Pennsylvania Death Review Teams 2023 Annual Report

Office of Drug Surveillance and Misuse Prevention

&

Bureau of Health Promotion and Risk Reduction

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Pennsylvania
Department of Health

Background

Act 101 of 2022 was signed into law on November 3, 2022, and amends the Act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929. Act 101 of 2022, authorizes the creation of county suicide or overdose death review teams and outlines the process for establishing these teams.

A county, or two or more counties, may establish a suicide death review team, an overdose death review team, or both, to collect and examine suicide or overdose fatality information. The goal of this information gathering is to improve community resources and systems of care to reduce suicide and overdose fatalities.

Death review teams must be multidisciplinary and culturally diverse. Professionals and representatives from organizations that provide services or community resources for families in the community are to be included among those death review team members selected. Members of overdose death review teams and suicide death review teams are to be chosen from the categories outlined in Act 101.

County death review teams are required to notify the PA Department of Health (DOH) of their establishment. A death review team is also required to submit an annual report to DOH and publish this report to the Department of Health's or local government's publicly accessible internet website. Additionally, DOH is required to submit an annual report to the Governor and General Assembly summarizing the death review team’s reports and recommendations relating to the reduction of risk of death by suicide and overdose. This report includes information from teams who conducted case reviews between January 1, 2023, to December 31, 2023.

Local Death Review Teams

There are 10 local death review teams who have notified DOH of their establishment. Of these, four teams conducted case reviews and produced an annual report for CY2023. Table 1 outlines the types of teams, lead agency, and status during the January 1, 2023 – December 31, 2023 period.

Table 1: Local Death Review Teams

County	Lead Agency	Overdose Review	Suicide Review	Reviewed Cases in CY2023
Berks	Council on Chemical Abuse and Berks County Office of Mental Health and Developmental Disabilities	X	X	No
Carbon	Carbon Monroe Pike Mental Health and Developmental Services		X	No
Lackawanna	Lackawanna County District Attorney's Office	X		Yes
Lancaster	Penn Medicine Lancaster General Health	X		Yes
Monroe	Carbon Monroe Pike Mental Health and Developmental Services		X	No
Monroe	Monroe County Office of the District Attorney	X		Yes
Northampton	Bethlehem Health Bureau	X		No
Pike	Pike County District Attorney's Office	X	X	No
Tioga	Tioga County Partnership for Community Health	X	X	No
York	City of York Bureau of Health	X	X	Yes

Summary of Local Reports

Death review teams who reviewed cases in CY2023 provided their annual reports to the Department. The following serves as a summary of the reporting teams' case review, decedent characteristics, review barriers, and recommendations. For more information, including detailed information of progress in implementing recommendations locally, please see the death review teams' individual annual reports.

Lackawanna County Overdose Death Review Team

Team Structure

The Lackawanna County Overdose Death Review Team is led by the Lackawanna County District Attorney's Office and membership consists of the following agencies and organizations:

- Dunmore Police Department
- Scranton Police Department
- Lackawanna county Prison
- Pennsylvania State Parole Board
- Lackawanna County Probation and Parole
- Lackawanna County Treatment Court
- Lackawanna County Coroner's Office
- PA Ambulance
- Geisinger Medical Center Emergency Room
- The Wright Center for Community Health
- Lackawanna/Susquehanna Office of Drug and Alcohol
- Lackawanna County Behavioral Health/Disabilities/Treatment
- Lackawanna County Veterans Affairs
- Lackawanna County Office of Youth and Family Services, Outreach Center for Community Resources

Team Background/History

The Lackawanna overdose death review team held its first informational/buy-in meeting in August 2020 and began its initial case reviews in October 2020. Since then, the team has convened monthly to review overdose cases, gather data, and generate recommendations. The team also holds semi-annual data and recommendations meetings focused exclusively on overdose and drug data, as well as data trends and updates related to previous recommendations. These meetings help outline the team's priorities and efforts for the next six months. Because CY2023 was the first year for required reporting, the Lackawanna County Overdose Death Review Team opted to provide information about all cases reviewed by the team from quarter 4 of CY2020 through quarter 4 of CY2023. Table 2 shows the number of cases reviewed each year by the Lackawanna death review team.

