2021 Overdose Prevention and Response Survey Report

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2021 Overdose Prevention and Response Survey Report

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Introduction

Increasing fatal and non-fatal overdoses, particularly those related to opioids, dominated headlines related to public health as drug induced fatalities have totaled over 932,000 since 1999. Public focus on this tragedy has understandably lessened somewhat during the ongoing COVID-19 pandemic, but deaths from the overdose epidemic have accelerated in the intervening two years. In November 2021, the National Center for Health Statistics reported that, over the 12-month period ending in April, over 100,000 people died after overdosing–an almost 30% increase over the previous year. This grim milestone underscores the urgency with which we must act–not least by better supporting those providing overdose prevention and response (OPR) services on the ground. Often, much of this day-to-day work is accomplished by local health departments (LHDs) that play an integral role in planning, coordinating, and implementing services in response to the epidemic.

Background

As the frontline of the public health response to this crisis, LHDs are not only the boots on the ground, but also are uniquely positioned to collect data and identify future national trends. Well before official data was published, LHDs working with NACCHO since the onset of the pandemic reported increases in overdoses that dwarf those of years' past.

Despite this crucial role, there information about how LHDs are conducting OPR activities is still lacking. After first addressing this gap in the 2018 Forces of Change survey, NACCHO conducted a targeted survey of LHD OPR activities in 2019 and developed a corresponding report detailing findings. The goal of the initial

survey was to create a foundational understanding of the LHD OPR ecosystem to inform priorities at the local, state, and national levels. While this effort was largely successful, interpretation of the data was limited by its representativeness. This, along with changes to the circumstances of the epidemic, led NACCHO to redesign and disseminate a new OPR Survey to further this goal.

Methods

Study population

There are approximately 2,800 agencies or units that meet the definition of an LHD, for purposes of surveying. Some states have a public health system structure that includes both regional and local offices of the state health agency. In those states, the state health agency chooses to respond to the survey at either the regional or local level, but not at both levels.

NACCHO used a database of LHDs to identify LHDs for inclusion in the study population. For the 2021 OPR survey, a total of 2,457 LHDs were included in the study population. Rhode Island was excluded from the study because the state has no sub-state public health units.

Sampling

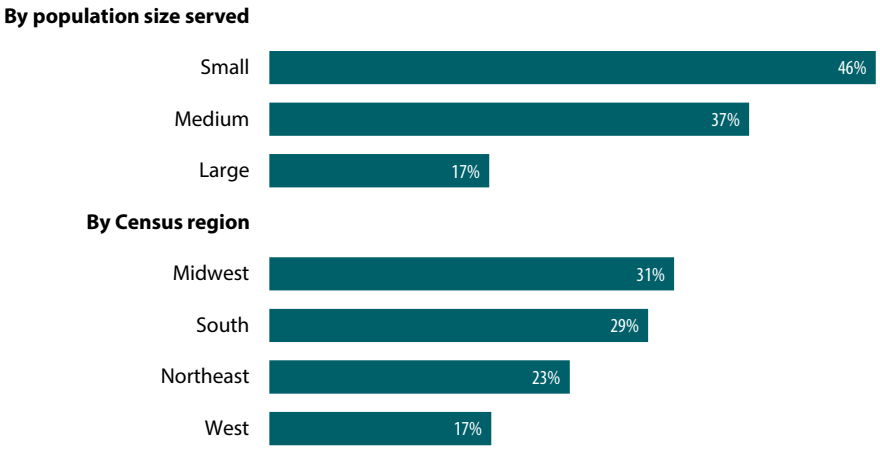
NACCHO administered the web-based survey from March to May 2021 to a stratified random sample of 766 LHDs, with strata defined by the size of population served and United States census regions. A total of 196 LHDs completed the survey for a response rate of 26%.

Analysis

Nationally representative estimates were computed using survey weights to be representative of various jurisdiction sizes and geography (U.S. Census region) in the U.S., such that LHDs within a region and jurisdiction size were weighted proportionally to their distribution nationwide. Some detail may be lost in the figures due to rounding.

Figure 1. Respondents by LHD characteristics

Percent of LHDs *(n=196)*



Throughout this report, statistics are compared across three categories of jurisdiction size (i.e., population size served). Small LHDs serve populations of less than 50,000 people. Medium LHDs serve populations of 50,000 to 499,999 people. Large LHDs serve populations of 500,000 people or more.

Statistics are also compared across U.S. Census regions. All LHDs in each state are classified as being in the North, South, Midwest, or West, per the U.S. Census Bureau.

Limitations

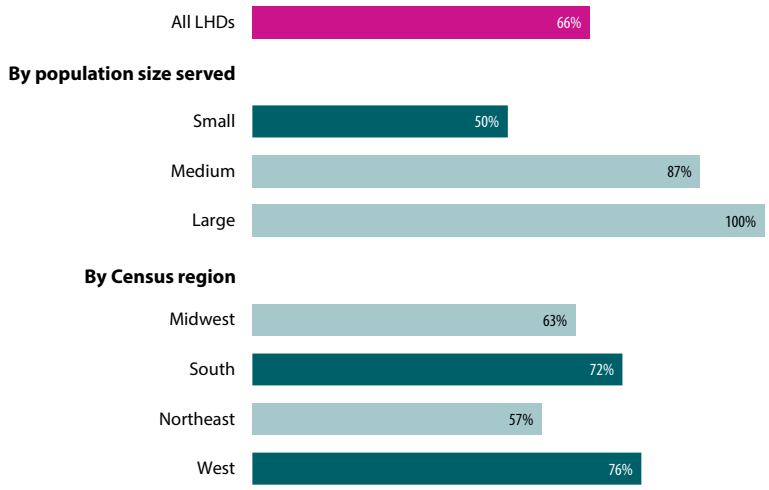
All data were self-reported by LHD staff and are not independently verified. LHDs may have provided incomplete, imperfect, or inconsistent information for various reasons. In addition, non-response bias could impact the results presented in this report, and any comparisons presented are not tested for statistical significance.

