

UNINTENTIONAL OPIOID-INVOLVED OVERDOSE DEATHS, GEORGIA, 2017-2020

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OPIOID-INVOLVED OVERDOSE MORTALITY SURVEILLANCE, GEORGIA, 2017-2020

The purpose of this report is to describe unintentional opioid-involved overdose deaths in Georgia from 2017 to 2020, including those involving prescription opioids and/or illicit opioids. This report was created with data from the State Unintentional Drug Overdose Reporting System (SUDORS), which contains detailed investigation, autopsy, and toxicology information from Coroners/Medical Examiners. This report can be used to better understand the demographics and circumstances of unintentional opioid-involved overdose deaths in Georgia, to inform partners of overdose risk-factors and intervention points, and to guide overdose prevention efforts in Georgia.

Key Findings

- Opioid-involved overdose deaths had been decreasing from 2017 to 2019 but started to increase at the end of 2019 and increased at an alarming rate through 2020. Fentanyl has largely been driving the increase in drug overdose deaths since 2020.
- Both urban and rural areas are affected by the epidemic. Although counties with the highest populations have the highest counts of opioid-involved overdose deaths, high opioid-involved overdose deaths rates are distributed across the state.
- 91% of opioid-involved overdose deaths in Georgia involved more than one substance, and in several
 parts of the state, there was a notable increase from 2017 to 2020 in the median number of positive
 substances on postmortem toxicology screen, indicating a rise in polysubstance use in those areas. In
 2020, fentanyl caused the highest number of opioid-involved overdose deaths in most areas of the state,
 and while benzodiazepines were the most common substance category paired with opioids, stimulants,
 antihistamines, and gabapentin have all been increasingly paired with opioids.
- Although opioid-involved overdose deaths increased from 2017 to 2020, the number of opioid-involved overdose decedents with opioid prescriptions filled within 6 months of death decreased 33%, indicating that opioid-involved overdose deaths increasingly involved an illicit opioid or one obtained illicitly.
- Men and persons aged 35-44 years have the highest opioid-involved overdose deaths rates.
- Although White males and females have the highest rates of opioid-involved overdose deaths compared to other races, Hispanic males had the highest rate increase from 2017 to 2020, followed by Black males.
- From 2017 to 2020, any opioid-involved overdose deaths increased at a faster pace among Black (111%) and Hispanic (153%) decedents than among White (13%) decedents. Similarly, from 2017 to 2020, fentanyl-involved overdose deaths increased at a faster pace among Black (405%) and Hispanic (500%) decedents than among White (211%) decedents. These dramatic increases highlight the need for education and prevention efforts aimed specifically towards the Black and Hispanic populations.
- 20% of opioid-involved overdose decedents had a diagnosed mental health problem at the time of death. Mental health diagnosis is an important opportunity for healthcare professionals to assess and address co-occurring substance use disorder.
- 88% of opioid-involved overdose decedents had a known substance abuse problem. People with substance use disorders, as well as their friends and family, should always keep naloxone nearby and be prepared to use it to reverse an overdose and prevent a death.
- 67% of opioid-involved overdoses occurred at the decedent's home, and 57% had a potential bystander present at the time of death. It is important to never use drugs alone, to keep naloxone in the home, and for friends and family to be prepared to administer naloxone.
- From 2017 to 2020, naloxone administration in response to the fatal overdose increased 128%, which highlights some of the successes of Georgia's overdose prevention response in getting naloxone in the hands of EMS providers and individuals.

DATA DESCRIPTION

Data Source

The State Unintentional Drug Overdose Reporting System (SUDORS) collects detailed investigative and toxicological information from coroners/medical examiners (CME) about unintentional and undeterminedintent drug overdose deaths to better understand the changing nature of the opioid epidemic and inform key stakeholders. Unintentional drug overdose deaths were derived from the death certificates of Georgia and non-Georgia residents who died in Georgia. Drug overdose deaths are deaths where the death certificate (DC) AND/OR the CME report indicates that acute drug toxicity directly caused the death.

Case Definitions

Opioid-involved overdose death

Includes any case with an opioid listed in the cause of death. Involves both prescription opioid pain relievers (e.g., hydrocodone, oxycodone, and morphine), opioids used to treat addiction (e.g., methadone), as well as heroin and synthetic opioids (e.g., fentanyl that may be prescription or illicitly manufactured). Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for opioids are also included.

Rx opioid-involved overdose death

Includes any case with a prescription opioid listed in the cause of death, including morphine, codeine, oxycodone, oxymorphone, tramadol, buprenorphine, methadone, hydrocodone, hydromorphone, meperidine, tapentadol, noscapine, dihydrocodeine, prescription fentanyl, alfentanil, sufentanil, or other prescription opioid. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for Rx opioids are also included.

Heroin-involved overdose death

Includes any case with heroin and/or heroin metabolite listed in the cause of death. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for heroin and/or heroin metabolite are also included.

Fentanyl-involved overdose death

Includes any case with fentanyl and/or fentanyl metabolite listed in the cause of death. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for fentanyl and/or fentanyl metabolite are also included.

Cocaine-involved overdose death

Includes any case with cocaine and/or cocaine metabolite listed in the cause of death or positive on a tox screen. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for cocaine and/or cocaine metabolite are also included.

Methamphetamine-involved overdose death

Includes any case with methamphetamine listed in the cause of death or positive on a tox screen. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for methamphetamine are also included.

Benzodiazepine-involved overdose death

Includes any case with a benzodiazepine (e.g., alprazolam, clonazepam, diazepam, etc.) listed in the cause of death or positive on a tox screen. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for benzodiazepines are also included.

Antihistamine-involved overdose death

Includes any case with an antihistamine (e.g., diphenhydramine, hydroxyzine, promethazine, etc.) listed in the cause of death or positive on a tox screen. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for antihistamines are also included.

Gabapentin-involved overdose death

Includes any case with gabapentin listed in the cause of death or positive on a tox screen. Deaths with vague cause of death text (e.g., "mixed drug toxicity" or "polysubstance overdose") that have positive tox results for gabapentin are also included.

Other Definitions or Limitations

Data quality is dependent upon the level of detail in medical examiner and coroner reports and the reception of the reports from those entities.

Data is subject to change due to data quality improvements.

Data shown on this report may not depict the true burden of overdose deaths in Georgia.

Rate indicates the number of deaths among Georgia residents per 100,000 population using 2017, 2018, 2019, or 2020 Census data as the denominator.

Rates for categories with fewer than 5 deaths may not be accurate and are not displayed.

Underlying Cause of Death ICD-10 Code Description

Unintentional poisoning

X40 (accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics), X41 (accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified), X42 (accidental poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified), X43 (accidental poisoning by and exposure to other drugs acting on the autonomic nervous system), X44 (accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances)

Poisoning of undetermined intent

Y10 (poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent), Y11 (poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent) Y12 (poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified, undetermined intent), Y13 (poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent), Y14 (poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent)

UNINTENTIONAL OPIOID-INVOLVED OVERDOSE DEATHS BY DRUG TYPE, GEORGIA, 2017-2020



- Any opioid-involved overdose deaths increased significantly (55%) from 2019 to 2020, after decreasing from 2017 to 2019.
- Rx opioid-involved overdose deaths increased by 14% from 2019 to 2020, after decreasing from 2017 to 2019.
- Fentanyl-involved overdose deaths exhibited a steady upward trend from 2017 to 2020, with the most significant increase (141%) occurring from 2019 to 2020.
- Heroin-involved overdose deaths increased 36% from 2019 to 2020.



- Opioid-involved overdose deaths had been decreasing from 2017 to 2019 but started to increase at the end of 2019 and have been increasing at an alarming rate since.
- Fentanyl has largely been driving the increase in drug overdose deaths since 2020.

UNINTENTIONAL OPIOID-INVOLVED OVERDOSE DEATHS BY SELECTED DEMOGRAPHICS, GEORGIA, 2017-2020



- Opioid-involved overdose deaths rates decreased among all age categories from 2017 to 2019, except among persons aged 65+.
- From 2019 to 2020, all age categories experienced an increase in opioid-involved overdose death rates, with the most significant increase (72%) occurring among females aged 35-44.



