ONEIDA COUNTY OVERDOSE FATALITY REVIEW

OFR REPORTS #1-4 2022-2024

CROSS-CASE ANALYSIS

OPIOID TASK FORCE CHAIRS:

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The scourge of drug overdoses continues to cast a dark shadow across communities, with each fatality leaving an indelible mark on families, friends, and the societal fabric. In an effort to confront this crisis more effectively, our team has undertaken a meticulous analysis of our first four overdose fatality review cases. This report aims not only to shed light on the individual stories and circumstances surrounding these tragic events but also to rigorously examine the commonalities and patterns that emerge when these cases are juxtaposed.

Through a comprehensive review process, we have delved into various aspects of each case, including the demographic details, health history, socioeconomic background, and the sequence of events leading to the overdose. By synthesizing this information, we seek to identify underlying themes and factors that are recurrent across these cases. These insights are crucial in understanding the broader context of the overdose epidemic and in formulating targeted interventions.

This report also marks a significant step towards a proactive and informed response to the overdose crisis. The latter part of the document presents a set of strategic opportunities and recommendations. These are aimed at addressing the identified themes and issues, with the ultimate goal of reducing the incidence of drug overdoses and saving lives. Our approach is rooted in a multi-faceted perspective, encompassing public health, policy, community engagement, and law enforcement strategies.

As we present this report, it is our hope that the findings and recommendations herein will serve as a valuable resource for policymakers, healthcare providers, community leaders, and all stakeholders committed to combating the overdose epidemic. Together, we can turn the tide against this crisis and pave the way for a healthier, safer future.

Emerging Themes

This section of the report is dedicated to unraveling these themes, which are not only pivotal in understanding each individual case but are also instrumental in recognizing broader trends and systemic issues. The identification of these themes is a crucial step towards developing targeted interventions and preventative strategies. Each theme encapsulated here is the result of careful examination, reflecting a confluence of various factors such as societal influences, healthcare system interactions, individual behaviors, and potential gaps in services.

List of Emerging Themes (bookmark links)

Themes with Supporting Points:

A. Encounters with law enforcement may have provided potential opportunities for follow-up or referrals to appropriate services/ programs.

Supporting Points:

a. Man with mental illness relied on law enforcement "for initial contact in crisis situations" (because of lack of transportation). [OFR #1]
    i. If law enforcement had multiple interactions with the decedent in a state of crisis, (A) are there records of the nature of those interactions? (B) was he entered in their system/could he have been flagged in case of repeat encounters? (C) could they have referred him for treatment?

b. Minor was issued a warrant arrest and was twice the subject of a "Missing Person" report handled by law enforcement, all within two months – with no apparent or documented consequences, follow-up or referrals. [OFR #2]

c. Woman called the police regarding hurting herself in 2015, had three criminal encounters (illegal driving, fights) and was the subject of a Missing Person report in 2016, and had warrants issued for her arrest in 2017. Despite these numerous interactions with the PD, no further information on outcomes, follow-up, or referrals for support or services is available. [OFR #3]

d. Veteran had "frequent interactions" with law enforcement (minor offenses) and was quickly released back onto the streets – referred to in the report as a "pattern of missed opportunities for more substantive intervention." [OFR #4]

B. The system could move faster to escalate cases and deploy adequate help/interventions prior to an individual nearing or reaching acute crisis.

Supporting Points:

a. 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). [OFR #1]
    i. "...they have to get so bad... before they get the help they need." [OFR #1, NoK]

b. "CPS case history... did not describe a situation of "persistent neglect" that warranted acute intervention." [OFR #2]
    i. HOWEVER: This minor was in the system in 2006, 2012, and more frequently since 2016.
    ii. HOWEVER: His custodian (great aunt) tried many avenues to get help. ("She used a lot of the tools that she saw at her disposal.") [OFR #2]
        1. "Missing persons" reports did not result in follow-up

2. "Person in Need of Supervision" (PINS) designation was ineffectual ("does not appear to 'have any teeth'"). [OFR #2]

c. "...his behaviors and activities hadn't led to any more significant interventions based on current policy and law." [OFR #2]
   i. "...the decedent's drug use had not been documented prior to his death... his criminal history was petty..." [OFR #2]
   ii. His was not considered a Juvenile Delinquent case – thus court-ordered interventions were not initiated.
      1. HOWEVER: His father's residence, where he kept running away to and wanted to live, was DEEMED a "hotspot."
      2. HOWEVER: "...the individuals he was known to associate with WERE known to law enforcement..." [OFR #2]

d. "Unfortunately, his behavior... 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)." [OFR #2]
   i. HOWEVER: From January to June of 2022, he was the subject of four reports/incidents involving law enforcement, the school, and OCSD.
   ii. A CPS case was finally opened – one month before he overdosed.