Local Overdose Prevention and Response Data

A majority of LHDs reported being engaged in work to prevent and respond to unintentional drug overdoses.[1] Not conducting OPR activities was more common in smaller jurisdictions, as only half LHDs from these communities reported engaging in this work. Responses across regions also showed some variability, with LHDs in the West and South most likely to conduct these activities.

Figure 2. LHDs engaged in overdose prevention and response work

Percent of LHDs *(n=191)*



As LHDs serve as hubs for their community's public health response, conducting both their own activities as well as facilitating, coordinating, and augmenting those of partners, it is concerning that so many reported not being not engaged in any OPR work. This problem is exacerbated by geography, with LHDs serving smaller communities much less likely to be engaged in this work. While several barriers to local OPR work are identified throughout this report, it is crucial that NACCHO and its partners engage with LHDs experiencing other effects of under-resourcing to better understand and address these barriers.

[1] Statistics in this report were normalized to provide nationwide estimates for all LHDs, rather than just those who responded that they engaged in OPR work.

As part of the survey, LHDs were asked about the following topic areas covered throughout the remainder of this report.

- Barriers
- Workforce
- Funding
- Overdose Prevention and Response Activities
- Impact of COVID-19
- Partnerships
- Data Collection
- Overdose Trends
- Evaluation

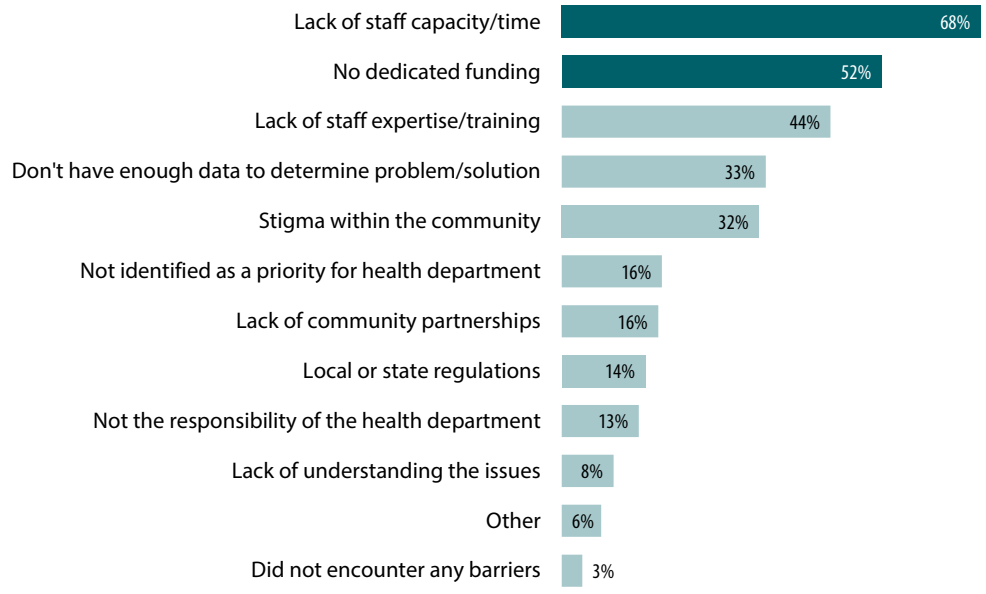
Barriers

While LHD staff have worked tirelessly to stem a swift increase of overdose fatalities, they continue to face several barriers to their work—some of which are discussed at greater length throughout the report.

LHDs most commonly reported limited workforce and financial capacity as barriers they face. In addition, lack of staff expertise and training, lack of data, and stigma related to drug use in the community are other common barriers faced by LHDs. While the first two are directly related to a lack of resources, stigma within the community is a widely reported issue that pervades all levels of a community's response to the overdose epidemic and results in worse outcomes for people who use drugs. Resources related to stigma can be found **here**. NACCHO has also compiled resources related to stigma in the toolkit linked at the end of the document.

Figure 3. Barriers preventing LHD from conducting OPR activities

Percent of LHDs *(n=186)*



Workforce

3

The average number of full-time equivalents engaged in LHD OPR work

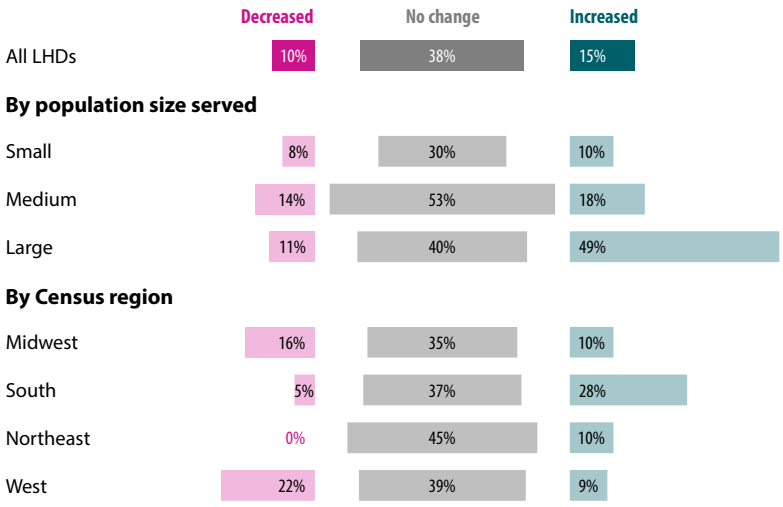
"All staff [have] been actively engaged in the COVID-19 response. The Drug Prevention Coordinator will…start resuming many of her normal duties… in May 2021."

