2025 THE STATE OF OPIOID OVERDOSE AND RESPONSE IN THE U.S.

Mental Health America

ACKNOWLEDGEMENTS

Mental Health America (MHA) was founded in 1909 and is the leading national nonprofit dedicated to the promotion of mental health, well-being, and illness prevention. Our work is informed, designed, and led by the lived experience of those most affected. Operating nationally and in communities across the country, Mental Health America advocates for closing the mental health equity gap, while increasing nationwide awareness and understanding through public education, research, direct service and policy, making MHA a national standard bearer in public mental health advocacy and community-based solutions.

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INTRODUCTION

Since 1999, nearly one million people have died of an opioid overdose.[1] In 2017, President Trump declared the opioid crisis a public health emergency, leading to increased investment and implementation of interventions to decrease overdoses. At the same time, millions of dollars have been awarded to cities and states from opioid-related settlements, further increasing resources for overdose prevention, harm reduction, and response.

According to the Centers for Disease Control and Prevention (CDC), overdose was and remains the leading cause of death for Americans ages 18-44, and overdoses involving synthetic opioids, primarily fentanyl, still make up most drug overdose deaths in the United States.[2] Between 2023 and 2024, there was a 27% decrease in the number of overdose deaths in the U.S., the lowest number of overdose deaths in one year since 2019.[3] The decrease in overdose deaths involving opioids highlights the important role of opioid prevention strategies that include public education, increased funding, and the greater availability of low-cost resources like naloxone. Although many states are making progress in preventing opioid overdose deaths, that progress is not uniform across the U.S. States differ significantly in their implementation of overdose prevention strategies, substance use education, and access to opioid use treatment and recovery.

The opioid crisis requires consistent short- and long-term solutions to keep individuals safe and save lives while expanding access to treatment and lasting recovery. The following report details state-level data and recommendations for action across the continuum of services and supports for opioid use, including prevention, treatment, and recovery. The data presented throughout this report show us how, where, and to whom states and localities need to provide early and preventive substance use education and access to lifesaving resources to prevent overdoses.

EXECUTIVE SUMMARY

The goal of this report is to use publicly available national data to identify where in the country additional investments are most needed and highlight specific policy recommendations that would have the highest impact for preventing and reducing opioid deaths. The rankings and policy recommendations for action are categorized into four sections: public health, health care, schools, and jails.

Public health

- Public health data represent the overall risk and protective factors of every state. These indicators include opioid overdose rates, presence of community-based substance use prevention messaging, and access to naloxone and fentanyl drug testing equipment at the state level.
- Public health recommendations focus on the role and funding of public health departments in a system of care. Recommendations include educating communities on opioid risk and access to community-level harm reduction measures, attending to the safety of the community by strategically evaluating need, and allocating resources for opioid overdose prevention strategies.

Health care

- Health care data represent rates of opioid addiction and treatment for each state. These indicators include prevalence of opioid use, access to medication-assisted treatment (MAT) and access to recovery resources for people with opioid use disorder (OUD) at the state level.
- Health care recommendations focus on the role of, and funding needed for health care systems. Recommendations address the specific interventions needed to increase access to care and recovery services in primary care and non-specialty mental health settings for people at the highest risk for opioid overdose death.

Schools

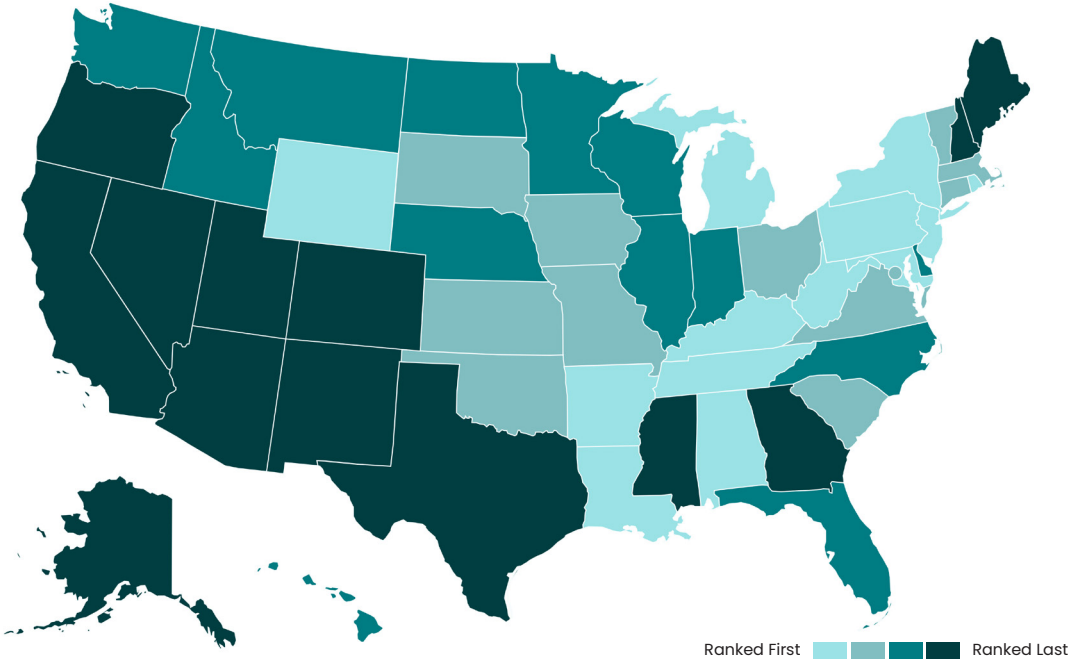
- School data represent state-level access to opioid use prevention education in schools for both students and parents.
- School recommendations focus on the role and funding needed for schools to address opioid overdose at the earliest moment in life span development. Recommendations include guidance for substance use education, access to naloxone in spaces with higher risk of overdose, and equipping parents with resources to address opioid use and overdose prevention with their families.

Jails

- Jail data represent state-level access to naloxone and MAT for people with OUD upon release from jail.
- Jail recommendations focus on the role of, and funding needed for incarceration systems to reduce opioid overdoses, especially for those who are returning to community settings. Recommendations include distribution of naloxone, and enhanced connections to community-based treatment resources for people leaving incarceration.

Collectively, the measures and recommendations represent the various points in the system of care with the greatest potential impact for reducing opioid deaths. For each sector, the report provides: a list of the indicators used for scoring, the overall ranking results, the specific policy recommendations for each system of care, and a breakdown of findings for each indicator. For more information on methodology for calculating the overall rankings, refer to the methodology section on page 48.

PUBLIC HEALTH RANKING



Rank	State
1	Arkansas
2	Kentucky
3	West Virginia
4	New Jersey
5	Michigan
6	Pennsylvania
7	Wyoming
8	New York
9	Rhode Island
10	Louisiana
11	Alabama
12	Maryland
13	Tennessee
14	Massachusetts
15	Vermont
16	Ohio
17	South Dakota

Rank	State
18	Missouri
19	South Carolina
20	Kansas
21	District of Columbia
22	Virginia
23	Iowa
24	Connecticut
25	Oklahoma
26	Indiana
27	Idaho
28	Hawaii
29	Wisconsin
30	Montana
31	North Carolina
32	North Dakota
33	Delaware
34	Washington

Rank	State
35	Minnesota
36	Nebraska
37	Illinois
38	Florida
39	Georgia
40	Maine
41	Oregon
42	Colorado
43	California
44	Utah
45	Mississippi
46	Arizona
47	Nevada
48	Texas
49	New Hampshire
50	New Mexico
51	Alaska

A strong public health approach to reducing opioid deaths requires enhanced tracking of where deaths are likely to occur and the implementation of broad community-based prevention strategies. Public health strategies include public education, public access to harm reduction interventions, and community access to health care that can provide opioid-related support at scale.

Public health indicators

- Provisional number of overdoses from all opioids per 100,000 people
- State naloxone dispensing rate per 100 individuals in the state population
- Percentage of youth reporting they have seen or heard alcohol or drug prevention messages from a source outside of school
- Number of pharmacies per 1,000 people in the state population
- Percentage of adults who report they do not have a personal doctor or health care provider

Relevant data not included in ranking

- States in which fentanyl drug-checking equipment possession and/or free distribution is permitted by state law

Overall public health ranking

The states with the highest risk for opioid overdose and lowest access to public health interventions were located in the southwestern U.S. The 10 states with the highest need for strategic public health opioid investment are: Alaska, New Mexico, New Hampshire, Texas, Nevada, Arizona, Mississippi, Utah, California, and Colorado. These states have the highest rates of overdose, lowest rates of naloxone access, and lowest rates of community prevention programming.

STRATEGIC PUBLIC HEALTH APPROACH TO OPIOID DEATHS: POLICY RECOMMENDATIONS

The public health department's roles in preventing opioid overdose deaths are to broadly educate communities on opioid risk, to collect data on where overdose prevention strategies are being successful, to deliver resources in places where the general public is most likely to need or seek opioid-related support, and to target resources for opioid overdose prevention where they are needed most. **To better implement a public health approach to reducing opioid deaths, states with the worst outcomes should implement the following strategies:**

- **Invest in a no-wrong-door approach** to naloxone distribution within communities. This includes provision of naloxone to law enforcement, crisis teams and community service providers, peer support specialists, schools, and other public spaces where people may overdose (see box below).
- **Ensure pharmacists have the knowledge and resources necessary** to support in-person education on overdose symptoms and using naloxone.
- **Create public health outreach and education programs** on overdose symptoms, risks, and harm reduction techniques in places where people may need or seek support for opioid use within communities (e.g., pharmacies, faith-based institutions), especially in rural communities and health care deserts.
- **Create better data collection systems** for where naloxone is distributed beyond pharmacies.
- **Educate community members about their rights** around possession and distribution of fentanyl drug-checking equipment, especially in states that do not explicitly permit it in state law.

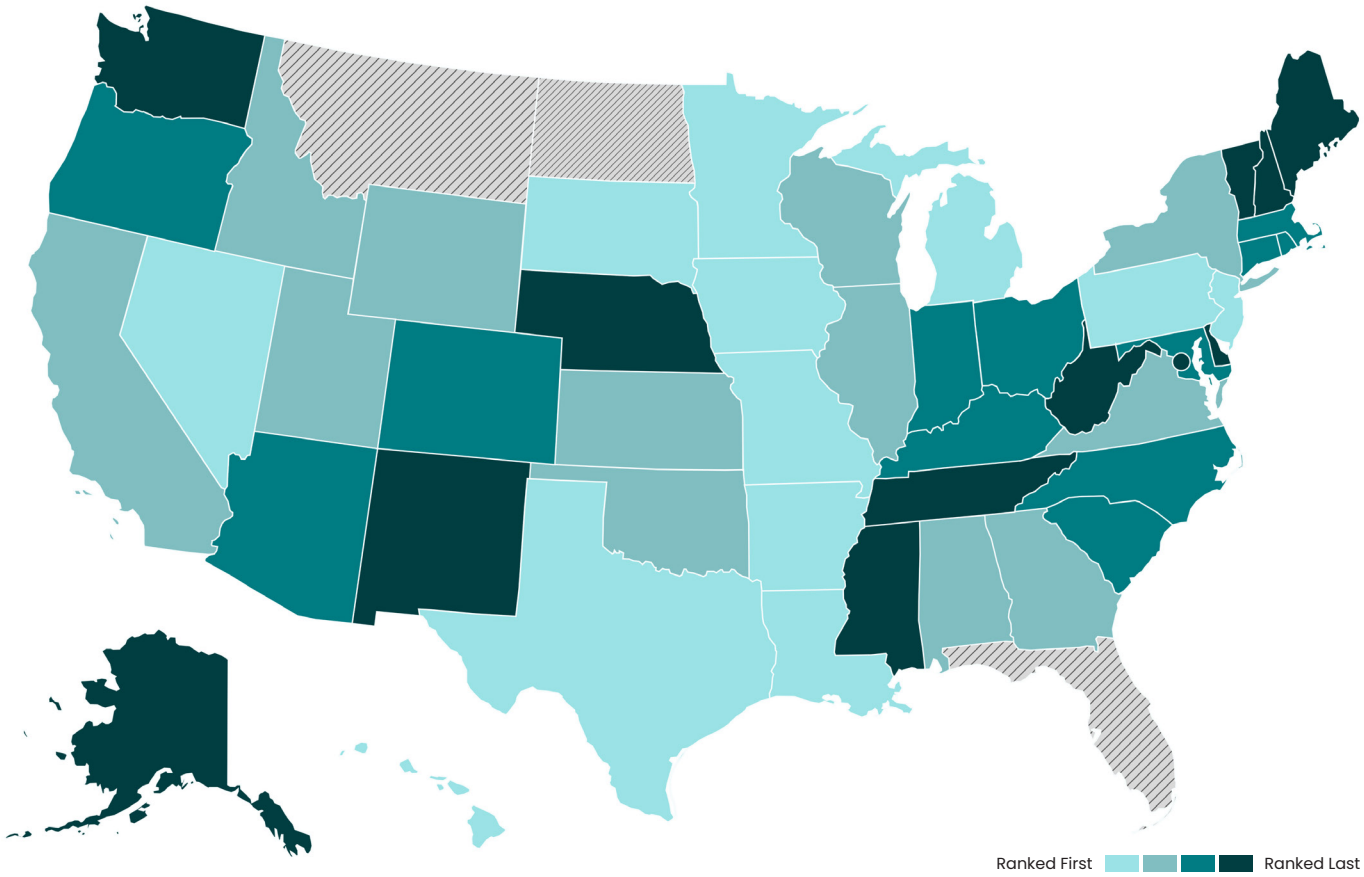
Putting naloxone with defibrillators in public spaces

Naloxone can only be effective if people can access it when they need it. Brain death begins to occur within 4 to 6 minutes of an opioid overdose.[4] According to a 2023 meta-analysis on naloxone distribution, 98.3% of people survived when naloxone was administered by people who use drugs, 95% survived when it was administered by family, friends, or other community members, and 92.4% survived when administered by law enforcement. The survival rate for law enforcement was likely lowest because by the time emergency services were called and arrived on the scene of an overdose, it was too late.[5] For the best chance of saving someone's life, naloxone must be available to bystanders within four minutes of every location where a person may experience an overdose.

State and local public health departments should leverage the existing infrastructure around Automated External Defibrillators (AEDs) to expand naloxone access in public spaces. Cardiac arrest follows a similar trajectory to opioid overdose in which survival depends on receiving defibrillation as soon as possible, before waiting for emergency services to arrive. Following recognition of the life-saving potential of AEDs, many states enacted legislation requiring public places like schools, parks, and state-owned facilities to have an AED on-site.

Public health departments can use the infrastructure that already exists by adding naloxone kits and instructions for use to defibrillator sites, where laypeople may need to intervene in an opioid overdose. Some states, like Rhode Island, New York, and West Virginia, have already begun to introduce these "naloxone boxes" in public spaces.[6] When available near clinics and other high-traffic areas, these boxes have been shown to increase naloxone distribution in communities, open conversations about opioid risk, and even reach high-risk populations that may otherwise be missed by targeted distribution.[7]

PROVISIONAL NUMBER OF OVERDOSES FROM ALL OPIOIDS



In 2024, over 54,000 people died of an opioid overdose, a significant decrease from overdose rates in 2023. According to the CDC, 30,000 fewer people died from an opioid overdose in 2024 compared to 2023.
The highest rates of opioid overdose in 2024 were in New Hampshire and Maine, both with an overdose rate of over 100 per 100,000 people in the state population.[8]

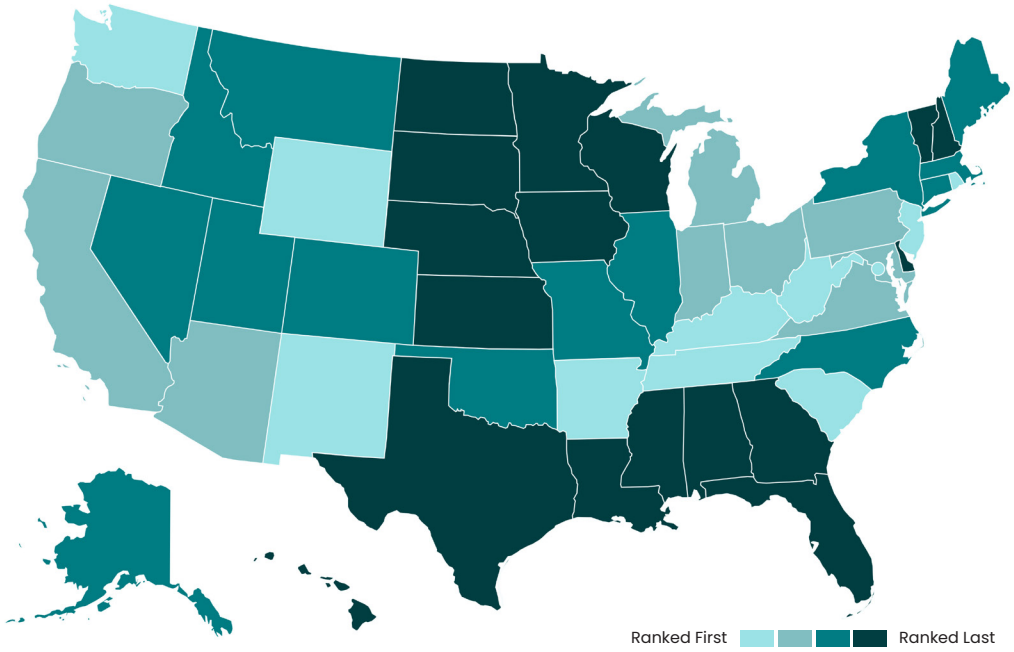
Between 2023 and 2024, all states except for South Dakota had decreases in opioid overdose deaths. In South Dakota, the number of opioid overdose deaths remained the same across both years.

States in the western half of the U.S. experienced smaller decreases in opioid overdose deaths than those in the eastern half of the country. West Virginia, Arkansas, and Wisconsin had the greatest decreases in opioid overdose deaths (greater than 45%). These reductions in opioid deaths demonstrate the impact of increased investment and the continued need for surveillance data for tailored community response.

Rank	State	Number of overdose deaths per 100,000 people	Total number of overdose deaths
1	Missouri	1.55	96
2	Pennsylvania	3.70	479
3	South Dakota	4.13	38
4	Minnesota	5.04	289
5	Arkansas	5.28	162
6	Iowa	5.33	171
7	New Jersey	5.40	502
8	Michigan	6.73	676
9	Nevada	7.67	245
10	Texas	7.90	2,411
11	Louisiana	8.42	385
12	Hawaii	8.85	127
13	New York	9.22	1,804
14	Idaho	9.93	195
15	Wyoming	9.93	58
16	Georgia	11.33	1,250
17	Kansas	11.73	345
18	Utah	13.20	451
19	Wisconsin	13.26	784
20	Virginia	13.44	1,171
21	Oklahoma	14.16	574
22	Illinois	14.99	1,881
23	California	15.22	5,930
24	Alabama	15.64	799
25	Indiana	16.70	1,146
26	Colorado	17.23	1,013
27	Massachusetts	19.08	1,336
28	Ohio	19.29	2,273
29	South Carolina	19.45	1,045
30	North Carolina	19.51	2,114
31	Maryland	21.68	1,340
32	Rhode Island	21.72	238
33	Arizona	23.31	1,732
34	Kentucky	23.49	1,063
35	Connecticut	23.69	857
36	Oregon	25.35	1,073
37	Tennessee	26.10	1,860
38	Vermont	27.34	177
39	Delaware	28.78	297
40	Mississippi	31.74	933
41	Washington	32.33	2,526
42	West Virginia	35.59	630
43	Alaska	37.63	276
44	Nebraska	48.02	950
45	District of Columbia	48.31	328
46	New Mexico	82.06	1,735
47	Maine	104.82	1,463
48	New Hampshire	109.55	1,536
49	Florida	*	*
50	Montana	*	*
51	North Dakota	*	*
	Overall	**16.30**	**54,743**

*Indicates that the state did not have data that met NVDRS data quality standards.