Table 2. Number of cases Reviewed by Year by the Lackawanna Overdose Death Review Team

Year	Total
2020*	5
2021	20

2022	20
2023	19
Total	**64**

*Case reviews began in quarter 4, 2020.

Results/Findings and Analysis

Demographics of the reviewed cases:

- 63% of cases were male and 36.9% were female, determined by gender assigned at birth.
- Majority (98.5%) of cases were white and all were not Hispanic or Latino.
- 61% of cases' highest education obtained was a high school diploma or GED.

The following data were captured through case review and may be underreported due to stigma, personal bias, and limited access to data. However, the Lackawanna County Overdose Death Review Team found this information important in developing recommendations for community interventions.

- Approximately two-thirds of decedents (66%) did not have any children under the age of 18 years at the time of the overdose incident.
- Most decedents had a history of arrest (71%), 46% were formerly incarcerated, and 21% had no criminal justice history.
- Of the 56 cases where reported age of first substance use was available, the mean age of first use was 16 years. Age of first use ranged from 10 to 50 years but concentrated on the teenage years.
- Almost all decedents had a known history of substance use disorder or diagnosis (97%).
- Approximately two-thirds of decedents had no known history of receiving social services (62%). Of those who did receive social services, the most common services were Supplemental Security Income (22%) and child Protective Services (10%).
- Sixty-three percent of decedents had experienced trauma or violent events. Decedents were most commonly victims of physical violence (25%), sexual violence (18%), and emotional abuse or neglect (14%).
- Of the 68% of decedents for whom data were available, decedents averaged 5.9 known arrests over their lifetime with a standard deviation of 5.7 arrests. Counts of arrests ranged from 1 to 24.
- 53% of decedents had a history of health conditions. The most common health condition reported was mental health (21%), followed by injuries requiring medical treatment (13%), and chronic illness other than cancer (13%).
- 77% of decedents had a history of mental or behavioral health diagnosis.
- Of the 65 cases where age was reported, the average age at time of overdose death was 38 years old. Ages at time of overdose death ranged from 20 to 63 years and appeared to be evenly spread across this range.

Recommendations

The Lackawanna County Overdose Death Review team reported the following recommendations in their 2020-2023 report. Please note that this list is not inclusive of all

recommendations generated or implemented by the team but provides the most frequent and notable recommendations and achievements.

Improving Systems of Care

- Develop EMS leave behind program, including training for EMS providers, in Lackawanna County.
- Obtain funding for the development of a Lackawanna County Quick Response Team (QRT) to provide outreach and follow-up after a non-fatal overdose.
- Provide follow-up support and resources (including recovery kits) for individuals present at the scene of an overdose.

Community Resources

- Increase provision of evidence-based drug and alcohol prevention programs in Lackawanna County schools.
- Create a harm reduction flier for distribution with accompanying naloxone at Lackawanna County Prison and local rehabilitation facilities.
- Develop a grief resources pamphlet.
- Increase awareness of Lackawanna County fentanyl data and trends.
- Develop and release social media and public relations campaigns to decrease stigma and increase education/awareness regarding SUD, fentanyl, “One Pill can Kill,” harm reduction, etc.
- Obtain funding for expansion of police drug enforcement efforts to decrease drug supply.
- Increase post-incarceration/re-entry programming, support, and services.
- Increase training and programs to make the community more trauma informed.
- Increase affordable and suitable housing options for people with SUD.

Improving Sources of Information

- Identify gaps in data provided at death review team meetings and seek the addition of new agency members to fill those gaps.
- Develop more effective data reporting methods related to fatal overdoses and recent release from prison.
- Develop and implement next-of-kin (NOK) satisfaction survey to improve the NOK interview process and increase the quality and quantity of family member information contributed to reviews.
- Increase awareness and utilization of the naloxone by mail program.

Improving Legislation, Policy, and Practice

- Decriminalize fentanyl testing strips.
    - Note: this was accomplished statewide through PA Act 111 of 2022. For more information, please see: https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2022&sessInd=0&act=111 .
- Increase access to fentanyl testing strips throughout the community.
- Implement Medication Assisted Treatment (MAT) program within Lackawanna County Prison.
- Obtain naloxone for Lackawanna County Detective Division.