As the most common barrier to engaging in work to prevent and respond to unintentional drug overdoses, it is not surprising that LHDs reported a wide variability in the overall workforce capacity to provide needed services to their community. In 2021, the median number of full-time equivalents (FTEs) engaged in OPR work among LHDs was 0.5, with small LHDs having none, medium LHDs having one, and large LHDs having four **(Appendix A). In general, smaller communities are more likely to be served by LHDs not engaged in OPR work and do not have the workforce capacity to begin engaging.** While services in these communities may be offered by other organizations, LHDs are key hubs of public health knowledge and resources, ensuring all those who need services have reasonable means of access to it.

LHDs were also asked how their OPR staffing changed compared to the previous year. Most commonly, they reported maintaining workforce levels, a positive outcome given the extreme staffing pressure placed on LHDs by the COVID-19 pandemic. However, as expected, responses varied based on population size and Census region. Large LHDs were slightly more likely to have increased their OPR workforce as they were to have

Figure 4. Changes in LHD staffing in 2021 compared to 2020

Percent of LHDs; N/A not displayed *(n=196)*



maintained it. LHDs in the West and Midwest reported decreased workforces more often than those in the South and Northeast. Interestingly, not a single LHD in the Northeast region reported a staffing reduction.

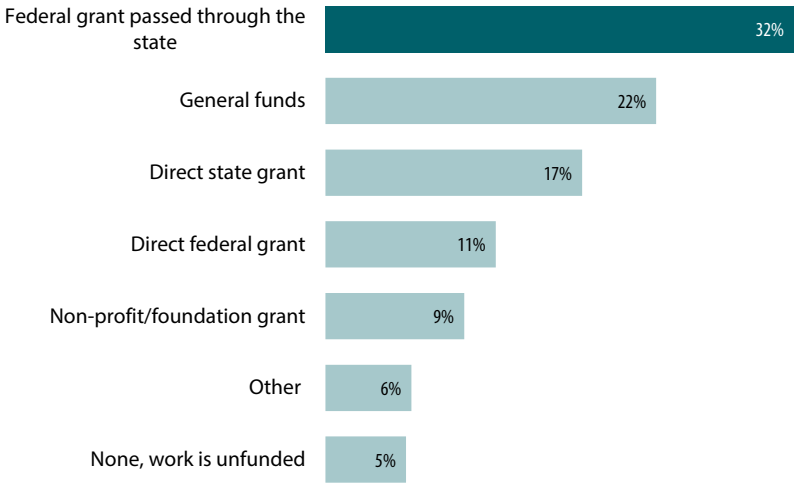
LHDs that indicated that staffing had decreased were asked what contributed to this reduction. The most common reason was COVID-19 response, with all but one indicating this was, at least in part, responsible. Half of LHDs also indicated staff turnover—unrelated to budgetary changes—contributed to staffing reductions.

Funding

Funding for LHDs can vary widely for a variety of reasons, including the size of the population served, local government priorities, and the availability of grant funding. **The most common source of funding for LHD OPR work was federal grant funding passed through the state. While this funding is vital, pass-through funding presents several issues for LHDs.** Pass-through funds are earmarked and come with a host of programmatic and reporting requirements. While these are in many cases understandable, it can leave LHDs without the flexibility needed to respond to their communities needs in the most efficient manner possible while also stretching the capacity of their limited staff by increasing reporting requirements. Additionally, as these pass-through funds may have originally been from a federal source before being allocated to the states, there may be another set of programmatic and reporting requirements for LHDs to fulfill before receiving the funds. For a more comprehensive view on how LHDs receive their funding, please visit NACCHO's Public Health Finance resource page.

Figure 5. Source of OPR funding

Percent of LHDs *(n=194)*



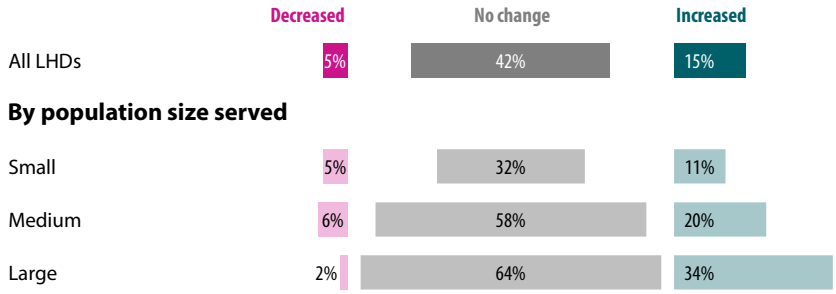
This figure does not display the proportion of LHDs where this question was not applicable (37%) because they do not or are unsure whether they conduct OPR activities.

[2] Median is less sensitive to outliers than mean and can provide a clearer picture of the true center of the data.

