## Table of Contents

Overdose Fatality Review Board Background, Goals, Members ............................................. 3

Cases Reviewed by the Overdose Fatality Review Board .................................................. 4

Commonalities of Decedents Identified by the Overdose Fatality Review Board ................. 5

Commonalities of Decedents Identified by the Overdose Fatality Review Board ................. 6

Recommendations from the Overdose Fatality Review Board ........................................... 7

  Substance Abuse Treatment and Mental Health Services ............................................... 7

  Law Enforcement and Judiciary .................................................................................. 8

  Medical Community ................................................................................................. 8

  Prevention ............................................................................................................... 9
Yavapai County Overdose Fatality Review Board

The Yavapai County Overdose Fatality Review Board (OFRB) was developed in August 2016, in order to address the Opioid Crisis.

The goal of the Yavapai County Overdose Fatality Review Board is to prevent overdose deaths by:

- Identifying overdose trends in Yavapai County;
- Identifying commonalities in overdose deaths;
- Making recommendations based on OFRB findings;
- Developing action steps that improve policies and programs to prevent overdose deaths.

Members of the Board include representatives from:

- Arizona Attorney General’s Office
- Central Arizona Fire District
- Cottonwood Police Department
- First Things First
- Life Line Ambulance
- MATFORCE
- Partners Against Narcotic Trafficking
- Prescott Police Department
- Prescott Valley Police Department
- Southwest Behavioral & Health Services
- Verde Valley Fire District
- West Yavapai Guidance Clinic
- Yavapai College Police Department
- Yavapai County Adult Probation
- Yavapai County Attorney’s Office
- Yavapai County Community Health Services
- Yavapai County Medical Examiner’s Office
- Yavapai County Public Defender’s Office
- Yavapai County Sheriff’s Office
- Yavapai County Superior Court
- Local pharmacists

The OFRB reviews selected, unintentional overdose cases. The OFRB examines the Medical Examiner’s report, police report, mental health history, medical history and the legal history of the decedent.

When possible the family is interviewed to gather additional information on drug and alcohol use history, employment, education, family dynamics, etc. The responding police officer also attends the OFRB review when possible.

Based on the information obtained the OFRB develops recommendations.
Cases Reviewed by the Overdose Fatality Review Board

From January to June 2017, nine overdose death cases were reviewed by the Yavapai County Overdose Fatality Review Board.

Demographics for 9 Overdose Cases Reviewed

Location of deaths:

- 3 Deaths in Prescott
- 2 Deaths in Cottonwood
- 2 Deaths in Prescott Valley
- 1 Death in Mayer
- 1 Death in Black Canyon City

In the nine deaths, the causes of death as listed by the Medical Examiner are as follows:

- 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

**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

**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

**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

**Employment & Housing**
- 8 of 9 were unemployed at time of death
- 7 of 9 were homeless at time of death

Please Note: This information is a snapshot of the total deaths and is not inclusive of all overdose deaths in Yavapai County.
History of Suicide Attempts

3 of 9 had a history of suicide attempts

First Drug of Use

6 of 9 used alcohol and marijuana at an early age

Drug-Related Deaths in Yavapai County

Commonalities of Decedents identified by the Overdose Fatality Review Board

Prescription Opioids

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

Health Issues

5 of 9 had significant medical issues

Please Note: This information is a snapshot of the total deaths and is not inclusive of all overdose deaths in Yavapai County.
Recommendations from the Overdose Fatality Review Board

Based on the review of the nine cases, recommendations were developed addressing:

1. Substance abuse treatment and mental health services
2. Law enforcement and judiciary
3. Medical community
4. Prevention

The MATFORCE Board of Directors, with the members of the Overdose Fatality Review Board, recommends that Yavapai County pursue the following strategies:

**Substance Abuse Treatment 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 services.

2. Establish swift engagement protocols in the criminal justice system for accessing treatment for offenders. Expand referral sources and treatment options.

3. Examine additional options for detox from heroin.

4. Advocate for the proper application of medication assisted treatment, including drug testing and behavioral therapy.

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 responded to 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 for first responders.

9. Increase access to family treatment for those engaged with Department of Child Safety.
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.

2. Establish protocols for testing unknown substances or suspected counterfeit prescription drugs that are present at an overdose death scene when possible.

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.

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.

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

9. Work to reduce local supply of drugs by targeted investigations into sources and traffickers of drugs into the county.

10. Strengthen mandatory sentencing laws for traffickers of heroin and other opioids similar to Arizona’s methamphetamine sentencing laws.

Medical Community

1. Encourage Medical Practitioners to utilize the Controlled Substance Prescription Monitoring Program on a consistent basis.

2. Encourage Medical Practitioners to limit opioid prescriptions, particularly when the patient has a history of substance abuse.
3. Encourage Medical Practitioners to limit opioid prescriptions for the treatment of chronic pain.

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

5. Promulgate standards of practice regarding opioid prescriptions for individuals using medical marijuana.

6. Improve access for Medical Practitioners to the Medical Marijuana Patient Database when prescribing other medications to the patient.

**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.

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.

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

**Did you know?**

As part of the State of Emergency, Dr. Christ from ADHS signed a statewide standing order for naloxone.

Anyone can go directly to a pharmacy and get naloxone – the standing order is the prescription and insurance covers the cost.