STATE NALOXONE DISPENSING RATE



Naloxone is a safe, non-addictive opioid overdose reversal agent that has been shown to reduce fatal drug overdoses. According to the "U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose," when communities make naloxone and overdose education available to residents, their rate of overdose deaths decreases.[9]

Currently, there are very few data sources on naloxone distribution outside of individual programs, due to a lack of infrastructure for standardized data collection across programs and providers distributing naloxone. One indicator that can be used to better understand how naloxone is getting into communities is the rate of naloxone prescriptions dispensed through retail pharmacies.

Nationally, the naloxone dispensing rate has increased every year since 2019, but there are wide disparities across states. In 2023, Texas, South Dakota, New Hampshire, Minnesota, Iowa, and Georgia had the lowest naloxone dispensing rates, at only 0.3 per 100 people in the population.

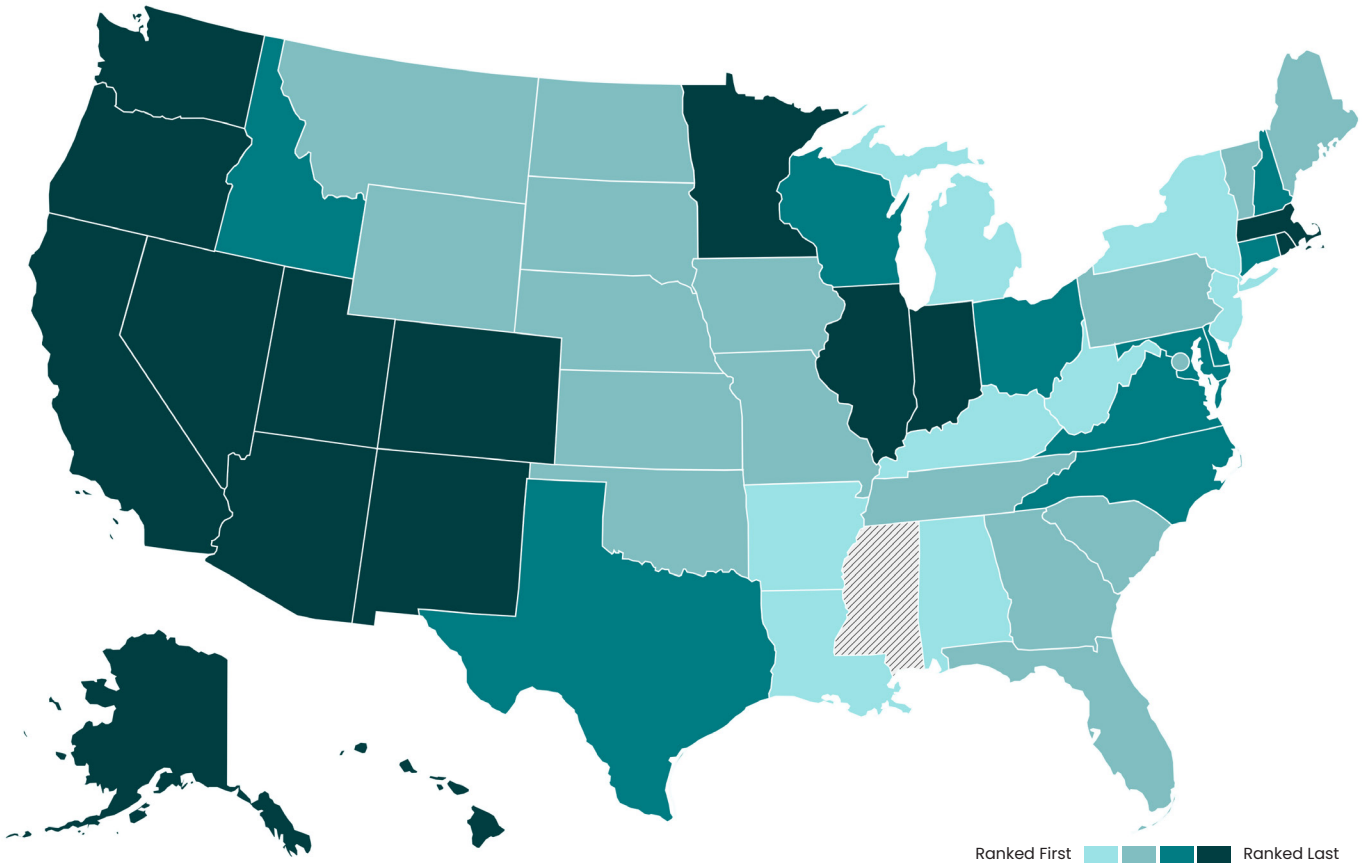
Increasing the availability of naloxone is a low-cost, high-reward strategy for combatting the opioid crisis. A recent meta-analysis of naloxone distribution programs across communities in the U.S. found 25 to 46% reductions in overdose rates following implementation.[10] Naloxone is easy to use and there is no risk to administering it, even if it is given to someone who is not overdosing on opioids.

However, naloxone can only be effective if people know where to get it and how and when to use it. A 2023 survey by the CDC found that the two main reasons people did not carry naloxone were because they didn't know where to get it and they didn't know how to use it.[11] States should invest in training programs to ensure pharmacists have the knowledge and resources necessary to support in-person education on overdose symptoms and naloxone use and dispense naloxone to community members. Public health departments should create outreach and education programs on overdose symptoms, risks, and harm reduction techniques in places where people may need or seek support for opioid use within communities, including pharmacies, faith-based institutions, and other community spaces. These programs are especially important in rural communities and health care deserts where people may be less able to access naloxone outside of retail pharmacies or where law enforcement and health care responses may be slower than needed to reverse an overdose.

Finally, public health systems need the funding and infrastructure to create better data collection systems about where naloxone is distributed beyond retail pharmacies. It is unlikely that these systems will be able to comprehensively track the use of naloxone in overdose reversals because people often do not report their use. However, these systems should be equipped to track where and how often naloxone is dispensed and who has been trained and equipped with naloxone across hospitals and specialty care, community-based nonprofits, EMTs and law enforcement, and other community partners to measure progress in overdose prevention.

Rank	State	Naloxone dispensing rate per 100 people
1	Wyoming	2.50
2	Arkansas	1.90
3	New Mexico	1.60
4	Rhode Island	1.40
5	Kentucky	1.30
6	District of Columbia	1.20
7	New Jersey	1.20
8	Tennessee	1.20
9	South Carolina	1.10
10	Washington	0.90
11	West Virginia	0.90
12	Indiana	0.80
13	Maryland	0.80
14	Ohio	0.80
15	Virginia	0.80
16	Arizona	0.70
17	California	0.70
18	Michigan	0.70
19	Oregon	0.70
20	Pennsylvania	0.70
21	Colorado	0.60
22	Maine	0.60
23	Massachusetts	0.60
24	Missouri	0.60
25	Nevada	0.60
26	New York	0.60
27	North Carolina	0.60
28	Oklahoma	0.60
29	Utah	0.60
30	Alaska	0.50
31	Connecticut	0.50
32	Idaho	0.50
33	Illinois	0.50
34	Montana	0.50
35	Alabama	0.40
36	Delaware	0.40
37	Florida	0.40
38	Hawaii	0.40
39	Kansas	0.40
40	Louisiana	0.40
41	Mississippi	0.40
42	Nebraska	0.40
43	North Dakota	0.40
44	Vermont	0.40
45	Wisconsin	0.40
46	Georgia	0.30
47	Iowa	0.30
48	Minnesota	0.30
49	New Hampshire	0.30
50	South Dakota	0.30
51	Texas	0.30
	Overall	**0.71**

NUMBER OF PHARMACIES PER 1,000 PEOPLE IN THE STATE POPULATION



In 2023, the Food and Drug Administration (FDA) approved Narcan, a naloxone product, for purchase over the counter (OTC) nationwide. Narcan is now available at most retail pharmacies, including CVS and Walgreens. However, if communities do not have access to a pharmacy, they will have less access to both prescription and OTC naloxone.

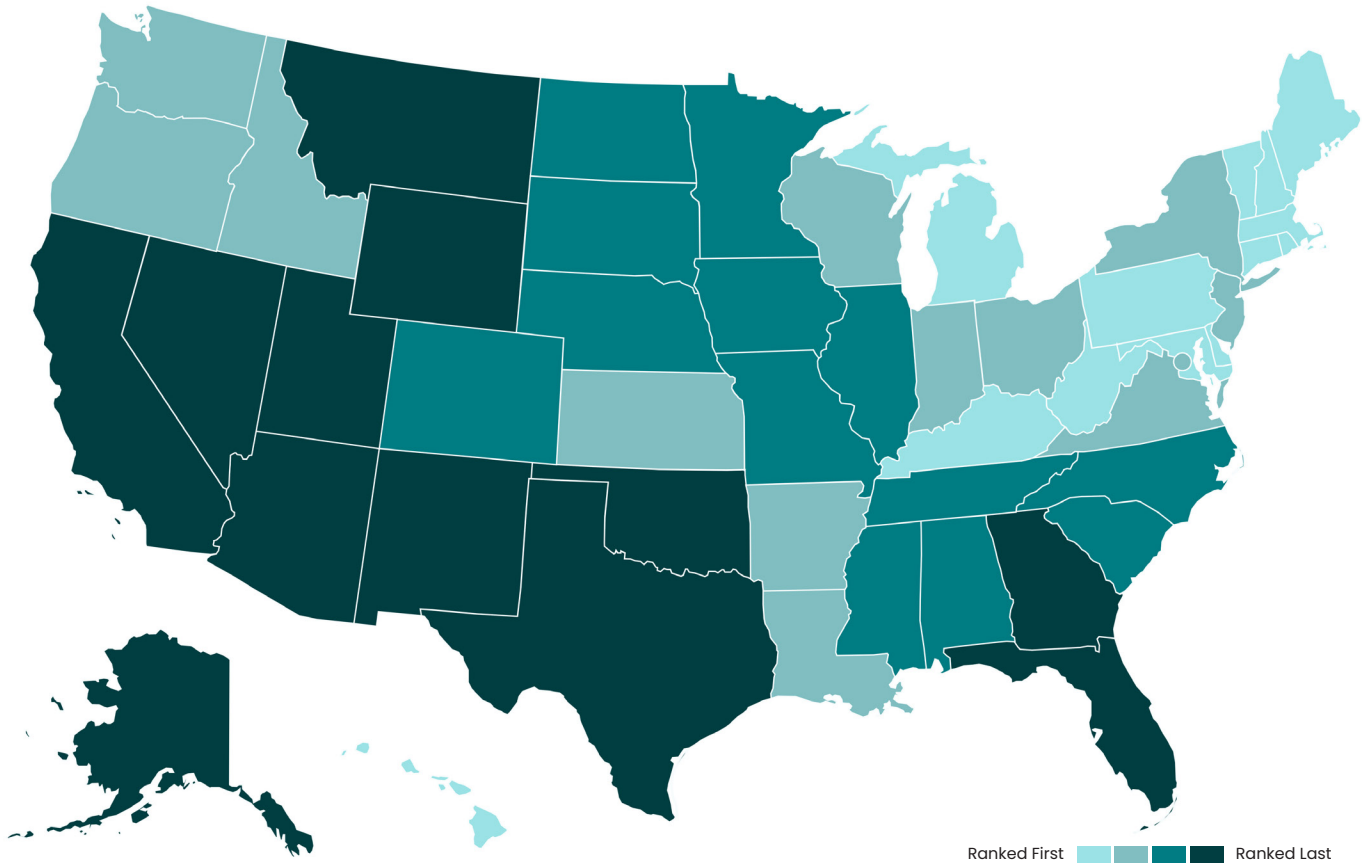
Most of the states with the lowest number of retail pharmacies per 1,000 people were located in the Western U.S. This is just reflective of state-level disparities, but these pharmacy deserts are even more pronounced at the county and ZIP code levels.

States with limited pharmacy access should invest in a no-wrong-door approach to naloxone distribution within communities, so that lifesaving supports are available to everyone within minutes of where someone may overdose. This includes increased distribution to law enforcement, crisis teams and community service providers, peer support specialists, as well as in schools and other public spaces where people may overdose.

Rank	State	Number of pharmacies per 1,000 people	Total number of pharmacies
1	West Virginia	0.29	516
2	Alabama	0.25	1,273
3	Kentucky	0.25	1,134
4	Louisiana	0.25	1,143
5	New York	0.25	4,939
6	Arkansas	0.24	735
7	Michigan	0.23	2,338
8	New Jersey	0.22	2,023
9	Florida	0.21	4,786
10	Iowa	0.21	665
11	Kansas	0.21	611
12	Maine	0.21	288
13	Montana	0.21	242
14	Nebraska	0.21	418
15	North Dakota	0.21	167
16	Oklahoma	0.21	835
17	Pennsylvania	0.21	2,725
18	South Dakota	0.21	191
19	Tennessee	0.21	1,527
20	District of Columbia	0.20	136
21	Georgia	0.20	2,179
22	Missouri	0.20	1,230
23	South Carolina	0.20	1,073
24	Vermont	0.20	127
25	Wyoming	0.20	115
26	Maryland	0.19	1,161
27	North Carolina	0.19	2,039
28	Ohio	0.19	2,262
29	Connecticut	0.18	661
30	Delaware	0.18	181
31	New Hampshire	0.18	259
32	Idaho	0.17	335
33	Texas	0.17	5,283
34	Virginia	0.17	1,507
35	Wisconsin	0.17	1,015
36	Arizona	0.16	1,153
37	Illinois	0.16	2,067
38	Indiana	0.16	1,127
39	Massachusetts	0.16	1,088
40	Minnesota	0.16	945
41	Rhode Island	0.16	172
42	California	0.15	5,893
43	Colorado	0.15	891
44	Hawaii	0.15	218
45	Nevada	0.15	490
46	New Mexico	0.15	311
47	Utah	0.15	518
48	Washington	0.15	1,175
49	Oregon	0.14	610
50	Alaska	0.12	88
51	Mississippi	*	*
	Overall	**0.19**	**62,865**

*Indicates that data was missing.

ADULTS WHO DO NOT HAVE A PERSONAL DOCTOR OR HEALTH CARE PROVIDER



Most of the states with the least access to health care providers are in the Southwest U.S. In Nevada, Wyoming, New Mexico and Texas, more than 1 in 4 people report that they do not have a person or group of providers that they think of as their personal health care provider.

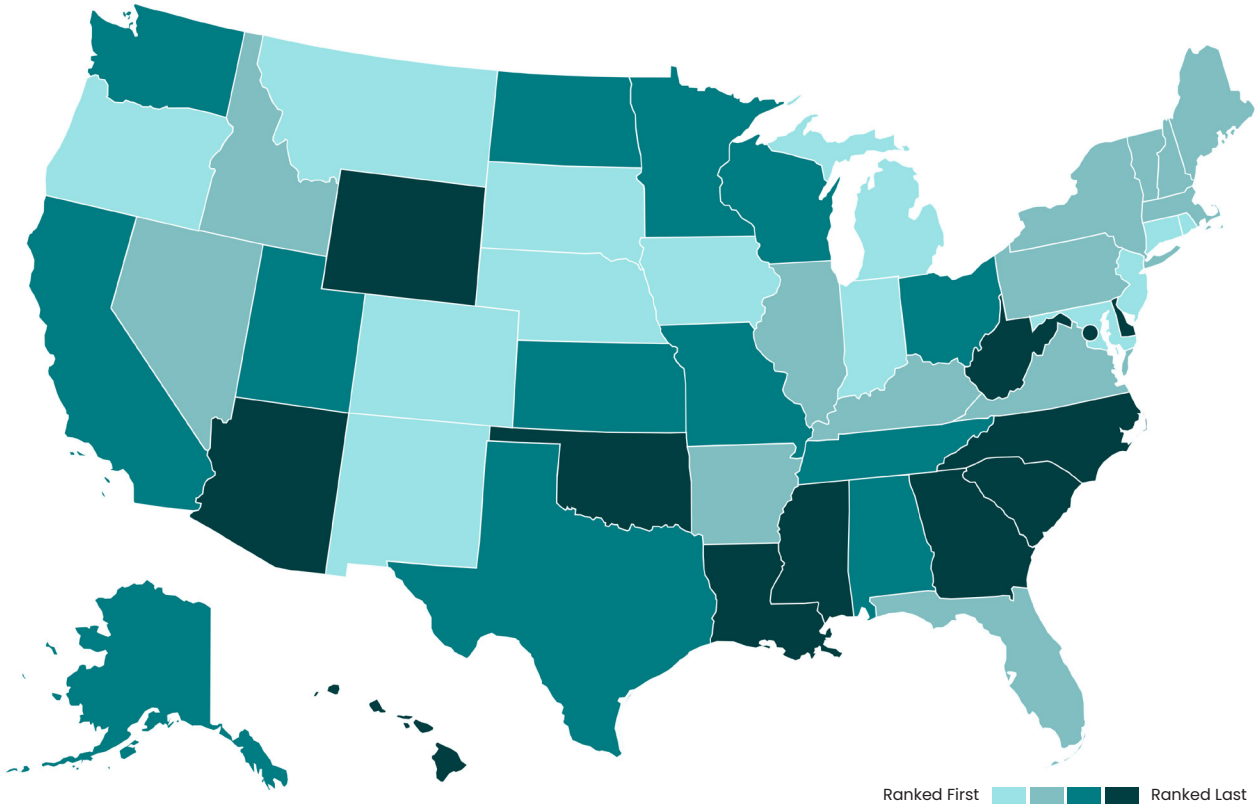
Access to health care is critical to ending the opioid overdose crisis. Health care providers can provide patients with substance use education, detect opioid or other substance use challenges early through screening, and connect patients with treatment and support for substance use if they screen at-risk. When people have access to a consistent personal doctor or health care provider, they can establish a more open and trusting patient-provider relationship. That relationship can enhance opportunities for patients to disclose opioid use.

At minimum, states where access to health care providers is limited should invest additional resources into public health departments to train community health workers and mobile teams to fill those gaps in care. In the short term, community health workers can conduct outreach to communities with limited access to health care and provide individuals at risk of overdose with harm reduction resources and supports.

Rank	State	Percentage	Weighted count
1	Maine	8.30%	93,115
2	Massachusetts	8.60%	483,148
3	New Hampshire	9.80%	111,267
4	Vermont	10.70%	55,922
5	Rhode Island	11.50%	100,059
6	Hawaii	11.60%	131,685
7	Pennsylvania	11.60%	1,191,605
8	Michigan	11.80%	926,122
9	Connecticut	12.70%	362,506
10	West Virginia	12.80%	182,350
11	Kentucky	13.00%	455,419
12	Maryland	13.00%	622,111
13	Delaware	13.50%	107,943
14	Wisconsin	14.50%	672,175
15	Louisiana	14.60%	514,677
16	Ohio	14.60%	1,332,407
17	Arkansas	14.90%	345,965
18	District of Columbia	15.10%	81,889
19	New Jersey	15.50%	1,111,991
20	Indiana	15.60%	810,713
21	Kansas	15.60%	349,193
22	Idaho	15.80%	230,771
23	Virginia	15.90%	1,073,741
24	Oregon	16.00%	543,765
25	New York	16.10%	2,508,119
26	Washington	16.20%	987,052

Rank	State	Percentage	Weighted count
27	Alabama	16.40%	646,066
28	South Dakota	16.40%	110,457
29	Nebraska	17.10%	254,992
30	Minnesota	17.30%	763,502
31	Missouri	17.70%	844,680
32	North Carolina	17.90%	1,490,484
33	Illinois	18.00%	1,775,709
34	North Dakota	18.00%	106,551
35	Iowa	18.10%	444,931
36	Mississippi	18.30%	412,589
37	South Carolina	18.70%	765,599
38	Colorado	18.90%	869,778
39	Tennessee	18.90%	1,033,243
40	Oklahoma	19.00%	578,724
41	Montana	19.80%	174,417
42	Utah	20.20%	490,252
43	California	20.30%	6,112,262
44	Florida	20.80%	3,673,515
45	Georgia	21.10%	1,753,884
46	Arizona	23.60%	1,346,221
47	Alaska	23.80%	130,129
48	Nevada	25.70%	632,341
49	Wyoming	25.90%	115,422
50	New Mexico	26.60%	438,965
51	Texas	26.60%	5,899,338
	Overall	**17.90%**	**46,748,176**

YOUTH REPORTING THEY HAVE SEEN OR HEARD ALCOHOL OR DRUG PREVENTION MESSAGES FROM A SOURCE OUTSIDE OF SCHOOL



Nationally, only 63% of youth report that they have seen or heard alcohol or drug prevention messages from a source outside of school. In Wyoming and South Carolina, the lowest-ranked states, only about half of youth have received prevention messaging in their communities.