Overall, only 5% of LHDs reported a decrease in OPR-related funding compared to the previous year. While any decrease during a period of rising overdose deaths is unfortunate, substantially more LHDs reported that they increased or maintained level funding. However, there was some variation in responses from the different sized LHDs. In particular, large LHDs were more likely to have increased funding than LHDs of other sizes.

Figure 6. Changes in LHD funding in 2021 compared to 2020

Percent of LHDs; N/A not displayed *(n=194)*



Most commonly, LHDs attributed funding decreases to the COVID-19 pandemic, as resources were diverted to respond to the acute and ongoing threat of the virus. In addition, many LHDs with decreased funding also cited the end of grant funding as a factor.

Overdose Prevention and Response Activities

OPR activities conducted by LHDs and their community partners are wide-ranging. LHDs are the hubs for services, resources, information, and education provided to people who use drugs and the community at large. Expanding the scope of and access to OPR services is vital to the effort to reduce the harm of overdoses.

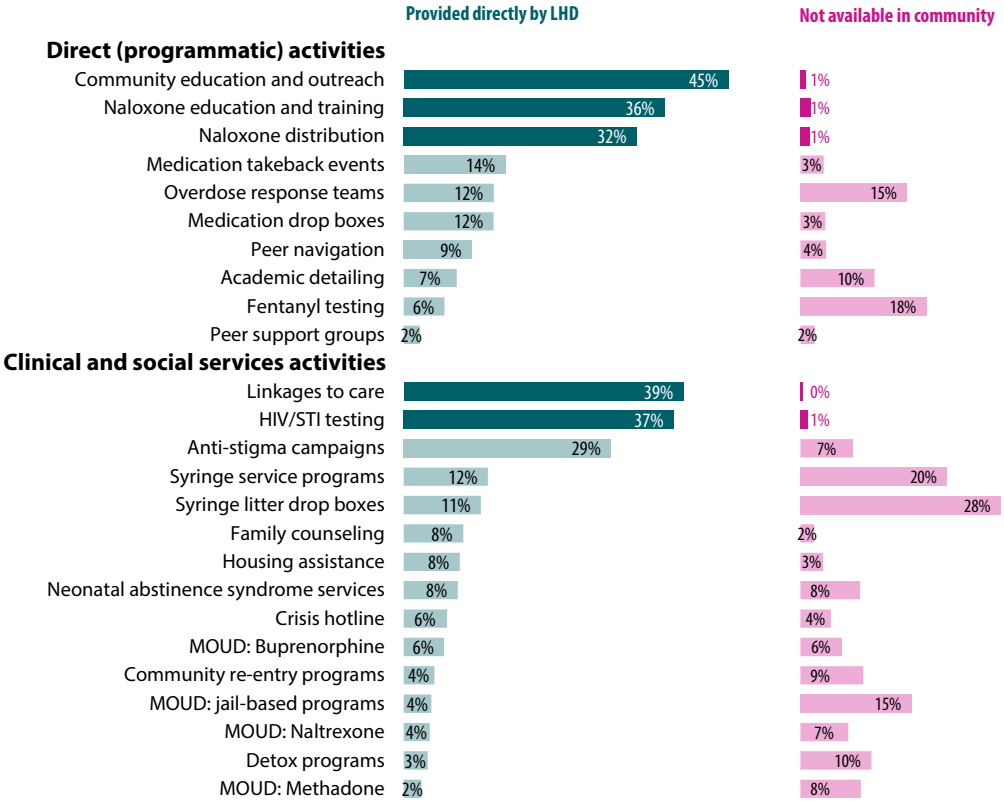
Respondents were asked to identify services available in their jurisdiction and, if available, which entity provides them (**Appendix B**). LHDs most commonly provided the following direct services: community education and outreach, linkages to care, HIV/STI testing, and naloxone education/training or distribution. These are also the most available OPR-related services, regardless of provider. The least common services (regardless of provider) included: quick response teams (QRTs), jail-based MOUD, fentanyl testing, syringe service programs, and public syringe disposal.

All the OPR-related services assessed, except for public syringe disposal, fentanyl testing, and academic detailing, were reportedly available in more than 30% of the surveyed jurisdictions. Many of these services are also offered by local partners, providing multiple points of access for the community. Compared to the 2019 report, LHDs are also increasingly likely to offer clinical services, such as MOUD or HIV/STI testing, fulfilling a critical role as these life-saving medical services can be underutilized when confined to more traditional clinical settings.

Some activities related to harm reduction, such as drug checking or the provision of clean needles, is limited in some jurisdictions by state or local policy and cannot be conducted regardless of LHD capacity to perform the work.

Figure 7. Services provided by LHDs during the past year

Percent of LHDs *(n=189–193)*



1 in 5

LHDs report that their community does not have an SSP.

"[We] partnered to bring in a mobile unit that will provide SSP and HIV/STD/HCV screening and care to high-risk communities. In addition, [we are] formalizing relationships with local SSP providers to ensure that this need is met independently by those in the community already doing the work."

These data also reveal several gaps in LHD staff's own knowledge of the services available in their community. More than one in seven LHDs did not know whether some services were provided, including academic detailing, neonatal abstinence syndrome services, fentanyl testing, peer navigation, and jail-based MOUD. These data highlight where information sharing is needed between LHDs and relevant partners, such as healthcare providers or the justice system. As many of these services are essential elements of comprehensive OPR efforts, it is crucial that we understand this disconnect and work to bridge the gap.

