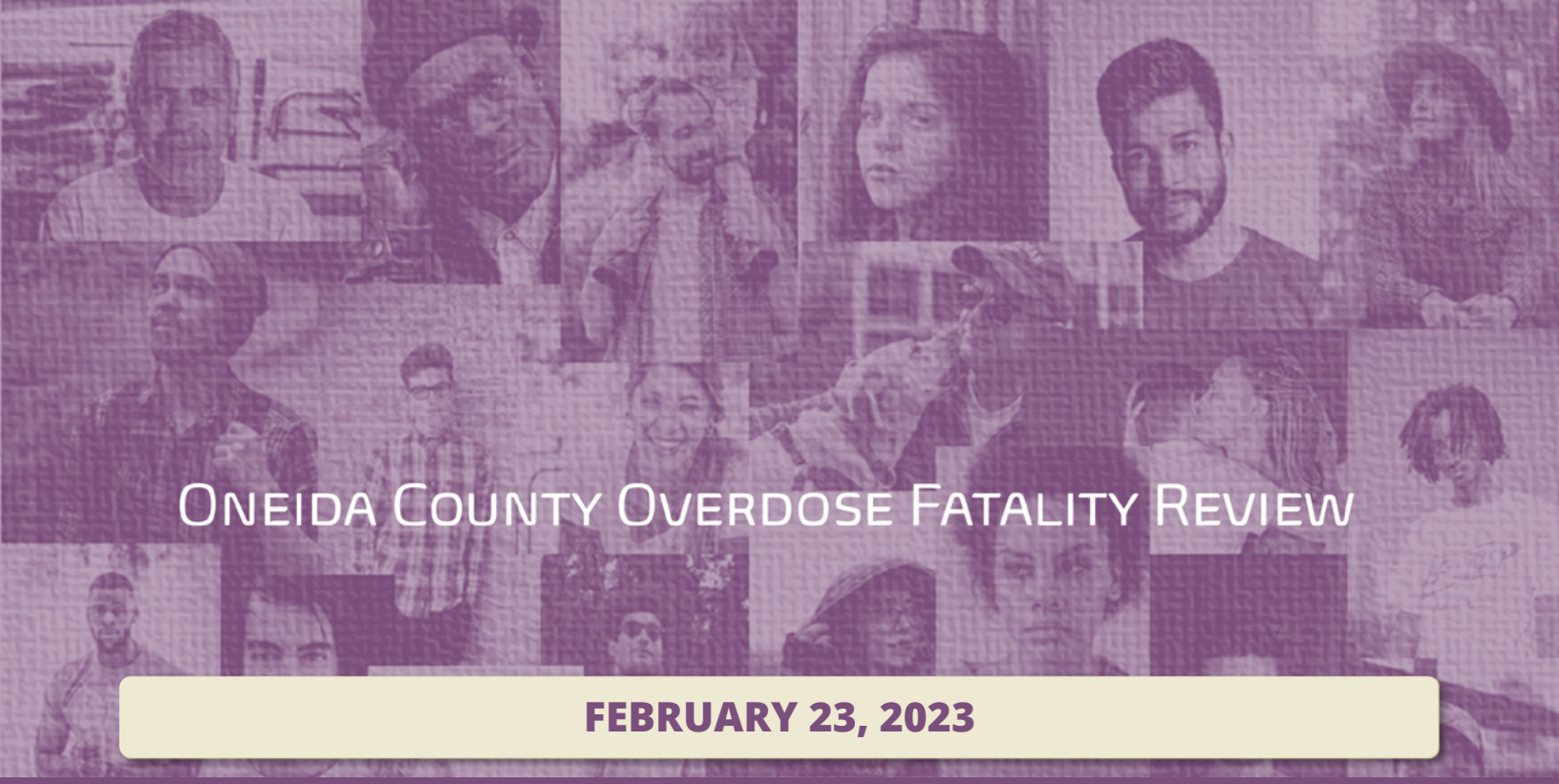
