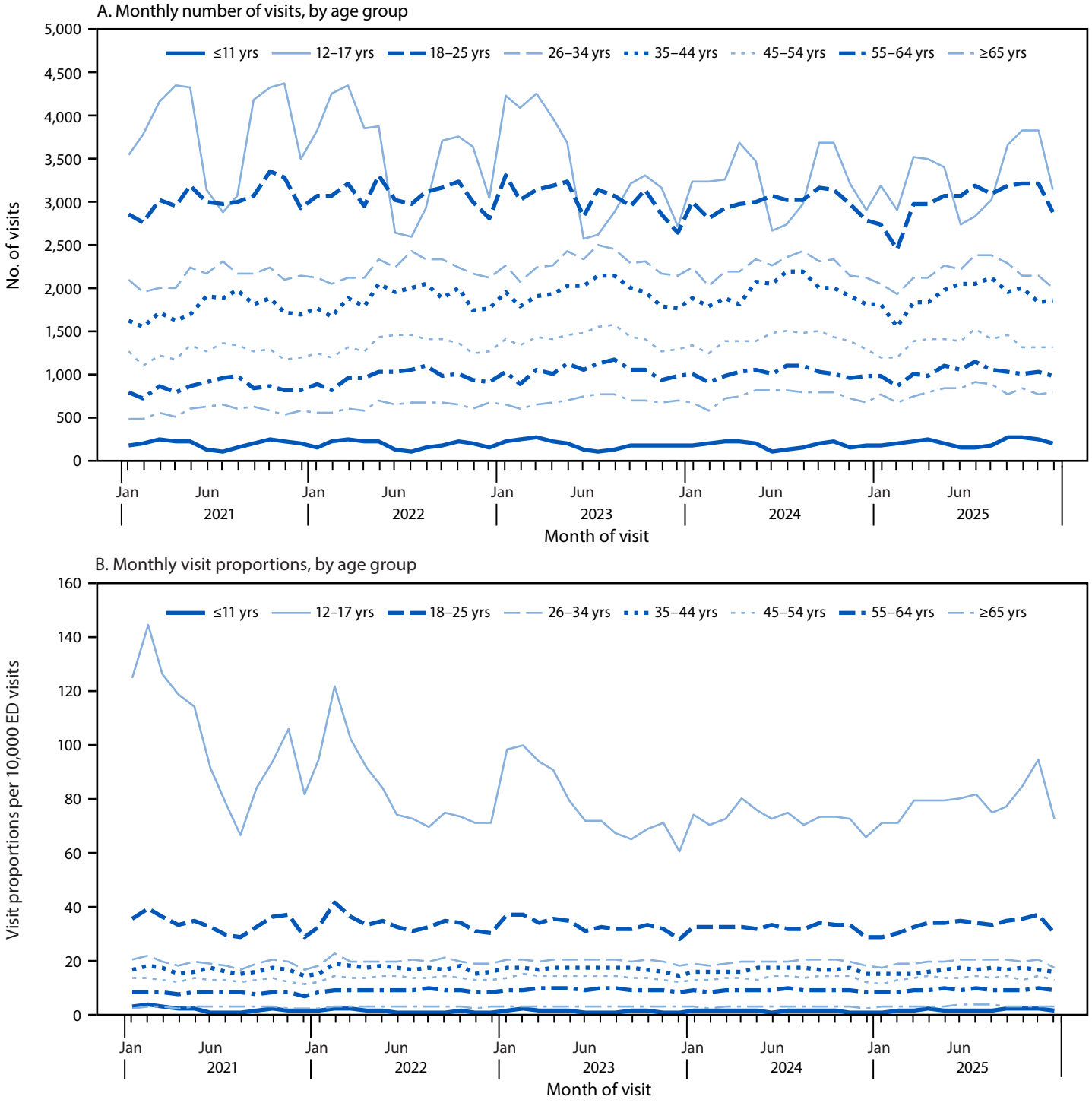
Timely monitoring and a comprehensive approach that both prevents suicidal behavior and supports persons who have attempted suicide are critical for all groups, especially those with high or increasing numbers and proportions of suicide attempts.