Although White males and females have the highest rates of opioid-involved overdose deaths compared to
other races, Hispanic males had the highest rate increase from 2017 to 2020, followed by Black males.

| Opioid-Involved Overdose Deaths by Selected Demographics, Georgia, 2017-2020 | | | | | | | | | |
|--|------------------------|------|-------------|-------------|------------|------|--------------|---------|--|
| | 2017 | 2017 | 2018 | 2018 | 2019 | 2019 | 2020 | 2020 | |
| | N (%) | Rate | N (%) | Rate | N (%) | Rate | N (%) | Rate | |
| Total | 986 (100.0) | 70.7 | 846 (100.0) | 60.3 | 808 (100) | 57.1 | 1256 (100.0) | 88.2 | |
| Age Group | | | 2 (0 2) | | 2 (1) | | 1 (0 1) | | |
| <15 | - 04 (0 E) | - | 2 (0.2) | - | 3 (.4) | - | | - 70 | |
| 25-34 | 94 (9.5) 282 (28 7) | 10.5 | 222 (27 5) | 4.5 15.8 | 100 (7.4) | 4.1 | 336 (26.8) | 7.2 | |
| 25-34 | 234 (23.7) | 17.1 | 217 (25 7) | 15.8 | 213 (26.4) | 15.5 | 367 (29.2) | 26.3 | |
| 45-54 | 216 (21.9) | 15.2 | 160 (18 9) | 11.3 | 164 (20.3) | 117 | 219 (17 4) | 15.7 | |
| 55-64 | 139 (14.1) | 11.0 | 130 (15.4) | 10.1 | 131 (16.2) | 10.0 | 175 (13.9) | 13.2 | |
| 65+ | 20 (2.0) | 1.4 | 39 (4.6) | 2.7 | 38 (4.7) | 2.5 | 53 (4.2) | 3.4 | |
| Sex | . , | | | | | | | | |
| Male | 627 (63.6) | 12.4 | 533 (63.0) | 10.4 | 529 (65.5) | 10.3 | 827 (65.8) | 15.9 | |
| Female | 359 (36.4) | 6.7 | 313 (37.0) | 5.8 | 279 (34.5) | 5.1 | 429 (34.2) | 7.8 | |
| Race/Ethnicity | | | | | | | | | |
| White, non- Hispanic | 837 (84.9) | 15.2 | 693 (81.9) | 12.6 | 616 (76.2) | 11.2 | 945 (75.2) | 17.1 | |
| Black, non- Hispanic | 122 (12.4) | 3.7 | 123 (14.5) | 3.7 | 154 (19.1) | 4.6 | 257 (20.5) | 7.5 | |
| Other, non- Hispanic/Unknown | 12 (1.2) | 1.9 | 13 (1.5) | 1.9 | 8 (1.0) | 1.2 | 16 (1.3) | 2.2 | |
| Hispanic | 15 (1.5) | 1.5 | 17 (2.0) | 1.7 | 30 (3.7) | 2.9 | 38 (3.0) | 3.6 | |
| Highest Education Level ¹ | | | | | | | | | |
| Pre-k – 12 th grade (no diploma) | 155 (15.7) | 18.3 | 151 (17.8) | 17.8 | 129 (16.0) | 15.2 | 201 (16.0) | 23.7 | |
| High school graduate/GED | 410 (41.6) | 21.3 | 329 (38.9) | 17.1 | 360 (44.6) | 18.7 | 561 (44.7) | 29.1 | |
| Some college credit (no degree) | 164 (16.6) | 11.6 | 146 (17.3) | 10.4 | 118 (14.6) | 8.4 | 186 (14.8) | 13.2 | |
| College degree or higher | 147 (14.9) | 5.2 | 130 (15.4) | 4.6 | 121 (15.0) | 4.3 | 167 (13.3) | 5.9 | |
| Unknown ² | 16 (1.6) | - | 20 (2.4) | - | 16 (2.0) | - | 35 (2.8) | - | |
| Marital Status | | | | | | | | | |
| Married | 231 (23.4) | 6.2 | 151 (17.8) | 4.1 | 155 (19.2) | 4.2 | 238 (18.9) | 6.4 | |
| Never Married | 429 (42.5) | 14.7 | 412 (48.7) | 14.2 | 387 (47.9) | 13.2 | 646 (51.4) | 22.2 | |
| Widowed | 41 (.416) | 9.0 | 36 (4.2) | 7.9 | 31 (3.8) | 6.8 | 46 (3.7) | 10.1 | |
| Divorced or separated | 262 (26.6) | 19.3 | 230 (27.2) | 17.0 | 228 (28.2) | 16.8 | 307 (24.4) | 22.7 | |
| Unknown ² | 23 (2.3) | - | 17 (2.0) | - | 7 (0.9) | - | 19 (1.5) | - | |
| Military (current or former) | | | | | | | | | |
| Yes | 55 (5.6) | 8.8 | 48 (5.7) | 7.7 | 45 (5.6) | 7.2 | 70 (5.6) | 11.2 | |
| No | 910 (92.3) | 12.3 | 783 (92.6) | 10.6 | 752 (93.3) | 10.2 | 1172 (93.3) | 15.9 | |
| Unknown ² | 21 (2.1) | - | 15 (1.8) | - | 9 (1.1) | - | 14 (1.1) | - | |

¹ Highest Education Level is displayed only for decedents age 25 and over as population estimates are not available for those younger than 25. ² Rates for unknown responses to variables could not be calculated.

GEOGRAPHICAL DISTRIBUTION OF UNINTENTIONAL OPIOID-INVOLVED OVERDOSE DEATHS, GEORGIA, 2017-2020



Opioid-Involved Overdose Deaths by Decedent Injury

- In 2017, 14% of Georgia counties had more than 10 opioid overdoses, compared to 19% in 2020. ٠
- During 2017 to 2020, 76% of opioid-involved overdose decedents overdosed in their county of residence.
- Richmond, DeKalb, Gwinnett, Cobb, and Fulton Counties had the highest number of overdoses in 2020, with 47, 91, 94, 129, and 156, ٠ respectively.

³ Injury location indicates the location where the decedent's fatal overdose symptoms first occurred and may be different than the location of death.



Percent Change in Opioid-Involved Overdose Deaths by Decedent Injury Location³ (Public Health Districts), Georgia, 2017 to 2020

Opioid-Involved Overdose Death Rates by Decedent Residence Location, Georgia, 2020

- 1-1 Northwest, 7 West Central, 10 Northeast, 8-2 Southwest, and 3-3 Clayton Public Health Districts had the highest percent change in opioid-involved overdoses from 2017 to 2020, 49% (70 to 104 overdoses), 50% (16 to 24 overdoses), 56% (43 to 67 overdoses), 69% (13 to 22 overdoses), and 106% (17 to 35 overdoses), respectively.
- Bleckley, Madison, Clay, Talbot, and Baker Counties had the highest opioid-involved overdose deaths rates, with 30.9, 34.8, 34.9, 65.1, and 67.3 deaths per 100,000, respectively.