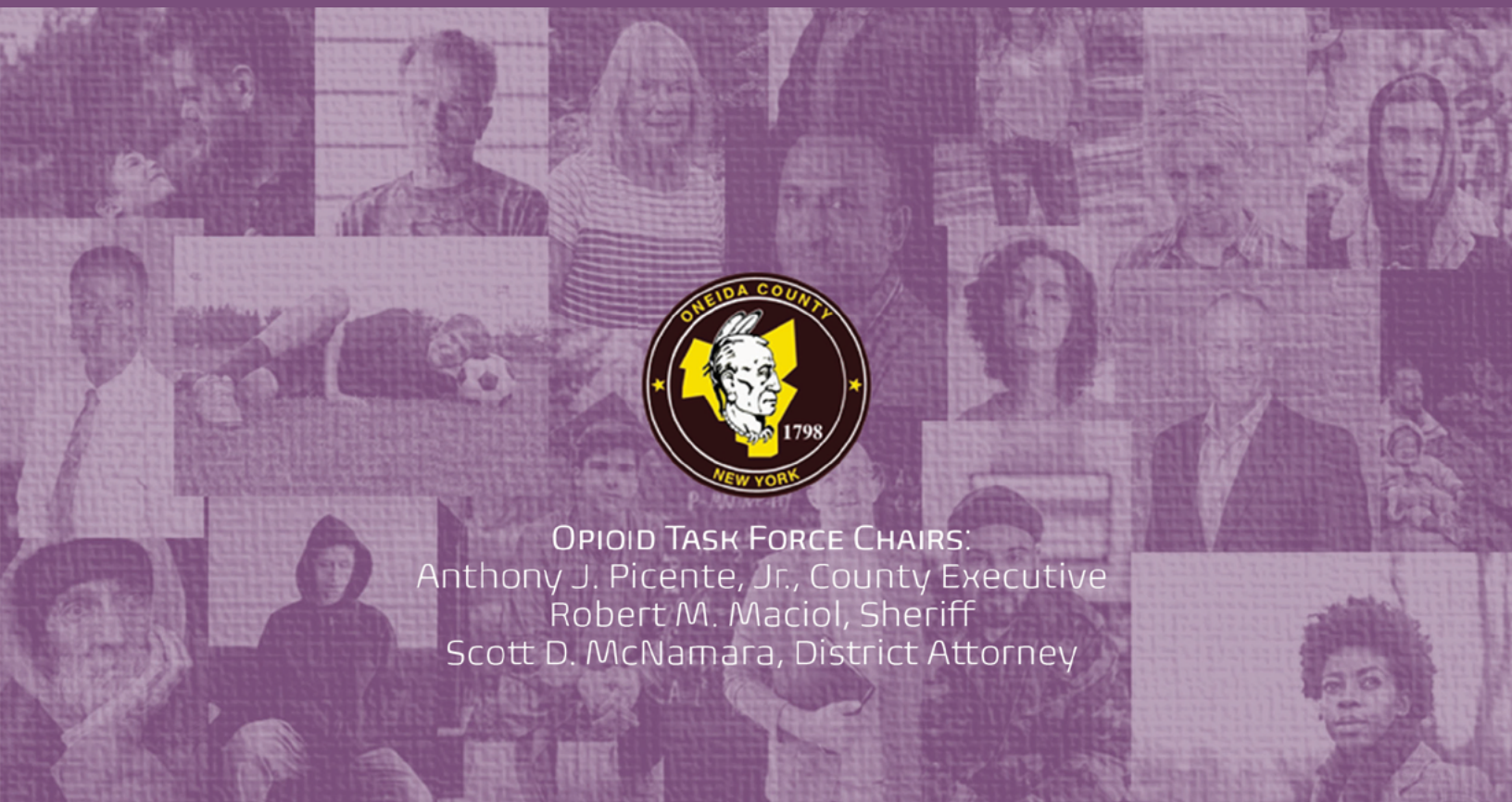