No single cause of suicide attempts exists (*7*). Risk factors for suicide attempts include, but are not limited to, job or financial problems, loss of relationships, and violence victimization; protective factors include access to health care, feeling connected to others, and having effective coping and problem-solving skills, among others (*7*). These and other factors might have varied during the study period and contributed to differential changes by group. For example, adolescents, especially girls, reported high levels of disconnection during periods of disruption to routines associated with the COVID-19 pandemic, which abated later in the study period (*8*). In contrast, older adults were disproportionately represented among those who had lost longer-term sources of social support, including close family members and friends, during the study period (*9*). However, these are just a few of many factors that might explain observed differences. In addition, youth suicide prevention measures, such as the 2021 Surgeon General's Advisory on Protecting Youth Mental Health, have been an area of focused public health activity in recent years (*10*) and might have helped reduce suicide attempts.

Limitations

The findings in this report are subject to at least six limitations. First, findings underestimate the number of suicide attempts, because not all suicide attempts, including those resulting in death and those among youths,[††] are treated in

FIGURE. Number of monthly emergency department* visits† for suspected suicide attempts (A) and visit proportions for suspected suicide attempts (B) per 10,000 emergency department visits for any reason, by age group and month — National Syndromic Surveillance Program, United States, 2021–2025



Abbreviations: ED = emergency department; NSSP = National Syndromic Surveillance Program.

* Filters were applied to only include data from facilities with a coefficient of variation ≤40 and an average weekly informative discharge diagnosis ≥70% for the entire study period. Of 5,398 facilities that shared data with CDC during 2021–2025, 3,184 facilities (59.0%) met the inclusion criteria after applying data quality filters. These facilities account for 80.6% of emergency department visits sent to NSSP during the analysis period.

† CDC Suicide Attempt (v2) | Definition Factsheet & Technical Brief

TABLE. Number of visits, visit proportions, visit ratios, and change in visit proportions in emergency department visits* for suspected suicide attempts,† by year, age group, and sex — National Syndromic Surveillance Program, United States, 2021–2025

Characteristic	Average monthly no. of ED visits for suspected suicide attempts§	Average monthly no. of ED visits for any reason§	Annual visit proportions for suspected suicide attempts, per 10,000 ED visits for any reason	Visit ratio (95% CI)¶	Percent change in annual visit proportions compared with 2021**
Year					
2021	13,668	8,210,951	16.6	Ref	Ref
2022	13,927	8,728,823	16.0	0.96 (0.95–0.97)††	−4.1
2023	14,104	8,949,090	15.8	0.95 (0.94–0.95)††	−5.3
2024	13,857	9,068,822	15.3	0.92 (0.91–0.92)††	−8.2
2025	13,889	8,974,256	15.5	0.93 (0.92–0.94)††	−7.0
Sex					
Female					
2021	8,404	4,461,529	18.8	Ref	Ref
2022	8,452	4,756,740	17.8	0.94 (0.94–0.95)††	−5.7
2023	8,519	4,896,000	17.4	0.92 (0.92–0.93)††	−7.6
2024	8,215	4,967,052	16.5	0.88 (0.87–0.89)††	−12.2
2025	8,281	4,924,062	16.8	0.89 (0.89–0.90)††	−10.7
Male					
2021	5,235	3,725,127	14.1	Ref	Ref
2022	5,447	3,954,674	13.8	0.98 (0.97–0.99)††	−2.0
2023	5,551	4,037,862	13.7	0.98 (0.97–0.99)††	−2.2
2024	5,614	4,086,977	13.7	0.98 (0.97–0.99)††	−2.2
2025	5,567	4,032,254	13.8	0.98 (0.97–0.99)††	−1.7
Age group, yrs					
≤11					
2021	195	905,313	2.2	Ref	Ref
2022	184	1,152,013	1.6	0.74 (0.70–0.79)††	−25.8
2023	187	1,124,019	1.7	0.77 (0.73–0.82)††	−23.0
2024	182	1,089,062	1.7	0.78 (0.73–0.82)††	−22.4
2025	209	1,024,123	2.0	0.95 (0.90–1.00)	−5.3
12–17					
2021	3,800	381,394	99.6	Ref	Ref
2022	3,540	427,278	82.9	0.83 (0.82–0.84)††	−16.8
2023	3,391	433,541	78.2	0.79 (0.77–0.80)††	−21.5
2024	3,225	440,170	73.3	0.74 (0.73–0.75)††	−26.5
2025	3,295	417,568	78.9	0.79 (0.78–0.80)††	−20.8
18–25					
2021	3,030	901,094	33.6	Ref	Ref
2022	3,078	908,498	33.9	1.01 (0.99–1.02)	0.8
2023	3,044	909,235	33.5	1.00 (0.98–1.01)	−0.4
2024	2,990	914,891	32.7	0.97 (0.96–0.99)††	−2.8
2025	3,003	891,690	33.7	1.00 (0.99–1.02)	0.2

See table footnotes on the next page.