| Opioid-Involved Overdose Deaths by Decedent Injury Location ³ , Georgia, 2017-2020 | | | | | | | | |
|---|------------|-------------------|-----------|-------------------|----------|-------------------|------------|-------------------|
| County | 2017 | 2017 | 2018 | 2018 | 2019 | 2019 | 2020 | 2020 |
| of Injury | N (%) | Rate ⁴ | N (%) | Rate ⁴ | N (%) | Rate ⁴ | N (%) | Rate ⁴ |
| Total | 986 | 100% | 846 | 100% | 808 | 100% | 1256 | 100% |
| Appling | - | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Atkinson | 2 (0.2) | - | 1 (0.1) | - | 1 (0.1) | - | - | - |
| Bacon | - | - | - | - | 2 (0.2) | - | - | - |
| Baker | - | - | - | - | - | - | 2 (0.2) | - |
| Baldwin | 2 (0.2) | - | 1 (0.1) | - | _ | - | 2 (0.2) | - |
| Banks | 3 (0.3) | - | 1 (0.1) | - | 2 (0.2) | - | 2 (0.2) | - |
| Barrow | 3 (0.3) | - | 10 (1.2) | 12.37 | 10 (1.2) | 12.01 | 11 (0.9) | 12.85 |
| Bartow | 13 (1.3) | 12.37 | 15 (1.8) | 14.10 | 17 (2.1) | 15.78 | 19 (1.5) | 17.36 |
| Ben Hill | 1 (0.1) | - | - | - | 2 (0.2) | - | 2 (0.2) | - |
| Berrien | 1 (0.1) | - | 1 (0.1) | - | 2 (0.2) | - | 2 (0.2) | - |
| Bibb | 16 (1.6) | 10.47 | 12 (1.4) | 7.84 | 10 (1.2) | 6.53 | 15 (1.2) | 9.82 |
| Bleckley | - | - | - | - | - | - | 4 (0.3) | - |
| Brantley | 1 (0.1) | - | 3 (0.4) | - | - | - | 1 (0.1) | - |
| Brooks | - | - | - | - | 2 (0.2) | - | - | - |
| Bryan | 5 (0.5) | 13.49 | 5 (0.6) | 13.12 | 1 (0.1) | - | 4 (0.3) | - |
| Bulloch | 4 (0.4) | - | 2 (0.2) | - | - | - | 1 (0.1) | - |
| Burke | 3 (0.3) | - | - | - | 3 (0.4) | - | 1 (0.1) | - |
| Butts | 4 (0.4) | - | 5 (0.6) | 20.67 | 3 (0.4) | - | 2 (0.2) | - |
| Calhoun | - | - | - | - | - | - | - | - |
| Camden | 3 (0.3) | - | 5 (0.6) | 9.31 | 5 (0.6) | 9.15 | 7 (0.6) | 12.64 |
| Candler | - | - | 1 (0.1) | - | - | - | - | - |
| Carroll | 20 (2.0) | 16.98 | 9 (1.1) | 7.62 | 21 (2.6) | 17.50 | 29 (2.3) | 23.84 |
| Catoosa | 9 (0.9) | 13.52 | 2 (0.2) | - | 9 (1.1) | 13.32 | 13 (1.0) | 19.12 |
| Charlton | 1 (0.1) | - | 1 (0.1) | - | - | - | 1 (0.1) | - |
| Chatham | 27 (2.7) | 9.29 | 24 (2.8) | 8.30 | 21 (2.6) | 7.26 | 42 (3.3) | 14.51 |
| Chattahoochee | - | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Chattooga | 5 (0.5) | 20.19 | 1 (0.1) | - | 2 (0.2) | - | 6 (0.5) | 24.15 |
| Cherokee | 36 (3.7) | 14.5 | 32 (3.8) | 12.59 | 17 (2.1) | 6.57 | 35 (2.8) | 13.19 |
| Clarke | 12 (1.2) | 9.44 | 4 (0.5) | - | 15 (1.9) | 11.69 | 17 (1.4) | 13.30 |
| Clay | - | - | - | - | - | - | - | - |
| Clayton | 17 (1.7) | 5.96 | 14 (1.7) | 4.83 | 18 (2.2) | 6.16 | 35 (2.8) | 11.96 |
| Clinch | - | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Cobb | 125 (12.7) | 16.54 | 88 (10.4) | 11.62 | 66 (8.2) | 8.68 | 129 (10.3) | 16.91 |
| Coffee | 4 (0.4) | - | 5 (0.6) | 11.60 | 3 (0.4) | - | 1 (0.1) | - |
| Colquitt | 1 (0.1) | - | 2 (0.2) | - | 2 (0.2) | - | 7 (0.6) | 15.37 |
| Columbia | 11 (1.1) | 7.25 | 11 (1.3) | 7.13 | 11 (1.4) | 7.02 | 19 (1.5) | 11.85 |
| Cook | - | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Coweta | 13 (1.3) | 9.08 | 4 (0.5) | - | 7 (0.9) | 4.71 | 13 (1.0) | 8.62 |
| Crawford | 1 (0.1) | - | - | - | - | - | 1 (0.1) | - |
| Crisp | 3 (0.3) | - | - | - | - | - | 1 (0.1) | - |
| Dade | 4 (0.4) | - | 1 (0.1) | - | 4 (0.5) | - | 3 (0.2) | - |
| Dawson | 4 (0.4) | - | 4 (0.5) | - | 1 (0.1) | - | 2 (0.2) | - |
| Decatur | - | - | 1 (0.1) | - | 2 (0.2) | - | 1 (0.1) | - |

⁴ Rates calculated using county of injury may not depict the true burden of opioid-involved overdose death rates in Georgia because it does not capture overdoses which occurred in Georgia but where the decedent died out of state and overdoses that occurred among Georgia residents who died out of state.

| DeKalb | 68 (6.9) | 9.03 | 65 (7.7) | 8.59 | 70 (8.7) | 9.22 | 91 (7.2) | 11.94 |
|------------|------------|-------|------------|-------|------------|-------|------------|-------|
| Dodge | 3 (0.3) | - | 1 (0.1) | - | 1 (0.1) | - | 4 (0.3) | - |
| Dooly | - | - | - | - | - | - | 1 (0.1) | - |
| Dougherty | 6 (0.6) | 6.70 | 2 (0.2) | - | 8 (1.0) | 9.10 | 7 (0.6) | 8.09 |
| Douglas | 14 (1.4) | 9.73 | 15 (1.8) | 10.32 | 12 (1.5) | 8.20 | 19 (1.5) | 12.84 |
| Early | - | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Echols | 1 (0.1) | - | - | _ | - | - | - | - |
| Effingham | 4 (0,4) | - | 3 (0.4) | _ | 1 (0.1) | - | 3 (0.2) | - |
| Elbert | 2 (0.2) | - | 1 (0.1) | - | - | - | 2 (0.2) | - |
| Emanuel | 1 (0.1) | - | 2 (0.2) | - | - | - | 2 (0.2) | - |
| Evans | - | - | - | - | - | - | - | - |
| Fannin | 2 (0.2) | - | - | _ | 1 (0.1) | - | 4 (0.3) | - |
| Fayette | 8 (0.8) | 7.12 | 3 (0.4) | - | 16 (2.0) | 13.98 | 4 (0.3) | - |
| Floyd | 8 (0.8) | 8.20 | 10 (1.2) | 10.21 | 12 (1.5) | 12.18 | 13 (1.0) | 13.18 |
| Forsyth | 20 (2.0) | 8.77 | 9 (1.1) | 3.80 | 12 (1.5) | 4.91 | 17 (1.4) | 6.78 |
| Franklin | 3 (0.3) | - | 1 (0.1) | - | 4 (0.5) | - | 2 (0.2) | - |
| Fulton | 122 (12.4) | 11.71 | 127 (15.0) | 12.09 | 101 (12.5) | 9.49 | 156 (12.4) | 14.48 |
| Gilmer | 9 (0.9) | 29.34 | - | - | 4 (0.5) | _ | 4 (0.3) | _ |
| Glascock | - | _ | - | - | - | - | - | - |
| Glynn | 11 (1.1) | 12.90 | 7 (0.8) | 8.21 | 7 (0.9) | 8.21 | 7 (0.6) | 8.18 |
| Gordon | 6 (0.6) | 10.51 | 3 (0.4) | - | 2 (0.2) | - | 2 (0.2) | - |
| Grady | - | _ | - | - | 1 (0.1) | - | - | - |
| Greene | - | - | 3 (0.4) | - | 1 (0.1) | - | 1 (0.1) | - |
| Gwinnett | 67 (6.8) | 7.28 | 58 (6.9) | 6.25 | 51 (6.3) | 5.45 | 94 (7.5) | 9.97 |
| Habersham | 1 (0.1) | - | 3 (0.4) | - | 2 (0.2) | - | 3 (0.2) | - |
| Hall | 19 (1.9) | 9.53 | 19 (2.2) | 9.40 | 23 (2.8) | 11.25 | 29 (2.3) | 14.04 |
| Hancock | - | - | 1 (0.1) | - | 1 (0.1) | - | - | - |
| Haralson | 2 (0.2) | - | 5 (0.6) | 16.93 | 4 (0.5) | - | 11 (0.9) | 36.20 |
| Harris | 1 (0.1) | - | 1 (0.1) | - | 2 (0.2) | - | 1 (0.1) | - |
| Hart | - | - | 1 (0.1) | - | 3 (0.4) | - | 3 (0.2) | - |
| Heard | 1 (0.1) | - | 1 (0.1) | - | - | - | 1 (0.1) | - |
| Henry | 13 (1.3) | 5.76 | 23 (2.7) | 9.99 | 14 (1.7) | 5.97 | 17 (1.4) | 7.12 |
| Houston | 15 (1.5) | 9.77 | 6 (0.7) | 3.86 | 7 (0.9) | 4.43 | 15 (1.2) | 9.37 |
| Irwin | - | - | - | - | 2 (0.2) | - | - | - |
| Jackson | 9 (0.9) | 13.33 | 8 (0.9) | 11.36 | 8 (1.0) | 10.96 | 12 (1.0) | 15.75 |
| Jasper | 1 (0.1) | - | 2 (0.2) | - | - | - | 2 (0.2) | - |
| Jeff Davis | 2 (0.2) | - | - | - | 3 (0.4) | - | 1 (0.1) | - |
| Jefferson | 1 (0.1) | - | - | - | - | - | - | - |
| Jenkins | - | - | - | - | - | - | 1 (0.1) | - |
| Johnson | - | - | - | - | - | - | - | - |
| Jones | 3 (0.3) | - | 4 (0.5) | - | 2 (0.2) | - | 1 (0.1) | - |
| Lamar | 1 (0.1) | - | 1 (0.1) | - | - | - | - | - |
| Lanier | - | - | - | - | - | - | - | - |
| Laurens | 3 (0.3) | - | 3 (0.4) | - | 3 (0.4) | - | 4 (0.3) | - |
| Lee | - | - | 1 (0.1) | - | - | - | - | - |
| Liberty | 2 (0.2) | - | 2 (0.2) | - | 1 (0.1) | - | 4 (0.3) | - |
| Lincoln | 1 (0.1) | - | - | - | - | - | 1 (0.1) | - |
| Long | 2 (0.2) | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Lowndes | 6 (0.6) | 5.20 | 4 (0.5) | - | 4 (0.5) | - | 5 (0.4) | 4.23 |
| Lumpkin | 5 (0.5) | 15.21 | 3 (0.4) | - | 5 (0.6) | 14.88 | 3 (0.2) | - |
| Macon | - | - | - | - | 1 (0.1) | - | - | - |
| Madison | 3 (0.3) | - | 3 (0.4) | - | 6 (0.7) | 20.08 | 4 (0.3) | - |

