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The 2025 Georgia Social Indicator Study—Opioids

Volume IV. Georgia's County-Level Social Indicator Study to Assess Substance Use and Related Consequences

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Acknowledgments

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1. Introduction

This report presents findings from the 2025 Georgia county-level Social Indicator Study (SIS)—Opioids report. This opioid county-level SIS will serve as a timely resource for characterizing opioid use and prevention needs at the county level. This report should be used in conjunction with the Georgia county-level Social Indicator Study (SIS)—Overall report to obtain a comprehensive perspective on the opioid use landscape for prevention planning, including harm reduction strategies.

The focus of this report is an opioid prevention needs assessment and planning profile for each of Georgia's 159 counties, including the display of three risk domains composed of 24 social indicators derived from four archival sources. The data collection procedures and analysis methodologies used for producing the planning profiles are summarized in **Section 2**. Findings from the trend analyses conducted on selected indicators of opioid use at the state and county levels are provided in **Section 3**. The planning profiles, presented in **Section 4**, reflect various dimensions of opioid use and opioid use–related problems and outcomes that may exist in communities. The profiles were designed to provide local planners and service providers with a concise, visual summary of each county's pattern of opioid use–related indicators. We have also integrated the trend analysis findings into the profiles to show significant changes (favorable and unfavorable) in key indicators. Statewide trends or patterns with regard to the risk construct scores and ranks are presented in **Section 5**.

Section 6 is devoted to issues regarding the application of opioid social indicator data to prevention planning and includes recommendations for data dissemination to facilitate effective use, as well as strategies for incorporating a social indicator approach into the state's prevention planning system.

Volume II contains the opioid planning profiles for each of Georgia's 159 counties. The tables in **Volume III** contain opioid indicator values at the county level. **Appendix A** details the steps in using an opioid county-level profile to craft a prevention story.

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2. Data Collection and Analysis

2.1 Selection of Social Indicators

Archival indicators were selected for this study on the basis of general data availability, especially at the county level; particular interest expressed by the Georgia Department of Behavioral Health and Developmental Disabilities; and conceptual appeal. A total of 24 indicators were collected and organized into three domains and the general concepts that they appeared to reflect. The domains, the specific indicators within each category, the indicator definitions, the years for which archival data were collected, the indicator data sources, and associated notes for each indicator are displayed in **Table 1**.

2.2 Data Sources and Collection Procedures

Data were collected by RTI International from a variety of state and federal agencies. State data sources were the Georgia Student Health Survey (GSHS); Georgia Department of Public Health, including the Online Analytical Statistical Information System OASIS), and Georgia Bureau of Investigation. We also drew on the National Emergency Medical Services Information System, a federal source.

Table 1. Archival Indicator Categories, Variables, and Data Years

Archival Indicator	Definition	Data Years	Data Source	Notes
A. Past-30-Day Opioid Use				
A1. Past-30-Day Prescription Drug Use (MS & HS)	Percentage of students reporting prescription painkiller, tranquilizer or sedative, stimulant, or other prescription drug use for nonmedical reasons in past 30 days	School year (SY) 2021–2022 through SY2023–2024	Georgia Student Health Survey (GSHS)	County assignment based on school location
A8. Past-30-Day Heroin Use (MS & HS)	Percentage of students reporting heroin use in past 30 days			
A11. Lifetime Prescription Drug Use (MS & HS)	Percentage of students reporting ever using prescription drugs for nonmedical reasons			

(continued)

Table 1. Archival Indicator Categories, Variables, and Data Years (cont.)

Archival Indicator	Definition	Data Years	Data Source	Notes
B. Availability of Opioids				
B3. Heroin Reports	Number of heroin reports per 10,000 persons	2020–2024	Georgia Bureau of Investigation (GBI)	Includes reports mentioning heroin, diacetylmorphine (chemical name), 6-mam, or 6 monoacetylmorphine (heroin metabolites) in the result field
B6. Fentanyl Reports	Number of fentanyl reports per 10,000 persons			Includes reports mentioning fentanyl or any of its medical or illicitly manufactured variants[a]
B7. Opioid Reports	Number of opioid reports per 10,000 persons			Includes reports mentioning fentanyl (any variant), heroin (any variant), buprenorphine, codeine, oxycodone, oxymorphone, hydromorphone, hydrocodone, meperidine, methadone, tramadol, or morphine in the results field
C. Consequences of Opioid Use				
C4. Opioid-Related Hospitalizations and Emergency Room Visits, Any Age	Number of opioid-related hospitalizations or emergency room visits per 10,000 persons of any age	2019–2023	Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS)[b]	Numbers show ER visit or hospitalization involving any opioid overdose. Includes prescription opioid pain relievers (e.g., hydrocodone, oxycodone, morphine); opioids used to treat addiction (e.g., methadone); and heroin, opium, and synthetic opioids (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured).
C4a. Opioid-Related Hospitalizations and Emergency Room Visits, Age 0 to 19	Number of opioid-related hospitalizations or emergency room visits per 10,000 persons age 0 to 19			
C4b. Opioid-Related Hospitalizations and Emergency Room Visits, Age 20 to 24	Number of opioid-related hospitalizations or emergency room visits per 10,000 persons age 20 to 24			
C4c. Opioid-Related Hospitalizations and Emergency Room Visits, Age 25–64	Number of opioid-related hospitalizations or emergency room visits per 10,000 persons age 25 to 64			
C4d. Opioid-Related Hospitalizations and Emergency Room Visits, Age 65 or Older	Number of opioid-related hospitalizations or emergency room visits per 10,000 persons age 65 or older			

(continued)

Table 1. Archival Indicator Categories, Variables, and Data Years (cont.)

Archival Indicator	Definition	Data Years	Data Source	Notes
C. Consequences of Opioid Use (cont.)				
C7. Any Opioid-Related Overdose Deaths[c]	Number of overdose deaths due to any opioid-related cause per 10,000 persons	2019–2023 (same as above)	Department of Public Health, OASIS[b] (same as above)	Numbers show ER visit or hospitalization involving any opioid overdose. Includes prescription opioid pain relievers (e.g., hydrocodone, oxycodone, morphine); opioids used to treat addiction (e.g., methadone); and heroin, opium, and synthetic opioids (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured).
C7a. Any Opioid-Related Overdose Deaths, Age 0 to 19	Number of overdose deaths due to any opioid-related cause per 10,000 persons age 0 to 19			
C7b. Any Opioid-Related Overdose Deaths, Age 20 to 24	Number of overdose deaths due to any opioid-related cause per 10,000 persons age 20 to 24			
C7c. Any Opioid-Related Overdose Deaths, Age 25 to 64	Number of overdose deaths due to any opioid-related cause per 10,000 persons age 25 to 64			
C7d. Any Opioid-Related Overdose Deaths, Age 65 or Older	Number of overdose deaths due to any opioid-related cause per 10,000 persons age 65 or older			
C8. Heroin-Related Overdose Deaths[c]	Number of overdose deaths due to any heroin-related cause per 10,000 persons			
C9. Fentanyl-Related Overdose Deaths	Number of overdose deaths due to any fentanyl-related cause per 10,000 persons			Includes synthetic opioids other than methadone (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured).
C9a. Fentanyl-Related Overdose Deaths, Age 0 to 19	Number of overdose deaths due to any fentanyl-related cause per 10,000 persons age 0 to 19			
C9b. Fentanyl-Related Overdose Deaths, Age 20 to 24	Number of overdose deaths due to any fentanyl-related cause per 10,000 persons age 20 to 24			
C9c. Fentanyl-Related Overdose Deaths, Age 25 to 64	Number of overdose deaths due to any fentanyl-related cause per 10,000 persons age 25 to 64			
C9d. Fentanyl-Related Overdose Deaths, Age 65 or Older	Number of overdose deaths due to any fentanyl-related cause per 10,000 persons age 65 or older			

(continued)

Table 1. Archival Indicator Categories, Variables, and Data Years (cont.)

Archival Indicator	Definition	Data Years	Data Source	Notes
C. Consequences of Opioid Use (cont.)				
C16. Patients Receiving Naloxone	Percentage of patients receiving naloxone relative to national average[d]	April 2024–April 2025	National Emergency Medical Services Information System	▪ Data reported for previous 12 months from date of access ▪ County is compared to national average rate of 37.1% and classified into the following categories: – Zero or Much Lower than Average = 0%–18% – Lower than Average = 19%–32% – Near National Average = 33%–40% – Higher than Average = 41%–73% – Much Higher than Average = 74%–100%
C17. Infants Born With Neonatal Abstinence Syndrome (NAS)	Number of infants born with NAS per 1,000 live births	2017–2021	Georgia Department of Public Health, Georgia Strategic Prevention System	▪ Data pooled for years 2017–2021 ▪ Rates are not calculated for the counties with counts less than or equal to 5 ▪ NAS identified by ICD 10 code P96 listed in diagnostic code of hospital discharge data ▪ NAS cases defined as Tier 2, passive surveillance cases ▪ Cases are not confirmed using medically abstracted records

Note. GSHS = Georgia Student Health Survey; HS = high school; MS = middle school; SY = school year.

[a] For a full list of terms, see Zibbell, J. E., Aldridge, A., Grabenauer, M., Heller, D., Clarke, S. D., Pressley, D., & Smiley-McDonald, H. (2023). Associations between opioid overdose deaths and drugs confiscated by law enforcement and submitted to crime laboratories for analysis, United States, 2014–2019: An observational study. *Lancet Regional Health–Americas, 25,* Article 100569.

[b] For all data from OASIS, the county assignment is based on the patient's or subject's residence.

[c] The indicator terminology was updated from the 2019 SIS Report to more accurately reflect the label for the data from its original source; however, the data from the 2019 and 2025 reports are comparable.

[d] The national average rate of 37.1% is derived from the national count of naloxone administrations given by EMS providers to nonfatal overdose patients.

Most indicators included in this study (Table 1) were obtained from standard administrative and reporting databases generated by the source agencies. A few of the indicators were obtained via special request through the state agencies. As a result, we expect that the data collection procedures used to collect these indicators are valid and reliable. The frequency distribution of each indicator was examined, and indicators with unusual distributions or extreme values were noted and adjusted or dropped, as necessary.

Data provided from the GSHS did not contain county assignments and instead were organized by school system and individual school. Thus, we assigned a county name to each system name on the basis of the school address for school systems that were separated by smaller geographic areas or regions (such as a city). County assignment for the GSHS indicators were based on school location, rather than the place of residence for each individual or respondent. GSHS respondents who could not be assigned to a particular county on the basis of their school and system name were excluded from the analyses, including from the state estimates for Georgia presented in **Section 3**. This approach excludes such students as those enrolled online or virtually or through the Department of Juvenile Justice or the Department of Corrections.

In SY2022, three counties did not provide any high-school-level GSHS data (Lumpkin, Taliaferro, and Tattnall). In SY2023, one county (Taliaferro) did not provide any middle-school-level data, and five counties (Clay, Jenkins, Quitman, Tattnall, and Wheeler) did not provide any high-school-level data. In SY2024, seven counties (Brooks, Clay, Echols, Hart, Lumpkin, Jefferson, Schley) did not provide any middle-school-level data, and six counties (Brooks, Clay, Echols, Hart, Lumpkin, Schley) did not provide any high-school-level data.

2.3 Analytic Procedures

2.3.1 Epidemiological Profiles

The following section outlines the analytic steps for creating the county ranks, opioid indicator risk scores, and overall opioid risk scores presented in **Section 5** and **Volume II**.

Step 1: Calculating Rates or Percentages

To make the data comparable across counties with different population sizes, a rate (e.g., the number of reported deaths per 10,000 persons) or percentage (e.g., the percentage of students reporting heroin use in the past 30 days) was calculated. Each rate or percentage was based on a numerator that reflected the number of events or population of interest for a given year and a denominator that reflected the base on which the rate or percentage was calculated.[1]

[1] To more accurately account for changes in population, for the 2025 SIS Report the denominators used to calculate rates reflected the population for the given year. This was an improvement over the methodology used in the 2019 SIS Report, where the same denominator was applied for all years of data analyzed.

Step 2: Computing Risk Scores

A main feature of the risk profiles is that they provide, for each county, a graphic display of its risk factor levels and problems related to opioid use, relative to the average across the 159 counties (or state average). A statistical procedure, standardization, was performed to create these relative measures, termed risk scores. Standardized values for each of the 24 indicators were calculated for each county by subtracting the state mean value from the county value and dividing by the standard deviation. This procedure produced new values of the indicators that have a mean of zero and a standard deviation of 1.0, regardless of the original units of measurement. The indicators were defined such that higher values reflected greater levels of opioid use and opioid use–related problems.

