New York State

Opioid Annual Data Report

2025

New York State Department of Health

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Introduction

Public Health Law Section 3309(5)[1] requires the New York State (NYS) Commissioner of Health to publish findings on statewide opioid overdose data annually. In this report, the New York State Department of Health (NYSDOH) provides an overview of opioid-related morbidity and mortality across NYS, including:

- Opioid overdose deaths
- Naloxone administration encounters
- Opioid overdose hospitalizations and emergency department (ED) visits
- Treatment admissions for opioid dependency
- Opioid prescribing
- Prevalence of opioid use behaviors and opioid dependency

Opioids include both prescription opioid pain relievers such as hydrocodone, oxycodone, fentanyl, and morphine, as well as illegal opioids such as heroin, illicitly manufactured fentanyl and fentanyl analogues, and opium.

Most of the data in this report are presented at the state level. County-level data are available on the New York State Opioid Data Dashboard and County Opioid Quarterly Reports on the NYSDOH Opioid-related Data website.[2]

This report provides information to assist agencies and programs across the state in planning and tailoring interventions to address the ongoing opioid crisis.

Please direct questions or requests for additional information to opioidprevention@health.ny.gov

This annual report was supported by the Grant or Cooperative Agreement Number NU17CE010215 funded by the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or the Department of Health and Human Services.

[1] Opioid overdose prevention, N.Y. Public Health Law, Section (§) 3309. Accessed July 2025. https://www.nysenate.gov/legislation/laws/PBH/3309

[2] Opioid-related Data in New York State. New York State Department of Health. Accessed July 2025. https://health.ny.gov/statistics/opioid/

Glossary

Acronym/Abbreviation	Definition
BNE	Bureau of Narcotic Enforcement
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CDS	Client Data System (OASAS)
DEA	Drug Enforcement Administration
ED	Emergency Department
EMS	Emergency Medical Services
ePCR	Electronic Patient Care Reports
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10	International Classification of Disease, Tenth Revision
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
I-STOP	Internet System for Tracking Over Prescribing
LA	Long-acting
MAT Act	Mainstreaming Addiction Treatment Act
MME	Morphine Milligram Equivalents
MPEs	Multiple-provider Episodes
NEMSIS	National EMS Information Systems
NH	Non-Hispanic
NSDUH	National Survey of Drug Use and Health
NYC	New York City
NYCDOHMH	New York City Department of Health and Mental Hygiene
NYS	New York State
NYSDOH	New York State Department of Health
NYS excluding NYC	New York State excluding New York City
OASAS	Office of Addiction Services and Supports
ODUH	Office of Drug User Health
OUD	Opioid Use Disorder
PCR	Patient Care Report
PMP	Prescription Monitoring Program
SA	Short-acting
SEP	Syringe Exchange Program
SOOTM	Synthetic Opioids Other Than Methadone
SPARCS	Statewide Planning and Research Cooperative System
STSEP	Second-tier Syringe Exchange Program
SUD	Substance Use Disorder
US	United States
WONDER	Wide-ranging ONline Data for Epidemiological Research
YRBSS	Youth Risk Behavior Surveillance System

Background

In NYS, both fatal and nonfatal overdoses involving opioids have increased since 2010. Overdose deaths involving any opioid among NYS residents increased more than 400 percent from 1,074 deaths in 2010 to historically high at 5,361 deaths in 2022 then slightly declined to 5,308 deaths in 2023.[3] Using established methods, the estimated cost of opioid-related overdose death in 2022 was nearly 62 billion dollars in NYS.[4] This rise in overdose deaths also disproportionately affects racial and ethnic minority populations.[5,6]

In recent State of the State addresses, Governor Hochul has highlighted the need to continue expanding and enhancing the public health approach to fight the opioid crisis. In line with this call, the NYSDOH and the Office of Addiction Services and Supports (OASAS) coordinate to enhance existing public health programs, interventions, and healthcare system-based approaches, as well as develop novel strategies and programs. Deploying a public health strategy to address the crisis includes, but is not limited to, prevention programs, harm reduction services, ensuring linkage to treatment and clinical care, strengthening public health surveillance and epidemiology, and implementing evidence-based community interventions.

In its continuous commitment to implementing this wide-ranging public health approach, the NYSDOH takes advantage of resources, expertise, and capabilities across units to develop comprehensive public health programing driven by a sophisticated data and information infrastructure.[7] The NYSDOH has a strong drug and opioid surveillance and epidemiology system in place that utilizes multiple statewide data sources such as mortality, ED visits, hospitalizations, multiple survey data sources, and emergency medical services (EMS) to support response and prevention activities. The Opioid Surveillance Team in the Office of Science, together with subject matter experts across the Department (Bureau of Narcotic Enforcement (BNE), AIDS Institute, Office of Health Insurance Programs, Bureau of Community Chronic Disease Prevention, Division of State Emergency Medical Services, and Center for Environmental Health) as well as from other agencies like OASAS and the New York/New Jersey High Intensity Drug Trafficking Area, works to utilize and make these data available to partners in the form of dashboards, comprehensive reports, and special topic Data to Action reports. Furthermore, enhanced surveillance efforts have been established to expand capabilities

[3] Centers for Disease Control and Prevention. Multiple Cause of Death. CDC WONDER. Accessed July 2025. https://wonder.cdc.gov/

[4] Luo F, Li M, Florence C. State-Level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose — United States, 2017. *MMWR Morb Mortal Wkly Rep*. 2021;70:541–546. doi: http://dx.doi.org/10.15585/mmwr.mm7015a1

[5] Friedman J, Akre S. COVID-19 and the Drug Overdose Crisis: Uncovering the Deadliest Months in the United States, January–July 2020. *Am J Public Health*. 2021;111(7):1284-1291. doi:10.2105/AJPH.2021.306256. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8493145/

[6] Kariisa M, Seth P, Jones CM. Increases in Disparities in US Drug Overdose Deaths by Race and Ethnicity: Opportunities for Clinicians and Health Systems. *JAMA.* 2022;328(5):421–422. doi:10.1001/jama.2022.12240. https://jamanetwork.com/journals/jama/article-abstract/2794593

[7] Opioid-related Data in New York State. New York State Department of Health. Accessed September 2025. https://health.ny.gov/statistics/opioid/

through more complete, timely, and accurate data linkages among relevant datasets within the Department. These data are used to inform policy decisions, guide program planning and implementation, and better respond to the opioid epidemic in NYS.

In addition, the NYSDOH regularly engages with external partners such as local health departments, treatment and mental healthcare providers, health systems and insurers, law enforcement and public safety agencies, researchers and information technology experts, community-based organizations, and persons who use drugs. Through these partnerships, the NYSDOH is leading, developing, and supporting a complex and comprehensive set of programs and interventions designed to fight the opioid crisis. The role for the NYSDOH has grown since this initial work and continues to rapidly expand to include additional evidence-based strategies under primary, secondary, and tertiary prevention.

Consistent with the NYSDOH vision and mission, programs and interventions designed to fight the opioid crisis recognize historic and structural racism, rely on person-centered services and anti-racism and anti-stigma premises; and are grounded in health equity while addressing social determinants of health. Program and interventions are developed and implemented based on the following premises:

- Historically, communities of color bore the brunt of the war on people who use drugs. Racial equity and health equity should be at the forefront of strategies to respond to the opioid crisis.
- Addressing social determinants of health and each person's specific needs are critical components to successfully implementing *meaningful* person-centered public health interventions. A significant group of people who do have a substance use disorder (SUD) and/or for whom drug treatment has failed, do not see drug treatment as the solution.
- The risk of a fatal overdose is not only among those persons with a SUD. In the present illicit substance landscape, mainly driven by synthetic opioids such as fentanyl and other novel psychoactive substances, an overdose may happen with little or no prior problematic drug use.

Following these and core public health principals, the NYSDOH has led the response with evidence-based strategies and implemented and supported a wide range of programs focused on primary prevention (interventions designed to reduce the exposure to opioids and associated risks), secondary prevention (aimed at diagnosing and treating SUD) and tertiary prevention designed to prevent fatal and nonfatal overdoses and adverse outcomes associated with drug use including infectious disease prevention. In practice and through programmatic implementation, prevention strategies overlap with many programs providing a myriad of interventions across the prevention continuum.

Primary prevention is aimed towards reducing exposure to opioids and associated risks, including prevention of SUD. Specific strategies include:

- Promote and support clinician education by developing a statewide program to enhance clinician education on pain management, palliative care, and SUD prevention including appropriate safe prescribing methods.[8]
- Monitor and identify improper and/or fraudulent prescribing through strengthening the Prescription Monitoring Program (PMP) by modernizing and improving ease of access.
- Improve infrastructure and applications including implementing the Internet System for Tracking Over-Prescribing (I-STOP) Act.
- Collaborate with local, state, and federal law enforcement agencies in the investigation of improper and fraudulent prescribing and responding to disruptions in patient care.
- Implement programs for the safe disposal of unused controlled substance medications and expanding the options available to collect controlled substances for purpose of disposal, including take-back events, mail-back programs, and collection receptacle locations.

Secondary prevention strategies focus on expanding access for screening, diagnoses, and treatment of opioid and other SUDs well as initiatives to reduce stigma. Specific strategies include:

- Provide clinician education on how to identify, screen, and treat SUD.
- Increase access and utilization of evidence-based medication for opioid use disorder (OUD) by increasing access to both low threshold medication access and comprehensive linkages to care and treatment.
- Reduce stigma and provide culturally appropriate prevention and harm reduction interventions by expanding education for consumers, families, and healthcare providers to reduce stigma against people who use drugs.

Secondary prevention, highlighted programs:

- Drug User Health Hubs, initiated in 2016, provide a welcoming, non-stigmatizing, and low-threshold setting that improves the availability and accessibility of medications for OUD, harm reduction supplies, as well as primary care, mental health services including crisis and grief support, referrals, and linkage to an array of other healthcare and supportive services for persons who use drugs. In addition, programs conduct anti-stigma trainings and work with various partners such as law-enforcement agencies, jails, and hospitals to receive direct referrals. The low-threshold nature of the Drug User Health Hubs makes them excellent resources for families to refer loved ones.

[8] Overdose Prevention - Guideline Recommendations and Guiding Principles. Centers for Disease Control and Prevention. Accessed July 2025. https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/recommendations-and-principles.html?CDC_AAref_Val=https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/recommendations-principles.html

- The Buprenorphine Access Initiative, initiated in 2016, increases access to buprenorphine, an effective medication for the treatment of OUD. It prevents drug withdrawal, blocks or diminishes the effects of other opioids, and prevents the powerful cravings that accompany the reduction of opioid use. The risk of an opioid overdose is also reduced for persons taking buprenorphine. Expanded points of access to buprenorphine include Syringe Exchange Programs (SEPs), Drug User Health Hubs, primary care, emergency departments and urgent care, Federally Qualified Health Centers, community-based organizations, correction facilities, and re-entry programs. Enacted legislation (Chapter 432 of the Laws of 2021) helps to significantly expand buprenorphine and methadone access in correctional settings.

- NY MATTERS, initiated in 2017, is a statewide referral network, including an electronic referral platform developed by the NYSDOH, to rapidly refer patients with OUD from emergency departments, OB/GYN offices, correction facilities, inpatient units, pre-hospital settings, etc., to community-based clinics and peer navigation services. Connections and appointments with outpatient treatment organizations can take place in as little as 24 hours from their initial referral. The NY MATTERS program has a presence in over 10 counties throughout the State, with large concentrations in the Western NY, Capital District, Central, and Hudson Regions.

For tertiary prevention, the NYSDOH deploys and coordinates interventions to expand capacity to prevent and respond to opioid overdoses, works to enhance data infrastructure to strengthen response capacity, and focuses on reducing the prevalence of HIV and HCV among persons who use drugs. Specific strategies include:

- Assist local public health partners and community coalitions in building capacity to address the opioid crisis by supporting the implementation of evidence-based interventions such as Post-overdose Outreach teams and Overdose Fatality Reviews.
- Provide timely public access to county-level data on major opioid-related measures available on a quarterly basis to assist communities in assessing their local burden; and near real-time data through the syndromic surveillance program data to prepare, identify, and respond to drug overdose spikes.
- Continue to adopt new, and adapt existing, testing technologies to monitor the illicit drug supply, and rapidly identify emergent risks while providing tools to people who use drugs such as fentanyl and xylazine test strips and point of care drug checking services to increase their information and awareness of substance use risk.
- Expand support for and access to harm reduction interventions, including access to sterile syringes and naloxone.

Tertiary prevention, highlighted programs:

- Overdose Data to Action Grant in States: Since 2015, NYS has been among the federally funded jurisdictions charged with improving surveillance of fatal and nonfatal drug overdoses to inform the implementation of evidence-based and innovative prevention initiatives. The Office of Drug User Health (ODUH) leads a large cross departmental team that works to improve access to near real-time data such as syndromic surveillance

and emergency medical services encounters to identify and respond to clusters and spikes as well as capturing detailed information on the circumstances surrounding overdose deaths through the State Unintentional Drug Overdose Reporting System. These data are used to inform prevention strategies such as improving partnerships between state and local health departments and organizations, establishing programs for linking people to care and treatment, improving provider and health system support, and empowering people who use drugs to make safer choices.

- The Safe Sharps Collection Program established in 2001, expands settings for the disposal of used needles and other sharps. Through this program, pharmacies, health clinics, community-based organizations, public transportation facilities, housing projects, police stations, bus depots, and other venues have become sites for sharps collection. Sharps collection kiosks and wall-mounted units are provided free of charge to registered sites. The program also provides small personal sharps containers (Fitpacks) that may be disposed with regular garbage.

- Community Opioid Overdose Prevention Programs, first authorized in April 2006, train individuals to recognize opioid overdoses and to respond appropriately by calling 911 and administering naloxone to reverse overdoses. Currently, over 1,000 registered programs with 5,385 sites offer training and either provide naloxone at no cost to persons they have trained or refer these individuals to pharmacies to obtain naloxone. Through the Department's Naloxone Co-payment Assistance Program, individuals with prescription drug coverage as part of their health insurance have their co-payments of up to $40 covered, resulting in no or lower out-of-pocket expenses. Trained responders include individuals who are themselves at risk for an overdose, their family and friends, individuals working for agencies providing services to individuals at risk for an overdose, and others in the community who may be positioned to intervene in an overdose.

- "Safer Choices", a harm reduction anti-stigma campaign was developed and released in 2023. The multi-media campaign began with a focus on social media platforms and web-based resources, as a way to equip individuals with an understanding of how to reduce overdose. The campaign emphasizes the importance of naloxone as a life-saving tool in the event of an overdose as well as strategies such as testing drugs and aims to reduce the stigma associated with drug use.

- Post Overdose Follow-up, initiated in 2019, allows the ODUH to provide navigator services to individuals who have survived an overdose. The program also provides services to family, friends, and associates of people who have died of an overdose and whom are also at risk of experiencing a fatal overdose.

- ODUH Drug Checking Programs provide on-site drug checking services in Drug User Health Hubs utilizing test strips and advance drug checking technology through a spectroscopy machine. This provides participants with essential information to make an informed decision regarding their potential use, serving as a key harm reduction intervention. ODUH provides program oversight including funding for the equipment, training and expert consultation, and confirmatory laboratory services.

- SEPs, which date from 1992, reduce transmission of HIV and hepatitis C virus among people who inject drugs by furnishing new, sterile syringes to enrolled participants, enabling them to use a new syringe for every injection. SEPs also facilitate the collection and disposal of used syringes. There are currently over 30 approved SEPs in NYS, offering services through multiple sites and models including office based, street based, mobile van, community outreach, peer-delivered syringe exchange, remote access, vending machines, and by special arrangements. To complement the work of SEPs, community-based organizations, local health departments, and health clinics have the option to become Second-tier Syringe Exchange Programs (STSEPs). STSEPs are like SEPs and allow government agencies and not-for-profit organizations to provide syringes to their existing patients and clients.

- The Expanded Syringe Access Program, which began in 2001, enhances access to new, sterile syringes through pharmacies, health care facilities, and health care practitioners, which have registered with NYSDOH. Under recent legislation (Chapter 433 of the Laws of 2021), a 10-syringe cap and pharmacy registration requirement have been lifted.

Executive Summary

This report aims to provide a comprehensive overview of opioid-related data for NYS residents. It presents the most recent and complete information available on drug and opioid-related overdose deaths and death rates by age, gender, race, ethnicity for the state and by geographic location. Overall data on emergency department and hospital utilization for the treatment of opioid overdoses, and disorders are provided, as well as data on the volume of naloxone (opioid antagonist) administrations by pre-hospital services (emergency medical services, law enforcement, and community programs). Statewide information from the NYS OASAS is presented on individuals enrolled in SUD treatment programs for heroin and for any opioid reported as a primary substance of use at admission. PMP data on dispensed opioid analgesic and benzodiazepine prescriptions are provided, as are data on prescription opioids for outpatient treatment, for the state total and by age, gender, and region. Lastly, survey data on opioid and other substances are presented.

Depending on the data source and the nature of the indicator, several types of estimates are presented in this report. Rates per 100,000 population are used for mortality, morbidity, and treatment. Rates per 1,000 unique 911 EMS dispatches are used for EMS-related indicators, while rates per 1,000 population are used for opioid prescriptions. Percentages are used for survey-related data, for EMS-related indicators, and for several other opioid prescription-related indicators.

County maps are provided throughout the report. The county colors are based on the ranks of county rates from the lowest to the highest as follows:

- The YELLOW category includes 50 percent of counties with the lowest estimates; those in quartile 1 and quartile 2.
- The BLUE category includes 25 percent of counties with the highest estimates; those in quartile 4.
- The GREEN category includes counties between the lowest 50 percent and the highest 25 percent (i.e., 25 percent of counties or those in quartile 3).

For detailed methodology, data sources, indicator descriptions, suppression criteria, and limitations, please see the Methods section at the end of this report.

Opioid Mortality

Provisional data by the CDC have shown that overdose deaths involving drugs in NYS have declined considerably during 2023 to early 2024.[9] NYS remains cautiously optimistic and continues to focus on leveraging every tool available, from innovative prevention, treatment, harm reduction, and recovery services, to reach more New Yorkers who are impacted by opioids and overdose.[10]

[9] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional Drug Overdose Death Counts. National Center for Health Statistics. 2025. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[10] Governor Hochul Announces Progress on Addressing the Opioid and Overdose Epidemic Across New York. Accessed July 2025. https://www.governor.ny.gov/news/governor-hochul-announces-progress-addressing-opioid-and-overdose-epidemic-across-new-york

Overdose deaths involving any opioid among NYS residents increased more than 400 percent from 1,074 deaths in 2010 to historically high at 5,361 deaths in 2022 then slightly declined to 5,308 deaths in 2023.[11] Despite the decline, the 2023 crude rate of 27.1 overdose deaths involving any opioid per 100,000 population in NYS was still almost five times that of 5.5 in 2010. The crude rate was highest among those aged 45-64 years (47.8 per 100,000), followed closely by those aged 25-44 years (42.3 per 100,000). The rates were about three times higher among males (41.0 per 100,000) as compared to females (13.9 per 100,000). Crude rates were higher among Black non-Hispanic (49.5 per 100,000) and American Indian or Alaska Native non-Hispanic (37.3 per 100,000) individuals, and slightly higher among New York City (NYC) residents (28.9 per 100,000) as compared to residents in NYS excluding NYC (25.8 per 100,000). In 2023, synthetic opioids other than methadone (SOOTM), predominantly illicitly manufactured fentanyl, were present in 93.0 percent of all overdose deaths involving any opioid. Most of the upward opioid-related mortality trends have been driven by deaths involving SOOTM, which had an overall increase of 638.9 percent from 2015 (668 deaths) to 2023 (4,936 deaths). The number of overdose deaths involving commonly prescribed opioids, including medications such as Vicodin® or Oxycodone®, increased by 81.2 percent, from 737 deaths in 2010 to a peak of 1,336 in 2021, and then declined to 1,144 in 2023.

In NYS, the number of overdose deaths involving cocaine increased 409.5 percent, from 634 overdose deaths in 2015 to 3,230 deaths in 2023. Between 2022 and 2023 the number of overdose deaths involving cocaine increased by 12.6 percent from 2,869 to 3,230 deaths. Deaths involving cocaine with SOOTM present increased from 142 in 2015 to 2,556 in 2023, representing a 1,700.0 percent increase. However, deaths involving cocaine without SOOTM present observed a much smaller increase (37.0 percent) from 492 deaths in 2015 to 674 deaths in 2023. This indicates that the increase in overdose deaths involving cocaine has been driven by the presence of opioids, specifically illicit fentanyl. Similar trends have been observed across the country.[12]

It is possible that raised awareness of opioid overdoses, improvements in technology and resources for toxicology testing, and improved cause-of-death reporting have contributed to a portion of these observed increases.

Naloxone Administration

Naloxone is a medication often used when an opioid overdose is suspected as it may reverse the effects when administered timely. In NYS, there were 18,001 unique naloxone administrations reported by EMS agencies during 2024, representing a 17.1 percent decrease from 21,711 administrations in 2023. In NYC, 11,269 unique naloxone administrations were reported electronically by EMS agencies during 2024, representing a 14.8 percent decrease from 13,219

Please note: this report includes the final data for various data sources; therefore, the detailed provisional data are not included.

[11] Centers for Disease Control and Prevention. Multiple Cause of Death 1999-2020. CDC WONDER Online. Accessed April 2025. https://wonder.cdc.gov/mcd-icd10.html

[12] Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic. Centers for Disease Control and Prevention, Health Alert Network. 2020 (CDCHAN-00438). Accessed May 2025. https://stacks.cdc.gov/view/cdc/98848

administrations in 2023. In NYS excluding NYC, unique naloxone administrations decreased 20.7 percent from 8,492 in 2023 to 6,732 during 2024.

Administrations were higher on Tuesdays and Fridays, highlighting a need for individuals using substances such as opioids to obtain naloxone in their communities and always have it available. The distribution of unique administrations varied across months of the year, with counts generally being the highest during May-July.

NYS is a leader in the implementation of public health programming to prevent death from opioid overdoses. The State's multi-pronged approach also includes a focus on building overdose response capacity within communities throughout the state via the Community Opioid Overdose Prevention programs.

Through organizations registered with the NYSDOH, community laypersons are trained to act in the event of a suspected opioid overdose. There are currently more than 1,300 registered Community Opioid Overdose Prevention programs, with over 1,590,000 individuals trained by them since the initiative's inception in 2006. Of these, over 187,000 were public safety personnel including law enforcement, fire fighters, and EMS responders, and the rest were community responders. Community responders are trained in identifying signs and symptoms of an opioid overdose and steps in how to respond to an overdose and how to administer naloxone.[13]

In 2024, there were 1,349 naloxone administration reports by law enforcement to the NYSDOH and 1,790 reports by Community Opioid Overdose Prevention programs. For both law enforcement and community naloxone administrations, it is important to note they are known to be underreported and thus not representative of all law enforcement and community naloxone administrations occurring in NYS.

Reporting by participants in these programs can have significant time lags with the possibility of delays in reporting to the NYSDOH up to a year after administration. To increase reporting, the Opioid Overdose Prevention Program team has increased follow-up with community registered programs, which may impact counts in this and other reports. In total, including unique administrations by EMS agencies, there were 21,140 reported naloxone administrations in NYS in 2024. For additional information about the State's Harm Reduction programs, please see the Office of Drug User Health webpage.

Suspected Opioid Overdose

Although naloxone administration has served as a useful marker for opioid overdoses, there are instances when naloxone is administered to individuals who are presenting with symptoms similar to an overdose (such as loss of consciousness) but are not experiencing an actual overdose. Conversely, individuals with a suspected opioid overdose who present mild symptoms and do not meet clinical requirements, may not receive naloxone as a component of emergency care. As such, these encounters are not captured in the counts of naloxone administration. To

[13] New York State's Opioid Overdose Prevention Program. New York State Department of Health. Accessed May 2025. https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/training_calendar.htm

improve surveillance and monitoring, an indicator for "suspected opioid overdose" was developed using EMS data. Suspected opioid overdoses include events where naloxone was administered (by EMS responders or by others before EMS responders' arrival) and the patient improved in response to naloxone, or evidence of a possible opioid overdose was observed based on recorded patient chief complaint, physical signs, or the EMS provider's impression.

In 2024, there were 21,652 suspected opioid overdose encounters, representing a 20.6 percent decrease from 27,257 suspected opioid overdose encounters in 2023. In 2024, approximately 67 percent of suspected opioid overdose encounters received naloxone administration.

Overdose Deaths Involving Opioids and Nonfatal Opioid-Related Hospital Events

The NYSDOH combines multiple data sources to measure opioid use and overdose. This includes overdose deaths involving any opioid from mortality data sources and ED visits and hospital discharge data for non-fatal outpatient involving opioid overdose and use disorders. Collectively, these opioid events are a representation of overall health impacts of opioids within NYS.

Among NYS residents in 2023, there were 42,758 opioid-related and overdose events, representing a crude rate of 218.5 per 100,000 population, a 5.7 percent decrease from 231.6 per 100,000 (45,572 events) in 2022. Though there was a 9.0 percent decrease from 2022 (427.3 per 100,000) to 2023 (388.8 per 100,000) among those aged 25-44 years, the 2023 rate for this group remained highest of all age groups. Compared to 2022, rates increased 10.3 percent for residents aged 0-17 (from 5.8 per 100,000 to 6.4 per 100,000), and 1.9 percent for residents aged 65+ (from 102.6 per 100,000 to 104.5 per 100,000). Rates were highest among Black non-Hispanic individuals (286.9 per 100,000), followed by Hispanic (239.2 per 100,000) and White non-Hispanic individuals (153.4 per 100,000). The rate was nearly three times higher among males (329.7 per 100,000) than among females (112.2 per 100,000). NYC had a higher rate (287.7 per 100,000) than NYS excluding NYC (168.0 per 100,000). The counties with the highest rates for overdose deaths involving opioids and nonfatal opioid-related hospital events, in order, were Bronx, Chautauqua, New York, Cattaraugus, Sullivan, Niagara, Dutchess, Schenectady, Delaware, Ulster, Kings, Richmond, Monroe, Broome, Chemung, and Erie.

Opioid-Related Hospital Events

Among NYS residents in 2023, there were 12,063 hospital discharges for opioid use (including overdose and disorders), representing a crude rate of 61.6 per 100,000 population. This was a decrease of 5.6 percent from 65.3 per 100,000 (12,851 discharges) in 2022. The rate in 2023 was highest among those aged 25-44 years (108.0 per 100,000) and among Black non-Hispanic individuals (82.4 per 100,000). The rate was just over two and a half times higher among males (90.1 per 100,000) than among females (34.5 per 100,000). NYC had a higher rate (72.0 per 100,000) than NYS excluding NYC (54.0 per 100,000).

In 2023, there were 12,647 ED visits (including outpatients and patients subsequently admitted) due to an opioid-involved overdose among NYS residents, representing a crude rate of 64.6 per 100,000 population. This represents an 8.6 percent decrease from 13,837 (70.3 per 100,000) ED visits (including outpatients and patients subsequently admitted) in 2022. The decrease in crude

rate was greatest among White non-Hispanic residents (16.8% decrease from 53.6 per 100,000 to 44.6 per 100,000), residents aged 18-24 years (22.5 percent decrease from 44.0 per 100,000 to 34.1 per 100,000) and residents aged 45-64 years (12.8 percent decrease from 104.6 per 100,000 to 101.8 per 100,000). The rate in 2023 was highest among those aged 45-64 years, and the rate for males was more than two and a half times higher than for females. NYC had a higher rate (80.7 per 100,000) compared to NYS excluding NYC (52.9 per 100,000).

Among NYS residents, the number of newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances decreased 19.4 percent from 1,165 in 2022 to 939 in 2023, and the rate per 1,000 newborn discharges decreased from 6.0 to 4.9.

Office of Addiction Services and Supports Client Data

The NYS OASAS provided data on unique individuals enrolled in substance use disorder treatment programs who reported a primary substance use at admission for any opioid (including heroin) between 2010 and 2024. The source of this information is the Client Data System (CDS) which collects data on people treated in all OASAS-certified substance use disorder treatment programs. Data are collected at admission and discharge from a level of care within a provider in NYS. The CDS does not have data for individuals who get treated by the United States (US) Department of Veterans Affairs, go outside NYS for treatment, are admitted to hospitals but not to an OASAS-certified treatment program, or receive treatment from a physician outside the OASAS system of care. Because a significant amount of time often elapses from an individual's initial use of an opioid and their admission to treatment, OASAS considers the number of individuals enrolled in treatment for opioids to be a trailing indicator of the prevalence of opioid misuse.

Statewide, the crude rate of unique individuals enrolled for any opioid increased 17.1 percent between 2010 (484.6 per 100,000) and 2016 (567.6 per 100,000). The rate of unique individuals enrolled has since declined each year from 2017 (570.4 per 100,000) to 2024 (451.2 per 100,000), a decline of 20.9 percent. Regionally, the rate of unique individuals enrolled for any opioid for NYS excluding NYC showed a 57.2 percent increase between 2010 (331.2 per 100,000) and 2017 (520.5 per 100,000), while there was an 8.3 percent decline in the rate of unique individuals for any opioid enrolled for NYC during this same period (from 694.5 per 100,000 to 637.0 per 100,000). Since 2017, the rate of unique individuals enrolled has continued to decline in both regions. During 2024, the counties with the highest crude rates of unique individuals enrolled for any opioid (including heroin) were mostly rural counties. It is important to recognize that enrollment rates are affected by the availability of treatment programs at the local level.

New Yorkers aged 25-34 consistently had the highest rate of unique individuals enrolled for any opioid (including heroin) between 2013 and 2019, while those aged 35-44 had the highest rate from 2020 to 2024. Throughout this period, more than twice as many males as females were admitted for any opioid (including heroin). Since 2017, there has been a decrease in the rates for both males and females.

Prescription Monitoring Program

In 2024, 5,166,245 opioid analgesic prescriptions were dispensed to NYS residents, a crude rate of 264.0 per 1,000 population, which is the lowest rate since 2014 (483.5 prescriptions per 1,000 population).[14] During the past ten years, NYS observed a consistent reduction in the number of opioid analgesic prescriptions and rates per 1,000 population. The rate for opioid analgesic prescriptions was more than two times higher in NYS excluding NYC (340.3 per 1,000) than in NYC (158.8 per 1,000) for 2024. Overall, short-acting (SA) oxycodone is the most often prescribed opioid analgesic, followed by SA hydrocodone and SA tramadol. The rate of prescribing long-acting (LA) oxycodone, SA codeine, and LA fentanyl has remained lower due to differences in therapeutic indications.

Among opioid-naïve patients, a larger number of supply days for the first (initial) opioid prescription is strongly associated with developing long-term opioid use.[15] In July 2016, NYS limited the initial prescribing of opioids for acute pain to no more than a seven-day supply.[16] In NYS, the percentage of initial opioid prescriptions for more than a seven-day supply remained stable at 14.7 percent from 2022 to 2024. During 2022-2024, the percentage of initial prescriptions for more than a seven-day supply was consistently higher in NYS excluding NYC compared to NYC.

Initiating treatment for chronic pain with LA or extended-release opioids is associated with higher risk of overdose than the initiation of treatment with immediate-release opioids.[17] The percentage of episodes in which patients were both opioid-naïve and received LA opioid prescriptions decreased slightly in NYS between 2022 (1.0 percent) and 2024 (0.9 percent). During 2022-2024, the percentage was consistently higher in NYS excluding NYC compared to NYC.

In NYS, an increase occurred in the crude rate of patients who received opioid prescriptions from five or more prescribers and dispensed at five or more pharmacies in a three-month rolling period (multiple-provider episodes (MPEs)) between 2021 (1.1 per 100,000 population) and 2024 (1.3 per 100,000).

[14] New York State Opioid Data Dashboard. New York State Department of Health. Accessed May 2025. https://apps.health.ny.gov/public/tabvis/PHIG_Public/opioid/

[15] Shah A, Hayes CJ, Martin BC. Factors Influencing Long-Term Opioid Use Among Opioid Naive Patients: An Examination of Initial Prescription Characteristics and Pain Etiologies. *J Pain*. 2017 Nov;18(11):1374-1383. Accessed May 2025. https://doi.org/10.1016%2Fj.jpain.2017.06.010

[16] Laws and Regulations - Public Health Law §3331(5)(b)-(c) - New Legislation Enacted to Limit Initial Opioid Prescribing to a 7 Day Supply for Acute Pain. Bureau of Narcotic Enforcement. New York State Department of Health. Accessed May 2025. https://www.health.ny.gov/professionals/narcotic/laws_and_regulations/

[17] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*. 2016;65(No. RR-1):1–49. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Opioid analgesics prescribed in higher dosages (≥ 90 morphine milligram equivalents (MME)) are associated with higher risks of opioid use disorder (OUD), overdose, and death.[17,18] In NYS, the percentage of patients receiving one or more opioid analgesic prescriptions with a total daily dose of 90 or greater MME for at least one day, declined between 2021 (9.8 percent) and 2024 (8.9 percent). Statewide, patients aged 55-64 years had the highest percentage for both males (12.8 percent) and females (11.2 percent).

The risk of opioid overdose increases when an opioid is taken in combination with other drugs, including benzodiazepines (e.g., alprazolam, diazepam etc.).[17] Among patients receiving at least one prescription for an opioid analgesic or at least one prescription for a benzodiazepine, the percentage with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions declined between 2021 (8.1 percent) and 2024 (7.4 percent) in NYS. From 2021-2024, NYS excluding NYC had consistently higher percentages of overlapping prescriptions compared to NYC. Statewide, in 2024, the percentage was higher among females than among males for all age groups. The percentage was highest among those aged 65 and older for both female (11.6 percent) and male (9.8 percent) patients in 2024.

Among patients in NYS receiving one or more opioid analgesic prescriptions, the percentage with two or more calendar days of overlapping opioid analgesic prescriptions declined between 2021 (15.2 percent) and 2024 (14.7 percent). From 2021-2024, NYS excluding NYC had consistently higher percentages compared to NYC. In 2024, the percentage was higher among males than females, in all age groups, except among those aged 65 years and older.

In NYS, more than 87,000 patients received at least one buprenorphine prescription for outpatient treatment of OUD in 2024. The crude rate of patients who received buprenorphine for OUD increased between 2021 (407.5 per 100,000 population) and 2023 (446.0 per 100,000) by 9.5 percent and stayed relatively stable in 2024 at 444.7 per 100,000. The rate was more than three times higher in NYS excluding NYC than for NYC during 2024. Note, on December 29, 2022, the X-waiver was eliminated as part of the omnibus spending bill, under the Mainstreaming Addiction Treatment Act (MAT Act). The removal of the X-waiver means that any Drug Enforcement Administration (DEA)-registered prescriber of controlled substances can now prescribe buprenorphine for treatment of OUD, provided that they comply with all other DEA and State requirements. NYSDOH will monitor the impact of the X-waiver elimination on buprenorphine prescribing.

Discontinuation of buprenorphine treatment sooner than 6 months is associated with poorer outcomes including substance misuse and overdose.[19] Between 2022 and 2024, the number of individuals on buprenorphine for treatment of OUD increased by 7.4 percent from 81,669 in

[18] Perry A, Krawczyk N, Samples H, Martins SS, Hoffman K, Williams NT, Hung A, Ross R, Doan L, Rudolph KE, Cerdá M. Opioid Dose, Duration, and Risk of Use Disorder in Medicaid Patients with Musculoskeletal Pain. Pain Med. 2025 Jun 24:pnaf077. doi: 10.1093/pm/pnaf077. Epub ahead of print. PMID: 40581761.

[19] Williams AR, Samples H, Crystal S, Olfson M. Acute Care, Prescription Opioid Use, and Overdose Following Discontinuation of Long-Term Buprenorphine Treatment for Opioid Use Disorder. Am J Psychiatry. 2020 Feb 1;177(2):117-124. doi: 10.1176/appi.ajp.2019.19060612. Epub 2019 Dec 2. PMID: 31786933; PMCID: PMC7002204. Accessed May 2025.
https://pmc.ncbi.nlm.nih.gov/articles/PMC7002204/.

2022 to 87,673 in 2024. During the same period, the percentage of cohort patients receiving continuous buprenorphine for treatment of OUD for 6 months or more slightly decreased from 71.4 percent in 2022 to 67.9 percent in 2024. From 2022 to 2024, the percentages were consistently higher in NYS excluding NYC than in NYC. Historically, NYC has had greater availability of methadone treatment for OUD as compared with NYS excluding NYC.[20]

The National Survey on Drug Use and Health (NSDUH)

2023-2024 NSDUH data were not available at the time this report was assembled. For 2022 and earlier data, please see the New York State Opioid Annual Report 2024 (page 84).

The Youth Risk Behavior Surveillance System (YRBSS)

The Youth Risk Behavior Surveillance System (YRBSS) provides data on self-reported use of substances in high school students (9th grade to 12th grade).[21] In 2023, the prevalence of lifetime use of cocaine, heroin, methamphetamine, and lifetime injection of an illegal drug among high school students was higher in NYC than in both NYS excluding NYC and the United States (cocaine: 5.4 percent in NYC, 4.2 percent NYS excluding NYC, 2.5 percent in the US; heroin: 4.2 percent in NYC, 3.8 percent in NYS excluding NYC, 1.6 percent in the US; methamphetamine: 3.7 percent in NYC, 3.5 percent in NYS excluding NYC, 1.8 percent in the US; injection of an illegal drug: 4.0 percent in NYC; 2.9 percent in NYS excluding NYC, 1.2 percent in the US).

In 2023, among high school students in NYS excluding NYC, the prevalence for substance use was generally higher among male, Black non-Hispanic, Asian non-Hispanic, and 11th grade students. Among high school students in NYC, the prevalence was generally higher among male, Black non-Hispanic, American Indian/Alaskan Native, and 12th grade students.

Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide random telephone and cellular surveillance survey designed by the CDC. The survey is conducted in all 50 states and US territories. BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. Data from the BRFSS are useful for planning, initiating, and supporting health promotion and disease prevention programs at the state and federal level, and monitoring progress toward achieving health objectives for the state and nation. New York State's BRFSS sample is representative of the adult population living in private residences or college housing who have either a landline or

[20] Tuazon E, Kunins H, Paone D. Buprenorphine and Methadone Dispensing in New York City. New York City Department of Health and Mental Hygiene: Epi Data Brief (96); November 2017. Accessed May 2025. https://www.nyc.gov/assets/doh/downloads/pdf/epi/databrief96.pdf

[21] Youth Risk Behavior Surveillance System (YRBSS). Centers for Disease control and Prevention. Accessed May 2025. Youth Risk Behavior Surveillance System (YRBSS) | CDC

cellular telephone, aged 18 years and older. Therefore, adults living in group homes or congregate settings are not included in the survey.[22]

In 2023, among NYS population aged 18 years and older, the age-adjusted percentage of people who self-reported misuse of prescription pain medication in the past 12 months increased to 5.7 percent from 4.7 percent in 2022. The highest crude percentage was observed among those aged 65 years and older (6.6 percent), followed by those aged 35-44 years (6.2 percent) and those aged 45-54 years (5.9 percent). Among racial and ethnic groups, the age-adjusted percentage was highest among Hispanic individuals (14.3 percent) and lowest among White non-Hispanic individuals (2.0 percent). The prevalence was about twice as high among NYC residents (8.1 percent) compared to that among residents living outside of NYC (4.2 percent). The age-adjusted percentage was higher among female residents (6.2 percent) compared to male residents (5.2 percent). Compared to 2022, there was an increase in the prevalence of adults who self-reported prescription pain medication misuse in the past 12 months among all age groups except those aged 55-64 years. The age-adjusted prevalence increased among all subpopulations, except among White non-Hispanic individuals.

Population Survey on Use of Opioids and Other Substances

The NYSDOH conducts an annual survey of NYS adult residents to understand public perceptions of key health issues, including opioid use.[23] The most recent public perception poll among adult NYS residents in February 2025 showed that "fentanyl use", a newly added option, was considered by most (72 percent of New Yorkers) as a very serious public health problem, followed by prescription opioid misuse (63 percent) and heroin use (62 percent). These remained the highest concerns compared to other public health problems, such as alcohol consumption and access to healthy food and beverages (unpublished data).

[22] Behavioral Risk Factor Surveillance System (BRFSS). New York State Department of Health. Accessed July 2025. https://www.health.ny.gov/statistics/brfss/

[23] Division of Chronic Disease Prevention - Chronic Disease Public Opinion Poll. Division of Chronic Disease Prevention and Siena College Research Institute. New York State Department of Health. Accessed May 2025. health.ny.gov/statistics/prevention/injury_prevention/information_for_action/

1 - Opioid Overdose Mortality Data

According to death certificate data reported to the NYSDOH, opioid-related overdose deaths have increasingly involved fentanyl.[24,25] Fentanyl is a potent synthetic opioid with medical uses; as such, it is listed within the International Classification of Disease, Tenth Revision (ICD-10) category for poisoning by "synthetic opioids other than methadone" (SOOTM) under ICD-10 code T40.4, along with other synthetic opioid analgesics, such as tramadol. Fentanyl is 50-100 times more potent than morphine.[26] Prescription fentanyl is primarily prescribed to manage acute and chronic pain associated with advanced cancer. Non-pharmaceutical grade fentanyl is illicitly manufactured. Illicit fentanyl is often mixed with heroin and has also been identified in counterfeit pills, formed to look like oxycodone and other prescription medications.[27] Because it is not possible to distinguish illicit fentanyl from medically administered fentanyl in postmortem toxicology testing, all fentanyl-related deaths are classified in the same way – as SOOTM – and are assigned ICD-10 code T40.4.

[24] Data to Action: Fentanyl-related deaths in New York State outside of New York City, 2015-2017. New York State Department of Health. Accessed May 2025. https://www.health.ny.gov/statistics/opioid/data/pdf/nysdoh_dta1_fentanyl.pdf

[25] Nolan ML, Mantha S, Tuazon E, Paone D. Unintentional Drug Poisoning (Overdose) Deaths in New York City in 2018. New York City Department of Health and Mental Hygiene: Epi Data Brief (116); August 2019. Accessed May 2025. https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief116.pdf

[26] Overdose Prevention - Fentanyl. Centers for Disease Control and Prevention. Accessed May 2025. https://www.cdc.gov/overdose-prevention/about/fentanyl.html

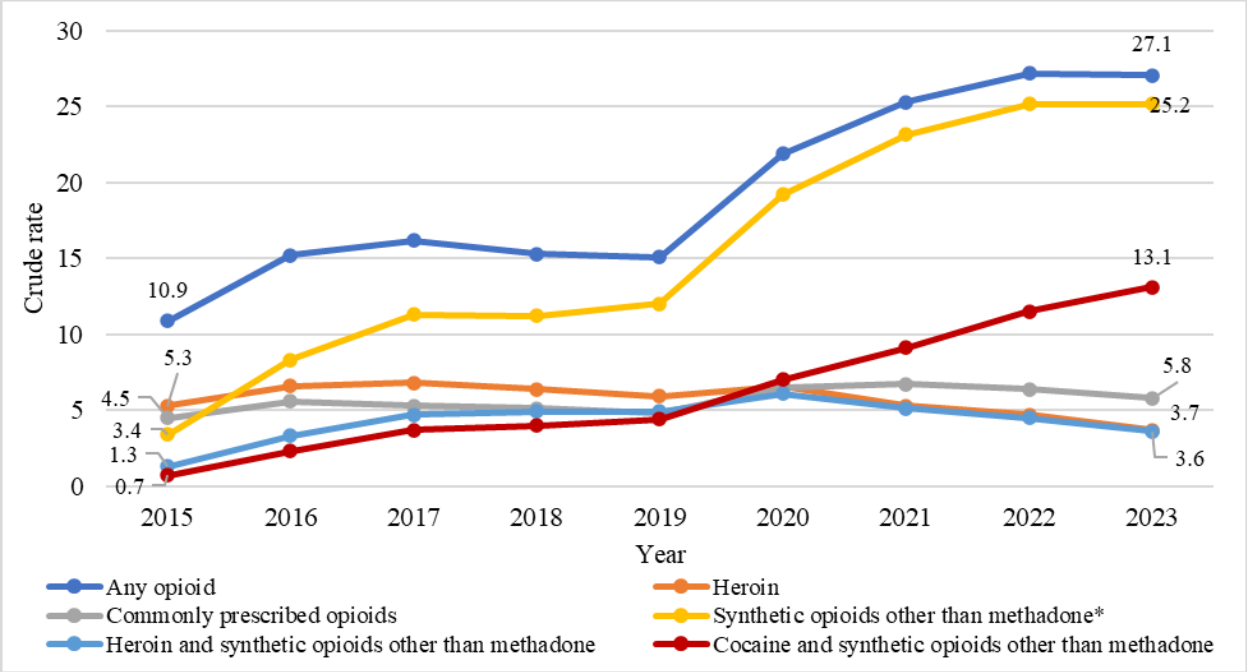
[27] Seth P, Rudd RA, Noonan RK, Haegerich TM. Quantifying the Epidemic of Prescription Opioid Overdose Deaths. *Am J Public Health*. 2018;108(4):500-502. https://doi.org/10.2105/AJPH.2017.304265

Overdose deaths involving opioids and other substances

Among NYS residents, there were 5,308 overdose deaths involving any opioid in 2023, a decrease of 1.0 percent from 5,361 in 2022 (Figure 1.1). The crude rate of overdose deaths involving any opioid decreased from 27.2 per 100,000 population in 2022 to 27.1 per 100,000 population in 2023. Despite the decrease, the 2023 crude rate was about two and a half times the 2015 rate of 10.9 per 100,000 population. It should be noted that categories of opioids and other substances involved in overdose deaths presented below are not mutually exclusive. A death can involve multiple substances, and that these deaths largely involved SOOTM. Figure 1.1 displays overdose deaths involving SOOTM as well as deaths involving any opioid, heroin (with and without SOOTM), other commonly prescribed opioids (ICD-10 codes T40.2 and T40.3), such as hydrocodone and oxycodone, and deaths involving cocaine and SOOTM. The crude rate of overdose deaths involving SOOTM is 25.2 per 100,000 in 2023. From 2015 to 2023, the crude rates of overdose deaths involving SOOTM for NYS were consistently higher than that of US.[28] Between 2022 and 2023, a 13.9 percent increase was observed for deaths involving cocaine and SOOTM, with the rate increasing from 11.5 to 13.1 per 100,000 population. Compared to 2022, the 2023 crude rate of overdose deaths decreased 21.3 percent for heroin and decreased by 9.4 percent for commonly prescribed opioids.

[28] Garnett MF, Miniño AM. Drug Overdose Deaths in the United States, 2003–2023. National Center for Health Statistics: NCHS Data Brief (522); December 2024. Accessed May 2025. https://www.cdc.gov/nchs/data/databriefs/db522.pdf

Figure 1.1 Overdose deaths involving opioids and other substances, crude rate per 100,000 population, New York State, 2015-2023

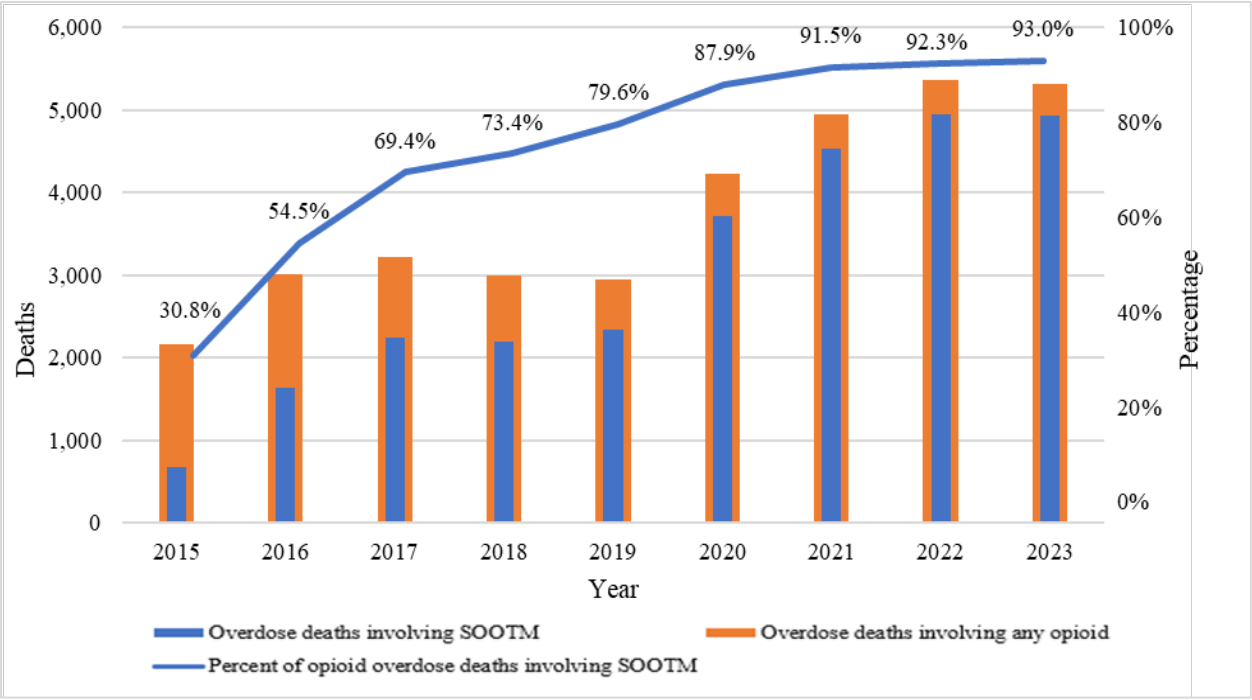


Multiple cause of death ICD-10 definitions: Any opioid – T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Synthetic opioids other than methadone), T40.6 (Other and unspecified narcotics); Heroin – T40.1; Commonly prescribed opioids – T40.2 (e.g., hydrocodone, oxycodone), T40.3; Synthetic opioids other than methadone (SOOTM) – T40.4; Heroin and synthetic opioids other than methadone – T40.1 AND T40.4; Cocaine and synthetic opioids other than methadone – T40.5 (cocaine) AND T40.4.
* Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.
Data sources: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
For detailed data for the Figure, see Appendix: Data Table 1.1.

Opioid overdose deaths involving SOOTM

From 2015 to 2023, the percentage of any opioid overdose deaths that involved SOOTM increased from 30.8 to 93.0 percent, a total increase of 201.9 percent (Figure 1.2).

Figure 1.2 Percentage of opioid overdose deaths involving synthetic opioids other than methadone*, New York State, 2015-2023

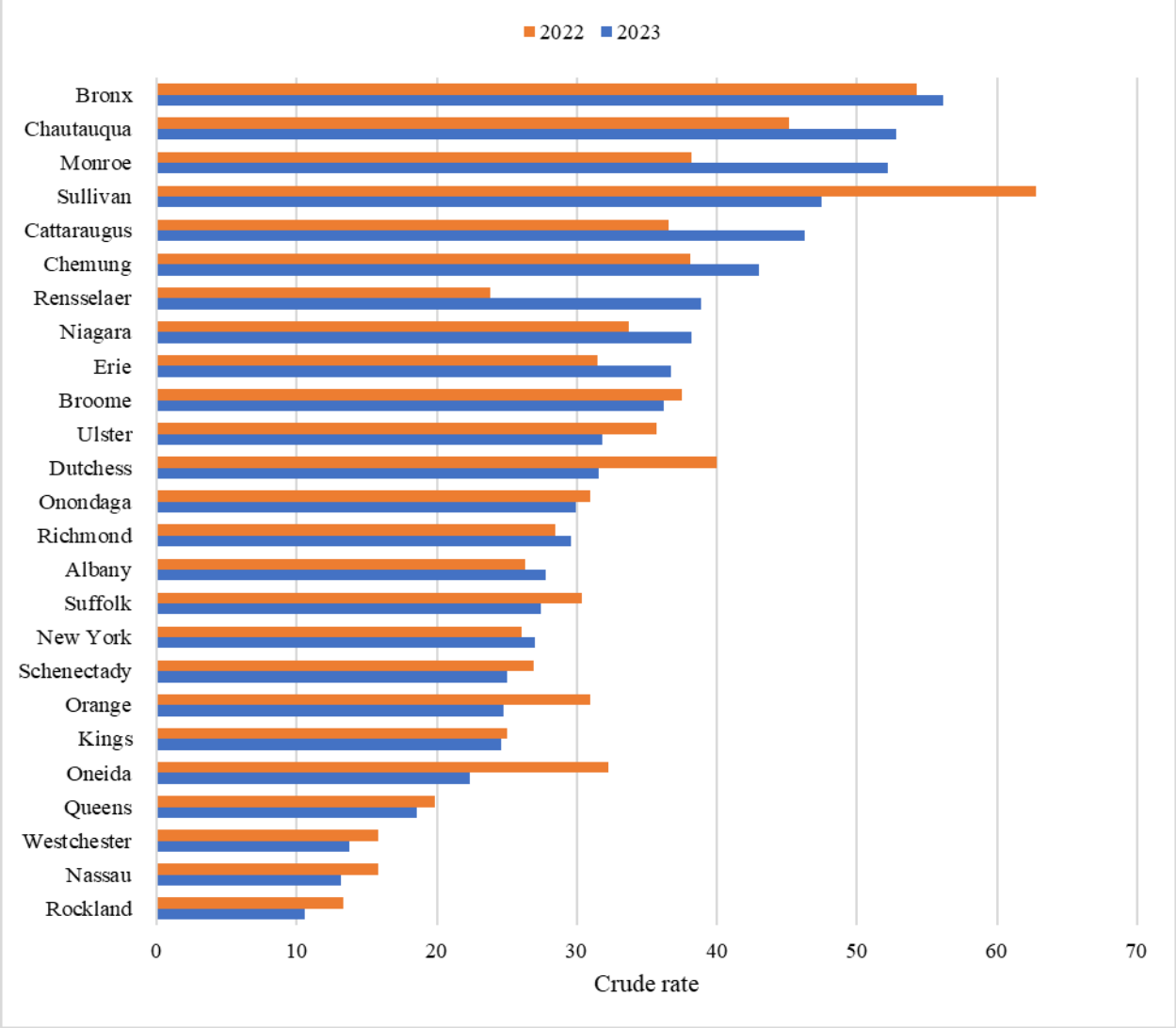


* Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.
Data sources: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
For detailed data for the Figure, see Appendix: Data Table 1.2.