| Marion | - | - | 2 (0.2) | - | - | - | - | - |
|------------|----------|-------|----------|-------|----------|-------|----------|-------|
| McDuffie | 2 (0.2) | - | 2 (0.2) | - | 3 (0.4) | - | 4 (0.3) | - |
| McIntosh | 1 (0.1) | - | - | - | 3 (0.4) | - | 2 (0.2) | - |
| Meriwether | - | - | 3 (0.4) | - | 1 (0.1) | - | 3 (0.2) | - |
| Miller | - | - | - | - | - | - | 1 (0.1) | - |
| Mitchell | 3 (0.3) | - | - | - | - | - | - | - |
| Monroe | 3 (0.3) | - | 2 (0.2) | _ | 1 (0.1) | - | 1 (0.1) | - |
| Montgomery | 1 (0.1) | - | - | _ | - | - | 1 (0.1) | - |
| Morgan | 1 (0.1) | - | 1 (0.1) | - | - | - | 2 (0.2) | - |
| Murray | 2 (0.2) | - | 2 (0.2) | - | 2 (0.2) | - | 2 (0.2) | - |
| Muscogee | 10 (1.0) | 5.15 | 11 (1.3) | 5.67 | 6 (0.7) | 3.06 | 15 (1.2) | 7.64 |
| Newton | 12 (1.2) | 11.10 | 5 (0.6) | 4.56 | 3 (0.4) | - | 13 (1.0) | 11.47 |
| Oconee | 3 (0.3) | - | 2 (0.2) | - | 4 (0.5) | - | 4 (0.3) | - |
| Oglethorpe | - | - | - | _ | 1 (0.1) | - | 1 (0.1) | - |
| Paulding | 13 (1.3) | 8.15 | 13 (1.5) | 7.92 | 11 (1.4) | 6.52 | 19 (1.5) | 10.96 |
| Peach | 1 (0.1) | - | 3 (0.4) | - | 1 (0.1) | - | 4 (0.3) | - |
| Pickens | 3 (0.3) | - | 5 (0.6) | 15.63 | 1 (0.1) | - | 2 (0.2) | - |
| Pierce | 1 (0.1) | - | - | _ | 2 (0.2) | - | 2 (0.2) | - |
| Pike | 1 (0.1) | - | 1 (0.1) | - | 1 (0.1) | - | - | - |
| Polk | 6 (0.6) | 14.26 | 1 (0.1) | - | - | - | 6 (0.5) | 14.01 |
| Pulaski | 2 (0.2) | - | - | - | - | - | - | - |
| Putnam | 2 (0.2) | - | 1 (0.1) | _ | 1 (0.1) | - | 2 (0.2) | - |
| Quitman | - | - | - | - | - | - | - | - |
| Rabun | 3 (0.3) | - | - | _ | 3 (0.4) | - | 4 (0.3) | - |
| Randolph | - | - | - | - | - | - | 1 (0.1) | - |
| Richmond | 31 (3.1) | 15.36 | 39 (4.6) | 19.35 | 32 (4.0) | 15.80 | 47 (3.7) | 23.26 |
| Rockdale | 5 (0.5) | 5.54 | 8 (0.9) | 8.83 | 4 (0.5) | - | 12 (1.0) | 13.20 |
| Schley | - | - | - | - | - | - | - | - |
| Screven | - | - | - | - | - | - | 1 (0.1) | - |
| Seminole | 2 (0.2) | - | 2 (0.2) | - | - | - | - | _ |
| Spalding | 3 (0.3) | - | 5 (0.6) | 7.56 | 2 (0.2) | - | 6 (0.5) | 8.90 |
| Stephens | 1 (0.1) | - | 2 (0.2) | - | 1 (0.1) | - | 1 (0.1) | - |
| Stewart | - | - | - | - | - | - | - | - |
| Sumter | 1 (0.1) | - | 2 (0.2) | - | 4 (0.5) | - | 1 (0.1) | - |
| Talbot | - | - | - | - | 1 (0.1) | - | 2 (0.2) | _ |
| Taliaferro | - | - | - | - | 1 (0.1) | - | - | - |
| Tattnall | 5 (0.5) | 19.74 | 1 (0.1) | - | - | - | - | - |
| Taylor | 1 (0.1) | - | - | - | - | - | 1 (0.1) | - |
| Telfair | 2 (0.2) | - | - | - | - | - | 1 (0.1) | - |
| Terrell | - | - | - | - | 1 (0.1) | - | 2 (0.2) | - |
| Thomas | 1 (0.1) | - | 2 (0.2) | - | - | - | - | - |
| Tift | 2 (0.2) | - | 2 (0.2) | - | 2 (0.2) | - | 3 (0.2) | - |
| Toombs | 2 (0.2) | - | 1 (0.1) | - | 1 (0.1) | - | - | - |
| Towns | 3 (0.3) | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Treutlen | - | - | - | - | - | - | - | - |
| Troup | 6 (0.6) | 8.60 | 5 (0.6) | 7.14 | 3 (0.4) | - | 7 (0.6) | 9.97 |
| Turner | 1 (0.1) | - | 1 (0.1) | - | - | - | - | _ |
| Twiggs | - | - | 1 (0.1) | - | - | - | - | - |
| Union | 3 (0.3) | - | - | - | 1 (0.1) | - | 1 (0.1) | - |
| Upson | 2 (0.2) | - | 4 (0.5) | - | - | - | 2 (0.2) | - |
| Walker | 4 (0.4) | - | 3 (0.4) | - | 6 (0.7) | 8.60 | 12 (1.0) | 17.11 |
| Walton | 10 (1.0) | 10.92 | 13 (1.5) | 13.90 | 12 (1.5) | 12.69 | 13 (1.0) | 13.42 |

| Ware | 3 (0.3) | - | 2 (0.2) | - | 5 (0.6) | 13.99 | 9 (0.7) | 25.12 |
|---------------------------|---------|-------|----------|---|---------|-------|----------|-------|
| Warren | 1 (0.1) | - | - | - | - | - | - | - |
| Washington | - | - | - | - | - | - | - | - |
| Wayne | 3 (0.3) | - | 2 (0.2) | - | 1 (0.1) | - | 6 (0.5) | 19.98 |
| Webster | - | - | - | - | - | - | - | - |
| Wheeler | - | - | - | - | - | - | - | - |
| White | 2 | - | 2 (0.2) | - | 2 (0.2) | - | 6 (0.5) | 19.30 |
| Whitfield | 12 | 11.47 | 4 (0.5) | - | 6 (0.7) | 5.73 | 9 (0.7) | 8.67 |
| Wilcox | - | - | - | - | - | - | - | - |
| Wilkes | 2 | - | 2 (0.2) | - | 2 (0.2) | - | 1 (0.1) | - |
| Wilkinson | - | - | - | - | - | - | 1 (0.1) | - |
| Worth | - | - | 2 (0.2) | - | 4 (0.5) | - | 1 (0.1) | - |
| Out of State ⁵ | 1 | - | 2 (0.2) | _ | 4 (0.5) | - | 4 (0.3) | _ |
| Unknown ² | 7 | _ | 19 (2.2) | - | 8 (1.0) | _ | 30 (2.4) | _ |

⁵ The victim was injured out of state but died in Georgia. Rates were not calculated for injuries that occurred out of state.