Each risk score measure represents the number of standard deviation units a county's value lies away from the mean value across all counties, which is zero. Defining the risk score values in this manner means that each risk score implicitly provides a comparison between the county and the mean value across all counties, or the state average. In addition, converting all of the indicators to the same scale facilitates comparison across the indicators to identify those that are unusually high or low.

In addition to computing the 24 individual opioid risk scores by county, we created an overall opioid risk index for each county. We also included standardized values for three additional indicators (Opioid-Related Hospitalizations and Emergency Room Visits, Any Opioid-Related Overdose Deaths, and Any Fentanyl-Related Overdose Deaths) for persons of any age on the profiles; however, these values are included for reference only. When age-specific categories were available, the indicator for Persons Any Age was excluded from the overall county risk score calculation. Because the measures for the 24 risk scores are in standardized form, they could be combined directly without concern for differences in their original units of measurement. The overall opioid risk score, therefore, was defined as the mean value of the 24 risk subconstructs that were indicative of risk. It provides a measure of the overall level of opioid abuse problems and risks in each county relative to those in other counties in the state. One limitation of the index, however, is that each risk score contributes equally to the calculation of the overall opioid risk score value (i.e., each indicator implicitly receives a weight of 1).

For reference, we also provide the overall county risk score determined in the Georgia county-level Social Indicator Study (SIS)—Overall report. This opioids report should be used in conjunction with the overall report to obtain a comprehensive perspective on the opioid use landscape for prevention planning, including harm reduction strategies.

Step 3: Ranking Individual Risk Scores and Overall Risk Index

To allow for further comparisons by the individual opioid risk scores and overall opioid risk score, we ordered each risk score and the overall opioid risk score from lowest to highest and ranked them from 1 to 159. Counties with high rankings by opioid risk score were at highest risk for that particular indicator, whereas counties with low rankings were at lower

risk. Similarly, counties with high rankings on the overall opioid risk score are viewed as having higher overall levels of opioid use problems than counties with lower rankings. The process of ranking was automated for the current report. Ranking occurred through program coding in such a way that if several counties had the same or minimally different values on the risk index, they were assigned the same rank.

2.3.2 Trend Analysis

In addition to allowing for comparisons of risk between counties, the profiles highlight changes that may signal areas of consistently increasing or decreasing risk within each county. These findings are critical in the context of a relative risk framework, because even counties that have lower risk than other counties in the state may have increased in risk relative to their own previous rankings.

We used linear regression models for each county to determine whether the change in each social indicator over time was statistically significant. Linear regressions were chosen over other options (e.g., polynomials) as the relatively small numbers of data points and years in the trends analysis were better described with a straight line across indicators. We then classified each significant trend on the basis of whether it had changed in a direction that was favorable (decreasing risk) or unfavorable (increasing risk).

Although these trend analyses use the most recent years of available data for all indicators, they do not necessarily examine the same time period across all indicators. For example, the most recent data years for one indicator may run from 2020 through 2024, whereas another indicator may have complete data only for years 2019 through 2023. The analyzed trend periods for each indicator are noted in each county profile.

Because of the way that linear regression models work, trend analyses cannot be, and were not, run in the following cases:

1. If the county had fewer than 3 years of data available.
2. If the actual trend line across years is perfectly straight (e.g., change between 2020 and 2021 is 0.12 and change between 2021 and 2022 is also 0.12), including cases for which values for the indicators equal zero across all years.

We did not conduct trend analyses for the following indicators because of data inconsistency and incompleteness:

- Percentage of Patients Receiving Naloxone Relative to National Average: Only a single year of data was available for this indicator.
- Infants Born with Neonatal Abstinence Syndrome (NAS) per 1,000 Live Births: Because of small cell sizes, it was possible to present only a 5-year pooled measure with data from 2017 through 2021.

2.4 Limitations

As with any study, the archival data used in this report had several limitations, which are noted below.

- There was a wealth of data available at the county level in the state of Georgia; however, space limitations on creating a brief profile meant that many datasets had to be excluded from this analysis in order to provide a brief overview of the risk profile of each county.
- There were several limitations with data from the GSHS:
  - In SY2022 and SY2023, participation in the GSHS was not mandatory; however, in SY2024 participation was again compulsory for Georgia middle and high schools. As such, the number of responses in SY2024 is significantly higher than in SY2022 and SY2023.
  - Several counties in Georgia did not have any high school or middle school respondents in one or more of the years SY2022–SY2024. In SY2022, Lumpkin, Taliaferro, and Tattnall Counties did not have any high school respondents. In SY2023, there were no high school respondents in Clay, Jenkins, Quitman, Tattnall, and Wheeler Counties and no middle school respondents in Taliaferro County. In SY2024, there were no high school respondents in Brooks, Clay, Echols, Hart, Lumpkin, and Schley Counties and no middle school respondents in Brooks, Clay, Echols, Hart, Jefferson, Lumpkin, and Schley Counties. Inferences about the level of risk on GSHS indicators in these counties may be difficult.
  - Several counties (Atkinson, Bacon, Baker, Banks, Berrien, Brantley, Brooks, Bryan, Burke, Calhoun, Camden, Carroll, Charlton, Chatham, Chattahoochee, Cherokee, Clay, Columbia, DeKalb, Dodge, Dooly, Douglas, Fannin, Forsyth, Franklin, Glynn, Hancock, Harris, Heard, Jenkins, McIntosh, Morgan, Murray, Newton, Oglethorpe, Peach, Pike, Putnam, Quitman, Screven, Taliaferro, Tift, Turner, Twiggs, Ware, Wheeler, Wilcox, and Wilkinson) had a very small number of respondents for the middle school or high school GSHS survey, or both, in at least one year (i.e., there were fewer than 30 middle school or high school respondents). Therefore, the change in percentage and risk score, as well as the overall opioid risk score, may be slightly misleading.
- Data from the National Forensic Laboratory Information System (NFLIS) were not available in 2025. Therefore, we obtained a different dataset from the Georgia Bureau of Investigation. The Drug reports from the Georgia Bureau of Investigation are not representative of the total number of drug seizures in Georgia. They are a subset of the total drug items seized and submitted for testing, typically for the purposes of providing evidence in a court case.[2] Furthermore, because of the raw nature of the data and the algorithm used to calculate drug report counts, in cases of re-analysis where the original drug report was corrected, we were unable to update the item counts to reflect the corrected report. However, these instances were extremely rare, accounting for less than 0.1% of all drug report cases.
- Data regarding the percentage of patients receiving naloxone were available only compared to the national average and were reported as a range (rather than as a value). Therefore, we were able only to quantify naloxone administrations on a scale of 1–5 relative to the national average rather than using the true percentage for the county.

[2] For an in-depth look at how these data are created and can be used or interpreted, refer to Pitts, W. J., Heller, D., Smiley-McDonald, H., Weimer, B., Grabenauer, M., Bollinger, K., ... Pressley, D. (2023). Understanding research methods, limitations, and applications of drug data collected by the National Forensic Laboratory Information System (NFLIS-Drug). *Journal of Forensic Sciences*, *68*(4), 1335–1342.

- Cases of Infants Born With Neonatal Abstinence Syndrome (NAS) were reported by the Georgia Department of Public Health as pooled 5-year estimates because of small sample sizes, and there was cell suppression for counties that had fewer than five cases. This approach limited rate calculations and made county-level trend analyses impossible.

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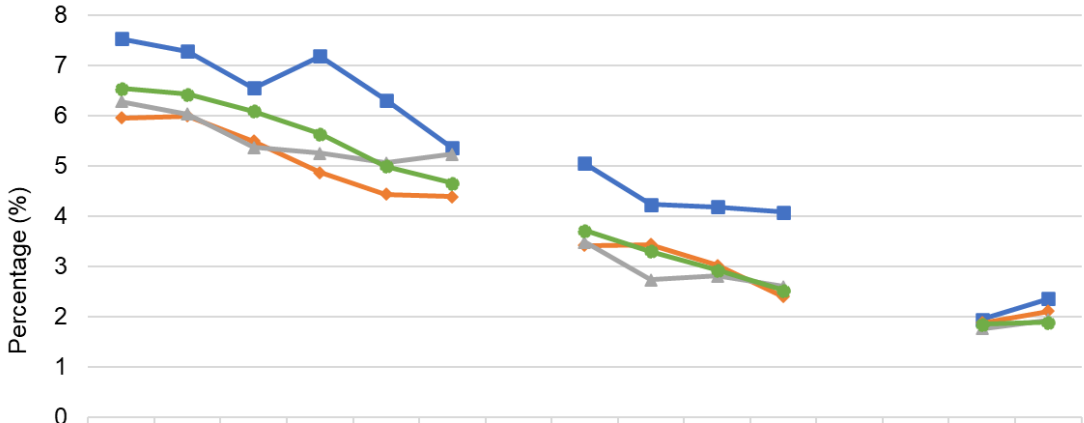
3. Georgia Opioid Use and Related Trends in Consequences

3.1 Comparison of Georgia Past-30-Day Consumption Indicators With Neighboring States and the United States

This section compares trends in past-30-day prescription drug misuse for the state of Georgia with those in the United States and in the neighboring states of Alabama and Florida. This graph presents data from the National Survey on Drug Use and Health State Report from 2008–2009 through 2022–2023.

Figure 1. Percentage Reporting Past-30-Day Prescription Drug Misuse Among Youth Ages 12 to 17 in the United States, Alabama, Florida, and Georgia, 2008–2009 through 2022–2023



	2008 – 2009	2009 – 2010	2010 – 2011	2011 – 2012	2012 – 2013	2013 – 2014	2014 – 2015	2015 – 2016	2016 – 2017	2017 - 2018	2018 - 2019	2019 - 2020	2020 - 2021	2021 - 2022	2022 - 2023
Alabama	7.54	7.29	6.56	7.19	6.32	5.37		5.05	4.24	4.19	4.08			1.95	2.36
Florida	5.96	6.00	5.50	4.87	4.44	4.40		3.42	3.44	3.03	2.40			1.88	2.11
Georgia	6.29	6.04	5.37	5.26	5.07	5.24		3.49	2.74	2.82	2.60			1.77	1.94
United States	6.55	6.43	6.09	5.64	5.00	4.67		3.72	3.31	2.93	2.53			1.85	1.89

NOTE: Data were not available in 2014–2015 because of the NSDUH redesign or in 2019–2021 because of data collection limitations imposed by the COVID pandemic.

SOURCE: National Survey on Drug Use and Health (NSDUH).

Descriptive Highlights in 2022–2023

Although we did not conduct statistical testing to compare the geographic regions, we did notice one difference for this indicator: The percentage of youth age 12 to 17 reporting past-month pain reliever misuse was slightly lower in Georgia (1.94%) than in neighboring states (2.36% in Alabama and 2.11% in Florida); however, the percentage was slightly higher than in the United States overall (1.89%).

3.2 State- and County-Level Trends

This section presents trends for the state of Georgia overall for each of the 24 indicators. The graphs reflect up to five of the most recent years for which data are available on each indicator. These graphs reflect the same trend years described in the profiles. The graphics can be used as a baseline to which the trends in the counties can be compared. For indicators with only a single year of data available, it was not possible to compare trends.

The "Significant Findings" text that follows several of the figures summarizes only statistically significant trends for each set of indicators. Where no trend analysis was possible, "Descriptive Findings" of the data are noted and provided.

The "County-Level Findings" text describes the numbers of counties with a statistically significant trend for each set of indicators. We grouped the results by the type of result (e.g., "favorable" and "unfavorable" trends) and present comments only on significant trends. Refer to Table 2 for the full table of results.

Overall Highlights of Changes Over Time in Opioid Indicators

In recent years Georgia primarily mixed trends in the opioid indicators. The key favorable and unfavorable trends in opioid indicators at the state level are summarized below.

