The Decline Was a Beginning. Here Is What We Should Do Next.

By Melissa Kilpatrick, LADAC II, QCS

Tennessee recorded about 31 percent fewer overdose deaths in 2024 than in 2023. Nationally, overdose mortality experienced the largest single-year decline ever recorded in the United States. More than 25,000 Americans who likely would have died at 2023 rates are still alive today.

Many of the structures most responsible for sustaining long-term recovery receive comparatively little attention because they operate as maintenance systems rather than crisis systems.

Recovery housing that does not evict for a relapse. Peer specialists who keep showing up after the formal treatment ends. Transportation to the appointments people cannot otherwise reach. Long-term outpatient care that follows a person past the first 90 days. Community outreach in the places the formal system rarely enters. Employment support that survives the first relapse. Childcare that makes it possible for a parent to keep an appointment.

You cannot point to what they prevented. The overdose that did not happen. The arrest that did not happen. The 4 a.m. call to the Department of Children's Services that did not need to be placed. Successful prevention work is invisible by definition. It leaves no headline.

Yet these supports are frequently among the first treated as expendable because prevention rarely generates the same urgency, visibility, or political attention as crisis response.

The recent decline in overdose deaths did not happen in isolation. It occurred alongside years of expanded naloxone access, broader availability of medication-assisted treatment, peer support integration, public health outreach, and recovery infrastructure that helped more people survive long enough to stabilize.

But a decline is not a conclusion. It is a moment that asks a question.

The question is what Tennessee chooses to build with the room the decline created.

For the last twenty years, Tennessee's response to addiction has largely been organized around crisis. Emergency rooms. Detox beds. Short-term inpatient stays. Court intervention after the overdose, the arrest, the collapse. Necessary systems, but temporary ones. Built to stop immediate harm, not to sustain long-term recovery. This pattern is not unique to public funding. Commercial insurance covers the same acute episodes and applies the same utilization limits to long-term recovery support. The bias is built into the payor system,

not just the state budget.

But crisis stabilization and long-term recovery are not the same thing. One interrupts immediate danger. The other requires sustained infrastructure over time.

None of them designed to walk with someone into the next year of their life.

The decline did not happen because acute care got better at responding to emergencies.

It happened because, alongside acute care, something else started to work.

Naloxone went from prescription-only to over-the-counter. Buprenorphine prescribing opened to any DEA-registered clinician at the end of 2022, after the federal restriction that for decades limited it to specially-trained doctors was lifted. Telehealth medication-assisted treatment expanded what could happen between in-person visits. Emergency department buprenorphine inductions became standard practice in more hospitals than ever before. Medicaid coverage in many states extended past the historical 28-day inpatient window.

In other words, the parts of the system that started to function less like emergency response and more like long-term community health.

It is also important to be honest about what else changed during this period. Recent studies indicate that one significant contributor to the 2024 decline was a change in the illicit fentanyl supply itself. DEA laboratory testing showed average fentanyl powder purity falling from roughly 19 percent in 2022 to about 11 percent in 2024, and the share of seized counterfeit pills containing a potentially lethal dose dropped from 7 of 10 to 5 of 10. Fentanyl-involved deaths nationally fell from approximately 76,000 in 2023 to 48,000 in 2024, a 34 percent drop that accounted for nearly all of the overall mortality decline.

Supply matters. But supply is not a strategy. The supply changes, often in directions no one chose, and the only system durable enough to hold ground regardless is one designed to last.

That is the lesson worth holding onto.

Because the 2025 data already shows what happens when long-term infrastructure fails to keep pace with an increasingly dangerous drug supply.

Nationally, the decline continued. Provisional CDC data released in May 2026 shows overdose deaths fell roughly 14 percent for the twelve months ending in December 2025. In Davidson County, the largest urban county in Tennessee, overdose deaths in the first quarter of 2025 fell another 21 percent from the same period in 2024.

But in Hamilton County, the pattern reversed. The county recorded 120 overdose incidents in 2024 with five fatalities. In 2025, the county recorded 90 overdose incidents with seventeen fatalities. Fewer overdoses. Three times the deaths. Whatever people were using became dramatically more lethal in a single year.

In October 2025, the Tennessee Department of Health identified a new synthetic opioid in the state's drug supply called cychlorphine. By June 2026, the drug has been linked to nearly sixty fatal overdoses, concentrated heavily in East Tennessee. Cychlorphine is roughly ten times more potent than fentanyl. Naloxone reverses it, but reversal often requires repeat dosing. Naloxone training is available free across Tennessee through Regional Overdose Prevention Specialists in every health region.

The supply changes faster than acute care can respond to it. It always will. That is not a failure of acute care. It is the nature of the work. The only response durable enough to track, recognize, and adapt to whatever shows up next is one with continuous community presence. Peers who hear about new compounds before the labs confirm them. Pharmacists who notice a pattern in repeat naloxone fills. Outreach workers who pass warnings through networks the formal system cannot reach. Clinicians who stay long enough to recognize a new fatality pattern before the next person dies. If you are one of these people, your observations matter more than you may have been told they do.

That is not acute care. That is community health.

So the choice in front of Tennessee is not whether to fund treatment. The state already funds treatment. The choice is how.

Tennessee can keep funding addiction the way it has been funded, as a chain of acute episodes with no sustainable handoff between them. An ambulance ride. An emergency room visit. A detox stay. A discharge that returns the person to the same conditions that produced the crisis, with nothing built around them to hold what they just started.