TOXICOLOGIC ANALYSIS OF UNINTENTIONAL OPIOID-INVOLVED OVERDOSE DEATHS, GEORGIA, 2017-2020



- The most significant increase in the number of opioid-involved overdose deaths that involved another substance was in deaths that also involved methamphetamine, with a 71.1% increase from 2019 to 2020.
- Opioid-involved overdose deaths that also involved antihistamines and gabapentin saw substantial increases from 2019 to 2020, with 61.6% and 54.6%, respectively.
- Opioid-involved overdose deaths that also involved cocaine increased from 2017 to 2020, with the most significant increase (23.5%) occurring from 2019 to 2020.
- Benzodiazepines were the most common co-occurring substance category from 2017 to 2020.

Top Opioid in Cause of Death by Decedent Injury Location³ (Public Health Districts), Georgia, 2017

Top Opioid in Cause of Death by Decedent Injury Location³ (Public Health Districts), Georgia, 2020



- From 2017 to 2020, there was a significant increase in fentanyl as the leading cause of opioid-involved overdose deaths across Georgia.
- In 2017, fentanyl was the top opioid in cause of death in three Public Health districts (3-3 Clayton, 3-5 DeKalb, and 9-1 Coastal), while other opioids such as oxycodone, heroin, morphine, and hydrocodone were more prevalent in other districts.
- By 2020, fentanyl became the dominant cause of opioid-involved overdose deaths in 15 of 18 (83%) Public Health districts.





* Deaths that had an unknown county of injury were not included in these counts. Categories are not mutually exclusive.

| Opioid-Involved Overdose Deaths by Cause of Death Drug Type & Selected Demographics, Georgia, | | | | | | | | | |
|---|-------------|-------------|-------------|--------------|--------------|--|--|--|--|
| | | 2017-2020 | | | | | | | |
| | 2017 | 2018 | 2019 | 2020 | % Change | | | | |
| | N (% of OI- | (count) from | | | | |
| | OD) | OD) | OD) | OD) | 2017 to 2020 | | | | |
| Any Opioid-Involved | 986 (100.0) | 846 (100.0) | 808 (100.0) | 1256 (100.0) | 27.4% | | | | |
| Age Group | | | | | | | | | |
| <15 | 0 | 2 (0.2) | 3 (.4) | 1 (0.1) | N/A | | | | |
| 15-24 | 94 (9.5) | 65 (7.7) | 60 (7.4) | 105 (8.4) | 11.7% | | | | |
| 25-34 | 283 (28.7) | 233 (27.5) | 199 (24.6) | 336 (26.8) | 18.7% | | | | |
| 35-44 | 234 (23.7) | 217 (25.7) | 213 (26.4) | 367 (29.2) | 56.8% | | | | |
| 45-54 | 216 (21.9) | 160 (18.9) | 164 (20.3) | 219 (17.4) | 20.0% | | | | |
| 55-64 | 139 (14.1) | 130 (15.4) | 131 (16.2) | 175 (13.9) | 25.9% | | | | |
| 65+ | 20 (2.0) | 39 (4.6) | 38 (4.7) | 53 (4.2) | 165% | | | | |
| Sex | | | | | | | | | |
| Male | 627 (63.6) | 533 (63.0) | 529 (65.5) | 827 (65.8) | 31.9% | | | | |
| Female | 359 (36.4) | 313 (37.0) | 279 (34.5) | 429 (34.2) | 19.5% | | | | |
| Race/Ethnicity | | | | | | | | | |
| White, non-Hispanic | 837 (84.9) | 693 (81.9) | 616 (76.2) | 945 (75.2) | 12.9% | | | | |
| Black, non-Hispanic | 122 (12.4) | 123 (14.5) | 154 (19.1) | 257 (20.5) | 110.7% | | | | |
| Other, non-Hispanic/Unknown | 12 (1.2) | 13 (1.5) | 8 (1.0) | 16 (1.3) | 33.3% | | | | |
| Hispanic | 15 (1.5) | 17 (2.0) | 30 (3.7) | 38 (3.0) | 153.3% | | | | |

| | 2017 N (% of Ol- OD) | 2018 N (% of Ol- OD) | 2019 N (% of Ol- OD) | 2020 N (% of Ol- OD) | % Change (count) from 2017 to 2020 |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|--|
| Rx Opioid-Involved | 464 (47.1) | 378 (44.7) | 311 (38.5) | 356 (28.3) | -23.3% |
| Rx Opioid-Involved Demographics | N (% of Rx Opioid- Involved) | % Change (count) from 2017 to 2020 |
| Age Group | | | | | |
| <15 | - | - | 2 (1.0) | 1 (0.2) | N/A |
| 15-24 | 20 (4.3) | 13 (34.4) | 10 (3.2) | 12 (3.4) | -40.0% |
| 25-34 | 80 (17.2) | 68 (18.0) | 43 (13.8) | 54 (15.2) | -32.5% |
| 35-44 | 113 (24.4) | 97 (2.4) | 71 (22.8) | 99 (27.8) | -12.4% |
| 45-54 | 144 (31.0) | 86 (22.8) | 81 (26.0) | 78 (21.9) | -45.8% |
| 55-64 | 89 (19.2) | 84 (22.2) | 76 (24.4) | 84 (23.6) | -5.6% |
| 65+ | 18 (4.0) | 30 (8.0) | 28 (9.0) | 28 (7.9) | 55.6% |
| Sex | | | | | |
| Male | 233 (50.2) | 199 (52.6) | 157 (50.5) | 181 (50.8) | -22.3% |
| Female | 231 (49.8) | 179 (47.4) | 154 (49.5) | 175 (49.2) | -24.2% |
| Race/Ethnicity | | | | | |
| White, non-Hispanic | 412 (88.8) | 332 (87.8) | 259 (83.3) | 277 (77.8) | -32.8% |
| Black, non-Hispanic | 46 (9.9) | 41 (10.8) | 43 (13.8) | 70 (19.7) | 52.2% |
| Other, non-Hispanic/Unknown | 4 (0.9) | 2 (0.5) | 4 (1.3) | 6 (1.7) | 50.0% |
| Hispanic | 2 (0.4) | 3 (0.8) | 5 (1.6) | 3 (0.8) | 50.0% |

| | 2017 N (% of Ol- OD) | 2018 N (% of Ol- OD) | 2019 N (% of Ol- OD) | 2020 N (% of Ol- OD) | % Change (count) from 2017 to 2020 |
|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|--|
| Fentanyl-Involved | 239 (24.2) | 285 (33.7) | 340 (42.1) | 820 (65.3) | 243.1% |
| Fentanyl-Involved Demographics | N (% of Fentanyl- Involved) | N (% of Fentanyl- Involved) | N (% of Fentanyl- Involved) | N (% of Fentanyl- Involved) | % Change (count) from 2017 to 2020 |
| Age Group | | | | | |
| <15 | - | 1 (0.4) | 1 (0.3) | - | N/A |
| 15-24 | 35 (14.6) | 28 (9.8) | 36 (10.6) | 87 (10.6) | 148.6% |
| 25-34 | 84 (35.1) | 100 (35.1) | 112 (32.9) | 252 (30.7) | 200.0% |
| 35-44 | 55 (23.0) | 69 (24.2) | 97 (28.5) | 247 (30.1) | 349.1% |
| 45-54 | 43 (18.0) | 46 (16.1) | 50 (14.7) | 134 (16.3) | 211.6% |
| 55-64 | 22 (9.2) | 33 (11.6) | 37 (10.9) | 82 (10.0) | 272.7% |
| 65+ | - | 8 (2.8) | 7 (2.0) | 18 (2.3) | N/A |
| Sex | | | | | |
| Male | 169 (70.7) | 201 (70.5) | 243 (71.5) | 579 (70.6) | 242.6% |
| Female | 70 (29.3) | 84 (29.5) | 97 (28.5) | 241 (29.4) | 244.3% |
| Race/Ethnicity | | | | | |
| White, non-Hispanic | 189 (79.1) | 225 (78.9) | 242 (71.2) | 587 (71.6) | 210.6% |
| Black, non-Hispanic | 37 (15.5) | 47 (16.5) | 77 (22.6) | 187 (22.8) | 405.4% |
| Other, non-Hispanic/Unknown | 7 (2.9) | 5 (1.8) | 4 (1.2) | 10 (1.2) | 42.9% |
| Hispanic | 6 (2.5) | 8 (2.8) | 17 (5.0) | 36 (4.4) | 500.0% |