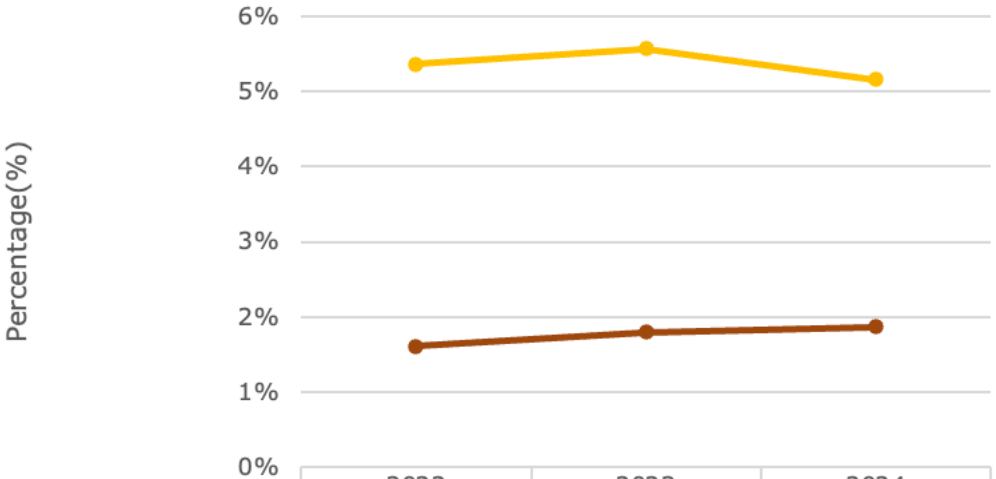
Favorable Trends

- Among high school students in Georgia, from SY2022 to SY2024 there was a decrease in the percentage of students reporting past-30-day use prescription drug use on the GSHS.
- The total number of drug reports for heroin and opioids per 10,000 persons in Georgia, obtained by the Georgia Bureau of Investigation, significantly decreased from 2020 to 2024.

Unfavorable Trends

- The numbers of deaths from opioid-related overdoses and from fentanyl-related overdoses per 10,000 persons in Georgia both increased from 2019 to 2023.
    - The number of deaths from opioid-related overdoses and fentanyl-related overdoses also increased among persons age 0 to 19, persons age 25 to 64, and persons age 65 or older.

Figure 2. Percentage Reporting Past-30-Day Substance Use Among Middle School Students in Georgia, by Substance, SY2022–SY2024



	2022	2023	2024
Prescription drugs	5.36%	5.57%	5.16%
Heroin	1.61%	1.80%	1.87%

NOTES: Prescription drug use includes prescription drug painkillers, tranquilizers or sedatives, stimulants, or other drugs. SY = school year.

SOURCE: Georgia Student Health Survey.

Significant Findings

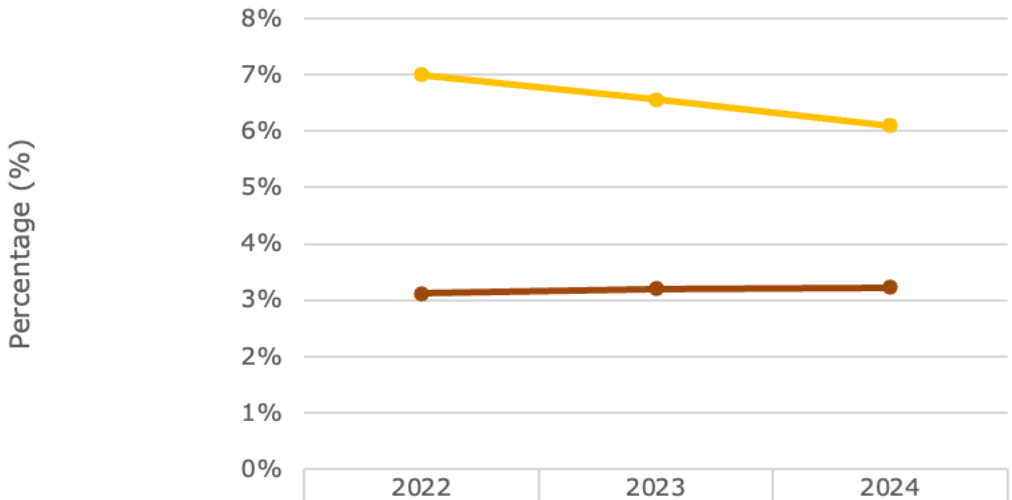
- The percentage of middle school students reporting past-30-day substance use in Georgia did not change significantly between SY2022 and SY2024 for prescription drugs or heroin.

County-Level Findings

Between SY2022 and SY2024, among middle school students,

- 1 county (0.63%) experienced a favorable trend and 4 counties (2.52%) experienced unfavorable trends in past-30-day prescription drug use
- No counties (0%) experienced favorable trends and 2 counties (1.26%) experienced unfavorable trends in past-30-day heroin use

Figure 3. Percentage Reporting Past-30-Day Substance Use Among High School Students in Georgia, by Substance, SY2022–SY2024



	2022	2023	2024
Prescription drugs	7.00%	6.56%	6.10%
Heroin	3.12%	3.20%	3.23%

NOTES: Prescription drug use includes prescription drug painkillers, tranquilizers or sedatives, stimulants, or other drugs. SY = school year.

SOURCE: Georgia Student Health Survey.

Significant Findings

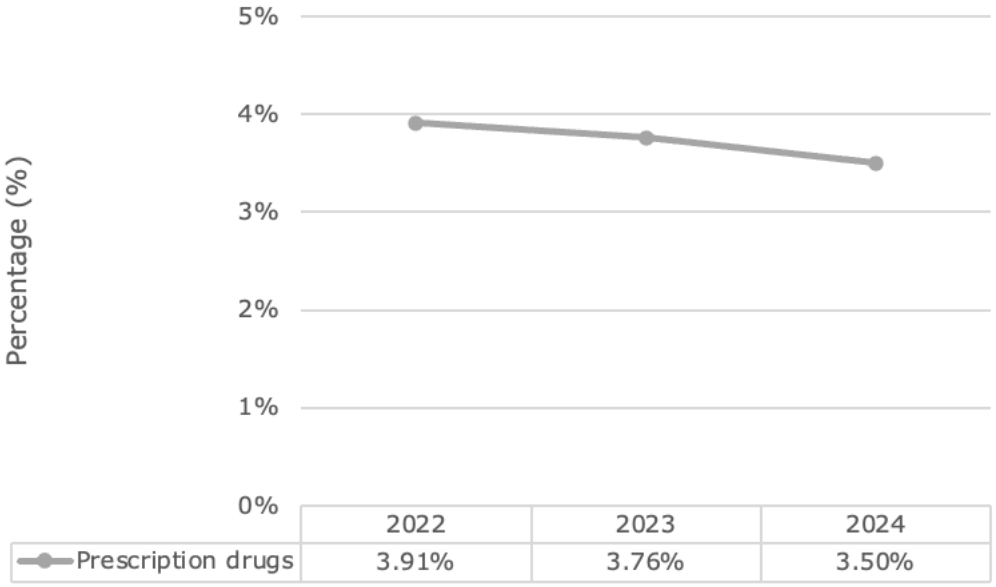
- The percentage of high school students reporting past-30-day substance use in Georgia decreased each year from SY2022 to SY2024 for the following substances:
  - Prescription drugs (decreased from 7.00% in SY2022 to 6.10% in SY2024)

County-Level Findings

Between SY2022 and SY2024, among high school students,

- 5 counties (3.14%) experienced favorable trends and no counties (0%) experienced unfavorable trends in past-30-day prescription drug use
- 1 county (0.63%) experienced a favorable trend and 5 counties (3.14%) experienced unfavorable trends in past-30-day heroin use

Figure 4. Percentage Reporting Lifetime Prescription Drug Use Among Middle School Students in Georgia, SY2022–SY2024



NOTE: SY = school year.

SOURCE: Georgia Student Health Survey.

Significant Findings

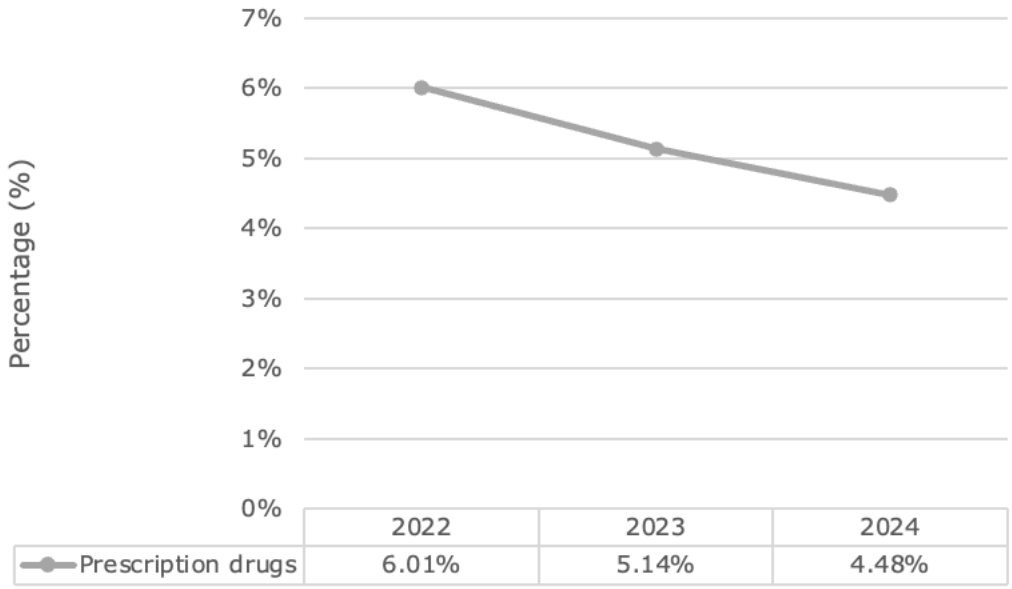
- The percentage of middle school students reporting lifetime prescription drug use in Georgia did not change significantly between SY2022 and SY2024.

County-Level Findings

Between SY2022 and SY2024, among middle school students,

- 5 counties (3.14%) experienced favorable trends and no counties (0%) experienced unfavorable trends in lifetime prescription drug use

Figure 5. Percentage Reporting Lifetime Prescription Drug Use Among High School Students in Georgia, SY2022–SY2024



NOTE: SY = school year.

SOURCE: Georgia Student Health Survey.

Significant Findings

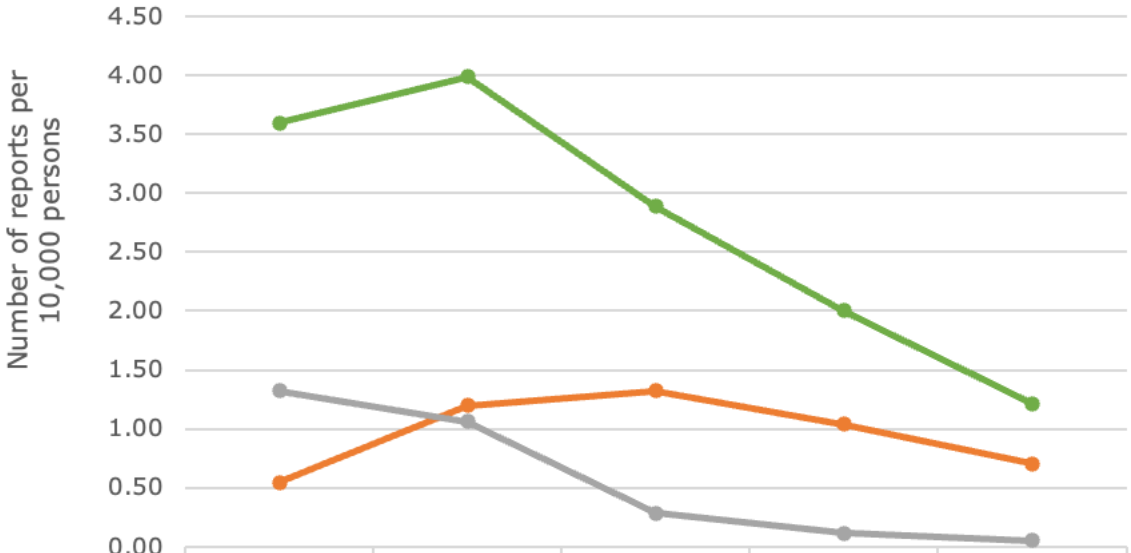
- The percentage of high school students reporting lifetime prescription drug use in Georgia did not change significantly between SY2022 and SY2024.