Overdose deaths involving any opioid by county

In NYS, among counties with 30 or more overdose deaths involving any opioid in 2023, the crude rate per 100,000 population for overdose deaths involving any opioid was highest in Bronx County (56.2 per 100,000) (Figure 1.3). The next ten counties with the highest crude rates were Chautauqua, Monroe, Sullivan, Cattaraugus, Chemung, Rensselaer, Niagara, Erie, Broome, and Ulster. Rensselaer County had the largest absolute increase (15.1 per 100,000) from 2022 (23.8 per 100,000) to 2023 (38.9 per 100,000). As noted above, in 2023, over 90 percent of opioid overdose deaths involved SOOTM.

Figure 1.3 Overdose deaths involving any opioid, crude rate per 100,000 population, by county^, New York State, 2022 and 2023



Data sources: CDC WONDER, accessed May 2025

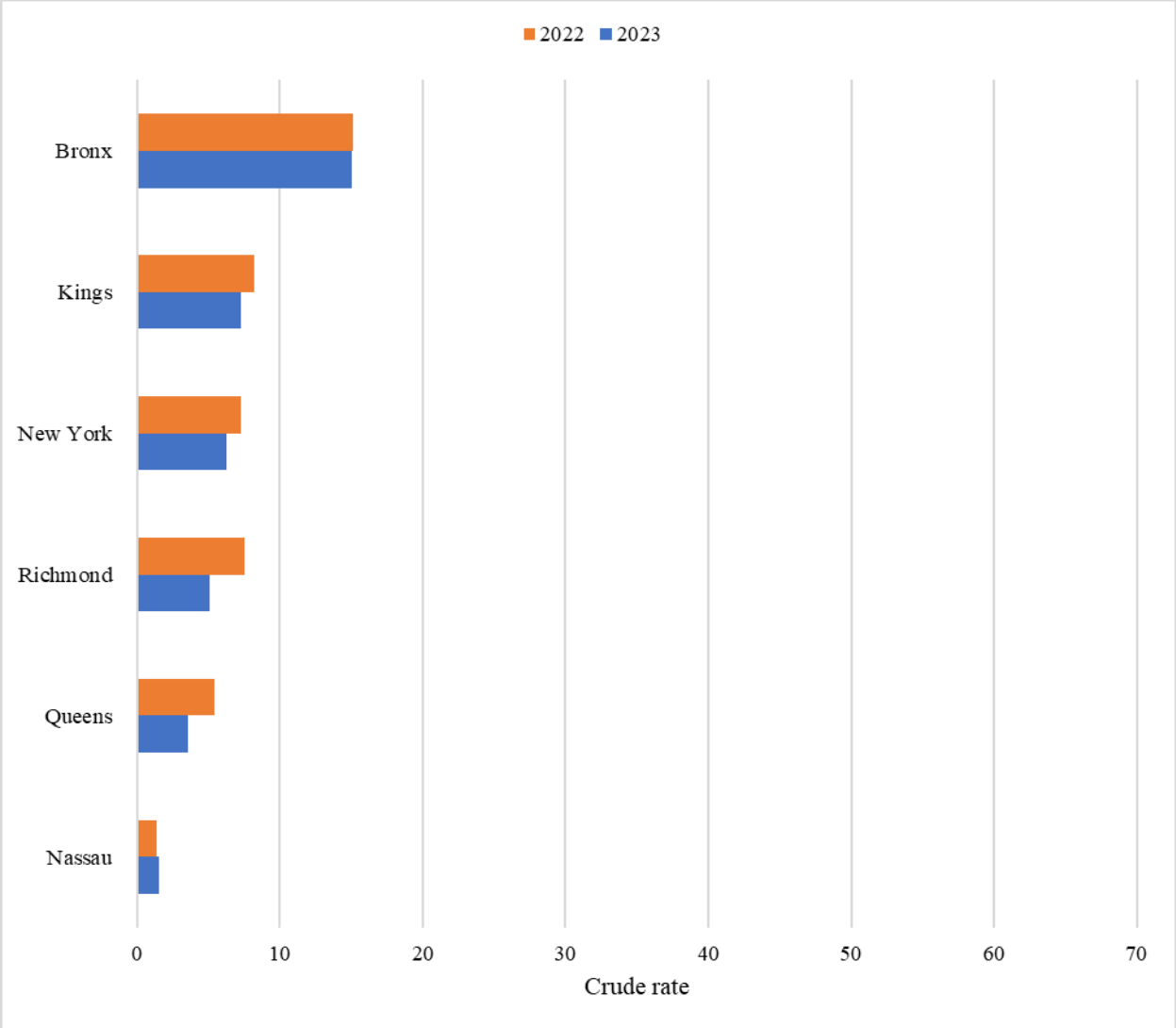
^ For the purpose of presenting comparison for counties using the most complete data, 2022 statistics for Monroe County are provided by New York State Vital Statistics, as of April 2024.

For county data on overdose deaths involving any opioid, see Appendix: Data Table 1.3.

Overdose deaths involving heroin by county

In NYS, among the nine counties with 20 or more overdose deaths involving heroin in 2023, the crude rate per 100,000 population for overdose deaths involving heroin was highest in Bronx County (15.0 per 100,000) (Figure 1.4). The six counties with the highest crude rates were Bronx, Kings, New York, Richmond, Queens, and Nassau.

Figure 1.4 Overdose deaths involving heroin, crude rate per 100,000 population, by county, New York State, 2022 and 2023

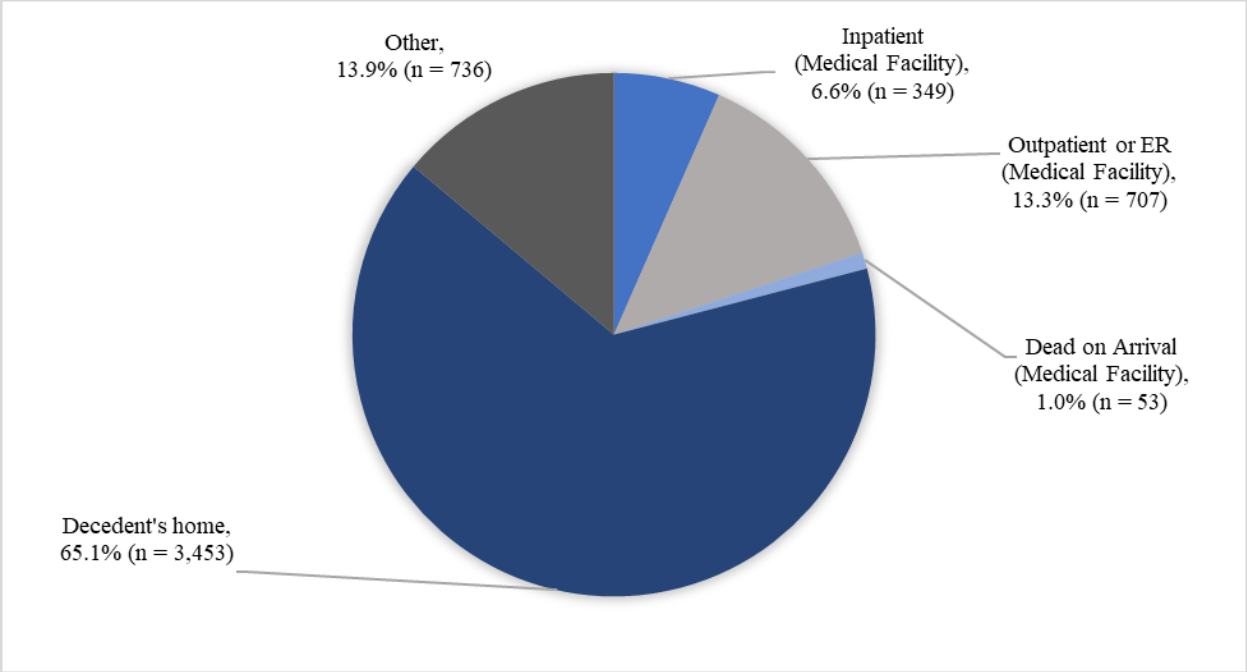


Data sources: CDC WONDER, accessed April 2025
For county data on overdose deaths involving heroin, see Appendix: Data Table 1.4.

Overdose deaths involving any opioid by place of death

In NYS during 2023, the largest percentage of overdose deaths involving any opioid occurred at the decedent's home (65.1 percent), remaining stable from 2022 (64.4 percent, data not shown) (Figure 1.5). It is important to note this large percentage of overdose deaths that occurred in the home, as it may indicate those who used alone, or were not able to access naloxone or care in a timely manner. This can inform programmatic interventions and responses such as encouraging people who use drugs to avoid using alone, be trained to use naloxone and have it available, to create a safety plan, utilize drug checking services and test all drugs with fentanyl test strips before using them.

Figure 1.5 Overdose deaths involving any opioid, by place of death, New York State, 2023

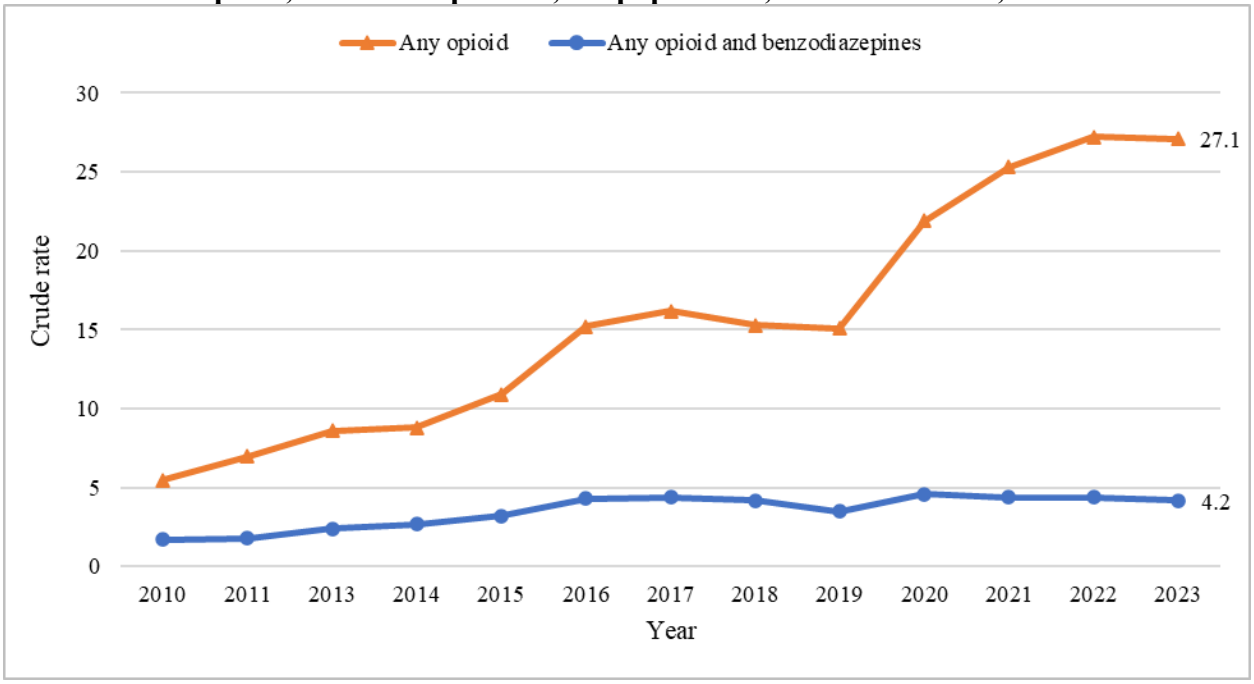


Data sources: CDC WONDER, accessed April 2025
Note: The number of overdose deaths involving opioid in "Nursing home/long term care" and "Place of death unknown" is under 10, therefore does not meet reporting criteria.
For detailed data for the Figure, see Appendix: Data Table 1.5.

Overdose deaths involving any opioid and benzodiazepines

The risk of an opioid overdose increases when opioids are taken in combination with benzodiazepines (e.g., Xanax® [alprazolam], Valium® [diazepam]).[29] It is important to monitor the involvement of multiple substances when assessing the risk of opioid overdose. In NYS, while the rate of overdose death involving any opioid and benzodiazepines gradually increased between 2010 and 2016, it has been relatively steady after that (Figure 1.6). Compared to 2022, in 2023, the crude rate of overdose death involving any opioid and benzodiazepines decreased by 4.5 percent (from 4.4 to 4.2 per 100,000), and the rate of overdose death involving any opioid decreased by 0.4 percent (from 27.2 to 27.1 per 100,000).

Figure 1.6 Overdose deaths involving any opioid and overdose deaths involving any opioid and benzodiazepines, crude rate per 100,000 population, New York State, 2010-2023



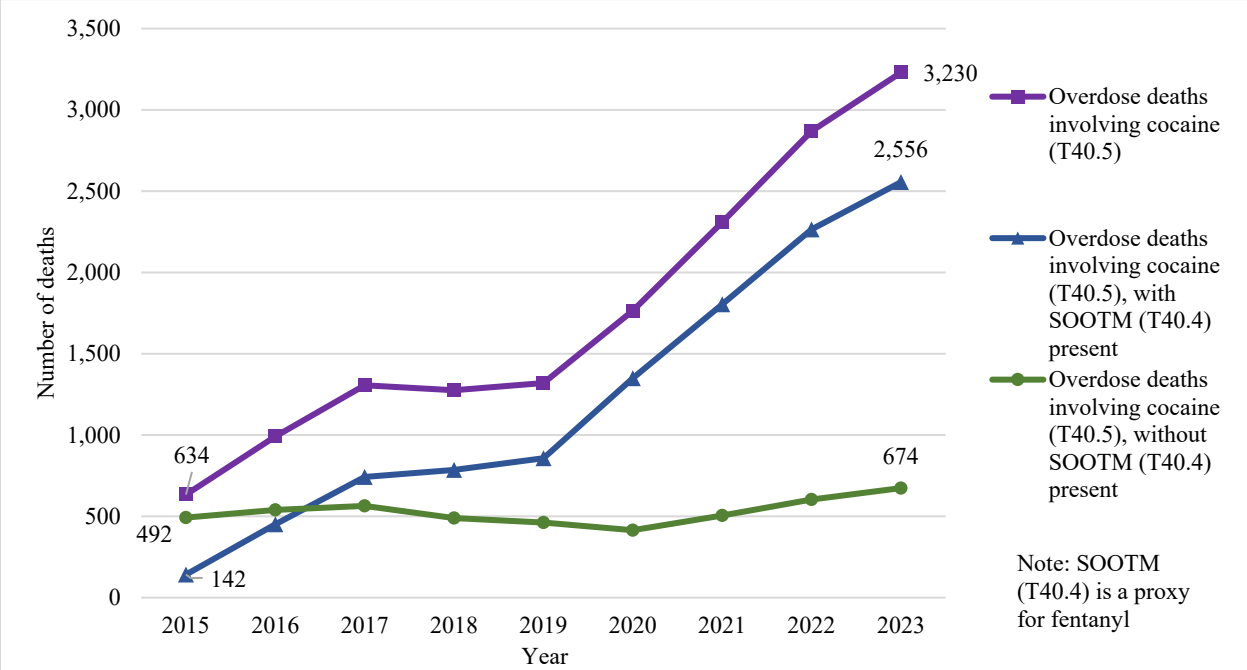
Multiple cause of death ICD-10 definitions: Any opioid – T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Synthetic opioids other than methadone), T40.6 (Other and unspecified narcotics); Any opioid and benzodiazepines – T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Synthetic opioids other than methadone), T40.6 (Other and unspecified narcotics) AND T42.4 (Benzodiazepines).
Data sources Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
For detailed data for the Figure, see Appendix: Data Table 1.6.

[29] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*. 2016;65(No. RR-1):1–49. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Overdose deaths involving cocaine with and without SOOTM present

The number of overdose deaths involving cocaine in NYS increased from 634 overdose deaths in 2015 to 3,230 deaths in 2023 – a 409.5 percent increase (Figure 1.7). Between 2022 (2,869 deaths) and 2023 (3,230 deaths), the number of overdose deaths involving cocaine increased by 12.6 percent. The sharp rise since 2015 was largely driven by the involvement of SOOTM, predominantly illicit fentanyl. The number of overdose deaths involving cocaine *without* SOOTM present increased by 37.0 percent, from 492 deaths in 2015 to 674 deaths in 2023. However, the number of overdose deaths involving cocaine *with* SOOTM present increased by 2,414 deaths over the same period, from 142 in 2015 to 2,556 in 2023, marking a 1700.0 percent increase. This indicates that the increase in overdose deaths involving cocaine has been driven by the presence of opioids, specifically fentanyl. Similar trends are being observed across the country.[30]

Figure 1.7 Overdose deaths involving cocaine with and without synthetic opioids other than methadone* present, New York State, 2015-2023



* Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.
Note: Cocaine overdose is identified by ICD-10 code T40.5.
Data sources: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
For detailed data for the Figure, see Appendix: Data Table 1.7.

[30] Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic. Centers for Disease Control and Prevention, Health Alert Network. 2020 (CDCHAN-00438). Accessed July 2025. https://archive.cdc.gov/emergency_cdc_gov/han/2020/han00438.asp

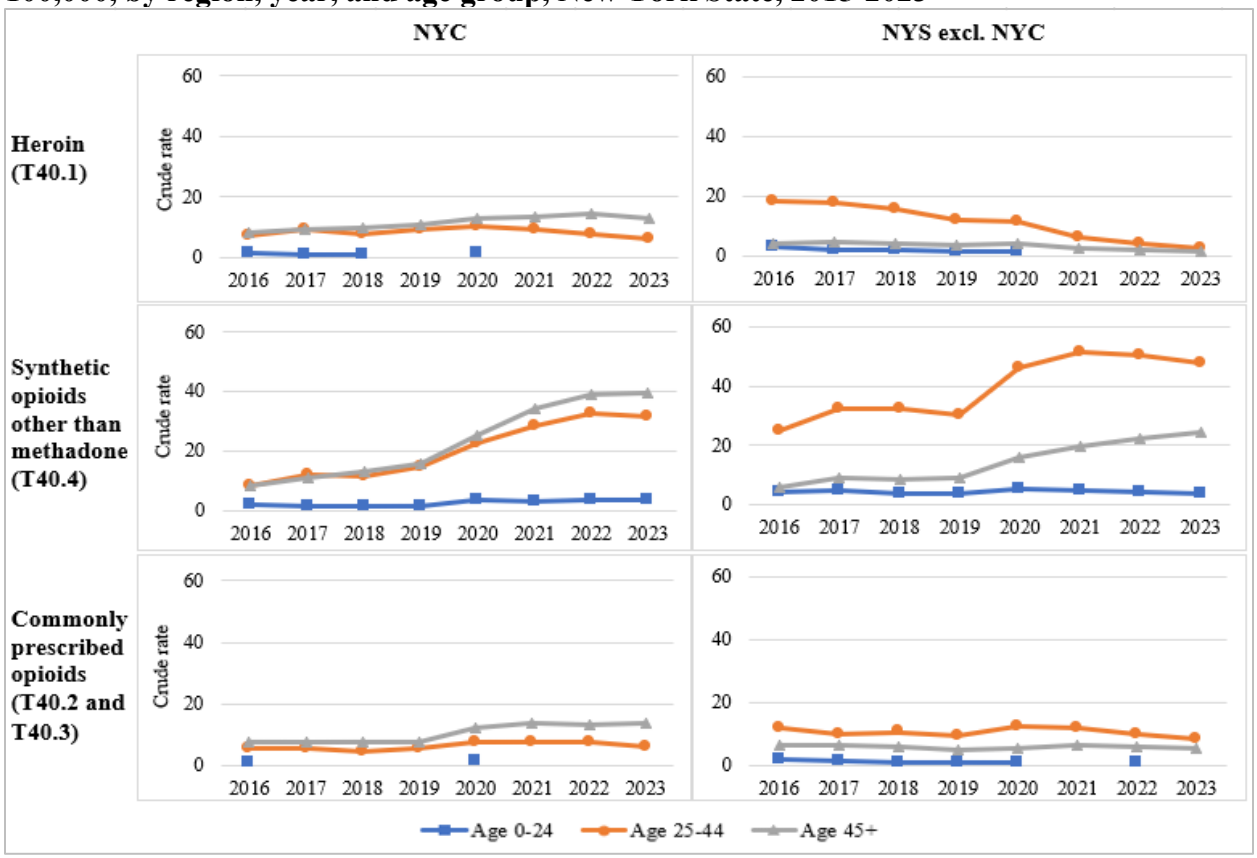
Overdose deaths involving heroin, SOOTM, and commonly prescribed opioids by region, year, and age group

Among New Yorkers aged 25-44 years, between 2015-2020 the crude rate of overdose deaths involving heroin was lower in NYC than in NYS excluding NYC. This changed from 2021 onward when the rate in NYC became higher than in NYS (Figure 1.8). From 2018 to 2023, the crude rate among those aged 25-44 years in NYS excluding NYC decreased 84.6 percent (15.6 to 2.4 per 100,000). In NYC, the crude rate of overdose deaths involving heroin among those aged 25-44 years increased from 2018 to 2020 by 30.4 percent (7.9 to 10.3 per 100,000 population). Since 2020, the rate decreased by 42.7 percent to 5.9 per 100,000 population in 2023. In 2023 in NYC, the highest rate was among those aged 45 years and older (12.7 per 100,000).

Among New Yorkers aged 25-44 years, the crude rate of overdose deaths involving SOOTM was lower in NYC than it was in NYS excluding NYC for every year during 2015-2023. The 2023 crude rate of overdose deaths involving SOOTM among those aged 25-44 years was one and a half times higher in NYS excluding NYC (47.6 per 100,000) than it was in NYC (31.8 per 100,000). Compared to 2022, the rate among this age group decreased by 2.8 percent in NYC (32.7 to 31.8 per 100,000). In 2023 in NYC, the highest rate was among those aged 45 years and older (39.4 per 100,000).

During 2015 to 2019, the crude rate of overdose deaths involving commonly prescribed opioids remained fairly steady among all age groups and across regions, with the highest rates among those aged 25-44 years residing in NYS excluding NYC. From 2019 to 2023, the crude rate among those aged 45 years and older residing in NYC increased by 81.3 percent from 7.5 per 100,000 in 2019 to 13.6 per 100,000 in 2023.

Figure 1.8 Overdose deaths involving heroin (T40.1), synthetic opioids other than methadone (T40.4)*, and commonly prescribed opioids (T40.2 and T40.3)^, crude rate per 100,000, by region, year, and age group, New York State, 2015-2023



NYS excl. NYC = New York State excluding New York City

* Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.

^ Commonly prescribed opioids are identified by ICD-10 codes T40.2 (Other opioids, e.g., hydrocodone, oxycodone), T40.3 (Methadone).

Note: For years and age groups with fewer than 20 deaths, rates are not shown.

Data sources: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025

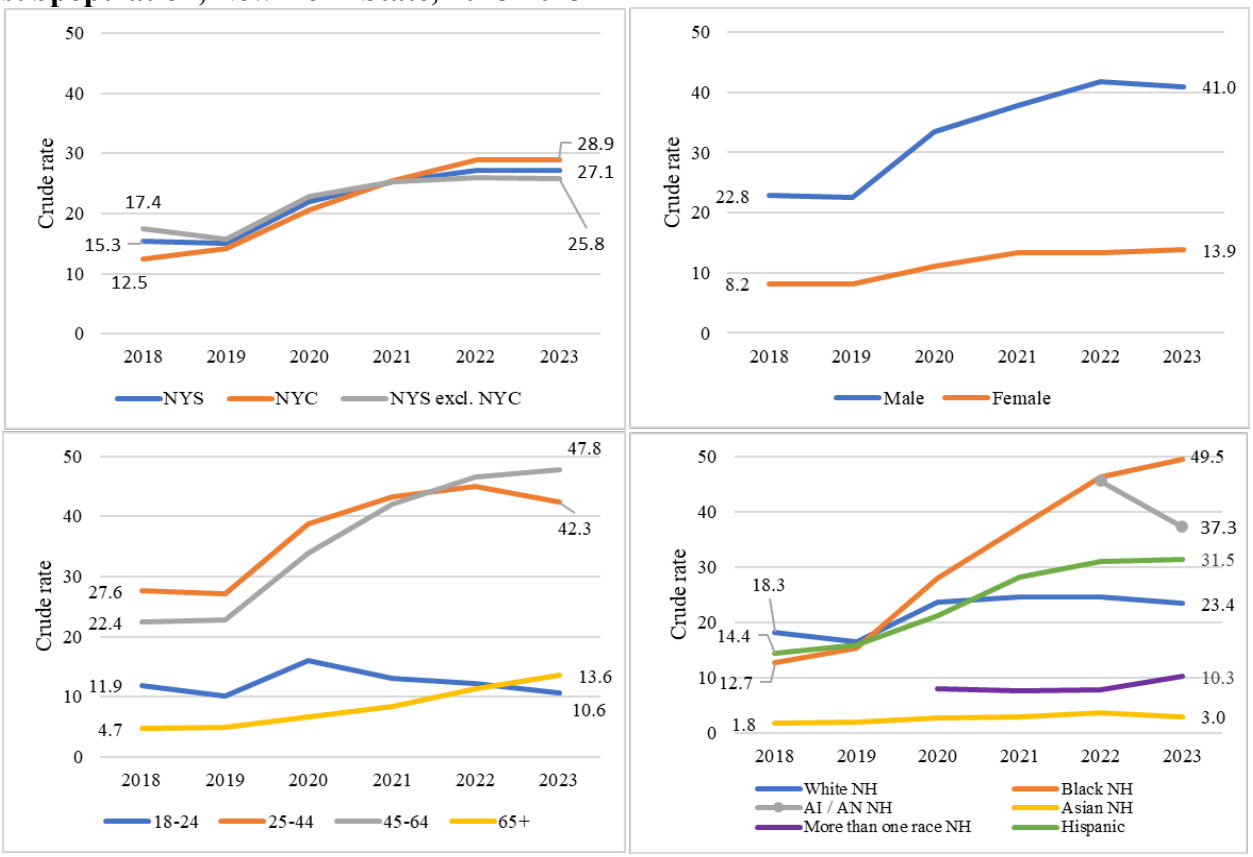
For detailed data for the Figure, see Appendix: Data Table 1.8.

Overdose deaths involving any opioid by subpopulation

In 2023 the crude rate of overdose deaths involving any opioid was higher among residents in NYC (28.9 per 100,000 population) than in NYS excluding NYC (25.8 per 100,000) (Figure 1.9). From 2018 to 2023, the crude rates in NYC increased 131.2 percent from 12.5 to 28.9 per 100,000.

In NYS during 2023, the crude rate of overdose deaths involving any opioid was about three times higher among males (41.0 per 100,000) as compared to females (13.9 per 100,000). The crude rates were highest among individuals aged 45-64 years (47.8 per 100,000) and those aged 25-44 years (42.3 per 100,000), Black non-Hispanic individuals (49.5 per 100,000), American Indian or Alaska Native individuals (37.3 per 100,000), and Hispanic individuals (31.5 per 100,000). From 2018 to 2023, the crude rates among Black non-Hispanic individuals increased 289.8 percent from 12.7 to 49.5 per 100,000.

Figure 1.9 Overdose deaths involving any opioid, crude rate per 100,000 population, by subpopulation, New York State, 2018-2023



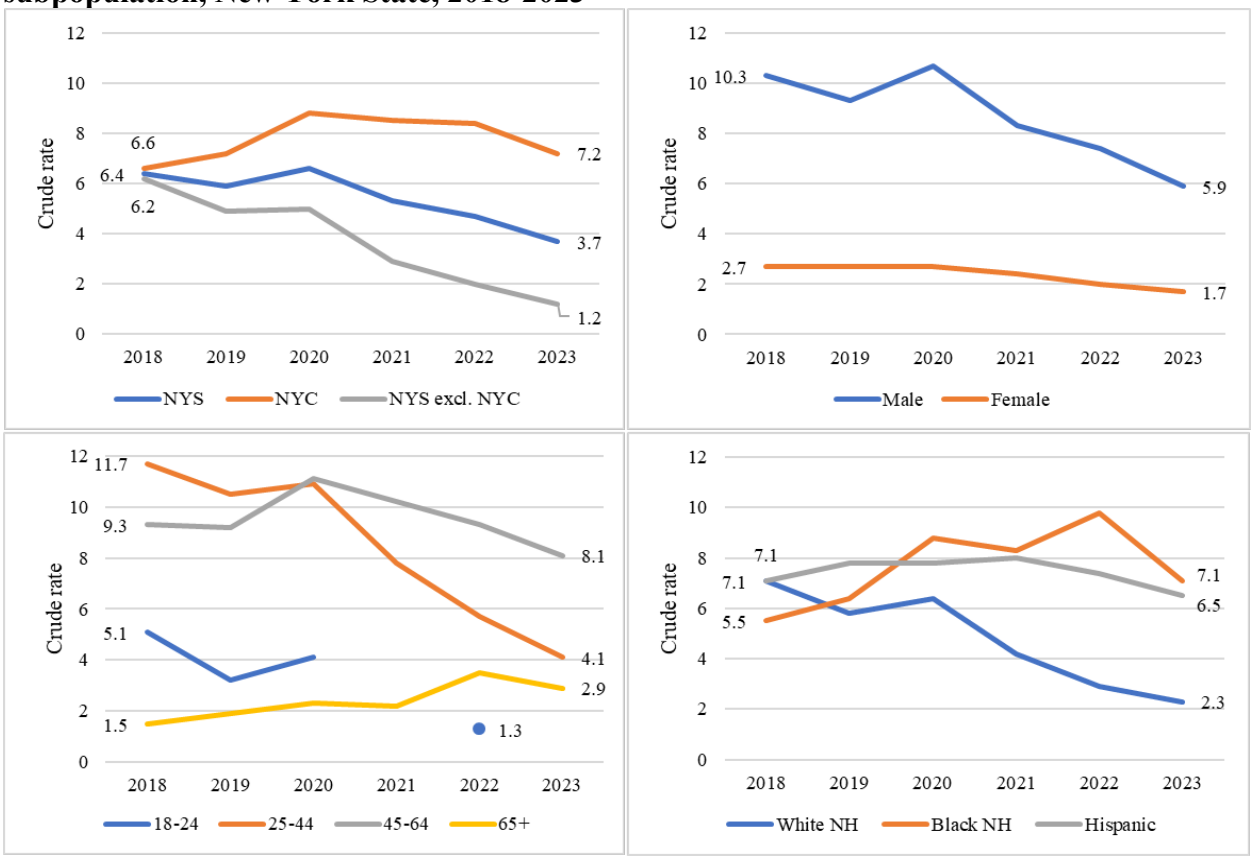
White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN NH = American Indian or Alaska Native non-Hispanic; Asian NH = Asian non-Hispanic; NYS excl. NYC = New York State excluding New York City
Data for Native Hawaiian/Other Pacific Islander NH do not meet reporting criteria and are therefore not shown.
Data sources: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
For detailed data for the Figure, see Appendix: Data Table 1.9.

Overdose deaths involving heroin by subpopulation

In 2023, the crude rate of overdose deaths involving heroin was more than five times higher in NYC (7.2 per 100,000) than in NYS excluding NYC (1.2 per 100,000) (Figure 1.10). From 2018 to 2020, the crude rate of overdose deaths involving heroin in NYC increased by 33.3 percent from 6.6 to 8.8 per 100,000. The rate since declined 18.2 percent to 7.2 in 2023. The crude rate in NYS excluding NYC decreased by 80.6 percent from 6.2 to 1.2 per 100,000.

In NYS in 2023, the crude rate of overdose deaths involving heroin was highest among males (5.9 per 100,000), individuals aged 45-64 years (8.1 per 100,000) and Black non-Hispanic individuals (7.1 per 100,000). From 2018 to 2022, the crude rate increased 78.2 percent from 5.5 to 9.8 per 100,000 among Black non-Hispanic individuals, before declining 27.6 percent to 7.1 in 2023.

Figure 1.10 Overdose deaths involving heroin, crude rate per 100,000 population, by subpopulation, New York State, 2018-2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; NYS excl. NYC = New York State excluding New York City

Data for American Indian/Alaska Native NH, Asian NH, Native Hawaiian/Other Pacific Islander NH and More than one race NH do not meet reporting criteria and are therefore not shown.

Data sources: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025

For detailed data for the Figure, see Appendix: Data Table 1.10.

2 - Naloxone Administrations

Naloxone (Narcan® and other brands) is an opioid antagonist used in the event of a suspected opioid overdose. Administrations of naloxone are given for patients presenting with signs and symptoms of a potential opioid overdose.

Naloxone Administrations by Emergency Medical Services

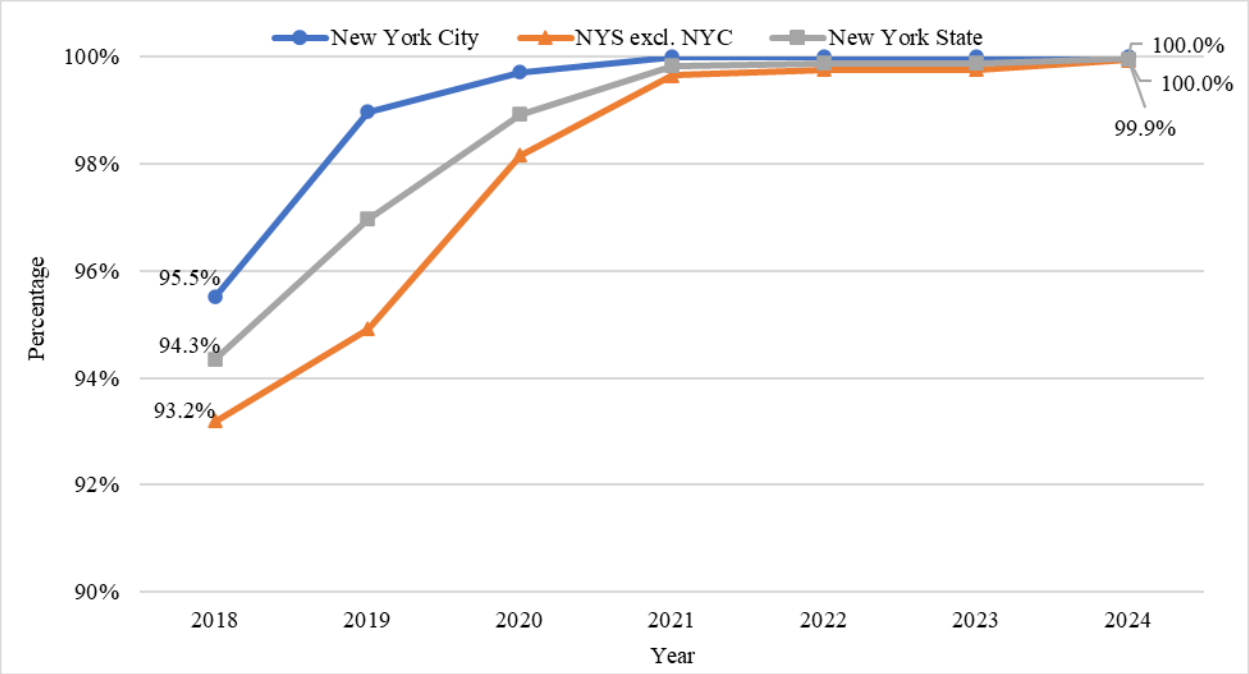
Naloxone has been actively administered by both Advanced Life Support and Basic Life Support providers in the treatment of potential opioid overdoses for many years. Many regions of NYS rely on Basic Life Support agencies to provide emergency medical response by Emergency Medical Technicians and Certified First Responders. EMS agencies administer the highest number of naloxone administrations reported in NYS as compared to law enforcement and community responders. Counts of unique administrations of naloxone by EMS agencies in NYS are based on information submitted to the NYSDOH Division of State Emergency Medical Services through electronic Patient Care Reports (ePCRs).

911 EMS dispatches reported electronically

Over the past decade, the NYS EMS agencies across the state have made significant progress toward increasing electronic reporting of Patient Care Reports (PCRs) and improving their data quality. The ePCR data have been improved in quality and coverage, therefore, enabled NYSDOH, local health departments and local communities to use these data for timely reporting and responding to important adverse health outcomes and public health concerns. Specifically, improvements have allowed for efficient and effective monitoring of opioid overdoses (approximately captured by the administration of naloxone, a medication used when an opioid overdose is suspected that reverses the effects when administered timely). Quality ePCR data are extremely important because these data allow the DOH the ability to fully capture naloxone encounters for all treated patients regardless of the outcome (whether they were admitted to emergency departments, released after treatment, or died on scene).

In 2024, 100 percent of all 911 EMS dispatches in NYS were reported electronically via ePCR in the ImageTrend platform, an increase from 94.3 percent in 2018 (Figure 2.1). Improvements in data reporting for New York City (NYC) and NYS excluding NYC during 2018-2024 followed similar patterns to the NYS total. Electronic coverage increased from 95.5 percent in 2018 to 100 percent in 2024 in NYC. For NYS excluding NYC, coverage increased from 93.2 percent in 2018 to 99.9 percent in 2024.

Figure 2.1 Percentage of 911 EMS dispatches reported electronically, by region, New York State, 2018-2024

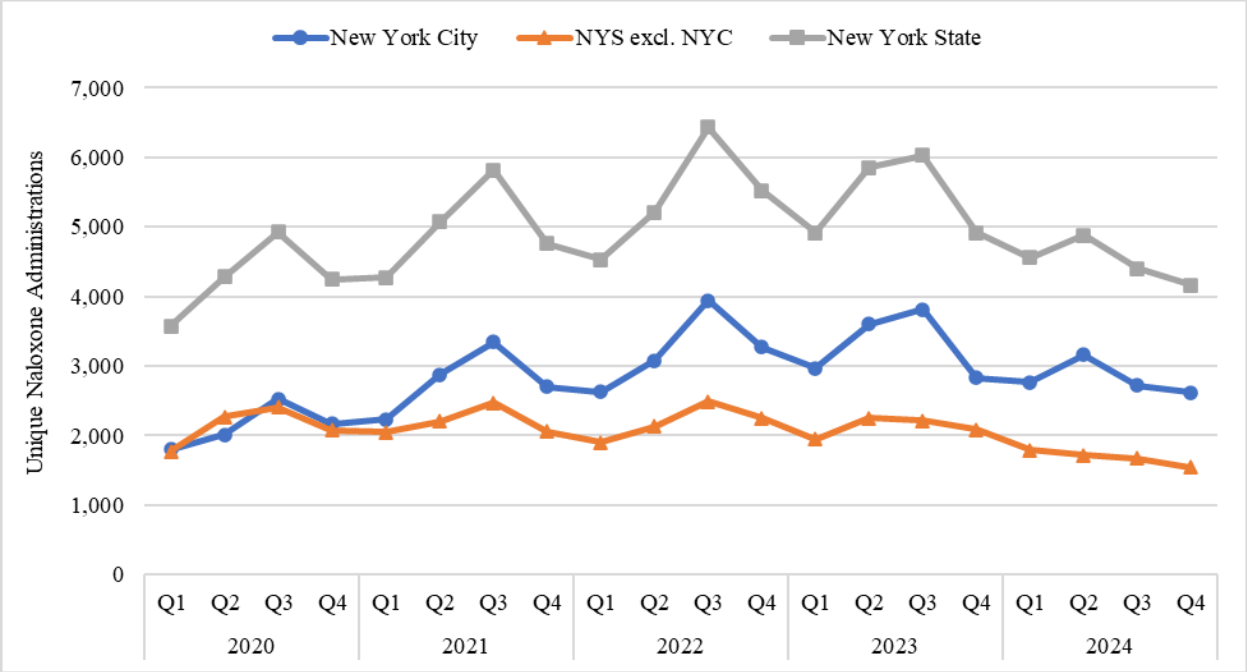


NYS excl. NYC = New York State excluding New York City
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.1.

Unique naloxone administrations by EMS agencies

The number of reported unique naloxone administrations by EMS in NYS decreased by 17.1 percent from 21,711 in 2023 to 18,001 in 2024 (Appendix: Data Table 2.2). Between 2023 and 2024, July through September (Quarter 3) of 2023 had the highest number of reported administrations (6,030 administrations) (Figure 2.2). In NYC, 11,269 unique naloxone administrations were reported during 2024, representing a 14.8 percent decrease from 13,219 administrations in 2023. In NYS excluding NYC, unique naloxone administrations decreased 20.7 percent from 8,492 in 2023 to 6,732 during 2024.

Figure 2.2 Number of unique* naloxone administrations by EMS agencies, by region, New York State, 2020-2024



NYS excl. NYC = New York State excluding New York City

* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter. As such, additional data validation steps have been taken to deduplicate multiple administrations and counts may differ from previous annual and quarterly reports.

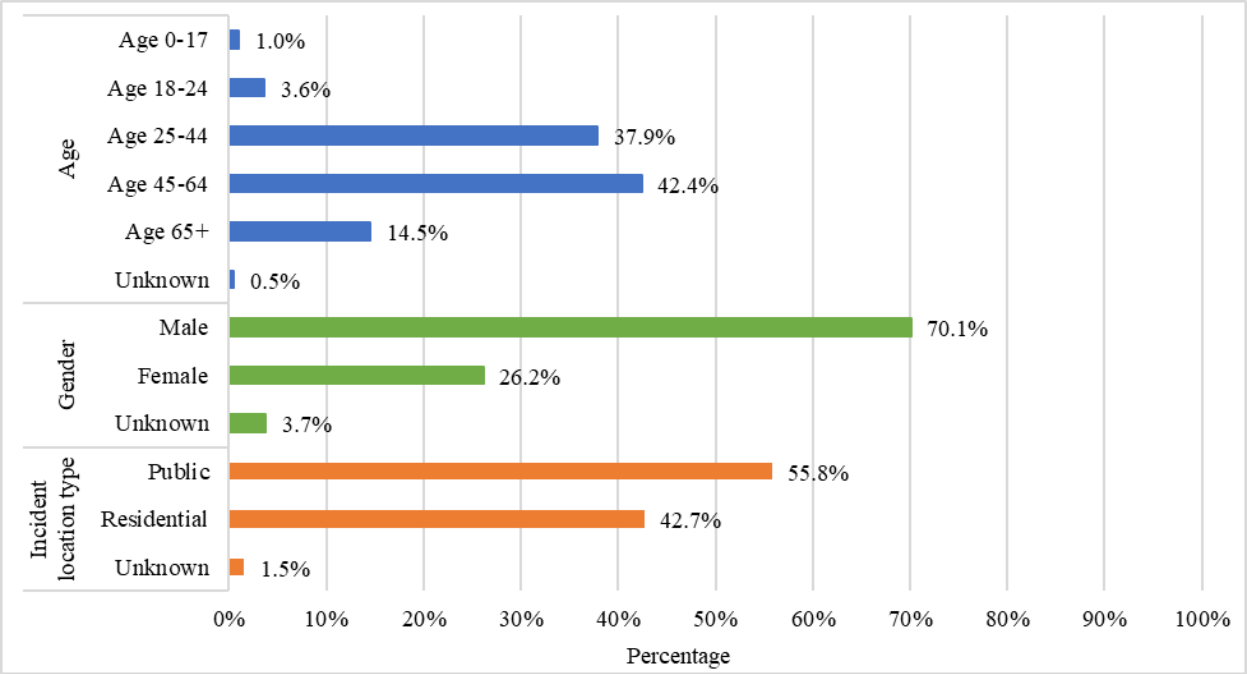
Note: Counts may have been affected by changes in documentation systems used by EMS agencies.

Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025

For detailed data for the Figure, see Appendix: Data Table 2.2.

In 2024, the highest number of unique naloxone administrations were administered to individuals aged 45-64 years, with 7,641 administrations (42.4 percent), followed closely by those aged 25-44 years, with 6,827 administrations (37.9 percent) (Figure 2.3). Most of these administrations by EMS personnel were administered to males, accounting for 12,621 administrations (70.1 percent).

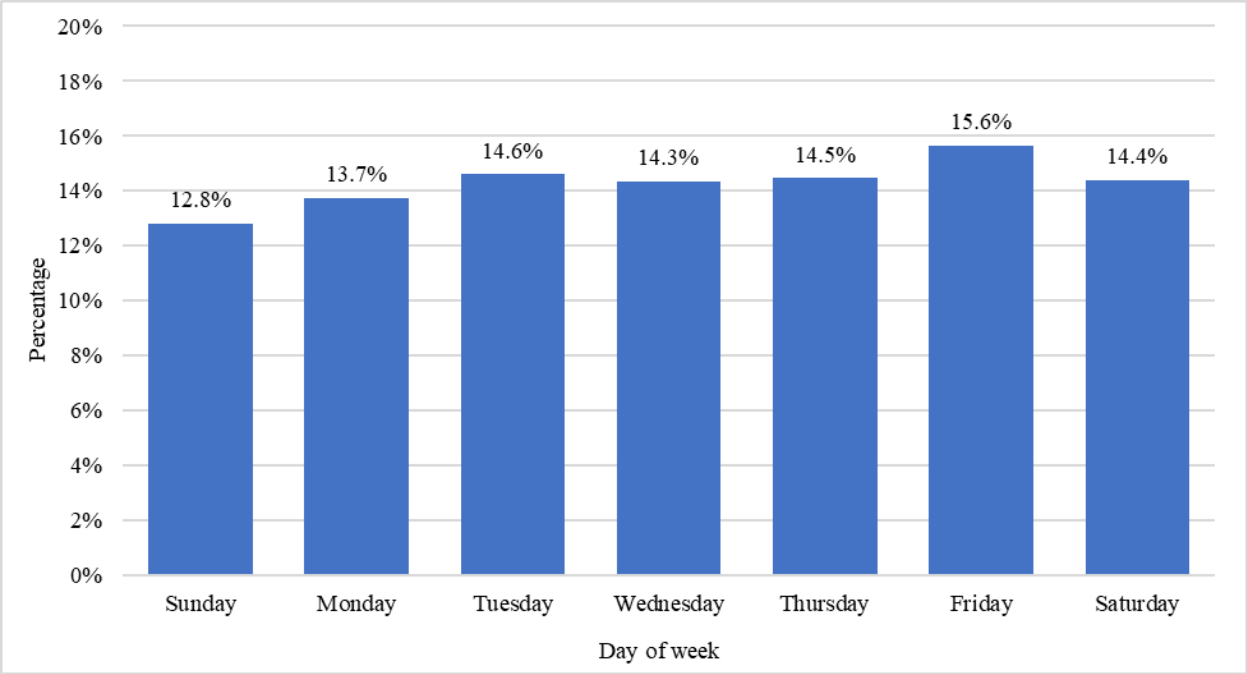
Figure 2.3 Percentage of unique* naloxone administrations by EMS agencies, by age group, gender, and incident location type, New York State, 2024



* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter. As such, additional data validation steps have been taken to deduplicate multiple administrations and counts may differ from previous annual and quarterly reports.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.3.

In 2024, Friday was the day of the week during which the highest number of unique naloxone administrations by EMS occurred (2,817 administrations, or 15.6 percent), followed by Tuesday (2,628 administrations, or 14.6 percent) (Figure 2.4). This highlights the need for individuals using opioids to obtain naloxone in their communities and always have it available. The fewest administrations occurred on Sundays (2,306 administrations or 12.8 percent) and Mondays (2,471 administrations, or 13.7 percent). In general, the distribution of unique administrations varied across months of the year, with counts being the highest during the summer months (data not shown). The month with the highest number of naloxone administrations in 2024 was May (1,780 administrations, or 9.9 percent), while the month with the lowest number was December (1,268 administrations, or 7.0 percent).

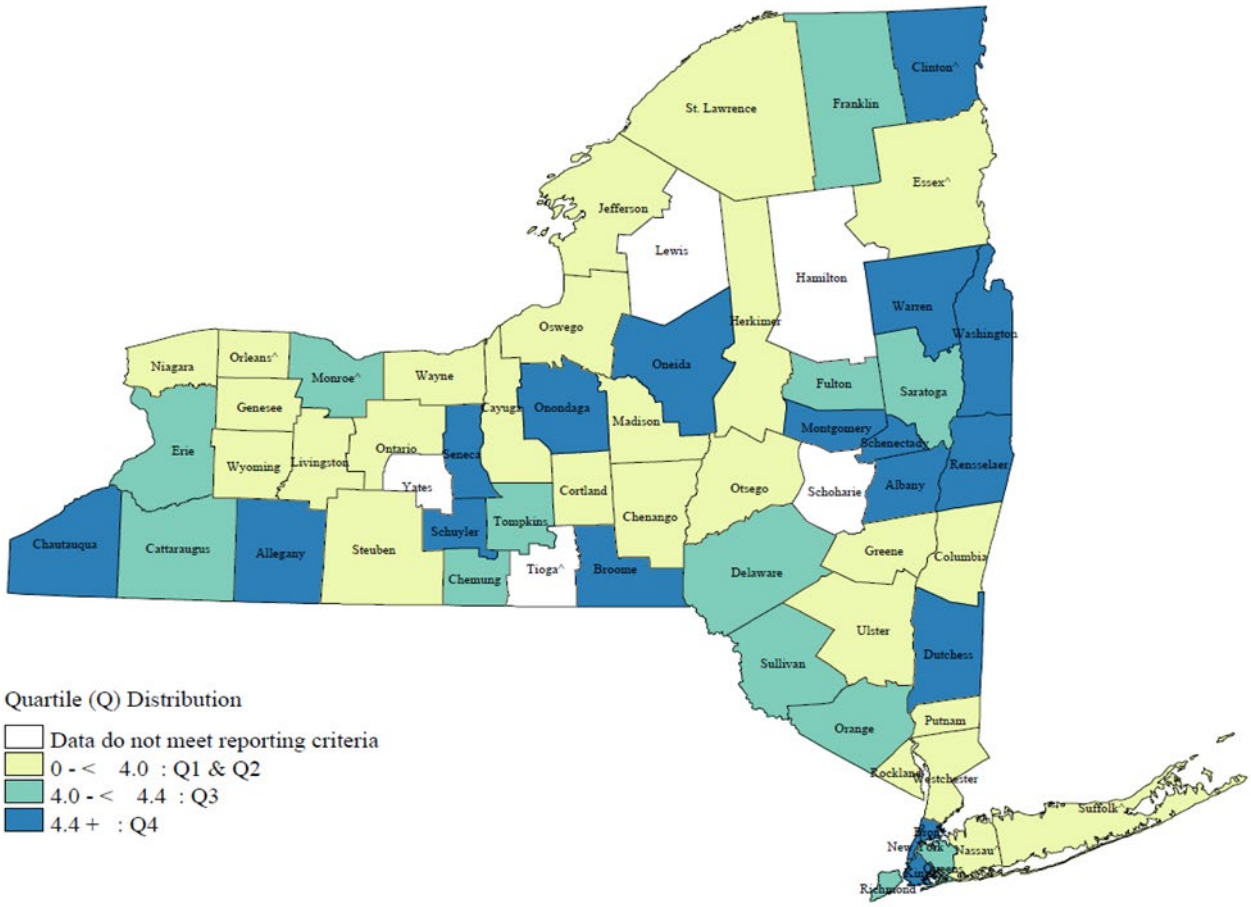
Figure 2.4 Percentage of unique* naloxone administrations by EMS agencies, by day of the week, New York State, 2024



* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter. As such, additional data validation steps have been taken to deduplicate multiple administrations.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.4.

Figure 2.5 shows variation in the county rate of unique naloxone administrations per 1,000 unique 911 EMS dispatches in 2024. The counties shown in blue were in the highest quartile (crude rates greater than or equal to 4.4 per 1,000) of naloxone administration per 1,000 unique 911 EMS dispatches. The counties with the highest rates of unique naloxone administrations in 2024, in order, were New York, Bronx, Washington, Rensselaer, Clinton, Seneca, Kings, Onondaga, Allegany, Oneida, Montgomery, Chautauqua, Broome, Schenectady, Dutchess, Albany, Schuyler, and Warren. Counties shown in yellow had the lowest rates of naloxone administration per 1,000 unique dispatches.

Figure 2.5 Unique* naloxone administrations by EMS agencies, crude rate per 1,000 unique 911 EMS dispatches, by county, New York State, 2024



* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter.
^ Data for this county may be incomplete because of a known reporting issue under review. Please interpret with caution.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
For detailed data for the map, see Appendix: Data Table 2.5.

Naloxone Administrations by Community Programs

The Department of Health's ODUH uses a harm reduction approach with programmatic roots in the State's network of 37 syringe exchange programs. It also has an emphasis on expanding access to medication for OUD, including buprenorphine and methadone. These medications help prevent death from overdose. The State's multi-pronged approach complements the longstanding efforts by EMS agencies throughout NYS and focuses on building overdose response capacity within communities throughout the state. This community capacity comprises trained responders, including individuals who use opioids, their families and friends, staff of agencies who work with people who use drugs, law enforcement personnel, firefighters, drug treatment providers, correction facility guards, incarcerated persons about to be released and their family members, and others. The core of this program is for community "laypersons" to be trained to recognize and respond to opioid overdoses by organizations registered with NYSDOH. These individuals are known as trained overdose responders. Under regulation, these entities or providers may maintain regulated opioid overdose prevention programs and include:

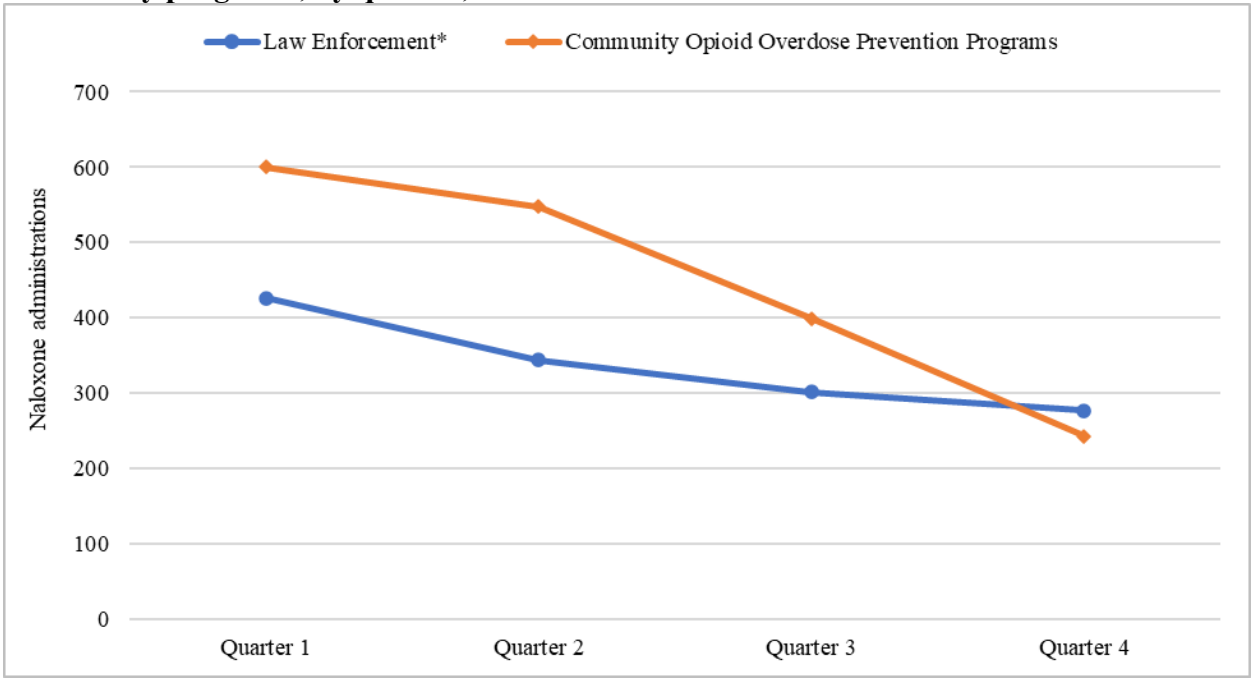
- a healthcare facility licensed under the Public Health Law;
- a physician, physician assistant, or nurse practitioner who is authorized to prescribe the use of an opioid antagonist;
- a drug treatment program licensed under the Mental Hygiene Law;
- a not-for-profit community-based organization incorporated under the not-for-profit corporation law and having the services of a Clinical Director; and
- a local health department.