ED settings; reductions in care-seeking behaviors might have further reduced the number of ED visits in the early parts of the study period, which coincided with the pandemic. Second, whether ED care-seeking behavior for suicide attempts was similar to that for other conditions during this period is unclear, which would affect observed visit proportions. Third, unavailability of population sizes for ED catchment areas precluded calculations of ED visit rates per population. Fourth, underascertainment of suicide attempts is likely given the administrative nature of the data and reliance on limited documentation in medical records. Fifth, findings of this study cannot be directly compared with those from studies using different definitions of suspected suicide attempts. Finally, this analysis did not examine state or local trends that could help guide prevention strategies to reduce suicide attempts and related behaviors.

Implications for Public Health Practice

The number of ED visits for suspected suicide attempts remains high; therefore, prevention of suicide and suicide attempts in all persons, especially in groups with high or increasing proportions of ED visits for suspected suicide attempts, is an important consideration when planning public health activities. This prioritization includes incorporating less

†† In 2023, 9% of high school students reported attempting suicide in the previous year; 2% reported being injured in a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the previous year. Youth Risk Behavior Survey Data Summary & Trends Report: 2013-2023

TABLE. (*Continued*) Number of visits, visit proportions, visit ratios, and change in visit proportions in emergency department visits* for suspected suicide attempts,† by year, age group, and sex — National Syndromic Surveillance Program, United States, 2021–2025

Characteristic	Average monthly no. of ED visits for suspected suicide attempts§	Average monthly no. of ED visits for any reason§	Annual visit proportions for suspected suicide attempts, per 10,000 ED visits for any reason	Visit ratio (95% CI)¶	Percent change in annual visit proportions compared with 2021**
26–34					
2021	2,132	1,105,516	19.3	Ref	Ref
2022	2,219	1,106,705	20.0	1.04 (1.02–1.06)††	4.0
2023	2,288	1,124,130	20.4	1.06 (1.04–1.07)††	5.6
2024	2,244	1,133,131	19.8	1.03 (1.01–1.04)††	2.7
2025	2,167	1,094,934	19.8	1.03 (1.01–1.04)††	2.6
35–44					
2021	1,753	1,066,530	16.4	Ref	Ref
2022	1,882	1,084,368	17.4	1.06 (1.04–1.08)††	5.6
2023	1,954	1,131,362	17.3	1.05 (1.03–1.07)††	5.1
2024	1,965	1,160,538	16.9	1.03 (1.01–1.05)††	3.0
2025	1,909	1,145,749	16.7	1.01 (1.00–1.03)	1.4
45–54					
2021	1,249	957,694	13.0	Ref	Ref
2022	1,338	960,735	13.9	1.07 (1.04–1.09)††	6.8
2023	1,421	988,055	14.4	1.10 (1.08–1.13)††	10.3
2024	1,402	1,000,079	14.0	1.07 (1.05–1.10)††	7.5
2025	1,360	985,064	13.8	1.06 (1.04–1.08)††	5.9
55–64					
2021	852	1,024,512	8.3	Ref	Ref
2022	973	1,046,374	9.3	1.12 (1.09–1.15)††	11.8
2023	1,038	1,068,765	9.7	1.17 (1.14–1.20)††	16.8
2024	1,013	1,077,546	9.4	1.13 (1.10–1.16)††	13.1
2025	1,021	1,066,350	9.6	1.15 (1.12–1.18)††	15.2
≥65					
2021	572	1,819,254	3.1	Ref	Ref
2022	636	1,996,054	3.2	1.01 (0.98–1.05)	1.5
2023	693	2,111,587	3.3	1.04 (1.01–1.08)††	4.4
2024	744	2,208,088	3.4	1.07 (1.04–1.11)††	7.1
2025	803	2,275,042	3.5	1.12 (1.09–1.16)††	12.3

Abbreviations: ED = emergency department; Ref = referent group.

* Filters were applied to only include data from facilities with a coefficient of variation ≤40 and an average weekly informative discharge diagnosis ≥70% for the entire study period. Of 5,398 facilities that shared data with CDC during 2021–2025, a total of 3,184 facilities (59.0%) met the inclusion criteria after applying data quality filters. These facilities account for 80.6% of ED visits sent to the National Syndromic Surveillance Program during the analysis period.