County-Level Findings

Between SY2022 and SY2024, among high school students,

- 3 counties (1.89%) experienced favorable trends and 1 county (0.63%) experienced an unfavorable trend in lifetime prescription drug use

Figure 6. Drug Reports per 10,000 Persons in Georgia, by Substance, 2020–2024



	2020	2021	2022	2023	2024
Fentanyl	0.54	1.20	1.32	1.04	0.70
Heroin	1.32	1.06	0.29	0.11	0.06
Opioids	3.60	3.99	2.89	2.00	1.21

SOURCE: Georgia Bureau of Investigation.

Significant Findings

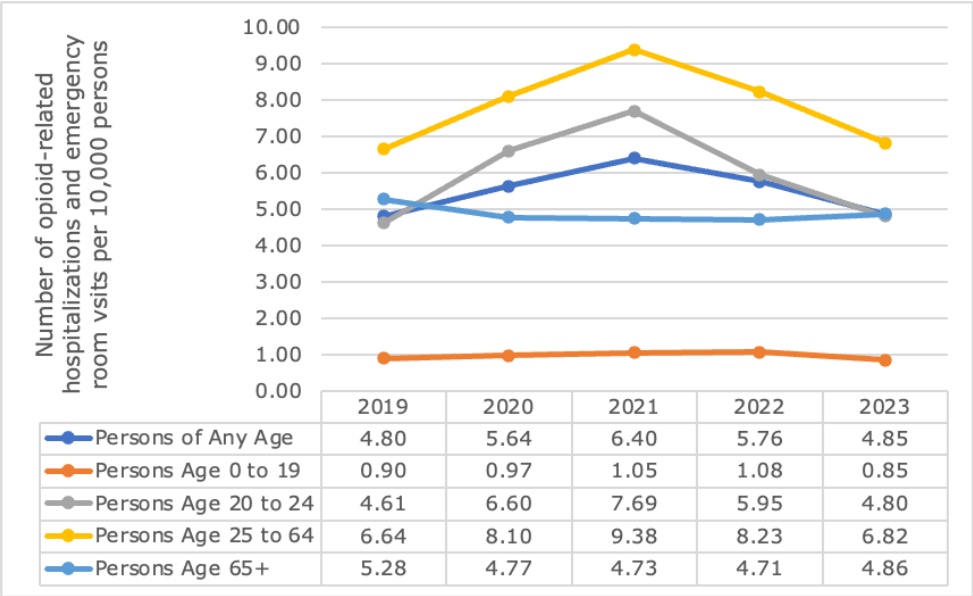
- The rate of drug reports (e.g., number per 10,000 persons) in Georgia decreased from 2020 to 2024 for the following substances:
  - Heroin (decreased from 1.32 reports per 10,000 persons in 2020 to 0.06 reports per 10,000 persons in 2024)
  - Opioids (initially increased from 3.60 reports per 10,000 persons in 2020 to 3.99 reports per 10,000 persons in 2021, then decreased to 1.21 reports per 10,000 persons in 2024)

County-Level Findings

Between 2020 and 2024,

- 41 counties (25.79%) experienced favorable trends and no counties (0%) experienced unfavorable trends in heroin reports per 10,000 persons
- 1 county (0.63%) experienced a favorable trend and 2 counties (1.26%) experienced unfavorable trends in fentanyl reports per 10,000 persons
- 34 counties (21.38%) experienced favorable trends and 1 county (0.63%) experienced an unfavorable trend in opioid reports per 10,000 persons

Figure 7. Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 Persons in Georgia, by Age Group, 2019–2023



	2019	2020	2021	2022	2023
Persons of Any Age	4.80	5.64	6.40	5.76	4.85
Persons Age 0 to 19	0.90	0.97	1.05	1.08	0.85
Persons Age 20 to 24	4.61	6.60	7.69	5.95	4.80
Persons Age 25 to 64	6.64	8.10	9.38	8.23	6.82
Persons Age 65+	5.28	4.77	4.73	4.71	4.86

NOTE: ER visit or hospitalization involving any opioid overdose. Includes prescription opioid pain relievers (e.g., hydrocodone, oxycodone, and morphine); opioids used to treat addiction (e.g., methadone); and heroin, opium, and synthetic opioids (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured). ER visits and hospitalizations may represent multiple visits by the same individual.

SOURCE: Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS).

Significant Findings

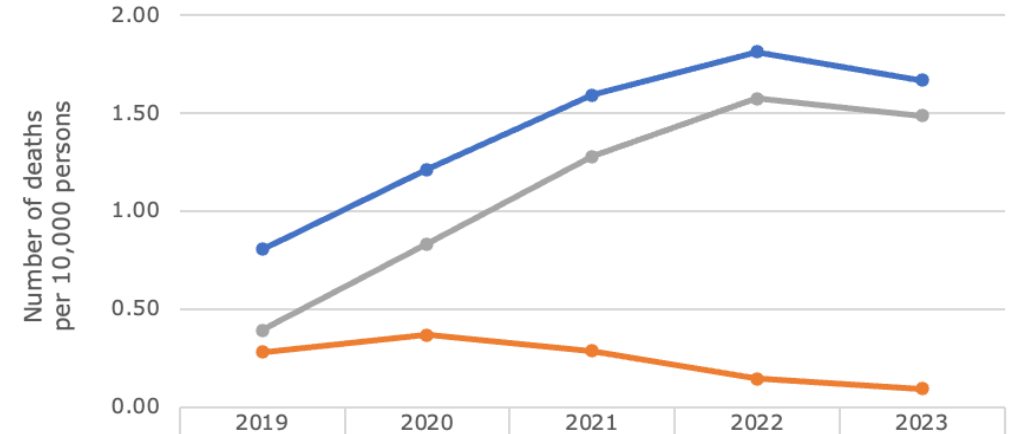
- The number of opioid-related hospitalizations and emergency room visits per 10,000 persons in Georgia did not change significantly between 2019 and 2023.

County-Level Findings

Between 2019 and 2023,

- 6 counties (3.77%) experienced favorable trends and 3 counties (1.89%) experienced unfavorable trends in Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 persons
- 5 counties (3.14%) experienced favorable trends and no counties (0%) experienced unfavorable trends in Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 persons age 0 to 19
- 1 county (0.63%) experienced favorable trends and 2 counties (1.26%) experienced unfavorable trends in Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 persons age 20 to 24
- 7 counties (4.40%) experienced favorable trends and 2 counties (1.26%) experienced unfavorable trends in Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 persons age 25 to 64
- 8 counties (5.03%) experienced favorable trends and 3 counties (1.89%) experienced unfavorable trends in Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 persons age 65 or older

Figure 8. Any Drug-Related Overdose Deaths per 10,000 Persons in Georgia, by Substance and Type, 2019–2023



	2019	2020	2021	2022	2023
Any opioid	0.80	1.21	1.59	1.81	1.67
Heroin	0.28	0.37	0.29	0.14	0.09
Fentanyl	0.39	0.83	1.28	1.57	1.49

NOTE: Opioid-related overdose deaths involve prescription opioid pain relievers (e.g., hydrocodone, oxycodone, morphine); opioids used to treat addiction (e.g., methadone); and heroin, opium, and synthetic opioids (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured). Fentanyl-related overdose deaths involve synthetic opioids other than methadone (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured).

SOURCE: Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS).

Significant Findings

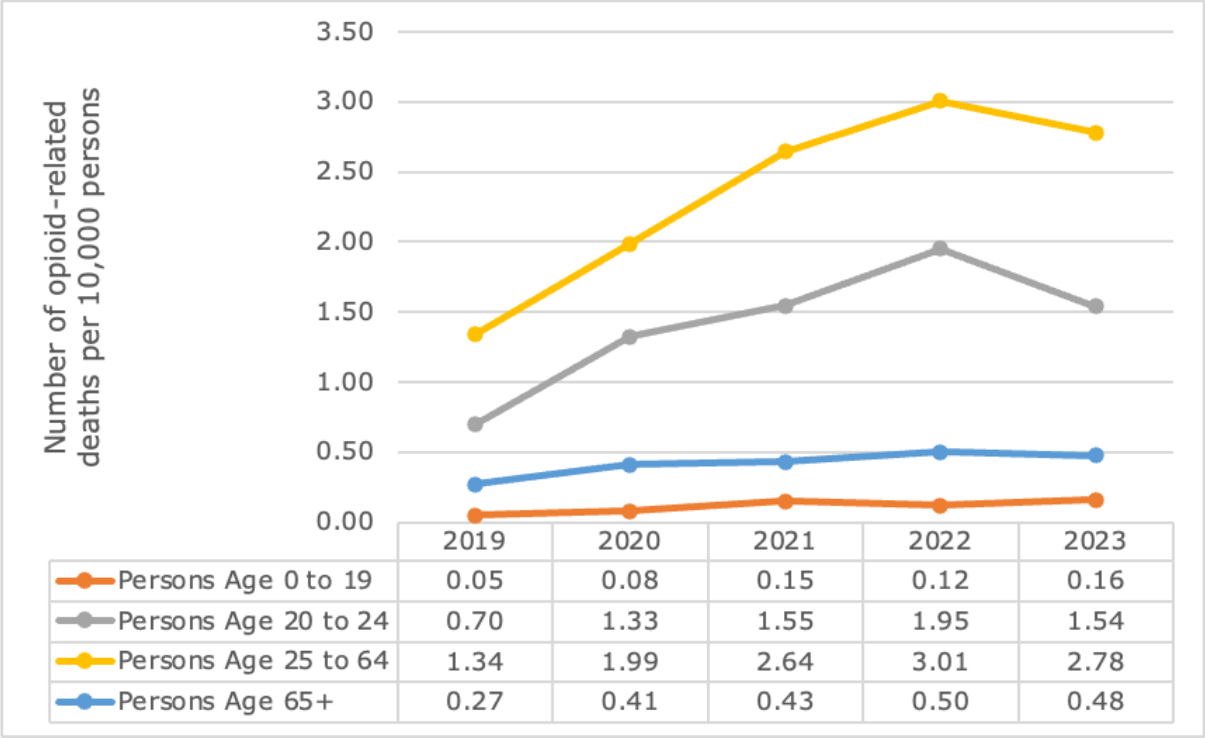
- The number of opioid-related overdose deaths per 10,000 persons increased from 0.80 deaths per 10,000 persons in Georgia in 2019 to 1.67 deaths per 10,000 persons in 2023. However, the rate peaked in 2022 at 1.81 overdose deaths per 10,000 persons.
- The number of fentanyl-related overdose deaths per 10,000 persons increased from 0.39 deaths per 10,000 persons in Georgia in 2019 to 1.49 per 10,000 persons in 2023. However, the rate peaked in 2022 at 1.57 overdose deaths per 10,000 persons.

County-Level Findings

Between 2019 and 2023,

- No counties (0%) experienced favorable trends and 20 counties (12.58%) experienced unfavorable trends in any opioid-related overdose deaths per 10,000 persons
- 10 counties (6.29%) experienced favorable trends and no counties (0%) experienced unfavorable trends in heroin-related overdose deaths per 10,000 persons
- No counties (0%) experienced favorable trends and 28 counties (17.61%) experienced unfavorable trends in fentanyl-related overdose deaths per 10,000 persons

Figure 9. Opioid-Related Overdose Deaths per 10,000 Persons in Georgia, by Age Group, 2019–2023



	2019	2020	2021	2022	2023
Persons Age 0 to 19	0.05	0.08	0.15	0.12	0.16
Persons Age 20 to 24	0.70	1.33	1.55	1.95	1.54
Persons Age 25 to 64	1.34	1.99	2.64	3.01	2.78
Persons Age 65+	0.27	0.41	0.43	0.50	0.48

NOTE: Opioid-related overdose deaths involve prescription opioid pain relievers (e.g., hydrocodone, oxycodone, and morphine); opioids used to treat addiction (e.g., methadone); and heroin, opium, and synthetic opioids (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured).

SOURCE: Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS).