In many municipalities, law enforcement personnel are frequently the first on the scene of an overdose. This report presents data on administrations of naloxone, including the number of naloxone administration reports received by NYSDOH for 2024 from EMS (n = 18,001), law enforcement (n = 1,349), and Community Opioid Overdose Prevention programs (n = 1,790) (Appendix: Data Table 2.12). For additional information about the State's harm reduction programs, please see the Office of Drug User Health webpage. All naloxone administration data are based on self-report. There are instances in which not all data fields are completed by the responder. There is often a lag in data reporting. Increases seen over time may represent increased follow-up with community registered programs and may or may not indicate an increase in overdose events, thus all data should be interpreted with caution. Naloxone data reflect the county in which the overdose occurred and in which the naloxone was administered – not necessarily the county of the overdosed person's residence.

Naloxone administration reports by law enforcement and community programs

In NYS during 2024, the highest numbers of naloxone administrations by law enforcement agencies were reported in January through March (426 administrations, Quarter 1), followed by April through June (344 administrations, Quarter 2). The highest numbers of naloxone administrations by Community Opioid Overdose Prevention programs were reported in January through March (600 administrations, Quarter 1), closely followed by April through June (548 administrations, Quarter 2) (Figure 2.6).

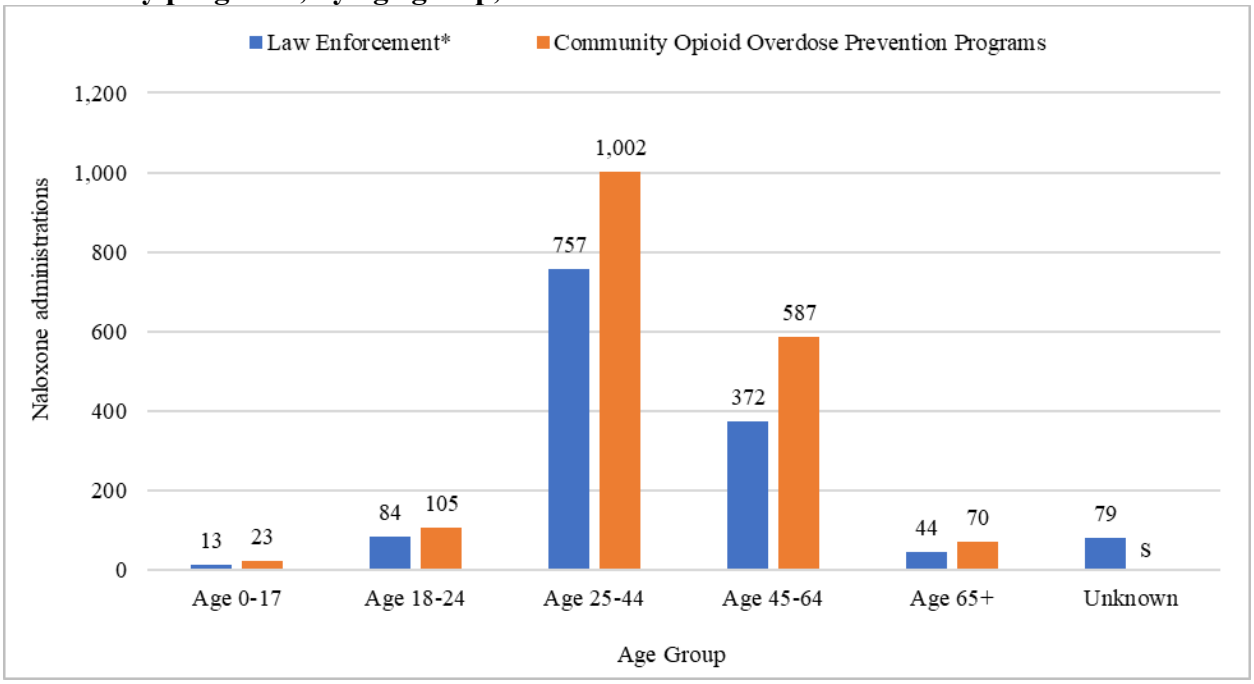
Figure 2.6 Number of naloxone administration reports by law enforcement* and community programs, by quarter, New York State 2024



* The law enforcement category does not comprehensively capture administrations reported in New York City and Nassau County.
Data source: New York State Department of Health AIDS Institute; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.6.

In NYS in 2024 for both law enforcement agencies and Community Opioid Overdose Prevention programs most naloxone administrations were administered to individuals aged 25-44 years, followed by those aged 45-64 years (Figure 2.7).

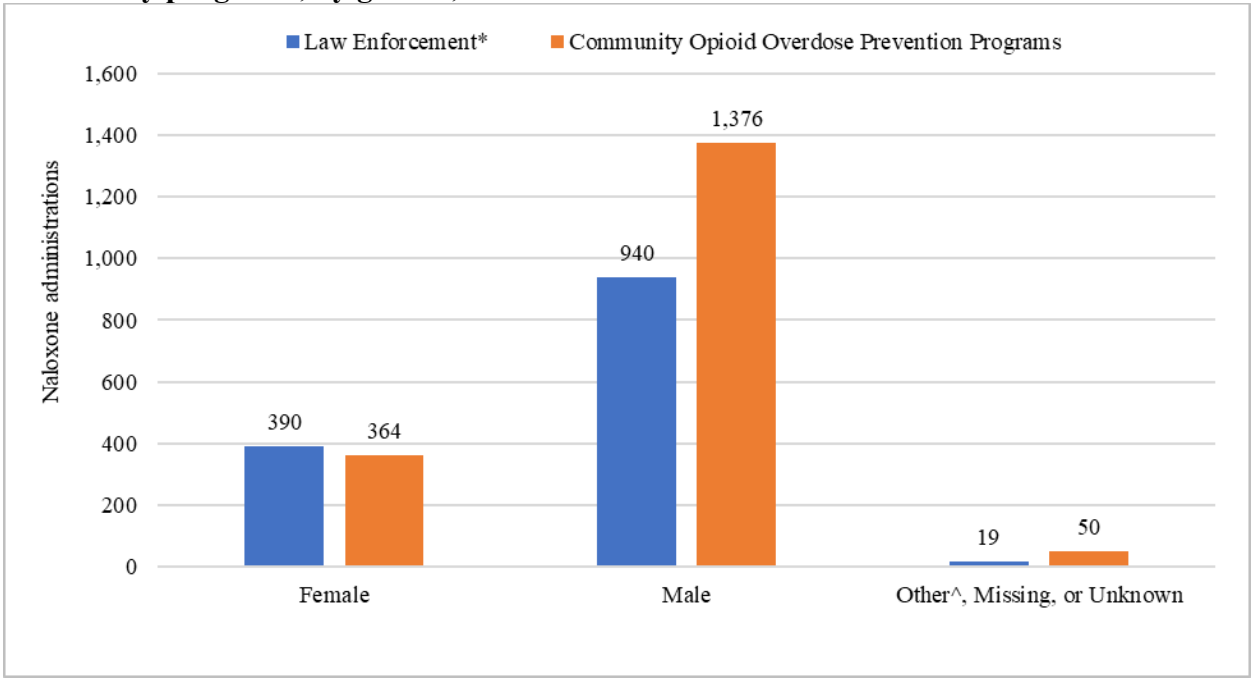
Figure 2.7 Number of naloxone administration reports by law enforcement* and community programs, by age group, New York State 2024



s: Data do not meet reporting criteria.
* The law enforcement category does not comprehensively capture administrations reported in New York City and Nassau County.
Data source: New York State Department of Health AIDS Institute; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.7.

In NYS during 2024, most naloxone administrations were administered to males according to reports from both law enforcement agencies and Community Opioid Overdose Prevention programs (Figure 2.8). This was similar to the pattern among EMS administrations.

Figure 2.8 Number of naloxone administration reports by law enforcement* and community programs, by gender, New York State 2024



* The law enforcement category does not comprehensively capture administrations reported in New York City and Nassau County.
^ Other includes "Transgender", " Non-binary", "Gender Non-conforming" and "Other, not specified".
Data source: New York State Department of Health AIDS Institute; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.8.

Suspected Opioid Overdose

An opioid overdose occurs when opioids negatively affect the part of the brain that regulates breathing, resulting in slowed or ineffective breathing, which can be life threatening. Since administrations of naloxone are given to patients presenting with signs and symptoms of a suspected opioid overdose, this is often used as a proxy indicator for opioid overdose. Although naloxone administration has served as a useful marker for opioid overdoses, there are instances when naloxone is administered to individuals who are presenting with symptoms similar to an overdose (such as loss of consciousness) but are not experiencing an actual overdose. Conversely, individuals with a suspected opioid overdose who present mild symptoms and do not meet clinical requirements, may not receive naloxone as a component of emergency care. As such, these encounters are not captured in the counts of naloxone administration. To improve surveillance and monitoring, an indicator for "suspected opioid overdose" was developed using EMS data. Suspected opioid overdoses include events where naloxone was administered (by EMS responders or by others before EMS responders' arrival) and the patient improved in response to naloxone, or evidence of a possible opioid overdose was observed based on recorded patient chief complaint, physical signs, or the EMS provider's impression.

Starting in 2021, the quality of EMS data recorded on the ePCRs significantly improved through the complete transition from the National EMS Information Systems (NEMSIS) 2.2.1 standard to the NEMSIS 3.5.0 standard in the ImageTrend platform. As a result, more complete and better-quality data allowed for the development and standardization of this indicator.

Suspected Opioid Overdose Definition using EMS Data

The NYS definition for suspected opioid overdose includes EMS responses for which *ANY* of the following criteria is true.

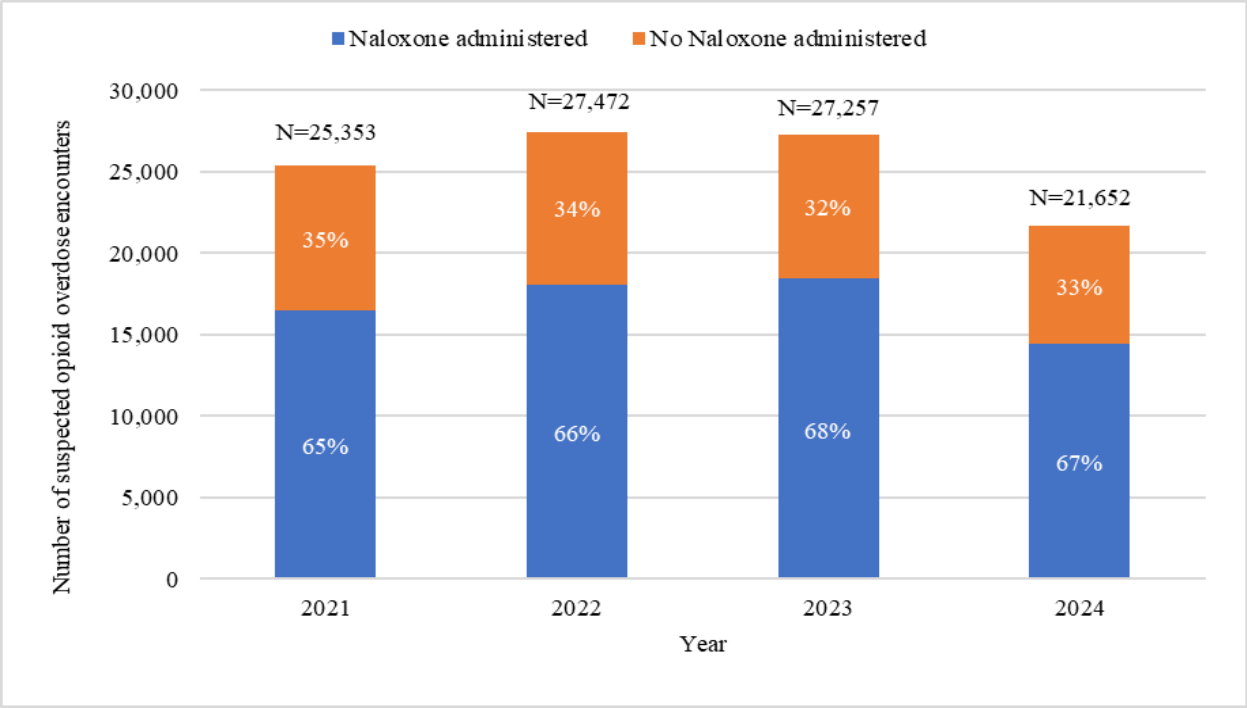
- Naloxone administered with positive response; or,
- Provider impressions indicate poisoning by opioids *and* naloxone is administered or at least two keywords indicating an opioid overdose mentioned in narrative; or,
- Provider impressions indicate opioid related disorder *and* naloxone is administered or at least three keywords indicating an opioid overdose mentioned in narrative; or,
- Provider impressions indicate unspecified drug overdose *and* opioid term is mentioned in narrative *and* response to naloxone is not worse *and* no narcotics are administered by EMS; or
- Provider impressions indicate unspecified drug overdose, cardiac arrest, apnea, or respiratory failure *and* opioid term is mentioned in narrative *and* no narcotics are administered by EMS *and* patient fatality is indicated; or,
- Opioid term *and* overdose term mentioned in narrative (with no exclusion term) *and* at least two keywords indicating an opioid overdose mentioned in narrative *and* no narcotics are administered by EMS.

For a more detailed methodology, see the section titled NYS Suspected Opioid Overdose Syndrome – NEMSIS v3.5.0 under Methods.

EMS suspected opioid overdose encounters with and without reported naloxone administration on scene

In 2024, there were 21,652 suspected opioid overdose encounters, representing a 20.6 percent decrease from 27,257 in 2023. In 2024, approximately 67 percent of suspected opioid overdose encounters received naloxone administration, consistent with prior years (Figure 2.9). The remaining 33 percent of the suspected opioid overdoses, in which naloxone may not have been administered include patients who were dead at scene, or those who presented with mild symptoms and did not meet clinical requirements for a naloxone administration. As such, these encounters are not captured in the counts of naloxone administration.

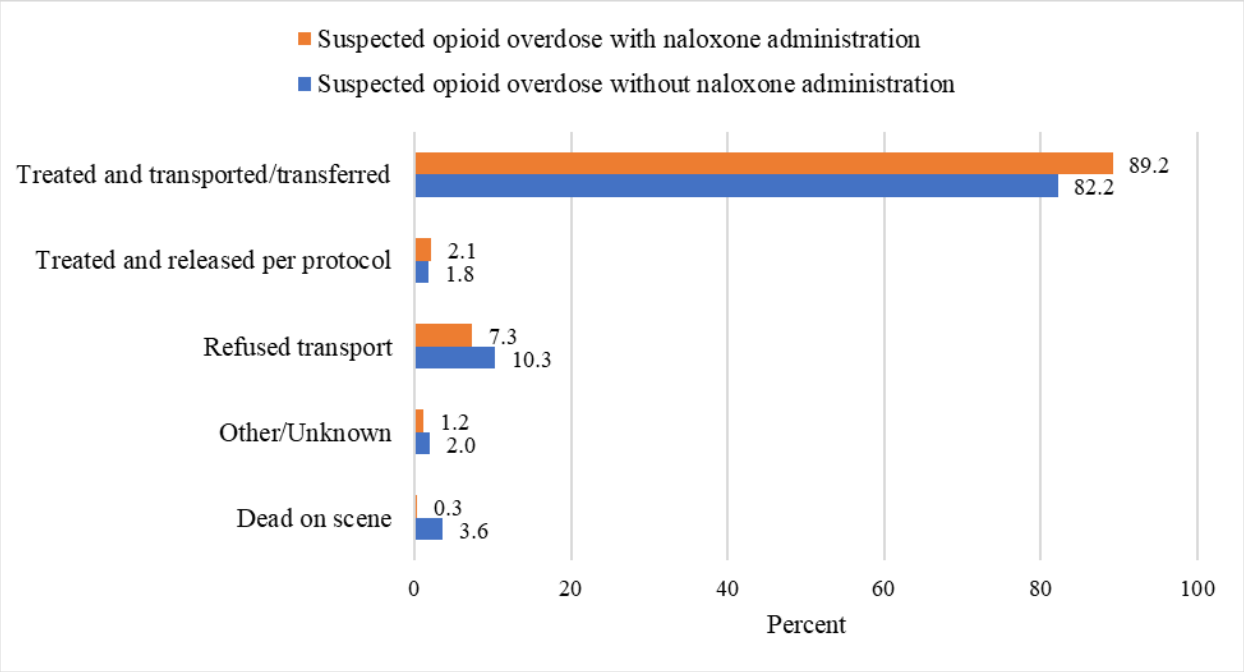
Figure 2.9 EMS suspected opioid overdose encounters with and without* reported naloxone administration on scene, New York State, 2021 to 2024



* These include unique naloxone administrations reported in the medication administered structured field and may include bystander and administrations prior to EMS arrival.
Data source: NYSDOH, Division of State Emergency Medical Services; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.9.

In 2024, 89.2 percent of suspected opioid overdose encounters with reported naloxone administration were treated and transported/transferred, compared to 82.2 percent of suspected opioid overdose encounters without reported naloxone administration (Figure 2.10). The proportion of suspected opioid overdose patients who refused transport to a medical facility was higher among those without naloxone administration (10.3 percent), compared to those received naloxone (7.3 percent).

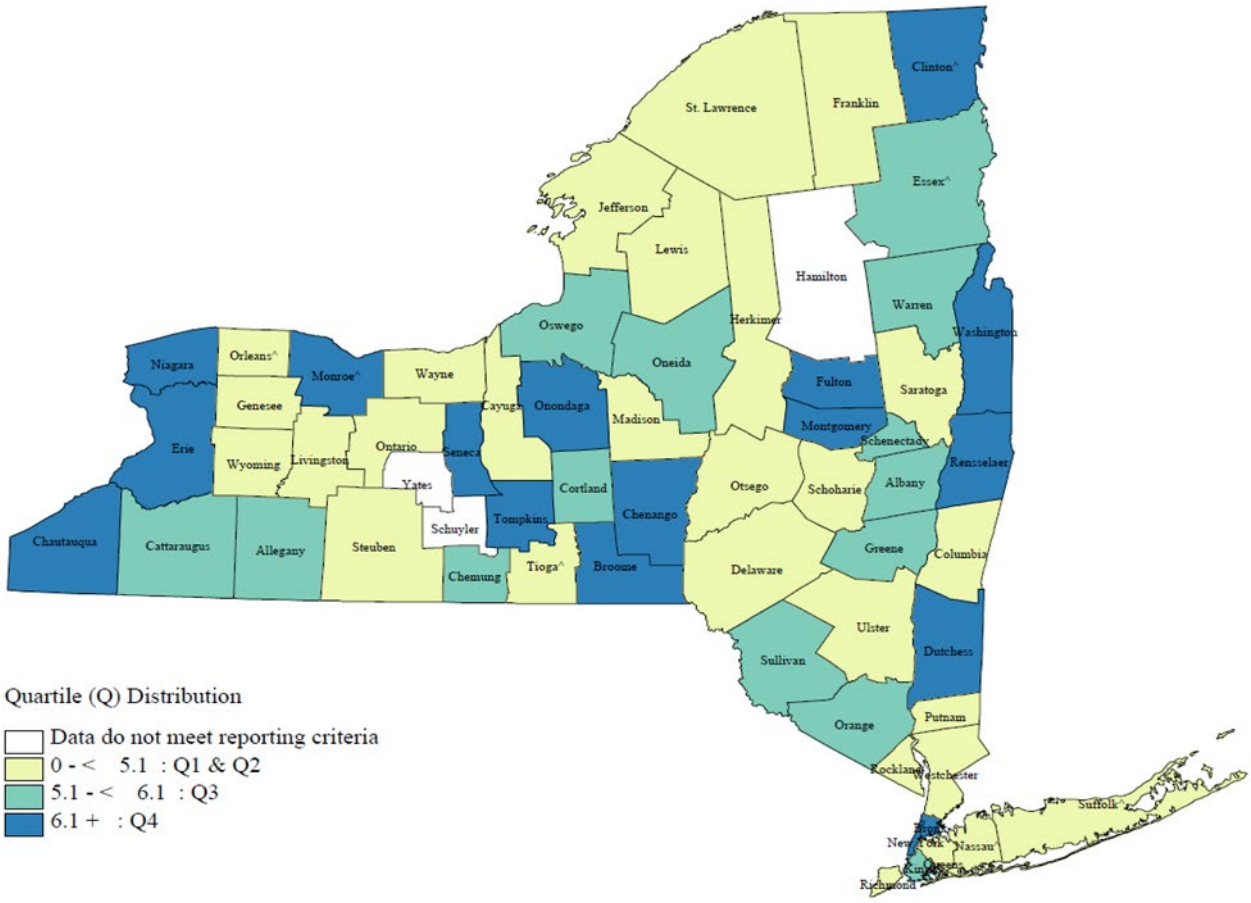
Figure 2.10 Percentage of EMS suspected opioid overdose encounters with and without* reported naloxone administration, by patient disposition^, New York State, 2024



* These include unique naloxone administrations reported in the medication administered structured field and may include bystander and administrations prior to EMS arrival.
^ The patient disposition for an EMS event identifying whether a patient received care and/or services and transport.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 2.10.

Figure 2.11 shows variation in the county rate of suspected opioid overdoses per 1,000 unique 911 EMS dispatches in 2024. The counties shown in blue had the highest crude rates (rates greater than or equal to 6.1 per 1,000) of suspected opioid overdoses encounters per 1,000 unique 911 EMS dispatches. The counties with the highest rates of suspected opioid overdoses in 2024, in order, were Tompkins, Broome, Onondaga, New York, Monroe, Erie, Rensselaer, Niagara, Chenango, Bronx, Chautauqua, Montgomery, Seneca, Dutchess, Washington, Clinton, and Fulton. Counties shown in yellow had the lowest rates of suspected opioid overdoses per 1,000 unique dispatches.

Figure 2.11 EMS suspected opioid overdose encounters, crude rate per 1,000 unique 911 EMS dispatches, by county, New York State, 2024



^ Data for this county may be incomplete because of a known reporting issue under review. Please interpret with caution.

Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025

For detailed data for the map, see Appendix: Data Table 2.11.

3 - Hospitalization and Emergency Department Visits Data

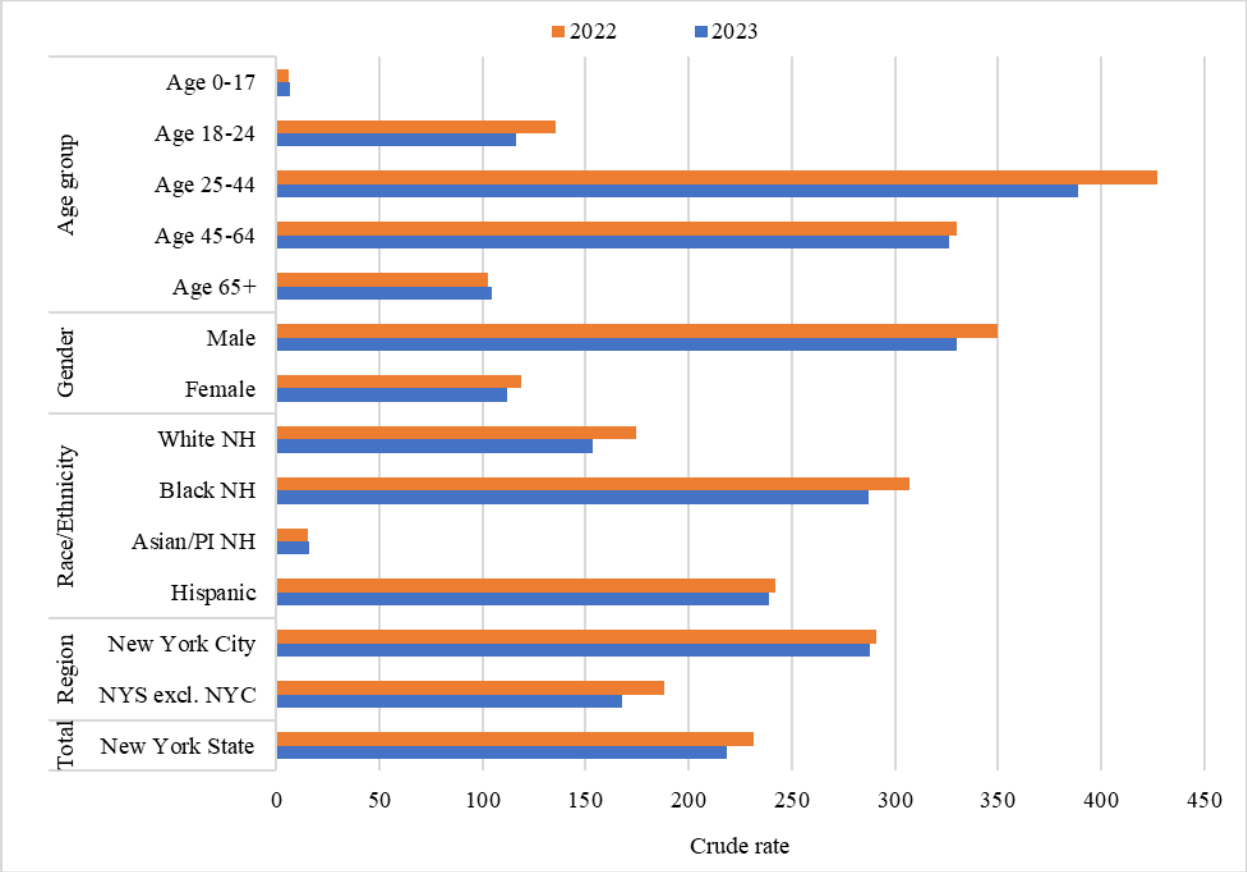
Severe drug overdoses are often treated in the emergency departments and hospitals. Data for both ED visits and hospital admissions are obtained from the Statewide Planning and Research Cooperative System (SPARCS) database. These are important data sources to examine the burden by opioids on a part of the healthcare system.

ED and hospitalization indicators are based on diagnosis codes in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) reported in records by the EDs and hospital facilities and are limited by the quality of reporting and coding by the facilities. The indicators are defined based on the principal diagnosis code.

Overdose deaths involving opioids and nonfatal opioid-related hospital events

The NYSDOH combines multiple data sources to measure opioid use and overdose. This includes overdose deaths involving any opioid from mortality data sources and ED visits and hospital discharge data for non-fatal outpatient involving opioid overdose and use disorders. Collectively, these opioid events are a representation of overall health impacts of opioids within NYS. Among NYS residents in 2023, there were 42,758 opioid-related and overdose events, representing a crude rate of 218.5 per 100,000 population, a 5.7 percent decrease from 231.6 per 100,000 (45,572 events) in 2022 (Figure 3.1). Although there was a 9.0 percent decrease from 2022 (427.3 per 100,000) to 2023 (388.8 per 100,000) among those aged 25-44 years, the 2023 rate for this group remained the highest among all age groups. Compared to 2022, rates increased 10.3 percent for residents aged 0-17 (from 5.8 per 100,000 to 6.4 per 100,000), and 1.9 percent for residents aged 65+ (from 102.6 per 100,000 to 104.5 per 100,000). The rate was almost three times higher among males (329.7 per 100,000) than among females (112.2 per 100,000). The 2023 rate was highest among Black non-Hispanic individuals (286.9 per 100,000), followed by those for Hispanic (239.2 per 100,000), and White non-Hispanic individuals (153.4 per 100,000). In 2023, NYC had a higher rate (287.7 per 100,000) than NYS excluding NYC (168.0 per 100,000).

Figure 3.1 Overdose deaths involving opioids and nonfatal opioid-related hospital events, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023



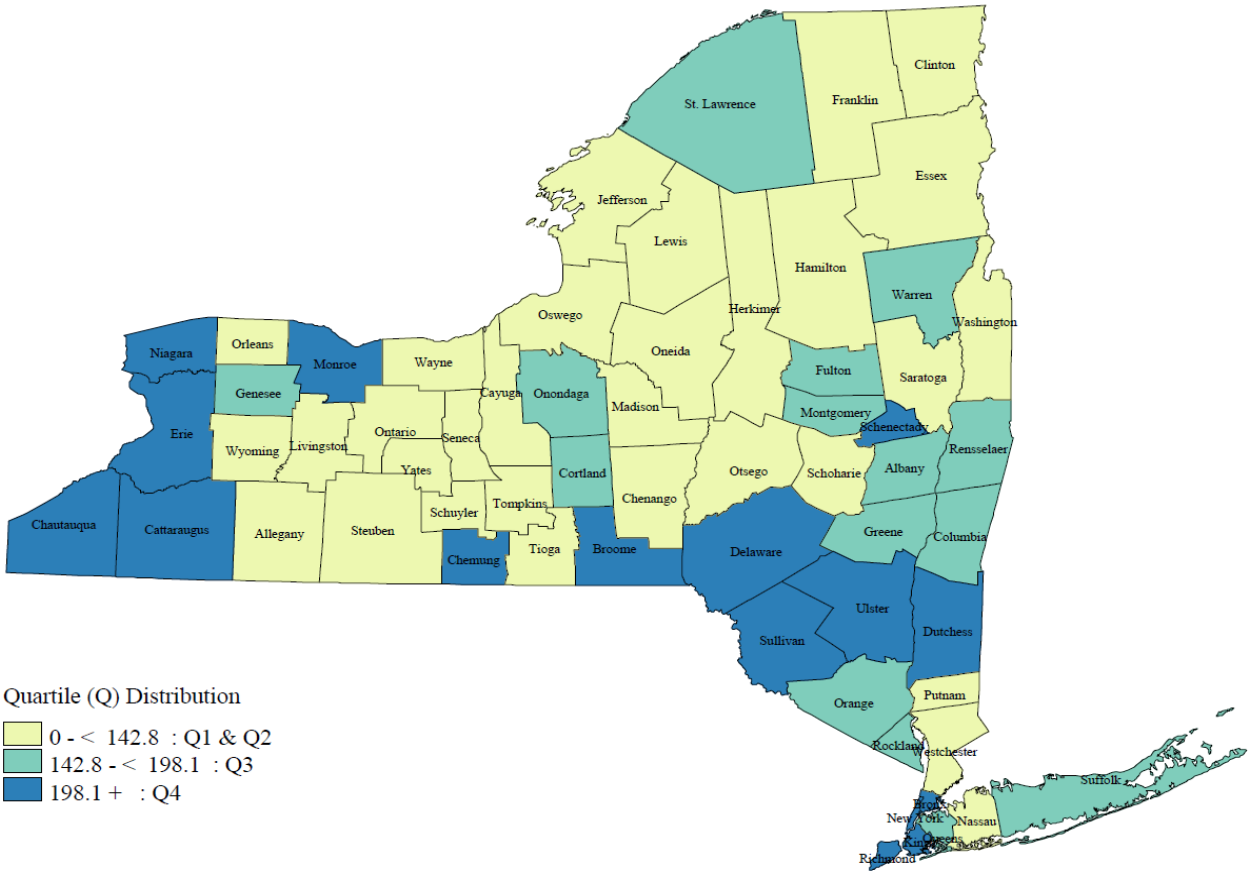
White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH= Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City

Data sources: Death data are from CDC WONDER, accessed April 2025; ED Visits and Hospital Discharges are from New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), as of April 2025

For detailed data for the Figure, see Appendix: Data Table 3.1.

In 2023, the 16 counties with overdose deaths involving opioids and nonfatal opioid-related hospital events in the highest quartile (crude rates greater than or equal to 198.1 per 100,000 population), in order, were Bronx, Chautauqua, New York, Cattaraugus, Sullivan, Niagara, Dutchess, Schenectady, Delaware, Ulster, Kings, Richmond, Monroe, Broome, Chemung, and Erie (Figure 3.2).

Figure 3.2 Overdose deaths involving opioids and nonfatal opioid-related hospital events, crude rate per 100,000 population, by county, New York State, 2023



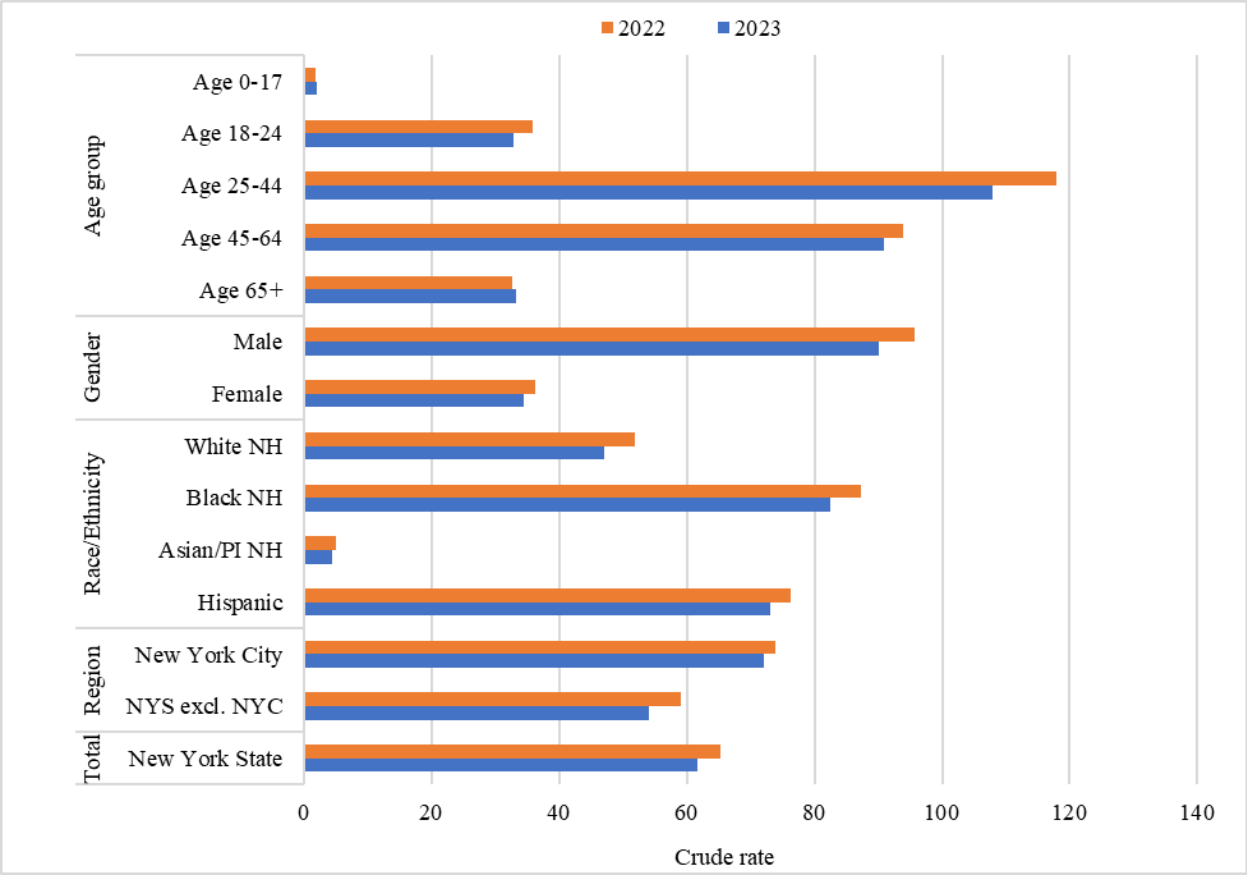
Data sources: Death data are from CDC WONDER, accessed April 2025; ED Visits and Hospital Discharges are from New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), as of April 2025

For detailed data for the map, see Appendix: Data Table 3.2.

Hospital discharges involving opioids

Among NYS residents in 2023, there were 12,063 hospital discharges for opioid use (including overdose and disorders), representing a crude rate of 61.6 per 100,000 population (Figure 3.3). This was a decrease of 5.6 percent from 65.3 per 100,000 (12,851 discharges) in 2022. In 2023, the rate was highest among those aged 25-44 years (108.0 per 100,000), followed by the rate among those aged 45-64 years (90.8 per 100,000). The rate among males (90.1 per 100,000) was over two and a half times higher than that among females (34.5 per 100,000). The rate was highest among Black non-Hispanic individuals (82.4 per 100,000), followed by those for Hispanic (73.1 per 100,000) and White non-Hispanic individuals (47.0 per 100,000). NYC (72.0 per 100,000) had a higher rate than NYS excluding NYC (54.0 per 100,000).

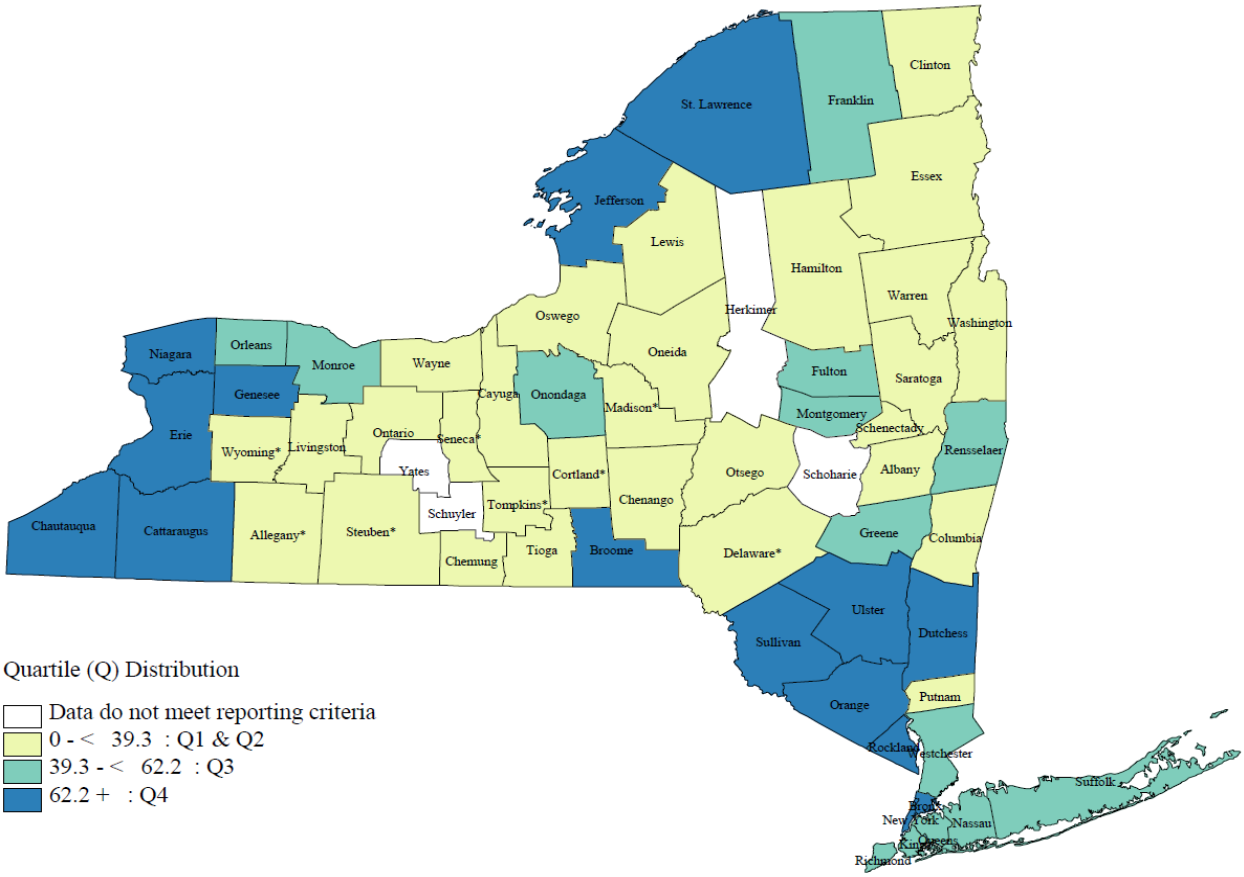
Figure 3.3 Hospital discharges involving opioid use (including overdose and disorders), crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH= Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 3.3.

The 15 counties in the highest quartile (crude rates greater than or equal to 62.2 per 100,000 population) for hospital discharges due to opioid use (including overdose and disorders) in 2023, in order, were Bronx, Dutchess, Chautauqua, St. Lawrence, Ulster, Niagara, New York, Erie, Rockland, Jefferson, Orange, Genesee, Sullivan, Broome, and Cattaraugus (Figure 3.4).

Figure 3.4 Hospital discharges involving opioid use (including overdose and disorders), crude rate per 100,000 population, by county, New York State, 2023

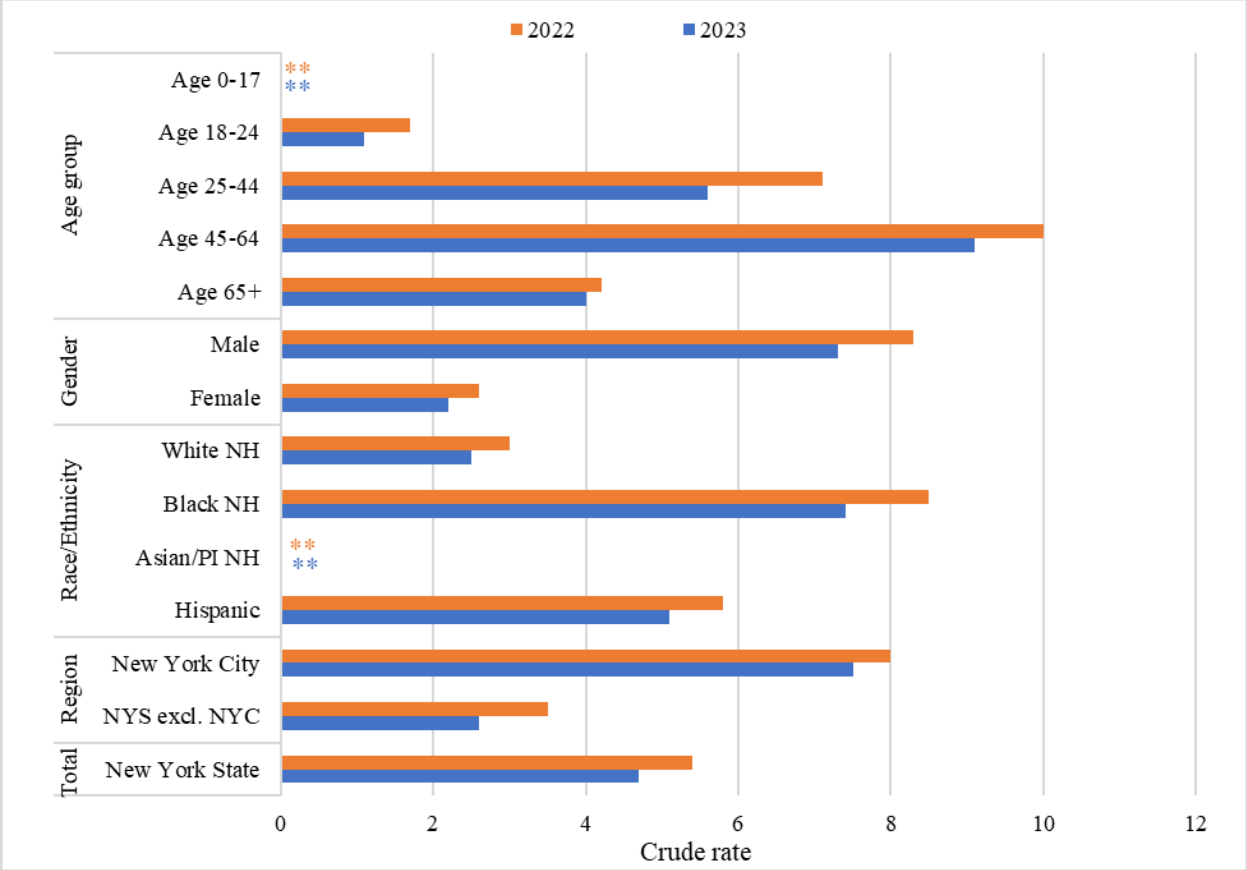


* Fewer than 10 events in the numerator, therefore the rate is unstable.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the map, see Appendix: Data Table 3.4.

Hospital discharges involving heroin overdose

The rates of the hospital discharges involving heroin overdose for all sub-population categories decreased from 2022 to 2023. Among NYS residents, the number of hospital discharges involving heroin overdose decreased from 1,064 in 2022 (5.4 per 100,000) to 917 in 2023 (4.7 per 100,000) (Figure 3.5). In 2023, the rate was highest among those aged 45-64 years (9.1 per 100,000), followed by the rate among those aged 25-44 years (5.6 per 100,000). The 2023 rate was over three times higher among males (7.3 per 100,000) than that among females (2.2 per 100,000). The rate in 2023 was highest among Black non-Hispanic individuals (7.4 per 100,000), followed by the rates for Hispanic (5.1 per 100,000) and White non-Hispanic individuals (2.5 per 100,000). In 2023, NYC had a rate (7.5 per 100,000), which was more than two times higher than the rate for NYS excluding NYC (2.6 per 100,000).

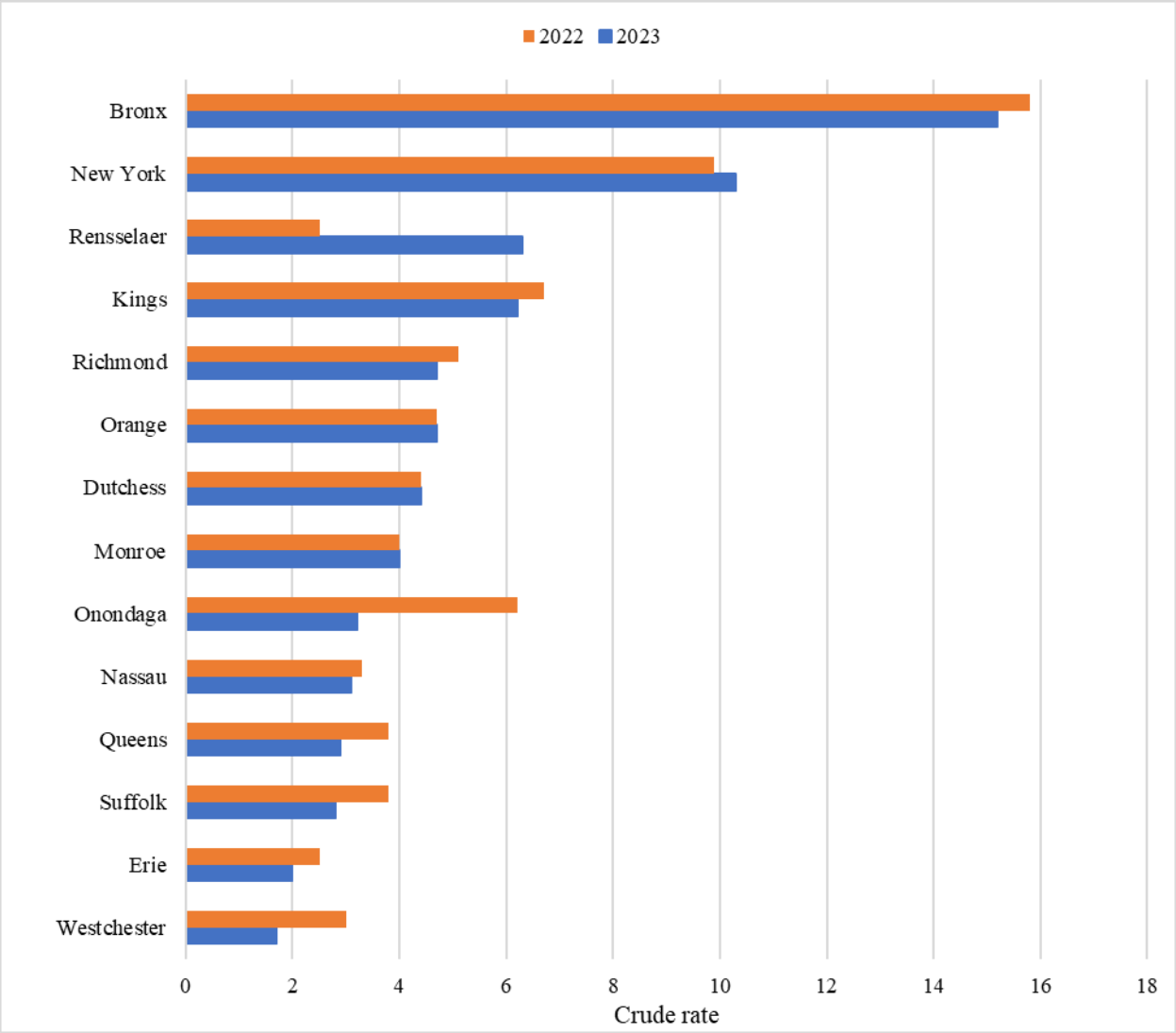
Figure 3.5 Hospital discharges involving heroin overdose, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 3.5.

In 2023, among counties with ten or more hospital discharges involving heroin overdose, the fourteen counties with the highest crude rates were Bronx, New York, Rensselaer, Kings, Richmond, Orange, Dutchess, Monroe, Onondaga, Nassau, Queens, Suffolk, Erie, and Westchester (Figure 3.6). While most counties represented here experienced a decline in crude rates from 2022 to 2023, New York and Rensselaer experienced increases.

Figure 3.6 Hospital discharges involving heroin overdose, crude rate per 100,000 population, by county, New York State, 2022 and 2023

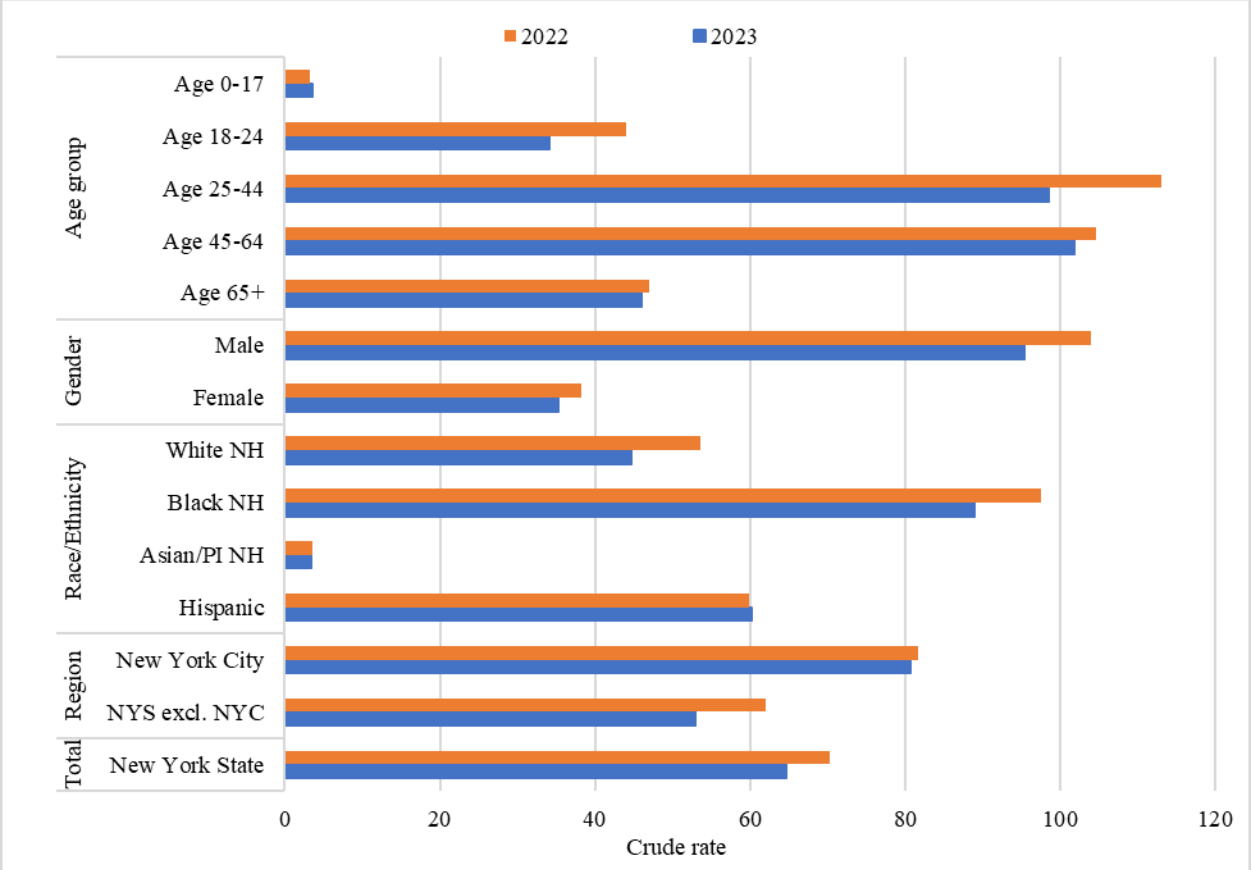


Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 3.6.