The COVID-19 pandemic and the necessity of an intensive public health mobilization and response significantly impacted the capacity of LHDs to continue other services in the same manner as they had pre-pandemic. Safety considerations were necessary, staff were deployed to testing/vaccine clinics or became contract tracers, and funding was rerouted to support these services. This, combined with overlapping national, state, and local regulations on activities that were in place to mitigate the spread of the virus, caused several unforeseen effects on the regular activities of LHDs. OPR work was no exception. At least two-thirds of LHDs offering OPR services reported some degree of impact on those services. The most impacted services were those that required face-to-face communication, including family counseling, community education and outreach, and medication takeback events—with at least 90% of LHDs reporting disruptions to their provision of each of these services (**Appendices C.1 and C.2**).

1 in 6

LHDs modified naloxone distribution for safety during the pandemic.

"[We] developed a curbside delivery of naloxone during the pandemic through a texting system. This took the place of our community outreach. Have delivered over 400 naloxone kits since COVID-19 started."

Fortunately, LHDs were very good at avoiding the total cessation of services. In most cases, service provision was modified for safety. This could take the form of modifying hours, moving activities outdoors, providing PPE, or transitioning to the virtual or no-contact provision of services. A few services—including HIV/STI testing, anti-stigma campaigns, public syringe disposal, and medication drop boxes—were more likely to be limited than modified or terminated. While we cannot dismiss that the almost overnight shift in the manner in which services were provided caused severe disruption to the OPR landscape, LHDs rose to the occasion and continued to provide vital services to their community despite the circumstances.

Local health departments were very good at avoiding the total cessation of services. In most cases, service provision was modified for safety.

Partnerships

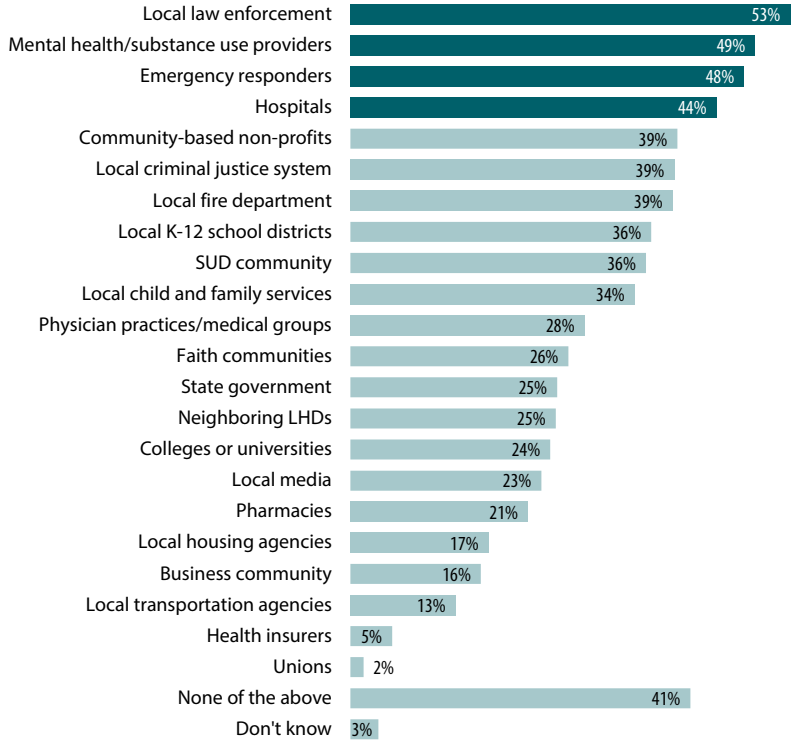
As noted in the section on OPR services, partnerships are a vital piece of the overall community response to the overdose epidemic. LHDs engage in many, often overlapping partnerships with first responders, health care systems, and many others to deliver services.

As the community hub for public health work, LHDs work with a wide variety of organizations to coordinate a comprehensive response to the overdose epidemic. **As these organizations are some of the most likely to interact with people who use drugs, cultivating fruitful partnership with them is critical to developing a comprehensive ecosystem of support for community prevention and response activities.**

Although 36% of LHDs currently partner with the SUD community, most of these agencies work with the recovery community while fewer engage families and friends of people who use drugs or the active use community. Collaboration between other departments of local government and among peer LHDs is also inconsistent. While 39% of LHDs partner with the local criminal justice system, fewer than 20% work with local housing and transportation agencies.

Figure 8. Partner organizations for conducting OPR activities

Percent of LHDs *(n=191)*



4 in 10

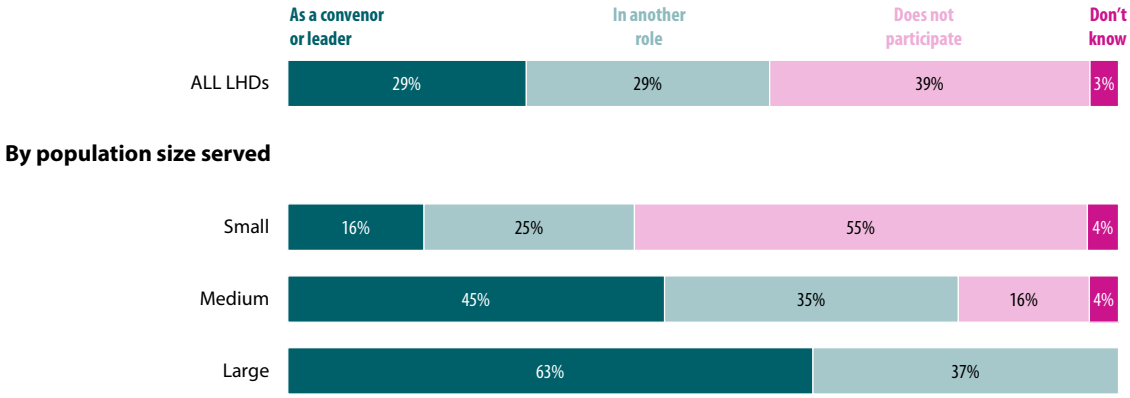
LHDs reported partnering with law enforcement, EMS, mental health, or hospitals.