- Ensure all Lackawanna County law enforcement officers have access to naloxone and naloxone training.
- Distribute recovery kits in Lackawanna County emergency rooms.
- Increase use of naloxbox/naloxone vending machines to increase public access to naloxone (particularly in high-activity drug areas and with the homeless population).

Local Progress

The team has implemented several activities as a result of the recommendations, please see their full report for additional details. The Lackawanna County Overdose Death Review Team's 2020-2023 report can be requested by emailing Kim Potter (potterk@lackawannacounty.org).

Barriers

Throughout their three and a half years of implementation, Lackawanna County Overdose Death Review Team has encountered and mitigated several barriers. The most common challenge faced were concerns about confidentiality, particularly when the team operated prior to supporting legislation being passed in Pennsylvania. The team also used confidentiality agreements, data sharing agreements, interagency affiliation agreements, and next-of-kin consent to mitigate confidentiality concerns. Additionally, during the COVID-19 pandemic, the team also navigated virtual convenings due to stay-at-home orders and implemented new policies and procedures, identified and secured a HIPAA-compliant virtual platform, and added additional safeguards for case reviews to mitigate the unique considerations of virtual convening. Other barriers included limited access to timely and comprehensive data on overdose fatalities, competing priorities and staff turnover of team members, logistics of implementing a variety of recommendations from less intricate short-term initiatives to complex long-term projects, and maintaining long-term buy-in and participation from key partners.

The Lackawanna County Overdose Death Review Team's 2020-2023 report can be requested emailing Kim Potter (potterk@lackawannacounty.org).

Lancaster County Overdose Death Review Team

Team Structure

The Lancaster County Overdose Death Review Team is led by Penn Medicine Lancaster General Health and membership consists of the following agencies and organizations:

- Pathways Center for Grief and Loss
- Lancaster County Coroner's Office
- Lancaster County Adult Probation and Parole
- Lancaster County Behavioral Health and Developmental Services
- Compass Mark
- School District of Lancaster
- Community Services Group (CSG)
- Lancaster County Children & Youth Agency
- The GateHouse
- Lancaster County Emergency Management Agency
- Lancaster County Prison

- Lancaster Harm Reduction Project

Team Background/History

In 2022, members of Joining Forces, a cross-sector group of individuals and organizations collaborating to reduce deaths from opioids and heroin, and other community partners began planning for a local Overdose Fatality Review (OFR) team. In 2023, the Lancaster County Commissioners officially established this Overdose Death Review Team with Lancaster General Health as the lead agency. The Lancaster County Overdose Death Review Team meets every other month to review cases of overdose deaths and in 2023 the team reviewed a total of 10 fatalities.

Case Inclusion Criteria

In 2023, the team selected cases to review based on the following criteria:

- Geography: Death occurred within Lancaster and decedent was a resident of Lancaster County
- Cause of Death: All deaths involved fentanyl, which is the most common cause of overdose death in Lancaster County.
- Demographics/Risk Factors: The team aimed for diverse representation of sex/gender, race, ethnicity, and age to represent the deaths occurring in Lancaster County. The team ensured that case reviews included the highest-risk groups based on local epidemiologic data (males, Hispanic/Latino or black race, age 25-54).
- Data Availability: Toxicology reports were available, and coroner's investigation was completed. A next-of-kin interview as completed and/or substantial information was available from agency records for review.

Results/Findings and Analysis

- Most of the cases reviewed in 2023 were males, between the ages of 25-54, and white race. These demographics reflect the majority of the deaths in Lancaster County. The team also intentionally selected females and individuals of Black and Hispanic race to ensure their approach was equitable.
- All deaths reviewed in 2023 were caused by fentanyl, alone or in combination with another drug. The toxicology reports also showed that the individuals used multiple substances, including cocaine, methamphetamine, alcohol, marijuana, and xylazine.
- Majority of cases showed evidence of injection (60% of cases reviewed), followed by evidence of snorting/sniffing (30%).
- Most individuals (9 out of 10 cases) were using drugs alone when they died. There was only one case where another person witnessed the drug use that resulted in a fatal overdose and in this particular case, the bystander administered naloxone. In all other cases, it was too late to provide naloxone when the person was discovered.
- Six out of 10 cases had a known nonfatal overdose prior to their fatal overdose.
- Due to legal restrictions on sharing information, complete medical records were not available to the team in 2023. However, based on the coroner's investigation, family interviews, and prison records the team identified that mental health conditions were the most commonly known medical issue for reviewed cases.
- Four cases had a known emergency department (ED) visit in the 12-months prior to death and 7 had an ED visit within 5-years prior to death. Two individuals had known ED visits for a non-fatal overdose in the 12-months prior to death.