Emergency department visits involving any opioid overdose

Among NYS residents, the number of all ED visits (including outpatients and patients subsequently admitted) involving any opioid overdose decreased from 13,837 in 2022 (70.3 per 100,000) to 12,647 in 2023 (64.6 per 100,000) (Figure 3.7). In 2023, the rate was highest among those aged 45-64 years (101.8 per 100,000), followed by the rate among those aged 25-44 years (98.5 per 100,000). The 2023 rate was more than two and a half times higher among males (95.3 per 100,000) than that among females (35.3 per 100,000). The rate was highest among Black non-Hispanic individuals (88.9 per 100,000), followed by the rates for Hispanic (60.2 per 100,000) and White non-Hispanic individuals (44.6 per 100,000). In 2023, the rate for NYS excluding NYC (52.9 per 100,000) was lower than NYC (80.7 per 100,000).

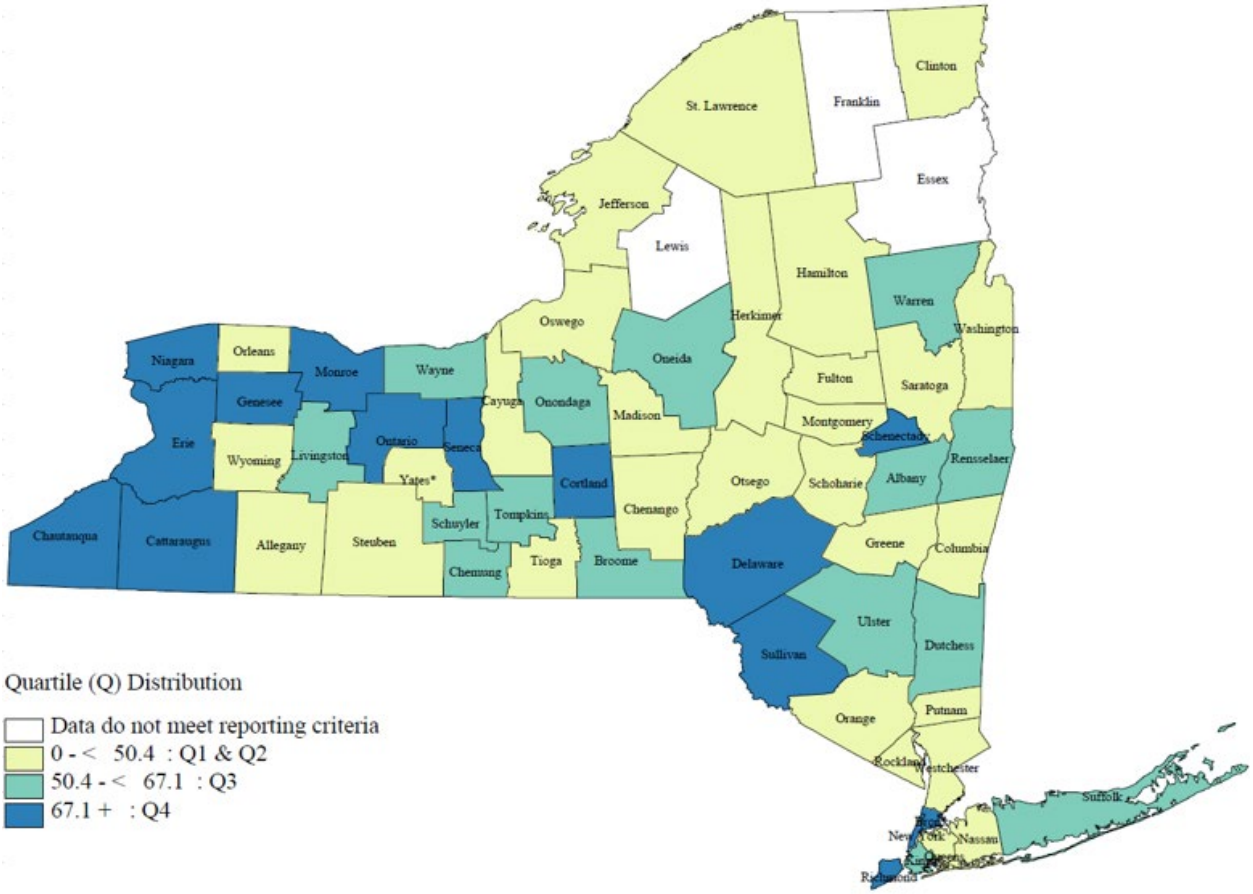
Figure 3.7 All emergency department visits (including outpatients and admitted patients) involving any opioid overdose, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 3.7.

In 2023, the 15 counties in the highest quartile (crude rates greater than or equal to 67.1 per 100,000 population) for ED visits due to any opioid overdose, in order, were Chautauqua, Bronx, New York, Sullivan, Monroe, Niagara, Delaware, Cortland, Seneca, Cattaraugus, Schenectady, Richmond, Genesee, Ontario, and Erie (Figure 3.8).

Figure 3.8 All emergency department visits (including outpatients and admitted patients) involving any opioid overdose, crude rate per 100,000 population, by county, New York State, 2023

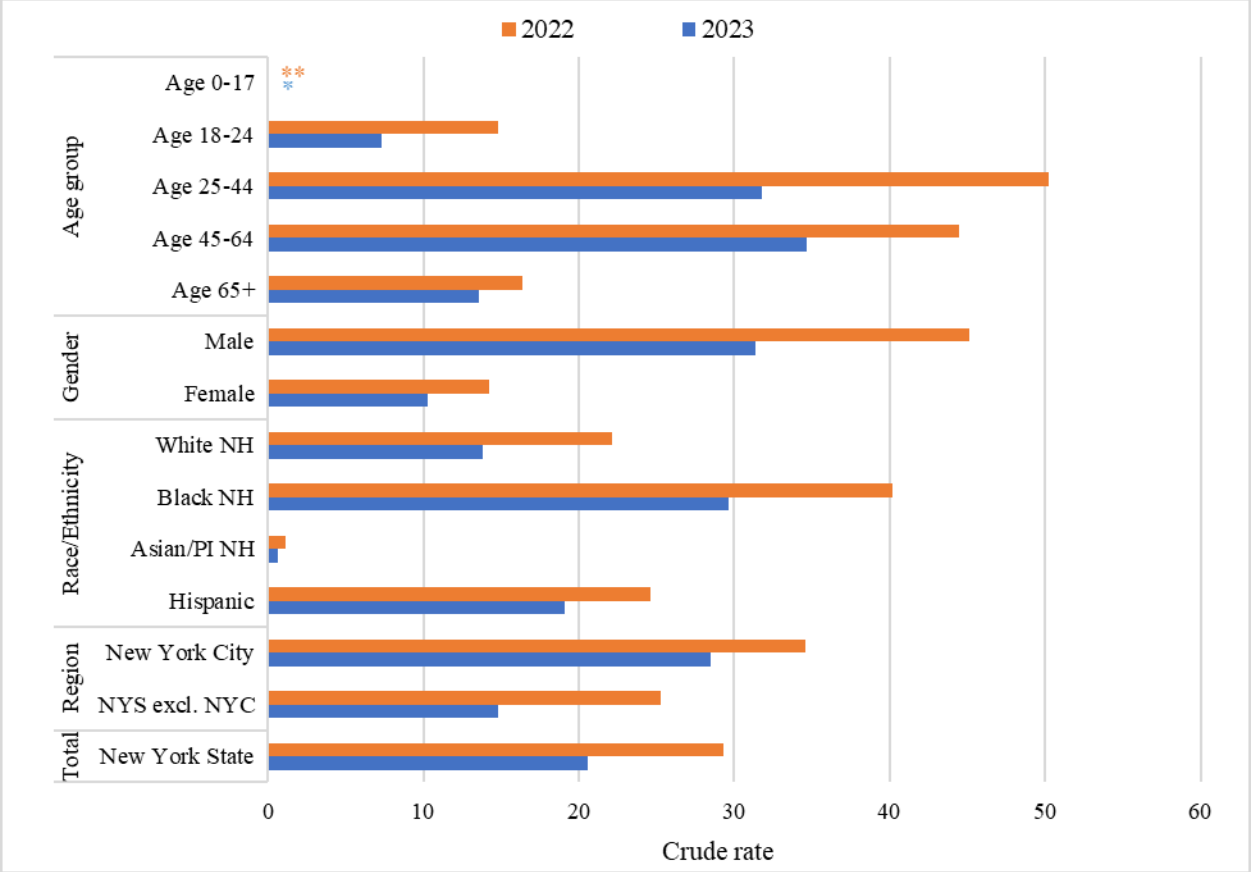


* Fewer than 10 events in the numerator, therefore the rate is unstable.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the map, see Appendix: Data Table 3.8.

Emergency department visits involving heroin overdose

Among NYS residents, the number of ED visits (including outpatients and subsequently admitted patients) involving any heroin overdose decreased by 30.0 percent from 5,759 in 2022 (29.3 per 100,000) to 4,030 in 2023 (20.6 per 100,000) (Figure 3.9). In 2023, the rate was highest among those aged 45-64 years (34.7 per 100,000), followed by the rate among those aged 25-44 years (31.8 per 100,000). The rate was more than three times higher for males (31.4 per 100,000) than that for females (10.3 per 100,000). The rate was highest among Black non-Hispanic individuals (29.6 per 100,000), followed by the rates for Hispanic (19.1 per 100,000) and White non-Hispanic individuals (13.8 per 100,000). In 2023, NYC (28.5 per 100,000) had a higher rate than that of NYS excluding NYC (14.8 per 100,000).

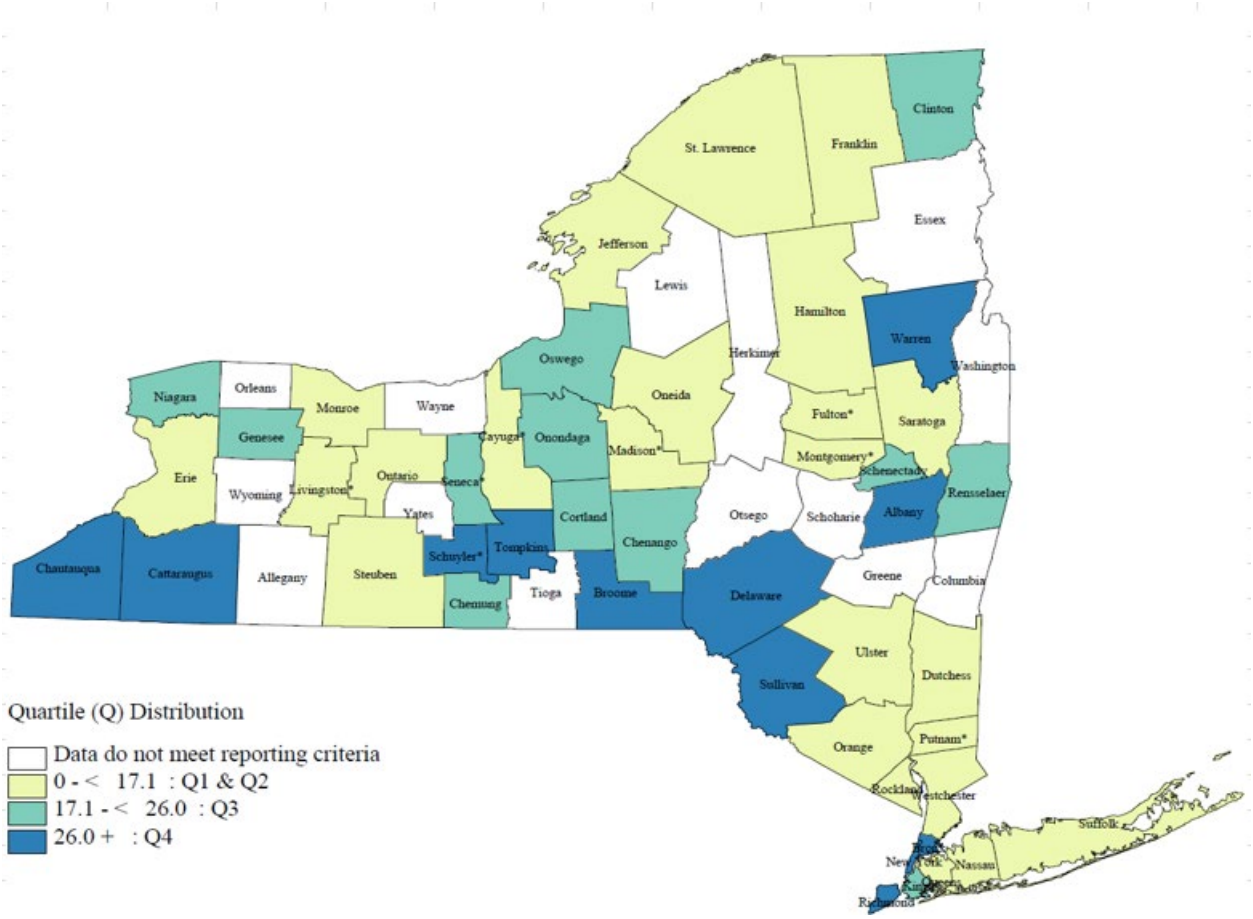
Figure 3.9 All emergency department visits (including outpatients and admitted patients) involving heroin overdose, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 3.9.

In 2023, the 11 counties in the highest quartile (stable crude rates greater than or equal to 26.0 per 100,000 population) for ED visits due to heroin overdose, in order, were Chautauqua, Bronx, Sullivan, New York, Warren, Delaware, Richmond, Cattaraugus, Broome, Albany, and Tompkins (Figure 3.10).

Figure 3.10 All emergency department visits (including outpatients and admitted patients) involving heroin overdose, crude rate per 100,000 population, by county, New York State, 2023

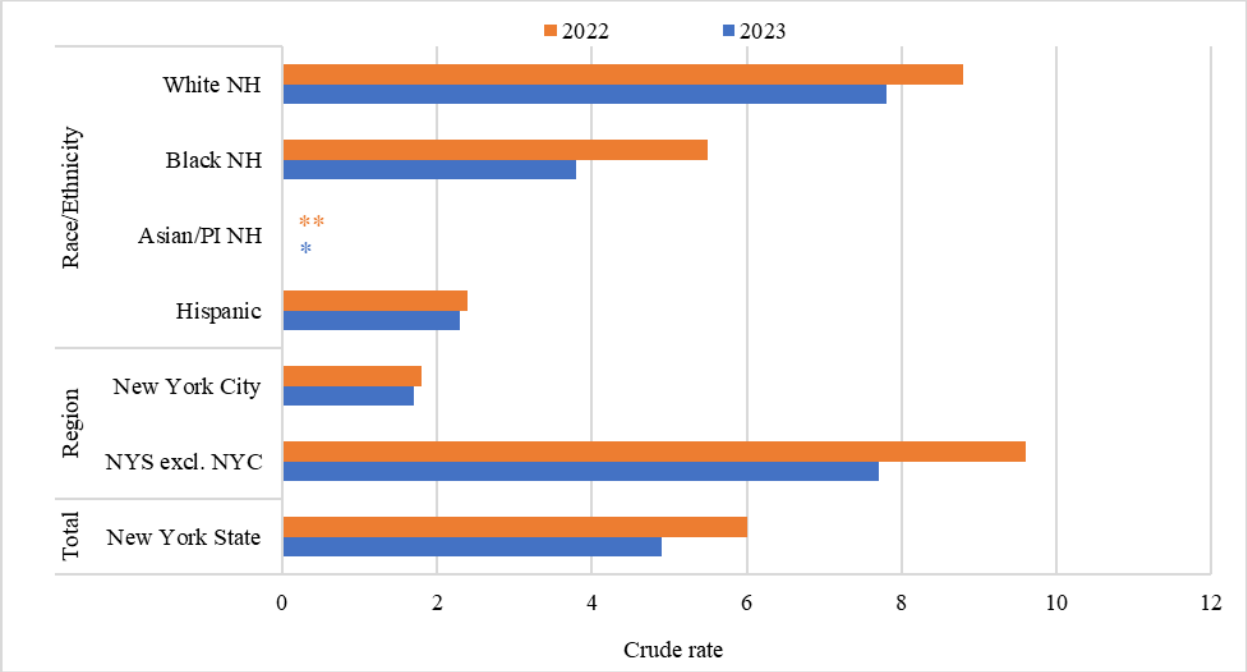


* Fewer than 10 events in the numerator, therefore the rate is unstable.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the map, see Appendix: Data Table 3.10.

Neonatal withdrawal syndrome

Among NYS residents, the number of newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances decreased 19.4 percent from 1,165 in 2022 to 939 in 2023, and the rate per 1,000 newborn discharges decreased from 6.0 to 4.9 (Figure 3.11). In 2023, the rate was highest among White non-Hispanic newborns (7.8 per 1,000), followed by the rates for Black non-Hispanic (3.8 per 1,000) and Hispanic newborns (2.3 per 1,000). In 2023, the rate for NYS excluding NYC (7.7 per 1,000) was over four and a half times higher than that of NYC (1.7 per 1,000).

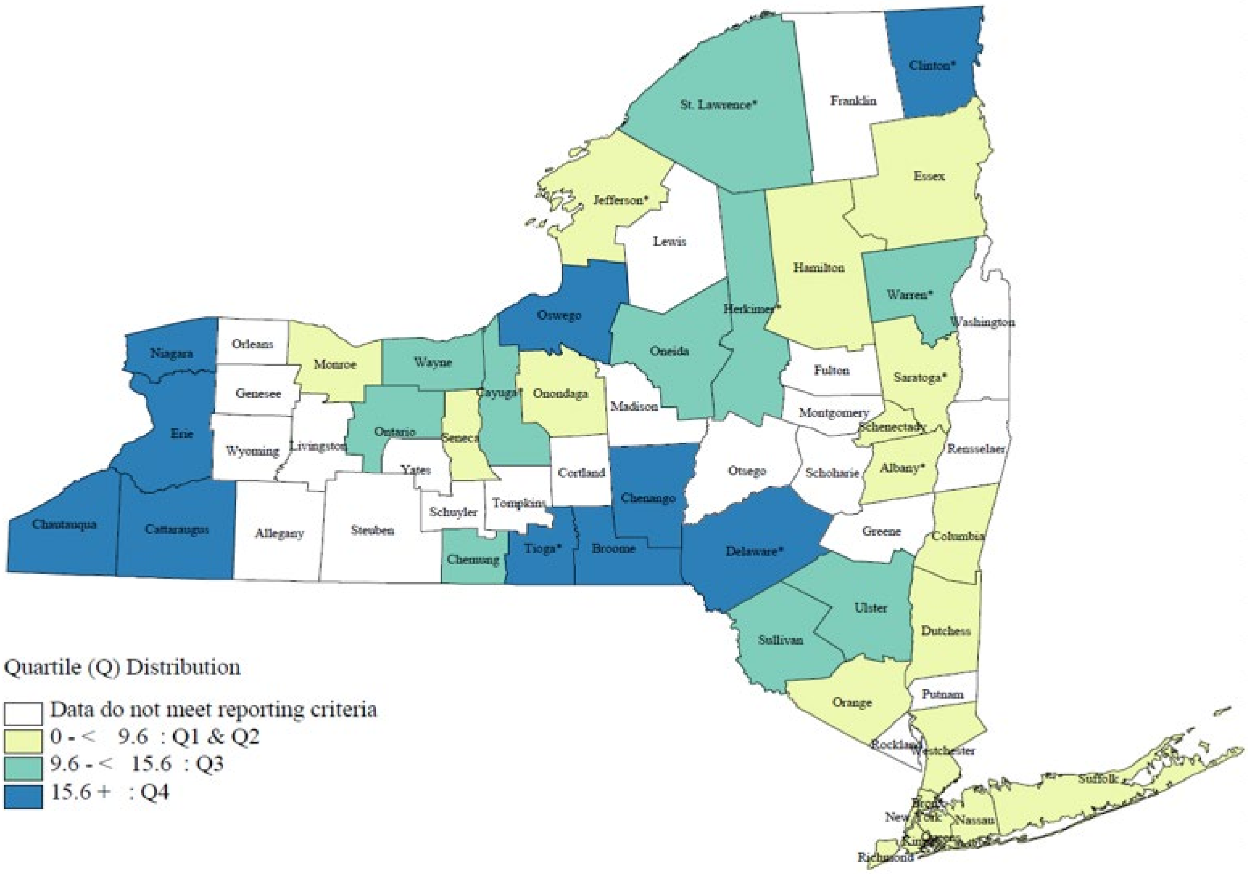
Figure 3.11 Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances (any diagnosis), rate per 1,000 newborn discharges, by subpopulation, New York State, 2022 and 2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 3.11.

In 2023, the seven counties in the highest quartile (stable crude rates greater than or equal to 15.6 per 1,000 newborn discharges) for newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances, in order, were Chenango, Oswego, Chautauqua, Cattaraugus, Niagara, Broome, and Erie (Figure 3.12).

Figure 3.12 Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances (any diagnosis), rate per 1,000 newborn discharges, by county, New York State, 2023



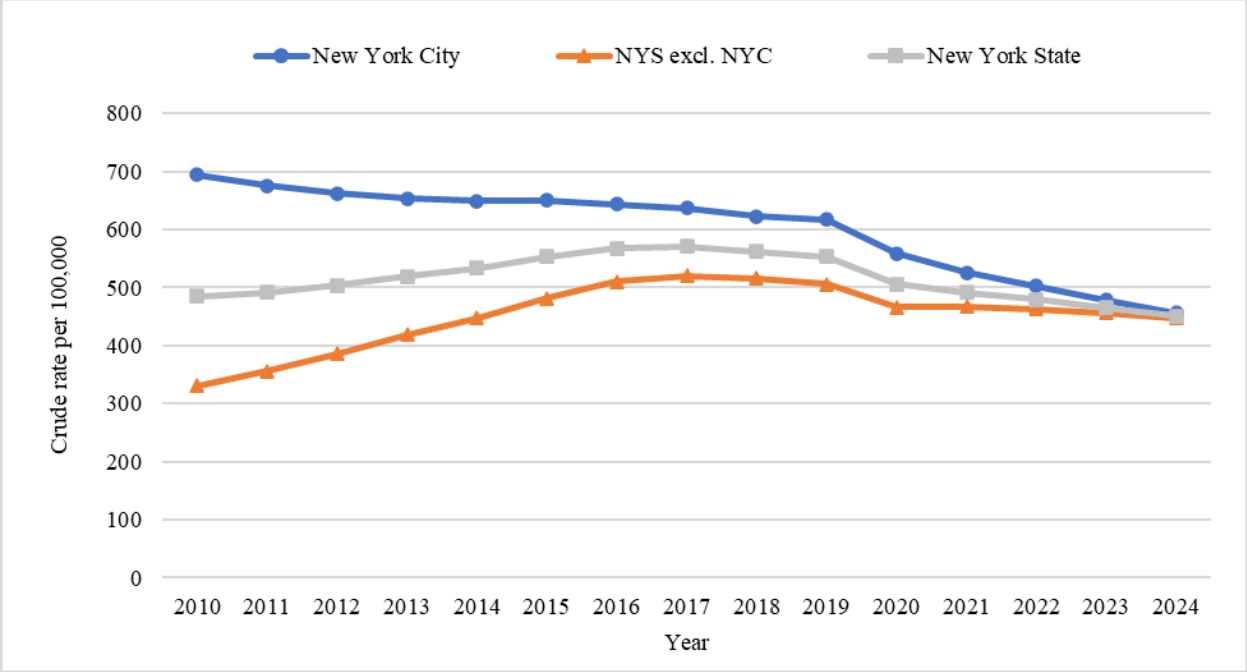
* Fewer than 10 events in the numerator, therefore the rate is unstable.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
For detailed data for the map, see Appendix: Data Table 3.12.

4 - New York State Office of Addiction Services and Supports (OASAS) Client Data

NYS's treatment system for OUD through OASAS consists of crisis services and non-crisis treatment services. Crisis services include hospital-based detoxification and medically monitored or supervised services in free-standing or hospital settings. Non-crisis treatment services include opioid (methadone, LA injectable naltrexone, and buprenorphine) treatment programs, other outpatient treatment, inpatient rehabilitation, and residential programs. Lengths of stay in these settings vary.

Among NYS residents in 2024, there were 76,646 unique individuals enrolled in OASAS-certified substance use disorder treatment programs for any opioid (including heroin) (Figure 4.1). This represented a crude rate of 451.2 per 100,000 population, a 3.1 percent decrease from 465.6 per 100,000 population in 2023. Rates across all regions have generally been decreasing since 2017.

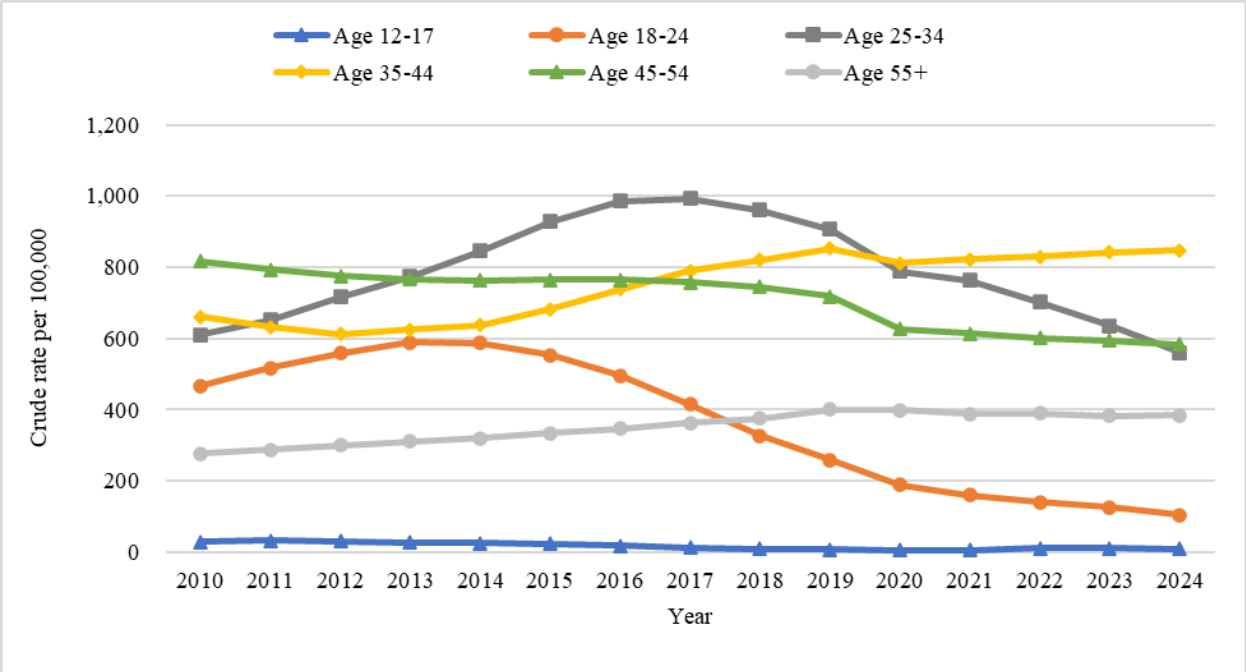
Figure 4.1 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioids (including heroin) as a primary substance at admission, crude rate per 100,000 population, by region, New York State, 2010-2024**



NYS excl. NYC = New York State excluding New York City
* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** The most recent information collected for the year of enrollment was used to determine the person's area of residence during the year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 4.1.

In 2024, New Yorkers aged 35-44 years had the highest rate (848.0 per 100,000 population) for unique individuals enrolled in OASAS-certified substance use disorder treatment programs for any opioid (including heroin), followed by those aged 45-54 years (583.4 per 100,000) and 25-34 years (560.8 per 100,000). Those aged 12-17 years consistently had the lowest rate per 100,000 among all age groups (Figure 4.2). The rates declined for those aged 18-24 years since 2014 and since 2017 for those aged 25-34.

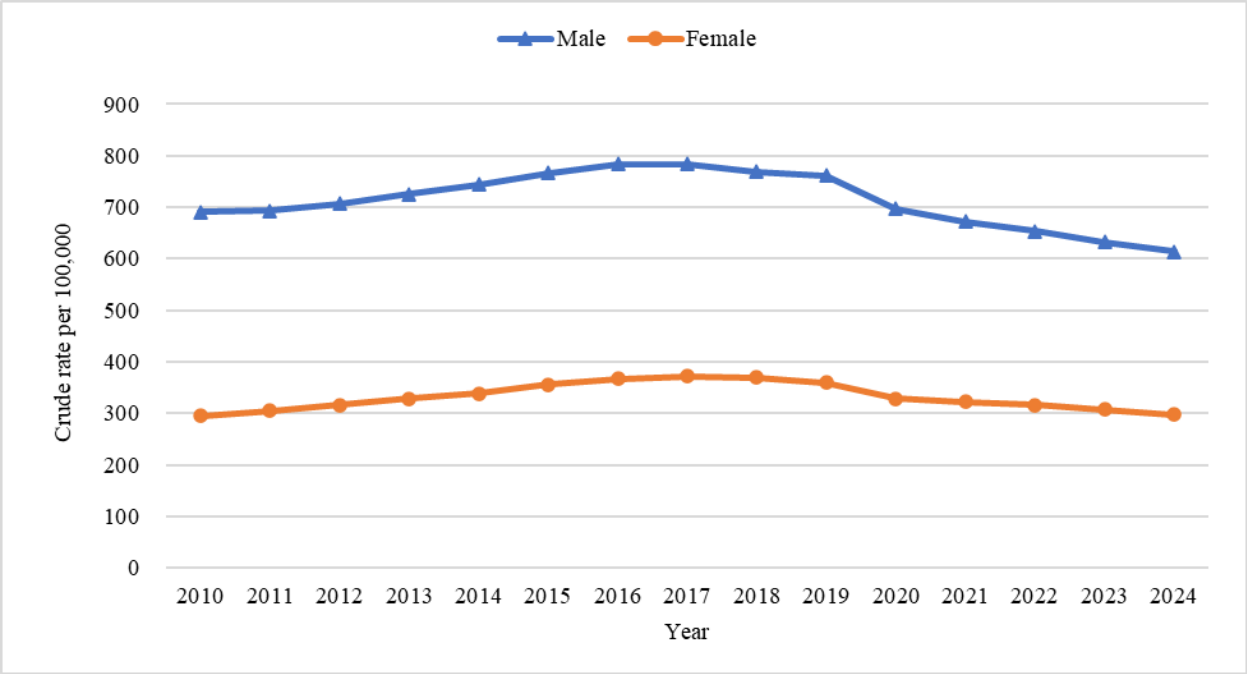
Figure 4.2 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by age group, New York State, 2010-2024**



* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** Age is calculated based on date of birth and the mid-point of the enrollment year (July 1st). Persons in treatment for many years will continue to age as time goes on and may move from one age group to the next group over time. The most recent service admission for the year of enrollment was used to determine the person's age group during the year. Each demographic category is mutually exclusive for the calendar year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 4.2.

From 2010 to 2024, the crude rates per 100,000 population for unique individuals enrolled in OASAS-certified substance use disorder treatment programs for any opioid (including heroin) were consistently more than two times higher for males as compared to females in NYS (Figure 4.3). In 2024, the crude rate per 100,000 population was 614.4 for males and 297.2 for females. Between 2010 and 2016, the rates for both sexes increased steadily before starting to decline in 2017.

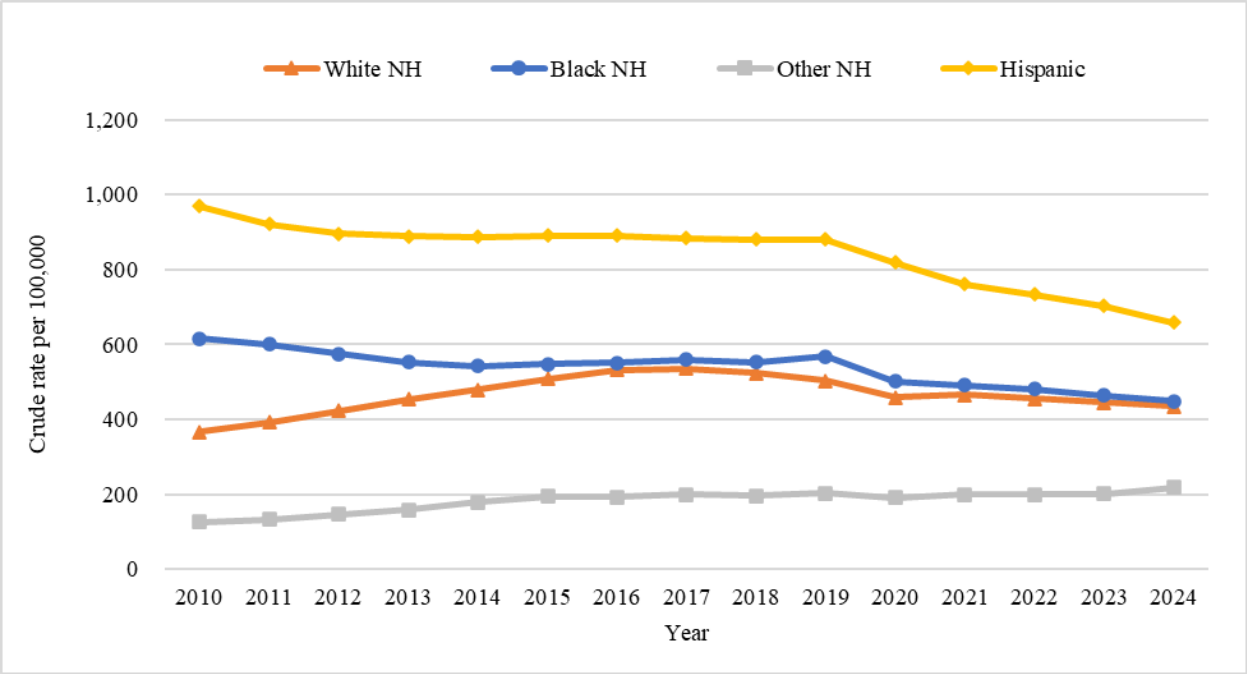
Figure 4.3 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by sex at birth, New York State, 2010-2024**



* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** The most recent service admission for the year of enrollment was used to determine the person's sex at birth during the year. Each demographic category is mutually exclusive for the calendar year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 4.3.

Hispanic New Yorkers consistently had the highest crude rates for unique individuals enrolled in OASAS-certified substance use disorder treatment programs for any opioid (including heroin), as compared to other racial and ethnic groups during 2010 to 2024 (Figure 4.4). In 2024, Hispanic individuals had the highest rate (658.4 per 100,000), as compared to Black non-Hispanic (449.3 per 100,000) and White non-Hispanic (435.9 per 100,000) individuals. The rate increased among Other non-Hispanic individuals between 2023 and 2024, while it decreased for other groups.

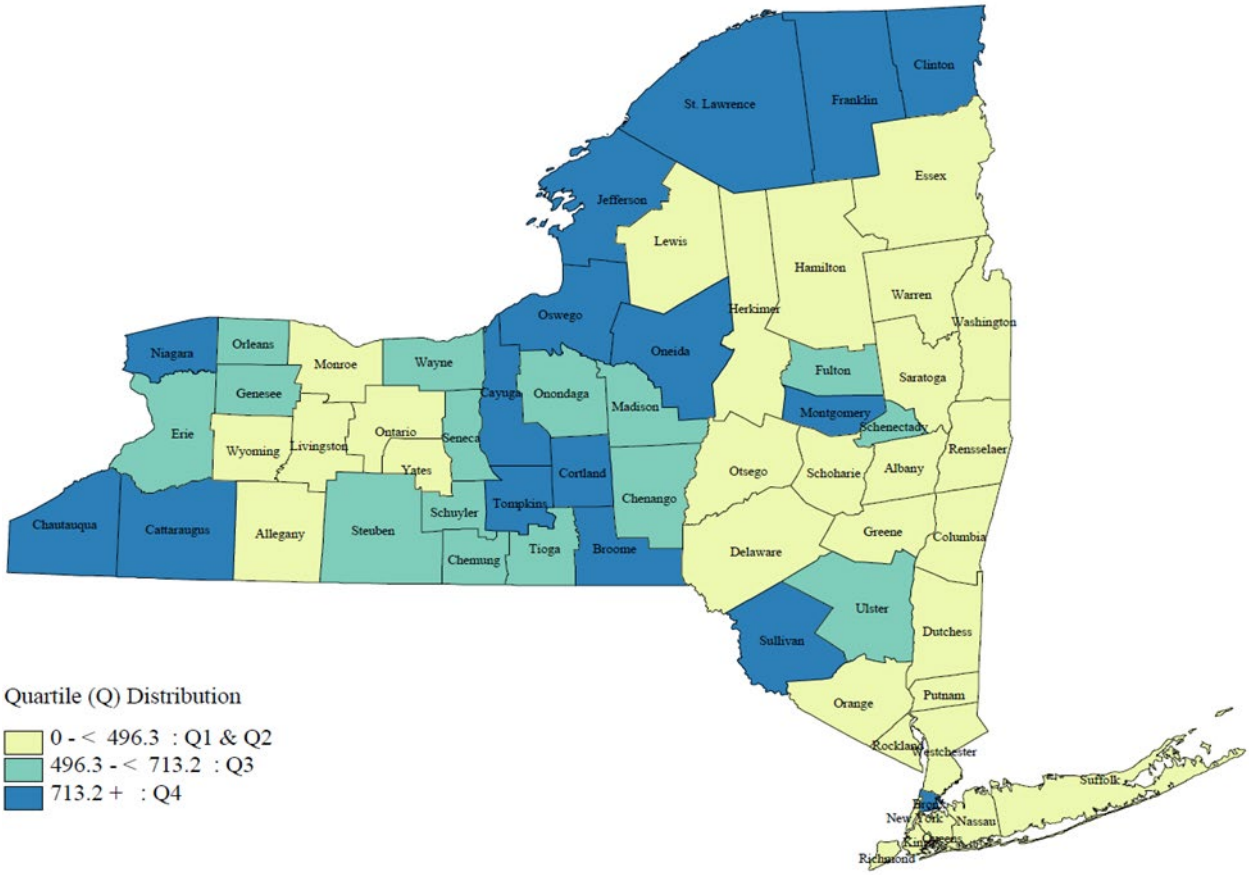
Figure 4.4 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by race and ethnicity, New York State, 2010-2024**



White NH = White non-Hispanic; Black NH = Black non-Hispanic; Other NH = Other non-Hispanic
* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** The most recent service admission for the year of enrollment was used to determine the person's race/ethnicity during the year. Each demographic category is mutually exclusive for the calendar year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 4.4.

In 2024, the 16 counties in the highest quartile (crude rates greater than or equal to 713.2 per 100,000 population)) for unique individuals enrolled in OASAS-certified treatment programs for any opioid (including heroin), in order, were Cortland, Clinton, Bronx, Broome, Montgomery, St. Lawrence, Cattaraugus, Niagara, Sullivan, Chautauqua, Tompkins, Cayuga, Oswego, Jefferson, Franklin, and Oneida (Figure 4.5).

Figure 4.5 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by county, New York State, 2024**



* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** The most recent information collected for the year of enrollment was used to determine the person's county of residence during the year. Each county enrollment count is mutually exclusive for the calendar year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
For detailed data for the map, see Appendix: Data Table 4.5.

5 - Prescription Monitoring Program Data

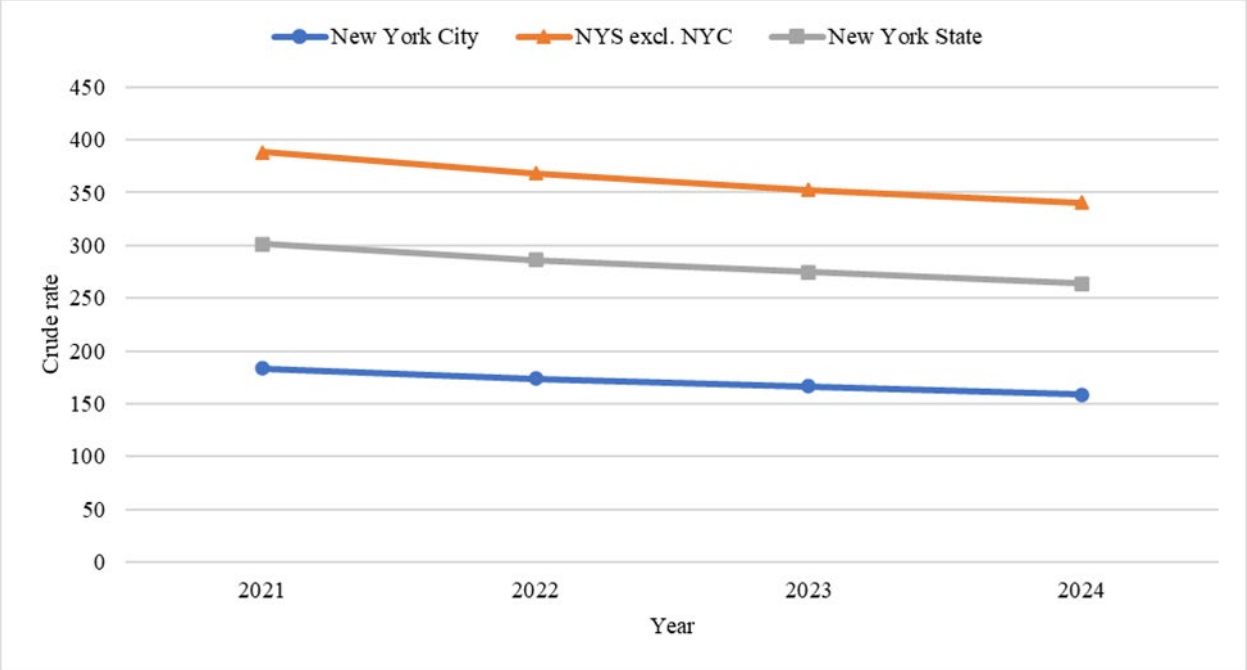
The New York State PMP Registry collects and displays dispensed controlled substance prescription data from pharmacies and practitioners registered with New York State. In February 2010, BNE implemented a prescription monitoring program that provided secure online access for practitioners to their patients' recent controlled substance prescription histories. The data, consisting of patient, prescriber, pharmacy, and controlled substance prescription information, are the basis for the information available to practitioners and pharmacists through the online PMP Registry application. It provides a patient's current controlled substance prescription information and up to a one-year history to practitioners and pharmacists to better evaluate drug therapy and to inform a practitioner of other controlled substance use. These data also identify potential sources of prescription drug diversion or abuse, including prescription fraud, multiple-provider episodes, and improper prescribing and dispensing.

For the purposes of this report, many statistics were calculated using the CDC national standard set of indicators. Therefore, the data in this report may not always be exactly comparable to other similar data the NYSDOH has reported in earlier publications. Specifically for this section, CDC's standards exclude from the analysis drugs that are not typically used in outpatient settings or are otherwise not critical for MME purposes.

Opioid analgesic prescriptions

In 2024, 5,166,245 opioid analgesic prescriptions were dispensed to NYS residents, a crude rate of 264.0 per 1,000 population (Figure 5.1), which is the lowest rate since 2014 (483.5 prescriptions per 1,000 population).[31] In NYS, the crude rate of opioid analgesic prescriptions declined consistently between 2021 (301.0 per 1,000 population) and 2024 (264.0 per 1,000), representing about a 12.3 percent reduction. During 2021-2024, NYS excluding NYC consistently had a higher rate of opioid analgesic prescriptions, compared to NYC, and in 2024, the rate was over two times higher for NYS excluding NYC (340.3 per 1,000) than NYC (158.8 per 1,000).

Figure 5.1 Opioid analgesic prescriptions, crude rate per 1,000 population, by region, New York State, 2021-2024

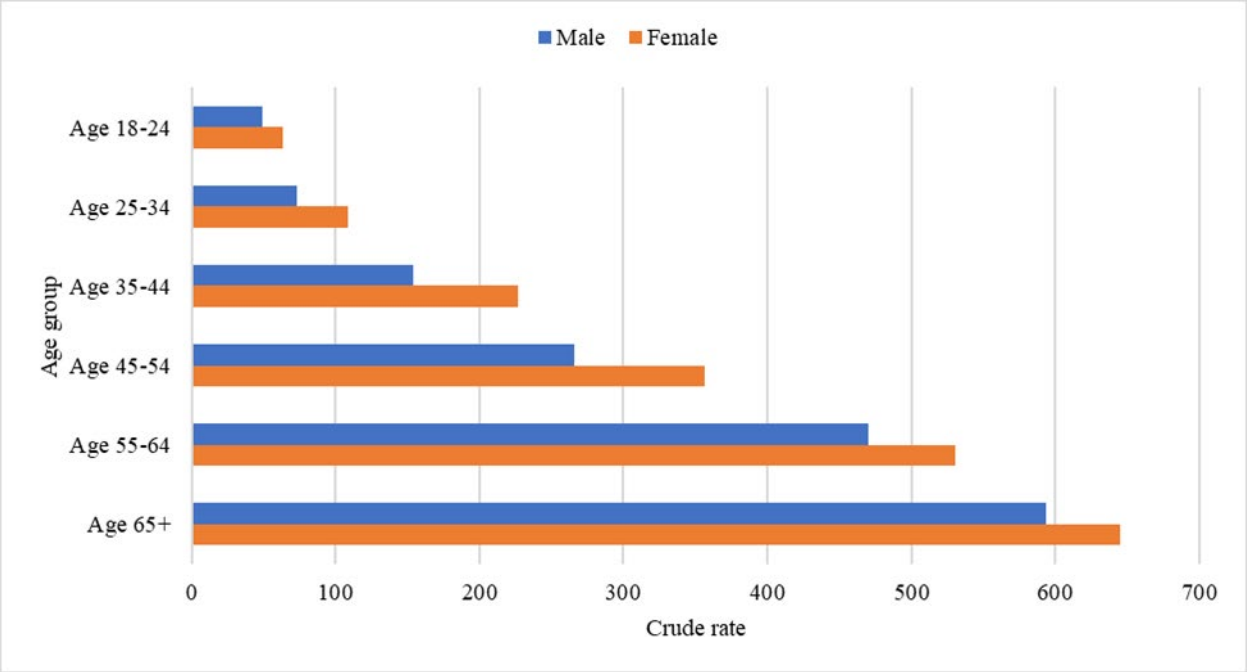


NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.1.

[31] New York State Opioid Data Dashboard. New York State Department of Health. Accessed May 2025. https://apps.health.ny.gov/public/tabvis/PHIG_Public/opioid/

In 2024, the crude rate of opioid analgesic prescriptions per 1,000 population was higher for females than it was for males across all age groups (Figure 5.2). The gap was largest among those aged 45-54 years, with crude rates of 266.0 per 1,000 for males and 356.7 per 1,000 for females.

Figure 5.2 Opioid analgesic prescriptions, crude rate per 1,000 population, by age and gender, New York State, 2024

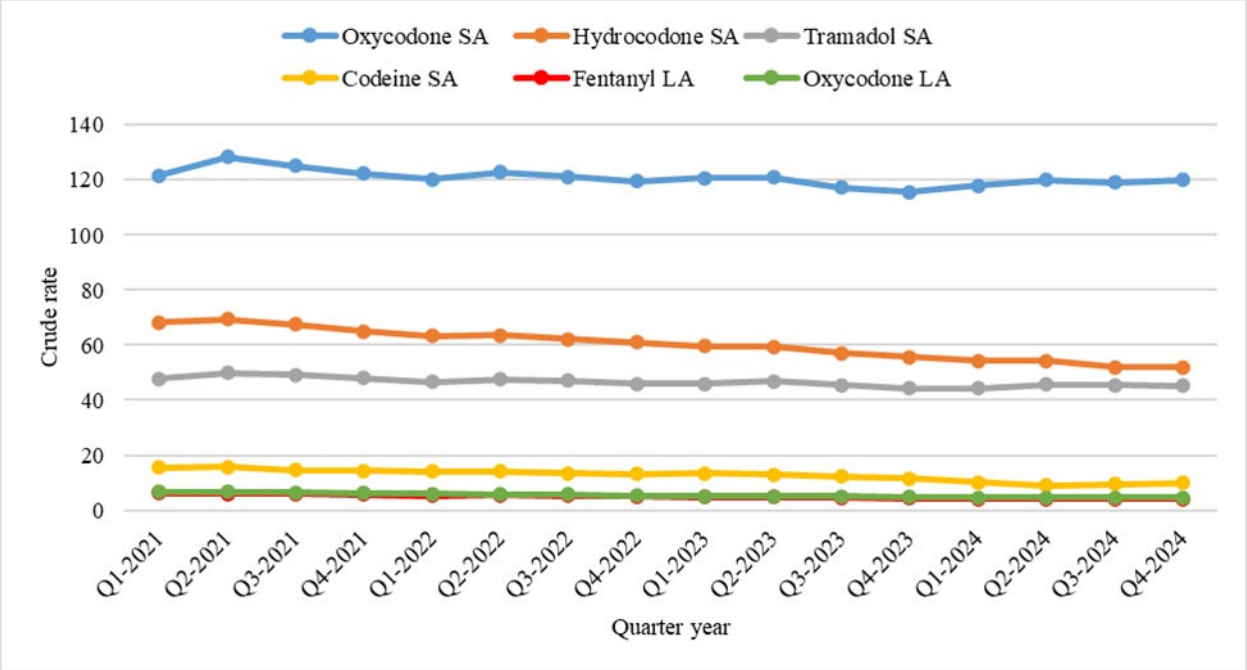


These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.2.

Commonly prescribed opioid analgesics

Overall, SA oxycodone is the most often prescribed opioid analgesic, followed by hydrocodone and tramadol (Figure 5.3). A quarterly average crude prescription rate per person-years for each year was calculated based on the crude rate for each quarter of that year. Between 2021 and 2024, there was about a 4.0 percent decline in the quarterly average crude prescription rate for SA oxycodone and a 21.5 percent decline in the quarterly average crude prescription rate for SA hydrocodone. The rate of prescribing LA oxycodone, SA codeine, and LA fentanyl has remained lower due to differences in therapeutic indications. Note, the trend in LA fentanyl is obscured by the similar trend in LA oxycodone.

Figure 5.3 Commonly prescribed opioid analgesics, crude rate per 1,000 person years*, by quarter, New York State, 2021-2024

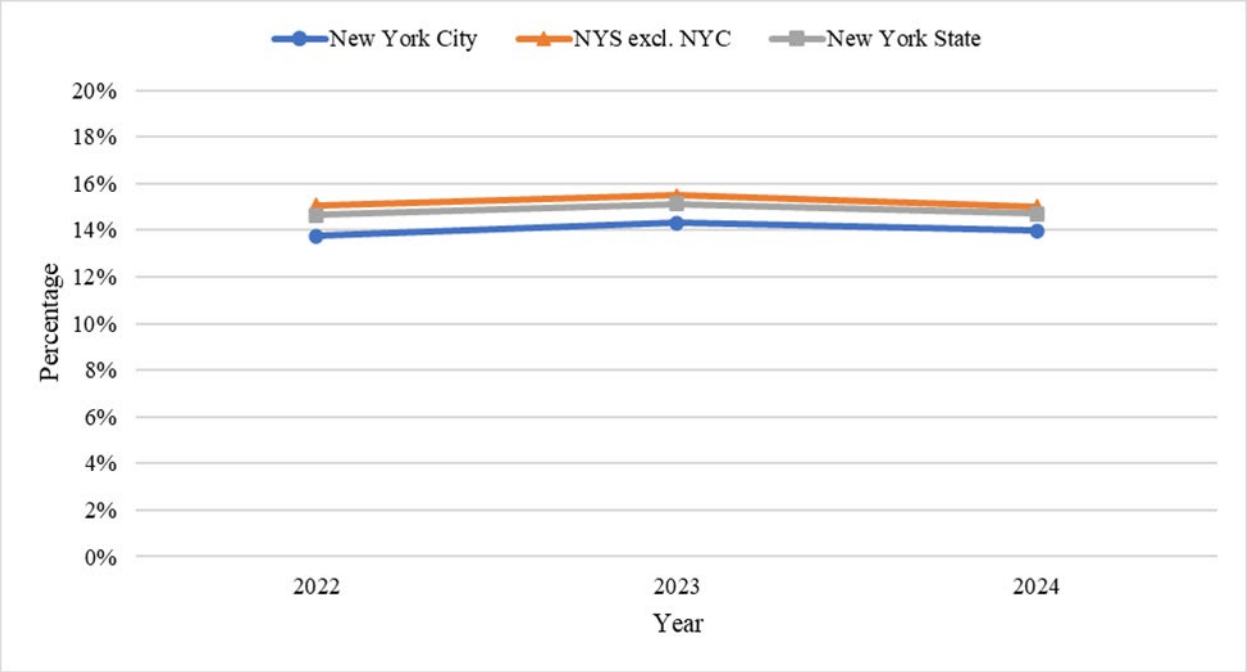


* The quarterly rates are calculated as follows: [# of events/(population*0.25 year)] * 1,000.
These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.3.

Opioid initial prescriptions for more than a seven-day supply

Among opioid-naïve patients, a larger number of supply days for the first (initial) opioid prescription is strongly associated with developing long-term opioid use.[32] In July 2016, NYS limited the initial prescription of opioids for acute pain to no more than a seven-day supply.[33] In NYS, the percentage of initial opioid prescriptions for more than a seven-day supply remained stable at 14.7 percent from 2022 to 2024 (Figure 5.4). During 2022-2024, the percentage of initial prescriptions for more than a seven-day supply was consistently higher in NYS excluding NYC than it was in NYC.

Figure 5.4 Percentage of episodes when an opioid-naïve patient received more than a seven-day supply for the initial opioid prescription, by region, New York State, 2022-2024



NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Opioid-naïve was defined as patients with no opioid prescription for pain in last 45 days.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.4.