| | 2017 N (% of Ol- OD) | 2018 N (% of Ol- OD) | 2019 N (% of Ol- OD) | 2020 N (% of Ol- OD) | % Change (count) from 2017 to 2020 |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|--|
| Heroin-Involved | 252 (25.6) | 326 (38.5) | 308 (38.1) | 419 (33.4) | 66.3% |
| Heroin-Involved Demographics | N (% of Heroin- Involved) | N (% of Heroin- Involved) | N (% of Heroin- Involved) | N (% of Heroin- Involved) | % Change (count) from 2017 to 2020 |
| Age Group | | | | | |
| <15 | - | - | - | - | N/A |
| 15-24 | 26 (10.3) | 31 (9.5) | 30 (9.7) | 31 (7.4) | 19.2% |
| 25-34 | 109 (43.3) | 116 (35.6) | 98 (31.8) | 126 (30.1) | 15.6% |
| 35-44 | 67 (26.6) | 90 (27.6) | 96 (31.2) | 134 (32.0) | 100.0% |
| 45-54 | 31 (12.3) | 54 (16.6) | 46 (14.9) | 72 (17.2) | 132.6% |
| 55-64 | 19 (7.5) | 29 (8.9) | 31 (9.5) | 45 (10.7) | 136.8% |
| 65+ | - | 6 (1.8) | 7 (2.3) | 11 (2.6) | N/A |
| Sex | | | | | |
| Male | 197 (78.2) | 242 (74.2) | 239 (77.6) | 306 (73.0) | 55.3% |
| Female | 55 (21.8) | 84 (25.8) | 69 (22.4) | 113 (27.0) | 101.8% |
| Race/Ethnicity | | | | | |
| White, non-Hispanic | 212 (84.1) | 258 (79.1) | 235 (76.3) | 342 (81.6) | 61.3% |
| Black, non-Hispanic | 33 (13.1) | 51 (15.6) | 56 (18.2) | 63 (15.0) | 90.9% |
| Other, non-Hispanic/Unknown | 2 (0.8) | 8 (2.5) | 2 (0.6) | 6 (1.4) | 200.0% |
| Hispanic | 5 (2.0) | 9 (2.8) | 15 (4.9) | 8 (1.9) | 60.0% |



Median Number of Positive Substances Detected on Postmortem Toxicology by Decedent Injury Location³ (Public Health Districts), Georgia, 2017 Median Number of Positive Substances Detected on Postmortem Toxicology by Decedent Injury Location³ (Public Health Districts), Georgia, 2020

- During 2017 to 2020, the median number of positive substances detected on postmortem toxicology for the state was 5, and 91% of deaths had more than one positive substance.
 - During the same period, there was a notable increase in the median number of positive substances detected on postmortem toxicology screens in several Public Health districts, indicating a rise in polysubstance use.
- In 2017, districts such as 3-1 Cobb-Douglas and 3-5 DeKalb had higher median numbers of positive substances at 5 and 7, respectively, while others like 5-1 South Central and 10 Northeast had lower medians of 3.
- By 2020, several districts experienced increases in the median number of positive substances detected on toxicology screens, including 2 North at 6, 3-1 Cobb-Douglas at 7, 3-5 DeKalb at 7, and 4 District 4 at 6.
- In 2017, the highest number of substances detected on postmortem toxicology was 21 in both 3-4 GNR and 3-5 DeKalb, compared to 19 positive substances in 2020 in 3-2 Fulton.

PRESCRIPTION INFORMATION FOR UNINTENTIONAL OPIOID-INVOLVED OVERDOSE DEATHS, GEORGIA, 2017-2020

| Opioid-Involved Overdose Deaths with Opio | oid Rx's within | 6 Months of D | Death, Georgia | , 2017-2020 |
|---|---------------------------|---------------------------|---------------------------|---------------------------|
| Characteristics of Opioid-Involved Overdose Deaths | 2017 No. Deaths (%) | 2018 No. Deaths (%) | 2019 No. Deaths (%) | 2020 No. Deaths (%) |
| TOTAL | 986 (100.0) | 846 (100.0) | 808 (100.0) | 1256 (100.0) |
| Total Number of Opioid-Involved Overdose Deaths with Opioid Rx's within 6 Months of Death | 408 (41.4) | 294 (34.8) | 283 (35.0) | 272 (21.7) |
| Number of Opioid Rx's within 30 Days of Death | | | | |
| 06 | 168 (17.0) | 106 (12.5) | 87 (10.8) | 95 (7.6) |
| 1-2 | 218 (22.1) | 172 (20.3) | 171 (21.2) | 155 (12.3) |
| 3-4 | 19 (1.9) | 14 (1.7) | 23 (2.8) | 22 (1.8) |
| 5+ | 3 (0.3) | 2 (0.2) | 2 (0.2) | - |
| Number of Doctors Prescribing Opioids within 6 Months of Death | | | | |
| 1-2 | 297 (30.1) | 212 (25.1) | 210 (26.0) | 244 (19.4) |
| 3-4 | 86 (8.7) | 62 (7.3) | 63 (7.8) | 28 (2.2) |
| 5-6 | 17 (1.7) | 14 (1.7) | 8 (1.0) | _ |
| 7+ | 8 (0.8) | 6 (0.7) | 2 (0.2) | _ |
| Number of Pharmacies Dispensing Opioids within 6 Months of Death | | | | |
| 1-2 | 336 (34.1) | 242 (28.6) | 239 (29.6) | 257 (20.5) |
| 3-4 | 56 (5.8) | 50 (5.9) | 39 (4.8) | 14 (1.1) |
| 5-6 | 13 (1.3) | 2 (0.2) | 4 (0.5) | 1 (0.1) |
| 7+ | 3 (0.3) | - | 1 (0.1) | - |
| Age Group Distribution of Cases with Active ⁷ Opioid Rx's | | | | |
| <15 | - | - | - | - |
| 15-24 | 20 (2.0) | 7 (0.8) | 5 (0.6) | 11 (0.9) |
| 25-34 | 75 (7.6) | 56 (6.6) | 44 (5.4) | 28 (2.2) |
| 35-44 | 95 (9.6) | 71 (8.4) | 66 (8.2) | 64 (5.1) |
| 45-54 | 121 (12.3) | 65 (7.7) | 65 (8.0) | 73 (5.8) |
| 55-64 | 79 (8.0) | 69 (8.2) | 81 (10.0) | 72 (5.7) |
| 65+ | 18 (1.8) | 26 (3.1) | 22 (2.7) | 24 (1.9) |
| Sex of Cases with Active ⁷ Opioid Rx's | | | | |
| Male | 220 (22.3) | 158 (18.7) | 161 (19.9) | 151 (12.0) |
| Female | 188 (19.1) | 136 (16.1) | 122 (15.1) | 121 (9.6) |
| Race/Ethnicity of Cases with Active ⁷ Opioid Rx's | | | | |
| White, non-Hispanic | 371 (37.6) | 258 (30.5) | 230 (28.5) | 229 (18.2) |
| Black, non-Hispanic | 31 (3.1) | 32 (3.8) | 45 (5.6) | 41 (3.3) |
| Other, non-Hispanic/Unknown | 4 (0.4) | 2 (0.2) | 3 (0.4) | - |
| Hispanic | 2 (0.2) | 2 (0.2) | 5 (0.6) | 2 (0.2) |

⁶ Decedent had prescriptions within 6 months of death, but the prescriptions were not active within 30 days of death.

⁷ Decedent had active prescription at time of death.