Oneida County Overdose Fatality Review

FEBRUARY 23, 2023

MEETING REFLECTIONS



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

We recognize that each case reviewed by the Oneida County Overdose Fatality Review Team 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.

Meeting Objective

The mission of the Oneida County OFR is to explore the issues and obstacles related to local drug overdose fatalities. The committee conducts confidential case reviews of overdose deaths that occur within our local jurisdiction. The OFR meeting participants examine a person's demographics, psychosocial history, treatment history, medical records, crisis system encounters, and other prominent risk factors associated with drug overdoses. From this, the OFR team aims 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.

Confidentiality

Agencies that agreed to share data, and participants of the OFR, all completed data-sharing and confidentiality agreements.

Methodology

Representatives from the Oneida County Opioid Task Force selected a drug overdose case for review by the team during our three hour meeting on February 23, 2023. 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 or undetermined manner of death.

Preliminary review of demographic data, death data (i.e. location, cause of death, forensic narrative), and case attributes was completed. The following data was collected on this case:

- **Decedent demographic data:** Age, sex, race, county of residence, length of residency, hospitalization history, law enforcement interaction history
- **Circumstances of fatal overdose:** Forensic investigator narrative, first responder reports (i.e. EMS, law enforcement), toxicology report
- **Medical history:** Hospitalization and well visit history
- **Case attributes** (decedent risk factors): DSS history, custody, and other factors
- **Next-of-Kin Interviews.** The decedent's great aunt (NOK and custodian) was interviewed for her perspective on the decedent, and to learn more about the person, risk factors, and other potential contributing factors. Excerpts from audio recordings were shared during the OFR.

Meeting Reflections

The case of "John Doe" was presented in summary and then the meeting was facilitated to encourage participation by all attendees (in-person and virtual). There was an enthusiasm from OFR members to explore the themes related to the decadent's overdose and advocate for system change and standards of care.

MEETING SUCCESSES:

- The data-sharing component of OFR gave our community an opportunity to examine system barriers, to discuss shared challenges and to provide local solutions to prevent future overdose deaths. Members also exchanged information and discussed programmatic successes.
- This case review discussion helped destigmatize substance use disorder by shifting the focus from the individual to the systems and environments that hinder successful treatment and recovery.

Key Factors

The group identified several factors that seemed to contribute to the decedent's overdose. Those factors included:

No Narcan by civilians on scene. The civilians on scene did not appear to have or use Narcan in an attempt to revive the decedent.

Decedent was unknown to many OFR member organizations. The decedent's drug use had not been documented prior to his death and only described in passing (but not emphasized) by the primary custodian during the NOK interview ("I caught him smoking pot out back…"). His criminal history was petty and did not rise to the level that would have required immediate intervention by Department of Family and Community Services. The decedent was relatively unknown to law enforcement, but the individuals that he was known to associate with is known to law enforcement. The residence of his father (where he spent some time leading up to his death) was deemed a "hotspot".

Typical non-acute DFCS history. The decedent's Child Protective Services case history is not atypical and did not describe a situation of persistent neglect that warranted acute intervention.

Strong family advocate with little power to control the situation. The decedent's primary custodian appeared to be a strong advocate for the decedent, although she may not have been as forthcoming regarding his drug use. That said, revealing that information may not have had a significant impact on her ability to get support. She used a lot of the tools that she saw at her disposal. Including the court system, PINS, requesting "bootcamp" programs, and law enforcement (by filing missing persons reports in an attempt to manage and control the decedent who would often run away to a family member's house).

It did not appear as though she was at all negligent in her care-giving or supervision. Overall, she seemed very emotional about her inability to control, supervise, or manage the decedent's behavior. She appealed to the court to intervene, but was met with what she described as delays.

While the decedent's primary custodian was asking for help, tools like PINS do not appear "to have any teeth". Because this was not a juvenile delinquent case and it was not a court ordered intervention, many of the recommendations or potential outcomes for intervention would be voluntary in their compliance.

It appears the primary custodian may have been a victim of stigma, or distrust due to her lack of disclosure, and was described by the OFR group as “a voice that was not heard”.

All of that said, it seems the best intentions of the primary custodian were pushing against a teenager who lacked discipline and was attracted to environments where he could do what he pleases. Unfortunately, his behavior at home, school, and in the public did not rise quickly enough to any level where an obvious agency or individual could have intervened and taken action with enough authority, enforcement, or consequences that it could have redirected his life.

Strategies

The group also identified strategies that could be considered to help prevent future overdoses:

- DFCS and the Courts. DFCS seems to enjoy a good relationship with the family court system that could help steer and guide these cases for early intervention and prevention. The system typically favors keeping the family together and his behaviors and activities had not led to any more significant intervention based on current policy and laws.
- Peer support/advocate. The decedent may have benefitted from a peer support program (that included home visits) by people with lived experience with this type of home/custody situation that can help offer support with avoiding potentially dangerous situations.
- Tools such as Naloxone and Fentanyl Test Kits. Additional awareness and access to naloxone and text kits, including campaigns that destigmatize the perceived need to carry these tools.

While this is only one case, the OFR team will review future cases for trends. We are grateful to all Oneida County OFR partners for their ongoing commitment to preventing future overdoses in our community.

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
OPIOID TASK FORCE

PREVENTION • SURVEILLANCE • RECOVERY • TREATMENT • HARM REDUCTION

Using Data, Collaboration & Innovation to Save Lives

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