One of the key roles of public health is to broadly educate the community about how to stay healthy. Youth are less likely to use substances in communities that are permeated with actionable information, norms against substance use, and anti-stigma messaging. For example, communities funded through the Drug Free Communities (DFC) program found decreases in alcohol, marijuana, tobacco, and prescription drug misuse among youth over a 30-day period.[12] The DFC model is successful in part because it is built by communities. An essential piece of DFC programs is the creation of coalitions of community-based organizations, parents, youth, and other stakeholders to create community-specific education and programming around opioid and other substance use prevention.[13] In 2018, President Trump increased support for the DFC program, awarding the most funding to the program since its creation in 1997. The federal government should match or increase funding levels for the DFC program to continue achieving positive outcomes in preventing youth substance use across the country. States should also dedicate additional funding through state and local grants to equip public health departments with the resources they need to create or sustain prevention-focused community programs in the absence of federal funding.

Rank	State	Percentage	Weighted count
1	Montana	75.00%	60,000
2	Indiana	70.80%	383,000
3	Rhode Island	70.80%	51,000
4	South Dakota	70.50%	52,000
5	Iowa	69.50%	179,000
6	Nebraska	69.50%	113,000
7	Michigan	69.10%	513,000
8	Connecticut	67.90%	178,000
9	Maryland	67.90%	315,000
10	New Jersey	67.30%	473,000
11	Colorado	67.20%	291,000
12	New Mexico	67.20%	112,000
13	Oregon	66.90%	200,000
14	Idaho	66.60%	112,000
15	Pennsylvania	66.50%	617,000
16	Vermont	66.40%	27,000
17	Nevada	66.00%	160,000
18	Maine	65.80%	59,000
19	New York	65.70%	886,000
20	Illinois	65.30%	638,000
21	Massachusetts	65.00%	313,000
22	Florida	64.90%	955,000
23	Arkansas	64.10%	154,000
24	New Hampshire	64.10%	59,000
25	Virginia	64.10%	407,000
26	Kentucky	63.70%	217,000
27	California	63.30%	1,890,000
28	Tennessee	63.20%	334,000
29	Washington	63.10%	352,000
30	Minnesota	63.00%	281,000
31	Wisconsin	62.50%	283,000
32	Utah	62.30%	203,000
33	North Dakota	62.20%	36,000
34	Kansas	61.80%	149,000
35	Texas	61.60%	1,576,000
36	Missouri	60.10%	286,000
37	Alabama	60.00%	226,000
38	Alaska	60.00%	35,000
39	Ohio	60.00%	536,000
40	District of Columbia	59.30%	20,000
41	North Carolina	59.30%	481,000
42	Oklahoma	59.30%	192,000
43	Arizona	57.50%	320,000
44	Mississippi	57.40%	140,000
45	Delaware	57.20%	42,000
46	Georgia	56.90%	505,000
47	Hawaii	56.60%	53,000
48	West Virginia	56.40%	71,000
49	Louisiana	54.50%	197,000
50	South Carolina	52.10%	206,000
51	Wyoming	50.80%	24,000
	Overall	**63.30%**	**15,962,000**

STATES IN WHICH FENTANYL DRUG-CHECKING EQUIPMENT POSSESSION AND/OR FREE DISTRIBUTION IS PERMITTED BY STATE LAW

The use of fentanyl as an adulterant in the illicit drug supply has been increasing within the U.S.[14] Even a small dose of fentanyl can be lethal, so it is extremely important that people who use drugs are able to know what they are taking. Fentanyl drug-checking equipment, including fentanyl test strips, are an inexpensive and easy-to-use tool to reduce the rate of overdose deaths.

Test strips can help keep people alive and safe long enough that they may access treatment and reach recovery in the future. Research in North Carolina and Rhode Island has shown that people who found that their drugs contained fentanyl using test strips were significantly more likely to change their use behavior to reduce overdose risk.[15] Drug-checking equipment therefore prevents overdose deaths by empowering people with more information to make decisions about their use. It can also help to open conversations about the risks involved in substance use with individuals who did not realize fentanyl may be present in the drugs they are taking.

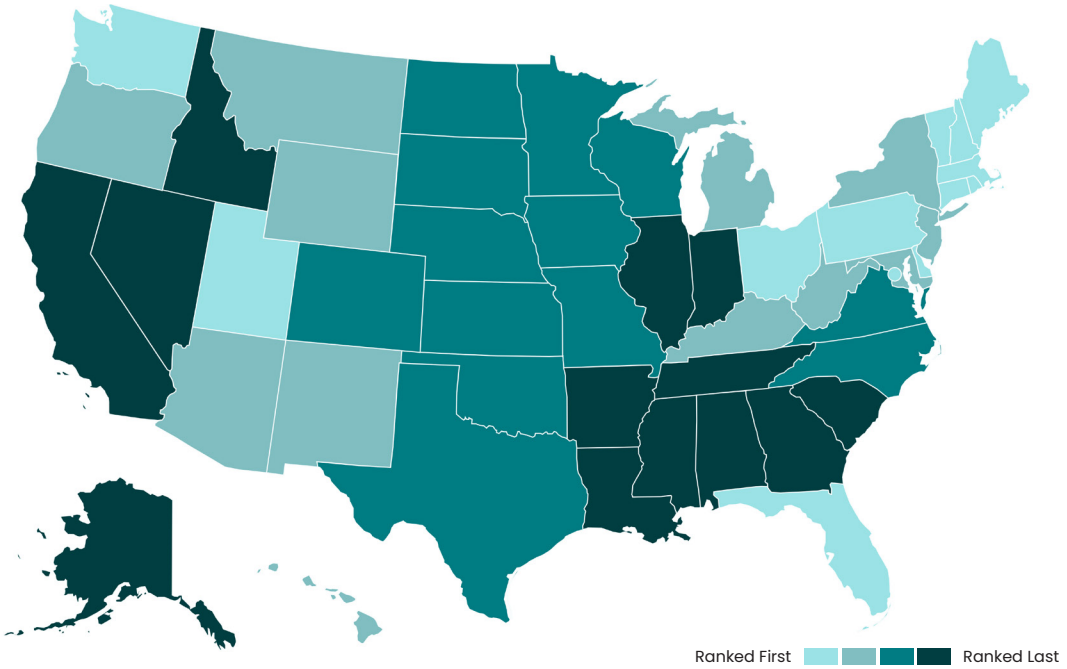
The Network for Public Health Law analyzed state laws on the possession, distribution, and sale of fentanyl drug-checking equipment across the U.S.[16] While most states and localities may not prosecute people solely for their possession of drug-checking equipment, without legislation explicitly stating the legality of fentanyl drug testing, organizations and people who use drugs may be deterred from possessing or distributing equipment that could prevent a fatal overdose. Without clear statewide guidance, there may also be wide disparities by locality in how the possession and distribution of drug-checking equipment is prosecuted, elevating the risk of overdose in some communities over others.

States should release guidance that explicitly permits fentanyl drug-checking equipment and invest in programs that distribute it into communities. In the short term, public health departments should broadly educate communities on the legality of fentanyl drug-checking equipment, especially in states that currently do not explicitly permit possession and distribution in state law.

State	Is possession of fentanyl drug-checking equipment permitted by state law?	Is free distribution of fentanyl drug-checking equipment permitted by state law?
Alabama	Yes	Yes
Alaska	Yes	Yes
Arizona	Yes	Yes
Arkansas	Yes	Yes*
California	Yes	Yes
Colorado	Yes	Yes
Connecticut	Yes	Yes
Delaware	Yes	Yes
District of Columbia	Yes	No
Florida	Yes	Yes
Georgia	Yes	Yes
Hawaii	Yes	Yes
Idaho	No	No
Illinois	No	Yes
Indiana	No	No
Iowa	No	No
Kansas	Yes	Yes
Kentucky	Yes	Yes
Louisiana	Yes	Yes
Maine	Yes	Yes
Maryland	Yes	Yes
Massachusetts	Yes	Yes
Michigan	Yes	Yes
Minnesota	Yes	Yes
Mississippi	Yes	Yes
Missouri	Yes	Yes
Montana	Yes	No
Nebraska	Yes	Yes
Nevada	Yes	Yes
New Hampshire	Yes	No
New Jersey	Yes	Yes
New Mexico	Yes	No
New York	Yes	Yes
North Carolina	Yes	No
North Dakota	No	No
Ohio	Yes	Yes
Oklahoma	Yes	Yes
Oregon	Yes	Yes*
Pennsylvania	Yes	Yes
Rhode Island	Yes	Yes
South Carolina	Yes	Yes
South Dakota	Yes	Yes
Tennessee	Yes	Yes
Texas	No	No
Utah	Yes	Yes
Vermont	Yes	Yes
Virginia	Yes	Yes
Washington	Yes	Yes
West Virginia	Yes	Yes
Wisconsin	Yes	Yes
Wyoming	Yes	Yes

*In Arkansas, free distribution is not permitted to youth under 18. In Oregon, it is not permitted to youth under 15.

HEALTH CARE RANKING



Rank	State
1	Maine
2	Vermont
3	Connecticut
4	Massachusetts
5	Rhode Island
6	Washington
7	Florida
8	New Hampshire
9	Delaware
10	Pennsylvania
11	District of Columbia
12	Utah
13	Ohio
14	New York
15	Oregon
16	Maryland
17	Hawaii

Rank	State
18	New Mexico
19	West Virginia
20	Arizona
21	Kentucky
22	Wyoming
23	New Jersey
24	Montana
25	Michigan
26	Virginia
27	North Dakota
28	Nebraska
29	Kansas
30	North Carolina
31	Colorado
32	Oklahoma
33	Minnesota
34	Wisconsin

Rank	State
35	Texas
36	Iowa
37	Missouri
38	South Dakota
39	Idaho
40	South Carolina
41	California
42	Illinois
43	Tennessee
44	Arkansas
45	Mississippi
46	Indiana
47	Nevada
48	Alabama
49	Louisiana
50	Georgia
51	Alaska

The health care system's approach to reducing opioid overdose deaths requires education and screening for those who may be at risk of opioid addiction and enhanced access to treatment and recovery services for those who need them. Health care strategies include screening people for risk of opioid addiction, expansion of treatment in both specialty and non-specialty health care settings, and investment in long-term community recovery services.

Health care indicators

- Percentage of adults (ages 18+) who report heroin use in the past year
- Number of people screening at-risk for prescription opioid addiction per 100,000 people in the state population
- Percentage of adults who needed but did not receive substance use treatment
- Number of buprenorphine practitioners per 100,000 people with OUD in the state population
- Number of opioid treatment programs (OTPs) per 100,000 people with OUD in the state population
- Number of treatment and addiction recovery residences per 1,000 people

Overall health care ranking

The states with the highest prevalence of opioid addiction and lowest access to opioid treatment and recovery services were located in the Southeastern U.S. The 10 states with the highest need for strategic opioid-related investment in health care settings are: Alaska, Georgia, Louisiana, Alabama, Nevada, Indiana, Mississippi, Arkansas, Tennessee, and Illinois. These states have the highest rates of heroin and opioid use, lowest rates of people receiving treatment for substance use, and lowest rates of available providers offering MAT, the gold standard for treating opioid addiction.

STRATEGIC HEALTH CARE APPROACH TO OPIOID DEATHS: POLICY RECOMMENDATIONS

The health care system's role in preventing opioid overdose deaths is to identify and treat people at risk of, and living with, opioid addiction. These approaches aim to support improved early identification of opioid risk, reduce interpersonal barriers to discussing opioid-related concerns, and increase access to the most effective and low-cost treatment options for OUD. **To better prevent opioid overdose deaths, states with the worst outcomes should implement the following strategies for the health care sector:**

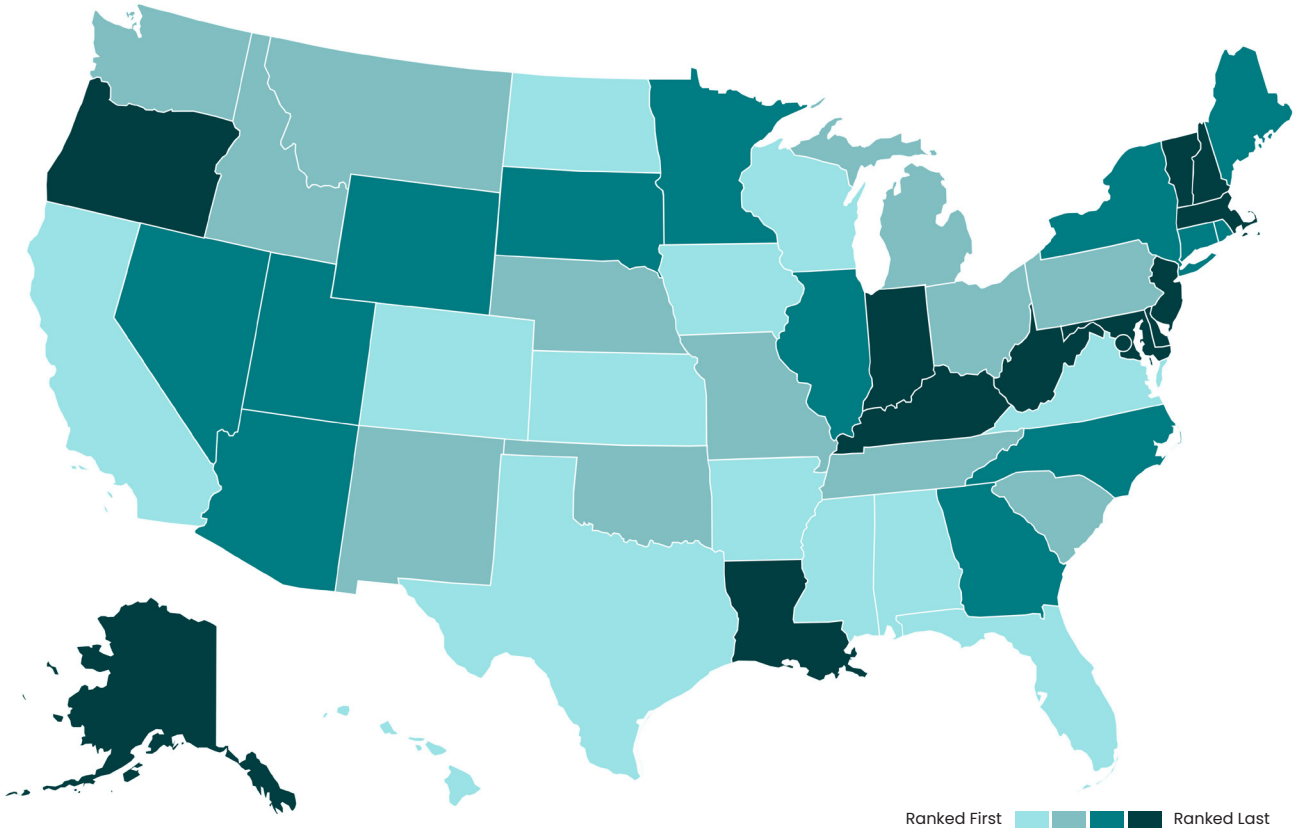
- **Train community health workers and health care providers** on educating patients about the risks of fentanyl in the drug supply and availability of naloxone and fentanyl test strips for people who use drugs.
- **Screen all adults for opioid and other substance use** in primary care and other non-specialty care settings where providers may be most likely to interact with individuals at high risk for early or unaddressed addiction.
- **Increase training for providers on compassionate engagement** with individuals with substance use disorders, with a focus on highly stigmatized conditions like OUD.
- **Educate primary care and other non-mental health providers** about state regulations on their ability to prescribe buprenorphine.
- **Develop programs to connect community-based organizations and peer support specialists** with clinicians to expand the reach of the buprenorphine workforce.[17]
- **Reevaluate existing state regulations and expand flexibilities around opioid treatment programs** (OTPs) to make MAT as accessible as possible. If it isn't possible to create new OTPs, states should invest funds into mental health systems to train and implement care teams to expand the reach of physical OTP sites.
- **Use data from state health departments** or other publicly available data sources to identify where there is a need for additional transitional and long-term community-based recovery supports (including stable housing and peer support) and focus investments in those areas.

Many of the state programs that have been successful at connecting people with opioid treatment and recovery services are funded by Medicaid. Medicaid covered nearly half of all adults with OUD in 2023, most of whom qualified for coverage as part of the Medicaid expansion population.[18] While there are still gaps in care, Medicaid has greatly increased access to opioid use treatment and recovery services including supportive housing and employment. The One Big Beautiful Bill[19] Act included significant cuts to Medicaid, threatening these programs even where they do exist. At the state level, Medicaid funding must be protected to maintain progress in reducing overdose deaths and expanding access to treatment.

Maintaining behavioral health surveillance data

The collection of data on behavioral health needs and access to care is essential to drive resources to people most in need of support. Divestment in data collection will ultimately raise costs. Without surveillance data, state agencies, policymakers, providers, and other stakeholders will not have the information necessary to direct resources to populations at greatest risk of negative outcomes. Measuring the effectiveness of policy or programming changes in improving behavioral health and access to care at the population level will also be impossible. The federal government must continue to appropriate funds for comprehensive surveillance of behavioral health prevalence and access to care through surveys like the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS). In the absence of federal funding, states must invest in the infrastructure and resources necessary for state health agencies to collect this data.

ADULTS (AGES 18+) WHO REPORT HEROIN USE IN THE PAST YEAR



Nationally, 0.33% of adults in the U.S. used heroin in the last year, totaling over 800,000 people. These rates were highest in Alaska and Maryland, where nearly 1% of the population had used heroin in the past year.