C. A lack of consistency and continuity of care is a common challenge.

Supporting Points:

a. Inconsistent access to medical care and mental health help – including changes in providers, treatments, and medications – contributed to the decedent's destabilization, as did interactions with law enforcement who were not adequately trained to deal with individuals with mental illness. [OFR #1]
b. Woman had more than 80 medical encounters in 7 years - and yet did not appear to have been referred for additional support or services. "A closer connection with a healthcare professional may have allowed for the observation of potential behaviors that put her at risk for accidental overdose." [OFR #3]
c. Veteran's difficulties were compounded by changes in his Case Manager and Substance Use Disorder treatment due to staff turnover, as well as difficulty getting appointments/access to health care and social services. [OFR #4]

D. Isolation compounds risk factors and by its nature is difficult to combat but easier for friends and family to observe and identify.

Supporting Points:

a. "No indication of strong supports/ connections outside of family." [OFR #1]

b. Decedent not closely connected even with family [OFR #3]
   i. Mother had little knowledge of decedent's current situation, stressors
   ii. Sister was supposedly closer to her but did not respond
   iii. Decedent's child's father moved out, relationship status nonexistent or unknown (with both child and child's father)
   iv. "She just locked herself in her room and she would just watch TV. That's all she used to do." [OFR #3, NoK]

c. Decedent's mother, previously a source of support, relocated; "the decedent's increasing social isolation appeared to correlate with the frequency and severity of his issues" [OFR #4]

E. At-risk individuals fear or distrust "the system" or individuals from which they need help.

Supporting Points:

a. Man with mental illness distrusts doctors. He fears hospitalization. He is afraid of being institutionalized. [OFR #1]

b. Rebellious minor distrusts the responsible attempts of his guardian (great aunt) to control his behavior and environment. [OFR #2]

c. Veteran struggling with Substance Use Disorder distrusts changes in Case Managers. [OFR #4]

F. Access to transportation is a hurdle, as is lack of knowledge of transportation options.

Supporting Points:

a. Resident of Boonville (isolated town 40 minutes north of Utica) has very limited transportation available [OFR #1]

b. Veteran is not aware of/unable to navigate transportation options (Medicaid, public transportation, etc.) to get to appointments [OFR #4]

Additional Insights

Beyond the primary themes identified in our analysis, there are additional insights that, while not as prominent, are crucial to enhancing our understanding of the overdose crisis. This section delves into these subtler yet significant findings, shedding light on aspects that did not rise to the level of the main themes but are nonetheless important in painting a complete picture. These insights offer valuable context and could potentially inform more nuanced aspects of policy and intervention strategies, thereby contributing to a more comprehensive approach to addressing the issue of drug overdoses.

- **Opportunity for Positive Impact**
  - The following summary would address the first three themes identified: Improved information sharing among agencies/ programs regarding incidents or causes for concern is needed in order to more effectively identify and support at-risk individuals, deploy proactive interventions, and reduce overdoses.
- **"Hotspot" designation**
  - Confirm description: *An address to which police are often called and/or illegal activity and/or drug use is suspected*
    - "hotspot" = access (to drugs) = influence (of drug culture)
    - Could be a very useful term for OD Prevention efforts… e.g. distribute Narcan in that neighborhood, geofence/ target that area with awareness campaigns, etc.
  - Who assigns the designation/based on what criteria?
  - Is it a formal/informal designation?
  - What actions does the designation trigger?
  - Is a cross-check conducted of individuals known to reside there and/or related to the owner, particularly minors?
  - Is the designation noted anywhere or conveyed to any other agencies?
- **Missing Person vs. "Vulnerable Youth?"**
  - Minor reported as a "Missing Person" was labeled a "frequent runaway" (fact) and "not in any danger" (opinion/speculation).
    - Should the situation end there? The designation of a "frequent runaway," particularly one with a history of abuse running to his father's house – a known "hotspot" - should maybe prompt additional questions or follow-up.
  - Is there – or could there be – a different designation/way to report a "Vulnerable Youth" or "Youth at Risk" rather than a Missing Person?
- **PINS designation**
  - Someone (guardian only?) can petition the court (Family Court?) for the designation of a Person in Need of Supervision (PINS).
    - What does PINS involve?
    - Who is responsible for the supervision or follow-through?
- **Schools: Partners in youth safety, health & wellness**
  - Schools should be encouraged to participate in reviews and reports when the decedent is a minor.
    - Reassure them about privacy/confidentiality measures.