- Most individuals (7 out of 10) accessed healthcare services in the 12-months prior to death and all (10 out of 10) accessed healthcare services in the 5-years prior to death. The ED and primary care were the most common services accessed.
- Mental health problems were very common in the cases that were reviewed. Based on prison records, family interviews, and the coroners investigation, the team found evidence that 8 individuals had some history of mental health problems, with depressive disorders (50%) and anxiety disorders (30%) being the most common. Additionally, four individuals had attempted suicide or expressed suicidal thoughts.
- Mental health treatment records were unavailable to the team for the 2023 case reviews. However, from other sources, the team learned that 6 individuals had received some mental health treatment in adulthood, often while in prison. Only 2 individuals had received treatment in the last 12 months prior to death, suggesting that several individuals may have had untreated mental health concerns when they experienced their fatal overdose. In next-of-kin (NOK) interviews, several family members noted that the decedents experienced life stresses, such as job loss or death of loved ones, that may have also affected mental health.
- The team did not have access to medical or social service records and could only gather information about trauma experiences from NOK interviews. The most commonly known trauma experience (40%) was substance abuse in the household. The team noted that due to record access limitations, other experiences were likely not reported or discovered by the team.
- All individuals (10) had a history of involvement with the criminal justice system. All had been arrested (10) and 8 had been incarcerated at least once. At the time of death, none of the individuals were incarcerated and three were known to be on community supervision (probation).
- Many of the individuals had multiple interactions with the criminal justice system. The median number of arrests was 5 while the median number of incarcerations was 6.
- Three of the individuals were employed at the time of their death. The team discovered that some individuals struggled to maintain employment due to issues related to addiction, mental health, and/or criminal justice record.
- The team found evidence that 9 individuals had substance use treatment at some time in their adult life.
- Majority of individuals (80%) experienced periods of abstinence from substance use, often during and after undergoing substance use treatment. Additionally, two individuals had been abstinent for 14 days prior to their death.

Recommendations

The Lancaster County Overdose Death Review team reported the following recommendations in their 2023 report:

<u>Anti-Stigma</u>

- Reduce stigma about substance use disorder and use of medications for treatment, particularly among healthcare providers, individuals who use drugs, and their family members.

Care Coordination

- Strengthen collaboration between primary care, mental health, and substance use treatment and recovery systems so that individuals can receive seamless care for both mental health and substance use disorders.
- Establish a community-wide system that provides case management, peer recovery support, crisis management, and reentry services to help individuals navigate the complex care networks.
- Continue to expand integrated behavioral health services in primary care settings.
- For individuals leaving recovery housing, provide peer navigators or case managers and comprehensive aftercare plans to support their continued recovery.
- Screen patients and clients for social needs that may create barriers to treatment and recovery and connect individuals with appropriate resources.

Corrections

- Create a system to share information about individuals' mental health and substance use concerns across county prisons to improve access to services.
- Upon release from the prison system, connect individuals with peer recovery support and care coordinators to assist with medical, mental health, and substance use treatment services.

Employment

- Implement workplace injury prevention programs and offer comprehensive health benefits for chronic pain management for employees.
- Enhance employment support services for individuals in recovery, including job placement assistance, legal support, skills training, and mentorship programs.

Family Support

- Connect families of overdose victims with support services (including Joining Forces for Children, Safe Families, Compass Mark's Family Services Advocate, and the Post-Overdose Response Team).

Harm Reduction

- Increase availability of naloxone and drug testing strips in a wider range of businesses and other community locations and provide clear education on how to use them to reduce the risk of overdose death.
- Increase naloxone prescriptions by primary care providers.
- Continue to promote the message to "Never Use Alone" and offer resources such as the Never Use Alone national hotline (1-877-696-1996).