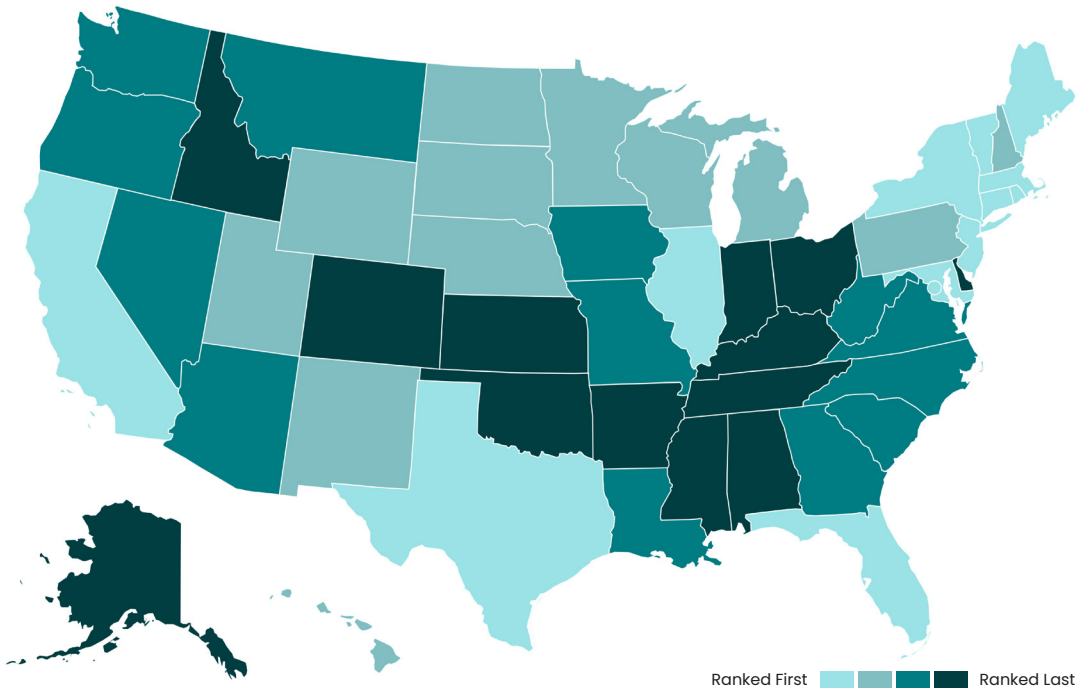
In 2023, about 7.4% of people who used opioids either used heroin only or used heroin in combination with prescription pain relievers. While drug overdose deaths involving heroin have decreased since 2017,[20] heroin use is still contributing to the opioid overdose crisis. One of the primary ways fentanyl has entered the drug supply is as an adulterant for heroin.[21] Many overdoses include a combination of heroin and other substances, or occur when heroin has been mixed with fentanyl, often without the user's knowledge.

Opioid overdose education and prevention programs should continue to address heroin use, with a focus on prevention of polysubstance use and education around the potential risk of fentanyl in the drug supply. The public mental health system should train community health workers and health care providers to educate patients – regardless of which substances they are using – about the risk of fentanyl and availability of naloxone and fentanyl test strips in the community.

Rank	State	Percentage	Weighted count
1	Arkansas	0.19%	4,000
2	Mississippi	0.22%	5,000
3	Hawaii	0.23%	3,000
4	Kansas	0.23%	5,000
5	Alabama	0.24%	9,000
6	Florida	0.25%	45,000
7	Virginia	0.25%	17,000
8	California	0.25%	76,000
9	Iowa	0.25%	6,000
10	Texas	0.26%	57,000
11	Colorado	0.26%	12,000
12	Wisconsin	0.27%	12,000
13	North Dakota	0.27%	2,000
14	South Carolina	0.28%	11,000
15	Montana	0.28%	2,000
16	Missouri	0.29%	14,000
17	Idaho	0.29%	4,000
18	Oklahoma	0.29%	9,000
19	Nebraska	0.29%	4,000
20	Pennsylvania	0.30%	31,000
21	New Mexico	0.31%	5,000
22	Tennessee	0.32%	17,000
23	Ohio	0.32%	29,000
24	Washington	0.32%	19,000
25	Michigan	0.32%	25,000
26	South Dakota	0.33%	2,000

Rank	State	Percentage	Weighted count
27	Illinois	0.33%	32,000
28	North Carolina	0.33%	27,000
29	Arizona	0.34%	19,000
30	Utah	0.34%	8,000
31	Georgia	0.34%	28,000
32	Nevada	0.35%	9,000
33	Minnesota	0.35%	16,000
34	Maine	0.36%	4,000
35	Rhode Island	0.36%	3,000
36	New York	0.37%	58,000
37	Wyoming	0.40%	2,000
38	Connecticut	0.42%	12,000
39	Indiana	0.43%	22,000
40	Vermont	0.44%	2,000
41	Oregon	0.44%	15,000
42	New Hampshire	0.47%	5,000
43	Kentucky	0.49%	17,000
44	New Jersey	0.50%	36,000
45	Louisiana	0.55%	19,000
46	Delaware	0.56%	4,000
47	District of Columbia	0.57%	3,000
48	Massachusetts	0.59%	33,000
49	West Virginia	0.62%	9,000
50	Maryland	0.77%	37,000
51	Alaska	0.80%	4,000
	Overall	**0.33%**	**851,000**

PEOPLE SCREENING AT-RISK FOR PRESCRIPTION OPIOID ADDICTION



From 2018 to 2024, over 6,000 people took a screen through MHA's National Prevention and Screening Program and scored at-risk for a prescription OUD. Over 40% of those individuals had never received treatment or support for their behavioral health before.

The U.S. Preventive Services Task Force recommends screening all adults for unhealthy substance use.[22] However, screening for OUD in primary care, the emergency room, and in other health care settings is inconsistent. Studies on provider perspectives on opioid screening have identified several barriers to implementation, including the complexity of screening tools, discomfort among providers in implementing screens, stigma,[23] and the need for clearer risk assessments to avoid biases in screening.[24]

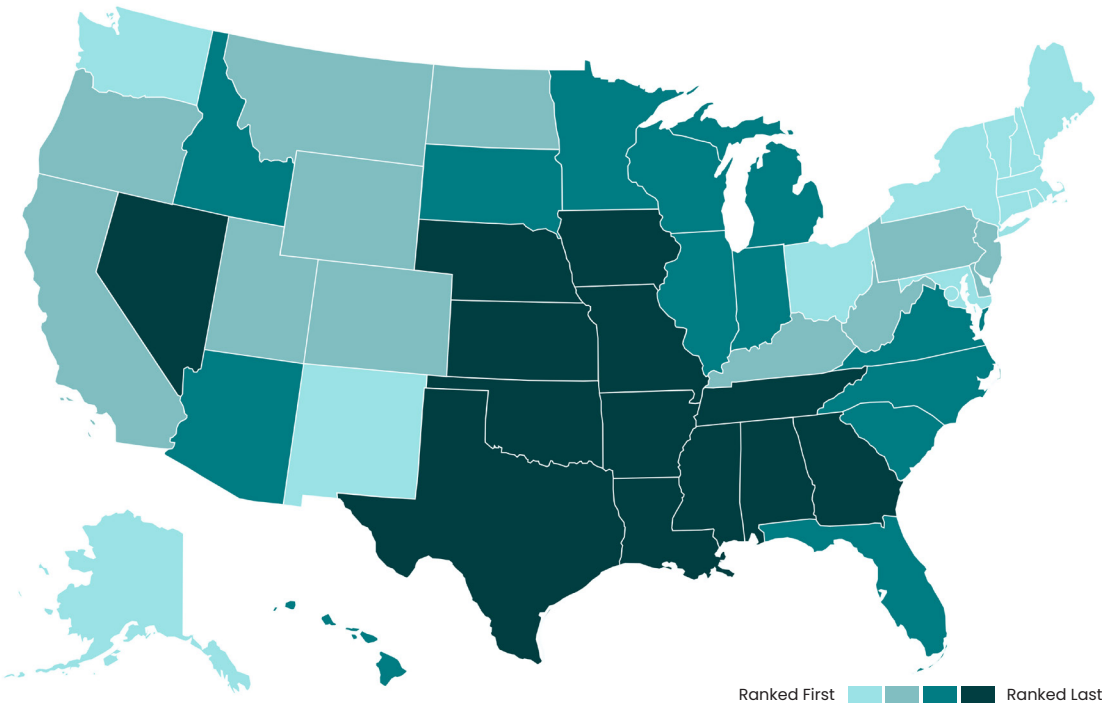
To reduce the risk of death among individuals living with opioid addiction, all adults must be screened for opioid and other substance use, especially in primary care and non-specialty settings where providers may be interacting with people at greatest risk for early or unaddressed addiction. Hospitals that have implemented universal screening protocols have found increases in connections to opioid disorder treatment and prescriptions for naloxone and decreases in daily opioid use following discharge.[25,26] Not only is universal screening important for early detection of opioid addiction, it also has the important benefit of normalizing conversations about substance use in the general population.

Stigma and negative health care experiences are common among people who use opioids. For screening to be effective, health care settings must create supportive environments that encourage opioid use disclosure and increase the likelihood that individuals will want to engage in further care. To promote better care,[27] states should increase mandated training for providers – both in medical school and continuing medical education – on compassionate engagement for individuals with substance use disorders, with a focus on highly stigmatized conditions like OUD.

Rank	State	Number screening at-risk per 100,000 people	Total number screening at-risk
1	Vermont	0.11	5
2	District of Columbia	0.15	7
3	New Jersey	0.17	108
4	Massachusetts	0.17	82
5	New York	0.18	247
6	Connecticut	0.18	46
7	Maryland	0.18	79
8	Illinois	0.19	169
9	Rhode Island	0.20	15
10	Texas	0.20	427
11	California	0.20	556
12	Maine	0.22	21
13	Florida	0.22	345
14	Utah	0.23	54
15	Pennsylvania	0.23	210
16	Wisconsin	0.24	97
17	South Dakota	0.24	15
18	North Dakota	0.24	13
19	Michigan	0.25	175
20	New Mexico	0.25	37
21	Minnesota	0.26	102
22	New Hampshire	0.27	26
23	Hawaii	0.27	27
24	Nebraska	0.27	37
25	Wyoming	0.27	11
26	Iowa	0.28	62

Rank	State	Number screening at-risk per 100,000 people	Total number screening at-risk
27	Virginia	0.28	169
28	Arizona	0.28	144
29	Missouri	0.28	121
30	Louisiana	0.28	91
31	Georgia	0.29	219
32	South Carolina	0.29	108
33	Nevada	0.29	65
34	North Carolina	0.29	219
35	Montana	0.29	23
36	West Virginia	0.31	38
37	Washington	0.31	167
38	Oregon	0.31	93
39	Ohio	0.32	264
40	Delaware	0.32	23
41	Idaho	0.32	44
42	Kansas	0.36	74
43	Arkansas	0.41	88
44	Kentucky	0.42	133
45	Colorado	0.43	177
46	Oklahoma	0.44	123
47	Indiana	0.44	210
48	Mississippi	0.53	108
49	Alabama	0.54	193
50	Tennessee	0.59	292
51	Alaska	0.68	35
	Overall	**0.29**	**6,194**

BUPRENORPHINE PRACTITIONERS PER 100,000 PEOPLE WITH OUD



Buprenorphine is one of the three FDA-approved medications for treating OUD. It is effective in diminishing withdrawal symptoms and cravings, reducing the risk of overdose, and lowering the potential for opioid misuse.[28] Buprenorphine is one of the most accessible medications for OUD, because it does not have to be administered as part of an OTP. Providers who are eligible to prescribe controlled substances can prescribe buprenorphine and patients can fill their prescription at any pharmacy.[29]

MAT is the most effective treatment for OUD[30] and is associated with reduced overdose and opioid-related morbidity when compared to other treatments.[31] However, despite its known efficacy, MAT is not widely used. In 2023, only 18% of people with OUD received MAT in the past year.[32] A 2024 study of Medicare beneficiaries found that even after a nonfatal overdose, only 4% of people received one of the three medications to treat OUD.[33]

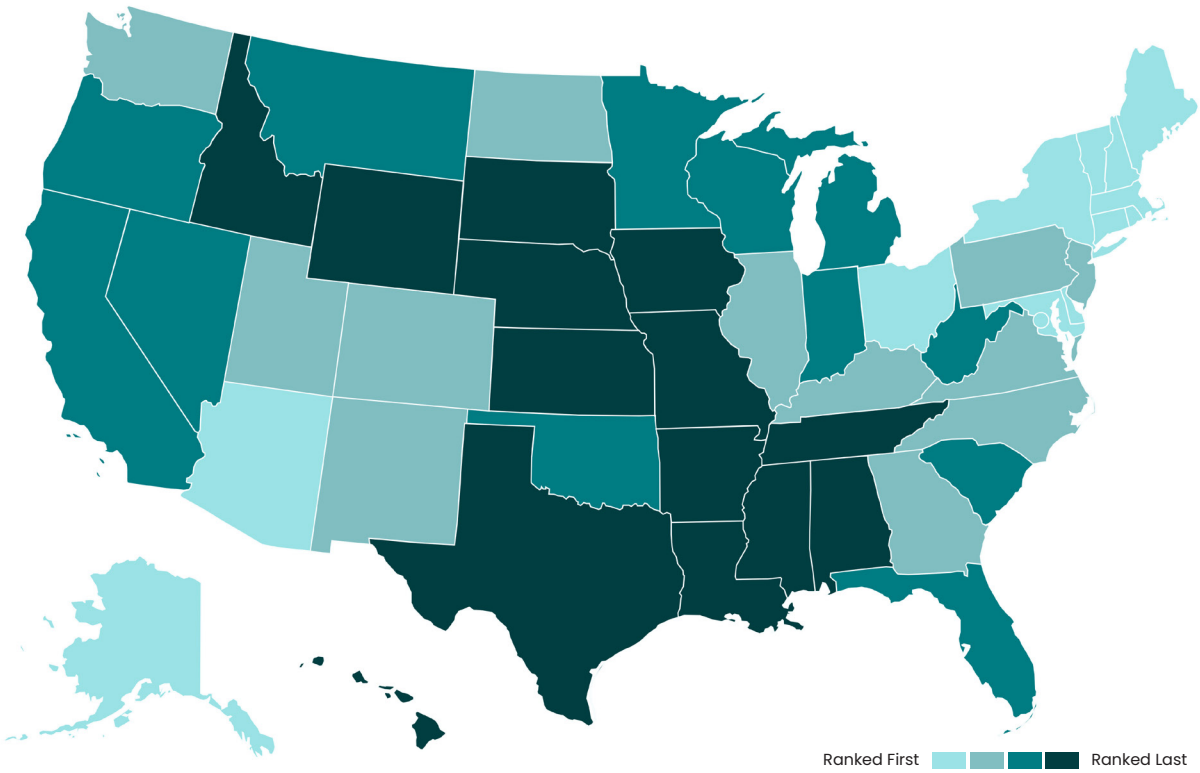
Access to buprenorphine is especially limited in the South and Midwest. Nearly every state ranked from 39 to 51 for the number of buprenorphine practitioners per 100,000 people with OUD were in the southeastern or midwestern U.S. Texas had the least access, with only 176 registered buprenorphine providers per 100,000 people with OUD in the state.

Access to MAT may be even more limited beyond what is captured in this indicator. This measure only captures the presence of licensed buprenorphine providers in each state. It does not measure whether those providers were administering buprenorphine treatment or offering treatment to new patients. There are also significant racial disparities in access to MAT. In 2022, 21.7% of white people with OUD received MAT in the past year, compared to only 11.2% of Black people.[34]

Offering buprenorphine treatment in non-specialty settings, like primary care clinics, can greatly increase access to MAT. State regulations and requirements around prescribing buprenorphine differ and lack of knowledge about requirements may be a barrier for primary care and other non-specialty providers to begin to prescribe buprenorphine.[35] State health and mental health departments should educate primary care and other non-mental health care providers about state regulations on their ability to prescribe buprenorphine and other treatments for OUD.
States should also use opioid settlement funds and grants to invest in the creation of new medication programs for people with OUD. Federally Qualified Health Centers (FQHCs) and other sites that are more likely to reach underserved populations should be given priority in receiving those funds. Finally, state mental health agencies should develop programs to connect community-based organizations and peer support specialists with clinicians so that they can initiate buprenorphine treatment outside of clinical settings, expanding the reach of the buprenorphine workforce.[36]

Rank	State	Number of buprenorphine providers per 100,000 people with OUD	Total number of buprenorphine practitioners
1	Vermont	1593.33	239
2	Massachusetts	1502.50	2,404
3	Alaska	1405.26	267
4	Maine	1358.82	462
5	District of Columbia	1300.00	221
6	New Hampshire	1206.25	386
7	Connecticut	1126.32	856
8	Washington	1089.94	1,842
9	Rhode Island	981.82	324
10	Maryland	933.12	1,465
11	New York	889.50	3,896
12	New Mexico	721.95	592
13	Ohio	720.38	2,298
14	West Virginia	704.69	451
15	New Jersey	684.83	1,445
16	Delaware	682.14	191
17	Montana	667.86	187
18	Colorado	667.53	1,028
19	Pennsylvania	665.80	2,297
20	Oregon	657.78	888
21	Wyoming	642.86	90
22	Utah	629.07	541
23	Kentucky	596.39	990
24	California	519.50	4,769
25	North Dakota	517.65	88
26	Arizona	507.23	1,192
27	North Carolina	502.76	1,458
28	Wisconsin	497.89	707
29	Minnesota	477.42	592
30	South Dakota	468.18	103
31	Michigan	464.34	1,263
32	Virginia	459.02	840
33	Hawaii	447.06	152
34	Indiana	441.40	821
35	Idaho	426.87	286
36	Illinois	415.25	1,416
37	Florida	389.44	2,286
38	South Carolina	362.35	587
39	Tennessee	358.94	743
40	Nevada	332.38	349
41	Missouri	329.03	612
42	Oklahoma	322.39	432
43	Kansas	322.06	219
44	Louisiana	318.75	561
45	Arkansas	304.40	277
46	Nebraska	281.40	121
47	Alabama	257.92	472
48	Georgia	244.51	802
49	Mississippi	236.00	236
50	Iowa	209.41	178
51	Texas	176.07	1,486
	Overall	**627.80**	**46,408**

OPIOID TREATMENT PROGRAMS (OTPS) PER 100,000 PEOPLE WITH OUD



OTPs are health care facilities that can provide all three medications for MAT for OUD. These programs must be accredited and certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). OTPs are designed to combine MAT for OUD with wraparound services and whole-person care, including peer support and coordinated physical and behavioral health care.

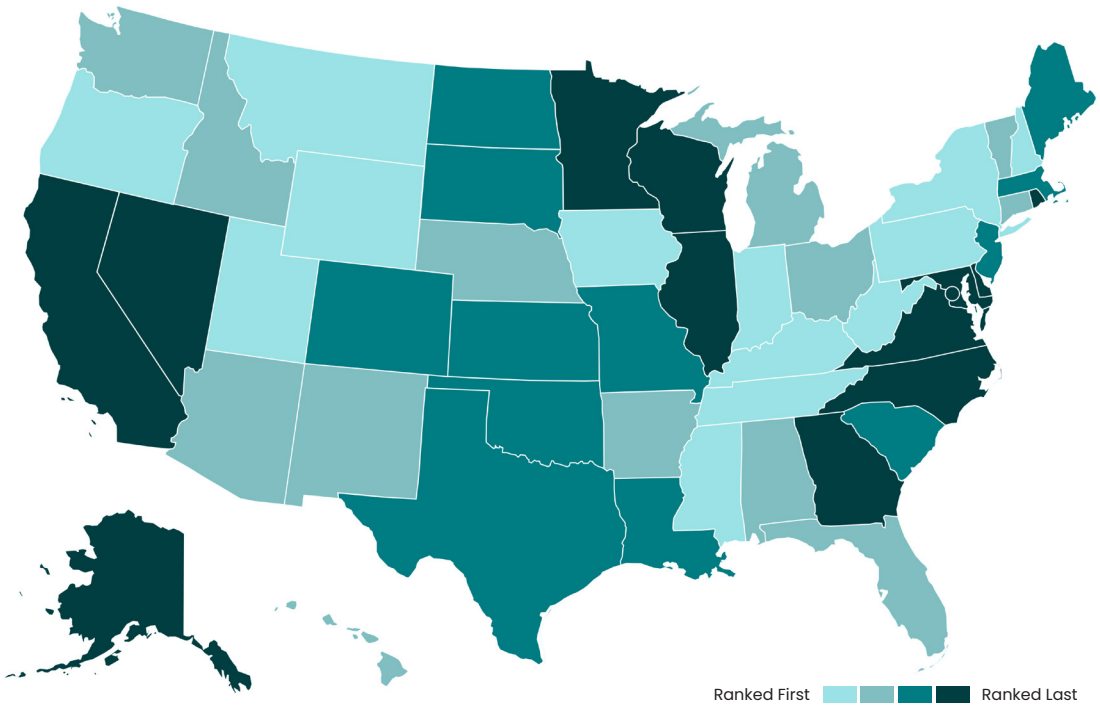
Wyoming, South Dakota, and Mississippi had the least OTPs per 100,000 people with OUD. Wyoming was the only state in the country with zero OTPs.