† CDC Suicide Attempt (v2) Definition Factsheet & Technical Brief

§ Rounded to nearest whole number.

¶ Visit ratio = (ED visits for suspected suicide attempts [comparison group] / All ED visits [comparison group]) / (ED visits for suspected suicide attempts [Reference] / All ED visits [Reference]).

** Percent change was calculated using the following equation: ([Comparison visit proportion for 2022, 2023, 2024, or 2025 – Reference visit proportion for 2021] / [Reference visit proportion for 2021]) × 100. Changes were calculated with unrounded visit proportions.

†† Statistically significant difference between comparison and reference periods.

commonly examined groups, including adults aged ≥26 years who have experienced sustained increases in recent years, as well as adolescents, for whom suspected suicide attempts remain high despite decreases. Further, timely monitoring of trends, especially considering increases during 2024–2025 in youths and adolescents, is important to facilitating prompt action. Strategies implemented as part of a comprehensive approach, such as through CDC's Comprehensive Suicide Prevention Program, are crucial to reducing suicide and suicide attempts. This approach is further detailed in CDC's Suicide Prevention Resource for Action (*7*) and the 2024 National Strategy for Suicide Prevention. This comprehensive approach incorporates downstream prevention measures that can support persons in crisis§§ and includes strategies that can be implemented in ED settings such as the Zero Suicide framework. However, upstream strategies, such as promoting connectedness, teaching coping and problem-solving skills, and strengthening economic supports, can be critically important to addressing population-specific factors and preventing persons from becoming suicidal in the first place. Together, upstream and downstream prevention are essential for reducing suicide attempts and suicides.

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§§ For persons in crisis, help is available through the Substance Abuse and Mental Health Services Administration's 988 Suicide and Crisis Lifeline (https://www.988lifeline.org) or by texting or calling 988.

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Notes from the Field

Drug Overdose Deaths in Hotels and Motels — United States, 2022–2024

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In 2024, at least 2,327 drug overdose deaths occurred in hotels and motels, the second most common location after houses and apartments (*1*). Analyses of overdose locations can help jurisdictions make decisions regarding optimal distribution of limited local resources for prevention, including opioid overdose reversal medications such as naloxone, and identify local options for substance use disorder treatment to prevent overdose deaths among residents (*2*–*4*). However, analyses of overdose locations do not always explicitly include hotels and motels (*4*). Public health interventions can benefit from improved understanding of the circumstances surrounding drug overdose deaths in hotels and motels, including whether local resources to prevent overdoses among residents might be used in these locations. CDC analyzed data from its State Unintentional Drug Overdose Response System (SUDORS) to characterize drug overdose deaths that occurred in hotels and motels during 2022–2024.

Investigation and Outcomes

Data Source and Analysis

SUDORS collects data on overdose deaths that were unintentional or of undetermined intent from death certificates, postmortem toxicology reports, and reports with contextual data about the circumstances of the death (e.g., coroner or medical examiner investigation reports, emergency medical services records, and medical records). CDC conducted a descriptive analysis of 2022–2024 SUDORS data from 47 jurisdictions (46 states and the District of Columbia).* The objective of this analysis was to describe certain characteristics of overdose deaths that occur in hotels and motels, including the demographic characteristics of decedents and the percentage who were residents of the same county where the hotel or motel was located, with the goal of identifying potential missed opportunities for intervention, prevention, and connection to treatment. This activity was reviewed by CDC, deemed not research, and conducted consistent with applicable federal law and CDC policy.†

Decedent Characteristics, Bystander Responses, Opioid Involvement, and Naloxone Use

Decedent characteristics. Among 191,575 overdose deaths during 2022–2024 across 47 SUDORS-participating jurisdictions, 9,651 (5.0%) occurred in hotels and motels.§ Among the decedents, 71.3% were male, 74.6% were aged 25–54 years, and 64.6% were White (Table).¶ Among the 9,344 (96.8%) overdose deaths in hotels and motels for whom the decedent's county of residence was known, 5,253 (56.2%) occurred in the county where the decedent lived.