- Ask for contacts for and/or academic, disciplinary and behavioral reports from their guidance counselor, teacher(s), school nurse, administrators.
- Many schools do full-circle reviews of students deemed at risk. They often have a great deal of information.

- **Improving Recovery Outcomes through Access to Conducive Housing**

  The success of recovery programs for individuals facing addiction challenges is heavily impacted by their living environments. Case study #4 highlights a critical issue: individuals, particularly those with low income, often find themselves in housing options situated in or near areas known for substance abuse activities, undermining their recovery efforts. To enhance the effectiveness of recovery programs, there is a pressing need to connect these individuals to spaces that support and reinforce their journey in recovery.

Opportunities For Improvement

1. Encounters with **law enforcemen**t may have potential opportunities for follow-up or referral to appropriate services/programs.
   - 1.1. Develop a system for law enforcement to note potential risk factors with individuals they encounter, easily submit for review (case workers?) and possible referral or follow up by appropriate agencies/programs.
     - 1.1.1. Tap OD Prevention settlement funds for additional resources?
2. The system **could move faster to escalate cases** and deploy adequate help/interventions prior to an individual reaching acute crisis.
   - 2.1. Change the metrics for elevating a person to next-level outreach, interventions, and/or services.
   - 2.2. Give heavier weight to custodians' reports & concerns: follow up, inquire, act, rather than judge or dismiss their information as incomplete
   - 2.3. Enable/encourage Common Sense Concern as a catalyst for inquiry, follow-up, action sharing of information and connecting the dots
   - 2.4. Create a way for youth/siblings to report concerns or observations (about their sibling) anonymously
     - 2.4.1. A variation on the "See Something, Say Something" campaign? (Know Something? Help Someone.)
     - 2.4.2. It's not snitching if you think someone may hurt themselves or someone else"
3. **A lack of consistency and continuity of care** is a common challenge.
   - 3.1. Implement standardized protocols and communication channels among healthcare providers, social services, and support groups to facilitate seamless transitions and consistent care, especially during critical handoff points like hospital discharge or transition to outpatient services.
   - 3.2. Invest in training for care coordinators who can oversee and manage individual cases, acting as a single point of contact for at-risk individuals to navigate the healthcare and social services system effectively, thereby reducing gaps in care and improving overall outcomes.

4. **Isolation** compounds risk and is difficult to combat.
    4.1. This seems to be a common factor among many of the cases reviewed. There is the opportunity for a public awareness campaign to help spot this trend among friends and family and provide them the talking points to engage them in a conversation and then refer them to services for support.

5. **At-risk individuals fear** or **distrust** "the system" or individuals from which they need help.
    5.1. Develop and promote community-based outreach programs that involve peer support specialists — individuals who have successfully navigated the system and can relate to and build trust with at-risk populations. These specialists can serve as bridges between the individuals and the services they need.
    5.2. Initiate training programs for healthcare providers, law enforcement, and social workers focusing on empathy, cultural competence, and trauma-informed care to foster a more understanding and supportive approach towards at-risk individuals.
    5.3. Create anonymous or confidential access points for services, such as hotlines or online platforms, where individuals can seek help without the fear of stigma or legal repercussions, thus building a foundation of trust and safety.

6. **Access to transportation** is a hurdle, as is lack of knowledge of transportation options.
    6.1. To mitigate the challenge of transportation access, the county should consider implementing a dedicated shuttle service that connects high-need areas with key health and treatment facilities. Additionally, a comprehensive awareness campaign should be launched, focusing on educating residents about existing transportation options, including any discounted or free services for those seeking treatment for substance use disorders. Furthermore, partnerships with local transportation companies and community organizations could be explored to facilitate more personalized and flexible transportation solutions for individuals in need of regular access to treatment and support services.

CONCLUSION

In conclusion, this report has illuminated critical themes and insights from our initial overdose fatality reviews, offering a clearer understanding of the multifaceted nature of this crisis. The recommendations provided aim to address the identified challenges and barriers, striving for a more effective and compassionate response to the needs of those at risk. It is our hope that these findings and suggestions will serve as a catalyst for meaningful change, fostering collaboration across various sectors and leading to a reduction in overdose fatalities. We acknowledge that this is an evolving challenge and commit to continuous learning and adaptation in our strategies. As a community, we must remain vigilant and proactive, working together to safeguard the well-being of all our members and to create a future where such tragedies are increasingly rare.

ONEIDA COUNTY
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