There are people who do hold onto recovery long enough to build a stable life. Those successes deserve celebrating. But there are far more who did not have the resources needed to sustain the health they were trying to build. Access to ongoing treatment when the formal stay ends. Stable housing. Employment that pays enough to support a family without grinding through three jobs at once. Childcare. Transportation. Time. These are not luxuries. They are the conditions under which a recovery can become a life.

The financial burden does not disappear when recovery infrastructure fails.

It reappears elsewhere. Emergency departments. County jails. Child welfare systems. Homelessness services. Lost productivity. Unreimbursed hospital care. Higher public expenditures spread across systems most people never think about until they personally encounter them.

Which means Tennessee is already paying for addiction either way.

The policy question is not whether the public bears the cost. It is whether those resources are invested early enough to reduce the long-term damage.

What that cycle actually looks like in practice is harder to see in a budget line, but every clinician in this state has watched some version of it.

Picture a woman in her thirties who has maintained sobriety for more than a year.

She has a steady job for the first time in her adult life. Her children are living with her grandparents, now in their eighties, because no one else in the family is able to care for them.

She works multiple jobs to help support that household while trying to build a life stable enough for her children to eventually return to.

But there is little left beyond survival.

No time to build community. No time to care for herself. Doctor and dental appointments are missed. Connection with her recovery community slowly fades. Twelve-step meetings become harder to attend. After long days, she returns home emotionally and physically depleted.

The work of surviving has consumed the work of staying well.

Once formal treatment ends, the structure around her begins to disappear. No one is checking in consistently. No one is helping her think through what happens when the weight of daily life becomes too heavy to carry alone.

Eventually, exhaustion gives way to relapse.

The relapse leads to a charge. The charge leads to jail. She loses the job. She leaves incarceration without stable housing.

Her grandparents are now raising small children again with no clear plan for what comes next.

Everything she built over that year collapses. Not because she failed to care about recovery, but because nothing stable had been built underneath her strong enough to help her sustain it.

That story is not rare. It is the predictable result of a system that treats addiction as a series of episodes instead of a long arc of healing.

Or Tennessee can fund the kind of infrastructure that holds long enough for real change to happen. Stability so people can heal, and then sustain what they healed. Treatment that supports the family alongside the individual, because no one recovers in isolation and no parent recovers without the children also being held.

Continuity that closes the gap between the day formal treatment ends and the day the rest of life starts pressing back. Community presence that lasts long enough for a recovery to become a life.

Same dollars. Different design.

The federal money for addiction was built for the crisis, not the recovery. Hospital beds, ambulance rides, emergency overdose reversal have stable federal funding. Recovery housing, peer support, transportation to appointments, childcare while parents are in treatment have to be cobbled together from scattered programs across multiple federal agencies that do not talk to each other. Tennessee has never built the bridges between them. That is why what works has been chronically underfunded. It is not a budget problem. It is a design problem.

When that redirect happens, the savings do not disappear. They show up in other line items. Fewer foster care placements mean more funding available for the schools those children attend. Fewer emergency department visits mean TennCare dollars stay in primary care. Fewer jail beds for addiction-related arrests mean county budgets are not absorbing what should never have been a criminal justice problem in the first place. Healthier parents mean more stable workforce participation in the rural counties that have been losing population for a decade. Communities with intact families need less crisis intervention and more of everything that actually builds a place worth living in.

The generational pattern is not a slogan. It is something this field watches in real time. Children of parents in stable recovery do better in school. Are less likely to enter foster care. Are less likely to enter the same disease themselves. When the people doing this work get the stability to do it for ten years instead of three, those patterns interrupt. Families stay intact. Counties stop losing their tax base. Schools stop absorbing the cost of preventable disruption. The curse that has moved through three or four generations of a family ends because somebody, somewhere, finally got the kind of help that was built to last.

That is what long-term community health looks like in practice. It is not abstract. It is what the people in the field who built the 2024 decline have been doing all along, often without the funding or recognition the work deserved.

Tennessee is now in a position most states would trade for. Crisis level mortality came down. The framework that produced the decline already exists, in pockets, across the state. The opportunity is to take what worked in those pockets and make it the default model rather than the exception.

That is the choice in front of the legislature, the governor's office, the Opioid Abatement Council, every county commission, and every health system in the state.

Acute funding produced acute responses. Continuous funding can produce continuous care. The same money, structured differently, supports the same workforce in a way that lets them stay long enough to actually finish the work they started.

The decline matters. Thousands of Tennesseans are alive today who likely would not have been a year earlier. The people who made that possible deserve credit, recognition, and the stability to keep going.

But the decline is not the end of anything. It is the proof of what works, and an invitation to build more of it.

I do not want to argue about ideology. I want to keep counting the people who are still alive. I want to keep counting the families who stayed intact. I want to keep counting the children who finished a school year in the same house. I want to keep counting the school budgets that grew because the systems upstream of them finally got designed for the way people actually heal.

If you live in Tennessee, the data for your county is at melissakilpatrick.com/counties. You can see what 2024 looked like for your community, and where the gains held or reversed.

The question now is not whether the decline was real. The question is whether Tennessee uses what the decline taught us, or files it away as a one-year anomaly.

The infrastructure that built this is already here. The people in the field are already doing the work. The choice is whether the rest of the system catches up with them.

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Disclosure: Kilpatrick is currently employed as Outpatient Clinical Director at JourneyPure, a private substance use disorder treatment provider in Tennessee. The opinions expressed are her own.