Bystander responses. Potential bystanders** were present or nearby at the time of the fatal overdose for 3,344 (34.7%) of these overdoses in hotels and motels. Among these fatal overdoses, 2,122 (63.5%) had either no documented bystander response or a delayed bystander response. In approximately one third (631; 29.7%) of fatal overdoses for which a bystander was present but the response was delayed or did not occur, the bystander's use of substances or alcohol was noted as a potential reason for the delayed or absent response.

Opioid involvement and naloxone administration. Opioids were involved in 8,254 (85.5%) overdose deaths in hotels and motels. In approximately one fifth (1,705; 20.7%) of these fatal overdoses, naloxone was administered. In at least 24 deaths, naloxone was administered by a hotel or motel employee.

* Restricted to deaths with contextual data from jurisdictions with death certificates and contextual data for ≥75% of deaths for at least one 6-month reporting period during 2022–2024 in the following 47 jurisdictions: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

† 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. Sect. 241(d); 5 U.S.C. Sect. 552a; 44 U.S.C. Sect. 3501 et seq.

§ Place of residence, injury, and death were obtained from the death certificate. If the place of injury where the overdose occurred (e.g., a hotel or motel, school, or house) was missing or unknown, the place of death was used to determine whether the overdose death occurred in a hotel or motel. If the county of injury was missing from the death certificate, the county of death was used in place of county of injury to determine whether a decedent lived in the same jurisdiction.

¶ Persons of Hispanic or Latino (Hispanic) ethnicity, regardless of race, were classified as Hispanic. Persons who were non-Hispanic were reported by their indicated single-race classification.

** A potential bystander was defined as a person aged ≥11 years who was physically nearby either during or shortly before the drug overdose and potentially had an opportunity to intervene in or respond to the overdose. This did not include persons in different self-contained parts of larger buildings (e.g., a person in the same hotel but in a different hotel room) but did include persons in a different room nearby where they might have had the opportunity to intervene if they had known the decedent was using drugs (e.g., the bathroom).

TABLE. Number and percentage of drug overdose deaths in hotels and motels,* by demographic characteristics of decedents, types of drugs involved, bystander responses, and naloxone use — State Unintentional Drug Overdose Reporting System, United States,† 2022–2024

Characteristic	No. (%)
Total	**9,651 (100.0)**
Age group, yrs§	
<15	16 (0.2)
15–24	391 (4.1)
25–34	2,115 (21.9)
35–44	2,907 (30.1)
45–54	2,182 (22.6)
55–64	1,617 (16.8)
≥65	422 (4.4)
Sex§	
Female	2,774 (28.7)
Male	6,877 (71.3)
Race and ethnicity§,¶	
American Indian or Alaska Native	186 (1.9)
Asian	74 (0.8)
Black or African American	2,042 (21.2)
Hispanic or Latino	890 (9.2)
Native Hawaiian or Pacific Islander	7 (0.1)
White	6,229 (64.6)
Other race or multiple races	130 (1.3)
Decedent lived in county of overdose**	5,253 (56.2)
Presence and reasons for nonresponse of potential bystanders	
Potential bystander present††	3,344 (34.7)
Did not respond or had a delayed response§§	2,122 (63.5)
Was spatially separated	682 (32.1)
Was using substances or alcohol	631 (29.7)
Did not recognize symptoms as an overdose	401 (18.9)
Did not recognize abnormalities	356 (16.8)
Was unaware decedent was using substances	279 (13.1)
Occurred in a public space; strangers did not intervene	45 (2.1)
Drugs involved¶¶	
Any opioid***	8,254 (85.5)
Illegally manufactured fentanyls	7,831 (81.1)
Any stimulant	6,662 (69.0)
Any opioid and any stimulant	5,450 (56.5)
Naloxone administered†††	**1,705 (20.7)**
By professional responder§§§,¶¶¶	913 (53.5)
By lay person§§§	373 (21.9)
By hotel staff member§§§,****	24 (1.4)
By unknown person§§§	530 (31.1)

TABLE. (*Continued*) Number and percentage of drug overdose deaths in hotels and motels,* by demographic characteristics of decedents, types of drugs involved, bystander responses, and naloxone use — State Unintentional Drug Overdose Reporting System, United States,† 2022–2024

* Data on place of residence, place of injury, and place of death were obtained from the death certificate. If the place of injury was missing or unknown, the place of death was used to determine whether the overdose death occurred in a hotel or motel.

