

ONEIDA COUNTY OVERDOSE FATALITY REVIEW

CASE #6, OFR REVIEW ON JANUARY 6, 2025

MEETING REFLECTIONS



OPIOID TASK FORCE CHAIRS:

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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 January 6, 2025. Case criteria included a date of death within the 2023 or 2024 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 “Barb Smith” 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 from the Overdose Fatality Review

Introduction

The following report expands upon themes and strategies discussed during the Overdose Fatality Review (OFR) for Case #2693 held on January 6, 2025. This case presented unique circumstances that diverged from previous reviews, providing an opportunity to examine underexplored dynamics in overdose fatalities. These insights aim to enhance preventive strategies, improve service coordination, and inform policy recommendations for Oneida County.

Key Themes

1. Episodic Care and System Disconnect

The decedent's history illustrated significant gaps in consistent care, underscoring systemic barriers in service continuity. Despite having private insurance, the decedent lacked a primary care provider, and there was no documented engagement with mental health or substance use treatment services.

Challenges:

- Fragmented care delivery due to turnover in healthcare.
- Limited engagement with preventive or supportive services despite outreach efforts by organizations like MCAT and ACR.
- Lack of comprehensive data-sharing and analysis to predict risk escalation.

Strategies:

- Develop a centralized system for tracking high-frequency interactions with law enforcement and emergency services to identify at-risk individuals.
- Enhance awareness of available services through regular inter-agency presentations, ensuring all stakeholders are well-informed about local resources.

2. Social and Family Isolation

The absence of family involvement was a critical factor in this case. The lack of a reliable social support network likely exacerbated vulnerabilities, particularly given the decedent's history of volatile relationships and interpersonal conflicts.

Challenges:

- Social isolation from quality family relationships compounded by a history of violent encounters and erratic behavior.
- Peers or acquaintances may have hesitated to seek help on behalf of the decedent due to fear of repercussions.

Strategies:

- Launch public service campaigns to normalize harm reduction and outreach efforts, emphasizing that seeking help is an act of care rather than surveillance.
- Introduce training sessions for community members to recognize signs of risk and engage with harm reduction and outreach programs like MCAT or ACR without fear of stigma.

3. Data Utilization and Predictive Analysis

One notable observation was the abundance of data available across various agencies but a lack of coordinated analysis. Significant patterns of law enforcement interactions and emergency room visits were identified, yet these data points remained siloed outside of this meeting.

Challenges:

- Insufficient integration of data between healthcare, law enforcement, and social services.

Strategies:

- Conduct an inventory of accessible data across all partner organizations and prioritize domains for analysis.
- Create protocols for earlier intervention based on predictive indicators, such as escalating emergency room visits or frequent law enforcement encounters.





Opportunities

Expanded Peer Support Programs

Participants recognized the potential of harm reduction peer programs, where individuals with lived experience provide guidance and support. These programs can bridge gaps in traditional care by offering relatable perspectives and fostering trust.

Recommendation: Maintain, and continue work to expand, the scope of peer support initiatives to include training sessions for family members and friends, equipping them with tools to offer immediate, non-judgmental support.

Public Awareness Campaigns

A recurring suggestion involved developing campaigns to destigmatize outreach efforts and educate the public about harm reduction programs. Such campaigns should frame outreach as an act of compassion and normalize the use of services like MCAT and ACR.

Recommendation: Revisit and sustain the deployment of campaigns (such as the “All of us” campaign) that include messaging to reassure individuals their outreach efforts will be received positively and highlights success stories from harm reduction programs.

Service Directory and Data Integration

To address knowledge gaps, participants proposed hosting longer meetings where each organization could present its available services. This approach would enhance inter-agency collaboration and awareness.

Recommendation: Maintain and commit to frequent updates to the service directory with detailed information on accessibility and eligibility criteria, enabling seamless referrals and reducing duplication of effort.

Conclusion

The review of Case #2693 underscored the necessity of proactive interventions and improved data coordination to prevent overdose fatalities. By implementing the strategies outlined in this report, Oneida County can address critical gaps in service delivery, foster greater collaboration among agencies, and ultimately reduce overdose deaths. These efforts must prioritize destigmatizing substance use disorders and normalizing outreach to at-risk individuals, ensuring no one is left behind in the fight against the opioid crisis.

Appendix A — Recommendation Workplan (To Be Developed by the State, County, and/or CBOs)

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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