- Of decedents who had an opioid prescription dispensed within 6 months of death and had an opioid included in their cause of death, many did not receive naloxone, and this is a critical opportunity for overdose prevention.
 - In 2017, 280 decedents had an opioid prescription within 6 months of death and had an opioid included in cause of death, but only 11% of them had naloxone administered in response to the fatal overdose.
 - In 2018, 202 decedents had an opioid prescription within 6 months of death and had an opioid included in cause of death, but only 19% of them had naloxone administered in response to the fatal overdose.
 - In 2019, 179 decedents had an opioid prescription within 6 months of death and had an opioid included in cause of death, but only 13% of them had naloxone administered in response to the fatal overdose.
 - In 2020, 156 decedents had an opioid prescription within 6 months of death and had an opioid included in cause of death, but only 15% of them had naloxone administered in response to the fatal overdose.

CIRCUMSTANCES SURROUNDING UNINTENTIONAL OPIOID-INVOLVED OVERDOSE DEATHS, GEORGIA, 2017-2020⁸

| Substance Use Circumstances Surrounding Opioid | -Involved Ov | e <mark>rdose De</mark> ath | is, Georgia, 2 | 017-2020 |
|---|---------------|-----------------------------|----------------|-------------|
| | 2017 | 2018 | 2019 | 2020 |
| Characteristics of Opioid-Involved Overdose Deaths | No. Deaths | No. Deaths | No. Deaths | No. Deaths |
| | (%) | (%) | (%) | (%) |
| TOTAL | 986 (100) | 846 (100) | 808 (100) | 1256 (100) |
| Decedent had known alcohol problem ⁹ | 129 (13.1) | 134 (15.8) | 150 (18.6) | 166 (13.2) |
| Decedent had known substance abuse problem | 800 (81.1) | 736 (87.0) | 707 (87.5) | 1115 (88.8) |
| Decedent was known to use marijuana products | - | - | 21 (2.6) | 62 (4.9) |
| Decedent was known to use tobacco products | - | - | 82 (10.1) | 362 (28.8) |
| Decedent had previous drug overdose (prior to fatal overdose) | 110 (11.2) | 87 (10.3) | 87 (10.8) | 139 (11.1) |
| Previous overdose within the last month before death | 23 (2.3) | 23 (2.7) | 26 (3.2) | 39 (3.1) |
| Previous overdose occurred between a month and a year before death | 29 (2.9) | 26 (3.1) | 17 (2.1) | 24 (1.9) |
| Previous overdose occurred more than a year before death | 17 (1.7) | 14 (1.7) | 14 (1.7) | 23 (1.8) |
| Previous overdose noted, timing unknown | 41 (4.2) | 24 (2.8) | 30 (3.7) | 53 (4.2) |
| Decedent had opioid use relapse (prior to fatal overdose) | 67 (6.8) | 66 (7.8) | 70 (8.7) | 117 (9.3) |
| Relapse occurred less than 2 weeks before death | 33 (3.3) | 49 (5.8) | 45 (5.6) | 70 (5.6) |
| Relapse occurred more than 2 weeks before death | 8 (0.8) | 3 (0.4) | 6 (0.7) | 21 (1.7) |
| Relapse noted, timing unknown | 26 (2.6) | 14 (1.7) | 19 (2.4) | 26 (2.1) |
| Decedent had history of treatment for substance abuse ¹⁰ | 128 (13.0) | 103 (12.2) | 109 (13.5) | 223 (17.8) |
| Current treatment at time of death | 44 (4.5) | 60 (7.1.) | 48 (5.9) | 69 (5.5) |
| No current treatment at time of death but treated in the past | 84 (8.5) | 43 (5.1) | 61 (7.5) | 154 (12.3) |
| Mental Health Circumstances Surrounding Opioid | -Involved Ove | erdose Death | s, Georgia, 2 | 017-2020 |
| | 2017 | 2018 | 2019 | 2020 |
| Characteristics of Opioid-Involved Overdose Deaths | No. Deaths | No. Deaths | No. Deaths | No. Deaths |
| | (%) | (%) | (%) | (%) |
| TOTAL | 986 (100) | 846 (100) | 808 (100) | 1256 (100) |
| Diagnosed mental health problem at time of death ¹¹ | 181 (18.4) | 159 (18.8) | 159 (19.7) | 249 (19.8) |
| Anxiety disorder | 38 (3.9) | 23 (2.7) | 22 (2.7) | 34 (2.7) |

Anxiety disorder
 38 (3.9)
 23 (2.7)
 22 (2.7)
 34 (2.7)

 Bipolar disorder
 35 (3.5)
 36 (4.3)
 32 (4.0)
 49 (3.9)

 Depression/dysthymia
 63 (6.4)
 50 (5.9)
 66 (8.2)
 95 (7.6)

¹¹ Decedent was known to have an unresolved mental health problem at the time of the fatal overdose. Mental health problems include those disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) with the exception of alcohol and other substance dependence.

⁸ The circumstances table capture specific circumstantial information surrounding the decedent's fatal overdose. This includes the decedent's mental health and substance use histories, and other notable life stressors. The circumstances are derived from information provided in CME investigation reports and EMS record narratives. For cases where a circumstance is not endorsed, the presence of that circumstance is either No or Unknown.

⁹ Decedent had a drinking problem or was addicted to alcohol at the time of the overdose; this excludes occasional drinking and resolved drinking problems.

¹⁰ Decedent was noted to have received current or past treatment for any substance use disorder (i.e., drug dependence or addiction), excluding alcohol. Treatment includes inpatient and outpatient rehabilitation, receiving Medication-Assisted Treatment (MAT) for drug abuse, was seeing a psychiatrist, and/or was going to Alcoholics or Narcotics Anonymous at the time of the fatal overdose.

| Post-traumatic stress disorder | 11 (1.1) | 3 (0.4) | 5 (0.6) | 19 (1.5) |
|--|------------------|------------------|------------------------------|------------|
| Schizophrenia | 9 (0.9) | 5 (0.6) | 7 (0.9) | 12 (1.0) |
| Other/Unknown | 25 (2.5) | 24 (2.8) | 27 (3.3) | 40 (3.2) |
| History of suicide attempts | 27 (2.7) | 20 (2.4) | 23 (2.8) | 32 (2.5) |
| History of suicidal plans and/or thoughts | 39 (4.0) | 40 (4.7) | 36 (4.5) | 51 (4.1) |
| Current depressed mood ¹² | 41 (4.2) | 48 (5.7) | 33 (4.1) | 44 (3.5) |
| Life Stressor Circumstances Surrounding Opioid- | Involved Ove | rdose Death | s, <mark>Georg</mark> ia, 20 | 017-2020 |
| | 2017 | 2018 | 2019 | 2020 |
| Characteristics of Opioid-Involved Overdose Deaths | No. Deaths | No. Deaths | No. Deaths | No. Deaths |
| | (%) | (%) | (%) | (%) |
| TOTAL | 986 (100) | 846 (100) | 808 (100) | 1256 (100) |
| Decedent was experiencing homelessness at the time of fatal overdose ¹³ | 14 (1.4) | 19 (2.2) | 18 (2.2) | 28 (2.2) |
| Decedent was released from an institution within 30 days prior to fatal overdose | 85 (8.6) | 92 (10.9) | 104 (12.9) | 154 (12.3) |
| Jail | 28 (2.8) | 27 (3.2) | 20 (2.5) | 46 (3.7) |
| Supervised residential facility related to alcohol or substance abuse treatment (e.g., residential rehabilitation) | 25 (2.5) | 33 (3.9) | 40 (5.0) | 45 (3.6) |
| Supervised residential facilities not related to alcohol or substance abuse treatment (e.g., halfway house) | 1 (0.1) | 2 (0.2) | 0 (0.0) | 1 (0.1) |
| Healthcare Facility | 31 (3.1) | 24 (2.8) | 43 (5.3) | 61 (4.9) |
| Other/Unknown | 0 (0.0) | 6 (0.7) | 1 (0.1) | 1 (0.1) |
| Decedent was being treated for pain at time of fatal overdose | 214 (21.7) | 191 (22.6) | 34 (4.2) | 45 (3.6) |
| Treated for acute pain | 24 (2.4) | 22 (2.6) | 17 (2.1) | 12 (1.0) |
| Treated for chronic pain | 79 (8.0) | 73 (8.6) | 12 (1.5) | 18 (1.4) |
| Treated for both acute and chronic | 6 (0.6) | 15 (1.8) | 2 (0.2) | 6 (0.5) |
| Treated for unknown type of pain | 105 (10.6) | 81 (9.6) | 3 (0.4) | 9 (0.7) |
| Death Scene Information & Response to Fatal O | verdose for C |)pioid-Involv | ed Overdose | Deaths, |
| Georgia, 20 | 017-2020 | | | |
| | 2017 | 2018 | 2019 | 2020 |
| Characteristics of Opioid-Involved Overdose Deaths | No. Deaths | No. Deaths | No. Deaths | No. Deaths |
| TOTAL | (%) | (%) | (%) | (%) |
| IOIAL | 986 (100) | 846 (100) | 808 (100) | 1256 (100) |
| Tupe of legation where fetal everdese accurred | 682 (69.17) | 527 (62.3) | 540 (66.8) | 797 (63.5) |
| Hotel (motel | 66 (67) | 61 (7 2) | A2 (E 2) | 96 (7.6) |
| House/motel | 773 (78 4) | 534 (63 1) | 43 (3.3) 579 (71 7) | 859 (68 4) |
| Motor vahicle | 19 (5 0) | 28 (3 3) | 3/ (/ 2) | 40 (3 2) |
| Public area (e.a. parking lot sidewalk natural area | 49 (5.0) | 20 (3.3) | 54 (4.2) | 40 (3.2) |
| park) | 16 (1.6) | 24 (2.8) | 16 (2.0) | 13 (1.0) |
| office building, industrial area) | 12 (1.2) | 6 (0.7) | 10 (1.2) | 21 (1.7) |
| Institution (jail, hospital, rehab facility) | 9 (0.9) | 10 (1.2) | 7 (0.9) | 26 (2.1) |
| Any scene evidence of drug use | 348 (35.3) | 342 (40.4) | 336 (41.6) | 513 (40.8) |