While buprenorphine is available in various health care settings, access to methadone is limited outside of OTPs. Increasing the number of OTPs is one strategy for ensuring that people have access to various forms of treatment and can use what works best for them.

States should reduce regulatory barriers to the creation of new OTPs. West Virginia, for example, has a legal moratorium on opening new OTPs and legislation to outlaw OTPs has been introduced in the state legislature.[37] Several other states and localities throughout the country also have limitations on where new OTPs can open – including zoning requirements – that can create barriers for treatment.[38] States with the fewest OTPs per 100,000 people with OUD should reevaluate existing regulations and expand flexibilities around OTPs to make MAT as accessible as possible. If it isn't possible to create new OTPs, mental health systems can train and implement care teams to expand the reach of physical OTP sites. For example, in New Jersey, mobile medication teams attached to OTPs have expanded the available reach of MAT without the need to open additional programs.[39]

Rank	State	Number of opioid treatment programs per 100,000 people with OUD	Total number of opioid treatment programs
1	Delaware	71.43	20
2	Massachusetts	71.25	114
3	Connecticut	71.05	54
4	Rhode Island	69.70	23
5	Maryland	68.79	108
6	Vermont	46.67	7
7	Alaska	42.11	8
8	Maine	41.18	14
9	Ohio	39.18	125
10	New Hampshire	37.50	12
11	District of Columbia	35.29	6
12	New York	32.88	144
13	Arizona	31.49	74
14	North Carolina	31.03	90
15	Pennsylvania	30.72	106
16	New Jersey	30.33	64
17	Colorado	28.57	44
18	Virginia	28.42	52
19	Kentucky	27.71	46
20	New Mexico	26.83	22
21	Illinois	26.39	90
22	Washington	23.67	40
23	North Dakota	23.53	4
24	Utah	22.09	19
25	Georgia	21.95	72
26	Michigan	19.85	54
27	Wisconsin	19.72	28
28	Florida	19.59	115
29	Oregon	19.26	26
30	California	18.74	172
31	South Carolina	17.90	29
32	Minnesota	16.13	20
33	Nevada	15.24	16
34	Oklahoma	14.93	20
35	Indiana	14.52	27
36	Montana	14.29	4
37	West Virginia	14.06	9
38	Kansas	13.24	9
39	Texas	11.49	97
40	Alabama	11.48	21
41	Tennessee	11.11	23
42	Iowa	9.41	8
43	Nebraska	9.30	4
44	Missouri	9.14	17
45	Idaho	8.96	6
46	Hawaii	8.82	3
47	Arkansas	6.59	6
48	Louisiana	6.25	11
49	Mississippi	5.00	5
50	South Dakota	4.55	1
51	Wyoming	0.00	0
	Overall	**25.48**	**2,089**

ADULTS WHO NEEDED BUT DID NOT RECEIVE SUBSTANCE USE TREATMENT



Nationally, 77% of adults who needed treatment for substance use disorder did not receive it, totaling nearly 40 million people. Over 80% of adults who needed care did not receive it in California, Georgia, and Illinois, the three bottom-ranked states.

West Virginia had the greatest access to substance use care for individuals who needed it. West Virginia and several of the other top-ranking states have made significant investments in expanding access to care. Kentucky (ranked third), for example, has invested millions of dollars into treatment through the Kentucky Opioid Response Effort (KORE).[40,41] These funds have been used to pay for treatment for those who were underinsured or could not afford care, expand substance use treatment through mobile outreach and linkages between hospitals and community programs, and connect people to recovery services. , However, most of the funding for KORE and for many treatment programs that have increased access to substance use care across states comes from federal funding, including Medicaid, which will be cut significantly through the One Big Beautiful Bill Act.[42]

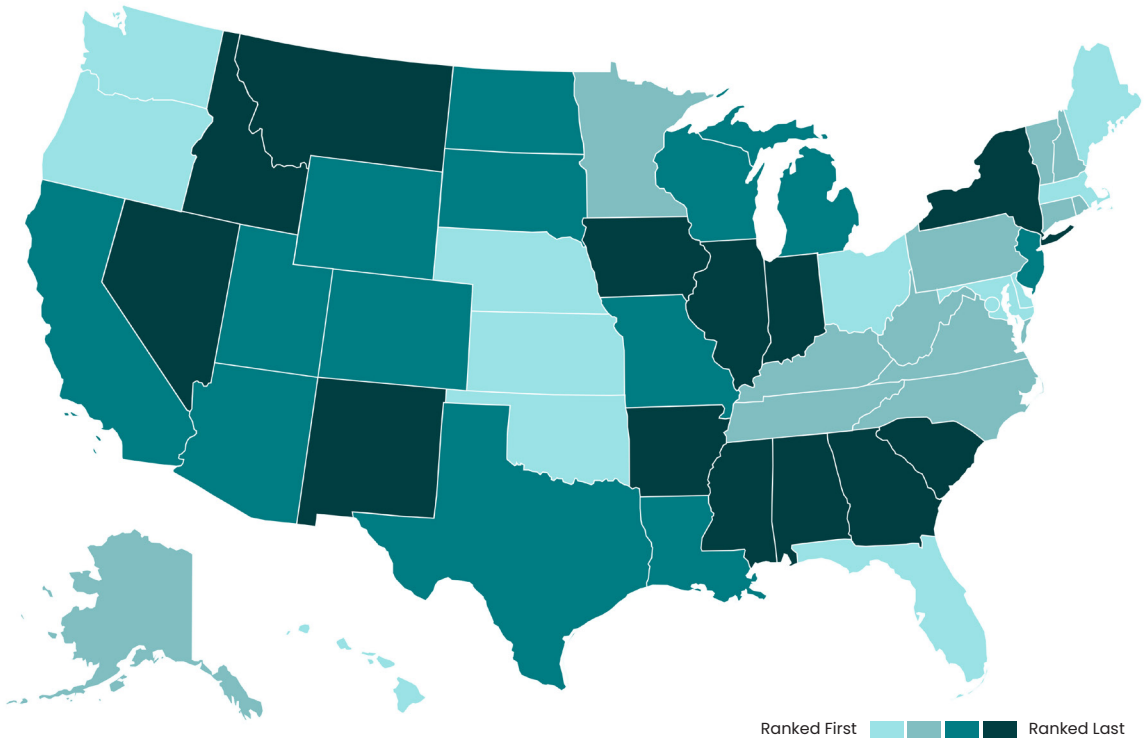
The Medicaid cuts passed in the One Big Beautiful Bill Act will have a particularly detrimental effect on already limited access to treatment for opioid use, especially in rural areas. While individuals with substance use disorders are exempt from work requirements for Medicaid coverage, they will still lose access to treatment due to hospital closures and reduction of state programs as a result of states needing to absorb federal cost-shifts. In some states, like Louisiana, most of the hospitals in rural areas are serving a high concentration of Medicaid patients, and may be at risk of closure once residents lose that coverage.[43] While the bill includes a $50 billion fund to support rural hospitals, experts estimate that will only cover about one third of what is needed for those hospitals to offset Medicaid cuts.[44] Further, almost every state currently uses at least one provider tax to help cover state Medicaid costs and increase matched federal funding. These taxes are a critical funding stream for state OTPs and rural hospitals,

many of which were already operating on very narrow margins. The One Big Beautiful Bill Act limits states' ability to raise or implement provider taxes and reduces existing provider taxes in expansion states. This change alone is estimated by the Congressional Budget Office to cut $191 billion in federal spending over the next 10 years,[45] likely forcing states to cut reimbursement and services.

Medicaid divestment impacts vulnerable populations, including people with opioid addiction, the most. These policies will lead to increases in opioid overdoses and deaths, and will undermine the progress states have made in increasing access to already limited treatment resources.

Rank	State	Percentage	Weighted count
1	West Virginia	70.85%	581,000
2	Utah	70.93%	96,000
3	Kentucky	71.33%	871,000
4	Pennsylvania	71.74%	361,000
5	Wyoming	72.30%	4,855,000
6	Mississippi	73.13%	860,000
7	Tennessee	73.22%	489,000
8	New Hampshire	74.41%	129,000
9	Montana	74.66%	118,000
10	Indiana	74.69%	2,424,000
11	Iowa	74.77%	1,357,000
12	New York	74.91%	155,000
13	Oregon	74.98%	228,000
14	Idaho	75.05%	1,596,000
15	Hawaii	75.32%	672,000
16	Arizona	75.34%	362,000
17	Alabama	75.38%	319,000
18	Vermont	75.49%	506,000
19	Michigan	75.57%	594,000
20	Connecticut	75.74%	212,000
21	Ohio	75.74%	665,000
22	Washington	75.89%	999,000
23	Florida	75.89%	1,224,000
24	Arkansas	76.01%	713,000
25	New Mexico	76.20%	311,000
26	Nebraska	76.42%	855,000
27	South Dakota	76.83%	150,000
28	Missouri	76.83%	210,000
29	Kansas	76.87%	471,000
30	Texas	76.95%	182,000
31	Maine	77.07%	990,000
32	Oklahoma	77.08%	278,000
33	South Carolina	77.43%	2,354,000
34	Colorado	77.48%	1,164,000
35	New Jersey	77.59%	91,000
36	Massachusetts	77.63%	1,490,000
37	North Dakota	77.66%	499,000
38	Louisiana	77.84%	610,000
39	Nevada	78.12%	1,516,000
40	Maryland	78.22%	177,000
41	Delaware	78.28%	615,000
42	North Carolina	78.45%	104,000
43	Virginia	78.72%	791,000
44	Minnesota	78.88%	3,023,000
45	Wisconsin	79.25%	277,000
46	Rhode Island	79.55%	96,000
47	District of Columbia	79.67%	992,000
48	Alaska	79.94%	969,000
49	Illinois	80.50%	216,000
50	Georgia	81.50%	778,000
51	California	82.05%	67,000
	Overall	**77.09%**	**39,662,000**

NUMBER OF TREATMENT AND ADDICTION RECOVERY RESIDENCES



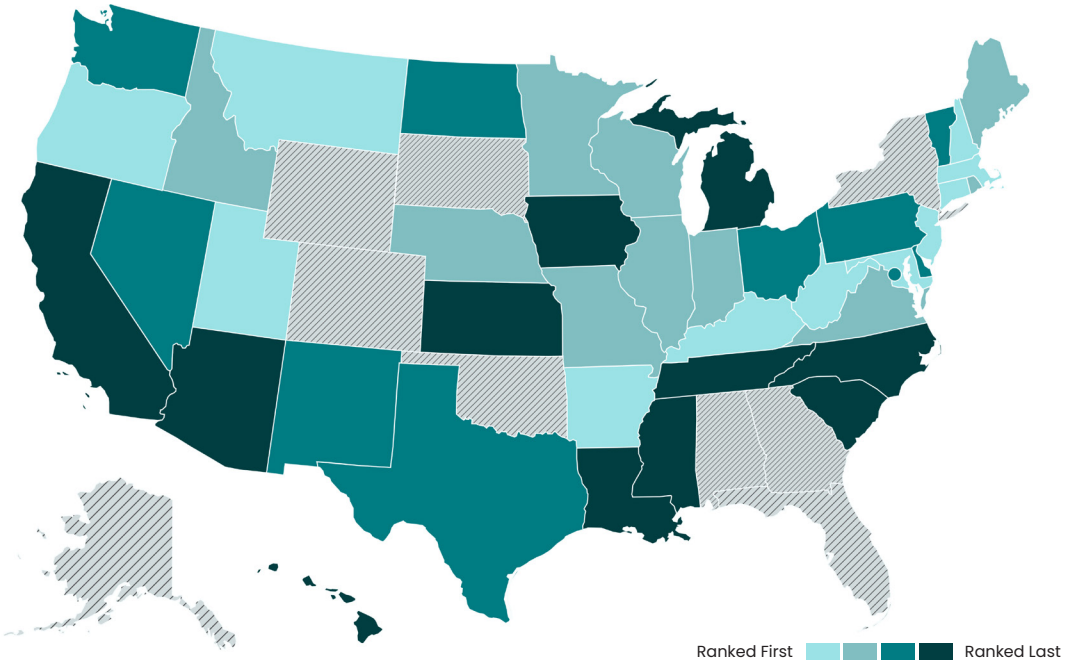
Recovery residences are drug- and alcohol-free homes where people experiencing substance use can live while transitioning into the community, often following treatment or incarceration.[46] They vary in terms of the level of support provided to residents, but the key components of certified recovery residences are provision of a safe and supportive living environment, connection to peer support, and connection to clinical services if needed. Research has shown that people with substance use disorders living in recovery residences were more likely to experience remission, more likely to be employed, and less likely to have been involved in the criminal justice system than those who lived at home and received usual care.[47]

Recovery residences are just one example of recovery-support services, but they can serve as a reflection of the state's investment in recovery for individuals with OUD. Most states in the U.S. had fewer than one recovery residence per 1,000 people with OUD. Delaware had the greatest access to recovery residences, with nearly four registered residences for every 1,000 people with OUD in the state population. Alabama, Arkansas, and Georgia, all states in the Southeast U.S., had the fewest recovery residences for the population with OUD.

At minimum, states should aim to have one recovery residence per 1,000 people with OUD in the state. States should use data from state health departments or other publicly available data sources to identify where there is a need for additional transitional and long-term community-based recovery supports and focus investments there. In locations with the greatest need, these investments should include training programs for recovery housing operators, peer support specialists, and recovery coaches – to expand and sustain the workforce necessary to deliver the essential components of recovery services.

Rank	State	Number of recovery residences per 1,000 people with OUD	Total number of recovery residences
1	Delaware	3.71	104
2	Florida	3.45	2,024
3	Maine	3.26	111
4	Oregon	2.96	399
5	District of Columbia	2.76	47
6	Washington	2.67	452
7	Oklahoma	2.38	319
8	Maryland	2.15	337
9	Kansas	1.93	131
10	Hawaii	1.85	63
11	Massachusetts	1.81	290
12	Ohio	1.81	577
13	Nebraska	1.79	77
14	New Hampshire	1.78	57
15	West Virginia	1.72	110
16	Rhode Island	1.70	56
17	Connecticut	1.55	118
18	Minnesota	1.53	190
19	Tennessee	1.34	278
20	Alaska	1.32	25
21	Kentucky	1.22	202
22	Vermont	1.20	18
23	North Carolina	1.19	345
24	Virginia	1.18	216
25	Pennsylvania	1.01	347
26	New Jersey	0.96	203
27	Louisiana	0.94	165
28	Missouri	0.90	167
29	Colorado	0.89	137
30	Wyoming	0.86	12
31	California	0.82	757
32	Arizona	0.79	185
33	Michigan	0.73	199
34	North Dakota	0.71	12
35	Texas	0.69	583
36	Wisconsin	0.69	98
37	Utah	0.69	59
38	South Dakota	0.68	15
39	Indiana	0.63	118
40	New York	0.56	244
41	South Carolina	0.55	89
42	New Mexico	0.54	44
43	Illinois	0.46	156
44	Mississippi	0.38	38
45	Iowa	0.38	32
46	Nevada	0.31	33
47	Idaho	0.31	21
48	Montana	0.29	8
49	Georgia	0.25	82
50	Arkansas	0.22	20
51	Alabama	0.16	30
	Overall	**1.27**	**10,400**

SCHOOLS RANKING



Rank	State
1	New Jersey
2	Utah
3	Connecticut
4	Massachusetts
5	Montana
6	Arkansas
7	Maryland
8	New Hampshire
9	Kentucky
10	West Virginia
11	Oregon
12	Rhode Island
13	Minnesota
14	Nebraska
15	Illinois
16	Maine
17	Wisconsin

Rank	State
18	Indiana
19	Missouri
20	Virginia
21	Idaho
22	New Mexico
23	Vermont
24	District of Columbia
25	North Dakota
26	Ohio
27	Nevada
28	Delaware
29	Washington
30	Texas
31	Pennsylvania
32	Iowa
33	Michigan
34	Louisiana

Rank	State
35	California
36	North Carolina
37	Kansas
38	Tennessee
39	Mississippi
40	South Carolina
41	Hawaii
42	Arizona
*	Alabama
*	Alaska
*	Colorado
*	Florida
*	Georgia
*	New York
*	Oklahoma
*	South Dakota
*	Wyoming

Schools have the opportunity to address opioid overdose risk at the earliest moment in lifespan development. School strategies include providing opioid education to both students and families, ensuring naloxone access in spaces with the highest risk of overdose, and equipping parents with the resources to address opioid use and overdose prevention with their families.

School indicators

- Percentage of youth reporting they did not receive drug or alcohol education in school in the past year
- Percentage of schools reporting they taught the difference between proper use and abuse of OTC and prescription medications
- Percentage of schools reporting they provide parents and families with health information about drug and alcohol prevention
- Percentage of youth reporting they have talked with a parent about the danger of tobacco, alcohol, or drugs

Two of the five indicators used in the Overall Schools Ranking were taken from the CDC's School Health Profiles data. Nine states are excluded from this ranking because they either did not participate in the School Health Profiles survey or did not collect representative state data.

Overall schools ranking

The 10 states with the highest need for strategic investment in school opioid overdose prevention are: Arizona, Hawaii, South Carolina, Mississippi, Tennessee, Kansas, North Carolina, California, Louisiana, and Michigan. These states had the lowest rates of school-based education on opioid and overdose prevention for youth and families.

STRATEGIC APPROACH TO OPIOID OVERDOSE PREVENTION IN SCHOOLS: POLICY RECOMMENDATIONS

The role of schools in preventing opioid deaths is to educate students and parents on opioid use and overdose prevention, and to ensure naloxone access in places where students are at greatest risk of overdose. **To better address a school-based approach to reducing opioid deaths, states with the worst outcomes should implement the following strategies:**

- **At minimum, provide guidance for schools to reevaluate health curriculum** to include substance use prevention education.
- **Include specific education on opioids and fentanyl** as part of required health curriculum, including how to recognize signs of overdose and how to be an active bystander.
- **Work with state and local health departments to offer professional development training** for teachers and faculty on the latest information around opioid use and overdose prevention in schools.
- **Partner with local health departments and Parent Teacher Associations** (PTAs) to gather information on what parents want or need to start conversations with their families about preventing opioid use, especially in communities that have experienced an overdose.

