Oneida County Overdose Fatality Review

An initiative of the Oneida County Opioid Task Force

SUMMARY OF RECOMMENDATIONS

November 21, 2022 Case Review

Opioid Task Force Chairs:
Anthony J. Picente, Jr., County Executive
Robert M. Maciol, Sheriff
Scott D. McNamara, District Attorney

Overdose Fatality Review

The OFR is a collaborative initiative of the Oneida County Opioid Task Force (OTF) with representatives from more than 30 government, health care, education, treatment and recovery, law enforcement, social service and other community-based organizations. Its mission is to explore the issues and obstacles related to drug overdose fatalities by conducting confidential case reviews of local overdose deaths. The shared understanding that overdose deaths are preventable and addiction is a disease that should be addressed without stigma and shame, guides the entire OFR process.

Participants examine a person's demographics, psychosocial history, treatment history, medical records, crisis system encounters, and other prominent risk factors associated with drug overdoses to identify missed opportunities for intervention to strengthen overdose prevention strategies, improve system-level operations, inform local service providers, public policy, and ultimately to reduce the number of overdose deaths in Oneida County.

Dedication

Recognizing that each case represents the death of a person whose absence is grieved by friends, family, and community. We dedicate this report to those who have lost their life and to those who have suffered the loss of a loved one to overdose.

Methodology

The OTF Overdose Response Team Data Analysis Sub-team selected a drug overdose case for review by the team on November 21, 2022. Case criteria included a date of death within the 2022 calendar year, a cause of death attributed to overdose of prescription or illicit drugs, and an accidental/ unintentional manner of death. ODMAP data was used for case selection as well as context for identifying an overdose death consistent with a current drug trend of concern (i.e., stimulant and fentanyl-related death, co-occurring mental health and substance use disorder). The following data was collected and reviewed:

- **Decedent demographic data.** Age, sex, race, county of residence, length of residency, veteran status, hospitalization history, incarceration history
- **Circumstances of fatal overdose.** Forensic investigator narrative, first responder reports, toxicology report, Medical Examiner autopsy report, and death certificate.
- **Medical history.** Hospitalization history, behavioral health medical provider, substance use treatment provider, medication history
- **Case attributes** (decedent risk factors). Diagnosed substance use disorder, mental health diagnosis, multiple emergency department ED/hospital visits, history of court ordered evaluation or treatment, and other factors.
- **Next-of-Kin Interviews.** The decedent's relatives were interviewed for their perspective on the decedents, and to learn more about the person, risk factors, and other potential contributing factors. Excerpts from audio recordings were shared during the OFR.

Key Factors

The group identified several factors that seemed to contribute to the decedent's addiction and eventual overdose:

- **Trauma.** Adverse Childhood Experience (ACE) event and traumatic event in early adulthood. Negative experiences in childhood and teenage years increase risk for chronic health problems, mental illness, and substance use in adulthood ACE Risk & Protective Factors.
- **Mental health.** Formal diagnosis of a mental health disorder and drug use to self-medicate. Complications related to treating psychosis from MH issue in combination with drug use especially psychostimulants.
- **Consistency of care.** The decedent and next of kin expressed concern for the turnover of staff at some facilities and the resulting changes in treatment/medications for mental illness by care providers.
- **Access to care.** Obstacles that limited access to care including poor access to transportation, causing reliance on law enforcement for initial contact in crisis situations.
- **Episodic treatment.** Decedent and family often sought and only received help when situations, particularly mental health issues rose to the level of acute crisis, and feeling the need to threaten self-harm to get help.
- **Social isolation.** The decedent valued socialization and faith, but no indications of strong supports/connections outside of family.