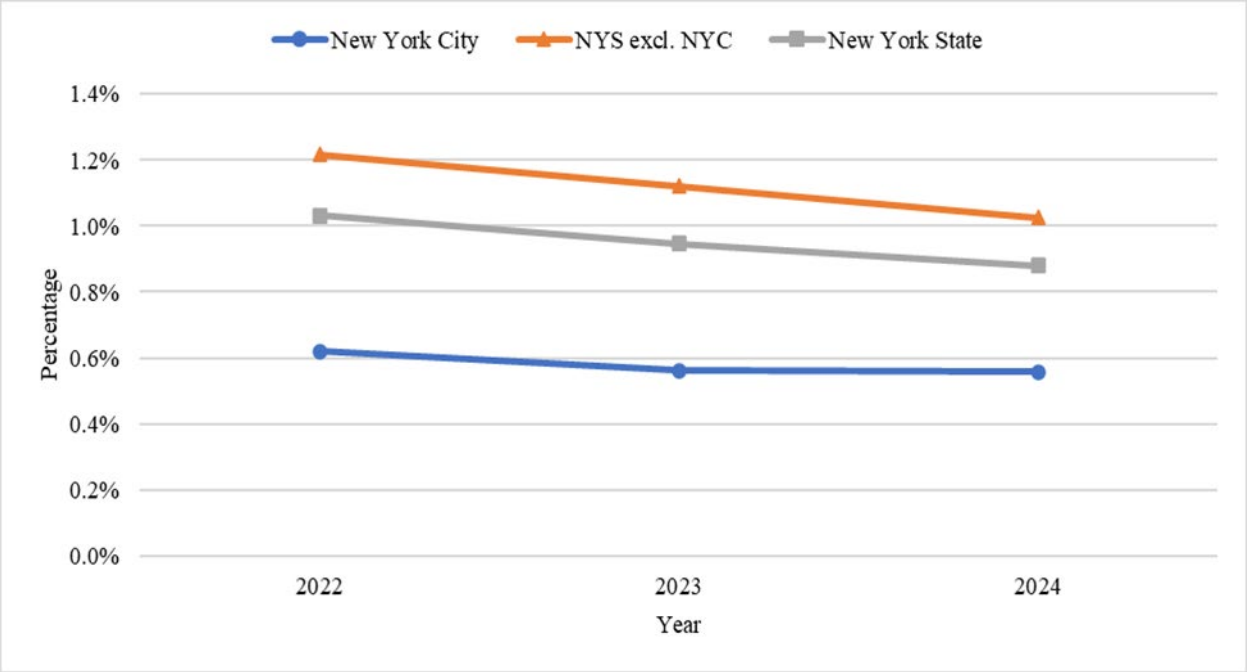
[32] Shah A, Hayes CJ, Martin BC. Factors Influencing Long-Term Opioid Use Among Opioid Naive Patients: An Examination of Initial Prescription Characteristics and Pain Etiologies. *J Pain*. 2017 Nov;18(11):1374-1383. https://doi.org/10.1016%2Fj.jpain.2017.06.010

[33] Laws and Regulations - Public Health Law §3331(5)(b)-(c) - New Legislation Enacted to Limit Initial Opioid Prescribing to a 7 Day Supply for Acute Pain. Bureau of Narcotic Enforcement. New York State Department of Health. Accessed May 2025. https://www.health.ny.gov/professionals/narcotic/laws_and_regulations/

Long-acting initial opioid prescriptions among opioid-naïve patients

Initiating treatment for chronic pain with LA or extended-release opioids is associated with higher risk of overdose than the initiation of treatment with immediate-release opioids.[34] The percentage of episodes in which patients were both opioid-naïve and received LA initial opioid prescriptions decreased slightly in NYS between 2022 (1.0 percent) and 2024 (0.9 percent) (Figure 5.5). During this same timeframe, the percentage was consistently higher in NYS excluding NYC than in NYC.

Figure 5.5 Percentage of episodes when an opioid-naïve patient received long-acting initial opioid prescription, by region, New York State, 2022-2024



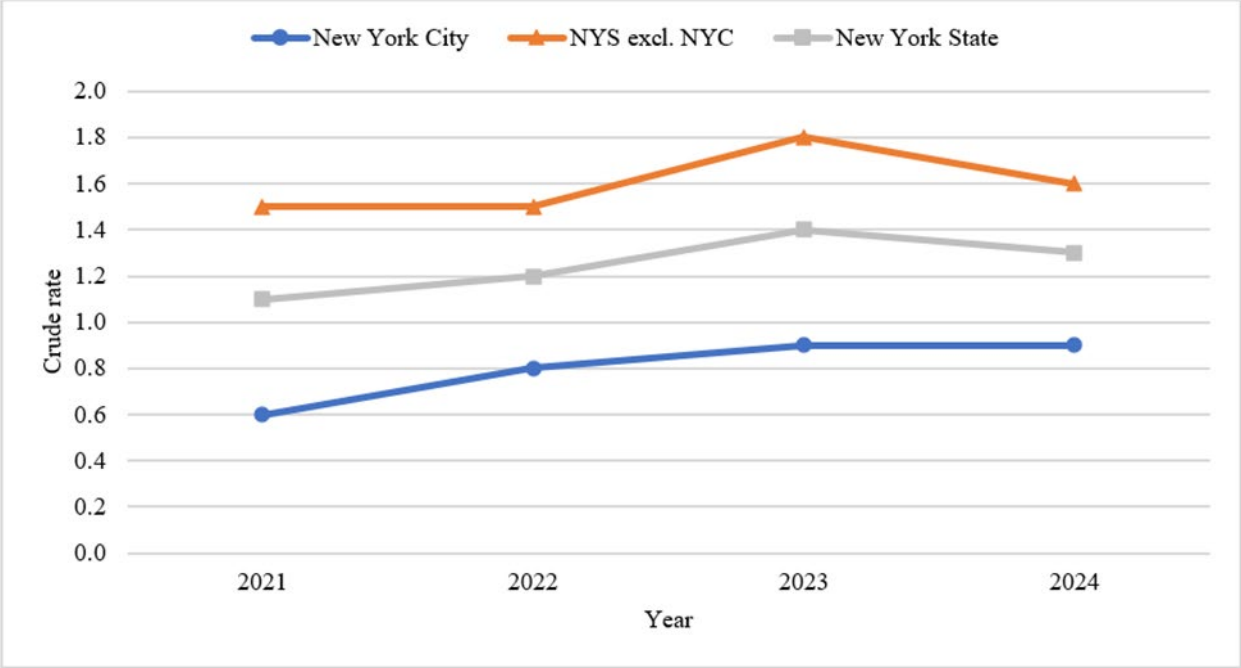
NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Opioid-naïve was defined as patients with no opioid prescription for pain in last 45 days.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.5.

[34] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*. 2016;65(No. RR-1):1–49. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Prescribed opioid analgesics from five or more prescribers and dispensed at five or more pharmacies

The number of patients who received opioid prescriptions from five or more prescribers, and dispensed at five or more pharmacies in a three-month rolling period (MPEs) increased slightly for NYS from a crude rate per 100,000 population of 1.1 in 2021 to 1.3 in 2024 (Figure 5.6). In NYS prescribers must consult the NYS PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances. This requirement aids practitioners to understand their patients' controlled substance history to appropriately prescribe and/or provide educational support and referrals. This contributes to lower rates of MPEs.

Figure 5.6 Patients with prescribed opioid analgesics from five or more prescribers and dispensed at five or more pharmacies in a three-month rolling period, crude rate per 100,000 population, by region, New York State, 2021-2024

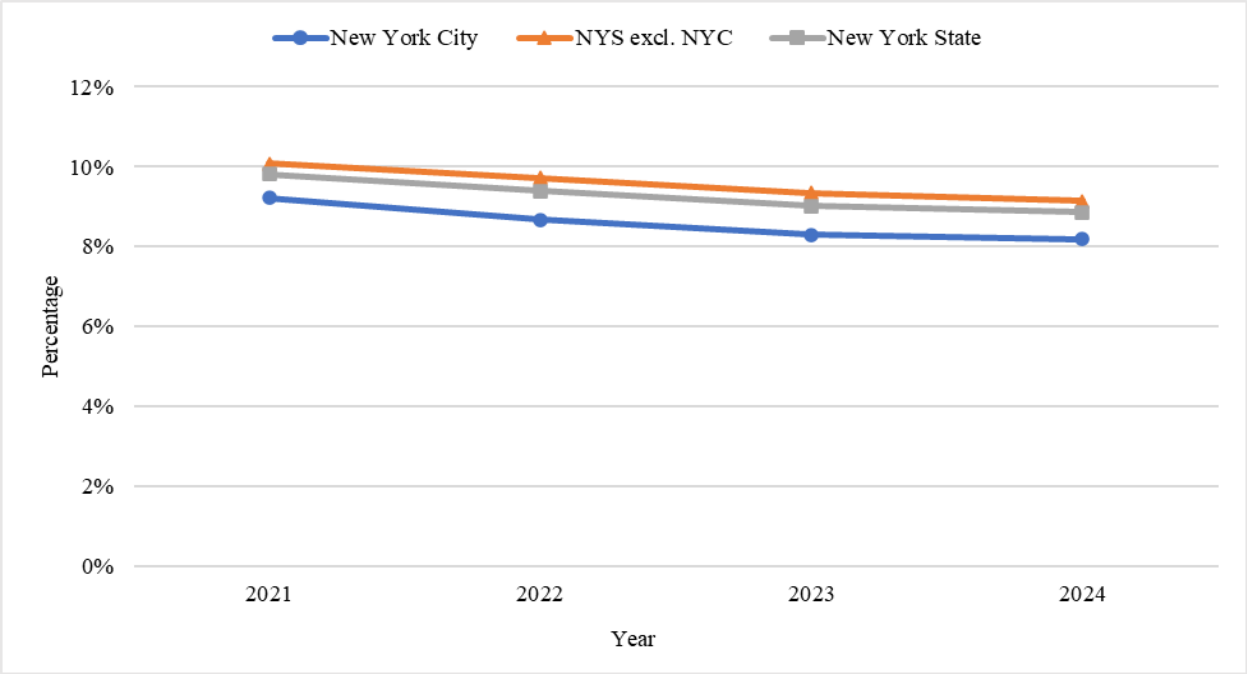


NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Patients with more than one MPE in a year are counted once within that year.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.6.

Prescribed opioid analgesics with total daily dose of ≥ 90 MME

Receiving opioid analgesics in higher dosages (≥ 90 MME) is associated with a higher risk of OUD, overdose, and death.[35,36] The percentage of patients receiving one or more opioid analgesic prescriptions with a total daily dose of ≥ 90 MME for at least one day declined between 2021 (9.8 percent) and 2024 (8.9 percent) in NYS (Figure 5.7). During 2021-2024, the percentage was consistently higher in NYS excluding NYC than in NYC.

Figure 5.7 Percentage of patients who were prescribed one or more opioid analgesics with a total daily dose of ≥ 90 MME on at least one day, by region, New York State, 2021-2024



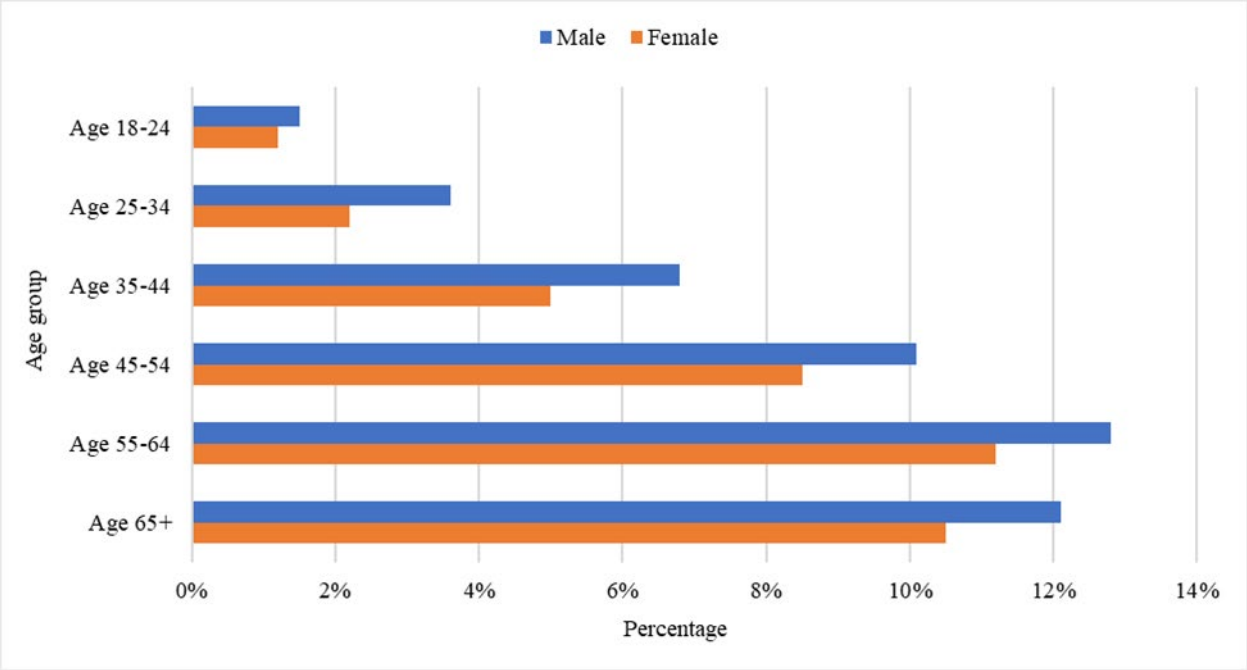
NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for pain and treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.7.

[35] Perry A, Krawczyk N, Samples H, Martins SS, Hoffman K, Williams NT, Hung A, Ross R, Doan L, Rudolph KE, Cerdá M. Opioid Dose, Duration, and Risk of Use Disorder in Medicaid Patients with Musculoskeletal Pain. Pain Med. 2025 Jun 24:pnaf077. doi: 10.1093/pm/pnaf077. Epub ahead of print. PMID: 40581761.

[36] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*. 2016;65(No. RR-1):1–49. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

In 2024, the percentage of patients receiving one or more opioid analgesic prescriptions with a total daily dose of ≥ 90 MME for at least one day was highest among those aged 55-64 years for both males (12.8 percent) and females (11.2 percent) (Figure 5.8). This was followed by those aged 65 years and older for both males (12.1 percent) and females (10.5 percent). The percentage of males receiving a daily dose of ≥ 90 MME was consistently higher than females for all age groups.

Figure 5.8 Percentage of patients who were prescribed one or more opioid analgesics with a total daily dose of ≥ 90 MME on at least one day, by age and gender, New York State, 2024



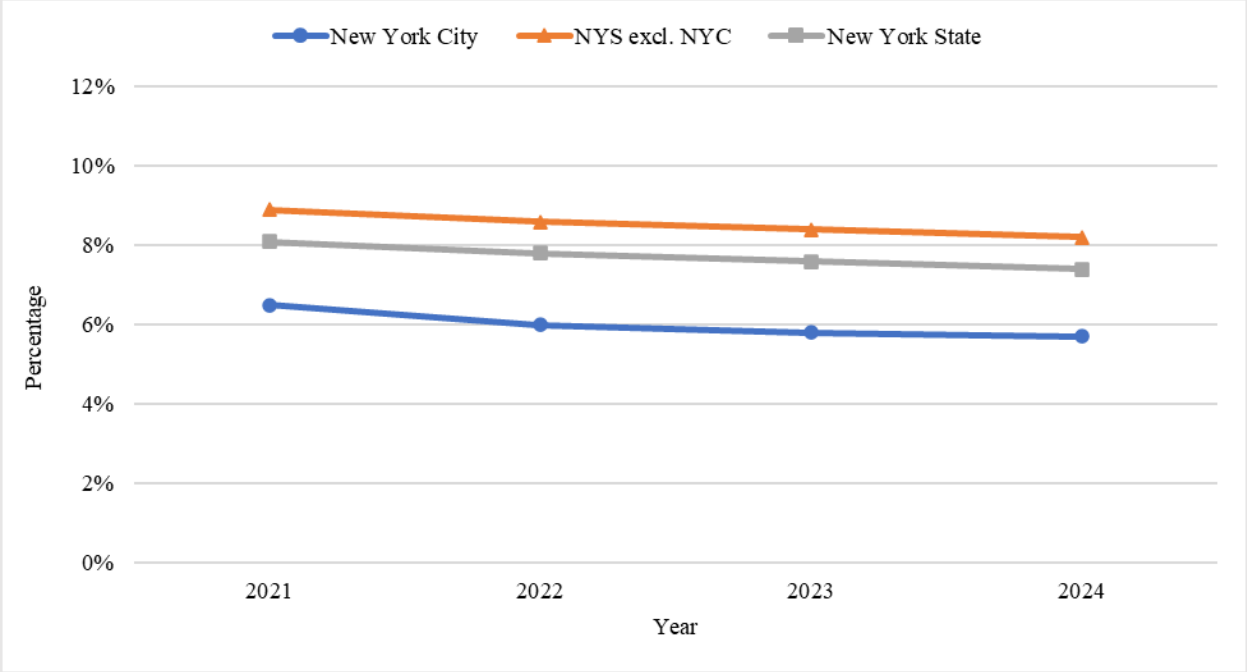
These data exclude buprenorphine prescriptions for pain and treatment of opioid use disorder.
MME: morphine milligram equivalents
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.8.

Overlapping opioid analgesic and benzodiazepine prescriptions

The risk of opioid overdose increases when an opioid is taken in combination with other drugs, including benzodiazepines (e.g., alprazolam, diazepam, etc.).[37] As such, it is important to monitor the co-prescribing and co-dispensing of these medications, as well as the potential for prescriptions to overlap, and to provide information about the increased risk of overdose when combining opioids and benzodiazepines, as well as other substances.

Among patients receiving at least one prescription for opioid analgesics or benzodiazepines, the percentage with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions declined between 2021 (8.1 percent) and 2024 (7.4 percent) in NYS (Figure 5.9). In 2024, the percentage was higher for NYS excluding NYC (8.2 percent) than for NYC (5.7 percent). NYS excluding NYC had consistently higher percentages of patients with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions during 2021-2024.

Figure 5.9 Percentage of patients* with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions, by region, New York State, 2021-2024

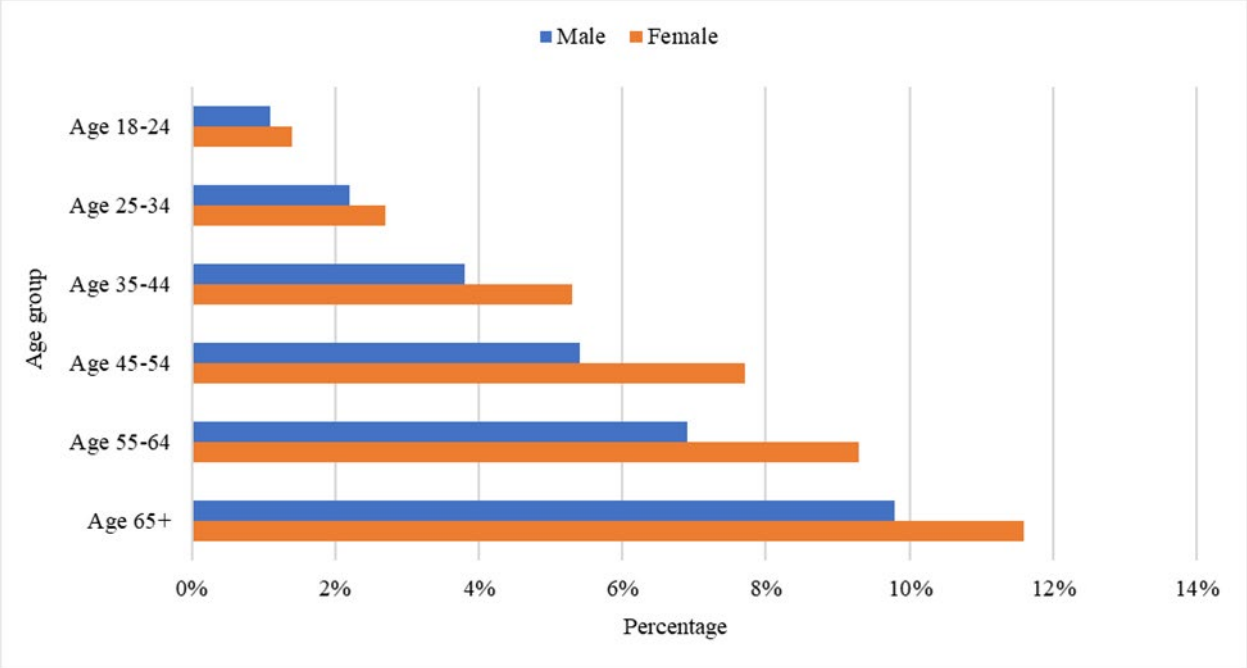


NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
* Patients with at least one prescription for opioid analgesics or benzodiazepines during a given year
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.9.

[37] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*. 2016;65(No. RR-1):1–49. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

In 2024, among patients with at least one prescription for opioid analgesics or benzodiazepines, the percentage who received two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions was higher among females than among males for all age groups (Figure 5.10). The percentage increased with age and was highest among those aged 65 years and older for both females (11.6 percent) and males (9.8 percent). The largest difference was seen among those aged 55-64 years (6.9 percent for males, 9.3 percent for females).

Figure 5.10 Percentage of patients* with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions, by age and gender, New York State, 2024

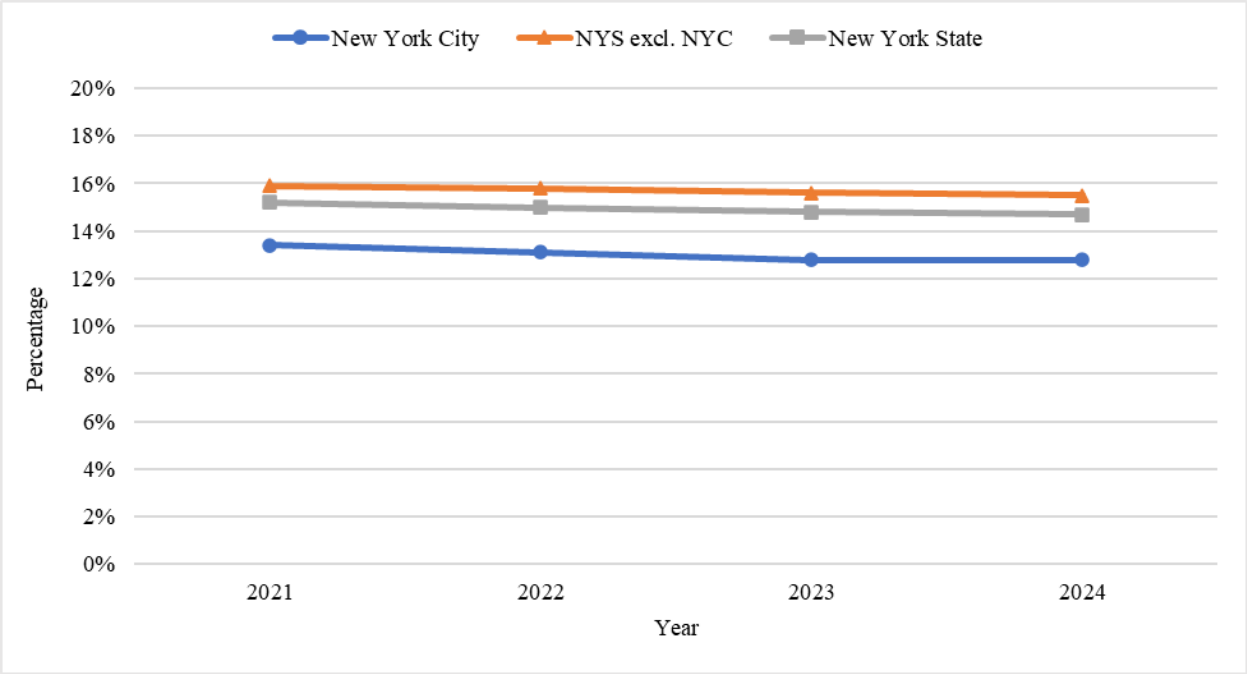


These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
* Patients with at least one prescription for opioid analgesics or benzodiazepines during a given year
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.10.

Overlapping opioid analgesic prescriptions

During 2021-2024, among patients receiving one or more opioid analgesic prescriptions in NYS, the percentage with two or more calendar days of overlapping opioid analgesic prescriptions steadily declined from 15.2 percent in 2021 to 14.7 percent in 2024 (Figure 5.11). In 2024, the percentage was higher for NYS excluding NYC (15.5 percent) than for NYC (12.8 percent). NYS excluding NYC had consistently higher percentages compared to NYC during 2021-2024.

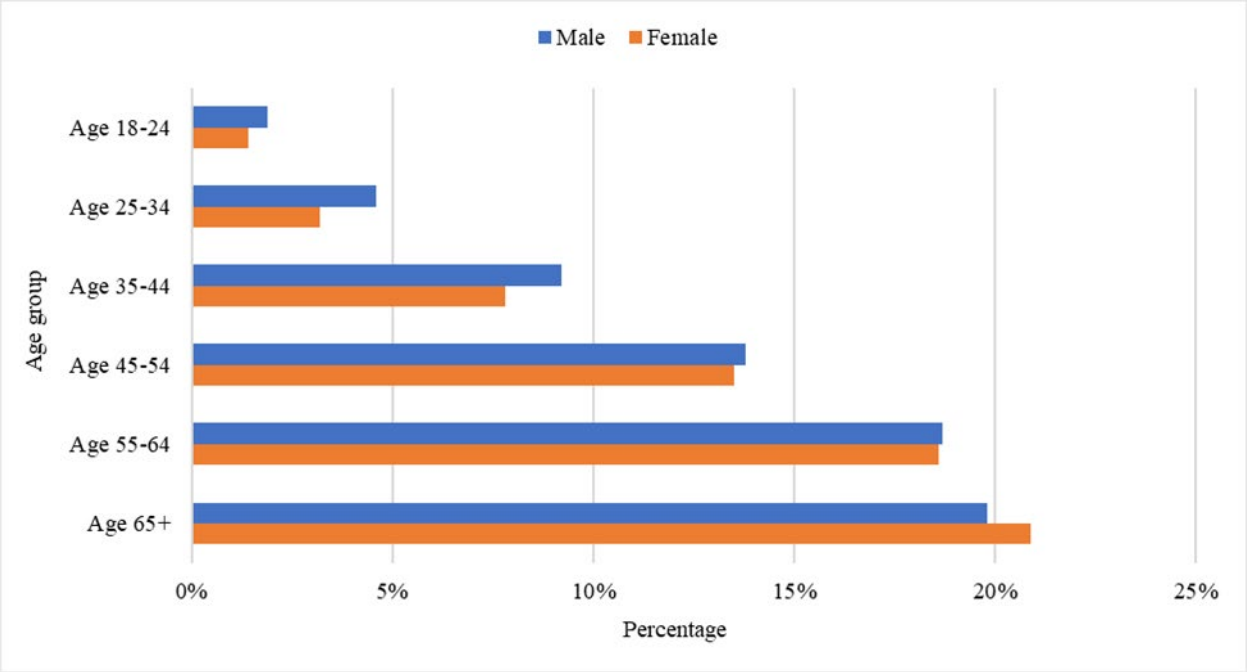
Figure 5.11 Percentage of patients* with two or more calendar days of overlapping opioid analgesic prescriptions, by region, New York State, 2021-2024



NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
* Patients with at least one prescription for opioid analgesics during a given year
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.11.

In 2024, among patients with at least one prescription for opioid analgesics, the percentage who had two or more calendar days of overlapping opioid analgesic prescriptions was higher among males than among females, except among those aged 65 years and older (Figure 5.12). The percentage was highest among those aged 65 years and older for both females (21.9 percent) and males (19.8 percent). The largest difference in percentage was seen among those aged 25-34 years and aged 35-44 years.

Figure 5.12 Percentage of patients* with two or more calendar days of overlapping opioid analgesic prescriptions, by age and gender, New York State, 2024

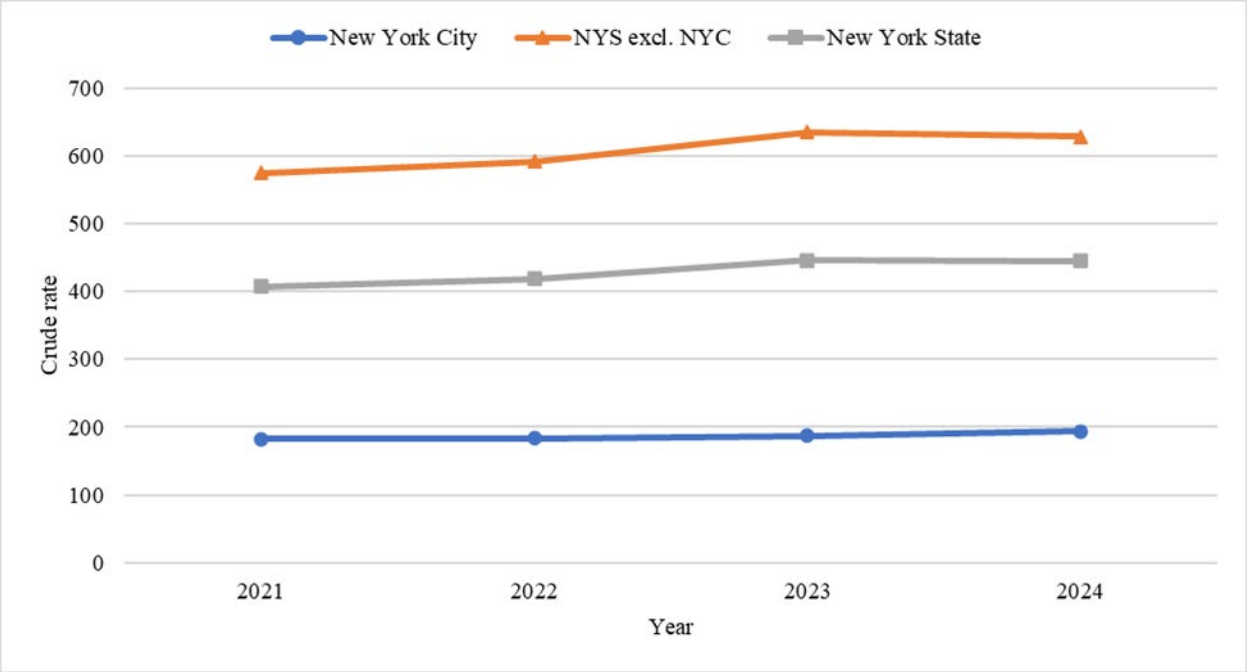


These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
* Patients with at least one prescription for opioid analgesics during a given year
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.12.

Buprenorphine prescription for opioid use disorder

In NYS, the crude rate of patients who received at least one buprenorphine prescription for OUD increased between 2021 (407.5 per 100,000 population) and 2023 (446.0 per 100,000) by 9.4 percent, and stayed relatively stable in 2024 at 444.7 per 100,000 (Figure 5.13). This trend was driven by increases between 2021 to 2023 in NYS excluding NYC. The rate for NYC increased gradually from 2021 (182.4 per 100,000) to 2024 (193.5 per 100,000). Rates in NYS excluding NYC were about three times higher than NYC during 2021-2024. On December 29, 2022, the X-waiver was eliminated as part of the Omnibus Spending Bill, under the MAT Act. The removal of the X-waiver means that any DEA-registered prescriber of controlled substances can now prescribe buprenorphine for treatment of OUD, provided that they comply with all other DEA and state requirements. The NYSDOH continues to monitor the impact of the X-waiver elimination on buprenorphine prescribing.

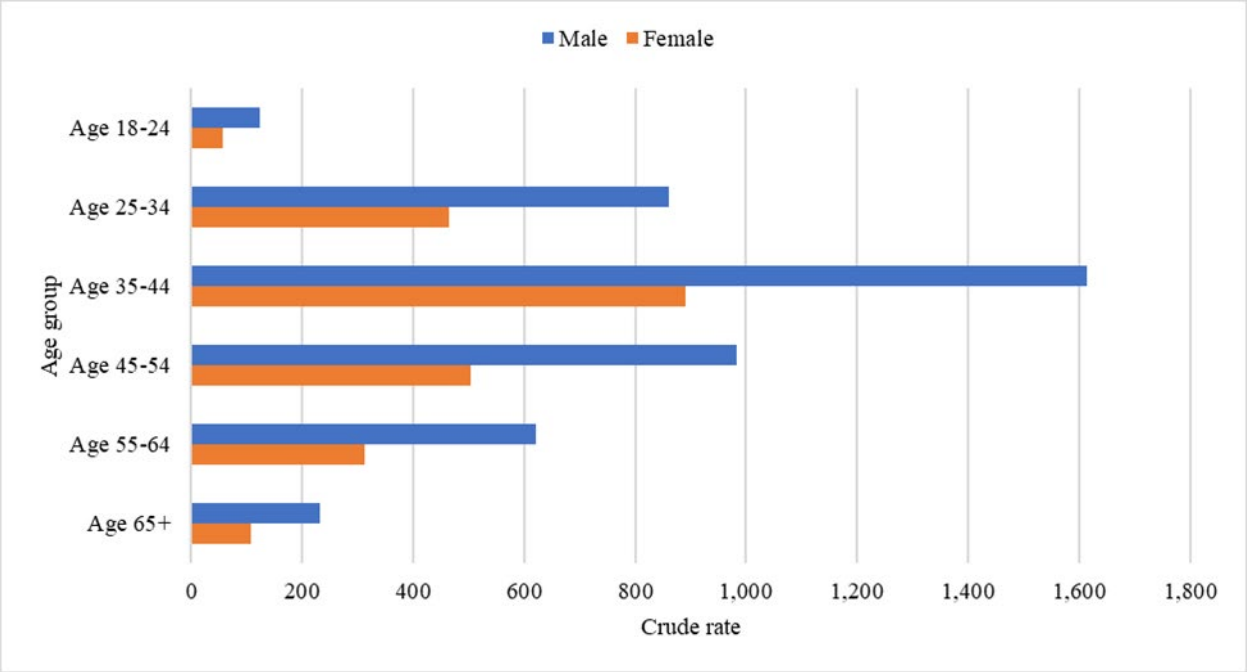
Figure 5.13 Patients who received at least one buprenorphine prescription for opioid use disorder, crude rate per 100,000 population, by region, New York State, 2021-2024



NYS excl. NYC = New York State excluding New York City
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.13.

In 2024, the crude rate of patients who received at least one buprenorphine prescription for OUD per 100,000 population was highest among those aged 35-44 years for both males (1613.4 per 100,000) and females (891.8 per 100,000), followed by those aged 45-54 years (982.5 per 100,000 for males and 503.3 per 100,000 for females) (Figure 5.14). The crude rate of patients who received at least one buprenorphine prescription for OUD was consistently higher for males than females for all age groups.

Figure 5.14 Patients who received at least one buprenorphine prescription for opioid use disorder, crude rate per 100,000 population, by age and gender, New York State, 2024



Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.14.

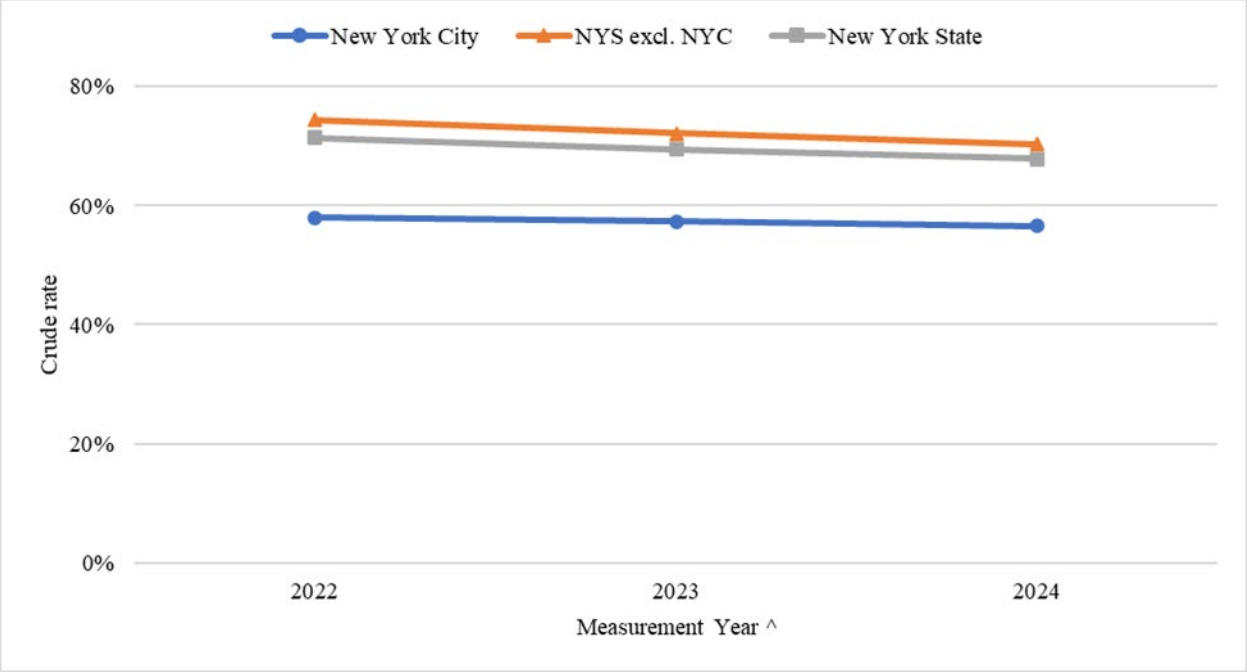
Continuous buprenorphine treatment for six months or more

Long-term, continuous treatment with buprenorphine is first-line therapy for OUD. Discontinuation of buprenorphine treatment sooner than six months is associated with poorer outcomes including substance misuse and overdose.[38] Between 2022 and 2024, the number of individuals on buprenorphine for treatment of OUD increased by 7.4 percent from 81,669 in 2022 to 87,673 in 2024. During the same period, the percentage of cohort patients receiving continuous buprenorphine for treatment of OUD* for six months or more slightly decreased from 71.4 percent in 2022 to 67.9 percent in 2024 (Figure 5.15). From 2022 to 2024, the percentages were consistently higher in NYS excluding NYC than in NYC. Historically, NYC has had greater availability of methadone treatment for OUD as compared with NYS excluding NYC.[39]

[38] Williams AR, Samples H, Crystal S, Olfson M. Acute Care, Prescription Opioid Use, and Overdose Following Discontinuation of Long-Term Buprenorphine Treatment for Opioid Use Disorder. Am J Psychiatry. 2020 Feb 1;177(2):117-124. doi: 10.1176/appi.ajp.2019.19060612. Epub 2019 Dec 2. PMID: 31786933; PMCID: PMC7002204. Accessed May 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC7002204/.

[39] Tuazon E, Kunins H, Paone D. Buprenorphine and Methadone Dispensing in New York City. New York City Department of Health and Mental Hygiene: Epi Data Brief (96); November 2017. Accessed May 2025. https://www.nyc.gov/assets/doh/downloads/pdf/epi/databrief96.pdf

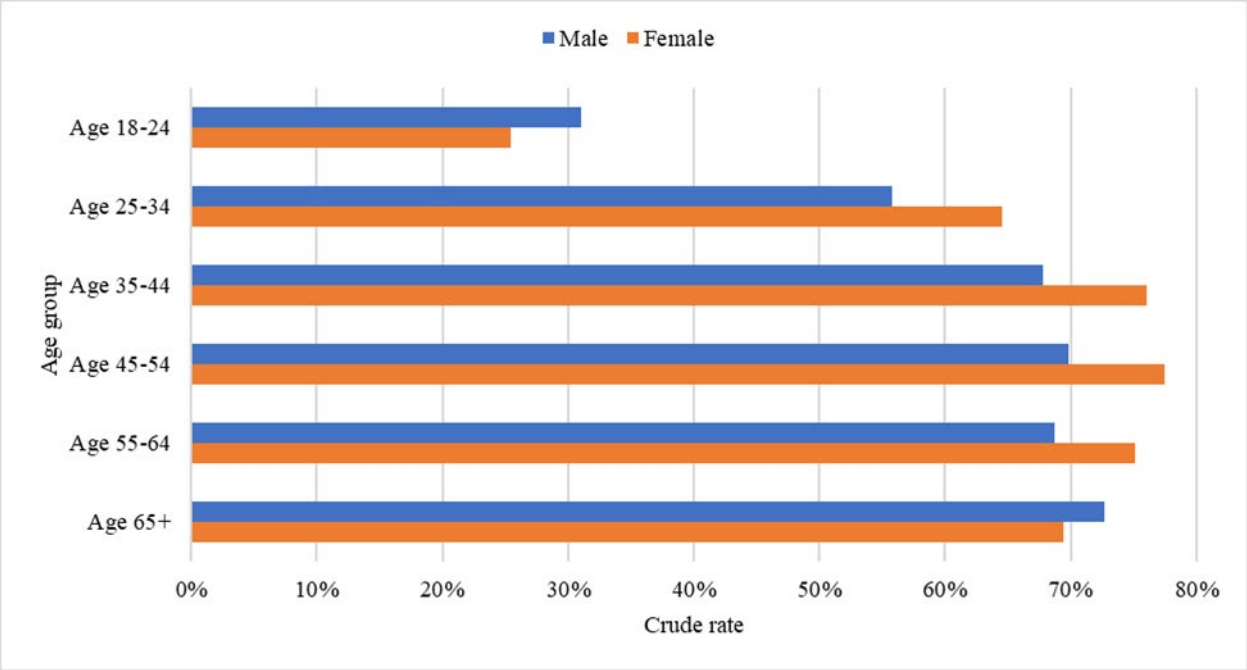
Figure 5.15 Percentage of cohort patients[#] receiving continuous buprenorphine for treatment of opioid use disorder* for six months or more, by region, New York State, 2022-2024^



NYS excl. NYC = New York State excluding New York City
New York State total includes records with missing or unknown county information.
* A treatment period is considered continuous when gaps between prescription supplies are no more than 30 days.
[#] A group of patients (cohort) with at least one buprenorphine prescription for treatment of opioid use disorder between July 1st of the preceding measurement year and June 30th of the current measurement year
^ A measurement year is a calendar year for which the cohort patients were followed up for at least six months. For example, calendar year 2024 is the measurement year for cohort patients with buprenorphine prescriptions between July1, 2023, and June 30, 2024.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.15.

In 2024, the percentage of cohort patients receiving continuous buprenorphine for treatment of OUD* for six months or more was highest among those aged 45-54 years for females (77.5 percent), and those aged 65 and older for males (72.7 percent) (Figure 5.16). Lowest treatment maintenance at six months or more was observed among those aged 18-24 years for both males (31.1 percent) and females (25.5 percent).

Figure 5.16 Percentage of cohort patients[#] receiving continuous buprenorphine for treatment of opioid use disorder* for six months or more, by age and gender, New York State, 2024^



* A treatment period is considered continuous when gaps between prescription supplies are no more than 30 days.
[#] A group of patients (cohort) with at least one buprenorphine prescription for treatment of opioid use disorder between July 1st of the preceding measurement year and June 30th of the current measurement year.
^ Measurement year 2024. A measurement year is a calendar year for which the cohort patients were followed up for at least six months. For example, calendar year 2024 is the measurement year for cohort patients with buprenorphine prescriptions between July1, 2023, and June 30, 2024
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 5.16.

6 - Population Surveys on Substance Use

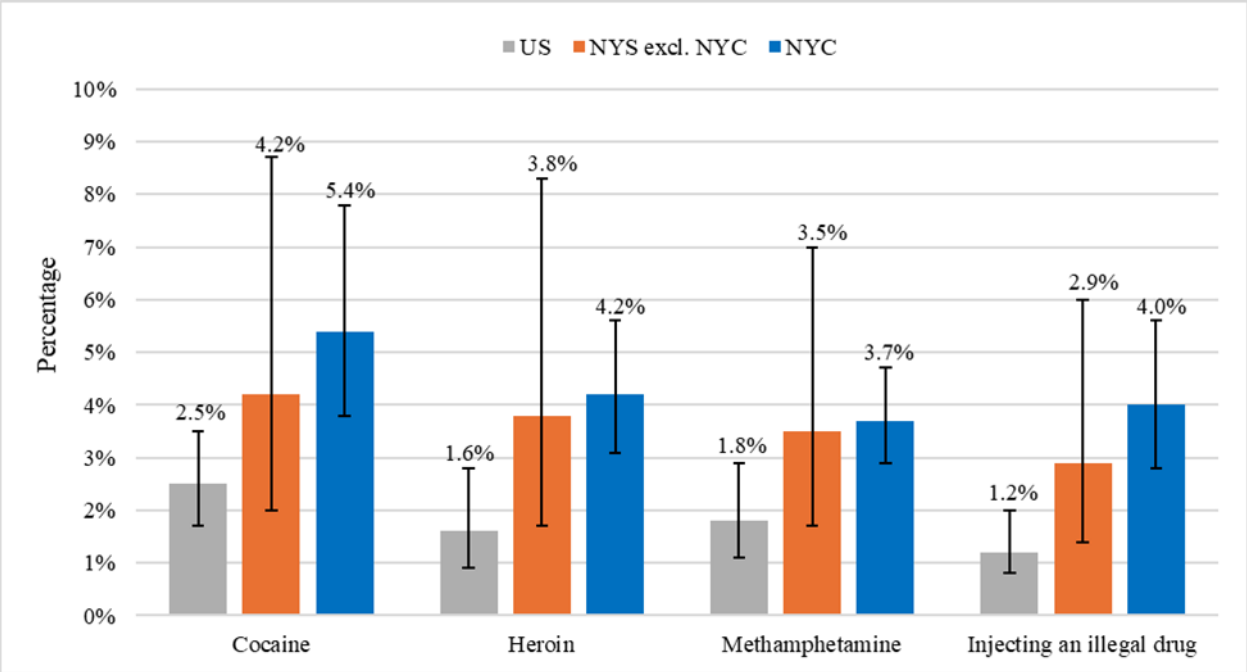
National Survey on Drug Use and Health (NSDUH)

2023-2024 NSDUH data were not available at the time this report was assembled. For 2022 and earlier data, please see the New York State Opioid Annual Report 2024 (page 84).

Youth Risk Behavior Surveillance System (YRBSS)

In 2023, the percentages of high school students in NYS who reported ever using cocaine (NYS excl. NYC: 4.2 percent; NYC: 5.4 percent), heroin (NYS excl. NYC: 3.8 percent; NYC: 4.2 percent), methamphetamine (NYS excl. NYC: 3.5 percent; NYC: 3.7 percent), and injection of an illegal drug (NYS excl. NYC: 2.9 percent; NYC: 4.0 percent) were higher than the percentages in the US, respectively (Figure 6.1). Percentages were slightly higher in NYC than NYS excluding NYC for all substances.

Figure 6.1 Percentage of high school students who report ever using a substance, 2023



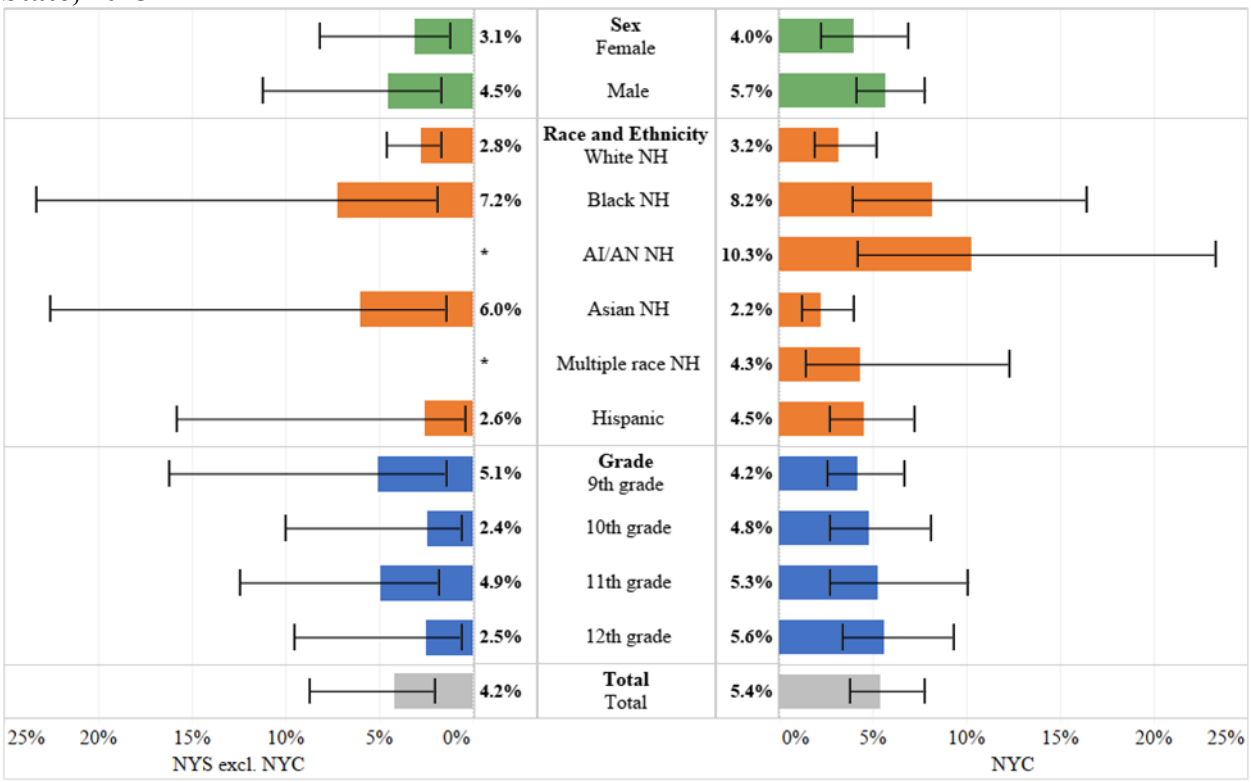
US = United States; NYS excl. NYC = New York State excluding New York City; NYC = New York City
Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 6.1.

High school students who report using cocaine

During 2023, 4.2 percent of all high school students in NYS excluding NYC reported ever using cocaine (Figure 6.2). This was highest among male (4.5 percent), Black non-Hispanic (7.2 percent), Asian non-Hispanic (6.0 percent), 9th grade (5.1 percent), and 11th grade (4.9 percent) students.

During the same year, 5.4 percent of high school students in NYC reported ever using cocaine (Figure 6.2). This was highest among male (5.7 percent), American Indian/Alaska Native non-Hispanic (10.3 percent), Black non-Hispanic (8.2 percent), and 12th grade students (5.6 percent).

Figure 6.2 Percentage of high school students who report ever using cocaine, New York State, 2023



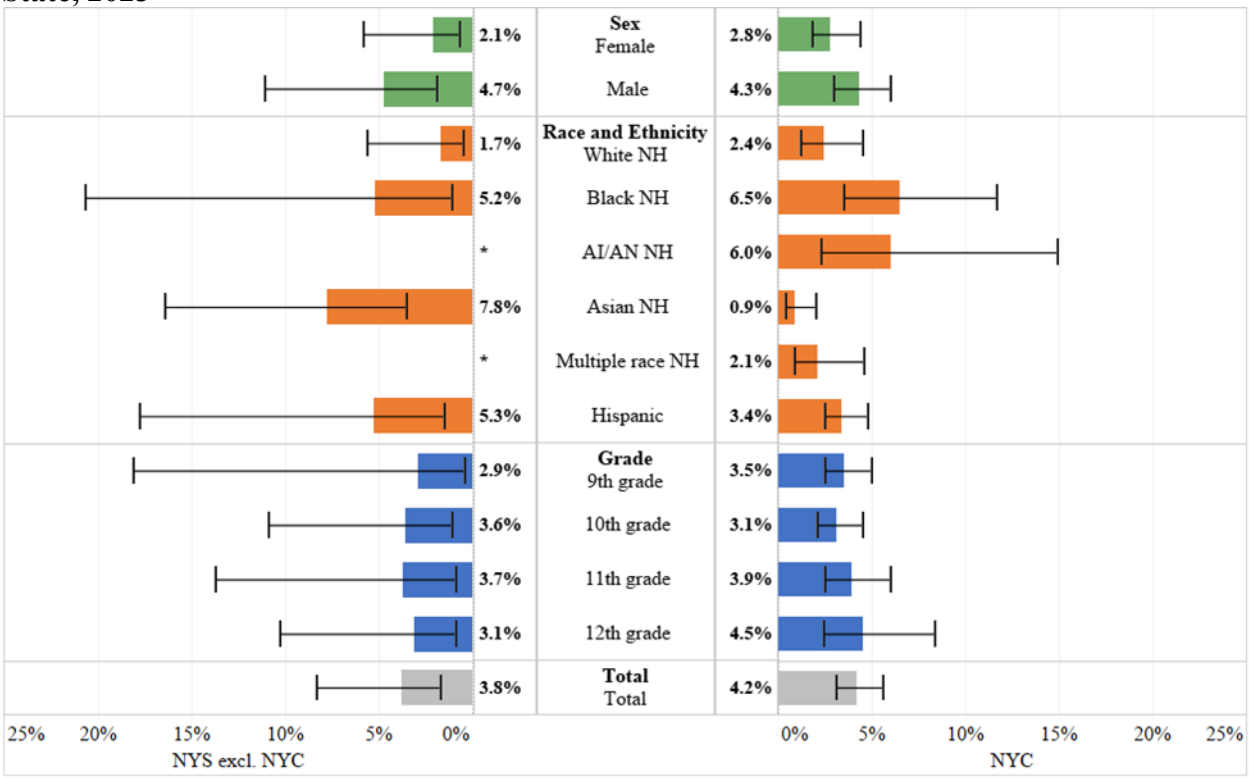
White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN NH = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City
Survey question: During your life, how many times have you used any form of cocaine, including powder, crack, or freebase?
* Data do not meet reporting criteria.
Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 6.2.

High school students who report using heroin

During 2023, 3.8 percent of high school students in NYS excluding NYC reported ever using heroin (Figure 6.3). This was highest among male (4.7 percent), Asian non-Hispanic (7.8 percent), Hispanic (5.3 percent), Black non-Hispanic (5.2 percent), and 11th grade (3.7 percent) students.

During the same period, 4.2 percent of high school students in NYC reported ever using heroin (Figure 6.3). This was highest among male (4.3 percent), Black non-Hispanic (6.5 percent), American Indian/Alaskan Native non-Hispanic (6.0 percent), and 12th grade (4.5 percent) students.