Significant Findings

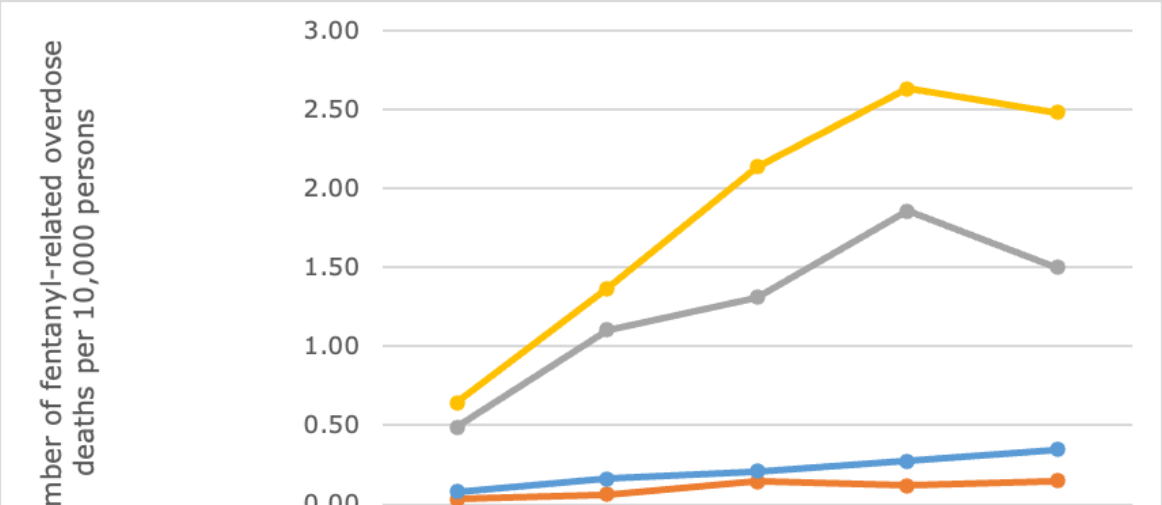
- The number of opioid-related overdose deaths among persons age 0 to 19 increased from 0.05 deaths per 10,000 persons in Georgia in 2019 to 0.16 deaths per 10,000 persons in 2023.
- The number of opioid-related overdose deaths among persons age 25 to 64 increased from 1.34 deaths per 10,000 persons in Georgia in 2019 to 2.78 deaths per 10,000 persons in 2023.
- The number of opioid-related overdose deaths among persons age 65 or older increased from 0.27 deaths per 10,000 persons in Georgia in 2019 to 0.48 deaths per 10,000 persons in 2023.

County-Level Findings

Between 2019 and 2023,

- No counties (0%) experienced favorable or unfavorable trends in any opioid-related overdose deaths per 10,000 persons age 0 to 19
- One county (0.63%) experienced a favorable trend and 4 counties (2.52%) experienced unfavorable trends in any opioid-related overdose deaths per 10,000 persons age 20 to 24
- No counties (0%) experienced favorable trends and 19 counties (11.95%) experienced unfavorable trends in any opioid-related overdose deaths per 10,000 persons age 25 to 64
- No counties (0%) experienced favorable trends and 1 county (0.63%) experienced unfavorable trends in any opioid-related overdose deaths per 10,000 persons age 65 or older

Figure 10. Fentanyl-Related Overdose Deaths per 10,000 Persons in Georgia, by Age Group, 2019–2023



	2019	2020	2021	2022	2023
Persons Age 0 to 19	0.03	0.06	0.15	0.12	0.15
Persons Age 20 to 24	0.49	1.10	1.31	1.86	1.50
Persons Age 25 to 64	0.64	1.37	2.14	2.63	2.48
Persons Age 65+	0.08	0.16	0.21	0.28	0.35

NOTE: Fentanyl-related overdose deaths involve synthetic opioids other than methadone (e.g., tramadol and fentanyl that may be prescription or illicitly manufactured).

SOURCE: Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS).

Significant Findings

- The number of fentanyl-related overdose deaths among persons age 0 to 19 increased from 0.03 deaths per 10,000 persons in Georgia in 2019 to 0.15 deaths per 10,000 persons in 2023.
- The number of fentanyl-related overdose deaths among persons age 25 to 64 increased from 0.64 deaths per 10,000 persons in Georgia in 2019 to 2.48 deaths per 10,000 persons in 2023.
- The number of fentanyl-related overdose deaths among persons age 65 or older increased from 0.08 deaths per 10,000 persons in Georgia in 2019 to 0.35 deaths per 10,000 persons in 2023.

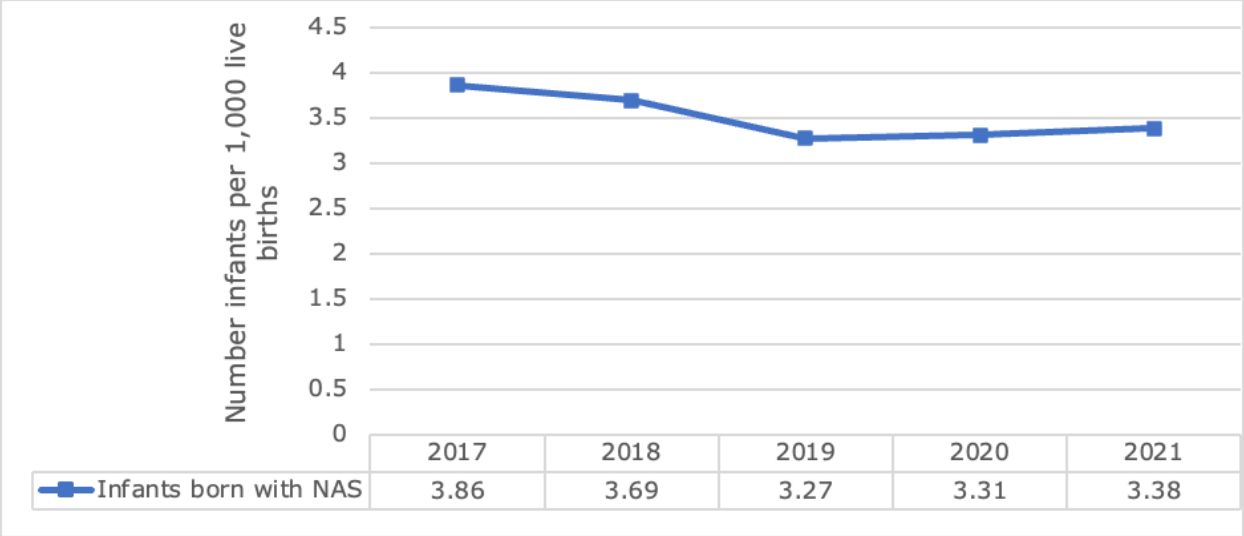
County-Level Findings

Between 2019 and 2023,

- No counties (0%) experienced favorable trends and 2 counties (1.26%) experienced unfavorable trends in any fentanyl-related overdose deaths per 10,000 persons age 0 to 19
- 1 county (0.63%) experienced a favorable trend and 6 counties (3.77%) experienced unfavorable trends in any fentanyl-related overdose deaths per 10,000 persons age 20 to 24

- No counties (0%) experienced favorable trends and 28 counties (17.61%) experienced unfavorable trends in any fentanyl-related overdose deaths per 10,000 persons age 25 to 64
- No counties (0%) experienced favorable trends and 2 counties (1.26%) experienced unfavorable trends in any fentanyl-related overdose deaths per 10,000 persons age 65 or older

Figure 11. Infants Born With Neonatal Abstinence Syndrome (NAS) per 1,000 Live Births in Georgia, 2017–2021



NOTE: Counties with 5 or fewer cases of NAS did not report a rate.

SOURCE: Georgia Department of Public Health and Georgia Strategic Prevention System.

Significant Findings

- The number of infants born with NAS per 1,000 live births in Georgia did not change significantly between 2017 and 2021.

County-Level Findings

- Trend analyses were not conducted.

3.3 County-Level Trend Frequencies

As described in **Section 2**, we conducted a trend analysis of each indicator in the Georgia Social Indicator Study for both the state and every county. We present the frequency of counties with statistically significant favorable and unfavorable trends in **Table 2** in order to quantify the number of counties with significant trends for each indicator. For completeness, we also present the number of counties that did not have a significant trend for each indicator, as well as the number of counties on which trend analyses could not be performed because of insufficient data. Finally, we present the overall trend at the state level for each indicator for comparison purposes to determine whether county trends are occurring in directions similar to those of the state trends.

Table 2. Result Frequencies in the County Trend Analysis of the 2025 Opioid Social Indicator Study, by Indicator

Indicator	Overall Trend for Georgia	Number of Counties with Favorable Trend N (%)	Number of Counties with Unfavorable Trend N (%)	Number of Counties with No Trend N (%)	Number of Counties Where Trend Analyses Not Performed[a] N (%)
Opioid Abuse					
Past-30-Day Prescription Drug Use—MS	None	1 (0.63%)	4 (2.52%)	118 (74.21%)	36 (22.64%)
Past-30-Day Heroin Use—MS	None	0 (0.00%)	2 (1.26%)	121 (76.10%)	36 (22.64%)
Lifetime Prescription Drug Use—MS	None	5 (3.14%)	0 (0.00%)	118 (74.21%)	36 (22.64%)
Past-30-Day Prescription Drug Use—HS	Favorable Trend	5 (3.14%)	0 (0.00%)	107 (67.30%)	47 (29.56%)
Past-30-Day Heroin Use—HS	None	1 (0.63%)	5 (3.14%)	106 (66.67%)	47 (29.56%)
Lifetime Prescription Drug Use—HS	None	3 (1.89%)	1 (0.63%)	108 (67.92%)	47 (29.56%)
Availability of Opioids					
Heroin Reports per 10,000 Persons	Favorable Trend	41 (25.79%)	0 (0.00%)	118 (74.21%)	0 (0.00%)
Fentanyl Reports per 10,000 Persons	None	1 (0.63%)	2 (1.26%)	156 (98.11%)	0 (0.00%)
Opioid Reports per 10,000 Persons	Favorable Trend	34 (21.38%)	1 (0.63%)	124 (77.99%)	0 (0.00%)
Consequences of Opioid Use					
Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 Persons, Any Age[b]	None	6 (3.77%)	3 (1.89%)	150 (94.34%)	0 (0.00%)

(continued)

Table 2. Result Frequencies in the County Trend Analysis of the 2025 Opioid Social Indicator Study, by Indicator (cont.)

Indicator	Overall Trend for Georgia	Number of Counties with Favorable Trend N (%)	Number of Counties with Unfavorable Trend N (%)	Number of Counties with No Trend N (%)	Number of Counties Where Trend Analyses Not Performed[a] N (%)
Consequences of Opioid Use (cont.)					
Per 10,000 Persons Age 0 to 19	None	5 (3.14%)	0 (0.00%)	154 (96.86%)	0 (0.00%)
Per 10,000 Persons Age 20 to 24	None	1 (0.63%)	2 (1.26%)	156 (98.11%)	0 (0.00%)
Per 10,000 Persons Age 25 to 64	None	7 (4.40%)	2 (1.26%)	150 (94.34%)	0 (0.00%)
Per 10,000 Persons Age 65+	None	8 (5.03%)	3 (1.89%)	148 (93.08%)	0 (0.00%)
Any Opioid-Related Overdose Deaths per 10,000 Persons, Any Age[b]	Unfavorable Trend	0 (0.00%)	20 (12.58%)	139 (87.42%)	0 (0.00%)
Per 10,000 Persons Age 0 to 19	Unfavorable Trend	0 (0.00%)	0 (0.00%)	159 (100.00%)	0 (0.00%)
Per 10,000 Persons Age 20 to 24	None	1 (0.63%)	4 (2.52%)	154 (96.86%)	0 (0.00%)
Per 10,000 Persons Age 25 to 64	Unfavorable Trend	0 (0.00%)	19 (11.95%)	140 (88.05%)	0 (0.00%)
Per 10,000 Persons Age 65+	Unfavorable Trend	0 (0.00%)	1 (0.63%)	158 (99.37%)	0 (0.00%)
Heroin-Related Overdose Deaths per 10,000 Persons	None	10 (6.29%)	0 (0.00%)	149 (93.71%)	0 (0.00%)
Fentanyl-Related Overdose Deaths per 10,000 Persons, Any Age[b]	Unfavorable Trend	0 (0.00%)	28 (17.61%)	131 (82.39%)	0 (0.00%)
Per 10,000 Persons Age 0 to 19	Unfavorable Trend	0 (0.00%)	2 (1.26%)	157 (98.74%)	0 (0.00%)
Per 10,000 Persons Age 20 to 24	None	1 (0.63%)	6 (3.77%)	152 (95.60%)	0 (0.00%)
Per 10,000 Persons Age 25 to 64	Unfavorable Trend	0 (0.00%)	28 (17.61%)	131 (82.39%)	0 (0.00%)
Per 10,000 Persons Age 65+	Unfavorable Trend	0 (0.00%)	2 (1.26%)	157 (98.74%)	0 (0.00%)

(continued)

Table 2. Result Frequencies in the County Trend Analysis of the 2025 Opioid Social Indicator Study, by Indicator (cont.)

