



## Indiana Drug Overdose Fatality Review

### KEY POINTS

Overdose was the leading cause of preventable injury death in 2008 in the United States.

Overdose Fatality Reviews (OFRs) are a multiagency, multidisciplinary approach to understanding the epidemiology and preventability of deaths related to drug overdose.

OFRs assess local overdose death cases and develop strategic policy recommendations based on identification of preventable risk factors and missed opportunities for intervention.

OFRs are a systems-based approach to enhancing local responses to the U.S. drug epidemic.

### Introduction to OFR in Indiana

Drug and alcohol overdose deaths are the number one cause of accidental death in Indiana according to the Indiana State Department of Health (ISDH).<sup>1</sup> The rise reflects a growing problem across the nation and as of 2008, overdose deaths are the leading cause of preventable injury death.<sup>2,3</sup>

OFRs are modeled after child fatality review teams, which debuted in 1978. By assembling multiagency, interdisciplinary teams, customarily including law enforcement, emergency responders, healthcare providers, public health, social services, medical examiners, and others, local fatality review committees assess whether a death could have been prevented.<sup>4</sup> Fatality reviews are now applied to better understand maternal and infant deaths, suicides, and is a commonly used tool in the medical setting to analyze hospital-based deaths.<sup>1</sup>

OFR teams recommend changes that strengthen system processes, communication, and collaborations among entities to affect long-term impacts on public health outcomes. The OFR findings inform agency activities and strategic planning related to overdose prevention at the state and local level.

Maryland was the first state to implement an OFR program, and today there are at least a half dozen additional states with such programs in place. As a result of their OFR program, Maryland has reported improved care referral systems, enhanced services for diverse client needs, and increased knowledge within participating agencies of community resources available to assist at-risk populations.<sup>3</sup> The ISDH developed an OFR pilot program modeled on Maryland's approach and drawing upon Indiana's current Child Fatality Review infrastructure. Researchers from Indiana University Richard M. Fairbanks School of Public Health are working closely with ISDH staff to evaluate the pilot programs, provide recommendations, and assess facilitators and barriers to successful OFR implementation in Indiana. We provide a description of Indiana's OFR process in the rest of this document.

### Overview of OFRs

An OFR team investigates circumstances leading up to an individual's overdose death. It explores the systems a person

contacted throughout his or her life to identify opportunities where improvement to such systems, policies, or services might help prevent future deaths.

The purpose of an OFR is to:<sup>1</sup>

- Identify common patterns among cases of drug-related overdose
- Improve incidence data to accurately record the number of overdose deaths in a county
- Define effective localized strategies for coordinating services related to overdose prevention
- Recommend changes to law, policy, and practice that relate to drug overdoses
- Promote coordination among agencies that investigate drug overdose deaths and provide services to families
- Develop plans for enhancing efforts of organizations that partner in local OFRs

### Operating an OFR

To operate an OFR, a county or region would assemble an interdisciplinary team that ideally consists of the following membership:

- County coroner
- Local pharmacist
- County health officer
- Local department of social services
- Prosecuting attorney representative
- Representative from school systems
- Department of Child Services (DCS) representative
- A state, county, or municipal law enforcement officer
- Pathologist
- Local medical provider/family physician
- The director of behavioral health services in the county
- An emergency medical services provider
- A representative of a hospital

- A health care professional who specializes in the prevention, diagnosis, and treatment of substance use disorders
- Representative of a local jail or detention center
- Representative from parole, probation, and community corrections
- Representative of juvenile services
- Department of Natural Resources (DNR) representative
- A member of the public with interest or expertise in the prevention and treatment of drug overdose deaths, appointed by the county health officer
- Any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer

Jurisdictions have the option to create a multi-jurisdictional team and combine resources. This is helpful for smaller counties and those that often review deaths of residents from neighboring jurisdictions.

All team proceedings are strictly confidential.<sup>1</sup> Except as necessary to carry out the OFR's purpose and duties, members of a local team and any person attending a meeting may not disclose what took place if it is not already public record.