Figure 6.3 Percentage of high school students who report ever using heroin, New York State, 2023



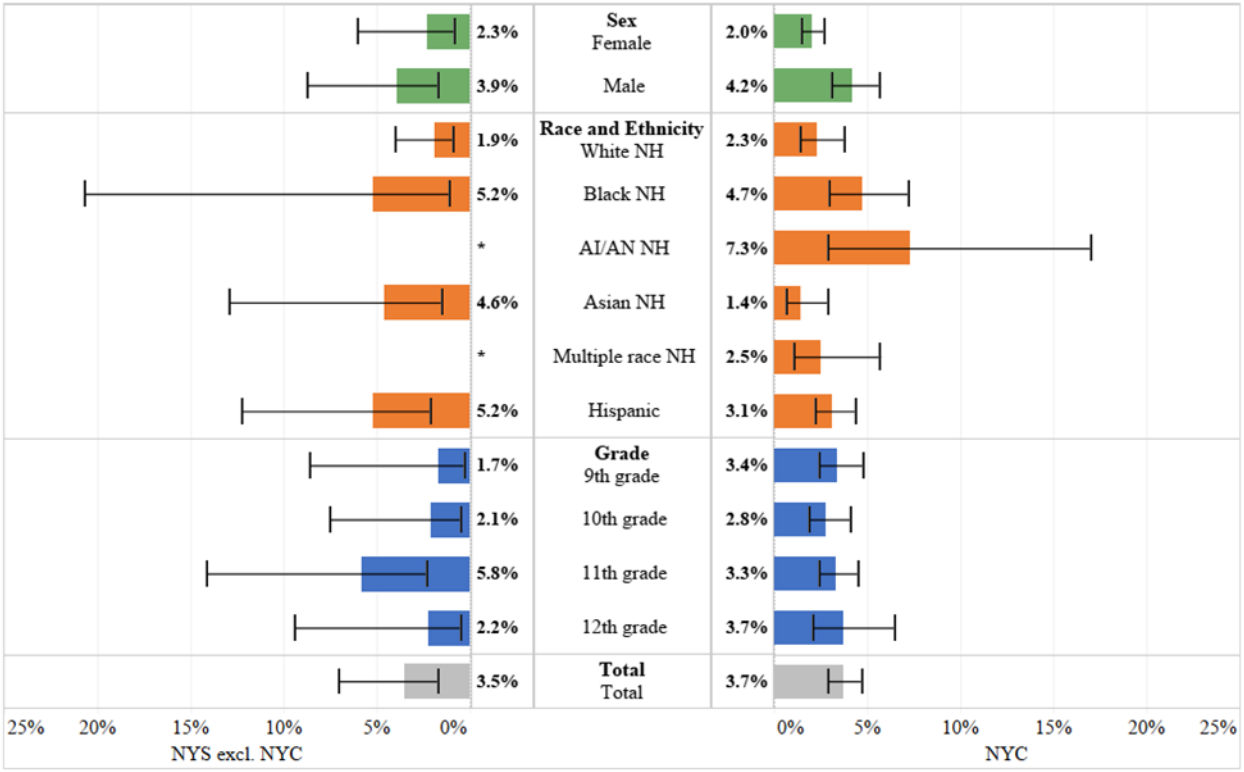
White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN NH = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City
Survey question: During your life, how many times have you used heroin (also called smack, junk, or China White)?
* Data do not meet reporting criteria.
Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 6.3.

High school students who report using methamphetamines

During 2023, 3.5 percent of high school students in NYS excluding NYC reported ever using methamphetamines (Figure 6.4). This was highest among male (3.9 percent), Black non-Hispanic and Hispanic (5.2 percent), Asian non-Hispanic (4.6 percent), and 11th grade (5.8 percent) students.

In the same year, 3.7 percent of high school students in NYC reported ever using methamphetamines (Figure 6.4). This was highest among male (4.2 percent), American Indian/Alaskan Native non-Hispanic (7.3 percent), Black non-Hispanic (4.7 percent), and 12th grade (3.7 percent) students.

Figure 6.4 Percentage of high school students who report ever using methamphetamines, New York State, 2023



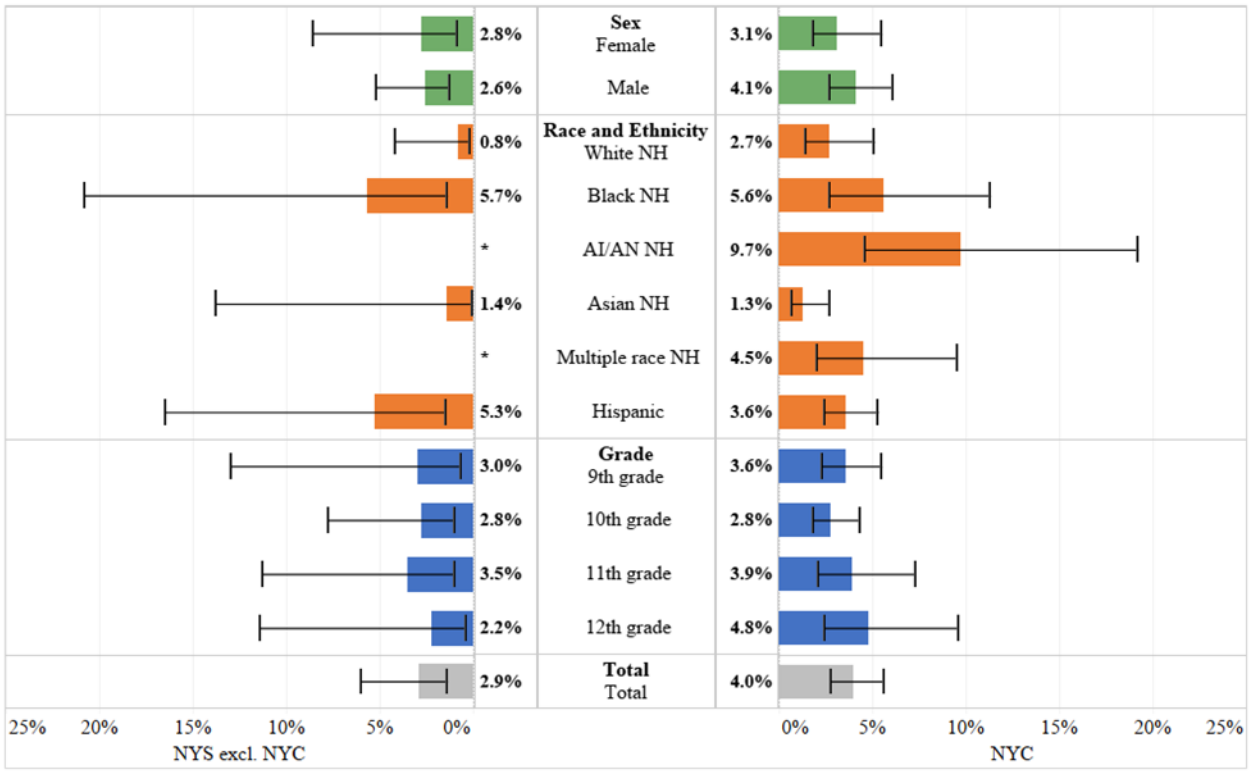
White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN NH = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City
Survey question: During your life, how many times have you used methamphetamines (also called speed crystal meth, crank, ice, or meth)?
* Data do not meet reporting criteria.
Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 6.4.

High school students who report injecting an illegal drug

During 2023, 2.9 percent of high school students in NYS excluding NYC reported ever injecting an illegal drug (Figure 6.5). This was highest among Black non-Hispanic (5.7 percent), Hispanic (5.3 percent), 9th grade (3.0 percent), 11th grade (3.5 percent) students. The percent of female students (2.8 percent) who reported injecting an illegal drug was slightly higher than male students (2.6 percent).

During the same year, 4.0 percent of high school students in NYC reported ever injecting an illegal drug (Figure 6.5). This was highest among male (4.1 percent), American Indian/Alaskan Native (9.7 percent), Black non-Hispanic (5.6 percent), Multiple race non-Hispanic (4.5 percent), and 12th grade (4.8 percent) students.

Figure 6.5 Percentage of high school students who report ever injecting an illegal drug, New York State, 2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN NH = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City
Survey question: During your life, how many times have you used a needle to inject any illegal drug into your body?
* Data do not meet reporting criteria.
Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025
For detailed data for the Figure, see Appendix: Data Table 6.5.

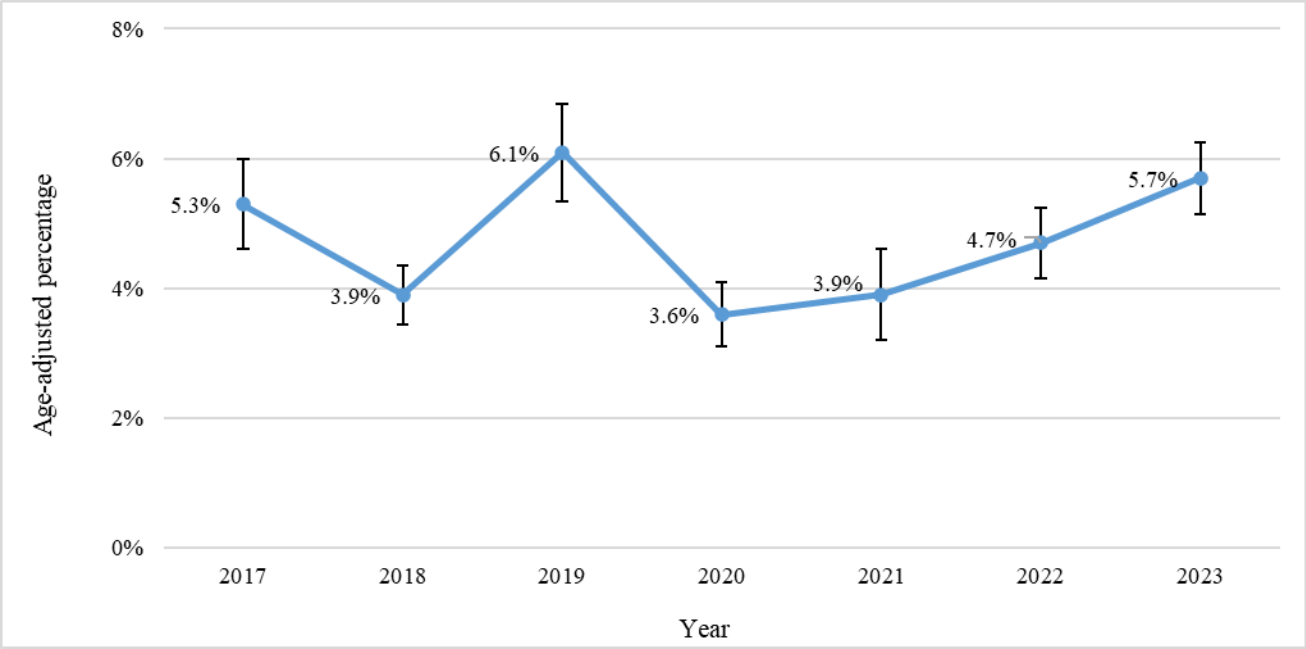
Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is an annual statewide random telephone and cellular surveillance survey designed by the CDC. The survey is conducted in all 50 states and US territories. BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population. Data from the BRFSS are useful for planning, initiating, and supporting health promotion and disease prevention programs at the state and federal level, and monitoring progress toward achieving health objectives for the state and nation. New York State's BRFSS sample is representative of the adult population living in private residences or college housing who have either a landline or cellular telephone. Therefore, adults living in group homes or congregate settings are not included in the survey.[40]

Self-reported prescription pain medication misuse in the past year

Among the NYS population aged 18 years and older from 2017 to 2023, the age-adjusted percentage of people who self-reported misuse of prescription pain medication in the past 12 months has fluctuated (Figure 6.6). But the percentage has been increasing since 2020 (3.6 percent), reaching an age-adjusted percentage of 5.7 percent in 2023.

Figure 6.6 Age-adjusted percentage of adults who self-reported prescription pain medication misuse in the past 12 months, New York State, 2017-2023



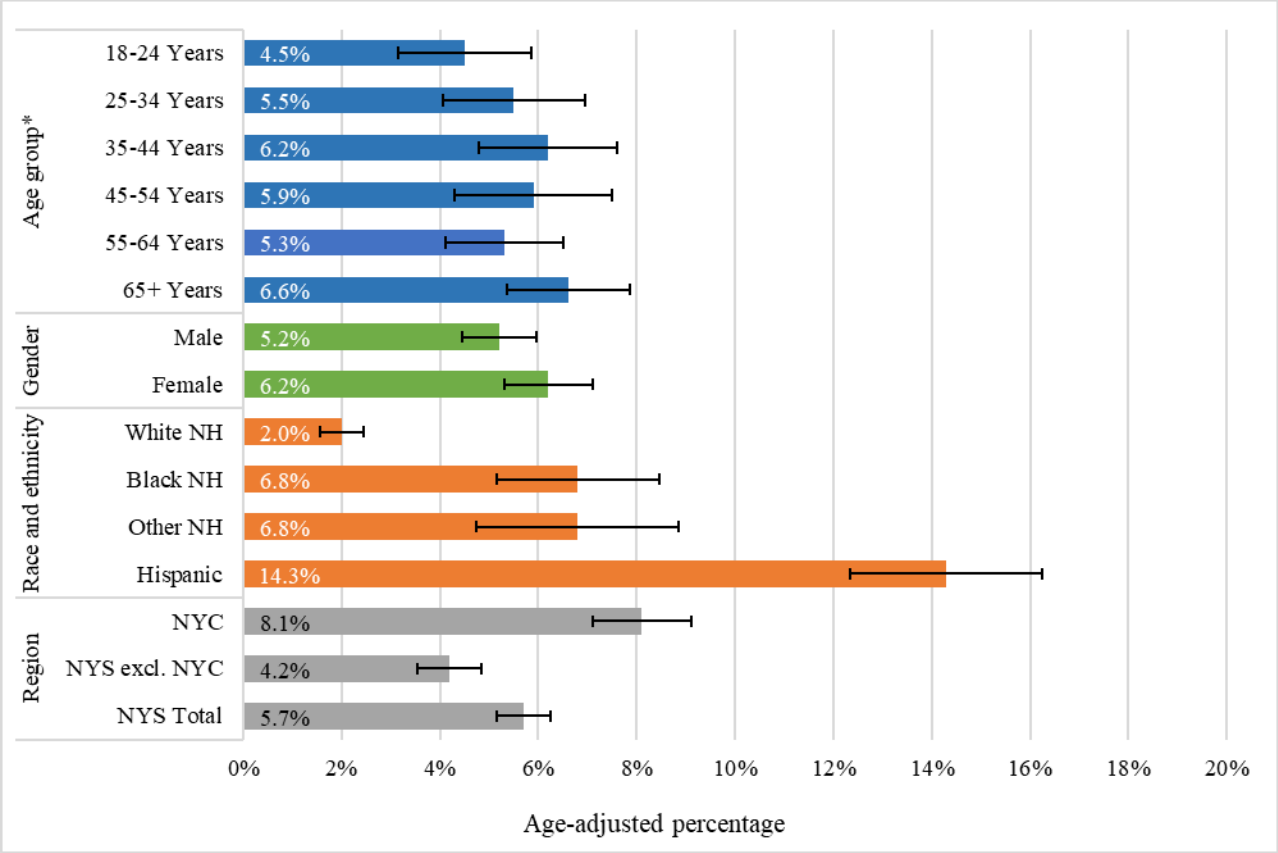
Survey question: In the past 12 months, have you used prescription pain medicine without a healthcare provider's prescription or differently than how the healthcare provider told you to use it?
Note: The population aged 18 years and older.
Data source: Behavioral Risk Factor Surveillance System (BRFSS); Data as of September 2024
For detailed data for the Figure, see Appendix: Data Table 6.6.

[40] Behavioral Risk Factor Surveillance System (BRFSS). New York State Department of Health. Accessed July 2025. https://www.health.ny.gov/statistics/brfss/

In 2023, among NYS residents aged 18 and older, the highest percentages of self-reported prescription pain medication misuse in the past 12 months were among those aged 65 years and older (6.6 percent), 35-44 years (6.2 percent), and 45-54 years (5.9 percent) (Figure 6.7). Among racial and ethnic groups, the age-adjusted percentage was highest among Hispanic individuals (14.3 percent) and lowest among White non-Hispanic individuals (2.0 percent). The age-adjusted prevalence was about twice as high among NYC residents (8.1 percent) compared to that among residents living outside of NYC (4.2 percent). The age-adjusted percentage was higher among female residents (6.2 percent) than male residents (5.2 percent).

Between 2022 and 2023, the percentage of prescription pain medication misuse among adults aged 55-64 years decreased from 5.7 percent to 5.3 percent. However, the percentage among adults aged 65 years and older, it increased from 4.4 percent to 6.6 percent; among those aged 35-44 years, it increased from 4.2 percent to 6.2 percent; and among those aged 45-54 years, it increased from 4.2 percent to 5.9 percent. The age-adjusted percent among Hispanic individuals increased from 9.8 percent to 14.3 percent; among females, it increased from 4.5 percent to 6.2 percent; and among NYC residents, it increased from 7.0 percent to 8.1 percent.

Figure 6.7 Age-adjusted percentage of adults who self-reported prescription pain medication misuse in the past 12 months, by subpopulation, New York State, 2023



White NH = White non-Hispanic; Black NH = Black non-Hispanic; NYC = New York City; NYS excl. NYC = New York State excluding New York City
Survey question: In the past 12 months, have you used prescription pain medicine without a healthcare provider's prescription or differently than how the healthcare provider told you to use it?
* Age groups show crude percentages.
Note: The population aged 18 years and older.
Data source: Behavioral Risk Factor Surveillance System (BRFSS); Data as of September 2024
For detailed data for the Figure, see Appendix: Data Table 6.7.

Public Opinion Survey of Public Health Issues

The Siena College Research Institute administers an annual survey of adult NYS residents on behalf of the NYSDOH. This survey aims to examine the general public's beliefs about public health issues and to assess public support for priority policies in chronic disease prevention and control. In NYS, reported attitudes about heroin and fentanyl use and prescription opioid misuse indicate an awareness of the risk of OUD.[41]

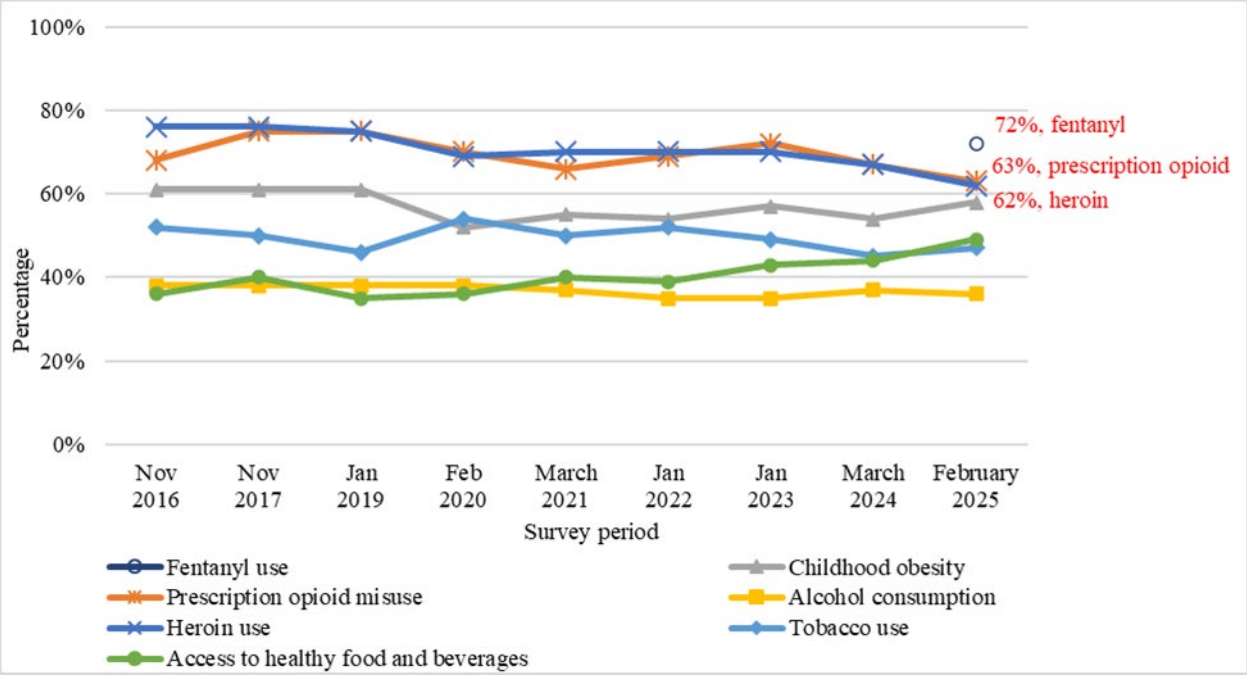
Perceptions of public health problems as "very serious"

In the most recent survey in February 2025 (unpublished data), 63 percent of New Yorkers reported that they consider prescription opioid misuse to be a "very serious" public health problem, representing a decrease from 67 percent in the March 2024 survey and 72 percent in the January 2023 survey (Figure 6.8). Similarly, 62 percent of New Yorkers considered heroin use to be a "very serious" public health problem. This decreased from 67 percent in March 2024 and from 70 percent between March 2021 and January 2023. Notwithstanding minor fluctuations over time and a steady decline in recent years, these issues have still consistently been reported as serious public health problems at higher percentages, compared to other areas of public health concern, such as "access to healthy food and beverages" and "alcohol consumption".

In the February 2025 survey, a new option for "fentanyl use" was added as a public health problem. This new option was reported by the highest percentage (72 percent) of New Yorkers as a "very serious" public health problem. Perception of opioids as a serious public health problem are similar across geographic regions of NYS. Across the state and across survey years, most New Yorkers have consistently reported that they consider heroin use and prescription opioid misuse, and in the most recent survey, fentanyl, to be a "very serious public health problem" (regional data not shown).

[41] Division of Chronic Disease Prevention - Chronic Disease Public Opinion Poll. Division of Chronic Disease Prevention and Siena College Research Institute. New York State Department of Health. Accessed May 2025. health.ny.gov/statistics/prevention/injury_prevention/information_for_action/

Figure 6.8 Perceptions of public health problems as "very serious" by adults in New York State, November 2016 – February 2025



Survey question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious problem or that it is not at all a serious public health problem.
Note: The February 2025 survey added "Fentanyl use" to the question.
Data source: New York State Department of Health/Siena College Research Institute, New York State Chronic Disease Public Opinion Poll; Data as of March 2025
For detailed data for the Figure, see Appendix: Data Table 6.8.

Acknowledgements

This report was prepared with the invaluable assistance from the following programs:

- New York State Department of Health:
  - Office of Science
  - AIDS Institute, Office of Drug User Health and Office of Program, Evaluation and Research
  - Division of State Emergency Medical Services
  - Bureau of Narcotic Enforcement
  - Bureau of Vital Records
  - Office of Health Services Quality and Analytics
  - Bureau of Chronic Disease Evaluation and Research
- New York State Office of Addiction Supports and Services

Methods

Indicators

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Overdose deaths involving any opioid	All poisoning deaths involving opioids, all manners, using all causes of death	Underlying cause of death, determined from the field designated as such, or, where missing or unknown, from the first-listed multiple cause of death field: X40-X44, X60-X64, X85, Y10-Y14 AND Any opioid in all other causes of death: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6	CDC WONDER
Overdose deaths involving heroin	Poisoning deaths involving heroin, all manners, using all causes of death	Underlying cause of death, determined from the field designated as such, or, where missing or unknown, from the first-listed multiple cause of death field: X40-X44, X60-X64, X85, Y10-Y14 AND Heroin in all other causes of death: T40.1	CDC WONDER
Overdose deaths involving commonly prescribed opioids	Poisoning deaths involving commonly prescribed opioids, all manners, using all causes of death	Underlying cause of death, determined from the field designated as such, or, where missing or unknown, from the first-listed multiple cause of death field: X40-X44, X60-X64, X85, Y10-Y14 AND any commonly prescribed opioid in all other causes of death: T40.2, T40.3 (e.g., hydrocodone, oxycodone)	CDC WONDER
Overdose deaths involving any synthetic opioid other than methadone	Poisoning deaths involving any synthetic opioid other than methadone, all manners, using all causes of death	Underlying cause of death, determined from the field designated as such, or, where missing or unknown, from the first-listed multiple cause of death field: X40-X44, X60-X64, X85, Y10-Y14 AND any other synthetic narcotics in all other causes of death: T40.4	CDC WONDER
Overdose deaths involving cocaine	Poisoning deaths involving cocaine, all manners, using all causes of death	Underlying cause of death, determined from the field designated as such, or, where missing or unknown, from the first-listed multiple cause of death field: X40-X44, X60-X64, X85, Y10-Y14 AND cocaine: T40.5	CDC WONDER
Overdose deaths involving opioids and nonfatal opioid related hospital events	Poisoning deaths involving any opioid, nonfatal outpatient ED visits and hospital discharges involving opioid abuse, poisoning, dependence, and unspecified use.	Underlying cause of death, determined from the field designated as such, or, where missing or unknown, from the first listed multiple cause of death field: X40-X44, X60-X64, X85, Y10-Y14 AND any opioid in all other causes of death: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6 ICD-10-CM: Opioid abuse (Principal Diagnosis: F1110, F11120, F11121, F11122, F11129, F1114, F11150, F11151, F11159, F11181, F11182, F11188, F1119); Opioid dependence and unspecified use (Principal Diagnosis: F1120, F11220, F11221, F11222, F11229, F1123, F1124, F11250, F11251, F11259, F11281, F11282, F11288, F1129, F1190, F11920, F11921, F11922, F11929, F1193, F1194, F11950, F11951, F11959, F11981, F11982, F11988, F1199); Opioid poisoning (Principal Diagnosis: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6 (Excludes 'adverse effect' or 'underdosing' as indicated by the values of 5 and 6 in the 6th character; and 'sequela' as indicated by the value of 'S' in the 7th character; e.g. T400X5S, T400X6S)	Vital Statistics and CDC WONDER SPARCS

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances	Neonatal withdrawal symptoms from maternal use of opioids or other substances and/or newborns affected by maternal use of opioids or other substances (other than cocaine) including opiates, sedative-hypnotics, and anxiolytics	ICD-10-CM: Principal Diagnosis: Z38 (liveborn infants) AND P96.1 (neonatal withdrawal symptoms from maternal use of opioids or other substances) or P04.49 (newborns affected by maternal use of opioids or other substances or P04.14 (newborns affected by maternal use of opiates) or P04.17 (newborns affected by maternal use of sedative-hypnotics) or P04.1A (newborns affected by maternal use of anxiolytics) in any other diagnoses	SPARCS
Hospital discharges involving opioid use (including overdose and disorders)	Opioid use includes abuse, poisoning, dependence, and unspecified use.	ICD-10-CM: Opioid abuse (Principal Diagnosis: F1110, F11120, F11121, F11122, F11129, F1114, F11150, F11151, F11159, F11181, F11182, F11188, F1119); Opioid dependence and unspecified use (Principal Diagnosis: F1120, F11220, F11221, F11222, F11229, F1123, F1124, F11250, F11251, F11259, F11281, F11282, F11288, F1129, F1190, F11920, F11921, F11922, F11929, F1193, F1194, F11950, F11951, F11959, F11981, F11982, F11988, F1199); Opioid poisoning (Principal Diagnosis: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6 (Excludes 'adverse effect' or 'underdosing' as indicated by the values of 5 and 6 in the 6th character; and 'sequela' as indicated by the value of 'S' in the 7th character; e.g. T400X5S, T400X6S)	SPARCS
Hospital discharges involving heroin overdose	Hospitalizations involving heroin poisonings	ICD-10-CM: Principal Diagnosis: T40.1 (Excludes 'adverse effect' or 'underdosing' as indicated by the values of 5 and 6 in the 6th character; and 'sequela' as indicated by the value of 'S' in the 7th character; e.g. T401X5S, T401X6S)	SPARCS
All emergency department visits involving opioid overdose	All emergency department visits (including outpatient and admitted patients) involving opioid poisonings	ICD-10-CM: Principal Diagnosis: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6 (Excludes 'adverse effect' or 'underdosing' as indicated by the values of 5 and 6 in the 6th character; and 'sequela' as indicated by the value of 'S' in the 7th character; e.g. T400X5S, T400X6S)	SPARCS
All emergency department visits involving heroin overdose	All emergency department visits (including outpatient and admitted patients) involving heroin poisoning	ICD-10-CM: Principal Diagnosis: T40.1 (Excludes 'adverse effect' or 'underdosing' as indicated by the values of 5 and 6 in the 6th character; and 'sequela' as indicated by the value of 'S' in the 7th character; e.g. T401X5S, T401X6S)	SPARCS

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Unique individuals enrolled in substance use disorder treatment programs who reported any opioid (including heroin) as the primary substance use at admission	Persons entering treatment for substance use disorders who reported a primary substance use at admission with heroin or any other/synthetic opioid. A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts. The most recent service admission for the year of enrollment was used to determine the persons demographic characteristic during the year. Each demographic category is mutually exclusive for the calendar	Other opioids include methadone, buprenorphine, oxycodone, as well as other/synthetic opioids. Even though OASAS does not collect all specific data related to other opioids (e.g., hydrocodone, pharmaceutical and/or non-pharmaceutical fentanyl, etc.), they can be reported in the category for other/synthetic opioid. Example: Primary substance=heroin, methadone, buprenorphine, or oxycodone	NYS OASAS Data Warehouse, Client Data System
911 Emergency Medical Services (EMS) dispatches	Each 911 EMS dispatch represents an instance where EMS were activated through a 911 call in response to a medical emergency or accidental injury. These dispatches may include emergency calls for medical assistance, critical care transports, or other urgent situations requiring EMS services. Records included in this measure are not deduplicated within each reporting agency, meaning multiple entries may exist for the same incident. However, the cancelled and out-of-state/country dispatches are excluded.		
Unique 911 Emergency Medical Services (EMS) dispatches	Each unique 911 EMS dispatch represents a deduplicated record of EMS responses initiated through a 911 request. Records are deduplicated within each reporting agency to ensure multiple entries for the same incident are not counted more than once. This measure excludes cancelled and out-of-state/country runs.		
Naloxone administration report by Emergency Medical Services (EMS)	Each naloxone administration report represents an EMS encounter when the administration of naloxone was given during the course of patient care. Multiple doses may be dispensed in an individual encounter and documented within a single administration report. Often, administrations of naloxone were given for patients presenting with similar signs and symptoms of a potential opioid overdose; final diagnosis of an opioid overdose is completed during definitive care or final evaluation.	Medication administered is equal to naloxone.	NYS ePCR data, and other regional EMS Program data collection methods

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Naloxone administration report by law enforcement	Each naloxone administration report represents a naloxone administration instance in which a trained law enforcement officer administered one or more doses of naloxone to a person suspected of an opioid overdose.	Not applicable	NYS Law Enforcement Naloxone Administration Database
Naloxone administration report by registered Community Opioid Overdose Prevention program	Each naloxone administration report represents a naloxone administration instance in which a trained responder administered one or more doses of naloxone to a person suspected of an opioid overdose. Naloxone administration instances that are not reported to the AIDS Institute by the registered Community Opioid Overdose Prevention programs are excluded from the county report.	Not applicable	NYS Community Opioid Overdose Prevention Naloxone Administration Database

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Suspected opioid overdose report by Emergency Medical Services (EMS)	If any one of the following conditions are met: 1) naloxone is administered with positive response (e.g., indicated by an improvement in respiratory status, potential increased in alertness, and possibly return of pupils to be more responsive), 2) provider impressions indicate poisoning by opioids, 3) provider impressions indicate opioid related disorder and naloxone is administered, 4) provider impressions indicate unspecified drug overdose and opioid term is mentioned in narrative and response to naloxone is not worse and no narcotics are administered by EMS, 5) provider impressions indicate unspecified drug overdose, cardiac arrest, apnea, or respiratory failure and opioid term is mentioned in narrative and naloxone is administered and patient fatality is indicated, 6) opioid term and overdose term mentioned in narrative (with no rule out term) and at least two additional terms indicating an opioid overdose mentioned in narrative and no narcotics are administered by EMS.	Please see the section titled NYS Suspected Opioid Overdose Syndrome – NEMSIS v3.5.0 for detailed methodology	NYS ePCR data, and other regional EMS Program data collection methods
Percentage of high school students who report ever using cocaine	Percentage of students who ever used cocaine (any form of cocaine, including powder, crack, or freebase, one or more times during their life)	Survey question: During your life, how many times have you used any form of cocaine, including powder, crack, or freebase? Responses: “A. 0 times B. 1 or 2 times C. 3 to 9 times D. 10 to 19 times E. 20 to 39 times F. 40 or more times”	YRBSS
Percentage of high school students who report ever using heroin	Percentage of students who ever used heroin (also called "smack," "junk," or "China White," one or more times during their life)	Survey question: “During your life, how many times have you used heroin (also called smack, junk, or China White)?” Responses: “A. 0 times B. 1 or 2 times C. 3 to 9 times D. 10 to 19 times E. 20 to 39 times F. 40 or more times”	YRBSS

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Percentage of high school students who report ever using methamphetamines	Percentage of students who ever used methamphetamines (also called "speed," "crystal meth," "crank," "ice," or "meth," one or more times during their life)	Survey question: During your life, how many times have you used methamphetamines (also called speed, crystal meth, crank, ice, or meth)? Responses: “A. 0 times B. 1 or 2 times C. 3 to 9 times D. 10 to 19 times E. 20 to 39 times F. 40 or more times”	YRBSS
Percentage of high school students who report ever injecting an illegal drug	Percentage of students who ever injected any illegal drug (used a needle to inject any illegal drug into their body, one or more times during their life)	Survey question: During your life, how many times have you used a needle to inject any illegal drug into your body? Responses: “A. 0 times B. 1 time C. 2 or more times”	YRBSS
Percentage of adults who have self-reported prescription pain medication misuse in the past 12 months	Percentage of New York adult residents aged 18 years and older who have self-reported misuse of prescription pain medication in the past 12 months	Survey question: “In the past 12 months, have you used prescription pain medicine without a healthcare provider's prescription or differently than how the healthcare provider told you to use it?” Responses: “A. Yes B. No"	BRFSS
Perception of heroin use as a “very serious” public health problem	Prevalence of NYS adults perceiving heroin use as a “very serious” public health problem	Residents aged 18 years or older are interviewed from within all regions in NYS to ensure a representative statewide sample. From 2013-2018 the survey was conducted via a random-digit dial telephone survey. Survey methods were changed in 2019 to include the addition of an online survey and may affect the ability to trend data. The overall sample is weighted by age, gender, reported race and ethnicity, and region to ensure statistical representativeness. Survey Question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious public health problem or that it is not at all a serious public health problem: Heroin use.	NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey
Perception of prescription opioid misuse and abuse as a “very serious” public health problem	Prevalence of NYS adults perceiving prescription opioid misuse and abuse to be a “very serious” public health problem	Residents aged 18 years or older are interviewed from within all regions in NYS to ensure a representative statewide sample. From 2013-2018 the survey was conducted via a random-digit dial telephone survey. Survey methods were changed in 2019 to include the addition of an online survey and may affect the ability to trend data. The overall sample is weighted by age, gender, reported race and ethnicity, and region to ensure statistical representativeness. Survey Question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious public health problem or that it is not at all a serious public health problem: Prescription opioid such as Percocet, OxyContin or Vicodin misuse and abuse.	NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Perception of alcohol consumption as a "very serious" public health problem	Prevalence of NYS adults perceiving alcohol consumption to be a "very serious" public health problem	Residents aged 18 years or older are interviewed from within all regions in NYS to ensure a representative statewide sample. From 2013-2018 the survey was conducted via a random-digit dial telephone survey. Survey methods were changed in 2019 to include the addition of an online survey and may affect the ability to trend data. The overall sample is weighted by age, gender, reported race and ethnicity, and region to ensure statistical representativeness. Survey Question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious public health problem or that it is not at all a serious public health problem: Alcohol consumption.	NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey
Perception of tobacco use as a "very serious" public health problem	Prevalence of NYS adults perceiving tobacco use to be a "very serious" public health problem	Residents aged 18 years or older are interviewed from within all regions in NYS to ensure a representative statewide sample. From 2013-2018 the survey was conducted via a random-digit dial telephone survey. Survey methods were changed in 2019 to include the addition of an online survey and may affect the ability to trend data. The overall sample is weighted by age, gender, reported race and ethnicity, and region to ensure statistical representativeness. Survey Question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious public health problem or that it is not at all a serious public health problem: Tobacco use.	NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey
Perception of childhood obesity as a "very serious" public health problem	Prevalence of NYS adults perceiving childhood obesity to be a "very serious" public health problem	Residents aged 18 years or older are interviewed from within all regions in NYS to ensure a representative statewide sample. From 2013-2018 the survey was conducted via a random-digit dial telephone survey. Survey methods were changed in 2019 to include the addition of an online survey and may affect the ability to trend data. The overall sample is weighted by age, gender, reported race and ethnicity, and region to ensure statistical representativeness. Survey Question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious public health problem or that it is not at all a serious public health problem: Childhood obesity.	NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey

Indicator	Definition	ICD-10 Codes/Detailed Explanation	Data Source
Perception of access to health food and beverages as a "very serious" public health problem	Prevalence of NYS adults perceiving access to healthy food and beverages to be a "very serious" public health problem	Residents aged 18 years or older are interviewed from within all regions in NYS to ensure a representative statewide sample. From 2013-2018 the survey was conducted via a random-digit dial telephone survey. Survey methods were changed in 2019 to include the addition of an online survey and may affect the ability to trend data. The overall sample is weighted by age, gender, reported race and ethnicity, and region to ensure statistical representativeness. Survey Question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious public health problem or that it is not at all a serious public health problem: Access to healthy food and beverages.	NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey
Perception of fentanyl use as a "very serious" public health problem	Prevalence of NYS adults perceiving fentanyl use as a "very serious" public health problem	Residents aged 18 years or older are interviewed from within all regions in NYS to ensure a representative statewide sample. From 2013-2018 the survey was conducted via a random-digit dial telephone survey. Survey methods were changed in 2019 to include the addition of an online survey and may affect the ability to trend data. The overall sample is weighted by age, gender, reported race and ethnicity, and region to ensure statistical representativeness. Survey Question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious public health problem or that it is not at all a serious public health problem: Fentanyl use.	NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey

Indicator	Numerator	Denominator
Opioid[a] analgesic prescription rate[e] per 1,000 population	Schedule II, III and IV opioid analgesic prescriptions[c] dispensed to state residents.	Midyear population for the calendar year under surveillance from US Census
Commonly prescribed opioid analgesic prescription rate per 1,000 person-years	Six commonly prescribed schedule II, III and IV opioid analgesic prescriptions[c] dispensed to state residents	Midyear population for the calendar year under surveillance from US Census * .25 year
Percentage of episodes when an opioid naïve patient received more than a seven-day supply for the initial opioid prescription[a]	Number of episodes when an opioid naïve patient received more than a seven-day supply for the initial opioid prescription[a]	Number of episodes when an opioid naïve patient received an opioid prescription[c]
Percentage of episodes when an opioid naïve patient received long-acting initial opioid prescription[a]	Number of episodes when an opioid naïve patient received long-acting initial opioid prescription[a]	Number of episodes when an opioid naïve patient received an opioid prescription[c]
Patients with prescribed opioid[a] analgesics from five or more prescribers and dispensed at five or more pharmacies in a three-month rolling period, rate per 100,000 population	Number of patients receiving prescriptions for opioid analgesics from five or more prescribers and that are dispensed at five or more pharmacies in a three-month rolling period. The numerator is a count of unique patients who experienced at least one multiple provider episode (MPE) in any three-month rolling period.	Midyear population for the calendar year under surveillance from US Census
Percentage of patients prescribed one or more opioid[c] analgesics with a total daily dose of ≥ 90 MME[b] on at least one day	Number of patients prescribed one or more opioid analgesic prescriptions[d] with a total daily dose of ≥ 90 MME[b] on at least one day	Number of patients who received one or more opioid analgesic prescriptions[d] during a given year
Percentage of patients with two or more calendar days of overlapping opioid[a] analgesic and benzodiazepine prescriptions	Patients with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions[c]	Patients with at least one prescription[c] for opioid analgesics or benzodiazepines during a given year
Percentage of patients with two or more calendar days of overlapping opioid[a] analgesic prescriptions	Patients with two or more calendar days of overlapping opioid analgesic prescriptions[c]	Patients with at least one prescription[c] for opioid analgesics during a given year
Patients who received at least one buprenorphine prescription for opioid use disorder, rate per 1,000 population	Patients who received at least one buprenorphine prescription for opioid use disorder	Midyear population for the calendar year under surveillance from US Census
Percentage of cohort patients[f] receiving continuous buprenorphine for treatment of opioid use disorder[g] for six months or more	Number of patients with continuous dispensed buprenorphine prescriptions for six months or more for treatment of opioid use disorder among patients receiving buprenorphine in a given measurement year[h]	Number of patients (cohort) with at least one buprenorphine prescription for treatment of opioid use disorder between July 1st of the preceding measurement year and June 30th of the current measurement year[h]

[a]: A comprehensive controlled substance list including drugs from CDC and NYS PMP was used for data analysis
[b]: Morphine milligram equivalents
[c]: Buprenorphine prescriptions for the treatment of substance use disorder were excluded.
[d]: Buprenorphine prescriptions for pain and the treatment of substance use disorder were excluded.
[e]: The rates presented are controlled substance prescription rates per population. These numbers are federally-standardized indicators used to measure types of progress toward combating the controlled substance epidemic in certain states. They are not rates of the number of different people who are receiving a controlled substance prescription in a certain population. Rather, they are rates of the number of specific controlled substance prescriptions written and dispensed within the period. For example, if a county has a rate of 25, that means there were 25 prescriptions per 1,000 people in the population. However, it does not necessarily mean that 25 out of 1,000 individuals received a prescription; all 25 controlled substance prescriptions could have been for one individual.
[f]: A group of patients (cohort) with at least one buprenorphine prescription for treatment of opioid use disorder between July 1st of the preceding measurement year and June 30th of the current measurement year.
[g]: A treatment period is considered continuous or maintained when gaps between prescription supplies are no more than 30 days.
[h]: A measurement year is a calendar year for which the cohort patients were followed up for at least six months. For example, calendar year 2024 is the measurement year for cohort patients with buprenorphine prescriptions between July1, 2023, and June 30, 2024.

NYS Suspected Opioid Overdose Syndrome – NEMSIS v3.5.0

Records for inclusion are limited to 911 Response, Intercept and Mutual aid.

1. NEMSIS v3 - Naloxone administration is documented (eMedications.03) ***AND*** [response to medication (eMedications.07) indicates patient improvement OR narrative (eNarrative.01) contains “improved”, “improvement in loc", “more responsive", “now awake”, “began breathing”, “became conscious”, “pt came to”, “pt woke up”, “became responsive”, “more alert”, “positive response to Narcan”].

2. Primary or secondary impression(s) indicate an opioid overdose:
    - NEMSIS v3 - Primary/secondary impression (eSituation.11, eSituation.12) starts with any of the following:
        - T40.0: Poisoning by, adverse effect of and underdosing of opium
        - T40.1: Poisoning by and adverse effect of heroin
        - T40.2: Poisoning by, adverse effect of and underdosing of opioids
        - T40.3: Poisoning by, adverse effect of and underdosing of methadone
        - T40.4: Poisoning by, adverse effect of and underdosing of other synthetic narcotics- Fentanyl, Tramadol, etc.
        - T40.6: Poisoning by, adverse effect of and underdosing of other and unspecified narcotics

    AND

    - Any of the following is true:
        - No naloxone administration is documented in (eMedications.03)
        - Naloxone administration is documented in (eMedications.03) and response to medication (eMedications.07) indicates patient improvement or unchanged.
        - Naloxone administration is documented in (eMedications.03) and response to medication (eMedications.07) is not documented.

3. Primary or secondary impression(s) indicate an opioid related disorder
    - NEMSIS v3 - Primary/secondary impression (eSituation.11, eSituation.12) starts with F11: Opioid related disorders

    AND

    - Naloxone administration is documented in eMedications.03 or eNarrative.01

4. Primary or secondary impression(s) indicate an unspecified drug overdose:
    - NEMSIS v3 - Primary or secondary impression (eSituation.11, eSituation.12) starts with any of the following:
        - T50.9: Poisoning by, adverse effect of and underdosing of other and unspecified drugs, medicaments, and biological substances
        - T65.9: Toxic effect of unspecified substance

    AND

    - Opioid term is mentioned in narrative:
        - Narrative (eNarrative.01) or complaint (eSituation.04) contains “opioid”, “opiate”, “opium”, “dope”, “smack”, “heroin”, “hod”, “speedball”, “methadone”, “suboxone”, “morphine”, “tramadol”, “buprenorphine”, “codeine”, “norco”, “oxy”, “vicodin”, “Percocet”,

"hydrocodone", "opana", "dilaudid", "hydromorphone", "fentanyl". Common misspellings and other variants of these terms are included.

AND

- Any of the following are true:
  - Naloxone administration is documented in eMedications.03 and response to medication (eMedications.07) indicates patient improvement or unchanged.
  - Naloxone administration is documented in eMedications.03 and response to medication (eMedications.07) is not documented.
  - Naloxone administration is documented in eNarrative.01.

AND

- Fentanyl (4337), Morphine (7052), Oxycodone (7804), Hydromorphone (3423), and Tramadol (10689) are not an administered medication in (eMedications.03).

5. Primary or secondary impression(s) indicate a non-specific drug or opioid overdose, cardiac arrest, apnea, or respiratory failure *AND* opioid term is mentioned in narrative *AND* naloxone is administered *AND* Patient fatality is indicated:
   - NEMSIS v3 (eSituation.11, eSituation.12):
     - Apnea: R06.81; Cardiac arrest: I46; Drug overdose codes: T40.0-T40.4, T40.6, T50.9, T65.9; Respiratory failure: J96.0, J96.9

   AND

   - Narrative (eNarrative.01) or complaint (eSituation.04) contains "opioid", "opiate", "opium", "dope", "smack", "heroin", "hod", "speedball", "methadone", "suboxone", "morphine", "tramadol", "buprenorphine", "codeine", "norco", "oxy", "vicodin", "Percocet", "hydrocodone", "opana", "dilaudid", "hydromorphone", "fentanyl". Common misspellings and other variants of these terms are included.

   AND

   - Naloxone administration is documented in eMedications.03 or eNarrative.01

   AND

   - Incident/Patient Disposition (eDisposition.12) indicates patient death.
   - Initial Patient Acuity (eSituation.13) or Final Patient Acuity (eDisposition.19) are Dead without Resuscitation Efforts (Black).
   - Reason CPR/Resuscitation Discontinued (eArrest.16) is 3016005 "Obvious Signs of Death".
   - End of EMS Cardiac Arrest Event (eArrest.18) is 3018001 Expired in ED 3018003 or Expired in the Field.

6. Opioid term mentioned in narrative (with no rule out term) AND overdose term mentioned in
narrative (with no rule out term) AND at least two additional terms (Narcan, method, LOC,

physiologic sign) mentioned in narrative AND there are no narcotic medications listed under
administered medications:

- NEMSIS v3 - Narrative or complaint contains opioid term AND overdose term (term is excluded if
  preceded by a rule out term: rule out", "r/o")
  - Opioid terms: "opioid", "opiate", "opium", "dope", "smack", "heroin", "hod", "speedball", "methadone", "suboxone", "morphine", "tramadol", "buprenorphine", "codeine", "norco", "oxy", "vicodin", "Percocet", "hydrocodone", "opana", "dilaudid", "hydromorphone", "fentanyl".

AND

  - Overdose terms: "overdose", "overdosed", "od", "od'd"

AND

- Narrative (eNarrative.01) or complaint (eSituation.04) contains a term from at least two of the following groups (common misspellings and other variants of these terms are included):
  - LOC: "nodding off", "unresponsive", "altered LOC", "AMS", "unconscious", "loss of consciousness"
  - Method: "inject", "snort", "tinfoil", "ingest", "smoke", "freebase", "syring" and "spoon", "needle" and "spoon"
  - Narcan: "Narcan", "naloxone"
  - Physiological sign: "pinpoint pupil", "injection mark", "track mark", "blue", "cyano", "stop breathing", "respiratory arrest", "inadequate breathing", "agonal breathing"

AND

- Fentanyl (4337), Morphine (7052), Oxycodone (7804), Hydromorphone (3423), and
  Tramadol (10689) are not an administered medication in eMedications.03

Data Sources

CDC WONDER:

State level opioid overdose mortality data were obtained from the Centers for Disease Control and Prevention Wide-ranging ONline Data for Epidemiological Research (CDC WONDER) Multiple Cause of Death Data query.

The confirmation and recording of opioid-related deaths are impacted by several factors, including toxicology testing, coroner/medical examiner systems and capacity, resource and funding availability, and the county in which death occurred. These may result in lack of identification of deaths caused by an opioid overdose, as well as variation in the information available with respect to specific substances involved. However, raised awareness of specific substances involved in overdoses, improvements in technology and resources for toxicology testing, and improved cause-of-death reporting have occurred in prior years. As a result, it is important to note that while there have been overall increases in the reported number of overdose deaths since 2010, a portion of the observed early increases are likely due to the improvements in reporting.

For information about CDC WONDER race and ethnicity groups, including which groups are included in the “other” category, please see:
https://wonder.cdc.gov/wonder/help/mcd.html#Race%20and%20Ethnicity%20Questions

Vital Records (Vital Statistics) Vital Event Registration:

New York State consists of two registration areas, New York City (NYC) and New York State exclusive of New York City (also referred to as Rest of State). NYC includes the five counties of Bronx, Kings (Brooklyn), New York (Manhattan), Queens, and Richmond (Staten Island); the remaining 57 counties comprise New York State exclusive of NYC. The NYSDOH Bureau of Vital Records processes data from live birth, death, fetal death, and marriage certificates recorded in New York State exclusive of NYC. Through a cooperative agreement, the NYSDOH receives data on live births, deaths, and fetal deaths recorded in NYC from the New York City Department of Health and Mental Hygiene (NYCDOHMH), and on live births and deaths recorded outside of New York State of residents of New York State from other states and Canada.

In general, vital event indicators for NYC geographical areas reported by the NYSDOH and the NYCDOHMH may be different because the former possibly includes all NYC residents' events, regardless of where they took place, and the latter reports events to NYC residents that took place in NYC.

Vital statistics mortality data include up to 20 causes of death. Frequencies are based on decedents’ county of residence, not the county where death occurred. This report’s mortality indicators reflect all manners and all causes of death. Data are frequently updated as additional confirmations on the causes of death and new records for all NYS resident deaths are received. Therefore, the frequencies published in subsequent reports may also differ due to timing and/or completeness of data.

Statewide Planning and Research Cooperative System (SPARCS):

SPARCS collects information about hospitalizations and emergency department (ED) visits through the patient discharge data system. Outpatient ED visits are events that did not result in admission to the hospital. Each hospitalization and outpatient ED visit receives an ICD-10-CM code at discharge that indicates the primary reason for the occurrence. There is also a first-listed cause, external cause of injury, and up to 24 other diagnosis codes recorded to further describe the hospitalization or ED visits.

Statistics in these tables are based on the primary diagnosis and first-listed cause of injury unless otherwise noted. An individual can have more than one hospitalization or ED visit. Numbers and rates are based on the number of discharges and not on the number of individuals seen. The frequencies are based on patients' county of residence, not the county where the incident occurred. County of residence was assigned based on ZIP Code for cases in which the patient county of residence was listed as unknown or missing, but a valid NYS ZIP Code was present. For indicators related to the ED data, the numbers represent ED visits for opioid overdose patients who were not subsequently admitted into the hospital.

New York State Emergency Medical Services (EMS) Data:

New York State maintains an EMS patient care data repository, in which all electronic Patient Care Report (ePCR) data are captured from across the State. As of June 2018, additional EMS electronic patient care data are being submitted in compliance with the National EMS Information Systems (NEMSIS) 3.4.0 standard (3.5.0 as of July 2024). The number of reported naloxone administrations for Erie, Niagara, Monroe, Onondaga, Schoharie, Montgomery, and Herkimer counties may have increased compared to previous reports, as an EMS agency covering those counties and responding to a large volume of 911 calls has had data submitted back starting in August 2016 until current calendar quarters. Additional historical data may be received for the five counties of New York City and other regions across New York State. Updates may be made to reported totals in subsequent reports as additional data become available.

Prior to January 2023, most data for Suffolk County are obtained through the Suffolk County Regional EMS Medical Control, to which all medication administrations by EMS–including naloxone–are required to be reported. Beginning in January 2023, the majority of Suffolk County data were reported via ePCR with a significantly smaller data set still being received through the County Regional EMS Medical Control. Thus, Suffolk County results in this report are a de-duplicated compilation of data received from Suffolk County Medical Control and data provided from ePCRs submitted. Part of the data for Richmond County is obtained directly from the EMS agency, due to a difference in reporting mechanisms. These records are also deduplicated with Richmond County data submitted via ePCR.

New York State Law Enforcement Naloxone Administration Dataset:

The NYS Law Enforcement Naloxone Administration dataset provides information on naloxone administrations by law enforcement officers in the case of a suspected opioid overdose. The information comes from a form that is submitted by officers following a naloxone administration. The form collects the age and gender of the individual receiving naloxone, the county and ZIP Code where the suspected opioid overdose occurred, aided status before and after naloxone administration, the suspected drug used, the number of naloxone vials administered by the officer, and whether the person lived. Initial trainings of law enforcement began in 2014 and are ongoing. The data do not yet comprehensively include the New York City Police Department and the Nassau County Police Department, which use a separate reporting mechanism.

New York State Community Opioid Overdose Prevention Program Dataset:

The NYS Community Opioid Overdose Prevention program dataset provides information on naloxone administrations by lay persons who have been trained by registered NYS Community Opioid Overdose Prevention programs in the case of a suspected opioid overdose. Naloxone administration reports are submitted by registered Community Opioid Overdose Prevention programs, not individual lay persons. The form collects information including age and gender of the individual receiving naloxone, the county and ZIP Code where the suspected opioid overdose occurred, aided status before naloxone administration, the number of naloxone doses administered by the responder, and whether the person lived.

Naloxone usage reports are submitted to the AIDS Institute (AI) by registered community programs after a naloxone kit has been used by a trained community responder. Beginning in May 2018, the AI Community Opioid Overdose Prevention program began the transition from a paper-based reporting system to an online system for naloxone usage reporting purposes. Data that had previously been collected using paper reports and manually entered in a database were migrated to an online platform where data are now stored and managed. This migration included all paper reports from program inception in 2006 through July 2018. Registered programs have been introduced to the online reporting system on a rolling basis. While most registered program are utilizing the online platform for reporting purposes, paper reports will continue to be accepted and naloxone administration data on these forms will be entered into the new online system. As of April 2019, a new ZIP Code file was introduced to improve reporting accuracy. This has resulted in shifts in the number of administrations in certain counties, depending upon the ZIP Code reassignment.

New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS):

NYS OASAS collects data on people treated in all OASAS-certified substance use disorder treatment programs. Data are collected through the OASAS CDS. Data are collected at admission and discharge from a level of care within a provider. Levels of care include crisis, residential, inpatient, outpatient, and opioid treatment. An individual in treatment in multiple levels of care during a year would be counted once.

