Yavapai County
Overdose Fatality Review Board

A Tool for Preventing Future Overdose Deaths

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Yavapai County Attorney
Chair, MATFORCE

Merilee Fowler
Executive Director, MATFORCE
- 501c3 organization
- Board of Directors
- Serves all Yavapai County
  - 9 incorporated communities
  - Over 30 unincorporated communities

- Community Coalition
  - 5 committees including Pharmacy Team, Prenatal Care Team
  - 279 committee members
2010
Identification of RX Overdose Deaths

2011
Reducing RX Misuse and Abuse #1 Priority

2012
Implementation of State RX Initiative

2015
Action Planning to Address Heroin
Detective James Tobin

August 2016
Development of Overdose Fatality Review Board
Goal of Yavapai County Overdose Fatality Review Board →

Prevent overdose deaths by:

- Identifying Overdose Trends in Yavapai County
- Identifying Commonalities in Overdose Deaths
- Making recommendations based on the OFRB reviews
- Develop action steps that improve policies and programs to prevent overdose deaths
Organizations represented on Review Board

- Arizona Attorney General’s Office
- Central Arizona Fire District
- Cottonwood Police Department
- Department of Child Safety
- First Things First
- Life Line Ambulance
- MATFORCE
- Partners Against Narcotic Trafficking
Members continued:

- Prescott Police Department
- Prescott Valley Police Department
- Southwest Behavioral & Health Services
- Triple Point Recovery
- Verde Valley Fire District
- West Yavapai Guidance Clinic
- Yavapai College Police Department
- Yavapai County Adult Probation
Members continued:

- Yavapai County Attorney’s Office
- Yavapai County Medical Examiner’s Office
- Yavapai County Public Defender’s Office
- Yavapai County Community Health Services
- Yavapai County Superior Court
- Yavapai Regional Medical Center
- Yavapai County Sheriff’s Office
- Local pharmacists
Overdose Deaths Reviewed

- 2016 – 80 Drug Related Deaths
  - 46 Accidental Drug Overdoses
  - 18 Undetermined
  - 47 of 80 deaths – Mixed Drugs or Mixed Drugs/Alcohol

- Drug induced death rate: 26.7 per 100,000
- Higher than State average of 16.9 per 100,000
- Yavapai County – 3rd highest of 15 counties
Information Reviewed

- Medical Examiner’s Report
- Toxicology Report
- Police Report
- Legal History
  - Probation
  - Yavapai County Attorney’s Office
- Family Interview
  - Release of Information Form
  - Verification may be required
- Medical History
- Mental Health History
- Information from Responding Officer
# Chart of Commonalities

**“Record Abstraction Form”**

<table>
<thead>
<tr>
<th>File #</th>
<th>Name of Decedent</th>
<th>Age/ Sex</th>
<th>Location</th>
<th>Date and Cause of Death</th>
<th>Reported Mental Illness</th>
<th>Young children in their custody at time of death</th>
<th>In Patient</th>
<th>Out Patient</th>
<th>Prior Treatment</th>
<th>Came to Yavapai County for Treatment/ Outside AZ</th>
<th>Previous Overdose of Significant Other</th>
<th>Homeless</th>
<th>Main Residence Outside of YC</th>
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<thead>
<tr>
<th>Main Residence Outside of YC</th>
<th>Previous Parole/ Probation</th>
<th>Jail Time</th>
<th>Family History of Substance Abuse</th>
<th>Early Age of Initiation of Alcohol</th>
<th>Early Age of Initiation of Marijuana/ Other Drugs</th>
<th>Physician prescribed opioids or other controlled substances</th>
<th>History of Suicide Attempt</th>
<th>History of Parole/ Probation at time of death</th>
<th>Jail Time</th>
<th>Interview Conducted</th>
<th>Previous Overdose prior to death</th>
<th>Homeless</th>
<th>Veteran</th>
<th>Other Notes</th>
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- **Legal History**
- **Physician prescribed opioids or other controlled substances**
- **History of Parole/ Probation at time of death**
- **Jail Time**
- **Interview Conducted**
- **Previous Overdose prior to death**
- **Homeless**
- **Veteran**
- **Other Notes**
Case Recommendations

Consensus on Recommendations for each Individual Case

Determination of Action Steps

Person(s) Organization(s) responsible to implement the recommendations
What have we learned?
9 Cases Reviewed
January - June 2017

- **4 females**
- **5 males**

Age Range: 20 – 53 years of age
Average age: 32 years
Location of 9 Deaths Reviewed

- 3 Deaths in Prescott
- 2 Deaths in Cottonwood
- 2 Deaths in Prescott Valley
- 1 Death in Mayer
- 1 Death in Black Canyon City
Cause of death as listed by the Medical Examiner

- 2 Cases: Heroin intoxication
- 2 Cases: Lethal effects of multiple drugs including lethal dose of fentanyl
- 2 Cases: Methamphetamine intoxication
- 2 Cases: Mixed drug intoxication including methamphetamine and heroin
- 1 Case: Mixed heroin and Oxycodone intoxication
Drug-Related Deaths in Yavapai County

Commonalities of Decedents

identified by the Overdose Fatality Review Board
Behavioral Health

8 of 9 had a reported mental illness

4 of 9 had a diagnosed Severe Mental Illness
Substance Abuse Treatment

7 of 9 had received outpatient treatment
5 of 9 had received inpatient treatment

2 of 9 had received Medication Assisted Treatment
1 of 9 came to Yavapai County for treatment
Employment & Housing

