

ONEIDA COUNTY OVERDOSE FATALITY REVIEW

CASE #4, OFR REVIEW ON DEC. 7, 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 (OFR)

The OFR is a collaborative initiative of the Oneida County Opioid Task Force (OTF) with representatives from more than 33 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. In the meeting, OFR team members review an individual's demographic details, psychosocial and treatment histories, medical records, crisis interactions, and key risk factors for drug overdoses. Their goal is to pinpoint overlooked chances for intervention, enhance overdose prevention tactics, optimize system efficiency, guide local services and policies, and ultimately decrease overdose fatalities 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 fatal drug overdose case to be reviewed by the OFR team. The case was reviewed during a two hour meeting on Dec. 7, 2023. Case criteria included a date of death within the 2023 calendar year, a cause of death attributed to overdose of prescription or illicit drugs, and an accidental or undetermined manner of death.

A 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
- **Circumstances of fatal overdose:** Forensic investigator narrative, first responder reports (i.e. EMS, law enforcement interaction), toxicology report
- **Medical history:** Hospitalization, family history, Substance Use Disorder treatment history, and wellness checkups
- **Case attributes** (decedent risk factors): DSS history, housing status history, and other factors

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 decedent’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.





Meeting Themes and Strategies

The key themes identified during the group review shed light on the decedent's background, missed opportunities for intervention, potential stressors, medical history, and gaps in public education and service provision. The following are the main findings:

Episodic Care:

Extended Challenge: The decedent experienced significant inconsistency in accessing vital services such as healthcare, mental health, and social services. This inconsistency was due to a mix of personal limitations in navigating the healthcare system, systemic barriers to accessing care, and a high turnover rate among healthcare and social service providers. The COVID-19 pandemic exacerbated these issues, forcing many services to switch to telemedicine, which posed its own set of challenges. Furthermore, these problems were indicative of broader, nationwide issues in workforce recruitment and retention within the healthcare and social services sectors.

Broader Context: This scenario is a reflection of a larger systemic problem where individuals with complex health and social needs fall through the cracks due to fragmented care delivery systems. The lack of continuity in care providers can disrupt the management of chronic conditions, lead to poor treatment outcomes, and increase the likelihood of emergency healthcare utilization.

Lack of Family Support:

Extended Challenge: The decedent's mother had been a significant source of support and stability prior to her relocation out of state. Her relocation left a substantial gap in his support network, leading to increased independence demands that he was ill-prepared to meet. This change significantly impacted his ability to manage his daily life and navigate the complexities of the systems he depended on.

Broader Context: The role of family and close social support networks is crucial in managing health and social challenges, particularly for individuals with complex needs. The loss or absence of such support can lead to increased vulnerability and a higher risk of adverse outcomes, including substance misuse and mental health crises.

Difficulty in Obtaining Personal Identification:

Extended Challenge: The decedent struggled to acquire critical personal identification documents like a birth certificate, social security card, and driver's license or sheriff identification card. This difficulty was a manifestation of his challenges in dealing with bureaucratic systems and also directly impeded his access to essential services such as housing and banking, which are crucial for stability and societal integration.

Broader Context: Access to personal identification is a foundational requirement for participating in many aspects of modern society. The inability to obtain these documents can create a vicious cycle where individuals are unable to access services, leading to further marginalization and disenfranchisement.

Interaction with the Legal System:

Extended Challenge: The decedent's frequent interactions with the legal system, often resulting in quick releases back onto the streets due to bail reform laws, indicated a pattern of missed opportunities for more substantive intervention. His offenses were not severe enough to warrant longer detentions, which might have provided more consistent access to substance use and healthcare services.

Broader Context: The intersection of substance use, mental health issues, and the criminal justice system is complex. Short-term incarcerations without addressing the underlying health and social issues often lead to a cycle of re-arrests and releases, failing to provide the support needed for rehabilitation and recovery.

Transportation Challenges:

Extended Challenge: The decedent did not own a car and lacked the financial means to maintain one. Despite the availability of public services like transportation vouchers and Medicaid-funded transportation, he faced difficulties in accessing these resources, managing the logistics of scheduling trips, and covering the costs associated with transportation.

Broader Context: Transportation is a critical but often overlooked component of accessing healthcare and social services. Lack of reliable transportation can be a significant barrier, particularly for individuals living in areas with limited public transportation options or those with physical, financial, or cognitive challenges.





Social Isolation:

Extended Challenge: The decedent's increasing social isolation appeared to correlate with the frequency and severity of his issues. Isolation likely exacerbated his struggles with substance use and mental health, as well as his ability to access and navigate support systems.

Broader Context: Social isolation is a significant risk factor for various health problems, including mental health issues and substance abuse. The lack of a supportive social network can lead to increased vulnerability and a decreased ability to cope with life's challenges.

Additional Insights:

Enhanced Harm Reduction Peer Service Programs: Expanding peer support programs, where individuals with lived experience provide support and guidance, can be highly effective. These programs offer relatable perspectives and practical advice, helping individuals navigate complex systems and find appropriate resources. These programs may also offer a sense of service continuity where other support agencies may be experiencing significant staff turnover.

Access to Substance Use Shelter/Housing: Developing specialized housing solutions that cater specifically to those struggling with substance use disorders can create stable environments conducive to recovery. The environment can also serve to benefit those experiencing social isolation and struggling with substance use, while also minimizing triggers associated with 3rd party substance use. These facilities should ideally offer integrated services, including counseling and healthcare, within a supportive community framework.

Conclusion

The findings of this overdose fatality review underscore the importance of proactive interventions and improved coordination among agencies in identifying and supporting individuals at risk of overdose. By addressing these key themes, Oneida County can work towards reducing overdose fatalities and providing more effective assistance to vulnerable individuals in the 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 organizational and/or programmatic level. OTF partners will report on the 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 for sharing data, 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 DISTRICT ATTORNEY OFFICE
ONEIDA COUNTY EMERGENCY SERVICES
ONEIDA COUNTY EXECUTIVE'S OFFICE
ONEIDA COUNTY HEALTH DEPARTMENT
ONEIDA COUNTY MENTAL HEALTH DEPARTMENT
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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). (<i>Examples of settings including but not limited to corrections, hospitals, primary care, shelters, etc.</i>)			
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).			



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