Indicator	Overall Trend for Georgia	Number of Counties with Favorable Trend N (%)	Number of Counties with Unfavorable Trend N (%)	Number of Counties with No Trend N (%)	Number of Counties Where Trend Analyses Not Performed[a] N (%)
Consequences of Opioid Use (cont.)					
Percentage of Patients Receiving Naloxone Relative to National Average	N/A	N/A	N/A	N/A	N/A
Infants Born With Neonatal Abstinence Syndrome (NAS) per 1,000 Live Births	None	N/A	N/A	N/A	N/A

NOTES: Summarizes county-level results from trend analyses described in **Section 2.3.2**.

[a]Trend analyses could not be performed for counties or indicators that had fewer than 3 years of data available. Refer to **Section 2.3.2** for further details.

[b] When age-specific categories were available, the indicator for Persons Any Age was excluded from the overall county risk score calculation.

4. Interpreting County Prevention Needs Assessment Profiles

This section provides guidelines for interpreting the county-level opioid prevention needs assessment profiles. A standardized value is plotted for each opioid indicator risk score to facilitate comparison across the indicators and comparison between the county and the average observed for all counties. A risk rank for each indicator and the county's overall opioid risk rank are also presented—the higher the rank, the higher the risk (that is, a rank of 1 indicates *lowest risk*). In addition, we provide the county's overall risk rank as determined in the Georgia county-level Social Indicator Study (SIS)—Overall report. This opioid report should be used in conjunction with the overall report to obtain a comprehensive perspective on the opioid use landscape for prevention planning, including harm reduction strategies.

The profiles in this report may be used to characterize counties in Georgia with respect to their levels of opioid-related problems. The profiles can also stimulate discussion and focus community attention on local opioid use issues and the reasons for the patterns observed in the profiles. In addition, the information contained in the profiles can assist prevention planners in determining appropriate prevention strategies and target groups. In reviewing the data for a particular county, one should consider the following.

- *First, examine actual values of all indicators for the county.* It also may be useful to examine the values for adjacent counties to determine whether regional patterns exist.
- *Examine indicators for which a county has extremely high or low values relative to the average across all counties*. The risk scores were converted to standardized values, such that for any indicator risk score, zero represents the mean value of all counties in the state. The scores represent the number of standard deviation units a county's value lies away from the mean for the indicator. As a general rule, most (about 68%) of the standardized scores for any given indicator are positioned between –1.0 and 1.0; these scores are considered typical. Scores between –1.0 and –2.0, or between 1.0 and 2.0, constitute about 27% of all scores and thus are somewhat uncommon. Scores lower than –2.0 or higher than 2.0, known as outliers, make up the final 5% and therefore are rare. Although the actual percentages vary somewhat depending on the shape of the distribution for each indicator, this general distribution suggests that indicators with a score less than –2.0 or greater than 2.0 may merit particular attention.

  The indicators are presented such that the higher standardized values (i.e., values to the right of the center line) reflect greater opioid use and opioid use–related problems relative to other counties, whereas lower standardized values (i.e., values to the left of the center line) reflect lower opioid use and opioid use–related problems relative to other counties. For example, a positive standardized score less than 1.0 for the Any Drug Reports rate would indicate that a county had a *slightly* higher-than-average rate of any drug reports. By contrast, a standardized score between –1.0 and –2.0 for the same indicator would show that a county had a *noticeably* lower-than-average rate of any drug reports. A standardized score between 2.0 and 3.0 would indicate that a county had an *unusually* higher-than-average rate.

Also, it may be useful to examine the standardized values observed for adjacent counties to determine whether regional patterns exist. Although standardized scores are useful, it is important to keep in mind that they are relative measures and provide only partial information about the potential prevention needs of a county. An indicator that is not highly problematic relative to the overall county average should not necessarily be discounted when one is considering the prevention needs of a given county. For example, even though the rate of any poisonings in a certain county is no higher than the average, it may still warrant interventions designed to reduce it further.

- *Examine indicators for which a favorable or unfavorable trend has been identified.* The profile presents significant trends for each indicator (i.e., whether the indicator value changed significantly between the first and last year specified in the data source note). Bars shaded with a polka dot pattern indicate a statistically significant trend in a favorable direction for that indicator. Bars shaded with a crosshatch pattern indicate a statistically significant trend in an unfavorable direction for that indicator. Bars without any pattern represent indicators that did not significantly change. Bars noted with "§" represent indicators on which trend analyses could not be performed because of insufficient data.

  It may be useful to examine the actual values for indicators observed to have a significant trend in order to determine the magnitude and direction of the trend. Bars shaded with a polka dot pattern, representing trends or changes in a favorable direction, should be examined to determine areas in which improvements are being made and to continue and maintain efforts in those areas. Bars shaded with a crosshatch pattern, representing trends or changes in an unfavorable direction, should be examined to identify areas where more attention and efforts may be needed to reduce risk.

- Use profile data in conjunction with other sources of information to inform the identification of appropriate and effective prevention programs and strategies. The profiles may provide some important clues about the types of approaches that are most needed and most appropriate in a given county. However, there is no proven or exact formula for identifying the most appropriate and effective prevention programs and strategies on the basis of an area's profile. In general, we recommend that problems, elevated risk factors, and suppressed protective factors be given extra attention in determining which types of prevention strategies are most needed for a given area.

  Decisions about which indicators are more important and in need of attention for any given area should include a consideration not only of whether the county's scores are high or low relative to those of other counties in the state, but also of how many individuals are affected by the factors and what changes can be observed in the factors across years. These types of information relate to describing the nature and extent of the opioid use problem in a community, along with characteristics of the community's population and various risk and protective factors that may influence opioid use levels in that community.

  However, even when the indicator data are helpful in suggesting appropriate approaches or foci for prevention efforts, the choice of which specific prevention programs and strategies to implement will likely require additional consideration based on other information. In particular, prevention planners will want to consider what prevention programs or strategies are known to be effective for the type of application or population they have in mind. Planners also may need to examine the prevention resources and capabilities in the community or nearby communities in order to make equitable and effective use of the limited prevention resources that

may be available. These additional considerations go beyond the specific focus of this initial study and report, but they are important components in an overall framework for prevention planning at the state and local levels.

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5. Overall Opioid Risk Score Rankings

The overall opioid risk scores by county are presented in **Tables 3** and **4** (Quintiles 1–3 and 4–5, respectively). As described in **Section 2**, the overall opioid risk scores were calculated as the standardized mean of all 24 indicators that were indicative of risk, equally weighted. These scores were then ordered from lowest to highest and ranked from 1 (lowest risk) to 159 (highest risk). To examine possible trends across the state, we grouped the overall opioid risk scores into five categories, or quintiles. The 32 counties with the lowest risk scores (ranked 1 to 32) were grouped into the first quintile, counties ranked 33 to 64 were grouped into the second quintile, counties ranked 65 to 96 were grouped into the third quintile, counties ranked 97 to 128 were grouped into the fourth quintile, and counties ranked 129 to 159 (highest risk scores) were grouped into the fifth quintile. This grouping depicts five levels, or gradations, of overall risk. Counties with high rankings are viewed as having higher overall levels of opioid use problems and risk factors for opioid use than counties with lower rankings. The detailed county risk profiles in ***Volume II*** provide a risk score for each of the 24 individual indicators.

We used tools in Microsoft Excel to generate a geographic information system (GIS) map displaying the overall opioid county rankings from the present (2025) Social Indicator Study (see **Figure 12**).

As stated previously, the county profiles and overall county risk scores provide a useful tool for planning at the local level. However, the profiles and overall opioid risk scores alone do not depict the complete picture, and users of this information should consult additional data and resources to complement the profiles and risk scores when planning services or programs.

Table 3. Overall Opioid Risk Score for Quintiles 1 Through 3, by County

Quintile 1 (Lowest Risk)			Quintile 2			Quintile 3		
County	Overall Rank	Overall Opioid Risk Score	County	Overall Rank	Overall Opioid Risk Score	County	Overall Rank	Overall Opioid Risk Score
Echols	-0.6992	1	Chattooga	-0.2412	33	Effingham	-0.1334	65
Glascock	-0.6132	2	Colquitt	-0.2405	34	Meriwether	-0.1201	66
Clay	-0.5963	3	Emanuel	-0.2324	35	Spalding	-0.1103	67
Chattahoochee	-0.5947	4	Early	-0.2209	36	Camden	-0.1030	68
Schley	-0.5946	5	Sumter	-0.2183	37	Lamar	-0.1025	69
Lanier	-0.5800	6	Henry	-0.2156	38	Mitchell	-0.0949	70
Lincoln	-0.5657	7	Wilkes	-0.2040	39	Laurens	-0.0936	71
Forsyth	-0.5298	8	Decatur	-0.2005	40	Cobb	-0.0908	72
Wilkinson	-0.4684	9	Johnson	-0.1987	41	Gwinnett	-0.0873	73
Jasper	-0.4456	10	Marion	-0.1969	42	Greene	-0.0815	74
Macon	-0.4292	11	Berrien	-0.1956	43	Lee	-0.0730	75
Grady	-0.4251	12	Evans	-0.1921	44	Brooks	-0.0718	76
Coffee	-0.3951	13	Bulloch	-0.1911	45	Jefferson	-0.0715	77
Seminole	-0.3637	14	Peach	-0.1908	46	Wheeler	-0.0698	78
Lowndes	-0.3596	15	Pulaski	-0.1884	47	Gordon	-0.0675	79
Heard	-0.3327	16	Randolph	-0.1877	48	Catoosa	-0.0648	80
Cook	-0.3220	17	Jenkins	-0.1847	49	Ware	-0.0618	81
Wilcox	-0.3184	18	Toombs	-0.1742	50	Dooly	-0.0615	82
Morgan	-0.2979	19	Tift	-0.1720	51	Douglas	-0.0576	83
Walton	-0.2925	20	Turner	-0.1699	52	Franklin	-0.0565	84
Terrell	-0.2797	21	Jackson	-0.1630	53	Worth	-0.0496	85
Cherokee	-0.2750	22	Tattnall	-0.1606	54	Oconee	-0.0448	86
Bryan	-0.2710	23	Gilmer	-0.1559	55	Habersham	-0.0405	87
Putnam	-0.2687	24	Dawson	-0.1556	56	Murray	-0.0404	88
Coweta	-0.2627	25	Telfair	-0.1548	57	Clayton	-0.0387	89
Talbot	-0.2610	26	Union	-0.1478	58	Monroe	-0.0342	90
Fayette	-0.2564	27	Harris	-0.1478	59	DeKalb	-0.0299	91
Calhoun	-0.2543	28	Atkinson	-0.1395	60	Rabun	-0.0266	92
Pierce	-0.2522	29	Floyd	-0.1381	61	Whitfield	-0.0213	93
Treutlen	-0.2478	30	Clinch	-0.1366	62	Burke	-0.0174	94
Thomas	-0.2473	31	Lumpkin	-0.1349	63	Glynn	-0.0108	95
Miller	-0.2460	32	Banks	-0.1339	64	Hall	-0.0040	96