† Restricted to deaths with contextual data from jurisdictions with death certificates and contextual data for ≥75% of deaths for at least one 6-month reporting period during 2022–2024 in the following 47 jurisdictions: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

§ Missing values were excluded from calculations of percentages. Percentages might not sum to 100 because of rounding. Fewer than 1% of deaths were missing age data and <5% of deaths were missing race and ethnicity classification data.

¶ Persons of Hispanic or Latino (Hispanic) ethnicity, regardless of race, were classified as Hispanic. Persons who were non-Hispanic were reported by their indicated single-race classification (American Indian or Alaska Native, Black or African American, White, or other race or multiple races).

** If county of injury was missing from the death certificate, county of death was used rather than county of injury to determine whether a decedent was a resident of the same jurisdiction. Denominator used in calculation of percentage was the total number of deaths with residence and place of injury or death (9,344).

†† Denominator was used to calculate the percentage of deaths without a response or with a delayed response. Bystander responses were not mutually exclusive. A potential bystander was defined as a person aged ≥11 years who was physically nearby either during or shortly before the drug overdose and potentially had an opportunity to intervene in or respond to the overdose. This did not include persons in different self-contained parts of larger buildings (e.g., a person in the same hotel but in a different hotel room) but did include persons in a different room nearby where they might have had the opportunity to intervene if they had known the decedent was using drugs (e.g., the bathroom).

§§ Denominator was used to calculate the percentage of deaths with potential reasons for an absence or delay in bystander response.

¶¶ A drug was considered involved in the death if it was listed as a cause of death on the death certificate or in the medical examiner or coroner report. Percentages might sum to >100 because drug categories were not mutually exclusive.

*** Deaths that had at least one opioid listed as a cause of death (i.e., illegally manufactured fentanyls, heroin, prescription opioids, and any other opioids) were considered opioid-involved deaths.

††† Denominator used in calculating percentage was the total number of deaths with opioids involved.

§§§ Denominator used in calculating percentage was the total number of deaths with opioids involved with evidence naloxone was administered.

¶¶¶ Professional responder categories included emergency medical services responders and firefighters, law enforcement officers, and hospital or other health care staff members.

**** Hotel or motel employees were identified based on review of a write-in field in the data entry system.

Preliminary Conclusions and Actions

Among overdose deaths that were unintentional or of undetermined intent that occurred in hotels and motels during 2022–2024, multiple potential opportunities for prevention were identified. More than one half (56.2%) of overdose deaths in hotels and motels occurred in the same county where the decedent lived, indicating that focusing local overdose prevention resources in these locations might be appropriate. During the same period, among fatal overdoses for which potential bystanders did not respond or had a delayed response, substance use by the bystander was identified as a reason in approximately 30% of cases, which is three times the percentage among all overdose deaths (8.7%–9.8%) (*1*). This finding suggests that some persons might go to hotels and motels for the purpose of using drugs with others. Among overdose deaths that occurred in hotels and motels, the percentage that involved opioids (85.5%) was higher than that of all overdose deaths (73.4%–81.7%) (*1*). Timely administration

Summary

What is already known about this topic?

In 2024, at least 2,327 drug overdose deaths that were unintentional or of undetermined intent occurred in hotels and motels. Location-specific overdose data might help guide distribution of overdose prevention resources.

What is added by this report?

During 2022–2024, at least 9,651 drug overdose deaths occurred in U.S. hotels and motels; more than one half (56.2%) occurred in the same county where the decedent lived. A potential bystander (a person who was physically nearby and had an opportunity to intervene) was present for 34.7% of deaths, but a timely response was delayed or did not occur in 63.5% of these deaths. Substance use by the bystander was a reason for 29.7% of nonresponses or delayed responses.

What are the implications for public health practice?

Enhancing drug overdose prevention strategies in hotels and motels, including providing information about local treatment options and opioid overdose reversal medication distribution and education, might help prevent overdose deaths in these settings.

of opioid overdose reversal medications by a bystander, such as a hotel or motel employee, can help prevent additional overdose deaths.

These findings suggest that including hotels and motels in overdose surveillance data analyses and, depending on the local context and resources, partnering with hotel and motel operators when planning overdose prevention programs might help public health officials improve the safety of guests and help prevent overdose deaths in these locations. Evidence-based strategies might include providing staff members with training on how to administer opioid overdose reversal medications, as well as education on overdose recognition and Good Samaritan Laws (*5*). In addition, overdose reversal kits and information about local substance use disorder treatment options might be made available in common areas of hotels and motels.

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