Naloxone in schools

Naloxone should be accessible everywhere that youth are at high risk of overdose, including in schools, youth centers, recreation and sports facilities, and on student transportation. In the 2022 to 2023 school year, naloxone was administered 31 times in the Los Angeles Unified School District and an estimated 45 times in the Prince George's County School District in Maryland to respond to overdoses.[48]

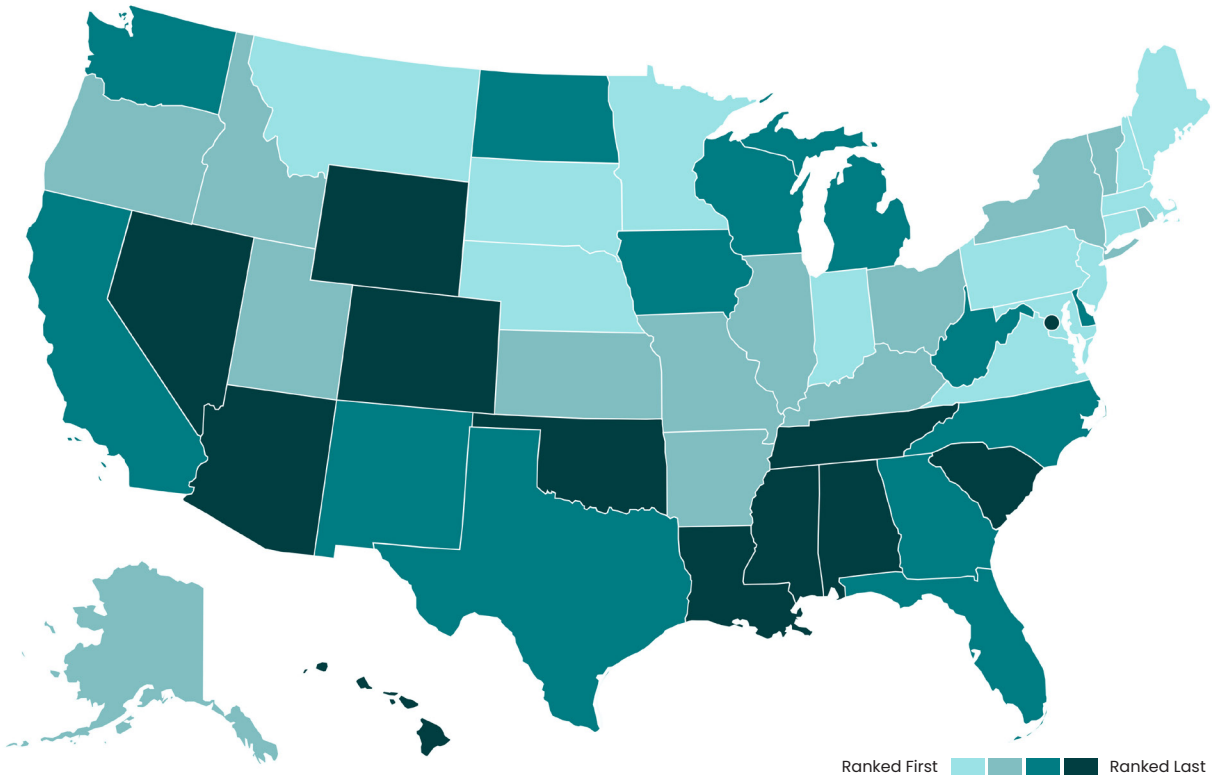
The National Association of School Nurses and SAMHSA both recommend that every person on school grounds, including every student, should be able to access naloxone and be prepared to administer it.[49] Many public school districts across the country have mandated stocking naloxone, including Dallas, Texas; Fairfax County, Virginia; and Miami-Dade County in Florida.[50] Several districts across the country have also changed their policies to allow students to carry naloxone,[51,52,53] which could enable even faster response times to an overdose if combined with education on opioid overdoses and naloxone use.

Thirty-six states have statutory language that expressly allows K-12 school employees to store, possess, and/or administer naloxone. Eight states (Arkansas, Connecticut, Florida, Maryland, New Jersey, Washington, and Wisconsin) also specifically mention storage, possession, and/or administration of naloxone in higher education.[54] However, these policies do not mandate that naloxone be available in every school, which can lead to wide disparities in access. At minimum, states should mandate that at least one opioid overdose reversal kit be available with a school nurse or faculty member on all public school campuses, similar to legislation passed in Arkansas.[55]

However, only having one overdose reversal kit is likely not sufficient for all schools. States should allocate additional resources for public health departments to conduct needs assessments to determine how much naloxone should be available in schools based on levels of community risk. States should appropriate funds, similar to the Municipal Naloxone Bulk Purchase Trust in Massachusetts,[56] to discount or pay for bulk purchasing of an adequate supply of naloxone to meet the requirements from those needs assessments. Public health departments can then work with schools to create naloxone distribution plans and ensure that school nurses or other qualified faculty members are supplied with the appropriate amount of naloxone at all times.

To ensure adequate response times to overdoses, schools should also consider including naloxone in tamper-resistant cases along with defibrillators for easy access near where students may be at greater risk of overdose, like in bathrooms and locker rooms (see box on naloxone and AEDs on page 4). Finally, all 50 states have legislation requiring school buses to carry clearly marked first aid kits. Schools should work with their public health departments to ensure that naloxone is included as part of those required first aid kits.

YOUTH REPORTING THEY DID NOT RECEIVE DRUG OR ALCOHOL EDUCATION IN SCHOOL IN THE PAST YEAR



Nationally, 38% of students reported they did not receive any drug or alcohol education in school in the past year. In Arizona and Oklahoma, the two bottom-ranked states, over half of students did not receive drug or alcohol education.

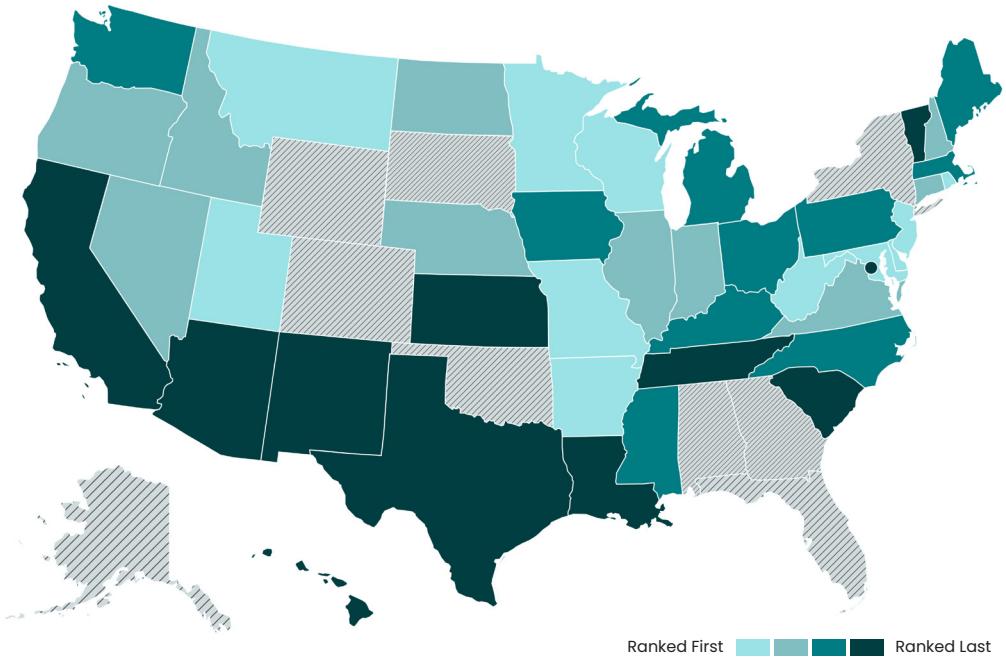
Providing drug education in health curriculum is an important first step in preventing opioid and other substance use. The CDC and National Health Education Standards (NHES) recognize alcohol and other drug use as a core topic area to address in health curriculum.[57] Schools in states ranked 39 to 51 for this measure should, at minimum, reevaluate health curriculum to include substance use education.

Drug education is important for preventing the future use of opioids and other drugs, but is also essential to teach students how to be active bystanders if they witness an overdose. Drug education in schools should include how to recognize the signs of an overdose and how to administer naloxone immediately, rather than waiting for help to arrive.

Rank	State	Percentage	Weighted count
1	Montana	22.70%	18,000
2	Massachusetts	24.80%	113,000
3	Indiana	25.50%	134,000
4	New Jersey	26.70%	177,000
5	Maine	28.00%	24,000
6	Nebraska	28.50%	45,000
7	New Hampshire	28.90%	25,000
8	Connecticut	29.80%	75,000
9	Minnesota	29.80%	128,000
10	Maryland	30.80%	138,000
11	Virginia	32.10%	196,000
12	South Dakota	32.30%	24,000
13	Pennsylvania	32.70%	286,000
14	Alaska	33.00%	18,000
15	Illinois	33.10%	311,000
16	Vermont	33.10%	13,000
17	Utah	33.30%	104,000
18	Oregon	33.60%	96,000
19	New York	34.10%	430,000
20	Missouri	34.20%	155,000
21	Kentucky	34.70%	113,000
22	Ohio	34.80%	297,000
23	Idaho	35.50%	57,000
24	Arkansas	35.70%	77,000
25	Rhode Island	35.70%	24,000
26	Kansas	36.30%	83,000

Rank	State	Percentage	Weighted count
27	New Mexico	37.10%	57,000
28	Delaware	37.50%	25,000
29	Florida	37.90%	534,000
30	North Dakota	38.00%	21,000
31	West Virginia	38.60%	45,000
32	Wisconsin	38.60%	166,000
33	Washington	39.40%	213,000
34	California	39.70%	1,090,000
35	Iowa	40.20%	102,000
36	Georgia	40.40%	332,000
37	North Carolina	41.10%	317,000
38	Michigan	41.90%	293,000
39	Texas	41.90%	986,000
40	Colorado	42.30%	178,000
41	Hawaii	42.60%	38,000
42	Nevada	43.50%	100,000
43	Wyoming	43.80%	19,000
44	District of Columbia	45.20%	14,000
45	Tennessee	45.20%	232,000
46	Louisiana	45.70%	154,000
47	Alabama	45.90%	156,000
48	Mississippi	48.00%	109,000
49	South Carolina	50.00%	186,000
50	Oklahoma	50.90%	155,000
51	Arizona	55.20%	296,000
	Overall	**37.70%**	**8,984,000**

SCHOOLS REPORTING THEY TAUGHT THE DIFFERENCE BETWEEN PROPER USE AND ABUSE OF OTC AND PRESCRIPTION MEDICATIONS



About 80% of all schools that participated in the CDC's School Health Profiles reported that they taught the difference between proper use and abuse of over the counter (OTC) and prescription medications. However, in Arizona (ranked last) only 35% of schools taught students about prescription medications.

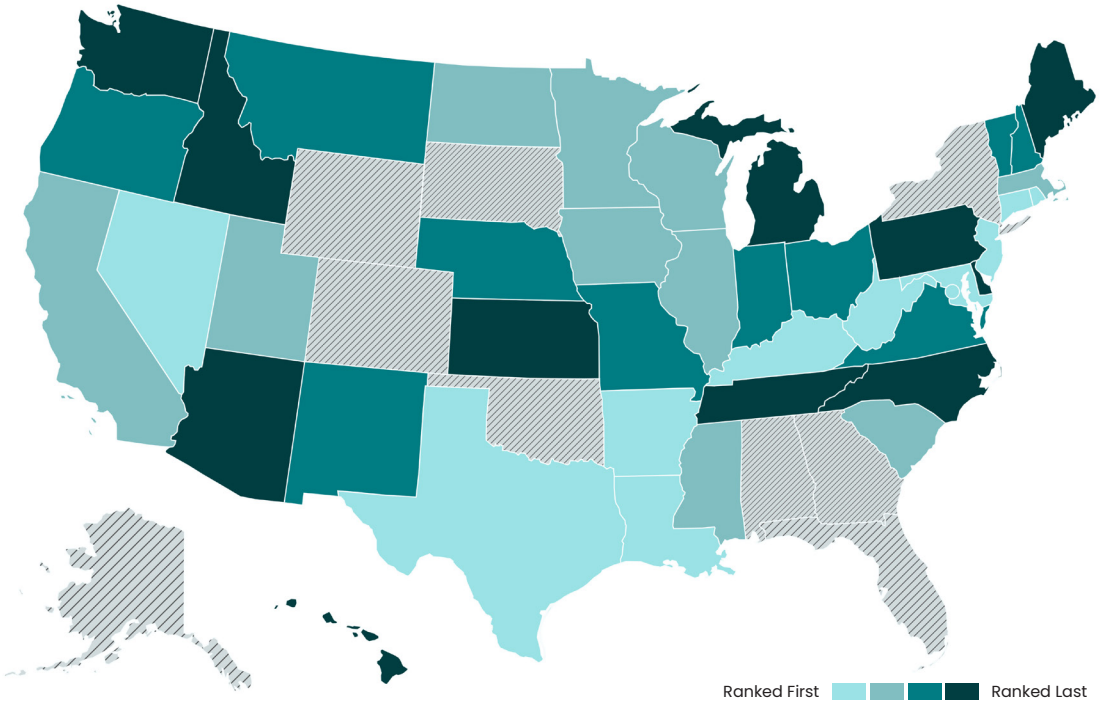
Education around misuse of prescription medications and the risk of fentanyl should be included in school health curriculum to keep pace with the changing landscape of substance use risk. There are free programs schools can use to incorporate lessons on opioid misuse and fentanyl. Operation Prevention, for example, is a free program created in partnership with the Drug Enforcement Administration (DEA) and Discovery Education and has lesson plans on opioid and prescription drugs for elementary, middle, and high school students. Schools should redesign current substance use prevention curricula to incorporate lesson plans on fentanyl, opioids, and use of prescription drugs. School administrators should also work with state and local health departments to offer professional development training for teachers and faculty on the latest information around opioid use and overdose prevention in schools.

Several states, including Oregon and Illinois,[58] have passed legislation to increase opioid and fentanyl education materials across schools statewide. In 2023, Oregon passed legislation that required the Oregon Health Authority, Oregon Department of Education, and Alcohol Drug Policy Commission to develop required lessons on synthetic opioids including fentanyl. Those developed lesson plans were required to be implemented in all Oregon middle and high schools beginning in the 2024 to 2025 school year.[59] Other states should consider similar legislation to designate resources for their state health departments and departments of education to design and implement opioid prevention lesson plans specific to their states.

Rank	State	Percentage	Count
1	Maryland	94.64%	226
2	Arkansas	94.35%	166
3	New Jersey	93.26%	136
4	Utah	92.65%	136
5	Minnesota	92.58%	241
6	Delaware	89.96%	56
7	West Virginia	89.86%	173
8	Missouri	88.51%	300
9	Wisconsin	88.50%	293
10	Montana	87.61%	247
11	Rhode Island	87.19%	89
12	Oregon	86.92%	162
13	Illinois	86.87%	266
14	Virginia	86.84%	178
15	North Dakota	85.93%	148
16	Indiana	85.46%	216
17	New Hampshire	85.23%	242
18	Nevada	85.11%	110
19	Idaho	84.29%	107
20	Connecticut	84.10%	216
21	Nebraska	83.68%	147
22	Maine	82.91%	183
23	Pennsylvania	82.52%	293
24	Mississippi	82.45%	224
25	Iowa	81.05%	212
26	Michigan	81.02%	258
27	North Carolina	78.34%	272
28	Ohio	78.15%	280
29	Massachusetts	76.90%	474
30	Kentucky	76.79%	236
31	Washington	75.49%	220
32	District of Columbia	75.00%	36
33	Louisiana	73.09%	188
34	South Carolina	72.65%	73
35	Kansas	72.07%	172
36	New Mexico	71.19%	193
37	Vermont	70.89%	131
38	Hawaii	66.63%	106
39	Tennessee	65.12%	296
40	Texas	64.35%	325
41	California	56.36%	253
42	Arizona	34.80%	218
43	Alabama	*	
44	Alaska	*	
45	Colorado	*	
46	Florida	*	
47	Georgia	*	
48	New York	*	
49	Oklahoma	*	
50	South Dakota	*	
51	Wyoming	*	
	Overall	**77.63%**	**8,252**

*Indicates that the state did not report data to CDC School Health Profiles.

SCHOOLS REPORTING THEY PROVIDE PARENTS AND FAMILIES WITH HEALTH INFORMATION ABOUT DRUG AND ALCOHOL PREVENTION



Overall, fewer than half of schools surveyed by School Health Profiles reported that they provided parents and families with information on drug and alcohol prevention. Schools in Arkansas, New Jersey, and Texas were most likely to provide parents with drug prevention information. In Kansas, Pennsylvania, and Hawaii, the three lowest-ranked states, only about one-third of schools provided parents with health information on drug prevention.

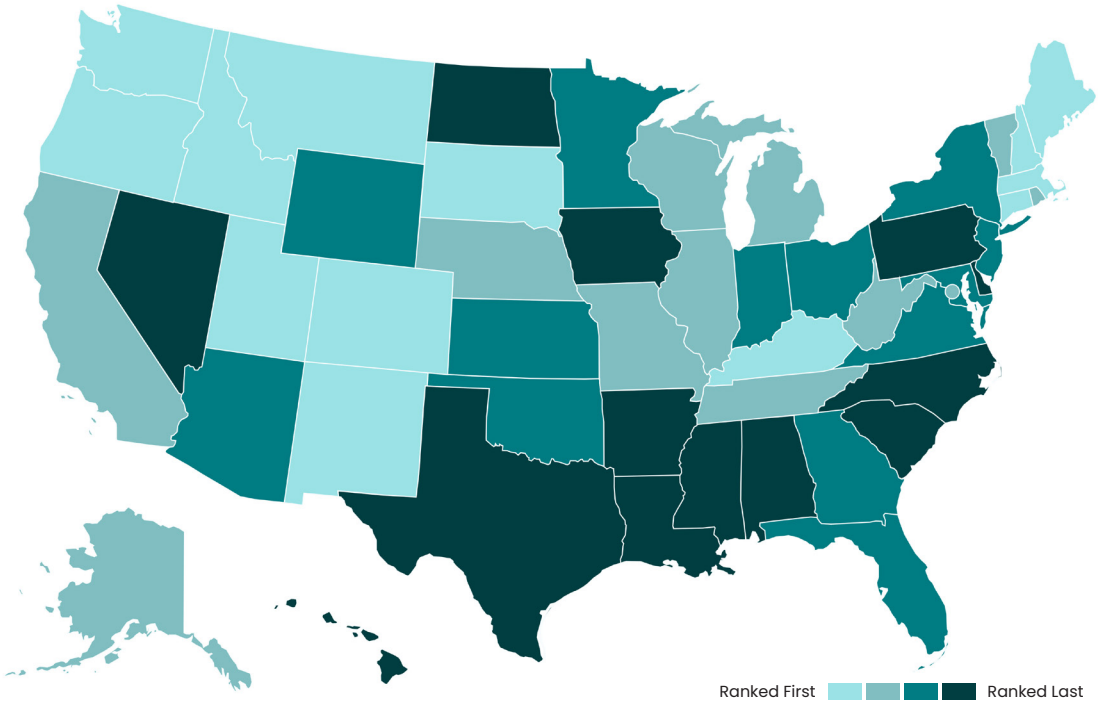
Opioid overdose prevention education should go beyond the school walls. Schools should provide parents and families with resources to better understand the risk of overdose, even among youth using substances for the first time. From 2019 to 2021, over 90% of overdose deaths among youth ages 10 to 19 involved opioids, but only 35% of them had a history of opioid use. About 25% of youth overdose deaths had evidence of counterfeit pills, where youth may not have known that the drug they were taking contained fentanyl or other substances.[60] Schools should partner with state and local health departments to supply local updated information on the changing landscape and risk associated with youth substance use in their community.

Providing local information to families ensures that they are best equipped to recognize risk and implement prevention strategies that work best for their families. Ideally, parents should be given these educational resources before an overdose happens. However, it is especially important to equip all parents districtwide with resources and information on overdose prevention following an overdose in the community, as other youth may be exposed to the same source of drugs that may contain lethal additives like fentanyl.