Recommendations

The following overdose prevention strategies were recommended for adoption at the system and organizational level and integration into OTF projects:

- **Peer support/advocate.** Peer support services (including home visits) by people with lived experience can offer support with coping habits, managing recovery, and navigating services. Maximize awareness and usage of tools that provide linkage to peer support in various community settings (i.e., NY MATTERS Program).
- **Expanded harm reduction promotion.**
  - Increase awareness of resources such as Naloxone and Fentanyl Test Strips including campaigns that destigmatize need to carry these tools and increasing knowledge of risks associated with illicit fentanyl and stimulants (i.e., cocaine, methamphetamine).
  - Increase awareness and promotion of Never Use Alone Hotline.
  - Increase public education on recognition of signs of overdose.
- **Family loss program.** Post overdose follow up program supporting families experiencing grief from loss due to overdose death.
- **Law enforcement high-risk referrals.** Law enforcement referral process for intervention prior to overdose, arrest and/or crisis situations.
- **Holistic treatment.** Consider programs that go beyond the patient and support the entire family with education about substance use disorder, mental health, services in the community, and how to access them.
- **User-friendly centralized and coordinated resources**. Strategies that facilitated a more coordinated and centralized system of care and/or additional training about referral sources may help (i.e., regular trainings provided to local healthcare providers on behavioral health trends and community resources).

Implementation

The recommended strategies will be integrated into the Opioid Task Force as projects as well as promoted to partners for adoption at the organization and/or programmatic level. OTF partners will report on progress of collaborative interventions and highlight ways in which recommendations have been implemented at the system, agency/ sector and/or population-specific level. Subcommittees with neutral conveners and representatives from key partner agencies may be formed to develop strategic implementation workplans.

Acknowledgements

Our sincerest thanks to the organizations participating in this overdose fatality review and sharing data as well as insights, experiences and expertise that fostered an objective, thoughtful and honest evaluation of actions that can help prevent future overdose deaths.

ACR Health
Beacon Center
Center for Family Life & Recovery, Inc.
Helio Health
Midstate EMS
Mohawk Valley Crime Analysis Center
Mohawk Valley Health System
Mohawk Valley Housing & Homeless Coalition
National Association of County & City Health Officials
NY MATTERS
NY/NJ High Intensity Drug Trafficking Area
NYSDOH Office of Drug User Health
Oneida County Department of Family & Community Services
Oneida County Emergency Services
Oneida County Executive's Office
Oneida County Health Department
Oneida County Mental Health Department
Oneida County Planning Department
Oneida County Probation
Oneida County Sheriff's Office
Oneida County Law Department
Oneida Health Hospital
Onondaga County Medical Examiner's Office
Primeau-Fahey Studios
Rome City School
Salvation Army
Upstate Family Health Center
Utica Police Department

Appendix A—Recommendation Workplan (To Be Developed)

Recommendation Type	Recommendation	Activity/Action Steps	Lead Agency & Supporting Agencies	Timeline
Systemic	**Peer support/advocate.** Peer support services (including home visits) by people with lived experience can offer support with coping habits, managing recovery, and navigating services. Maximize awareness and usage of tools that provide linkage to peer support in various community settings (i.e., NY MATTERS Program). (*Examples of settings including but not limited to corrections, hospitals, primary care, shelters, etc.)*			
Agency/Sector-specific	**Expanded harm reduction promotion.**			
	¨ Increase awareness of resources such as Naloxone and Fentanyl Test Strips including campaigns that destigmatize need to carry these tools and increasing knowledge of risks associated with illicit fentanyl and stimulants (i.e., cocaine, methamphetamine).			
	¨ Increase awareness and promotion of Never Use Alone Hotline.			
	¨ Increase public education on recognition of signs of overdose.			
Population-specific	**Family loss program.** Post overdose follow up program supporting families experiencing grief and loss due to overdose death.			
Agency/Sector-specific	**Law enforcement high-risk referrals.** Law enforcement referral for process for intervention prior to overdose, arrest and/or crisis situations.			
Systemic	**Holistic treatment.** Consider programs that go beyond the patient and support the entire family with education about substance use disorder, mental health, and services in the community, and how to access them.			
Systemic	**User-friendly centralized and coordinated resources**. Strategies that facilitated a more coordinated and centralized system of care and/or additional training about referral sources may help (i.e., regular trainings provided to local healthcare providers on behavioral health trends and community resources).			

ONEIDA COUNTY
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