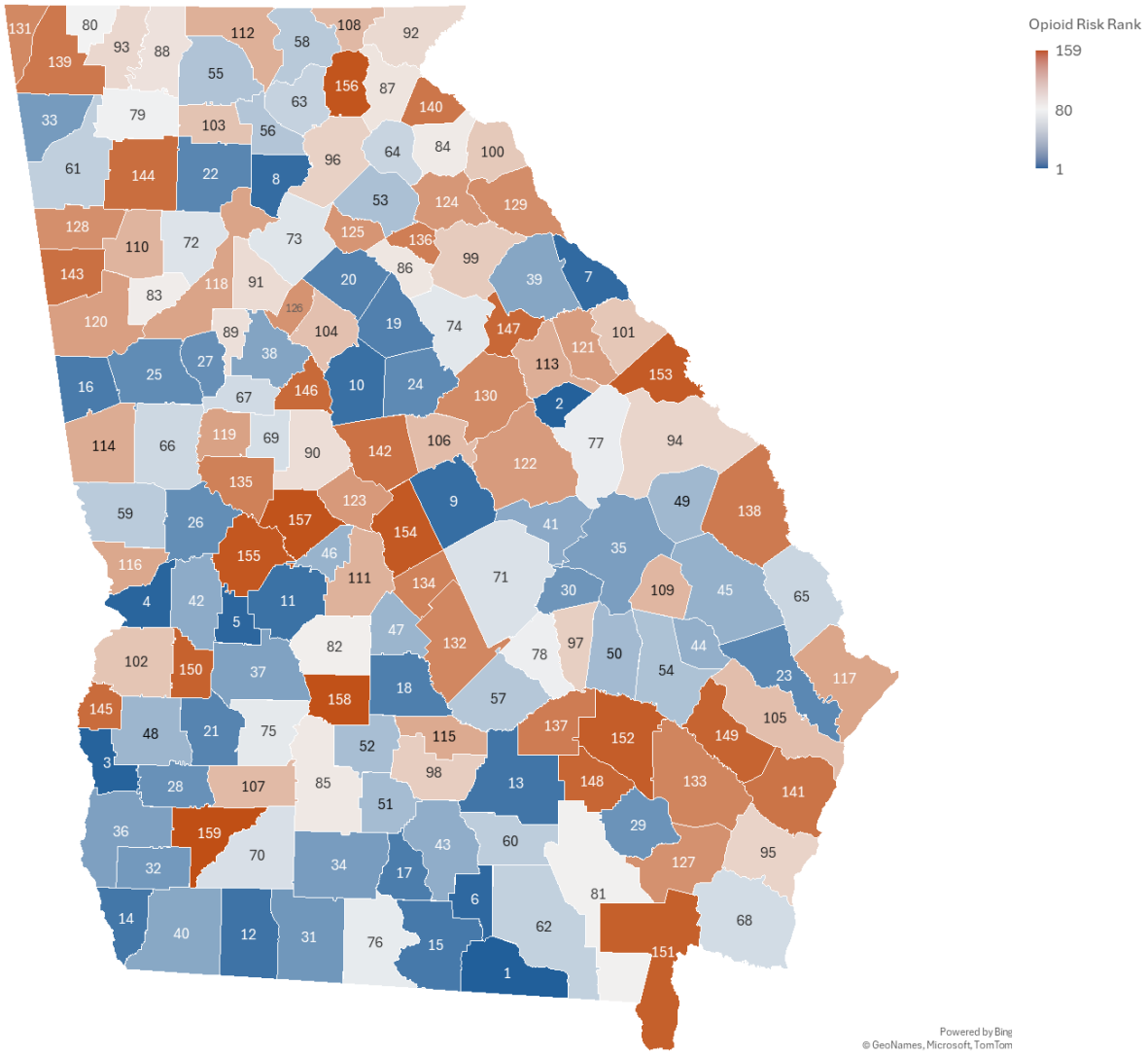
NOTE: Lower scores/ranks indicate lower risk; higher scores/ranks indicate higher risk.

Table 4. Overall Opioid Risk Score for Quintiles 4 and 5, by County

Quintile 4			Quintile 5 (Highest Risk)		
County	Overall Rank	Overall Opioid Risk Score	County	Overall Rank	Overall Opioid Risk Score
Montgomery	-0.0006	97	Elbert	0.2484	129
Irwin	0.0035	98	Hancock	0.2536	130
Oglethorpe	0.0090	99	Dade	0.2762	131
Hart	0.0121	100	Dodge	0.2868	132
Columbia	0.0221	101	Wayne	0.2900	133
Stewart	0.0369	102	Bleckley	0.2928	134
Pickens	0.0483	103	Upson	0.2975	135
Newton	0.0582	104	Clarke	0.3088	136
Liberty	0.0598	105	Jeff Davis	0.3153	137
Baldwin	0.0621	106	Screven	0.3241	138
Dougherty	0.0629	107	Walker	0.3688	139
Towns	0.0685	108	Stephens	0.3742	140
Candler	0.0697	109	McIntosh	0.3937	141
Paulding	0.0717	110	Jones	0.3982	142
Houston	0.0727	111	Haralson	0.4229	143
Fannin	0.0925	112	Bartow	0.4435	144
Warren	0.1042	113	Quitman	0.4621	145
Troup	0.1071	114	Butts	0.4667	146
Ben Hill	0.1127	115	Taliaferro	0.5162	147
Muscogee	0.1176	116	Bacon	0.5374	148
Chatham	0.1231	117	Long	0.5505	149
Fulton	0.1337	118	Webster	0.5806	150
Pike	0.1443	119	Charlton	0.6050	151
Carroll	0.1476	120	Appling	0.6707	152
McDuffie	0.1606	121	Richmond	0.6926	153
Washington	0.2029	122	Twiggs	0.6978	154
Bibb	0.2046	123	Taylor	0.7364	155
Madison	0.2051	124	White	0.7525	156
Barrow	0.2339	125	Crawford	0.7790	157
Rockdale	0.2386	126	Crisp	0.8153	158
Brantley	0.2405	127	Baker	1.5357	159
Polk	0.2476	128			

NOTE: Lower scores/ranks indicate lower risk; higher scores/ranks indicate higher risk.

Figure 12. Opioid-Only County Rankings in the Georgia Social Indicator Study, 2025



6. Using Social Indicator Studies for Effective Prevention Planning

Guidelines for interpreting the social indicator profiles, and for making prevention planning decisions based on them, were provided in **Section 4**. Those guidelines emphasized that there are no rigid rules or formulas for how profile data should be translated into program planning decisions. Rather, some general principles, along with some cautions, were presented with respect to how the data might best be used for this purpose. Different communities may focus on different aspects of the data and interpret them in ways that seem most useful and appropriate for those communities. All communities are encouraged to combine the profile data with local knowledge and other available information to form a more comprehensive assessment of their opioid use consumption, consequences, and prevention needs. This report should be used in conjunction with the Georgia county-level Social Indicator Study (SIS)—Overall report to obtain a comprehensive perspective on the opioid use landscape for prevention planning, including harm reduction strategies.

6.1 Suggestions for Data Dissemination

The greatest potential impact of this report is likely to be achieved when it is in the hands of those involved in direct service to communities—for example, local prevention providers, planners, and policy makers. Although the data may serve several important functions at the state level, the planning and provision of prevention services in Georgia is largely orchestrated at the regional and local levels. Therefore, the primary objective of this report is to provide information that can support this process. Regional prevention staff, coalition coordinators, and directors and staff of community-based organizations all are potential users of these data. In addition to informing the prevention planning process, the data can be useful for focusing public attention on opioid use, risk factors, and potential solutions. Simultaneously, the data may stimulate a greater interest in and understanding of data-driven approaches to assessing prevention needs in communities. The data also can be helpful in new funding applications for prevention resources, for which statements of need are a required component. Because of the breadth of indicators assembled in this report and their relevance to many facets of social well-being, the potential audience may extend beyond the opioid use prevention community and include other social service agencies and community-based organizations as well as public officials, businesses, and the general public.

These data will serve as key indicators of prevention need (i.e., needs assessment) and can be leveraged when the OPS applies for future funding from SAMHSA's Center for Substance Abuse Prevention. Additionally, this report contains opioid use–related consequence indicators identified as state priority issues. Communities applying for relevant funding mechanisms can use these data to justify their needs.

6.2 Using and Sustaining Social Indicators as a Component of the State's Prevention Planning Infrastructure

The number of states that systematically compile and use social indicator data to inform prevention planning efforts continues to increase as requirements increase for data-driven approaches to planning and evaluation. This opioid-focused county-level SIS will serve as the foundation for data-driven opioid-related prevention planning in Georgia over the next several years. The goal is that this report will be helpful in further establishing the credibility and utility of social indicator approaches to prevention needs assessment, thus supporting continued development and maintenance of a social indicator component in state planning systems.

Table 5 provides several recommendations for supporting and sustaining the use of social indicators for prevention planning.

Table 5. Use and Maintenance of the Social Indicator Study in Georgia

Recommendation	Comments
Review the report for its utility to the state.	We recommend that Department of Behavioral Health and Developmental Disabilities decision makers and key prevention staff review the report for its relevance to the state's prevention planning process and for possible adaptations for continued use. Representatives from other state agencies also may be interested in reviewing the report and providing comments.
Disseminate the report to the local prevention providers and community coalition coordinators and gauge their interest in and use of the report.	These individuals are the ultimate users of the data contained in the report. Their buy-in is essential to the effective use of social indicator data for local planning purposes. These users can provide insights regarding ways to improve the data and the manner in which they are presented. Future possibilities may include online access to the report and automated annual updates.
Train potential data users on the interpretation and use of the epidemiological profiles.	It may be helpful to provide further guidance on the meaning and interpretation of the prevention needs assessment and planning profiles, as well as their design and use. Ideally, this training would also include the consideration of other data sources and how they can be integrated into the planning process.
Consider modifications to the list of indicators and the manner in which indicators are defined and displayed, on the basis of both user input and further research regarding the indicators' validity.	It is likely that additional useful indicators will be identified and that some current indicators will be determined to be of little relevance. Several other methodological features may merit consideration, including comparisons among subgroups of demographically similar counties and the inclusion of regional or national comparison data.

(continued)

Table 5. Use and Maintenance of the Social Indicator Study in Georgia (continued)

Recommendation	Comments
Define the role of social indicators in the state's planning process.	The manner in which social indicator data can be formally incorporated into the state planning process will need to be considered. This could vary from simply suggesting that local planners and providers use the data to requiring use of the data in justifying service plans and as a basis for making resource allocation decisions. Ultimately, the use of the social indicator data should be incorporated within the Strategic Prevention Framework as the required approach for supplying data for prevention-related needs assessments.
Commit to a permanent and sustainable infrastructure and support system.	To sustain the Social Indicator Study as a core component of the state's prevention planning process, Georgia will need to establish an appropriate infrastructure and means of support. One possibility is to contribute to the development of a coordinated social indicator system that would meet the needs of multiple units in the state's health and social services agencies. The Georgia state epidemiological outcomes workgroup may provide such an infrastructure.

SOURCE: Adapted from Georgia's County-Level Social Indicator Study to Assess Substance Use and Related Consequences Prevention Needs: 2019.

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Bibliography

Cagle, L. T., & Banks, S. M. (1986). The validity of assessing mental health needs with social indicators. *Evaluation and Program Planning, 99,* 127–152.

Calkins, R. F., Banks, C. E., & Weimer, B. J. (2002). *Assessing substance use prevention needs in Michigan counties: A study using social indicators*. *Final report*. Research Triangle Park, NC: RTI International.

Ciarlo, J. A., Tweed, D. L., Shern, D. L., Kirkpatrick, L. A., & Sachs-Ericsson, N. (1992). Validation of indirect methods to estimate need for mental health services: Concepts, strategy, and general conclusions. *Evaluation and Program Planning, 15,* 115–131.

McAuliffe, W. E., Dembling, B., Wilson, R., LaBrie, R., Geller, S., & Mulvaney, N. (1993). *Social indicator modeling for substance abuse treatment allocation*. Paper presented at the National Technical Center for Substance Abuse Needs Assessment Workshop Summary, Cambridge, MA.

Minnesota Department of Public Health, Chemical Dependency Division. (1994). *Substance abuse monitoring system: User's guide*. St. Paul, MN: Minnesota Department of Human Services.

New York State Office of Alcoholism and Substance Abuse Services. (1996). *Prevention risk indicator/services monitoring system: County risk profile for alcohol and substance abuse*. Albany, NY: Author.

Peterson, R. L. (2004). *Risk factors for adolescent drug and alcohol abuse in Arkansas 2003.* Little Rock, AR: Institute for Economic Advancement, College of Business, University of Arkansas at Little Rock.

Pitts, W. J., Heller, D., Smiley-McDonald, H., Weimer, B., Grabenauer, M., Bollinger, K., ... Pressley, D. (2023). Understanding research methods, limitations, and applications of drug data collected by the National Forensic Laboratory Information System (NFLIS-Drug). *Journal of Forensic Sciences, 68*(4), 1335–1342.

Sanchez, R., & Weimer, B. J. (2002). *Assessing substance use prevention needs using social indicators*. *Final report.* Research Triangle Park, NC: RTI International.

Simeone, R. S., Frank, B., & Aryan, Z. (1993). Needs assessment in substance misuse: A comparison of approaches and case study. *International Journal of the Addictions, 28,* 767–792.

Spencer, D. L., Kuo, J., & Flewelling, R. L. (2001). *Assessing substance use prevention needs in Vermont supervisory unions: A study using social indicators*. *Final report.* Research Triangle Park, NC: RTI International.

Stein-Seroussi, A. (1998). *Monitoring Connecticut's future: Social indicators associated with substance use* (report submitted to the Connecticut Department of Mental Health and Addiction Services). Chapel Hill, NC: Pacific Institute for Research and Evaluation.