Rank	State	Percentage	Count
1	Arkansas	70.30%	164
2	New Jersey	64.25%	132
3	Texas	61.71%	320
4	Connecticut	56.47%	214
5	West Virginia	55.92%	164
6	Kentucky	55.57%	233
7	District of Columbia	54.05%	35
8	Louisiana	53.53%	181
9	Maryland	53.51%	219
10	Rhode Island	52.19%	86
11	Nevada	51.16%	99
12	Mississippi	50.81%	225
13	Massachusetts	50.06%	458
14	California	49.70%	255
15	Wisconsin	48.94%	288
16	South Carolina	48.34%	72
17	Iowa	47.66%	197
18	Illinois	46.65%	263
19	North Dakota	46.38%	149
20	Minnesota	46.32%	235
21	Utah	46.27%	134
22	Oregon	45.46%	159
23	New Hampshire	44.74%	244
24	New Mexico	43.80%	179
25	Ohio	42.88%	260
26	Nebraska	42.85%	139
27	Montana	42.09%	245
28	Indiana	41.91%	202
29	Virginia	41.52%	179
30	Vermont	41.02%	127
31	Missouri	40.95%	295
32	Tennessee	40.46%	294
33	North Carolina	39.32%	258
34	Delaware	39.31%	56
35	Washington	38.61%	213
36	Michigan	38.37%	249
37	Idaho	36.13%	104
38	Arizona	36.11%	215
39	Maine	34.09%	171
40	Hawaii	33.39%	107
41	Pennsylvania	33.05%	292
42	Kansas	32.87%	170
43	Alabama	*	
44	Alaska	*	
45	Colorado	*	
46	Florida	*	
47	Georgia	*	
48	New York	*	
49	Oklahoma	*	
50	South Dakota	*	
51	Wyoming	*	
	Overall	**48.31%**	**8,032**

*Indicates that the state did not report data to CDC School Health Profiles.

YOUTH REPORTING THEY HAVE TALKED WITH A PARENT ABOUT THE DANGER OF TOBACCO, ALCOHOL, OR DRUGS



Only about half of youth in the U.S. report that they have talked with a parent about the danger of tobacco, alcohol, or drugs. Even in Arkansas (ranked 47th), where 70% of schools report they provide parents with information on drug and alcohol prevention, only 45% of youth say their parents have talked to them about it.

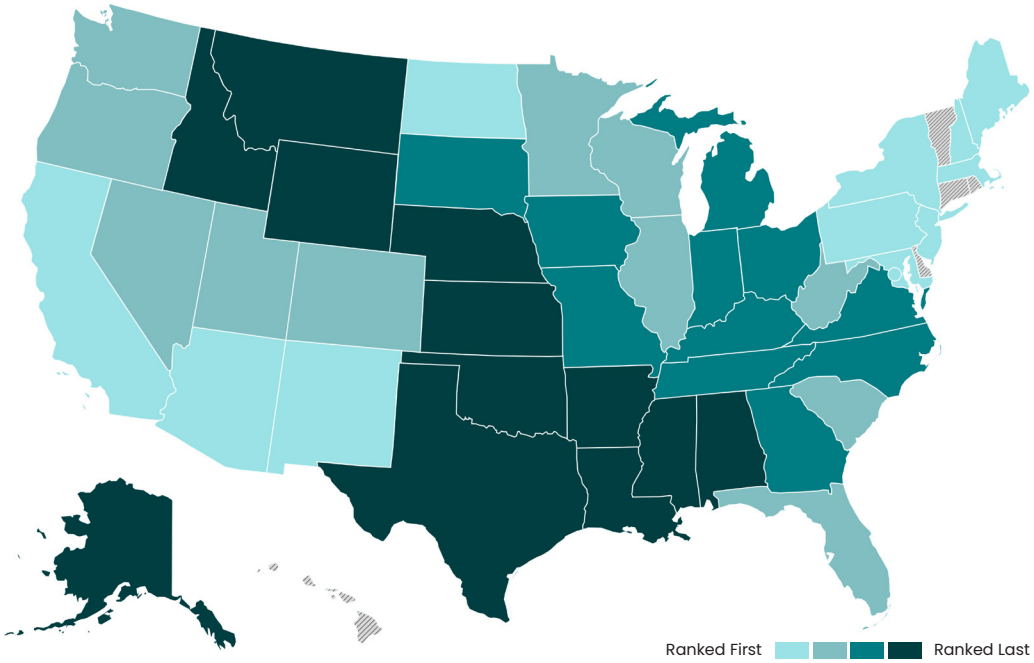
Family engagement is a key protective factor against youth substance use.[61] Not only do parents and families need to receive resources on opioid use and overdose prevention from the school, but they need to feel comfortable and supported in using them.

Schools should partner with both local health departments and PTAs to gather information on what parents want or need to start conversations about preventing opioid use, especially in communities that have experienced an overdose. Through these partnerships, health departments and families can co-design informational resources and workshops that would be most effective and useful to them within the context of their state or community.

Rank	State	Percentage	Weighted count
1	Utah	66.90%	217,000
2	Massachusetts	61.60%	295,000
3	South Dakota	60.80%	45,000
4	Connecticut	60.20%	157,000
5	Maine	59.30%	52,000
6	Kentucky	58.90%	205,000
7	New Mexico	58.60%	97,000
8	Colorado	58.50%	257,000
9	Montana	57.90%	47,000
10	Oregon	57.80%	174,000
11	New Hampshire	57.40%	53,000
12	Washington	57.00%	325,000
13	Idaho	56.20%	93,000
14	Nebraska	55.70%	91,000
15	Vermont	55.60%	23,000
16	Illinois	55.20%	544,000
17	Tennessee	55.00%	294,000
18	Missouri	54.80%	255,000
19	Wisconsin	54.80%	246,000
20	District of Columbia	54.40%	18,000
21	Rhode Island	54.10%	39,000
22	West Virginia	54.10%	67,000
23	California	53.10%	1,584,000
24	Michigan	53.00%	389,000
25	Alaska	52.00%	31,000
26	Maryland	51.80%	243,000

Rank	State	Percentage	Weighted count
27	New Jersey	51.80%	363,000
28	New York	51.70%	703,000
29	Oklahoma	51.40%	165,000
30	Kansas	51.00%	121,000
31	Virginia	51.00%	323,000
32	Ohio	50.70%	452,000
33	Arizona	50.60%	286,000
34	Wyoming	50.50%	24,000
35	Minnesota	50.40%	225,000
36	Indiana	50.00%	268,000
37	Florida	49.90%	734,000
38	Georgia	49.70%	444,000
39	Pennsylvania	49.60%	457,000
40	Louisiana	49.40%	177,000
41	Delaware	48.90%	36,000
42	North Carolina	48.60%	394,000
43	Nevada	48.50%	116,000
44	Texas	47.60%	1,219,000
45	North Dakota	47.30%	28,000
46	Iowa	46.50%	118,000
47	Arkansas	45.30%	109,000
48	Hawaii	45.10%	41,000
49	South Carolina	44.40%	177,000
50	Mississippi	38.50%	94,000
51	Alabama	35.10%	133,000
	Overall	**51.70%**	**13,049,000**

JAILS RANKING



Rank	State
1	District of Columbia
2	Massachusetts
3	Maryland
4	New Hampshire
5	New Jersey
6	New York
7	Arizona
8	Maine
9	New Mexico
10	Pennsylvania
11	California
12	North Dakota
13	Washington
14	Colorado
15	Wisconsin
16	South Carolina
17	Nevada

Rank	State
18	Illinois
19	West Virginia
20	Utah
21	Minnesota
22	Florida
23	Oregon
24	Virginia
25	Ohio
26	Michigan
27	Kentucky
28	Indiana
29	Tennessee
30	South Dakota
31	North Carolina
32	Missouri
33	Georgia
34	Iowa

Rank	State
35	Nebraska
36	Montana
37	Alabama
38	Texas
39	Kansas
40	Oklahoma
41	Louisiana
42	Idaho
43	Alaska
44	Wyoming
45	Arkansas
46	Mississippi
*	Connecticut
*	Delaware
*	Hawaii
*	Rhode Island
*	Vermont

People with OUD have an especially high risk of death upon release from incarceration, because their tolerance for opioids decreases while they are incarcerated.[62] A 2024 study in Minnesota found that overdose death rates were 15 to 28 times higher for people leaving jails and prisons than among the general population, with opioids being the leading cause of overdose.[63]

Jail indicators

- Percent of local jail jurisdictions and facilities that provide overdose reversal medications to detainees with OUD upon release
- Percent of local jail jurisdictions and facilities that provide a link to MAT in the community to detainees with OUD upon release

These indicators were collected by the Bureau of Justice Statistics (BJS) through the 2019 Census of Jails, a representative survey of the local jurisdictions and facilities in states with separate jail and prison systems. These data are collected every five years. The 2019 Census of Jails is the most recently available dataset for these measures. BJS has not done a similar collection of opioid use or treatment in prisons in the U.S.

*Connecticut, Delaware, Hawaii, Rhode Island, and Vermont have combined jail and prison systems and were excluded from this data collection and ranking. Alaska data is reflective of 15 locally operated jails outside of the combined jail and prison system.

Overall jails ranking

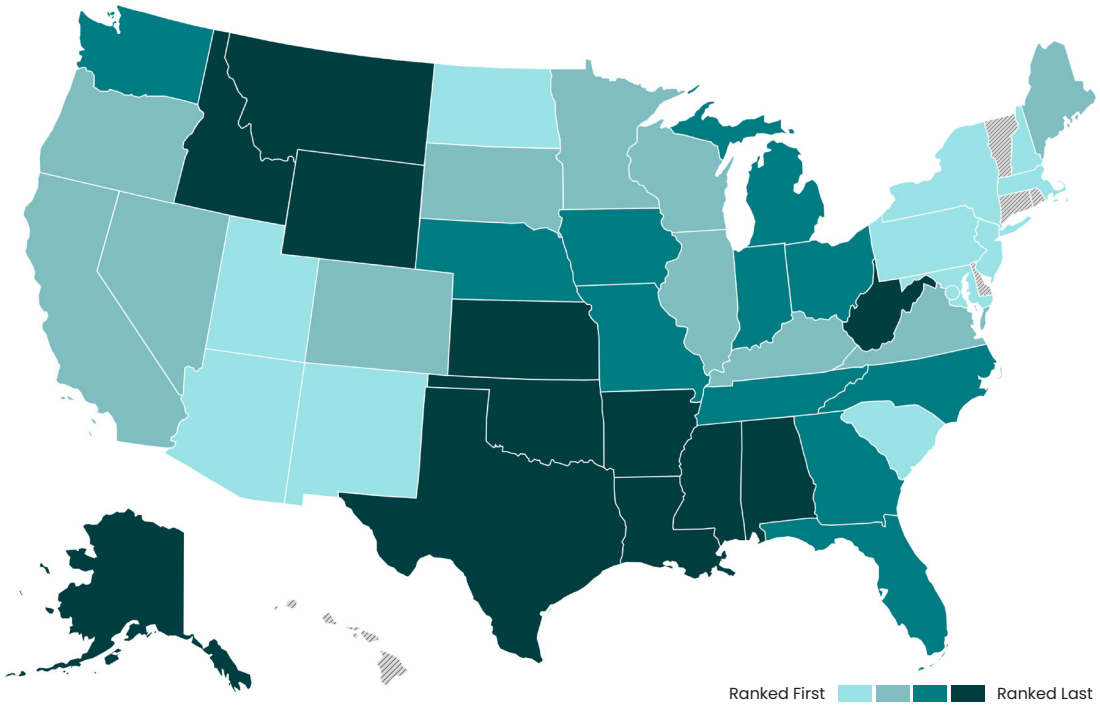
The 10 states with the highest need for strategic investment in opioid overdose prevention during community reentry are: Mississippi, Arkansas, Alaska, Idaho, Louisiana, Oklahoma, Kansas, Texas, Alabama, and Montana. These states have the lowest reported rates of naloxone provision and connection to MAT for people with OUD who were leaving incarceration.

STRATEGIC APPROACH TO OPIOID OVERDOSE PREVENTION UPON RELEASE FROM JAILS: POLICY RECOMMENDATIONS

The role of jails in preventing opioid overdose deaths is to equip people with OUD with naloxone and connections to community-based treatment as they leave incarceration. **To reduce opioid overdose deaths for people leaving jails and reentering communities, states with the worst outcomes should implement the following strategies:**

- **Pass state legislation or create statewide directives** that require all correctional facilities to provide people with known substance use disorders with naloxone upon release.
- **Dedicate funds for bulk ordering of naloxone** to ensure that there is enough supply for jails to carry out statewide mandates for naloxone provision.
- **Create a statewide joint strategy** between state corrections departments and state health departments to ensure continuity of MAT for people with OUD upon release from incarceration.
- **Contract with community providers, health care systems, or OTPs in communities** to provide transition services and ensure continuity of care. These contracts could include hiring case managers or navigators to help reinstate Medicaid coverage upon release.

LOCAL JAIL JURISDICTIONS AND FACILITIES THAT PROVIDE OVERDOSE REVERSAL MEDICATIONS TO DETAINEES WITH OUD UPON RELEASE



Studies show that people reentering communities from incarceration are at very high risk of overdose and death for the first two weeks following release.[64] Providing people with naloxone is an essential strategy to reduce their immediate risk of death during that time.

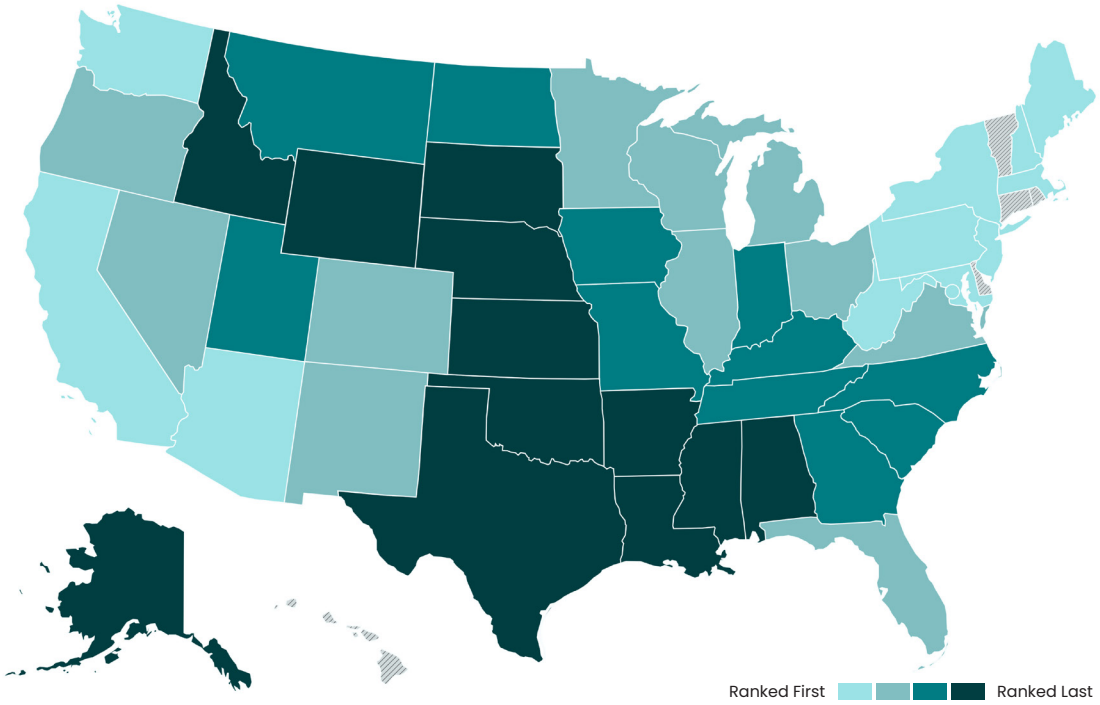
On average, only 31% of jails reported that they provide overdose reversal medications to detainees with OUD upon release from jail. This data was collected in 2019 and is the most recent data available from the Census of Jails. In recent years, some states have amended or passed new policies to ensure naloxone is given to people upon release from incarceration. For example, in Oklahoma (ranked 36th), a bill was passed in 2023 that directs the Department of Corrections and county jails to provide two doses of naloxone to people diagnosed with OUD when they leave incarceration.[65] West Virginia (ranked last) released a directive in 2024 requiring that adult facilities provide Narcan to inmates upon release if it is available and requested.[66]

States should pass legislation or instate directives that require all correctional facilities to provide people with naloxone and education on when and how to use it upon release. Individual correctional facilities in all states may be following this practice, but without a state mandate, there are disparities in who has access to lifesaving resources based solely on where they were detained. These directives should not be based on the availability of naloxone or requests by people leaving incarceration. States should dedicate specific funding for bulk ordering of naloxone to ensure that it is available to all people with known substance use disorders upon release.

Rank	State	Percentage
1	District of Columbia	100.00%
2	Massachusetts	63.60%
3	North Dakota	57.90%
4	New Mexico	57.90%
5	Maryland	56.30%
6	New Jersey	54.30%
7	New Hampshire	50.00%
8	Arizona	47.50%
9	South Carolina	44.60%
10	New York	43.30%
11	Pennsylvania	41.90%
12	Utah	41.70%
13	California	41.10%
14	Colorado	38.20%
15	South Dakota	38.20%
16	Nevada	37.80%
17	Illinois	36.70%
18	Minnesota	36.70%
19	Maine	34.90%
20	Wisconsin	34.20%
21	Oregon	33.30%
22	Kentucky	33.20%
23	Virginia	31.70%
24	Florida	27.80%
25	Indiana	27.80%
26	Tennessee	27.30%
27	Washington	25.10%
28	North Carolina	24.20%
29	Michigan	22.70%
30	Missouri	21.90%
31	Georgia	20.30%
32	Nebraska	19.50%
33	Ohio	19.10%
34	Iowa	18.70%
35	Alaska	15.40%
36	Oklahoma	15.10%
37	Alabama	14.40%
38	Kansas	13.90%
39	Montana	13.60%
40	Texas	13.50%
41	Louisiana	11.20%
42	Arkansas	9.90%
43	Wyoming	9.40%
44	Idaho	8.50%
45	Mississippi	6.40%
46	West Virginia	0.00%
47	Connecticut	*
48	Delaware	*
49	Hawaii	*
50	Rhode Island	*
51	Vermont	*
	Overall	**25.20%**

*Indicates that a state has combined jail and prison systems and was excluded from data collection.

LOCAL JAIL JURISDICTIONS AND FACILITIES THAT PROVIDE A LINK TO MAT IN THE COMMUNITY TO DETAINEES WITH OUD UPON RELEASE



On average, 37% of surveyed jails reported that they connected people with OUD to community-based MAT upon release from incarceration. Jails were less likely to provide this connection to care in southern and midwestern states. In Louisiana, Texas, Wyoming, Nebraska, Alabama, Arkansas, Kansas, Oklahoma, and South Dakota, fewer than 10% of jails provided a link to community-based MAT. In Alaska (ranked last), none of the surveyed jails connected people to MAT in the community.

Providing MAT to people with OUD prior to and during reentry into their community can reduce overdose risk by 75%.[67] Ideally, all individuals with OUD should receive MAT both while incarcerated and upon release from jail for the best recovery outcomes. At minimum, individuals who were receiving MAT prior to or during incarceration must be connected to care in the community before release. If people who had previously been receiving MAT are released without connections to care outside of incarceration, they are forced to choose between opioid withdrawal or use, which can lead to overdose.[68]

Several states ranked in the top 10 for this indicator have created statewide programs to ensure continuity of care upon release from incarceration. Massachusetts (ranked fourth), for example, has been a leader in expanding access to MAT both in correctional facilities and upon release. In 2018, Massachusetts passed legislation mandating that MAT be provided in correctional facilities and that jails facilitate continuation in the community upon release. That legislation included appropriations for jails to implement that mandate, which facilitated both provision of MAT in jails and partnerships with outside organizations to provide care in the community following release.[69]

Maine (ranked seventh)[70] and New Jersey (ranked 10th)[71] have also invested in expanded MAT for people leaving incarceration. Both states have a coordinated strategy across their departments of corrections and health and human services to ensure continuity of care for people upon release from jails across the state. Programs in New Jersey and Massachusetts have also instituted at least one full-time reentry counselor connecting people leaving incarceration with Medicaid coverage and community organizations providing treatment upon release. Research on these programs has found reduced overdose, death, and recidivism rates following reentry.[72,73]

To ensure continuity of care after incarceration, individuals should be linked to providers through warm handoffs, not just referrals to care. States should create a joint strategy between their departments of corrections and state health departments to ensure continuity of care across systems statewide. As part of this strategy, for best practice, states should contract with community providers, health care systems, or OTPs to provide transition services between correctional facilities and community care. These contracts can include hiring case managers, peer support specialists, or navigators to help reinstate Medicaid coverage and engage in case management upon release, which is essential to making sure people can access care immediately when reentering communities.