8 of 9 were unemployed at time of death

7 of 9 were homeless at time of death
Family History of Substance Abuse

5 of 9 had family members with a history of drug and alcohol addiction

3 of 9 had a significant other who died from a drug overdose
First Drug of Use

6 of 9 used alcohol and marijuana at an early age
Health Issues

5 of 9 had significant medical issues
Prescription Opioids

7 of 9 were prescribed opioids by a doctor at some time
History of Suicide Attempts

3 of 9 had a history of suicide attempts
Criminal History

5 of 9 were on probation or parole at the time of death

5 of 9 had spent time in jail and or prison
Yavapai County Overdose Fatality Review Board

November 20, 2017: Release of Community Report
31 Recommendations

- Substance Abuse and Mental Health Services
- Law Enforcement and Judiciary
- Medical Community
- Prevention
9 Recommendations

Substance Abuse and Mental Health Services

1. Mental health issues have played a role in the majority of reviewed deaths. Continue to expand resources for mental health.

2. Establish swift engagement protocols in the criminal justice system for accessing treatment for offenders. Expand referral sources and treatment options.
   - Yavapai County Reach Out Program

3. Examine additional options for detox from heroin.
   - Cause of Death: Methamphetamine Intoxication
Substance Abuse and Mental Health Services Recommendations

4. Advocate for the proper application of medication assisted treatment, including drug testing and behavioral therapy.
   - State Targeted Response Grant

5. Strengthen exit strategies from residential treatment and/or sober living environments.

6. Strengthen exit strategies and services provided to patients diagnosed with Severe Mental Illness.
7. Promote crisis treatment services in Yavapai County, including Terros Health Crisis Team; Spectrum Healthcare Crisis Team; and the West Yavapai Guidance Clinic Crisis Stabilization Unit.

8. Paramedics/First responders on the Overdose Fatality Review Board have gone on multiple emergency calls involving several of the decedents. When first responders go on calls, the addict is often asking for and wanting help. Develop and establish swift engagement for treatment protocols.

9. Increase access to family treatment for those engaged with Department of Child Safety.
10 Recommendations
Law Enforcement and Judiciary

1. Develop protocols to ensure law enforcement/first responder safety. For example, utilize gloves at all death scenes. In two of the cases reviewed, the source of fentanyl in the deaths had not been determined and could have caused lethal harm to the officers.
   - #1 Recommendation implemented in 2016 - 2017

2. Establish protocols for testing unknown substances or suspected counterfeit prescription drugs that are present at an overdose death scene when possible.
   - #2 Recommendation Implemented in 2017-2018

3. Insure that information from the county jail and/or arresting officer (i.e. drugs on a person’s body) is available to the judge for the pre-trial release decision.
   - Review of Heroin Deaths
   - Conversation with Judges
4. Officers completing Probable Cause Sheets should add prior knowledge/information on substance abuse for consideration in the case.

5. Amend the Public Safety Assessment tool to include information on current and past drug use to assist the judiciary in making release decisions.

6. Criminal histories from other states in the Public Safety Assessment are often incomplete. The Arizona Criminal Justice Commission needs to explore options for accessing more complete criminal history data from other states.

7. Work with city and town governments to address halfway houses and sobriety homes that have continuing criminal activity.
Law Enforcement and Judiciary Recommendations

8. Increase communication between local law enforcement agencies and Partners Against Narcotics Trafficking in cases involving overdose deaths.

9. Continue targeted investigations into sources and traffickers of drugs into the county.

10. Strengthen mandatory sentencing laws for traffickers of all opioids similar to Arizona’s methamphetamine sentencing laws.
6 Recommendations
Medical Community

1. Explore avenues for patients to be introduced to medication assisted treatment upon release from emergency departments.

2. Promulgate standards of practice regarding opioid prescriptions to individuals using medical marijuana.

3. Improve access for Medical Practitioners to the Medical Marijuana Patient Database when prescribing other medications to the patient.
4. Encourage Medical Practitioners to utilize the Controlled Substance Prescription Monitoring Program on a consistent basis.

5. Encourage Medical Practitioners to limit opioid prescriptions, particularly when the patient has a history of substance abuse.

6 Recommendations

Prevention

1. Increase prevention messaging throughout the state regarding all drugs.

2. Expand education for parents and youth in prevention of drug and alcohol use.

3. Increase access to Naloxone.

4. In one third of the cases reviewed, a significant family member had previously died from a drug-related death. Offer education and possible treatment to family members of drug overdose deaths.
Prevention Recommendations

5. Amend ARS 36-198.C to provide for (1) access to unredacted department incident reports and (2) the confidentiality of all information and records acquired by the local drug overdose fatality review board.

- **House Bill 2038 - Representative Heather Carter**

6. Continue the work of the MATFORCE Overdose Fatality Review Board in order to expand the base of knowledge and make future recommendations.

- Review of additional 12 cases from 2017 to date
- Comparison Report for 2016 and 2017 Drug Related Deaths
Implementation of Action Steps
What have we learned?
A majority of overdose deaths are mixed drug intoxication.

Meth is coming back with a vengeance:
- In 2016 more people died from meth intoxication than heroin intoxication.

There will always be the new drug to be concerned about, i.e., Synthetic fentanyl.

We have to create a culture of not using drugs:
- Stand with Me, Be Drug Free.
THANK YOU!