Medications for Substance Use Disorder

- Create a system to notify primary care providers about patient overdose deaths to promote evidence-based opioid prescribing practices and SUD treatment interventions.
- Enhance Medication-Assisted Treatment (MAT) access by educating primary care providers about evidence-based MAT options.

Mental Health

- Complete routine mental health screening in primary care and refer patients to mental health services.
- Continue to expand Mental Health First Aid; Question, Persuade, and Refer; and other training to empower family members to recognize and respond to mental health concerns in their loved ones.

Support Services
- Offer recovery support and case management services to individuals who are ineligible for traditional substance use disorder treatment based on the American Society of Addiction Medicine (ASAM) criteria.

School-Based Interventions
- Continue to support school-based interventions for preventing substance use.
- Support students who are witnessing and experiencing trauma from familial substance use or loss of a loved one to overdose.
- Equip parents with resources and tools to recognize and address risk factors for substance use in their children.
- Support and enhance school-based Student Assistance Programs (SAPs) to address concerns about mental health and substance use among students.

Trauma-Informed Practice
- Survey Lancaster County substance use treatment providers to assess current knowledge about trauma-informed practices and policies.
- Train substance use treatment providers in trauma-informed practices.
- Increase the availability of trauma-informed treatment resources and services for individuals with substance use disorder.

Xylazine-Related Interventions
- Offer accessible and affordable wound care for individuals affected by xylazine use and teach individuals how to self-care for wounds.
- Expand education for probation and parole officers on xylazine use and management strategies.
- Update and expand Narcan training programs to include specific information about responding to xylazine-related overdoses.

Local Progress

There are many individual organizations working to implement the recommendations made by the Lancaster County Overdose Death Review team. For more information, see the team's full 2023 report here: https://www.lancasterjoiningforces.org/wp-content/uploads/2024/02/Annual-Report-2023-FINAL.pdf .

Next Steps

The Lancaster County Overdose Death Review Team will continue to meet every other month throughout 2024 to review additional cases of overdose deaths. The team plans to review additional records that were not available in 2023, including, medical, education, mental health, and substance use treatment information, which will add to their understanding and ability to prevent future overdose deaths.

The Lancaster County Overdose Death Review Team intends to share their 2023 annual report widely with Lancaster County Stakeholders who are involved in substance use prevention, treatment, and recovery support. The full Lancaster County Overdose Death Review Team 2023 Annual Report can be accessed here: https://www.lancasterjoiningforces.org/wp-content/uploads/2024/02/Annual-Report-2023-FINAL.pdf .

Monroe County Overdose Death Review Team

Team Structure

The Monroe County Overdose Death Review Team is led by the Monroe County District Attorney's Office and membership consists of the following agencies and organizations:

- Monroe County District Attorney
- Monroe County Probation
- Monroe County Criminal Investigations
- Monroe County Correctional Facility
- Monroe County Children and Youth Services
- Monroe County Housing Authority
- Monroe County Veterans Affairs
- Monroe County Coroner
- Stroud Area Regional Police Department
- Federal Bureau of Investigations, Scranton
- Monroe County Magisterial District Judges
- Pocono Mountain Regional EMS
- Suburban EMS
- Lehigh Valley Hospital – Pocono
- Pennsylvania State Police – Stroudsburg
- Pocono Mountain Regional Police Department
- Carbon, Monroe, Pike Drug and Alcohol
- Carbon, Monroe, Pike Mental Health and Developmental Services
- Pyramid Healthcare
- Brookdale Recovery
- Justin's House for Men
- Applegate Recovery
- Pathstone Corporation
- East Stroudsburg University
- New Perspectives
- Primecare
- Northbound and Company
- Community Care Behavioral Health
- St. Luke's University Health Network
- Wilkes Barre VA Medical Center
- Monroe County Commissioners

Cases are selected by a selection committee consisting of the following agencies and organizations:

- District Attorney
- Coroner
- Probation and parole
- Single County Authority (Carbon, Monroe, Pike Drug and Alcohol)
- Pyramid Healthcare
- Northbound and Company

Team Background/History

The Monroe County Overdose Death Review team was established in November 2022 and met in January, March, May, June, September, and November in 2023. The selection committee can choose one or two decedents for each review, based upon the amount of information available at time of case selection. During the review, the team identifies risk factors, missed opportunities, and recommendations. An experienced barrier for the team was lack of participation from local hospitals.