"We invited ten hospitals treating the most number of opioid overdoses to participate in a learning collaborative to implement naloxone dispensing upon discharge from the Emergency Department."

One way that local organizations in OPR work towards a shared goal is by forming wider coalitions to share information and plan and coordinate a united response. **As the central locus for local public health, LHDs are often key leaders and conveners of wider partnership groups.**

Nearly three in five LHDs reported participating in an OPR-related coalition, either as conveners/leaders or in another role. Small LHDs were substantially less likely participate in any coalitions, compared to medium and large LHDs.

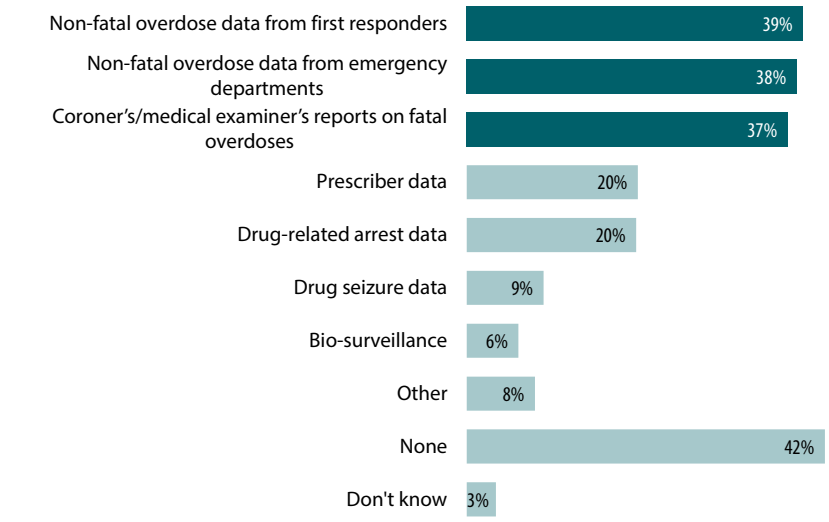
Figure 9. Participation in a community coalition formed to address the opioid overdose epidemic
Percent of LHDs *(n=188)*



Data Collection

Robust data access is an important tool in understanding the scope of the overdose epidemic, identifying new trends, and having accurate and sufficient information to drive decisions. Respondents were asked whether they collect or have access to data on a variety of opioid use and overdose-related indicators.

Figure 10. Data collected or accessible by LHDs related to overdose prevention and response
Percent of LHDs *(n=189)*



As might be expected, chief among these sources are non-fatal overdose reports from EMS and emergency departments, along with death reports from medical examiners/ coroners. However, small LHDs were much more likely to have limited or no access to data. Even the most common OPR-related data (i.e., non-fatal overdose data) is used by just over 25% of small LHDs. **More than two in five LHDs do not collect or access OPR-related data. However, most of these LHDs also do not conduct OPR work. Of LHDs that engage in OPR work, approximately 10% do not have access to data to inform their work.**

4 in 10

LHDs access EMS, ER, and Coroner/ME data related to fatal and non-fatal overdoses.

"We send out near real-time drug overdose alerts to our first responders and community partners. We are also working on sharing data reports and creating dashboards so the information is more readily available."

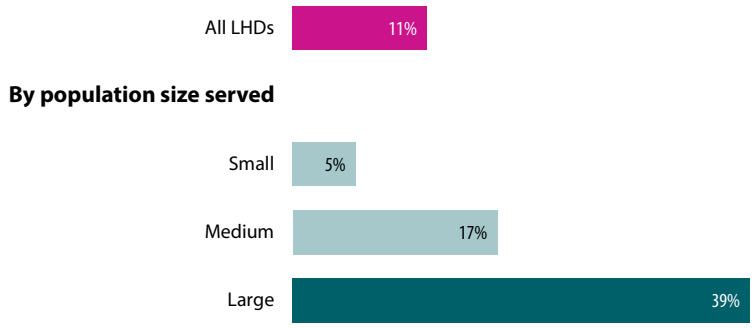
One particularly important data capability is syndromic surveillance—data collected by emergency departments and other clinical settings and usually reported within 24 hours of the initial patient encounter. These real-time data allow LHDs to inform their partners and people who use drugs about overdose spikes, which can be triggered by a number of factors, including changes in the drug supply, social stressors, or changes in access to prescription medication or MOUD. Nationally, 24% of LHDs have syndromic surveillance capabilities, but this appears to be driven by large jurisdictions, with 75% of large LHDs reporting this capability compared only 35% of medium and 13% of small LHDs. Of those with syndromic surveillance capabilities, 35% published overdose spike alerts or other warnings using these data.