A person admitted in a previous year could still be receiving treatment in subsequent years. They would be counted once for each year that are continuously enrolled in treatment.

Data excludes residents living outside of New York State and significant others. Individuals receiving substance use disorder (SUD) treatment may have had significant others who also received supportive services as part of social care for families and loved ones (such as counseling).

The 2018 population estimates are used to calculate rates for 2019 and 2020. The 2023 population estimates are used to calculate rates for 2023 and 2024.

Prescription Monitoring Program (PMP) Data:

The New York State Prescription Monitoring Program (PMP) Registry is an online registry that is administered by the New York State Department of Health's Bureau of Narcotic Enforcement (BNE). The registry collects dispensed prescription data for controlled substances in schedules II, III, IV and V that are reported by more than 5,000 separate dispensing pharmacies and practitioners registered with New York State. The data must be submitted to BNE within 24 hours after the prescription is dispensed. BNE closely monitors all submitted prescriptions and their associated information. The integrity of the data is achieved through a variety of system edits, and it is the responsibility of the pharmacies to provide timely and accurate data.

Effective August 27, 2013, NYS prescribers are required to consult the PMP Registry prior to writing a prescription for Schedule II, III, and IV controlled substances. The PMP provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. The PMP is available 24 hours a day/seven days a week via an application on the Health Commerce System (HCS). Patient reports include all controlled substances that were dispensed in New York State and reported by the pharmacy/dispenser for the past year. This information empowers practitioners to better evaluate their patients' treatment with controlled substances and determine whether there may be misuse or non-medical use. In addition, pharmacists can also access the registry to assist in the exercise of their professional judgment before dispensing the prescriptions for controlled substances.

The 2021-2023 population estimates are used to calculate rates for 2021-2023. The 2023 population estimates are used to calculate rates for 2024.

The Youth Risk Behavior Surveillance System (YRBSS):

What is the YRBSS?

The YRBSS is a national survey of youth and young adults in the US. It was developed to monitor priority health risk behaviors that are often established in childhood and adolescence. The YRBSS had been conducted every two years since 1991 and surveys high school students on substance use, physical activity, dietary behaviors, sexual behaviors, and behaviors related to injuries and violence. The national survey is conducted by CDC and the state, territorial, tribal government, and local surveys are administered by departments of health and education.

What is its use?

Health departments use the data for a variety of purposes. Among those are to provide information on prevalence and trends in health behaviors, identify demographic variations in health-related behaviors, provide comparable data, and measure progress toward achieving state and national health objectives.

Who is covered in the YRBSS?

The health characteristics estimated from the YRBSS pertain only to 9th through 12th grade students in public and private schools in the US.

A three-stage cluster sample design is employed to identify a nationally representative sample of 9th through 12th grade students. Primary sample units are used; schools are sampled from the primary sample units, and intact classes of a required subject or period are then randomly sampled from the selected schools. All students enrolled in the selected classes can participate in the survey.

Sites use a two-stage cluster design to generate a representative sample of students in 9th through 12th grade in their jurisdictions. For most sites, the first sampling stage involves selecting schools with probability proportional to school enrollment size. In the second stage, intact classes of a required subject or period are randomly sampled from the selected schools. All students enrolled in the selected classes can participate in the survey.

Behavioral Risk Factor Surveillance System (BRFSS):

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide telephone surveillance system designed and funded by the Centers for Disease Control and Prevention (CDC) and conducted by the NYSDOH Division of Chronic Disease and Prevention, Bureau of Chronic Disease Evaluation and Research. The BRFSS collects data on preventive health practices and risk behaviors that affect chronic diseases, injuries, and preventable infectious diseases. In addition to a set of core questions that CDC requires to be asked in all states either every year, or on a regular rotating basis, such as every other year, states may also include questions from a list of optional CDC questions or may add additional questions to serve their own specific state needs. Since 2018, questions on opioid use in the past 12 months have been included in the survey conducted in New York State.

New York State's BRFSS sample is designed to be representative of the adult population living in private residences or college housing who have either a landline or cellular telephone. Adults living in group homes or congregate settings are excluded from the survey. The BRFSS is designed to provide information for New York State, New York State excluding New York City, and New York City (5 boroughs combined).

Public Opinion Survey

Survey data were provided by Siena College Research Institute, who administers an annual survey to adult residents of the state of New York on behalf of the New York State Department of Health Division of Chronic Disease Prevention to examine the general public's beliefs about public health issues and to assess public support for priority policies in chronic disease prevention and control.

Data Suppression Rules for Confidentiality

In many instances, results are not shown (i.e., suppressed) to protect individuals' confidentiality. Suppression rules vary, depending on the data source.

Data Source	Suppression Criteria
Vital Statistics - Death Records	Denominator population <50
CDC WONDER	Numerator 1-9 deaths
Statewide Planning and Research Cooperative System (SPARCS) - ED and hospital records	Numerator 1-5 cases
OASAS Client Data System (CDS) - Enrollment	Numerator 1-9 unique individuals enrolled
Prehospital Care Reports	Numerator 1-10
NYS Law Enforcement Naloxone Administration Dataset	Numerator 1-10
NYS Community Opioid Overdose Prevention Program Dataset	Numerator 1-10
NYS Prescription Monitoring Program (PMP)	Numerator 1-5 cases
YRBSS	Unweighted denominator <30
BRFSS	Unweighted denominator <50 or Unweighted numerator 1-5 cases

Data Limitations

Data Source	Limitations
Vital Records	The accuracy of indicators based on codes found in vital statistics data is limited by the completeness and quality of reporting and coding. Death investigations may require weeks or months to complete; while investigations are being conducted, deaths may be assigned a pending status on the death certificate (ICD-10-CM underlying cause code of R99, "other ill-defined and unspecified causes of mortality"). Analysis of the percentage of death certificates with an underlying cause of death of R99 by age, over time, and by jurisdiction should be conducted to determine potential impact of incomplete underlying causes of death on drug overdose death indicators. The percentage of death certificates with information on the specific drug(s) involved in drug overdose deaths varies substantially by state and local jurisdiction and may vary over time. The substances tested for, the circumstances under which the tests are performed, and how information is reported on death certificates may also vary. Drug overdose deaths that lack information about the specific drugs may have involved opioids. Even after a death is ruled as caused by a drug overdose, information on the specific drug might not be subsequently added to the certificate. Therefore, estimates of fatal drug overdoses involving opioids may be underestimated from lack of drug specificity. Additionally, deaths involving heroin might be misclassified as involving morphine (a natural opioid), because morphine is a metabolite of heroin. The indicator "Overdose deaths involving synthetic opioids other than methadone (SOOTM)" includes overdose deaths due to pharmaceutically and illicitly produced opioids such as fentanyl.
CDC WONDER	For additional information about CDC WONDER, including limitations of Multiple Cause of Death data, please see: https://wonder.cdc.gov/wonder/help/mcd.html

Data Source	Limitations
Statewide Planning and Research Cooperative System (SPARCS)	The recent data may be incomplete and should be interpreted with caution. Health Care Facilities licensed in New York State, under Article 28 of the Public Health Law, are required to submit their inpatient and/or outpatient data to SPARCS. SPARCS is a comprehensive all-payer data reporting system established in 1979 as a result of cooperation between the healthcare industry and government. Created to collect information on discharges from hospitals, SPARCS now collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for hospitals, ambulatory surgical centers, and clinics, both hospital extension and diagnosis and treatment centers. Per NYS Rules and Regulations, Section 400.18 of Title 10, data are required to be submitted: (1) monthly, (2) 95% within 60 days following the end of the month of patient's discharge/visit, and (3) 100% are due 180 days following the end of the month of the patient discharge/visit. Failure to comply may result in the issuance of Statement of Deficiencies (SODs) and facilities may be subject to a reimbursement rate penalty. The accuracy of indicators, which are based on diagnosis codes (ICD-9-CM codes before Oct. 1, 2015, and ICD-10-CM on or after Oct. 1, 2015) reported by the facilities, is limited by the completeness and quality of reporting and coding by the facilities. The indicators are defined based on the principal diagnosis code or first-listed valid external cause code only. The sensitivity and specificity of these indicators may vary by year, hospital location, and drug type. Changes should be interpreted with caution due to the change in codes used for the definition. The SPARCS data do not include discharges by people who sought care from hospitals outside of NYS which may lower numbers and rates for some counties, especially those which border other states.
Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS)	The CDS includes data for individuals enrolled in the OASAS-certified treatment system. These data do not include individuals who do not enter treatment, get treated by the U.S. Department of Veterans Affairs (VA), go outside of New York State for treatment, are admitted to hospitals but not to substance use disorder (SUD) treatment, get diverted to other systems, or receive an addictions medication from a physician outside of the OASAS system of care. Data are considered to be substantially complete three months after the due date, but are able to be updated indefinitely. The accuracy of data depends on the completeness, consistency and quality of reporting and coding by the programs. The availability of substance use disorder treatment services within a county may affect the number of unique people enrolled who reside in that county.
Emergency Medical Services (EMS) Patient Care Reports (PCR)	Documentation data entry errors can occur and may result in 'naloxone administered' being recorded when a different medication had actually been administered. Patients who present as unresponsive or with an altered mental status with unknown etiology may be administered naloxone, as part of the treatment protocol, while attempts are being made to determine the cause of the patient's current unresponsive state or altered mental status. Electronic PCR data currently capture approximately 100% of all EMS data statewide. The remaining data are reported via paper PCR, from which extracting opioid/heroin overdoses and naloxone administrations is impractical. The Suffolk County Medical Control data do not include patients recorded as 'unresponsive/unknown' who received a treatment protocol that includes naloxone. The National Emergency Medical Services Information System (NEMSIS) is a universal standard for how EMS patient care data are collected. Prior to 2019, most EMS agencies in New York State adhered to the NEMSIS version 2.2.1 standard that was released in 2005. As of January 1, 2020, most have transitioned to the updated NEMSIS version 3.4.0 standard, which has improved the quality of EMS data. Further improvements have occurred with NEMSIS version 3.5.0 beginning in July 2024. Electronic PCR data are now captured.
NYS Law Enforcement Naloxone Administration Dataset	All data are self-reported by the responding officer at the scene. Not all data fields are completed by the responding officer. There is often a lag in data reporting. All data should be interpreted with caution. It is possible that not all naloxone administrations reported are for an opioid overdose. There are not toxicology reports to confirm suspected substances used. Increase may represent expansion of program and may or may not indicate an increase in overdose events. Data for New York City on naloxone administration reports by law enforcement are not included in this report. Data displayed for Nassau County on naloxone administration reports by law enforcement are not complete due to the use of an alternate reporting system.

Data Source	Limitations
NYS Community Opioid Overdose Prevention Program Dataset	All data are self-reported by the responder on the scene. Not all data fields are completed by the responder. There is often a lag in data reporting. All data should be interpreted with caution. Increase may represent expansion of program and may or may not indicate an increase in overdose events. Reporting administrations of naloxone to the NYSDOH is one of the mandated responsibilities of registered Community Opioid Overdose Prevention program directors. The actual number of incidents of naloxone administrations in the community may be higher than the number reported to the NYSDOH due to the delay in reporting. The actual number of naloxone administrations is likely to substantially exceed the number reported to the NYSDOH.
NYS Prescription Monitoring Program (PMP)	For all PMP indicators, NYSDOH applied several exclusions. Prescriptions for out-of-state patients or without a valid patient's NY ZIP code were removed from the analysis. Data from veterinarians and prescription drugs administered to animals were not included in the analysis of PMP data. Prescriptions filled for opioids that have supply days greater than 90 were eliminated from the analysis. Also, opioids not typically used in outpatient settings and cold formulations including elixirs, antitussives, decongestants, antihistamines, and expectorants were not included in the analysis. The Bureau of Narcotic Enforcement (BNE) conducts an annual update of the National Drug Code (NDC) file used to identify select opioids, benzodiazepines, and stimulants in the prescription monitoring program (PMP) data. The historic prescription data is updated using the most recent NDC file each year. The application of the updated NDC file to the historic data may result in modifications to previous years data and improves the accuracy and quality of the current year's data.
Youth Behavioral Risk Factor Surveillance System (YBRSS)	YRBSS has multiple limitations. First, all data are self-reported, and the extent of underreporting or overreporting of behaviors cannot be determined. Second, the national, state, and local school-based survey data apply only to youth who attend school and, therefore, are not representative of all persons in this age group due to a small portion of youth not enrolled in a high school program or who had not completed high school. Third, whereas YRBSS is designed to produce information to help assess the effect of broad national, state, and local policies and programs, it was not designed to evaluate the effectiveness of specific interventions (e.g., a professional development program, school curriculum, or media campaign).[42]
Behavioral Risk Factor Surveillance System (BRFSS)	https://www.cdc.gov/brfss/about/brfss_faq.htm https://www.cdc.gov/brfss/publications/data_qvr.htm
NYSDOH/Siena College Research Institute, Chronic Disease Prevention Public Opinion Survey	Survey data were collected through random-digit dialing samples of both landline and cell phone numbers and are potentially limited by non-response bias.

[42] Methodology of the Youth Risk Behavior Surveillance System – 2013. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/pdf/rr/rr6201.pdf

Appendix

Data Table 1.1 Overdose deaths involving opioids and other substances, crude rate per 100,000 population, New York State, 2015-2023

Year	Any opioid		Heroin		Commonly prescribed opioids		Synthetic opioids other than methadone*		Heroin and synthetic opioids other than methadone		Cocaine and synthetic opioids other than methadone	
	Deaths	Crude rate	Deaths	Crude rate	Deaths	Crude rate	Deaths	Crude rate	Deaths	Crude rate	Deaths	Crude rate
2023	5,308	27.1	733	3.7	1,144	5.8	4,936	25.2	712	3.6	2,556	13.1
2022	5,361	27.2	920	4.7	1,255	6.4	4,950	25.2	891	4.5	2,265	11.5
2021	5,017	25.3	1,047	5.3	1,336	6.7	4,594	23.2	1,013	5.1	1,804	9.1
2020	4,233	21.9	1,275	6.6	1,257	6.5	3,721	19.2	1,173	6.1	1,350	7.0
2019	2,939	15.1	1,145	5.9	939	4.8	2,338	12.0	949	4.9	858	4.4
2018	2,991	15.3	1,243	6.4	998	5.1	2,195	11.2	960	4.9	786	4.0
2017	3,224	16.2	1,356	6.8	1,044	5.3	2,238	11.3	923	4.7	742	3.7
2016	3,009	15.2	1,307	6.6	1,100	5.6	1,641	8.3	649	3.3	451	2.3
2015	2,166	10.9	1,058	5.3	895	4.5	668	3.4	263	1.3	142	0.7

* Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.
Multiple cause of death ICD-10 definitions: Any opioid – T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Synthetic opioids other than methadone), T40.6 (Other and unspecified narcotics); Heroin – T40.1; Commonly prescribed opioids – T40.2 (e.g., hydrocodone, oxycodone), T40.3; Synthetic opioids other than methadone – T40.4; Heroin and synthetic opioids other than methadone – T40.1 AND T40.4; Cocaine and synthetic opioids other than methadone – T40.5 (cocaine) AND T40.4.
Note: Death counts by substances are not mutually exclusive.
Data source: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
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Data Table 1.2 Percentage of opioid overdose deaths involving synthetic opioids other than methadone*, New York State, 2015-2023

Year	Overdose deaths involving synthetic opioids other than methadone	Overdose deaths involving any opioid	Percentage of overdose deaths involving synthetic opioids other than methadone
2023	4,936	5,308	93.0%
2022	4,950	5,361	92.3%
2021	4,594	5,017	91.6%
2020	3,721	4,233	87.9%
2019	2,338	2,939	79.6%
2018	2,195	2,991	73.4%
2017	2,238	3,224	69.4%
2016	1,641	3,009	54.5%
2015	668	2,166	30.8%

* Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.
Data source: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
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Data Table 1.3 Overdose deaths involving any opioid, crude rate per 100,000 population, by county, New York State, 2022 and 2023

County	2022			2023		
	Deaths	Population	Crude rate per 100,000 population	Deaths	Population	Crude rate per 100,000 population
Albany	83	315,811	26.3	88	316,659	27.8
Allegany	13	46,694	*	11	46,651	*
Bronx	749	1,379,946	54.3	762	1,356,476	56.2
Broome	74	197,117	37.5	71	196,077	36.2
Cattaraugus	28	76,439	36.6	35	75,600	46.3
Cayuga	16	74,998	*	11	74,485	*
Chautauqua	57	126,027	45.2	66	124,891	52.8
Chemung	31	81,426	38.1	35	81,325	43.0
Chenango	10	46,458	*	13	45,920	*
Clinton	18	78,753	*	**	78,115	**
Columbia	15	61,286	*	14	60,470	*
Cortland	10	46,126	*	**	45,752	**
Delaware	**	44,740	**	11	44,410	*
Dutchess	119	297,545	40.0	94	297,150	31.6
Erie	299	950,312	31.5	347	946,147	36.7
Essex	**	36,910	**	**	36,775	**
Franklin	**	46,373	**	**	46,502	**
Fulton	15	52,669	*	15	52,234	*
Genesee	15	57,535	*	16	57,529	*
Greene	11	48,061	*	**	47,062	**
Hamilton	0	5,118	*	0	5,082	*
Herkimer	12	59,822	*	14	59,484	*
Jefferson	20	116,637	17.1	26	114,787	22.7
Kings	648	2,590,516	25.0	630	2,561,225	24.6
Lewis	**	26,699	**	**	26,548	**
Livingston	12	61,516	*	11	61,158	*
Madison	14	67,097	*	13	66,921	*
Monroe^	339	752,035	45.0	391	748,482	52.2
Montgomery	**	49,623	**	12	49,368	*
Nassau	218	1,383,726	15.8	182	1,381,715	13.2
New York	417	1,596,273	26.1	431	1,597,451	27.0
Niagara	71	210,880	33.7	80	209,457	38.2
Oneida	74	228,846	32.3	51	227,555	22.4
Onondaga	145	468,249	31.0	140	467,873	29.9
Ontario	12	112,707	*	24	112,494	21.3
Orange	126	405,941	31.0	101	407,470	24.8
Orleans	**	39,318	**	**	39,124	**
Oswego	32	118,287	27.1	23	118,162	19.5

County	2022			2023		
	Deaths	Population	Crude rate per 100,000 population	Deaths	Population	Crude rate per 100,000 population
Otsego	13	60,636	*	21	60,126	34.9
Putnam	21	98,045	21.4	16	98,060	*
Queens	454	2,278,029	19.9	420	2,252,196	18.6
Rensselaer	38	159,853	23.8	62	159,305	38.9
Richmond	140	491,133	28.5	145	490,687	29.6
Rockland	45	339,022	13.3	36	340,807	10.6
Saratoga	28	238,797	11.7	24	238,711	10.1
Schenectady	43	160,093	26.9	40	159,902	25.0
Schoharie	**	30,063	**	**	30,105	**
Schuyler	**	17,650	**	**	17,507	**
Seneca	**	32,882	**	**	32,349	**
St. Lawrence	24	107,733	22.3	14	106,940	*
Steuben	25	92,599	27.0	21	92,162	22.8
Suffolk	464	1,525,465	30.4	418	1,523,170	27.4
Sullivan	50	79,658	62.8	38	79,920	47.5
Tioga	**	47,772	**	**	47,715	**
Tompkins	25	104,777	23.9	23	103,558	22.2
Ulster	65	182,319	35.7	58	182,333	31.8
Warren	10	65,599	*	12	65,380	*
Washington	24	60,841	39.4	10	60,047	*
Wayne	23	91,125	25.2	20	90,829	22.0
Westchester	156	990,427	15.8	137	990,817	13.8
Wyoming	**	39,666	**	**	39,532	**
Yates	0	24,451	*	**	24,472	**

* Crude rates are unreliable when there are fewer than 20 deaths and are therefore not shown.
** Counts and crude rates are suppressed when there are fewer than 10 deaths.
Data source: All other data are from CDC WONDER, accessed April 2025
^ For the purpose of presenting comparison for counties using the most complete data, 2022 statistics Monroe County are provided by New York State Vital Statistics, as of April 2024.
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Data Table 1.4 Overdose deaths involving heroin, crude rate per 100,000 population, by county, New York State, 2022 and 2023

County	2022			2023		
	Deaths	Population	Crude rate per 100,000 population	Deaths	Population	Crude rate per 100,000 population
Albany	**	315,811	**	**	316,659	**
Allegany	0	46,694	*	0	46,651	*
Bronx	208	1,379,946	15.1	204	1,356,476	15.0
Broome	**	197,117	**	**	196,077	**
Cattaraugus	**	76,439	**	0	75,600	*
Cayuga	**	74,998	**	0	74,485	*
Chautauqua	**	126,027	**	**	124,891	**
Chemung	**	81,426	**	0	81,325	*
Chenango	**	46,458	**	**	45,920	**
Clinton	0	78,753	*	**	78,115	**
Columbia	0	61,286	*	0	60,470	*
Cortland	**	46,126	**	0	45,752	*
Delaware	0	44,740	*	0	44,410	*
Dutchess	11	297,545	*	**	297,150	**
Erie	18	950,312	*	13	946,147	*
Essex	0	36,910	*	0	36,775	*
Franklin	0	46,373	*	0	46,502	*
Fulton	**	52,669	**	0	52,234	*
Genesee	**	57,535	**	0	57,529	*
Greene	**	48,061	**	0	47,062	*
Hamilton	0	5,118	*	0	5,082	*
Herkimer	0	59,822	*	0	59,484	*
Jefferson	0	116,637	*	0	114,787	*
Kings	212	2,590,516	8.2	186	2,561,225	7.3
Lewis	0	26,699	*	0	26,548	*
Livingston	**	61,516	**	0	61,158	*
Madison	**	67,097	**	**	66,921	**
Monroe^	12	752,035	*	**	748,482	**
Montgomery	0	49,623	*	0	49,368	*
Nassau	20	1,383,726	1.4	21	1,381,715	1.5
New York	117	1,596,273	7.3	101	1,597,451	6.3
Niagara	**	210,880	**	**	209,457	**
Oneida	**	228,846	**	**	227,555	**
Onondaga	12	468,249	*	**	467,873	**
Ontario	0	112,707	*	0	112,494	*
Orange	25	405,941	6.2	**	407,470	**
Orleans	**	39,318	**	0	39,124	*
Oswego	**	118,287	**	**	118,162	**

County	2022			2023		
	Deaths	Population	Crude rate per 100,000 population	Deaths	Population	Crude rate per 100,000 population
Otsego	0	60,636	*	**	60,126	**
Putnam	**	98,045	**	**	98,060	**
Queens	123	2,278,029	5.4	80	2,252,196	3.6
Rensselaer	**	159,853	**	**	159,305	**
Richmond	37	491,133	7.5	25	490,687	5.1
Rockland	**	339,022	**	**	340,807	**
Saratoga	**	238,797	**	**	238,711	**
Schenectady	**	160,093	**	**	159,902	**
Schoharie	0	30,063	*	0	30,105	*
Schuyler	0	17,650	*	**	17,507	**
Seneca	0	32,882	*	0	32,349	*
St. Lawrence	0	107,733	*	0	106,940	*
Steuben	**	92,599	**	0	92,162	*
Suffolk	25	1,525,465	1.6	19	1,523,170	*
Sullivan	**	79,658	**	**	79,920	**
Tioga	0	47,772	*	0	47,715	*
Tompkins	**	104,777	**	0	103,558	*
Ulster	**	182,319	**	**	182,333	**
Warren	0	65,599	*	0	65,380	*
Washington	**	60,841	**	0	60,047	*
Wayne	0	91,125	*	0	90,829	*
Westchester	20	990,427	2.0	16	990,817	*
Wyoming	0	39,666	*	0	39,532	*
Yates	0	24,451	*	0	24,472	*

* Crude rates are unreliable when there are fewer than 20 deaths and are therefore not shown.
** Counts and crude rates are suppressed when there are fewer than 10 deaths.
Data source: All other data are from CDC WONDER, accessed April 2025
^ For the purpose of presenting comparison among counties with more complete data, statistics for 2022 for Monroe County are provided by New York State Vital Statistics, as of July 2024.
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Data Table 1.5 Overdose deaths involving any opioid, by place of death, New York State, 2023

Place of death	Deaths (%)
Inpatient (medical facility)	349 (6.6%)
Outpatient or ER (medical facility)	707 (13.3%)
Dead on arrival (medical facility)	53 (1.0%)
Decedent's home	3,453 (65.1%)
Other	736 (13.9%)

Data source: CDC WONDER, accessed April 2025
Note: The number of overdose deaths involving opioid in "Nursing home/long term care" and "Place of death unknown" is under 10, therefore does not meet reporting criteria.
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Data Table 1.6 Overdose deaths involving any opioid and overdose deaths involving any opioid and benzodiazepines, crude rate per 100,000 population, New York State, 2010-2023

Year	Any opioid		Any opioid and benzodiazepines	
	Deaths	Crude rate per 100,000 population	Deaths	Crude rate per 100,000 population
2023	5,308	27.1	822	4.2
2022	5,361	27.2	859	4.4
2021	5,017	25.3	882	4.4
2020	4,233	21.9	893	4.6
2019	2,939	15.1	687	3.5
2018	2,991	15.3	821	4.2
2017	3,224	16.2	874	4.4
2016	3,009	15.2	843	4.3
2015	2,166	10.9	636	3.2
2014	1,739	8.8	538	2.7
2013	1,681	8.6	473	2.4
2012	1,530	7.8	427	2.2
2011	1,356	7.0	358	1.8
2010	1,074	5.5	328	1.7

Multiple cause of death ICD-10 definitions: Any opioid – T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Synthetic opioids other than methadone), T40.6 (Other and unspecified narcotics); Any opioid and benzodiazepines – T40.0 (Opium), T40.1 (Heroin), T40.2 (Other opioids), T40.3 (Methadone), T40.4 (Synthetic opioids other than methadone), T40.6 (Other and unspecified narcotics) AND T42.4 (Benzodiazepines).
Data source: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
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Data Table 1.7 Overdose deaths involving cocaine with and without synthetic opioids other than methadone* present, New York State, 2015-2023

Year	Overdose deaths involving cocaine (T40.5)		Overdose deaths involving cocaine (T40.5), *with* synthetic opioids other than methadone present		Overdose deaths involving cocaine (T40.5), *without* synthetic opioids other than methadone present	
	Count	Crude rate per 100,000 population	Count	Crude rate per 100,000 population	Count	Crude rate per 100,000 population
2023	3,230	16.5	2,556	13.1	674	3.4
2022	2,869	14.6	2,265	11.5	604	3.1
2021	2,309	11.6	1,804	9.1	505	2.5
2020	1,765	9.1	1,350	7.0	415	2.1
2019	1,320	6.8	858	4.4	462	2.4
2018	1,276	6.5	786	4.0	490	2.5
2017	1,306	6.6	742	3.7	564	2.8
2016	991	5.0	451	2.3	540	2.7
2015	634	3.2	142	0.7	492	2.5

* Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.
Note: Cocaine overdose is identified by ICD-10 code T40.5.
Data source: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
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Data Table 1.8 Overdose deaths involving heroin (T40.1), synthetic opioids other than methadone (T40.4)^, and commonly prescribed opioids (T40.2 and T40.3)[#], crude rate per 100,000, by region, year, and age group, New York State, 2015-2023

	Year	Heroin			Synthetic opioids other than methadone			Commonly prescribed opioids		
		Age group			Age group			Age group		
		0-24	*25-44*	*45+*	*0-24*	*25-44*	*45+*	*0-24*	*25-44*	*45+*
New York City	2023	*	5.9	12.7	3.3	31.8	39.4	*	6.1	13.6
	2022	*	7.6	14.3	3.4	32.7	39.2	*	7.4	13.3
	2021	**	9.4	13.5	2.7	28.4	34.3	*	7.5	13.6
	2020	1.3	10.3	13.0	3.6	22.3	25.1	1.1	7.6	12.1
	2019	*	9.2	10.6	1.6	14.5	15.7	*	5.5	7.5
	2018	1.1	7.9	9.6	1.5	11.3	13.0	*	4.3	7.5
	2017	1.0	9.1	9.1	1.5	12.0	11.1	*	5.3	7.3
	2016	1.3	7.2	8.2	1.8	8.0	8.0	0.9	5.4	7.6
	2015	1.1	6.0	5.3	*	2.0	1.9	*	4.2	5.6
New York State excl. New York City	2023	**	2.4	1.3	3.6	47.6	24.5	*	8.2	5.2
	2022	**	4.1	2.0	4.2	50.2	22.6	0.7	9.7	5.9
	2021	*	6.4	2.6	4.9	51.4	19.6	*	11.8	6.1
	2020	1.2	11.4	4.0	5.5	46.4	15.8	0.8	12.3	5.4
	2019	1.4	11.8	3.6	3.7	30.1	9.2	0.9	9.5	4.9
	2018	1.9	15.6	4.1	3.8	32.4	8.5	1.0	10.6	6.0
	2017	2.0	17.8	4.6	4.8	32.2	9.3	1.4	9.6	6.5
	2016	3.0	18.5	4.2	4.3	25.0	6.0	1.8	11.7	6.2
	2015	2.9	15.5	3.6	2.1	11.7	3.0	1.3	9.1	5.9

^ Synthetic opioids other than methadone (SOOTM) are identified by ICD-10 code T40.4 and serve as a proxy for fentanyl, which is a highly potent opioid now commonly found in the illicit drug market.
[#] Commonly prescribed opioids are identified by ICD-10 codes T40.2 (Other opioids, e.g., hydrocodone, oxycodone), T40.3 (Methadone).
* Rates are unreliable when there are fewer than 20 deaths and are therefore not shown.
** Rates are suppressed for death counts fewer than 10.
Data source: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025
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Data Table 1.9 Overdose deaths involving any opioid, crude rate per 100,000 population, by subpopulation, New York State, 2018-2023

Group	Characteristic		Year					
			2018	2019	2020	2021	2022	2023
Total	New York State	Deaths	2,991	2,939	4,233	5,017	5,361	5,308
		Rate	15.3	15.1	21.9	25.3	27.2	27.1
Region	New York City	Deaths	1,054	1,177	1,693	2,153	2,408	2,388
		Rate	12.5	14.1	20.5	25.4	28.9	28.9
	NYS excl. NYC	Deaths	1,937	1,762	2,540	2,864	2,953	2,920
		Rate	17.4	15.8	22.9	25.2	26.0	25.8
Gender	Male	Deaths	2,165	2,130	3,133	3,665	4,010	3,915
		Rate	22.8	22.5	33.4	37.8	41.7	41.0
	Female	Deaths	826	809	1,100	1,352	1,351	1,393
		Rate	8.2	8.1	11.1	13.3	13.4	13.9
Age group	Age 18-24	Deaths	214	179	275	228	220	184
		Rate	11.9	10.2	16.0	13.1	12.2	10.6
	Age 25-44	Deaths	1,465	1,436	2,038	2,311	2,378	2,236
		Rate	27.6	27.1	38.7	43.2	44.9	42.3
	Age 45-64	Deaths	1,152	1,153	1,686	2,169	2,339	2,368
		Rate	22.4	22.7	33.8	42.1	46.6	47.8
	Age 65+	Deaths	150	162	221	293	404	493
		Rate	4.7	4.9	6.6	8.4	11.3	13.6
Race and ethnicity	White NH	Deaths	1,978	1,784	2,507	2,681	2,635	2,470
		Rate	18.3	16.6	23.6	24.7	24.7	23.4
	Black NH	Deaths	361	434	784	1,064	1,313	1,386
		Rate	12.7	15.4	28.1	37.2	46.3	49.5
	AI/AN NH	Deaths	31	32	47	52	66	56
		Rate	1.8	1.9	2.7	2.9	3.6	3.0
	Asian NH	Deaths	14	17	11	18	27	22
		Rate	*	*	*	*	45.6	37.3
	NH / Other PI NH	Deaths	0	**	**	0	0	**
		Rate	*	**	**	*	*	**
	More than one race NH	Deaths	**	15	29	29	30	40
		Rate	**	*	8.0	7.7	7.8	10.3
	Hispanic	Deaths	541	601	793	1,091	1,198	1,219
		Rate	14.4	16.0	21.2	28.2	31.0	31.5

White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN NH = American Indian or Alaska Native non-Hispanic; Asian NH = Asian non-Hispanic; NH/Other PI NH = Native Hawaiian or Other Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City

* Crude rates are unreliable when there are fewer than 20 deaths and are therefore not shown.

** Counts and crude rates are suppressed when there are fewer than 10 deaths.

Data source: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025

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Data Table 1.10 Overdose deaths involving heroin, crude rate per 100,000 population, by subpopulation, New York State, 2018-2023

Group	Characteristic		Year					
			2018	2019	2020	2021	2022	2023
Total	New York State	Deaths	1,243	1,145	1,275	1,047	920	733
		Rate	6.4	5.9	6.6	5.3	4.7	3.7
Region	New York City	Deaths	554	604	725	719	697	596
		Rate	6.6	7.2	8.8	8.5	8.4	7.2
	NYS excl. NYC	Deaths	689	541	550	328	223	137
		Rate	6.2	4.9	5.0	2.9	2.0	1.2
Gender	Male	Deaths	973	878	1,005	806	716	566
		Rate	10.3	9.3	10.7	8.3	7.4	5.9
	Female	Deaths	270	267	270	241	204	167
		Rate	2.7	2.7	2.7	2.4	2.0	1.7
Age group	Age 18-24	Deaths	91	57	70	**	23	*
		Rate	5.1	3.2	4.1	**	1.3	*
	Age 25-44	Deaths	623	556	572	419	304	214
		Rate	11.7	10.5	10.9	7.8	5.7	4.1
	Age 45-64	Deaths	477	466	555	523	467	399
		Rate	9.3	9.2	11.1	10.2	9.3	8.1
	Age 65+	Deaths	47	64	77	77	125	105
		Rate	1.5	1.9	2.3	2.2	3.5	2.9
Race and ethnicity	White NH	Deaths	765	626	678	458	313	247
		Rate	7.1	5.8	6.4	4.2	2.9	2.3
	Black NH	Deaths	157	179	246	237	279	199
		Rate	5.5	6.4	8.8	8.3	9.8	7.1
	AI/AN NH	Deaths	**	**	**	**	**	**
		Rate	**	**	**	**	**	**
	Asian NH	Deaths	13*	11*	14*	14*	**	**
		Rate	*	*	*	*	**	**
	NH / Other PI NH	Deaths	0	**	**	0	0	**
		Rate	*	**	**	*	*	**
	More than one race NH	Deaths	**	**	10*	**	**	**
		Rate	**	**	*	**	**	**
	Hispanic	Deaths	268	292	293	310	288	251
		Rate	7.1	7.8	7.8	8.0	7.4	6.5

White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN NH = American Indian or Alaska Native non-Hispanic; Asian NH = Asian non-Hispanic; NH/Other PI NH = Native Hawaiian or Other Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City

* Crude rates are unreliable when there are fewer than 20 deaths and are therefore not shown.

** Counts and crude rates are suppressed when there are fewer than 10 deaths.

Data source: Data for New York State excluding New York City in 2021 are provided by New York State Vital Statistics, as of April 2023; all other data are from CDC WONDER, accessed April 2025

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Data Table 2.1 911 EMS dispatches reported electronically, by region, New York State, 2018-2024

Year	Region	EMS response reported electronically	Percentage
2024	New York City	2,089,723	100.0%
	NYS excl. NYC	2,403,565	99.9%
	New York State	4,493,288	100.0%
2023	New York City	2,014,389	100.0%
	NYS excl. NYC	2,244,707	99.8%
	New York State	4,259,096	99.9%
2022	New York City	2,011,229	100.0%
	NYS excl. NYC	2,226,004	99.8%
	New York State	4,237,233	99.9%
2021	New York City	1,938,248	100.0%
	NYS excl. NYC	1,917,474	99.7%
	New York State	3,855,722	99.8%
2020	New York City	1,800,785	99.7%
	NYS excl. NYC	1,810,262	98.2%
	New York State	3,611,047	98.9%
2019	New York City	1,929,152	99.0%
	NYS excl. NYC	1,809,925	94.9%
	New York State	3,739,077	97.0%
2018	New York City	1,820,448	95.5%
	NYS excl. NYC	1,813,064	93.2%
	New York State	3,633,512	94.3%

NYS excl. NYC = New York State excluding New York City
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
Data from previous annual reports might appear lower than the current annual report due to a lag in data reporting.
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Data Table 2.2 Number of unique* naloxone administrations by EMS agencies, by region, New York State, 2020-2024

Year/Quarter	Region		
	New York City	NYS excluding NYC	New York State
2024	**11,269**	**6,732**	**18,001**
Q1	2,766	1,795	4,561
Q2	3,163	1,720	4,883
Q3	2,723	1,675	4,398
Q4	2,617	1,542	4,159
2023	**13,219**	**8,492**	**21,711**
Q1	2,969	1,945	4,914
Q2	3,604	2,247	5,851
Q3	3,813	2,217	6,030
Q4	2,833	2,083	4,916
2022	**12,925**	**8,766**	**21,691**
Q1	2,630	1,899	4,529
Q2	3,081	2,128	5,209
Q3	3,942	2,489	6,431
Q4	3,272	2,250	5,522
2021	**11,143**	**8,778**	**19,921**
Q1	2,229	2,048	4,277
Q2	2,873	2,201	5,074
Q3	3,341	2,473	5,814
Q4	2,700	2,056	4,756
2020	**8,514**	**8,520**	**17,026**
Q1	1,802	1,770	3,572
Q2	2,009	2,271	4,280
Q3	2,523	2,403	4,926
Q4	2,180	2,076	4,248

* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter. As such, additional data validation steps have been taken to de-duplicate multiple administrations and counts may differ from previous annual and quarterly reports.
Note: Counts may have been affected by changes in documentation systems used by EMS agencies.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
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Data Table 2.3 Unique* naloxone administrations by EMS agencies, by age group, gender, and incident location type, New York State, 2024

Subpopulation	Number	Percentage
Age		
Age 0-17	173	1.0%
Age 18-24	657	3.6%
Age 25-44	6,827	37.9%
Age 45-64	7,641	42.4%
Age 65+	2,618	14.5%
Unknown	85	0.5%
Gender		
Male	12,621	70.1%
Female	4,709	26.2%
Unknown	671	3.7%
Incident location type		
Public	10,045	55.8%
Residential	7,684	42.7%
Unknown	272	1.5%

* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter. As such, additional data validation steps have been taken to deduplicate multiple administrations and counts may differ from previous annual and quarterly reports.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
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Data Table 2.4 Unique* naloxone administrations by EMS agencies, by day of the week, New York State, 2024

Day of week	Number of unique naloxone administrations	Percentage
Sunday	2,306	12.8%
Monday	2,471	13.7%
Tuesday	2,628	14.6%
Wednesday	2,582	14.3%
Thursday	2,603	14.5%
Friday	2,817	15.6%
Saturday	2,594	14.4%
Total	18,001	100.0%

* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter. As such, additional data validation steps have been taken to deduplicate multiple administrations.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
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Data Table 2.5 Unique* naloxone administrations by EMS agencies, crude rate per 1,000 unique 911 EMS dispatches, by county, New York State, 2024

County	Number of unique naloxone administrations (numerator)	Unique 911 EMS dispatches (denominator)	Crude rate per 1,000
Albany	357	80,545	4.4
Allegany	40	8,177	4.9
Broome	183	39,536	4.6
Cattaraugus	63	14,520	4.3
Cayuga	48	14,469	3.3
Chautauqua	106	22,854	4.6
Chemung	83	19,836	4.2
Chenango	21	6,300	3.3
Clinton^	62	9,705	6.4
Columbia	42	11,100	3.8
Cortland	26	9,282	2.8
Delaware	28	6,777	4.1
Dutchess	243	54,684	4.4
Erie	598	149,544	4.0
Essex^	20	5,185	3.9
Franklin	34	8,116	4.2
Fulton	44	10,532	4.2
Genesee	38	13,628	2.8
Greene	26	8,371	3.1
Hamilton	s	912	s
Herkimer	42	10,874	3.9
Jefferson	39	18,445	2.1
Lewis	s	3,344	s
Livingston	21	10,380	2.0
Madison	31	10,139	3.1
Monroe^	598	145,269	4.1
Montgomery	53	11,197	4.7
Nassau^	504	207,084	2.4
Niagara	146	38,174	3.8
Oneida	236	49,011	4.8
Onondaga	518	101,066	5.1
Ontario	44	19,456	2.3
Orange	225	52,760	4.3
Orleans^	16	5,065	3.2
Oswego	86	26,784	3.2
Otsego	22	7,992	2.8
Putnam	34	13,966	2.4

County	Number of unique naloxone administrations (numerator)	Unique 911 EMS dispatches (denominator)	Crude rate per 1,000
Rensselaer	165	23,629	7.0
Rockland^	93	42,562	2.2
Saratoga	118	29,424	4.0
Schenectady	181	40,652	4.5
Schoharie	s	3,951	s
Schuyler	12	2,721	4.4
Seneca	26	4,486	5.8
St. Lawrence	51	15,883	3.2
Steuben	53	18,992	2.8
Suffolk^	428	176,942	2.4
Sullivan	68	15,746	4.3
Tioga^	s	5,202	s
Tompkins	67	16,032	4.2
Ulster	101	28,813	3.5
Warren	60	13,685	4.4
Washington	57	8,028	7.0
Wayne	31	13,479	2.3
Westchester	490	162,886	3.0
Wyoming	18	4,559	3.9
Yates	s	3,220	s
NYS excl. NYC	6,734	1,855,971	3.6
Bronx	3,145	431,922	7.3
Kings	2,914	549,635	5.3
New York	3,147	417,834	7.5
Queens	1,634	405,080	4.0
Richmond	429	101,441	4.2
New York City	11,269	1,905,912	5.9
New York State	18,001	3,761,883	4.8

s: Data do not meet reporting criteria.
* Unique naloxone administrations represent an EMS encounter in which naloxone was administered during the course of patient care. Often, multiple administrations of naloxone may be given to an individual during the same patient encounter.
^ Data for this county may be incomplete because of a known reporting issue under review. Please interpret with caution.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
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Data Table 2.6 Naloxone administration reports by law enforcement* and community programs, by quarter, New York State, 2024

2024	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	January - March	April - June	July - September	October - December
Law Enforcement*	426	344	302	277
Community Programs	600	548	399	243

* The law enforcement category does not comprehensively capture administrations reported in New York City and Nassau County.
Data source: New York State Department of Health AIDS Institute. Data as of April 2025
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Data Table 2.7 Naloxone administration reports by law enforcement* and community programs, by age group, New York State, 2024

Age Group	Law Enforcement*	Community Programs
< 18 years	13	23
18-24 years	84	105
25-44 years	757	1,002
45-64 years	372	587
65+ years	44	70
Unknown	79	s

s: Data do not meet reporting criteria.
* The law enforcement category does not comprehensively capture administrations reported in New York City and Nassau County.
Data source: New York State Department of Health AIDS Institute. Data as of April 2025
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Data Table 2.8 Naloxone administration reports by law enforcement* and community programs, by gender, New York State, 2024

Gender	Law Enforcement*	Community Programs
Female	390	364
Male	940	1,376
Other^, Missing, or Unknown	19	50

* The law enforcement category does not comprehensively capture administrations reported in New York City and Nassau County.
^ Other includes "Transgender", " Non-binary", "Gender Non-conforming" and "Other, not specified".
Data source: New York State Department of Health AIDS Institute. Data as of April 2025
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EMS Suspected Opioid Overdose

Data Table 2.9 EMS suspected opioid overdose encounters with and without* reported naloxone administration on scene, New York State, 2021 to 2024

Year	Naloxone	Number	Percentage
2024	Administration	14,415	66.6%
	No administration	7,237	33.4%
	Total	**21,652**	100.0%
2023	Administration	18,446	67.7%
	No administration	8,811	32.3%
	Total	**27,257**	100.0%
2022	Administration	18,073	65.8%
	No administration	9,399	34.2%
	Total	**27,472**	100.0%
2021	Administration	16,467	65.0%
	No administration	8,886	35.0%
	Total	**25,353**	100.0%

* These include unique naloxone administrations reported in the medication administered structured field and may include bystander and administrations prior to EMS arrival.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
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Data Table 2.10 EMS suspected opioid overdose encounters with and without* reported naloxone administration, by patient disposition^, New York State, 2024

Disposition	Suspected Opioid Overdose			
	***Without* Naloxone Administration**		***With* Naloxone Administration**	
	Number	Percent	Number	Percent
Treated and transported/transferred	5,950	82.2%	12,851	89.2%
Treated and released per protocol	130	1.8%	297	2.1%
Refused transport	749	10.3%	1,058	7.3%
Other/unknown	145	2.0%	167	1.2%
Dead on scene	263	3.6%	42	0.3%

* These include unique naloxone administrations reported in the medication administered structured field and may include bystander and administrations prior to EMS arrival.
^ The patient disposition for an EMS event indicates whether a patient received care and/or services and transport.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
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Data Table 2.11 EMS suspected opioid overdoses encounters, crude rate per 1,000 unique 911 EMS dispatches, by county, New York State, 2024

County	Number of suspected opioid overdose (numerator)	Unique 911 EMS dispatches (denominator)	Crude rate per 1,000
Albany	478	80,545	5.9
Allegany	45	8,177	5.5
Broome	357	39,536	9.0
Cattaraugus	82	14,520	5.6
Cayuga	60	14,469	4.1
Chautauqua	156	22,854	6.8
Chemung	115	19,836	5.8
Chenango	45	6,300	7.1
Clinton^	59	9,705	6.1
Columbia	55	11,100	5.0
Cortland	47	9,282	5.1
Delaware	34	6,777	5.0
Dutchess	350	54,684	6.4
Erie	1,103	149,544	7.4
Essex^	29	5,185	5.6
Franklin	27	8,116	3.3
Fulton	64	10,532	6.1
Genesee	54	13,628	4.0
Greene	48	8,371	5.7
Hamilton	s	912	s
Herkimer	46	10,874	4.2
Jefferson	64	18,445	3.5
Lewis	12	3,344	3.6
Livingston	30	10,380	2.9
Madison	29	10,139	2.9
Monroe^	1,131	145,269	7.8
Montgomery	76	11,197	6.8
Nassau^	690	207,084	3.3
Niagara	274	38,174	7.2
Oneida	255	49,011	5.2
Onondaga	885	101,123	8.8
Ontario	47	19,456	2.4
Orange	271	52,760	5.1
Orleans^	24	5,065	4.7
Oswego	141	26,784	5.3
Otsego	37	7,992	4.6
Putnam	54	13,966	3.9

County	Number of suspected opioid overdose (numerator)	Unique 911 EMS dispatches (denominator)	Crude rate per 1,000
Rensselaer	174	23,629	7.4
Rockland^	117	42,562	2.7
Saratoga	135	29,424	4.6
Schenectady	221	40,652	5.4
Schoharie	17	3,951	4.3
Schuyler	10	2,721	3.7
Seneca	30	4,486	6.7
St. Lawrence	73	15,883	4.6
Steuben	64	18,992	3.4
Suffolk^	618	176,942	3.5
Sullivan	90	15,746	5.7
Tioga^	18	5,202	3.5
Tompkins	150	16,032	9.4
Ulster	145	28,813	5.0
Warren	74	13,685	5.4
Washington	49	8,028	6.1
Wayne	50	13,479	3.7
Westchester	714	162,886	4.4
Wyoming	19	4,559	4.2
Yates	s	3,220	s
NYS excl. NYC	10,053	1,855,971	5.4
Bronx	3,062	431,922	7.1
Kings	2,999	549,635	5.5
New York	3,442	417,834	8.2
Queens	1,675	405,080	4.1
Richmond	421	101,441	4.2
New York City	11,599	1,905,912	6.1
New York State	21,652	3,761,883	5.8

s: Data do not meet reporting criteria.
^ Data for this county may be incomplete because of a known reporting issue under review. Please interpret with caution.
Data source: New York State Department of Health Division of State Emergency Medical Services; Data as of April 2025
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Data Table 2.12 Naloxone administration reports by administrator type, New York State, 2024

Type	Naloxone Administration Reports
EMS	18,001
Law Enforcement	1,349
Community Opioid Overdose Prevention (COOP) Programs	1,790

Note: The EMS category does not capture administrations reported with missing incident county. The law enforcement category does not comprehensively capture administrations reported in New York City and Nassau County.
Data sources: New York State Department of Health Division of State Emergency Medical Services, data as of April 2025; New York State Department of Health AIDS Institute; Data as of April 2025
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Data Table 3.1 Overdose deaths involving opioids and nonfatal opioid-related hospital events, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023

Group	Characteristic	2022		2023	
		Numerator	Crude rate per 100,000 population	Numerator	Crude rate per 100,000 population
Age group	Age 0-17	234	5.8	255	6.4
	Age 18-24	2,364	135.2	2,020	116.0
	Age 25-44	22,700	427.3	20,535	388.8
	Age 45-64	16,643	329.9	16,151	326.0
	Age 65+	3,631	102.6	3,796	104.5
Gender	Male	33,602	349.8	31,506	329.7
	Female	11,957	118.8	11,235	112.2
Race and ethnicity	White NH	18,613	174.5	16,229	153.4
	Black NH	8,709	307.2	8,039	286.9
	Asian/PI NH	289	15.6	297	15.9
	Hispanic	9,378	241.9	9,264	239.2
Region	New York City	24,267	291.1	23,757	287.7
	NYS Excl NYC	21,305	187.9	19,001	168.0
Total	New York State	45,572	231.6	42,758	218.5

White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City

Data source: Death data are from CDC WONDER, accessed April 2025; ED Visits and Hospital Discharges are from New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), as of April 2025

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Data Table 3.2 Overdose deaths involving opioids and nonfatal opioid-related hospital events, crude rate per 100,000 population, by county, New York State, 2023

County	Numerator	Population	Crude rate per 100,000 population
Albany	624	316,659	197.0
Allegany	53	46,651	113.6
Bronx	7,252	1,356,476	534.6
Broome	420	196,077	214.2
Cattaraugus	222	75,600	293.7
Cayuga	87	74,485	116.8
Chautauqua	586	124,891	469.2
Chemung	172	81,325	211.5
Chenango	62	45,920	135.0
Clinton	73	78,115	93.5
Columbia	97	60,470	160.4
Cortland	66	45,752	144.3
Delaware	107	44,410	240.9
Dutchess	769	297,150	258.8
Erie	1,874	946,147	198.1
Essex	32	36,775	86.5
Franklin	30	46,502	64.1
Fulton	86	52,234	164.6
Genesee	95	57,529	165.1
Greene	88	47,062	187.0
Hamilton	0	5,082	0.0
Herkimer	60	59,484	100.9
Jefferson	158	114,787	137.6
Kings	5,843	2,561,225	228.1
Lewis	21	26,548	78.3
Livingston	65	61,158	106.3
Madison	62	66,921	92.6
Monroe	1,633	748,482	218.2
Montgomery	84	49,368	170.2
Nassau	1,595	1,381,715	115.4
New York	6,145	1,597,451	384.7
Niagara	549	209,457	262.1
Oneida	278	227,555	122.2
Onondaga	851	467,873	181.9
Ontario	159	112,494	141.3
Orange	696	407,470	170.8

County	Numerator	Population	Crude rate per 100,000 population
Orleans	42	39,124	106.8
Oswego	113	118,162	95.6
Otsego	69	60,126	114.8
Putnam	90	98,060	91.8
Queens	3,420	2,252,196	151.9
Rensselaer	295	159,305	185.2
Richmond	1,097	490,687	223.6
Rockland	496	340,807	145.5
Saratoga	243	238,711	101.8
Schenectady	396	159,902	247.7
Schoharie	29	30,105	95.7
Schuyler	21	17,507	118.8
Seneca	40	32,349	123.0
St. Lawrence	190	106,940	177.7
Steuben	114	92,162	123.7
Suffolk	2,746	1,523,170	180.3
Sullivan	221	79,920	276.5
Tioga	29	47,715	60.4
Tompkins	132	103,558	127.5
Ulster	427	182,333	234.2
Warren	116	65,380	177.4
Washington	46	60,047	76.6
Wayne	102	90,829	112.3
Westchester	1,227	990,817	123.8
Wyoming	36	39,532	90.6
Yates	16	24,472	64.6

Data sources: Death data are from CDC WONDER, accessed April 2025; ED Visits and Hospital Discharges are from New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), as of April 2025

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Data Table 3.3 Hospital discharges involving opioid use (including overdose and disorders), crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023

Group	Characteristic	2022		2023	
		Hospital discharges	Crude rate per 100,000 population	Hospital discharges	Crude rate per 100,000 population
Age group	Age 0-17	73	1.8	80	2.0
	Age 18-24	628	35.9	571	32.8
	Age 25-44	6,263	117.9	5,707	108.0
	Age 45-64	4,732	93.8	4,498	90.8
	Age 65+	1,155	32.6	1,207	33.2
Gender	Male	9,195	95.7	8,609	90.1
	Female	3,655	36.3	3,452	34.5
Race and ethnicity	White NH	5,538	51.9	4,975	47.0
	Black NH	2,476	87.3	2,309	82.4
	Asian/PI NH	92	5.0	84	4.5
	Hispanic	2,955	76.2	2,832	73.1
Region	New York City	6,157	73.9	5,949	72.0
	NYS Excl NYC	6,694	59.0	6,114	54.0
Total	New York State	12,851	65.3	12,063	61.6

White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.4 Hospital discharges involving opioid use (including overdose and disorders), crude rate per 100,000 population, by county, New York State, 2023

County	Hospital Discharges	Population	Crude rate per 100,000 population
Albany	106	316,659	33.5
Allegany	9	46,651	19.3*
Bronx	2,371	1,356,476	174.8
Broome	125	196,077	63.8
Cattaraugus	47	75,600	62.2
Cayuga	13	74,485	17.5
Chautauqua	146	124,891	116.9
Chemung	31	81,325	38.1
Chenango	15	45,920	32.7
Clinton	24	78,115	30.7
Columbia	17	60,470	28.1
Cortland	8	45,752	17.5*
Delaware	8	44,410	18*
Dutchess	385	297,150	129.6
Erie	785	946,147	83.0
Essex	12	36,775	32.6
Franklin	19	46,502	40.9
Fulton	24	52,234	45.9
Genesee	38	57,529	66.1
Greene	26	47,062	55.2
Hamilton	0	5,082	0.0
Herkimer	**	59,484	**
Jefferson	81	114,787	70.6
Kings	1,097	2,561,225	42.8
Lewis	10	26,548	37.7*
Livingston	16	61,158	26.2
Madison	6	66,921	9*
Monroe	412	748,482	55.0
Montgomery	24	49,368	48.6
Nassau	623	1,381,715	45.1
New York	1,346	1,597,451	84.3
Niagara	184	209,457	87.8
Oneida	44	227,555	19.3
Onondaga	243	467,873	51.9
Ontario	34	112,494	30.2
Orange	277	407,470	68.0