Warheit, G. J., Bell, R. A., & Schwab, J. J. (1977). *Needs assessment approaches: Concepts and methods*. Rockville, MD: National Institute of Mental Health.

Weimer, B. J., & Graham, P. W. (2006). *Governor's cooperative agreement state incentive planning and development grant: Social indicator study to assess substance use prevention needs at the state and county levels in Georgia*. *Final report*. Research Triangle Park, NC: RTI International.

Zechmann, A., Flewelling, R., & Van Eenwyk, J. (1995). *Youth risk assessment database: A comprehensive report*. Olympia, WA: Washington State Department of Mental Health.

Zibbell, J. E., Aldridge, A., Grabenauer, M., Heller, D., Clarke, S. D., Pressley, D., & McDonald, H. S. (2023). Associations between opioid overdose deaths and drugs confiscated by law enforcement and submitted to crime laboratories for analysis, United States, 2014–2019: An observational study. *Lancet Regional Health–Americas, 25,* Article 100569.

Appendix A.
Example of Prevention Storytelling Using a County-Level Profile

Telling a Prevention Story Using the County-Level Profiles

The profile and other sections of the report provide you with the four pieces of information outlined in Table A-1. You can use this information to help you tell the prevention story for your county.

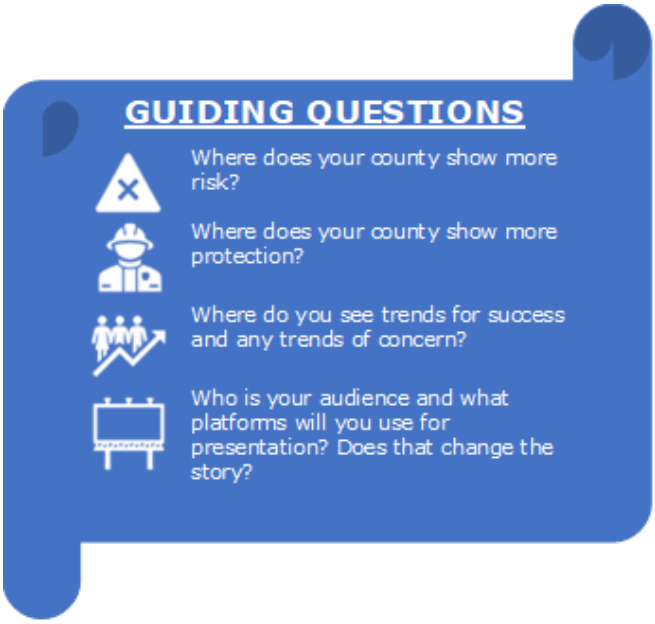

Table A-1. Where to Find and How to Use Data Elements in County Profiles

Data Element	Where Is It?	How Can I Use It?
Standardized risk scores for each indicator	▪ Volume III, County Risk Profile	▪ Compare your county risk to the average for all Georgia counties (represented by the center line, standardized to 0). ▪ Compare risk across indicators for your county (indicators with larger bars to the right of the line represent higher risk).
County rank for each indicator	▪ Volume III, County Risk Profile	▪ Compare your county to all counties on each indicator—the higher the value, the higher the risk (e.g., a rank of 159 indicates the county with the highest risk).
Overall county rank across all indicators	▪ Volume III, County Risk Profile ▪ Report Section 4	▪ Compare your county to all counties overall—the higher the value, the higher the risk (e.g., a rank of 159 indicates the county with the highest risk).
Prevalence value for each indicator (e.g., percentages, rates, or composite scores)	▪ Volume III	▪ Determine the actual value for the indicator and compare the value to other county values. Sometimes larger differences in risk scores and ranks may actually represent relatively minimal differences in prevalence.

When reviewing the county-level profile and thinking about the story that the data are telling, keep in mind the four guiding questions/principles shown in the sidebar. The text below provides a sample interpretation of the FICTITIOUS PROFILE that is located on the following pages.

1. Where does your county show more risk?

- All bars to the right of the center line represent indicators that show higher-than-average risk for your county.
- Bars that are more than two standard deviations above the average represent especially high-risk indicators.
- Check the related prevalence values to confirm whether those high-risk indicators provide cause for concern. An indicator with relatively low prevalence could still show up as being of higher-than-average risk for your county relative to other counties with even lower risk.

Example interpretation of FICTITIOUS PROFILE—high-risk indicators include

- Any opioid-related overdose deaths per 10,000 persons
- Fentanyl-related overdose deaths per 10,000 persons
- Heroin-related overdose deaths per 10,000 persons
- Fentanyl-related overdose deaths per 10,000 persons age 25 to 64

2. Where does your county show more protection?

- All bars to the left of the center line represent indicators with lower-than-average risk and may show you protective factors for your county.
- Bars that are more than two standard deviations below the average represent indicators with especially low risk (or high protection).

Example interpretation of FICTITIOUS PROFILE—low-risk (or high-protection) indicators include

- Lifetime prescription drug use among middle school school (MS) students
- Heroin reports per 10,000 persons
- Past-30 Day heroin use

Charts and graphs are effective tools that can capture the attention of all types of audiences. The following free resources provide guidance on how to create figures for your own presentations and reporting purposes:

- Chart Chooser
- The Dataviz Design Process: 7 Steps for Beginners
- Chartable: What to Consider When Creating Tables

3. Where do you see trends for success and any trends of concern?

- Bars with polka dot pattern show that the indicator moved in a favorable (good) direction during the specified trend years.

- Bars with crosshatch pattern show that the indicator moved in an unfavorable (bad) direction during the specified trend years.

Example interpretation of FICTITIOUS PROFILE—notable trends include these:

SUCCESS

- The number of heroin reports per 10,000 persons is moving in a favorable direction (i.e., the number is decreasing—law enforcement is finding less heroin in your county).

CONCERN

- The number of any opioid-related overdose deaths per 10,000 persons is moving in an unfavorable direction (i.e. the number is increasing—there are more opioid-related overdose deaths in your county).
- The number of fentanyl-related overdose deaths per 10,000 persons is moving in an unfavorable direction (i.e. the number is increasing—there are more fentanyl-related overdose deaths in your county).
- The number of fentanyl-related overdose deaths per 10,000 persons age 25 to 64 is moving in an unfavorable direction (i.e. the number is increasing—there are more fentanyl-related overdose deaths among persons age 25 to 64 in your county).

4. Who is your audience and what platforms will you use for presentation?

- Consider the individuals and audience with whom you are sharing this county-level risk and trends information. Consider potential partners you may engage to address specific issues identified by the county profile.
- What information will your audience need so that they can take action based on the information you share with them?
  a. Consequence indicators may capture the attention of all types of audiences and engage them in the discussion. Consumption indicators help provide an overview of the extent of the problem in the county.
  b. If you are having a town hall with a group of parents, you may want to focus on the family management and conflict indicators and show the percentages of perceived parental disapproval of substance use indicators for your county.
  c. If you are having a town hall with policy makers, you may want to focus on indicators representing the availability of opioids, as these indicators are more directly related to laws. Policy makers may also be interested in individual risk factors, as these indicators may be more actionable.

Example interpretation of FICTITIOUS PROFILE:

- In Fictitious County, the number of fentanyl-related overdose deaths per 10,000 persons was almost two standard deviations greater than the average percentage of all Georgia counties. This indicator demonstrates a very high risk in the county, and key stakeholders such as law enforcement and healthcare providers should be alerted.

Opioid Prevention Needs Assessment Profile for
Fictitious County

This profile presents standardized risk scores for each opioid indicator so you can compare your county's risk to the average for all Georgia counties (represented by the center line, standardized to 0) and compare risk across indicators for your county (indicators with larger bars to the right of the line represent higher risk). • The county rank compares your county to all counties on each opioid indicator—the higher the value, the higher the risk (i.e., a rank of 159 indicates the county with the *highest risk*). • The full *2025 Georgia Social Indicator Study— Opioids* report includes actual values for each opioid indicator for your county for each year and more detailed guidance on how to interpret this profile.

Risk Indicators — Average Across Counties

← *Lower Risk Score* | *Higher Risk Score* →

Opioid Abuse [1; a]	-3 -2 -1 0 1 2 3	County Rank
Past-30-Day Prescription Drug Use [2]—MS, %	-0.08	80
Past-30-Day Heroin Use—MS, %	-0.34	71
Lifetime Prescription Drug Use—MS, %	-0.36	89
Past-30-Day Prescription Drug Use [2]—HS, %	-0.25	18
Past-30-Day Heroin Use—HS, %	-0.33	62
Lifetime Prescription Drug Use—HS, %	-0.28	53
Availability of Opioids		
Heroin Reports per 10,000 Persons [3; b]	-0.35	12
Fentanyl Reports per 10,000 Persons [3; b]	0.75	135
Opioid Reports per 10,000 Persons [3; b]	0.22	126
Consequences of Opioid Use		
Opioid-Related Hospitalizations and Emergency Room Visits per 10,000 Persons, Any Age [4, 5; c]	1.28	100
Per 10,000 Persons Age 0 to 19	0.05	86
Per 10,000 Persons Age 20 to 24	1.06	126
Per 10,000 Persons Age 25 to 64	1.00	127
Per 10,000 Persons Age 65+	0.66	106
Any Opioid-Related Overdose Deaths per 10,000 Persons, Any Age [4, 5; c]	1.80	150
Per 10,000 Persons Age 0 to 19	1.04	118
Per 10,000 Persons Age 20 to 24	-0.03	15
Per 10,000 Persons Age 25 to 64	1.59	131
Per 10,000 Persons Age 65+	0.32	90
Heroin-Related Overdose Deaths per 10,000 Persons, Any Age [4, 5; c]	1.73	147
Fentanyl-Related Overdose Deaths per 10,000 Persons, Any Age [4, 5; c]	1.83	152
Per 10,000 Persons Age 0 to 19	1.04	100
Per 10,000 Persons Age 20 to 24	-0.03	64
Per 10,000 Persons Age 25 to 64	1.59	122
Per 10,000 Persons Age 65+	0.58	89
Percentage of Patients Receiving Naloxone Relative to National Average [6; d]	0.58	99
Infants Born With Neonatal Abstinence Syndrome (NAS) per 1,000 Live Births [7; e]	0.49	102

Opioid Indicator County Rank: 80 out of 159

County Population Characteristics [f]

2023 Total Population: 36,243
Population Rank: 54 out of 159

2023 Population Age 17 and Younger: 8,951
Population Rank: 108 out of 159

2023 Racial/Ethnic Composition:

White	65.5%	Black	30.4%
Asian	1.2%	Other+	0.7%
Two or more races			2.3%
Hispanic/Latino			5.2%

+Includes American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, and Other race.

Overall County Rank: 79 out of 159

White bars represent level of risk. The patterns below show significant trends—that is, whether the indicator value changed significantly between the first and last year specified in the data source.

(OR †) = Favorable trend
(OR ‡) = Unfavorable trend

(The † or ‡ symbol is used to denote a favorable or unfavorable trend, respectively, when the bar is too short to display a pattern, and the § symbol to denote insufficient data to test for trends. Trend tests could be conducted only for indicators with at least 3 years of data.)

Notes *(See Volume I, Table 1, for full definition of each indicator)*

GSHS = Georgia Student Health Survey; HS = high school; MS = middle school; n/a = not applicable.

1. County assignment based on school location.
2. Includes prescription drug painkillers, tranquilizers or sedatives, stimulants, and other prescription drugs.
3. Reports that were submitted to and analyzed by the GBI.
4. When age-specific categories were available, the indicator for Persons Any Age was excluded from the overall county risk score calculation.
5. County assignment based on patient/subject residence.
6. Data reported for previous 12 months from date of access. County percentage is compared to national average of 37.1% and classified into five categories.
7. Data pooled for years 2017–2021. Rates are not calculated for counties with counts less than or equal to 5.

Data Sources

a. Georgia Student Health Survey (GSHS), 2024 (trend years 2022–2024)
b. Georgia Bureau of Investigation, Division of Forensic Sciences, 2024 (trend years 2019–2024)
c. Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS), 2023 (trend years 2019–2023)
d. National EMS Information System (NEMSIS), April 2024–April 2025 (no trend analysis)
e. Georgia Department of Public Health, 2017–2021 (no trend analysis)
f. American Community Survey (ACS), 2019–2023 (trend years 2015–2019 through 2019–2023)