Evaluation

Evaluation allows LHDs to monitor, improve, and determine the impact of a public health program. It also contributes the evidence base for effective programming and identifies lessons learned for improving future initiatives. However, just over 10% of LHDs had conducted a formal evaluation to assess their OPR activities. Evaluation is a time- and knowledge-intensive activity, so it is perhaps unsurprising that so many LHDs have not conducted formal evaluations. Funding for evaluation can also eat away at thinly stretched budgets badly needed for the continued provision of programs and services. As is a theme, LHDs serving large jurisdictions seem to be more likely to have the resources to conduct evaluation than medium or small LHDs.

Figure 11. Conducted formal evaluation to assess overdose prevention and response activities

Percent of LHDs *(n=191)*



While evaluation can seem daunting, many LHDs simply start by manually adding program data into spreadsheet software such as Google Sheet or Microsoft Excel. Even a simple evaluation process can be valuable to LHDs hoping to maintain, expand, or advocate for important programs and services. Planning for evaluation is also an important process that helps clarify program goals and metrics at the outset. **Given the importance of evaluation to the expansion and replication of OPR program and services, it is crucial that NACCHO and partners focus on building LHD capacity to conduct evaluation.**

Overdose and Drug Use Trends

Over the last two decades, drug overdoses increased steadily, averaging 7% annually. However, the National Center for Health Statistics recently reported that **over 100,000 American suffered a fatal overdose between May 1, 2020 and April 30, 2021**. Unfortunately, this national data confirms the warning cries NACCHO heard during day-to-day interactions with LHDs.

Furthermore, according to our OPR survey, 35% of LHDs reported an increase in overdoses in 2020 compared to 2019. Of those LHDs, half estimated an increase of more than 20% (**Appendix D**). While the reasons for this drastic increase are many and include social stress related to the pandemic and changes in the drug supply, what is clear is that we are talking about increases that resource strapped LHDs cannot be expected to deal with absent a significant expansion in support. Notably, 21% of LHDs did not know how the number of overdoses in their jurisdiction had changed, which could indicate they did not have access to recent enough data to reliably make an estimate.

3 in 10

LHDs reported an increase in overdoses in their jurisdictions from 2019 to 2020.

"In 2020, [we] saw the highest on-record spike for youth overdose fatalities. In partnership with probation agencies, [we] developed targeted educational responses to implement within high-risk youth settings. During the 2021 calendar year, zero youth overdose fatalities have been reported."

Next Steps

NACCHO also asked LHDs which opportunities or resources they would be most interested in receiving information on from NACCHO or partner organizations. Grant opportunities was the most selected resource, but LHDs were also interested in local case studies/examples, factsheets or issue briefs, Internet-based training, outreach/communications, technical assistance, and in-person training.

In addition to this report, NACCHO plans to explore other ways to share information gathered from the survey, such as factsheets, journal articles, and conference presentations.

NACCHO also plans to continue working with select LHDs to gather more information through key informant interviews with LHDs who submitted interesting qualitative responses about their OPR work. NACCHO also plans to conduct follow up with the 17% of respondents who reported no longer conducting opioid prevention and response activities to gather additional insight.

NACCHO Opioid Epidemic Toolkit

NACCHO has developed a free, online toolkit of opioid epidemic resources categorized as either local, state, or federal resources within five topic areas: monitoring and surveillance, prevention, harm reduction and response, linkage to care, and stakeholder engagement and community partnerships. Those resources are **available here**.

Appendices

Appendix A: Mean and median number of employees and Full-Time Equivalents (FTEs)

	Number of Employees		Number of FTEs	
	Mean	Median	Mean	Median
All LHDs	4	1	2.7	0.5
By population size served				
Small	3	0	2.2	0
Medium	5	2	2.3	1
Large	11	6	9.6	4

n(employees)=174

n(FTEs)=165

Appendix B: Services provided by LHD or other organizations during the past year

Percent of LHDs (n=189–193)

	Performed by LHD directly	Contracted out by LHD	Provided by others in the community independent of LHD funding	Not available in community	Don't know	Not applicable
Direct (programmatic) activities						
Community education and outreach	45%	10%	39%	1%	3%	37%
Naloxone education and training	36%	8%	42%	1%	2%	37%
Naloxone distribution	32%	7%	42%	1%	2%	37%
Medication takeback events	14%	4%	45%	3%	3%	37%
Overdose response teams	12%	6%	25%	15%	14%	37%
Medication drop boxes	12%	3%	46%	3%	2%	37%
Peer navigation	9%	9%	33%	4%	17%	37%
Academic detailing	7%	4%	23%	10%	23%	37%
Fentanyl testing	6%	3%	20%	18%	19%	37%
Peer support groups	2%	4%	54%	2%	5%	37%
Clinical and social services activities						
Linkages to care	39%	12%	39%	0%	4%	37%
HIV/STI testing	37%	7%	41%	1%	2%	37%
Anti-stigma campaigns	29%	6%	37%	7%	7%	37%
Syringe service programs	12%	5%	22%	20%	8%	38%
Syringe litter drop boxes	11%	4%	15%	28%	10%	37%
Family counseling	8%	4%	53%	2%	4%	37%
Housing assistance	8%	4%	47%	3%	7%	37%
Neonatal abstinence syndrome services	8%	1%	33%	8%	18%	38%
Crisis hotline	6%	3%	48%	4%	6%	37%
MOUD: Buprenorphine	6%	5%	46%	6%	9%	37%
Community re-entry programs	4%	3%	40%	9%	9%	37%
MOUD: jail-based programs	4%	2%	29%	15%	15%	38%
MOUD: Naltrexone	4%	3%	43%	7%	10%	38%
Detox programs	3%	3%	45%	10%	5%	38%
MOUD: Methadone	2%	4%	44%	8%	8%	38%