County	Hospital Discharges	Population	Crude rate per 100,000 population
Orleans	16	39,124	40.9
Oswego	30	118,162	25.4
Otsego	10	60,126	16.6*
Putnam	29	98,060	29.6
Queens	911	2,252,196	40.4
Rensselaer	67	159,305	42.1
Richmond	224	490,687	45.7
Rockland	275	340,807	80.7
Saratoga	55	238,711	23.0
Schenectady	55	159,902	34.4
Schoharie	**	30,105	**
Schuyler	**	17,507	**
Seneca	7	32,349	21.6*
St. Lawrence	96	106,940	89.8
Steuben	9	92,162	9.8*
Suffolk	894	1,523,170	58.7
Sullivan	52	79,920	65.1
Tioga	10	47,715	21*
Tompkins	9	103,558	8.7*
Ulster	163	182,333	89.4
Warren	14	65,380	21.4
Washington	12	60,047	20.0
Wayne	19	90,829	20.9
Westchester	477	990,817	48.1
Wyoming	9	39,532	22.8*
Yates	**	24,472	**

* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.5 Hospital discharges involving heroin overdose, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023

Group	Characteristic	2022		2023	
		Hospital discharges	Crude rate per 100,000 population	Hospital discharges	Crude rate per 100,000 population
Age group	Age 0-17	**	**	**	**
	Age 18-24	29	1.7	20	1.1
	Age 25-44	378	7.1	298	5.6
	Age 45-64	507	10.0	450	9.1
	Age 65+	148	4.2	146	4.0
Gender	Male	800	8.3	698	7.3
	Female	264	2.6	219	2.2
Race and ethnicity	White NH	325	3.0	265	2.5
	Black NH	242	8.5	207	7.4
	Asian/PI NH	**	**	**	**
	Hispanic	223	5.8	196	5.1
Region	New York City	663	8.0	618	7.5
	NYS Excl NYC	401	3.5	299	2.6
Total	New York State	1,064	5.4	917	4.7

White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.6 Hospital discharges involving heroin overdose, crude rate per 100,000 population, by county, New York State, 2022 and 2023

County	2022		2023	
	Hospital discharges	Crude rate per 100,000 population	Hospital discharges	Crude rate per 100,000 population
Albany	19	6.0	9	2.8*
Allegany	0	0.0*	**	**
Bronx	219	15.8	206	15.2
Broome	10	5.1	9	4.6*
Cattaraugus	**	**	0	0.0*
Cayuga	**	**	**	**
Chautauqua	0	0.0*	**	**
Chemung	6	7.3*	**	**
Chenango	**	**	**	**
Clinton	**	**	**	**
Columbia	**	**	**	**
Cortland	**	**	**	**
Delaware	0	0.0*	**	**
Dutchess	13	4.4	13	4.4
Erie	24	2.5	19	2.0
Essex	**	**	**	**
Franklin	**	**	0	0.0*
Fulton	**	**	**	**
Genesee	**	**	**	**
Greene	**	**	0	0.0*
Hamilton	0	*	0	0.0*
Herkimer	0	0.0*	0	0.0*
Jefferson	7	6.1*	6	5.2*
Kings	174	6.7	159	6.2
Lewis	0	0.0*	**	**
Livingston	0	0.0*	**	**
Madison	**	**	0	0.0*
Monroe	30	4.0	30	4.0
Montgomery	**	**	**	**
Nassau	46	3.3	43	3.1
New York	158	9.9	164	10.3
Niagara	7	3.3*	**	**
Oneida	12	5.3	**	**
Onondaga	29	6.2	15	3.2
Ontario	**	**	**	**
Orange	19	4.7	19	4.7

County	2022		2023	
	Hospital discharges	Crude rate per 100,000 population	Hospital discharges	Crude rate per 100,000 population
Orleans	0	0.0*	**	**
Oswego	**	**	7	5.9*
Otsego	0	0.0*	**	**
Putnam	6	6.1*	**	**
Queens	87	3.8	66	2.9
Rensselaer	**	**	10	6.3
Richmond	25	5.1	23	4.7
Rockland	10	2.9	**	**
Saratoga	7	2.9*	**	**
Schenectady	10	6.3	**	**
Schoharie	0	0.0*	**	**
Schuyler	0	0.0*	**	**
Seneca	**	**	0	0.0*
St. Lawrence	**	**	**	**
Steuben	**	**	0	0.0*
Suffolk	58	3.8	42	2.8
Sullivan	**	**	**	**
Tioga	**	**	**	**
Tompkins	**	**	**	**
Ulster	12	6.6	**	**
Warren	**	**	**	**
Washington	**	**	0	0.0*
Wayne	**	**	0	0.0*
Westchester	30	3.0	17	1.7
Wyoming	0	0.0*	0	0.0*
Yates	0	0.0*	0	0.0*

* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.7 All emergency department visits (including outpatients and admitted patients) involving any opioid overdose, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023

Group	Characteristic	2022		2023	
		Emergency department visits	Crude rate per 100,000 population	Emergency department visits	Crude rate per 100,000 population
Age group	Age 0-17	129	3.2	138	3.5
	Age 18-24	769	44.0	593	34.1
	Age 25-44	6,001	113.0	5,201	98.5
	Age 45-64	5,279	104.6	5,042	101.8
	Age 65+	1,659	46.9	1,673	46.0
Gender	Male	9,977	103.9	9,106	95.3
	Female	3,852	38.3	3,532	35.3
Race and ethnicity	White NH	5,716	53.6	4,719	44.6
	Black NH	2,764	97.5	2,490	88.9
	Asian/PI NH	64	3.5	64	3.4
	Hispanic	2,317	59.8	2,333	60.2
Region	New York City	6,810	81.7	6,663	80.7
	NYS Excl NYC	7,027	62.0	5,984	52.9
Total	New York State	13,837	70.3	12,647	64.6

White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.8 All emergency department visits (including outpatient and admitted patients) involving any opioid overdose, crude rate per 100,000 population, by county, New York State, 2023

County	Emergency department visits	Population	Crude rate per 100,000 population
Albany	199	316,659	62.8
Allegany	17	46,651	36.4
Bronx	2,091	1,356,476	154.1
Broome	128	196,077	65.3
Cattaraugus	57	75,600	75.4
Cayuga	24	74,485	32.2
Chautauqua	263	124,891	210.6
Chemung	41	81,325	50.4
Chenango	22	45,920	47.9
Clinton	35	78,115	44.8
Columbia	17	60,470	28.1
Cortland	37	45,752	80.9
Delaware	36	44,410	81.1
Dutchess	174	297,150	58.6
Erie	635	946,147	67.1
Essex	**	36,775	**
Franklin	**	46,502	**
Fulton	26	52,234	49.8
Genesee	39	57,529	67.8
Greene	23	47,062	48.9
Hamilton	0	5,082	0.0
Herkimer	20	59,484	33.6
Jefferson	36	114,787	31.4
Kings	1,615	2,561,225	63.1
Lewis	**	26,548	**
Livingston	33	61,158	54.0
Madison	16	66,921	23.9
Monroe	689	748,482	92.1
Montgomery	21	49,368	42.5
Nassau	427	1,381,715	30.9
New York	1,670	1,597,451	104.5
Niagara	186	209,457	88.8
Oneida	137	227,555	60.2
Onondaga	296	467,873	63.3
Ontario	76	112,494	67.6

County	Emergency department visits	Population	Crude rate per 100,000 population
Orange	177	407,470	43.4
Orleans	19	39,124	48.6
Oswego	49	118,162	41.5
Otsego	24	60,126	39.9
Putnam	26	98,060	26.5
Queens	927	2,252,196	41.2
Rensselaer	86	159,305	54.0
Richmond	360	490,687	73.4
Rockland	85	340,807	24.9
Saratoga	73	238,711	30.6
Schenectady	118	159,902	73.8
Schoharie	12	30,105	39.9
Schuyler	11	17,507	62.8
Seneca	26	32,349	80.4
St. Lawrence	48	106,940	44.9
Steuben	43	92,162	46.7
Suffolk	803	1,523,170	52.7
Sullivan	79	79,920	98.8
Tioga	12	47,715	25.1
Tompkins	63	103,558	60.8
Ulster	110	182,333	60.3
Warren	41	65,380	62.7
Washington	17	60,047	28.3
Wayne	55	90,829	60.6
Westchester	267	990,817	26.9
Wyoming	11	39,532	27.8
Yates	6	24,472	24.5*

* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.9 All emergency department visits (including outpatient and admitted patients) involving heroin overdose, crude rate per 100,000 population, by subpopulation, New York State, 2022 and 2023

Group	Characteristic	2022		2023	
		Emergency department visits	Crude rate per 100,000 population	Emergency department visits	Crude rate per 100,000 population
Age group	Age 0-17	**	**	6	0.2*
	Age 18-24	258	14.8	127	7.3
	Age 25-44	2,669	50.2	1,681	31.8
	Age 45-64	2,247	44.5	1,720	34.7
	Age 65+	580	16.4	496	13.6
Gender	Male	4,331	45.1	2,997	31.4
	Female	1,426	14.2	1,030	10.3
Race and ethnicity	White NH	2,359	22.1	1,463	13.8
	Black NH	1,140	40.2	830	29.6
	Asian/PI NH	21	1.1	12	0.6
	Hispanic	953	24.6	741	19.1
Region	New York City	2,887	34.6	2,352	28.5
	NYS Excl NYC	2,872	25.3	1,678	14.8
Total	New York State	5,759	29.3	4,030	20.6

White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.10 All emergency department visits (including outpatient and admitted patients) involving heroin overdose, crude rate per 100,000 population, by county, New York State, 2023

County	Emergency department visits	Population	Crude rate per 100,000 population
Albany	85	316,659	26.8
Allegany	**	46,651	**
Bronx	743	1,356,476	54.8
Broome	54	196,077	27.5
Cattaraugus	21	75,600	27.8
Cayuga	8	74,485	10.7*
Chautauqua	83	124,891	66.5
Chemung	21	81,325	25.8
Chenango	11	45,920	24.0
Clinton	15	78,115	19.2
Columbia	**	60,470	**
Cortland	10	45,752	21.9*
Delaware	13	44,410	29.3
Dutchess	38	297,150	12.8
Erie	125	946,147	13.2
Essex	**	36,775	**
Franklin	0	46,502	0.0*
Fulton	8	52,234	15.3*
Genesee	10	57,529	17.4*
Greene	**	47,062	**
Hamilton	0	5,082	0.0*
Herkimer	**	59,484	**
Jefferson	18	114,787	15.7
Kings	605	2,561,225	23.6
Lewis	**	26,548	**
Livingston	6	61,158	9.8*
Madison	6	66,921	9*
Monroe	121	748,482	16.2
Montgomery	8	49,368	16.2*
Nassau	152	1,381,715	11.0
New York	567	1,597,451	35.5
Niagara	42	209,457	20.1
Oneida	38	227,555	16.7
Onondaga	113	467,873	24.2
Ontario	14	112,494	12.4

County	Emergency department visits	Population	Crude rate per 100,000 population
Orange	63	407,470	15.5
Orleans	**	39,124	**
Oswego	26	118,162	22.0
Otsego	**	60,126	**
Putnam	6	98,060	6.1*
Queens	300	2,252,196	13.3
Rensselaer	32	159,305	20.1
Richmond	137	490,687	27.9
Rockland	14	340,807	4.1
Saratoga	16	238,711	6.7
Schenectady	35	159,902	21.9
Schoharie	**	30,105	**
Schuyler	6	17,507	34.3*
Seneca	6	32,349	18.5*
St. Lawrence	14	106,940	13.1
Steuben	11	92,162	11.9
Suffolk	197	1,523,170	12.9
Sullivan	31	79,920	38.8
Tioga	**	47,715	**
Tompkins	27	103,558	26.1
Ulster	29	182,333	15.9
Warren	21	65,380	32.1
Washington	**	60,047	**
Wayne	**	90,829	**
Westchester	77	990,817	7.8
Wyoming	**	39,532	**
Yates	**	24,472	**

* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.11 Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances (any diagnosis), crude rate per 1,000 newborn discharges, by subpopulation, New York State, 2022 and 2023

Group	Characteristics	2022		2023	
		Neonatal withdrawal symptoms and/or affected by maternal use of opioids or other substances	Crude rate per 1,000 newborn discharges	Neonatal withdrawal symptoms and/or affected by maternal use of opioids or other substances	Crude rate per 1,000 newborn discharges
Race and ethnicity	White NH	621	8.8	512	7.8
	Black NH	92	5.5	57	3.8
	Asian/PI NH	**	0.3	8	0.6*
	Hispanic	80	2.4	77	2.3
Region	New York City	166	1.8	152	1.7
	NYS Excl NYC	999	9.6	787	7.7
Total	New York State	1,165	6.0	939	4.9

White NH = White non-Hispanic; Black NH = Black non-Hispanic; Asian/PI NH = Asian or Pacific Islander non-Hispanic; NYS excl. NYC = New York State excluding New York City
* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 3.12 Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances (any diagnosis), crude rate per 1,000 newborn discharges, by county, New York State, 2023

County	Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances	Newborn discharges	Crude rate per 100,000 population
Albany	7	1,891	3.7*
Allegany	**	342	**
Bronx	41	15,822	2.6
Broome	31	1,712	18.1
Cattaraugus	16	672	23.8
Cayuga	9	722	12.5*
Chautauqua	24	974	24.6
Chemung	11	758	14.5
Chenango	13	419	31.0
Clinton	8	498	16.1*
Columbia	0	329	0.0*
Cortland	**	370	**
Delaware	9	382	23.6*
Dutchess	20	2,342	8.5
Erie	140	8,217	17.0
Essex	0	116	0.0*
Franklin	**	307	**
Fulton	**	413	**
Genesee	**	468	**
Greene	**	307	**
Hamilton	0	27	0.0*
Herkimer	9	601	15*
Jefferson	7	1,533	4.6*
Kings	37	31,691	1.2
Lewis	**	214	**
Livingston	**	458	**
Madison	**	489	**
Monroe	44	7,087	6.2
Montgomery	**	452	**
Nassau	27	13,327	2.0
New York	27	13,636	2.0
Niagara	38	1,778	21.4

County	Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioids or other substances	Newborn discharges	Crude rate per 100,000 population
Oneida	22	2,064	10.7
Onondaga	24	4,365	5.5
Ontario	11	884	12.4
Orange	18	5,273	3.4
Orleans	**	329	**
Oswego	29	1,058	27.4
Otsego	**	336	**
Putnam	**	799	**
Queens	27	23,370	1.2
Rensselaer	**	980	**
Richmond	20	4,371	4.6
Rockland	**	5,329	**
Saratoga	9	1,741	5.2*
Schenectady	11	1,470	7.5
Schoharie	**	132	**
Schuyler	**	173	**
Seneca	0	258	0.0
St. Lawrence	9	748	12*
Steuben	**	703	**
Suffolk	103	15,066	6.8
Sullivan	12	887	13.5
Tioga	6	252	23.8*
Tompkins	**	464	**
Ulster	18	1,304	13.8
Warren	7	558	12.5*
Washington	**	345	**
Wayne	11	795	13.8
Westchester	14	7,830	1.8
Wyoming	**	313	**
Yates	**	157	**

* Fewer than 10 events in the numerator, therefore the rate is unstable.
** Data do not meet reporting criteria.
Data source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS); Data as of April 2025
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Data Table 4.1 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by region, New York State, 2010-2024**

Year	New York City		NYS excl. NYC		New York State	
	OASAS unique individuals enrolled	Crude rate per 100,000 population	OASAS unique individuals enrolled	Crude rate per 100,000 population	OASAS unique individuals enrolled	Crude rate per 100,000 population
2024	32,684	455.9	43,962	447.7	76,646	451.2
2023	34,261	477.9	44,836	456.6	79,097	465.6
2022	36,234	502.7	45,500	462.8	81,734	479.7
2021	38,273	525.4	46,132	467.3	84,405	492.0
2020	40,174	558.6	44,907	465.8	85,081	505.4
2019	44,399	617.3	48,770	505.8	93,169	553.5
2018	44,772	622.5	49,773	516.2	94,545	561.6
2017	45,999	637.0	50,189	520.5	96,188	570.4
2016	46,607	643.7	49,229	510.4	95,836	567.5
2015	47,013	650.1	46,474	481.2	93,487	553.5
2014	46,748	648.7	43,299	447.8	90,047	533.6
2013	46,871	653.4	40,513	419.1	87,384	518.9
2012	47,257	662.4	37,248	386.1	84,505	503.6
2011	47,789	675.8	34,220	355.5	82,009	491.2
2010	48,678	694.5	31,763	331.2	80,441	484.6

NYS excl. NYC = New York State excluding New York City

* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.

** The most recent information collected for the year of enrollment was used to determine the person's area of residence during the year. Each demographic category is mutually exclusive for the calendar year.

Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025

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Data Table 4.2 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by age group, New York State, 2010-2024**

Year	Age group	OASAS unique individuals enrolled	Crude rate per 100,000 population
2024	Age 12-17	124	9.0
	Age 18-24	1,833	105.3
	Age 25-34	15,346	560.8
	Age 35-44	21,586	848.0
	Age 45-54	13,781	583.4
	Age 55+	23,976	385.1
2023	Age 12-17	164	11.9
	Age 18-24	2,191	125.8
	Age 25-34	17,412	636.3
	Age 35-44	21,438	842.2
	Age 45-54	14,062	595.3
	Age 55+	23,830	382.8
2022	Age 12-17	150	10.8
	Age 18-24	2,450	140.1
	Age 25-34	19,471	703.2
	Age 35-44	21,102	829.8
	Age 45-54	14,482	601.7
	Age 55+	24,079	389.8
2021	Age 12-17	85	6.0
	Age 18-24	2,832	160.4
	Age 25-34	21,493	763.3
	Age 35-44	20,988	821.9
	Age 45-54	15,156	615.0
	Age 55+	23,851	388.3
2020	Age 12-17	85	6.2
	Age 18-24	3,393	189.0
	Age 25-34	22,669	788.0
	Age 35-44	19,728	812.5
	Age 45-54	15,979	626.2
	Age 55+	23,227	399.2
2019	Age 12-17	97	7.1
	Age 18-24	4,654	259.2
	Age 25-34	26,095	907.1
	Age 35-44	20,728	853.6
	Age 45-54	18,312	717.7
	Age 55+	23,283	400.2

Year	Age group	OASAS unique individuals enrolled	Crude rate per 100,000 population
2018	Age 12-17	138	10.1
	Age 18-24	5,884	327.7
	Age 25-34	27,660	961.5
	Age 35-44	19,930	820.8
	Age 45-54	19,033	745.9
	Age 55+	21,900	376.4
2017	Age 12-17	172	12.4
	Age 18-24	7,586	415.3
	Age 25-34	28,565	993.0
	Age 35-44	19,136	789.6
	Age 45-54	19,909	758.3
	Age 55+	20,820	363.6
2016	Age 12-17	252	18.0
	Age 18-24	9,234	495.8
	Age 25-34	28,323	985.5
	Age 35-44	17,942	738.2
	Age 45-54	20,545	765.2
	Age 55+	19,540	346.9
2015	Age 12-17	341	24.1
	Age 18-24	10,520	552.5
	Age 25-34	26,517	929.2
	Age 35-44	16,779	683.2
	Age 45-54	20,872	764.6
	Age 55+	18,458	333.7
2014	Age 12-17	372	26.0
	Age 18-24	11,439	586.5
	Age 25-34	23,970	846.6
	Age 35-44	15,834	638.3
	Age 45-54	21,117	763.0
	Age 55+	17,315	319.7
2013	Age 12-17	408	28.1
	Age 18-24	11,648	589.6
	Age 25-34	21,702	774.8
	Age 35-44	15,669	625.0
	Age 45-54	21,496	766.2
	Age 55+	16,461	310.6

Year	Age group	OASAS unique individuals enrolled	Crude rate per 100,000 population
2012	Age 12-17	457	31.0
	Age 18-24	11,133	559.3
	Age 25-34	19,770	716.0
	Age 35-44	15,538	613.4
	Age 45-54	22,023	775.3
	Age 55+	15,584	300.7
2011	Age 12-17	486	32.5
	Age 18-24	10,296	516.9
	Age 25-34	17,738	652.0
	Age 35-44	16,173	631.8
	Age 45-54	22,796	794.4
	Age 55+	14,520	286.9
2010	Age 12-17	452	29.7
	Age 18-24	9,263	467.0
	Age 25-34	16,321	611.2
	Age 35-44	17,184	661.1
	Age 45-54	23,518	816.9
	Age 55+	13,703	276.9

* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** Age is calculated based on date of birth and the mid-point of the enrollment year (July 1st). Persons in treatment for many years will continue to age as time goes on and may move from one age group to the next group over time. The most recent service admission for the year of enrollment was used to determine the person's age group during the year. Each demographic category is mutually exclusive for the calendar year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
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Data Table 4.3 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by sex at birth, New York State, 2010-2024**

Year	Female		Male	
	OASAS unique individuals enrolled	Crude rate per 100,000 population	OASAS unique individuals enrolled	Crude rate per 100,000 population
2024	26,017	297.2	50,599	614.4
2023	26,944	307.8	52,134	633.0
2022	27,784	316.4	53,947	653.3
2021	28,499	322.4	55,904	672.2
2020	28,646	328.2	56,434	696.4
2019	31,447	360.2	61,721	761.6
2018	32,223	369.1	62,321	769.0
2017	32,581	372.5	63,607	783.6
2016	32,129	366.7	63,707	784.1
2015	31,236	356.2	62,251	766.5
2014	29,691	338.7	60,356	744.1
2013	28,718	328.2	58,666	725.1
2012	27,561	316.0	56,944	706.7
2011	26,493	305.0	55,516	693.1
2010	25,484	294.9	54,957	690.5

* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.

** The most recent service admission for the year of enrollment was used to determine the person's sex at birth during the year. Each demographic category is mutually exclusive for the calendar year.

Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025

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Data Table 4.4 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by race and ethnicity, New York State, 2010-2024**

Year	Race/ethnicity	OASAS unique individuals enrolled	Crude rate per 100,000 population
2024	White NH	40,932	435.9
	Black NH	10,917	449.3
	Other NH	3,669	218.6
	Hispanic	21,128	658.4
2023	White NH	41,872	445.9
	Black NH	11,295	464.8
	Other NH	3,366	200.6
	Hispanic	22,564	703.2
2022	White NH	43,136	456.1
	Black NH	11,812	481.6
	Other NH	3,305	199.7
	Hispanic	23,481	733.4
2021	White NH	44,479	465.6
	Black NH	12,216	491.2
	Other NH	3,274	199.9
	Hispanic	24,436	760.7
2020	White NH	44,471	459.3
	Black NH	12,570	501.1
	Other NH	3,056	191.9
	Hispanic	24,984	819.1
2019	White NH	48,801	504.0
	Black NH	14,274	569.0
	Other NH	3,229	202.8
	Hispanic	26,865	880.8
2018	White NH	50,676	523.4
	Black NH	13,869	552.9
	Other NH	3,124	196.2
	Hispanic	26,876	881.2
2017	White NH	52,240	536.1
	Black NH	14,057	559.0
	Other NH	3,141	199.1
	Hispanic	26,750	883.5
2016	White NH	52,169	532.1
	Black NH	13,863	550.5
	Other NH	3,007	193.4
	Hispanic	26,797	890.8

Year	Race/ethnicity	OASAS admissions	Crude rate per 100,000 population
2015	White NH	50,194	508.7
	Black NH	13,783	547.5
	Other NH	2,957	194.0
	Hispanic	26,553	890.7
2014	White NH	47,546	479.3
	Black NH	13,640	542.8
	Other NH	2,665	178.6
	Hispanic	26,196	887.7
2013	White NH	45,274	454.6
	Black NH	13,857	553.4
	Other NH	2,326	159.5
	Hispanic	25,927	888.7
2012	White NH	42,344	424.0
	Black NH	14,297	574.5
	Other NH	2,090	146.2
	Hispanic	25,774	896.1
2011	White NH	39,241	392.4
	Black NH	14,857	600.8
	Other NH	1,853	132.8
	Hispanic	26,058	921.1
2010	White NH	36,686	366.5
	Black NH	15,128	616.4
	Other NH	1,711	125.9
	Hispanic	26,916	968.9

White NH = White non-Hispanic; Black NH = Black non-Hispanic; Other NH = Other non-Hispanic
* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** The most recent service admission for the year of enrollment was used to determine the person's race/ethnicity during the year. Each demographic category is mutually exclusive for the calendar year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
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Data Table 4.5 Unique individuals enrolled* in OASAS-certified treatment programs who reported any opioid (including heroin) as a primary substance at admission, crude rate per 100,000 population, by county, New York State, 2024**

County	OASAS unique individuals enrolled	Population	Crude rate per 100,000 population
Albany	1,073	279,871	383.4
Allegany	199	40,711	488.8
Bronx	11,873	1,143,496	1038.3
Broome	1,649	172,025	958.6
Cattaraugus	564	65,227	864.7
Cayuga	516	65,589	786.7
Chautauqua	881	108,411	812.6
Chemung	365	70,481	517.9
Chenango	257	39,909	644.0
Clinton	818	69,063	1184.4
Columbia	194	54,691	354.7
Cortland	501	40,340	1241.9
Delaware	160	40,129	398.7
Dutchess	1,235	263,134	469.3
Erie	4,142	822,216	503.8
Essex	151	33,350	452.8
Franklin	308	40,675	757.2
Fulton	270	45,718	590.6
Genesee	280	50,120	558.7
Greene	195	42,158	462.5
Hamilton	10	4,687	213.4
Herkimer	172	51,893	331.5
Jefferson	737	95,765	769.6
Kings	7,944	2,184,741	363.6
Lewis	84	22,615	371.4
Livingston	166	54,394	305.2
Madison	313	59,157	529.1
Monroe	2,667	651,298	409.5
Montgomery	379	41,862	905.4
Nassau	2,113	1,194,292	176.9
New York	6,629	1,452,432	456.4
Niagara	1,514	182,928	827.6
Oneida	1,399	196,149	713.2
Onondaga	2,646	404,702	653.8
Ontario	357	99,013	360.6
Orange	1,327	340,206	390.1
Orleans	244	34,374	709.8
Oswego	796	102,731	774.8
Otsego	200	54,353	368.0
Putnam	199	86,206	230.8

County	OASAS unique individuals enrolled	Population	Crude rate per 100,000 population
Queens	4,369	1,965,189	222.3
Rensselaer	552	140,209	393.7
Richmond	1,869	423,751	441.1
Rockland	609	272,263	223.7
Saratoga	651	209,982	310.0
Schenectady	745	137,480	541.9
Schoharie	112	26,783	418.2
Schuyler	81	15,335	528.2
Seneca	144	28,009	514.1
St. Lawrence	823	93,609	879.2
Steuben	459	79,530	577.1
Suffolk	4,953	1,323,139	374.3
Sullivan	564	68,479	823.6
Tioga	226	41,718	541.7
Tompkins	767	94,522	811.5
Ulster	905	162,919	555.5
Warren	259	58,259	444.6
Washington	189	53,087	356.0
Wayne	398	78,747	505.4
Westchester	2,280	858,869	265.5
Wyoming	81	34,880	232.2
Yates	83	20,731	400.4

* A person receiving treatment (one or more services, from one or more treatment programs) contributes only one count per calendar year. Totals cannot be summed across years as unique individuals may contribute to multiple year counts.
** The most recent information collected for the year of enrollment was used to determine the person's county of residence during the year. Each county enrollment count is mutually exclusive for the calendar year.
Data source: New York State Office of Addiction Services and Supports (OASAS) Data Warehouse, Client Data System (CDS); Data as of April 2025
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Data Table 5.1 Opioid analgesic prescriptions, crude rate per 1,000 population, by region, New York State, 2021-2024

Year	New York City		NYS excl. NYC		New York State	
	Number of opioid analgesics prescriptions	Crude rate per 1,000 population	Number of opioid analgesics prescriptions	Crude rate per 1,000 population	Number of opioid analgesics prescriptions	Crude rate per 1,000 population
2024	1,311,725	158.8	3,849,917	340.3	5,166,245	264.0
2023	1,376,470	166.7	3,990,451	352.7	5,373,214	274.5
2022	1,448,300	173.7	4,174,047	368.2	5,627,050	286.0
2021	1,553,160	183.5	4,421,981	388.2	5,977,190	301.0

NYS excl. NYC = New York State excluding New York City
The data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
Data Source: NYS Prescription Monitoring Program; Data as of April 2025
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Data Table 5.2 Opioid analgesic prescriptions, crude rate per 1,000 population, by age and gender, New York State, 2024

Age group	Gender	Number of opioid analgesics prescriptions	Crude rate per 1,000 population
Age 18-24	Male	42,952	49.3
	Female	54,927	63.1
Age 25-34	Male	100,046	73.4
	Female	149,706	108.9
Age 35-44	Male	195,537	153.9
	Female	288,760	226.5
Age 45-54	Male	308,648	266.0
	Female	428,653	356.7
Age 55-64	Male	591,465	470.2
	Female	707,415	530.3
Age 65+	Male	952,773	593.2
	Female	1,306,976	644.5

The data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.3 Commonly prescribed opioid analgesics, crude rate per 1,000 person-years*, by quarter, New York State, 2021-2024

		Crude rate per 1,000 population					
Year	Quarter	Oxycodone SA	Hydrocodone SA	Tramadol SA	Codeine SA	Fentanyl LA	Oxycodone LA
2024	Jan - Mar	118.0	54.3	44.4	10.2	4.2	4.6
	Apr - Jun	120.1	54.2	45.7	9.0	4.2	4.5
	Jul - Sep	119.0	51.9	45.4	9.5	4.1	4.5
	Oct - Dec	120.0	51.8	45.1	9.8	4.0	4.5
2023	Jan - Mar	120.7	59.6	45.9	13.3	4.8	5.1
	Apr - Jun	120.9	59.4	46.8	13.0	4.7	5.1
	Jul - Sep	117.2	57.0	45.4	12.3	4.6	5.0
	Oct - Dec	115.6	55.7	44.3	11.6	4.2	4.8
2022	Jan - Mar	120.2	63.3	46.7	14.2	5.4	5.9
	Apr - Jun	122.9	63.5	47.7	14.1	5.4	5.8
	Jul - Sep	121.2	62.2	47.2	13.4	5.4	5.6
	Oct - Dec	119.5	61.0	46.0	13.1	5.0	5.3
2021	Jan - Mar	121.7	68.3	47.8	15.4	6.2	6.7
	Apr - Jun	128.3	69.5	49.9	15.6	6.0	6.7
	Jul - Sep	125.0	67.6	49.1	14.6	6.0	6.5
	Oct - Dec	122.3	65.0	48.1	14.4	5.7	6.3

* The rates are calculated as follows: [# of events/(population*0.25 year)] * 1,000.
The data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.4 Percentage of episodes when an opioid-naïve patient received more than a seven-day supply for the initial opioid prescription, by region, New York State, 2022-2024

Year	Region	Number of episodes when an opioid-naive patient received more than a seven-day supply from the initial opioid prescription	Number of opioid naïve incidents	Percentage
2024	New York City	71,214	509,588	14.0
	NYS excl. NYC	170,617	1,135,451	15.0
	New York State	241,843	1,645,137	14.7
2023	New York City	75,322	526,650	14.3
	NYS excl. NYC	180,487	1,165,275	15.5
	New York State	255,821	1,692,022	15.1
2022	New York City	74,183	539,052	13.8
	NYS excl. NYC	178,846	1,186,867	15.1
	New York State	253,043	1,726,007	14.7

NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Opioid naïve was defined as patient with no opioid for pain prescription in last 45 days.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.5 Percentage of episodes when an opioid-naïve patient received long-acting initial opioid prescription, by region, New York State, 2022-2024

Year	Region	Number of episodes when patients were opioid naïve and received long-acting opioid prescription*	Number of opioid naïve incidents	Percentage
2024	New York City	2,842	509,588	0.6
	NYS excl. NYC	11,645	1,135,451	1.0
	New York State	14,487	1,645,137	0.9
2023	New York City	2,962	526,650	0.6
	NYS excl. NYC	13,062	1,165,275	1.1
	New York State	16,024	1,692,022	0.9
2022	New York City	3,340	539,052	0.6
	NYS excl. NYC	14,453	1,186,867	1.2
	New York State	17,794	1,726,007	1.0

NYS excl. NYC = New York State excluding New York City
The data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Opioid naïve was defined as patient with no opioid for pain prescription in last 45 days.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.6 Patients with prescribed opioid analgesics from five or more prescribers and dispensed at five or more pharmacies in a three-month rolling period, crude rate per 100,000 population, by region, New York State, 2021-2024

Year	New York City		NYS excl. NYC		New York State	
	Number of patients	Crude rate per 100,000 population	Number of patients	Crude rate per 100,000 population	Number of patients	Crude rate per 100,000 population
2024	73	0.9	185	1.6	258	1.3
2023	74	0.9	204	1.8	278	1.4
2022	63	0.8	174	1.5	237	1.2
2021	55	0.6	170	1.5	225	1.1

NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for the treatment of opioid use disorder.
Patients with more than one MPEs in a year are counted once within that year.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.7 Percentage of patients who were prescribed one or more opioid analgesics with a total daily dose of ≥ 90 MME on at least one day, by region, New York State, 2021-2024

Year	Region	Number of patients received opioid analgesics ≥ 90 MME	Number of patients received opioid analgesic prescriptions	Percentage
2024	New York City	39,901	486,818	8.2
	NYS excl. NYC	101,614	1,110,468	9.2
	New York State	141,530	1,597,384	8.9
2023	New York City	41,952	505,279	8.3
	NYS excl. NYC	107,132	1,146,556	9.3
	New York State	149,096	1,651,931	9.0
2022	New York City	44,955	518,559	8.7
	NYS excl. NYC	113,857	1,170,786	9.7
	New York State	158,829	1,689,439	9.4
2021	New York City	50,076	543,223	9.2
	NYS excl. NYC	122,938	1,219,851	10.1
	New York State	173,035	1,763,181	9.8

NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for pain and treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.8 Percentage of patients who were prescribed one or more opioid analgesics with a total daily dose of ≥ 90 MME on at least one day, by age and gender, New York State, 2024

Age group	Gender	Number of patients received opioid analgesics ≥ 90 MME	Number of patients received opioid analgesic prescriptions	Percentage
Age 18-24	Male	516	34,562	1.5
	Female	523	45,330	1.2
Age 25-34	Male	2,140	59,843	3.6
	Female	2,174	96,720	2.2
Age 35-44	Male	5,314	78,284	6.8
	Female	6,024	120,093	5.0
Age 45-54	Male	9,429	93,117	10.1
	Female	10,874	128,009	8.5
Age 55-64	Male	18,818	147,457	12.8
	Female	19,445	173,376	11.2
Age 65+	Male	30,640	253,536	12.1
	Female	35,320	334,881	10.5

These data exclude buprenorphine prescriptions for pain and treatment of opioid use disorder.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.9 Percentage of patients* with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions, by region, New York State, 2021-2024

Year	Region	Number of patients with two or more overlapping days	Number of patients received opioid or benzo prescriptions	Percentage
2024	New York City	43,754	768,030	5.7
	NYS excl. NYC	136,109	1,649,877	8.2
	New York State	179,874	2,418,065	7.4
2023	New York City	45,528	787,636	5.8
	NYS excl. NYC	142,640	1,688,230	8.4
	New York State	188,174	2,476,037	7.6
2022	New York City	48,470	804,853	6.0
	NYS excl. NYC	147,679	1,715,624	8.6
	New York State	196,156	2,520,636	7.8
2021	New York City	53,732	831,975	6.5
	NYS excl. NYC	157,664	1,768,701	8.9
	New York State	211,404	2,600,839	8.1

NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
* Patients with at least one prescription for opioid analgesics or benzodiazepines during a given year.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.10 Percentage of patients* with two or more calendar days of overlapping opioid analgesic and benzodiazepine prescriptions, by age and gender, New York State, 2024

Age group	Gender	Number of patients with two or more overlapping days	Number of patients received opioid or benzodiazepine prescriptions	Percentage
Age 18-24	Male	479	45,452	1.1
	Female	856	62,431	1.4
Age 25-34	Male	2,125	95,875	2.2
	Female	4,201	157,999	2.7
Age 35-44	Male	4,799	126,648	3.8
	Female	10,679	201,155	5.3
Age 45-54	Male	7,450	138,701	5.4
	Female	16,401	212,093	7.7
Age 55-64	Male	14,009	201,706	6.9
	Female	25,404	273,854	9.3
Age 65+	Male	33,466	340,832	9.8
	Female	59,028	509,785	11.6

These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
* Patients with at least one prescription for opioid analgesics or benzodiazepines during a given year.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.11 Percentage of patients* with two or more calendar days of overlapping opioid analgesic prescriptions, by region, New York State, 2021-2024

Year	Region	Number of patients with two or more overlapping days	Number of patients received opioid prescriptions	Percentage
2024	New York City	62,439	488,301	12.8
	NYS excl. NYC	172,916	1,114,855	15.5
	New York State	235,372	1,603,255	14.7
2023	New York City	65,017	506,389	12.8
	NYS excl. NYC	179,479	1,150,546	15.6
	New York State	244,511	1,657,032	14.8
2022	New York City	67,760	519,034	13.1
	NYS excl. NYC	185,668	1,173,395	15.8
	New York State	253,442	1,692,523	15.0
2021	New York City	73,095	543,723	13.4
	NYS excl. NYC	194,541	1,222,546	15.9
	New York State	267,651	1,766,376	15.2

NYS excl. NYC = New York State excluding New York City
These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
New York State total includes records with missing or unknown county information.
* Patients with at least one prescription for opioid analgesics during a given year.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.12 Percentage of patients* with two or more calendar days of overlapping opioid analgesic prescriptions, by age and gender, New York State, 2024

Age group	Gender	Number of patients with two or more overlapping days	Number of patients received opioid prescriptions	Percentage
Age 18-24	Male	665	34,576	1.9
	Female	625	45,337	1.4
Age 25-34	Male	2,777	59,869	4.6
	Female	3,061	96,760	3.2
Age 35-44	Male	7,207	78,371	9.2
	Female	9,352	120,180	7.8
Age 45-54	Male	12,911	93,262	13.8
	Female	17,240	128,175	13.5
Age 55-64	Male	27,566	147,689	18.7
	Female	32,309	173,681	18.6
Age 65+	Male	50,530	255,369	19.8
	Female	70,682	337,782	20.9

These data exclude buprenorphine prescriptions for treatment of opioid use disorder.
* Patients with at least one prescription for opioid analgesics during a given year.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.13 Patients who received at least one buprenorphine prescription for opioid use disorder, crude rate per 100,000 population, by region, New York State, 2021-2024

Year	New York City		NYS excluding NYC		New York State	
	Number of patients	Crude rate per 100,000 population	Number of patients	Crude rate per 100,000 population	Number of patients	Crude rate per 100,000 population
2024	15,977	193.5	71,053	628.1	87,037	444.7
2023	15,485	187.5	71,803	634.7	87,297	446.0
2022	15,285	183.4	67,113	592.0	82,402	418.9
2021	15,433	182.4	65,473	574.7	80,909	407.5

NYS excluding NYC = New York State excluding New York City
New York State total includes records with missing or unknown county information.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.14 Patients who received at least one buprenorphine prescription for opioid use disorder, crude rate per 100,000 population, by age and gender, New York State, 2024

Age group	Gender	Number of patients	Crude rate per 100,000 population
Age 18-24	Male	1,082	124.2
	Female	497	57.1
Age 25-34	Male	11,727	860.9
	Female	6,371	463.6
Age 35-44	Male	20,503	1,613.4
	Female	11,369	891.8
Age 45-54	Male	11,400	982.5
	Female	6,049	503.3
Age 55-64	Male	7,819	621.6
	Female	4,175	313.0
Age 65+	Male	3,729	232.2
	Female	2,161	106.6

Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.15 Percentage of cohort patients[#] receiving continuous buprenorphine for treatment of opioid use disorder* for six months or more, by region, New York State, 2022-2024^

Measurement Year^	Region	Number of patients receiving continuous buprenorphine for treatment of opioid use disorder for six months or more	Number of patients with at least one buprenorphine prescription for treatment of opioid use disorder	Percentage
2024	New York City	8,929	15,766	56.6
	NYS excl. NYC	50,603	71,897	70.4
	New York State	59,538	87,673	67.9
2023	New York City	8,800	15,349	57.3
	NYS excl. NYC	50,541	69,995	72.2
	New York State	59,345	85,352	69.5
2022	New York City	8,939	15,405	58.0
	NYS excl. NYC	49,344	66,261	74.5
	New York State	58,285	81,669	71.4

NYS excl. NYC = New York State excluding New York City
New York State total includes records with missing or unknown county information.
* A treatment period is considered continuous when gaps between prescription supplies are no more than 30 days.
[#] A group of patients (cohort) with at least one buprenorphine prescription for treatment of opioid use disorder between July 1st of the preceding measurement year and June 30th of the current measurement year
^ A measurement year is a calendar year for which the cohort patients were followed up for at least six months. For example, calendar year 2024 is the measurement year for cohort patients with buprenorphine prescriptions between July1, 2023, and June 30, 2024.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 5.16 Percentage of cohort patients[#] receiving continuous buprenorphine for treatment of opioid use disorder* for six months or more, by age and gender, New York State, 2024^

Age group	Gender	Number of patients receiving continuous buprenorphine for treatment of opioid use disorder for six months or more	Number of patients with at least one buprenorphine prescription for treatment of opioid use disorder	Percentage
Age 18-24	Male	318	1,024	31.1
	Female	126	495	25.5
Age 25-34	Male	6,674	11,953	55.8
	Female	4,098	6,344	64.6
Age 35-44	Male	14,093	20,770	67.9
	Female	8,624	11,337	76.1
Age 45-54	Male	8,064	11,550	69.8
	Female	4,668	6,026	77.5
Age 55-64	Male	5,403	7,861	68.7
	Female	3,185	4,238	75.2
Age 65+	Male	2,726	3,752	72.7
	Female	1,513	2,178	69.5

* A treatment period is considered continuous when gaps between prescription supplies are no more than 30 days.
[#] A group of patients (cohort) with at least one buprenorphine prescription for treatment of opioid use disorder between July 1st of the preceding measurement year and June 30th of the current measurement year.
^ Measurement year 2024. A measurement year is a calendar year for which the cohort patients were followed up for at least six months. For example, calendar year 2024 is the measurement year for cohort patients with buprenorphine prescriptions between July1, 2023, and June 30, 2024.
Data Source: New York State Prescription Monitoring Program; Data as of April 2025
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Data Table 6.1 Percentage of high school students who report ever using a substance, 2023

Substance, ever use	Region	Percentage	95% C.I. (confidence interval)	
			Low	High
Cocaine	United States	2.5%	1.7%	3.5%
	NYS excl. NYC	4.2%	2.0%	8.7%
	NYC	5.4%	3.8%	7.8%
Heroin	United States	1.6%	0.9%	2.8%
	NYS excl. NYC	3.8%	1.7%	8.3%
	NYC	4.2%	3.1%	5.6%
Methamphetamine	United States	1.8%	1.1%	2.9%
	NYS excl. NYC	3.5%	1.7%	7.0%
	NYC	3.7%	2.9%	4.7%
Injecting an illegal drug	United States	1.2%	0.8%	2.0%
	NYS excl. NYC	2.9%	1.4%	6.0%
	NYC	4.0%	2.8%	5.6%

NYS excl. NYC = New York State excluding New York City; NYC = New York City
Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025
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Data Table 6.2 Percentage of high school students who report ever using cocaine, New York State, 2023

Group	Characteristic	NYS excl. NYC			NYC		
		Percentage	95% C.I. (confidence interval)		Percentage	95% C.I. (confidence interval)	
			Low	High		Low	High
Total	Total	4.2%	2.0%	8.7%	5.4%	3.8%	7.8%
Grade	9th grade	5.1%	1.4%	16.2%	4.2%	2.6%	6.7%
	10th grade	2.4%	0.6%	10.0%	4.8%	2.7%	8.1%
	11th grade	4.9%	1.8%	12.4%	5.3%	2.7%	10.1%
	12th grade	2.5%	0.6%	9.5%	5.6%	3.4%	9.3%
Race and Ethnicity	White NH	2.8%	1.7%	4.6%	3.2%	1.9%	5.2%
	Black NH	7.2%	1.9%	23.3%	8.2%	3.9%	16.4%
	AI/AN NH	*			10.3%	4.2%	23.3%
	Asian NH	6.0%	1.4%	22.6%	2.2%	1.2%	4.0%
	Multiple race NH	*			4.3%	1.4%	12.3%
	Hispanic	2.6%	0.4%	15.8%	4.5%	2.7%	7.2%
Sex	Female	3.1%	1.2%	8.2%	4.0%	2.2%	6.9%
	Male	4.5%	1.7%	11.2%	5.7%	4.1%	7.8%

White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City

Survey question: During your life, how many times have you used any form of cocaine, including powder, crack, or freebase?

* Data do not meet reporting criteria.

Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025

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Data Table 6.3 Percentage of high school students who report ever using heroin, New York State, 2023

Group	Characteristic	NYS excl. NYC			NYC		
		Percentage	95% C.I. (confidence interval)		Percentage	95% C.I. (confidence interval)	
			Low	High		Low	High
Total	Total	3.8%	1.7%	8.3%	4.2%	3.1%	5.6%
Grade	9th grade	2.9%	0.4%	18.1%	3.5%	2.5%	5.0%
	10th grade	3.6%	1.1%	10.9%	3.1%	2.1%	4.5%
	11th grade	3.7%	0.9%	13.7%	3.9%	2.5%	6.0%
	12th grade	3.1%	0.9%	10.3%	4.5%	2.4%	8.4%
Race and Ethnicity	White NH	1.7%	0.5%	5.6%	2.4%	1.2%	4.5%
	Black NH	5.2%	1.1%	20.7%	6.5%	3.5%	11.7%
	AI/AN NH	*			6.0%	2.3%	14.9%
	Asian NH	7.8%	3.5%	16.4%	0.9%	0.4%	2.0%
	Multiple race NH	*			2.1%	0.9%	4.6%
	Hispanic	5.3%	1.5%	17.8%	3.4%	2.5%	4.8%
Sex	Female	2.1%	0.7%	5.8%	2.8%	1.8%	4.4%
	Male	4.7%	1.9%	11.1%	4.3%	3.0%	6.0%

White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City

Survey question: During your life, how many times have you used heroin (also called smack, junk, or China White)?

* Data do not meet reporting criteria.

Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025

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Data Table 6.4 Percentage of high school students who report ever using methamphetamines, New York State, 2023

Group	Characteristic	NYS excl. NYC			NYS excl. NYC		
		Percentage	95% C.I. (confidence interval)		Percentage	95% C.I. (confidence interval)	
			Low	High		Low	High
Total	Total	3.5%	1.7%	7.0%	3.7%	2.9%	4.7%
Grade	9th grade	1.7%	0.3%	8.6%	3.4%	2.4%	4.8%
	10th grade	2.1%	0.5%	7.5%	2.8%	1.9%	4.1%
	11th grade	5.8%	2.3%	14.1%	3.3%	2.4%	4.5%
	12th grade	2.2%	0.5%	9.4%	3.7%	2.1%	6.5%
Race and Ethnicity	White NH	1.9%	0.9%	4.0%	2.3%	1.4%	3.8%
	Black NH	5.2%	1.1%	20.7%	4.7%	3.0%	7.2%
	AI/AN NH	*			7.3%	2.9%	17.0%
	Asian NH	4.6%	1.5%	12.9%	1.4%	0.7%	2.9%
	Multiple race NH	*			2.5%	1.1%	5.7%
	Hispanic	5.2%	2.1%	12.2%	3.1%	2.2%	4.4%
Sex	Female	2.3%	0.8%	6.0%	2.0%	1.5%	2.7%
	Male	3.9%	1.7%	8.7%	4.2%	3.1%	5.7%

White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City

Survey question: During your life, how many times have you used methamphetamines (also called speed crystal meth, crank, ice, or meth)?

* Data do not meet reporting criteria.

Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025

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Data Table 6.5 Percentage of high school students who report ever injecting an illegal drug, New York State, 2023

Group	Characteristic	NYS excl. NYC			NYC		
		Percentage	95% C.I. (confidence interval)		Percentage	95% C.I. (confidence interval)	
			Low	High		Low	High
Total	Total	2.9%	1.4%	6.0%	4.0%	2.8%	5.6%
Grade	9th grade	3.0%	0.7%	13.0%	3.6%	2.3%	5.5%
	10th grade	2.8%	1.0%	7.8%	2.8%	1.8%	4.3%
	11th grade	3.5%	1.0%	11.3%	3.9%	2.1%	7.3%
	12th grade	2.2%	0.4%	11.4%	4.8%	2.4%	9.6%
Race and Ethnicity	White NH	0.8%	0.2%	4.2%	2.7%	1.4%	5.1%
	Black NH	5.7%	1.4%	20.8%	5.6%	2.7%	11.3%
	AI/AN NH	*			9.7%	4.6%	19.2%
	Asian NH	1.4%	0.1%	13.8%	1.3%	0.7%	2.7%
	Multiple race NH	*			4.5%	2.0%	9.5%
	Hispanic	5.3%	1.5%	16.5%	3.6%	2.4%	5.3%
Sex	Female	2.8%	0.9%	8.6%	3.1%	1.8%	5.5%
	Male	2.6%	1.3%	5.2%	4.1%	2.7%	6.1%

White NH = White non-Hispanic; Black NH = Black non-Hispanic; AI/AN = American Indian/Alaskan Native non-Hispanic; Asian NH = Asian non-Hispanic; Multiple race NH = Multiple race non-Hispanic; NYS excl. NYC = New York State excluding New York City; NYC = New York City

Survey question: During your life, how many times have you used a needle to inject any illegal drug into your body?

* Data do not meet reporting criteria.

Data source: Youth Risk Behavior Surveillance System (YRBSS); Data as of April 2025

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Data Table 6.6 Age-adjusted percentage of adults who self-reported prescription pain medication misuse in the past 12 months, New York State, 2017-2023

Year	Age-adjusted percentage (95% confidence interval)
2023	5.7 (5.2 - 6.3)
2022	4.7 (4.1 - 5.2)
2021	3.9 (3.2 - 4.6)
2020	3.6 (3.1 - 4.1)
2019	6.1 (5.3 - 6.8)
2018	3.9 (3.5 - 4.4)
2017	5.3 (4.6 - 6.0)

Survey question: In the past 12 months, have you used prescription pain medicine without a healthcare provider's prescription or differently than how the healthcare provider told you to use it?
Note: The population aged 18 years and older.
Data source: Behavioral Risk Factor Surveillance System (BRFSS); Data as of September 2024
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Data Table 6.7 Age-adjusted percentage of adults who self-reported prescription pain medication misuse in the past 12 months, by subpopulation, New York State, 2022 and 2023

Group	Characteristic	Age-adjusted percentage (95% confidence interval)	
		2022	2023
Age group*	Age 18-24	3.9 (2.4 – 5.4)	4.5 (3.2 – 5.9)
	Age 25-34	5.4 (4.0 – 6.8)	5.5 (4.1 – 7.0)
	Age 35-44	4.2 (3.0 – 5.5)	6.2 (4.8 – 7.6)
	Age 45-54	4.2 (3.1 – 5.3)	5.9 (4.3 – 7.5)
	Age 55-64	5.7 (4.0 – 7.4)	5.3 (4.1 – 6.5)
	Age 65+	4.4 (3.5 – 5.4)	6.6 (5.3 – 7.8)
Gender	Male	4.9 (4.0 – 5.7)	5.2 (4.5 – 6.0)
	Female	4.5 (3.8 – 5.2)	6.2 (5.3 – 7.1)
Race and ethnicity	White NH	2.3 (1.8 – 2.8)	2.0 (1.6 – 2.5)
	Black NH	5.0 (3.3 – 6.7)	6.8 (5.2 – 8.5)
	Other NH	6.7 (4.4 – 9.0)	6.8 (4.7 – 8.8)
	Hispanic	9.8 (8.2 – 11.4)	14.3 (12.4 – 16.3)
Region	New York City	7.0 (6.0 – 8.1)	8.1 (7.1 – 9.1)
	NYS excluding NYC	3.0 (2.5 – 3.6)	4.2 (3.5 – 4.8)
Total	New York State	4.7 (4.1 – 5.2)	5.7 (5.2 – 6.3)

White NH = White non-Hispanic; Black NH = Black non-Hispanic; NYS excl. NYC = New York State excluding New York City

Survey question: In the past 12 months, have you used prescription pain medicine without a healthcare provider's prescription or differently than how the healthcare provider told you to use it?

* Age groups show crude percentages.

Note: The population aged 18 years and older.

Data source: Behavioral Risk Factor Surveillance System (BRFSS); Data as of September 2024

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Data Table 6.8 Perceptions of public health problems as "very serious" among New York State residents, November 2016 – February 2025

Survey Period	Public health problem						
	Fentanyl use	Heroin use	Prescription opioid misuse and abuse	Childhood obesity	Tobacco use	Alcohol consumption	Access to healthy food and beverages
February 2025	72%	62%	63%	58%	47%	36%	49%
March 2024		67%	67%	54%	45%	37%	44%
January 2023		70%	72%	57%	49%	35%	43%
January 2022		70%	69%	54%	52%	35%	39%
March 2021		70%	66%	55%	50%	37%	40%
February 2020		69%	70%	52%	54%	38%	36%
January 2019		75%	75%	61%	46%	38%	35%
November 2017		76%	75%	61%	50%	38%	40%
November 2016		76%	68%	61%	52%	38%	36%

Survey question: For each of the following, tell me if you think it is a very serious public health problem, a somewhat serious public health problem, a not very serious problem or that it is not at all a serious public health problem.
Note: The February 2025 survey added "Fentanyl use" to the question.
Data source: New York State Department of Health /Siena College Research Institute, New York State Chronic Disease Public Opinion Poll; Data as of March 2025
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