For each case reviewed, team members access the individual's records, including information about physical health, mental health, and treatment for substance use disorder, maintained by a healthcare provider.

### Case Identification and Review

Cases for review are identified by the county coroner from deaths determined to be related to drug or alcohol overdose. Indiana law requires coroners who reasonably suspect the cause of death to be accidental or intentional overdose of a controlled substance to investigate further using available prescription drug monitoring program data and appropriate toxicology testing.<sup>5</sup> Timely death reviews are crucial for capturing the most accurate data and creating effective recommendations. For best practices, case discussion by the OFR should take place within 6 months of the death.<sup>1</sup>

Each case review depends on the quality of the data available to OFR team members, which is often contingent on the amount of interaction the decedent had with various systems. Each team member will query his or her respective agency's database. Data may be collected on an individual convicted of a crime that is related to the cause of death if available. Teams can also solicit the participation of surviving family members to hear their story and to assist with the team's investigation into the death.

Cases are reviewed by the team one at a time, using a process that closely mirrors the Review and Prevention of Child Deaths. The discussion begins with circumstances leading up to the individual's death and moves retrospectively through the person's life noting the history of interactions with various agencies. The team makes a determination to proceed based on the quality of the case information assessed and whether enough data exists to continue the review. This clarification process is meant to determine if all questions related to the case can be answered, and if the investigative reports give the team a clear picture of what caused the overdose. The intention is never to question whether the person or agency handling the investigation of a death made mistakes in some way.

The team examines cases selected for full review by examining the level of service delivery received. Each participating agency presents the data history collected from their organization about the individual. In particular, the team attempts to understand the timelines of services offered to the individual and family, if sufficient referrals were generated, if gaps in service existed, and what missed opportunities were present. Following the study of services, the OFR team determines risk factors by considering

the individual's personal experiences that may have influenced behavior and decision making. Risk factors may fall under a number of categories such as health, socioeconomic status, behavioral and environmental factors, and societal systems and infrastructure.

For each case, the team notes applicable prevention efforts that could have averted the overdose. One of the most significant effects of the OFR program is the opportunity it provides for interagency education and system strengthening, improving the collective knowledge among team members, informing area referral processes, and advancing local collaborative efforts.

### Recommendations Resulting from the OFR

The ultimate goal of OFRs is to use the insights gained from such reviews to improve statewide policies, procedures, and health outcomes. Over time, OFR teams summarize detailed characteristics of cases reviewed, the notable trends, and a list of recommendations with prioritized action steps. Outcomes from case reviews may include implementation of new local interventions, such as naloxone education for family members of people who use drugs, engagement of peer recovery programs in local response efforts, improved use of the prescription drug monitoring program by prescribing physicians, increased prevention efforts and service coordination directed toward families affected by substance use or an overdose, or improved care coordination for those leaving treatment programs. For example, Maryland recognized that when a so-called "pill mill" closes, area overdoses rise as displaced patients often turn to street drugs when their care is disrupted. They provided their OFR teams with education on the phenomenon and came up with ways to improve outreach and care coordination for displaced patients, with a goal of avoiding a spike in area overdose deaths the next time a clinic is closed.

Policy and program recommendations are based on overall data and trends and are applicable to policies at the local and state governmental level. Additionally, the OFR team may acknowledge the need for new project implementation and can identify opportunities for increased collaboration among agencies to reduce operation in silos.

### Conclusion

OFR is a localized tool able to mobilize strong leadership and respond to community-specific patterns related to drug overdose deaths. Although overdose is a difficult problem experienced on a national scale, changes driven by OFR can address unique challenges at the local level. Ultimately, OFR is a useful model to analyze data, trends, and garner interdisciplinary support to reduce the number of preventable deaths.

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### References

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- <sup>5</sup> Indiana General Assembly (2017). Indiana Code 2017 § 35-48-7-11.1. Retrieved from: <https://iga.in.gov/legislative/laws/2017/ic/titles/035>

### Issue Brief Preparation

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