As of June 2025, 27 states and the District of Columbia have pending or approved Medicaid Section 1115 waivers that allow them to provide people in correctional facilities with case management, MAT, and a 30-day supply of medication upon release, among other services. States that are ranked in the bottom 10 for this indicator that have not applied for a Section 1115 Reentry Demonstration Waiver should apply or determine other ways of paying for continuous care and case management.

Rank	State	Percentage
1	District of Columbia	100.00%
2	Maryland	91.60%
3	West Virginia	90.90%
4	Massachusetts	81.80%
5	New York	80.60%
6	New Hampshire	80.00%
7	Maine	77.40%
8	Arizona	70.00%
9	Washington	68.10%
10	New Jersey	67.10%
11	Pennsylvania	58.10%
12	California	49.80%
13	Ohio	48.00%
14	Wisconsin	47.70%
15	Colorado	47.30%
16	Florida	44.40%
17	Michigan	39.80%
18	Nevada	39.70%
19	New Mexico	37.80%
20	Illinois	37.70%

Rank	State	Percentage
21	Oregon	33.30%
22	Virginia	31.70%
23	Minnesota	31.50%
24	South Carolina	30.60%
25	Indiana	29.60%
26	Tennessee	29.20%
27	Utah	25.00%
28	North Carolina	24.00%
29	Kentucky	22.80%
30	North Dakota	21.10%
31	Missouri	19.80%
32	Iowa	17.60%
33	Georgia	16.80%
34	Montana	13.00%
35	Idaho	11.40%
36	Mississippi	10.10%
37	Louisiana	9.80%
38	Texas	8.90%
39	Wyoming	8.80%
40	Nebraska	8.70%

Rank	State	Percentage
41	Alabama	7.70%
42	Arkansas	7.30%
43	Kansas	6.80%
44	Oklahoma	4.50%
45	South Dakota	4.00%
46	Alaska	0.00%
47	Connecticut	*
48	Delaware	*
49	Hawaii	*
50	Rhode Island	*
51	Vermont	*
	Overall	**27.90%**

*Indicates that a state has combined jail and prison systems and was excluded from data collection.

METHODOLOGY

The rankings are based on the indicators outlined at the beginning of each section (public health, health care, schools, and jails). Each indicator was calculated using the most recently available data from 2018 to 2025. For more information on when and how indicators were collected, see the report glossary on page 49.

States with positive outcomes are ranked higher (closer to one) than states with poorer outcomes (closer to 51). The public health, health care, schools, and jails rankings were analyzed by calculating a standardized score (Z score) for each measure and ranking the sum of the standardized scores. For some measures, lower percentages equated to more positive outcomes (e.g., percentage of people without a health care provider or overdose rate). For others, lower percentages equated to more negative outcomes (e.g., number of pharmacies or OTPs). Here, the calculated standardized score was multiplied by -1 to obtain a reverse Z score that was used in the sum. All measures were considered equally important, so no additional weights were assigned to indicators to signify importance.

There are several indicators that did not have available data for every state. These include the provisional number of opioid overdoses per 100,000 people; number of pharmacies per 1,000 people in the state population; percent of schools reporting they taught the difference between proper use and abuse of OTC and prescription medications; percent of schools reporting they provide parents and families with health information about alcohol or drug prevention; percent of local jail jurisdictions and facilities that provide overdose reversal medications to detainees with OUD upon release; and percent of local jail jurisdictions and facilities that provide a link to MAT in the community to detainees with OUD upon release.

If a state was missing data for one indicator in a section, the standard weight of that indicator was redistributed to the other measures within that ranking group. For example, the public health ranking is comprised of standardized scores for five indicators. Each of the standardized Z scores makes up 1/5 of the sum of standardized scores for that ranking. If a state is missing data for one of the five indicators, the other four indicators would be weighted more heavily, as 1/4 of the sum of standardized scores. States that were missing data for more than one indicator in a section were excluded from that section's ranking.

Along with calculated rankings, each measure is ranked individually with an accompanying chart and table. The ranking is based on the Z scores. Data are presented with two decimal places when available.

Many individual states collect more opioid overdose, treatment, and prevention measures than are presented throughout this report. This report aggregates data from standardized, national sources to allow for comparisons on common metrics across states.

GLOSSARY

Public health indicators

Indicator	Description of measure	Source
Provisional number of overdoses from all opioids per 100,000 people	This provisional drug overdose death data was gathered from the CDC's National Vital Statistics System. Provisional counts are often incomplete and causes of death may be pending investigation resulting in an underestimate relative to final counts. To address this, methods were developed by the CDC to adjust provisional counts for reporting delays by generating a set of predicted provisional counts. This metric includes all deaths involving opioids, including: opium (T40.0); heroin (T40.1); natural opioid analgesics, including morphine and codeine, and semisynthetic opioids, including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone (T40.2); methadone, a synthetic opioid (T40.3); synthetic opioid analgesics other than methadone, including drugs such as fentanyl and tramadol (T40.4); or other and unspecified narcotics (T40.6). This latter category includes drug overdose deaths where 'opioid' is reported without more specific information to assign a more specific ICD-10 code. For more details, see the technical notes: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#selection_specific_states_jurisdictions Data collection year: 2024	CDC, National Center for Health Statistics, National Vital Statistics System, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#selection_specific_states_jurisdictions
State naloxone dispensing rate per 100 individuals in the state population	This data represents rates of retail pharmacy dispensed naloxone prescriptions per 100 persons per year from 2019 to 2023. This data was gathered from IQVIA Xponent and presented by the CDC. IQVIA Xponent is based on a sample of approximately 54,600 retail (non-hospital) pharmacies, which dispense nearly 94% of all retail prescriptions in the U.S. For this database, a prescription is a new or refilled prescription dispensed at a retail pharmacy in the sample and paid for by commercial insurance, Medicaid, Medicare, cash or its equivalent, and other third-party coverage. This database does not include mail-order prescriptions. Geographic location is based on the location of the prescriber. Methadone dispensed through methadone treatment programs is not included in the IQVIA Xponent data. For the calculation of dispensing rates, numerators are the projected total number of naloxone prescriptions dispensed annually at the state, county, or national level. Annual resident population denominators were obtained from the U.S. Census Bureau. These data do not include naloxone sold over the counter. Data collection years: 2019 to 2023.	CDC Overdose Prevention, Naloxone Dispensing Rate Maps, https://www.cdc.gov/overdose-prevention/data-research/facts-stats/naloxone-dispensing-rate-maps.html

Indicator	Description of measure	Source
Number of pharmacies per 1,000 people in the state population	The Associated Press has built a national dataset of open retail pharmacies as of February 2024 by combining state licensure records and data from the National Council for Prescription Drug Programs (NCPDP). The NCPDP, a standards development group for the pharmacy industry, relies on pharmacies to self-report ownership information and closures to them, and requires pharmacies to submit copies of their state licenses when they register with the organization. The NCPDP shared the license numbers of retail pharmacies it considered open as of February 2024 with the AP; in order to access this information, the AP paid the organization a membership fee of $825. The AP then matched those license numbers with state pharmacy licenses in 49 states and the District of Columbia to confirm that licenses were active and to extract more detailed geographic information on the location of pharmacies where possible. Pharmacies are usually required by law to report closures to states in which they are licensed. Retail pharmacies are chain and independent pharmacies that serve the public. Veterinary pharmacies and pharmacies in correctional facilities are excluded. For more details on methodology and limitations: https://apnews.com/article/pharmacy-closure-drugstore-cvs-walgreens-rite-aid-91967f18c0c059415b98fcf67ad0f84e Data collection year: 2024	AP reporting, state licensure records and data from the National Council for Prescription Drug Programs, American Community Survey 2022 5-Year Estimates, U.S. Census Bureau, Health Resources and Services Administration, https://apnews.com/article/pharmacy-closure-drugstore-cvs-walgreens-rite-aid-91967f18c0c059415b98fcf67ad0f84e Accessed May 21, 2025
Percentage of adults who report they do not have a personal doctor or health care provider	Data collected from the Behavioral Risk Factor Surveillance System, a system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. This indicator uses the variable PERSDOC3, which asks "Do you have one person or a group of doctors that you think of as your personal health care provider?" Data collection year: 2022	CDC, Behavioral Risk Factor Surveillance System 2022, https://www.cdc.gov/brfss/annual_data/annual_2022.html
Percentage of youth reporting they have seen or heard alcohol or drug prevention messages from a source outside of school	This indicator was calculated through the Restricted Data Analysis System (RDAS). Youth ages 12 to 17 were asked, "During the past 12 months, have they seen or heard alcohol or drug prevention messages from sources outside of school?" (variable name YEPVNTYR). This includes youth who responded "Yes" to that question. Data collection years: 2021 to 2022	SAMHSA, Center for Behavioral Health Statistics and Quality, 2022 National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases

Indicator	Description of measure	Source
States in which fentanyl drug-checking equipment possession and/or free distribution is permitted by state law	This indicator was gathered from the Network for Public Health Law's Harm Reduction and Overdose Prevention 50-State Survey August 2023 Update. The Network for Public Health Law systematically surveyed the relevant legal landscape in the fifty states, the District of Columbia, and Puerto Rico in August 2021, 2022, and 2023. This indicator outlines the characteristics of the law in each state as of August 31, 2023. For more information on methodology: https://www.networkforphl.org/wp-content/uploads/2023/11/50-State-DCE-Fact-Sheet-2023-2.pdf Data collection year: 2023	The Network for Public Health Law's Harm Reduction and Overdose Prevention 50-State Survey August 2023 Update, https://www.networkforphl.org/wp-content/uploads/2023/11/50-State-DCE-Fact-Sheet-2023-2.pdf

Health care indicators

Indicator	Description of measure	Source
Percentage of adults (ages 18+) who report heroin use in the past year	Adults aged 18+ were asked about whether they used heroin in the past year. Estimates for youths aged 12 to 17 are not available for past year heroin use because this outcome was extremely rare among youths aged 12 to 17 in the 2022 and 2023 National Surveys on Drug Use and Health. Data collection years: 2022 to 2023	SAMHSA, Center for Behavioral Health Statistics and Quality, 2022- 2023 National Survey on Drug Use and Health, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases/2022-2023
Number of people screening at-risk for prescription opioid addiction per 100,000 people in the state population	The numerator for this metric is number of people who took an addiction screen (CAGE-AID) through MHA's National Prevention and Screening Program (www.mhascreening.org), scored at-risk for addiction, and reported the substance they were struggling with as prescription opioids from 2018 to 2024. The denominator is the number of people in the state population based on 2022 U.S. Census population estimates. That was then multiplied by 100,000 to determine the rate of people screening at-risk for opioid addiction per 100,000 people in the state population. For more information on the methodology used for data collection through MHA's National Prevention and Screening Program: https://screening.mhanational.org/about-mha-screening/ For more information on CAGE-AID scoring: http://europepmc.org/abstract/med/7778330 Data collection years: 2018 to 2024	Mental Health America, National Prevention and Screening Program, https://screening.mhanational.org

Indicator	Description of measure	Source
Number of buprenorphine practitioners per 100,000 people with OUD in the state population	The numerator for this indicator is the number of buprenorphine practitioners listed for each state on SAMHSA's treatment locator (https://findtreatment.gov/locator). Buprenorphine practitioners are defined as providers who are qualified to offer buprenorphine, a medication approved by the FDA, for the treatment of OUD. This data was accessed May 21, 2025. The denominator is the number of people ages 12+ with OUD in the past year. This data was collected from the 2022-2023 National Survey on Drug Use and Health. OUD estimates are based on the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria. OUD is defined as meeting the criteria for heroin or pain reliever use disorder. See 2023 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions: https://www.samhsa.gov/data/report/2023-methodological-summary-and-definitions for details on who was eligible to receive questions on OUD. This figure was then multiplied by 100,000 to determine the number of buprenorphine providers per 100,000 people with OUD in each state. Data collection years: 2023 to 2025	SAMHSA, National Treatment Locator, https://findtreatment.gov/locator SAMHSA, Center for Behavioral Health Statistics and Quality, 2022- 2023 National Survey on Drug Use and Health, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases/2022-2023
Number of OTPs per 100,000 people with OUD in the state population	The numerator for this indicator is the number of opioid treatment programs listed for each state on SAMHSA's treatment locator (https://findtreatment.gov/locator). OTPs are defined as programs that administer and dispense FDA-approved medications for long-term treatment of OUD. In addition, patients receiving medications for opioid use disorder (MOUD) must also receive counseling and other behavioral therapies to include recovery supports to provide a whole-person approach. This data was accessed May 21, 2025. The denominator is the number of people ages 12+ with OUD in the past year. This data was collected from the 2022-2023 National Survey on Drug Use and Health. OUD estimates are based on the DSM-5 criteria. OUD is defined as meeting the criteria for heroin or pain reliever use disorder. See 2023 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions at: https://www.samhsa.gov/data/report/2023-methodological-summary-and-definitions for details on who was eligible to receive questions on OUD. This figure was then multiplied by 100,000 to determine the number of opioid treatment programs per 100,000 people with OUD in each state. Data collection years: 2023 to 2025	SAMHSA, National Treatment Locator, https://findtreatment.gov/locator SAMHSA, Center for Behavioral Health Statistics and Quality, 2022- 2023 National Survey on Drug Use and Health, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases/2022-2023

Indicator	Description of measure	Source
Percentage of adults who needed but did not receive substance use treatment	Not receiving substance use treatment among those needing treatment (%) = 100 * [X1 ÷ (X1 + X2)], where X1 is the number of adults ages 18+ not receiving treatment who needed treatment, X2 is the number of adults receiving treatment who needed treatment, and (X1+ X2) denotes the number of adults who needed treatment. Substance use disorder (SUD) estimates are based on DSM-5 criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. See 2023 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions: https://www.samhsa.gov/data/report/2023-methodological-summary-and-definitions for details on who was eligible to receive questions on SUD. Data collection years: 2022 to 2023	SAMHSA, Center for Behavioral Health Statistics and Quality, 2022- 2023 National Survey on Drug Use and Health, https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/state-releases/2022-2023
Number of treatment and addiction recovery residences per 1,000 people	This indicator is from state-level data compiled in the National Study of Treatment and Addiction Recovery Residences (NSTARR) project, the largest and most diverse study of recovery housing to date. Residences for which locating information was available were geocoded and linked with U.S. Census and other data to contextualize characteristics of where recovery residences are located. These reports are based on data collected between January 2020 and January 2021, representing 10,358 distinct recovery residences belonging to 3,628 different recovery housing providers. For a detailed description of methods: https://pubmed.ncbi.nlm.nih.gov/34871978 Data collection years: 2020 to 2021	NSTARR (2022). National Study of Treatment & Addiction Recovery Residences Report. Alcohol Research Group, Public Health Institute: Emeryville, CA. https://nstarr.arg.org/index.php/products-resources Date Accessed: May 21, 2025

School indicators

Indicator	Description of measure	Source
Percentage of youth reporting they did not receive drug or alcohol education in school in the past year	This indicator was calculated through the Restricted Data Analysis System (RDAS). This is a recoded variable, derived from the answers to YEDECLAS, YEDERGLR, and YEDESPCL. YEDECLAS asks youth ages 12 to 17, "During the past 12 months, have you had a special class about drugs or alcohol in school?" YEDERGLR asks youth ages 12 to 17, "During the past 12 months have you had films, lectures, discussions, or printed information about drugs or alcohol in one of your regular school classes such as health or physical education?" YEDESPCL asks youth ages 12 to 17, "During the past 12 months have you had films, lectures, discussions, or printed information about drugs or alcohol outside of one of your regular classes such as in a special assembly?" The recoded variable, ANYEDUC3 includes youth who responded "No" to all three questions. Data collection years: 2021 to 2022	SAMHSA, Center for Behavioral Health Statistics and Quality, 2021-2022 National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
Percentage of schools reporting they taught the difference between proper use and abuse of OTC and prescription medications	This data was collected by the CDC's 2022 School Health Profiles. Profiles surveys are conducted biennially by education and health agencies among middle and high school principals and lead health education teachers. The self-administered questionnaires provide data from the principal and the lead health education teacher at each sampled school. In 2022, 44 states, 28 school districts, two territories, and one tribe obtained data representative of their jurisdiction. From these sites, data were weighted to represent the population. For more information on School Health Profiles methodology: https://www.cdc.gov/school-health-profiles/about/index.html Data collection year: 2022	CDC School Health Profiles, https://www.cdc.gov/school-health-profiles/index.html

Indicator	Description of measure	Source
Percentage of schools reporting they provide parents and families with health information about drug and alcohol prevention	This data was collected by the CDC's 2022 School Health Profiles. Profiles surveys are conducted biennially by education and health agencies among middle and high school principals and lead health education teachers. The self-administered questionnaires provide data from the principal and the lead health education teacher at each sampled school. In 2022, 44 states, 28 school districts, two territories, and one tribe obtained data representative of their jurisdiction. From these sites, data were weighted to represent the population. For more information on School Health Profiles methodology: https://www.cdc.gov/school-health-profiles/about/index.html Data collection year: 2022	CDC School Health Profiles, https://www.cdc.gov/school-health-profiles/index.html
Percentage of youth reporting they have talked with a parent about the danger of tobacco, alcohol, or drugs in the past year	This indicator was calculated through the Restricted Data Analysis System (RDAS). This is a recoded variable, derived from the answer to YEPRTDNG. YEPRTDNG asks youth ages 12 to 17, "During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians -- whether or not they live with you." The recoded variable, PRTALK3 includes youth who responded "Yes" to that question. Data collection years: 2021 to 2022	SAMHSA, Center for Behavioral Health Statistics and Quality, 2021-2022 National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases

Jail indicators

Indicator	Description of measure	Source
Percent of local jail jurisdictions and facilities that provide overdose reversal medications to detainees with OUD upon release	This indicator was collected by the 2019 Census of Jails (COJ). The Bureau of Justice Statistics (BJS) periodically conducts the COJ, a complete enumeration of local jail jurisdictions and facilities and of the Federal Bureau of Prisons' (BOP) 12 detention facilities that function as jails. The COJ covers all local jails in 45 states and the District of Columbia. It excludes the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont, but includes 15 independently operated jails in Alaska. In 2019, BJS included an addendum to the COJ to measure local jail jurisdictions' OUD screening and treatment practices and the prevalence of screenings and treatment for OUD among persons confined in jail. For more information on methodology: https://bjs.ojp.gov/document/oudstlj19.pdf Data collection year: 2019	U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, https://bjs.ojp.gov/document/oudstlj19.pdf
Percent of local jail jurisdictions and facilities that provide a link to MAT in the community to detainees with OUD upon release	This indicator was collected by the 2019 Census of Jails (COJ). The BJS periodically conducts the COJ, a complete enumeration of local jail jurisdictions and facilities and of the Federal Bureau of Prisons' (BOP) 12 detention facilities that function as jails. The COJ covers all local jails in 45 states and the District of Columbia. It excludes the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont, but includes 15 independently operated jails in Alaska. In 2019, BJS included an addendum to the COJ to measure local jail jurisdictions' OUD screening and treatment practices and the prevalence of screenings and treatment for OUD among persons confined in jail. For more information on methodology: https://bjs.ojp.gov/document/oudstlj19.pdf Data collection year: 2019	U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, https://bjs.ojp.gov/document/oudstlj19.pdf

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