Appendix C.1: Services affected by the COVID-19 pandemic

Percent of LHDs, among those providing service directly or contracting it out during the past year (n=14–106)

	Service ended	Service was limited	Service provision was modified for safety	Service was not affected
Medication takeback events	25%	24%	41%	10%
Anti-stigma campaigns	10%	38%	31%	21%
Community education and outreach	10%	40%	43%	8%
Academic detailing	9%	31%	31%	29%
Peer support groups	8%	14%	43%	35%
Naloxone education and training	7%	29%	48%	16%
Peer navigation	6%	4%	66%	24%
Overdose response teams	5%	32%	50%	13%
Medication drop boxes	5%	27%	13%	54%
Naloxone distribution	3%	24%	48%	25%
MOUD: jail-based programs	2%	7%	44%	47%
HIV/STI testing	2%	50%	35%	14%
Linkages to care	1%	31%	52%	16%
Syringe service programs	0%	37%	51%	12%
Syringe litter drop boxes	0%	35%	14%	51%
Housing assistance	0%	33%	37%	30%
Fentanyl testing	0%	31%	64%	5%
Family counseling	0%	26%	65%	10%
MOUD: Buprenorphine	0%	25%	52%	23%
Neonatal abstinence syndrome services	0%	23%	50%	26%
Community re-entry programs	0%	20%	52%	28%
MOUD: Naltrexone	0%	13%	49%	38%
MOUD: Methadone	0%	11%	70%	20%
Crisis hotline	0%	8%	29%	62%
Detox programs	0%	5%	70%	24%

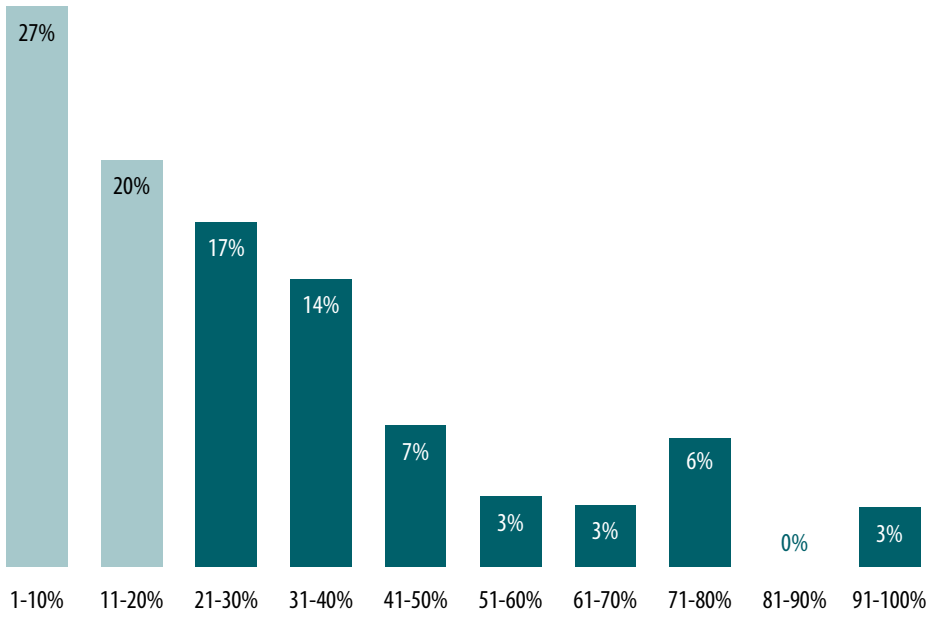
Appendix C. 2: Services affected by the COVID-19 pandemic

Percent of LHDs, excluding those reporting "don't know" (n=182–187)

	Service ended	Service was limited	Service provision was modified for safety	Service was not affected	Service was not provided by LHD prior to the pandemic
Community education and outreach	5%	20%	21%	4%	50%
Medication takeback events	4%	4%	7%	2%	82%
Naloxone education and training	3%	12%	20%	7%	59%
Anti-stigma campaigns	3%	12%	10%	7%	68%
HIV/STI testing	1%	20%	14%	6%	59%
Linkages to care	1%	13%	23%	7%	56%
Naloxone distribution	1%	8%	17%	9%	64%
Overdose response teams	1%	5%	8%	2%	84%
Medication drop boxes	1%	4%	2%	9%	84%
Academic detailing	1%	3%	3%	3%	89%
Peer navigation	1%	1%	11%	4%	83%
Syringe service programs	0%	6%	8%	2%	85%
Syringe litter drop boxes	0%	5%	2%	7%	87%
Family counseling	0%	3%	7%	1%	90%
Neonatal abstinence syndrome services	0%	3%	7%	1%	90%
Housing assistance	0%	3%	4%	3%	90%
Fentanyl testing	0%	2%	5%	0%	92%
MOUD: Buprenorphine	0%	2%	4%	2%	92%
Community re-entry programs	0%	1%	4%	2%	93%
MOUD: Methadone	0%	1%	4%	1%	95%
Detox programs	0%	0%	4%	1%	94%
MOUD: Naltrexone	0%	1%	3%	2%	94%
Crisis hotline	0%	1%	2%	5%	93%
Peer support groups	0%	1%	2%	2%	95%
MOUD: jail-based programs	0%	0%	2%	2%	95%

Appendix D. Approximate percentage increase in overdoses in 2020 compared to 2019

Percent of LHDs reporting increases in overdoses *(n=77)*



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