¹² Decedent was noted to be feeling depressed or down at the time of the overdose. This field is not endorsed solely because of a clinical depression diagnosis.

¹³ Homeless status includes individuals living without shelter or living in homeless shelters, abandoned buildings, local campgrounds. Homeless status does not included individuals living at motels, staying with friends, or currently houses individuals with pending evictions.

| 65 (6.6) | 66 (7.8) | 54 (6.7) | 72 (5.7) |
|------------|--|---|--|
| 283 (28.7) | 276 (32.6) | 282 (34.9) | 441 (35.1) |
| | | | |
| 383 (38.8) | 328 (38.8) | 288 (35.6) | 303 (24.1) |
| 263 (26.7) | 261 (30.9) | 221 (27.4) | 363 (28.9) |
| 72 (7.3) | 66 (7.8) | 70 (8.7) | 117 (9.3) |
| 48 (4.9) | 48 (5.7) | 55 (6.8) | 123 (9.8) |
| 80 (8.1) | 73 (8.6) | 59 (7.3) | 103 (8.2) |
| 495 (50.2) | 436 (51.5) | 481 (59.5) | 754 (60.0) |
| 99 (10.0) | 83 (9.8) | 115 (14.2) | 170 (13.5) |
| 843 (85.5) | 747 (88.3) | 740 (91.6) | 1164 (92.7) |
| 130 (13.1) | 140 (16.5) | 165 (20.4) | 297 (23.6) |
| 6 (0.6) | 5 (0.6) | 13 (1.6) | 25 (2.0) |
| 117 (11.9) | 117 (13.8) | 128 (15.8) | 282 (22.5) |
| 15 (1.5) | 12 (1.4) | 5 (0.6) | 14 (1.1) |
| 3 (0.3) | 10 (1.2) | 11 (1.4) | 21 (1.7) |
| - | 9 (1.1) | 3 (0.4) | 9 (0.7) |
| | 65 (6.6) 283 (28.7) 383 (38.8) 263 (26.7) 72 (7.3) 48 (4.9) 80 (8.1) 495 (50.2) 99 (10.0) 843 (85.5) 130 (13.1) 6 (0.6) 117 (11.9) 15 (1.5) 3 (0.3) - | 65 (6.6) 66 (7.8) 283 (28.7) 276 (32.6) 383 (38.8) 328 (38.8) 263 (26.7) 261 (30.9) 72 (7.3) 66 (7.8) 48 (4.9) 48 (5.7) 80 (8.1) 73 (8.6) 495 (50.2) 436 (51.5) 99 (10.0) 83 (9.8) 843 (85.5) 747 (88.3) 130 (13.1) 140 (16.5) 6 (0.6) 5 (0.6) 117 (11.9) 117 (13.8) 15 (1.5) 12 (1.4) 3 (0.3) 10 (1.2) - 9 (1.1) | $\begin{array}{c cccc} 65 & 66 & (7.8) & 54 & (6.7) \\ 283 & (28.7) & 276 & (32.6) & 282 & (34.9) \\ \hline \\ & & & & & \\ \hline \\ 383 & (38.8) & 328 & (38.8) & 288 & (35.6) \\ 263 & (26.7) & 261 & (30.9) & 221 & (27.4) \\ \hline \\ 72 & (7.3) & 66 & (7.8) & 70 & (8.7) \\ \hline \\ 48 & (4.9) & 48 & (5.7) & 55 & (6.8) \\ 80 & (8.1) & 73 & (8.6) & 59 & (7.3) \\ \hline \\ 495 & (50.2) & 436 & (51.5) & 481 & (59.5) \\ 99 & (10.0) & 83 & (9.8) & 115 & (14.2) \\ 843 & (85.5) & 747 & (88.3) & 740 & (91.6) \\ 130 & (13.1) & 140 & (16.5) & 165 & (20.4) \\ 6 & (0.6) & 5 & (0.6) & 13 & (1.6) \\ 117 & (11.9) & 117 & (13.8) & 128 & (15.8) \\ 15 & (1.5) & 12 & (1.4) & 5 & (0.6) \\ 3 & (0.3) & 10 & (1.2) & 111 & (1.4) \\ \hline \\ - & 9 & (1.1) & 3 & (0.4) \\ \hline \end{array}$ |

¹⁴ Any witness report or physical evidence of prescription drug use at the scene of the fatal overdose, including prescription bottles, patches, or vials.

¹⁵ Any witness report or physical evidence of illicit drug use at the scene of the fatal overdose, including illicit drugs and drug paraphernalia.

¹⁶ These data were derived from route of drug administration based on scene evidence information (E.g., witness report of injection drug use, needle/syringe on scene, track marks on decedent, etc.) provided in CME investigation reports and EMSs record narratives.

¹⁷ Any indication that substance(s) used leading up to the fatal overdose were orally ingested including witness reports of taking pills or tablets orally or ingesting liquid orally (e.g., liquid methadone), or the discovery of prescription pills, prescription bottles, liquid substance(s), or vials containing liquid substances at the scene of the overdose or on the decedent's body.

¹⁸ Any indication that of injection of substance(s) leading up to the fatal overdose including track marks on decedent or tourniquet, cooker, needle/syringe, and/or filter were found on the scene or on decedent.

¹⁹ Any indication that substance(s) used leading up to the fatal overdose were snorted or sniffed including witness reports of snorting (also called insufflation) or sniffing or drug paraphernalia at the overdose scene associated with snorting or sniffing including straws, rolled paper or dollar bills, razor blades, powder on table/mirror, and/or powder on decedent's nose.

²⁰ Any indication that substance(s) used leading up to the fatal overdose were smoked including witness reports of smoking and/or drug paraphernalia at the scene of the overdose associated with smoking such as pipes, stems, tinfoil, and vape pens.

²¹ Any indication that the decedent went unconscious rapidly (seconds to minutes) after taking drugs, including witness reports, location of drugs or drug paraphernalia near the decedent, and position of the decedent.

²² Any indication that an individual was physically nearby either during or shortly preceding a drug overdose who had an opportunity to intervene and respond to the overdose.

²³ Categories are not mutually exclusive as naloxone could have been administered by multiple individuals/entities.



- The most common place of injury for most opioid-involved overdose decedents was a house or apartment (72% during 2017 to 2020, but hotels/motels and motor vehicles were also a common place of injury.
- In 2017, the most common place of injury for opioid-involved overdoses other than a house or apartment, was a hotel or motel (39% of Public Health Districts), but that decreased to only 6% in 2020.
- In 2017, 17% of Public Health Districts had the highest number of injuries that didn't occur in a house or apartment, occurring in motor vehicles, which increased to 50% in 2020.