Results/Findings and Analysis

In 2023, 12 decedents were reviewed. Demographics of the reviewed cases:

- Nine decedents were male and three were female.
- Majority (9) were White, Non-Hispanic.
- A common theme observed among decedents was childhood trauma and lack of support for children and adolescents.
- Additionally, the team discovered a significant lack of communication across different disciplines and resulting in individuals often having to make multiple visits to hospitals prior to death.
- Fentanyl was detected in the toxicology reports of 11 of the 12 decedents, while methamphetamine was present in 5 cases.

Recommendations

The Monroe County Overdose Death Review team reported the following recommendations in their 2023 report:

- Co-response to non-fatal overdoses
- Law Enforcement Treatment Initiative (LETI)
- Leave-behind naloxone for EMS
- Encourage more victim advocacy in domestic violence cases
- Discharge planning from jail (to include providing naloxone and education on harm reduction)
- Encouraged communication across disciplines (medical, treatment, law enforcement)
- Create programs for education in schools / target teen population
- Implement a certified recovery specialist (CRS) program in the jail
- Identify available resources and encourage more resources for co-occurring treatment providers
- Better access to harm reduction materials (fentanyl and xylazine test strips, wound care, etc.)
- Revamp the hospital’s warm handoff program
- Implement a drug court
- Implement a re-entry program

- Implement a treatment program within jail which includes Medication for Opioid Use Disorder (MOUD)
- Provide transportation for individuals to get to and from treatment and support them in recovery
- Identify employers in our community willing to work with the recovery/criminal justice-involved population to help prevent unemployment

Local Progress

The team has implemented several activities as a result of the recommendations, please see their full report for additional details. The Monroe County Overdose Death Review Team's 2023 report can be requested by emailing Kim Lippincott at kliippincott@monroecountypa.gov .

Next Steps

The Monroe County Overdose Death Review team priorities moving forward include working towards closing the gaps in communication across disciplines and encouraging conversations regarding their efforts to better serve their community. The team also encourages partners to communicate with each other outside of case review for a well-rounded, and comprehensive approach to preventing overdoses and helping community members to live a substance-free lifestyle. The team is hopeful that members will work toward educating their agency staff members on identifying risk factors or red flags which may indicate that a person is at risk of overdose.

For more information, please see the Monroe County Overdose Death Review Team's 2023 report. A copy of the report can be requested by emailing Kim Lippincott at kliippincott@monroecountypa.gov .

York County Suicide and Overdose Death Review Team

Team Structure

The lead organization for the York County Suicide and Overdose Death Review Team is the City of York Bureau of Health. The steering committee consisting of the following roles and individuals:

- Chair: Pam Gay, York County Coroner's Office
- Facilitator: Dr. Matthew Howie, WellSpan Health
- Coordinators: Samantha Zahm, City of York Bureau of Health and Brittany Shutz, York Opioid Collaborative
- Data manager: City of York Bureau of Health

Committee members and partner agencies included:

- City of York Bureau of Health
- Persons with Lived/Living Experience
- UPMC in Central PA
- WellSpan Health
- WellSpan Philhaven, Behavioral health

- York County Children, Youth and Families
- York county Coroner's Office
- York County Department of Emergency Services, 911 Communications
- York County District Attorney's Office
- York County Human Services
- York County Prison
- York County Probation Department of Adult Services
- York Opioid Collaborative
- York/Adams Drug and Alcohol Commission
- York/Adams Mental Health – Intellectual and Developmental Disabilities (MH-IDD)

The team is multidisciplinary with members who can either share case-level data about the decedent and/or contribute their expertise in analyzing the available data.

Team Background/History

The York County Suicide and Overdose Death Review Team was created through a partnership involving the City of York Bureau of Health, the York Opioid Collaborative, and the County of York Offices of the Coroner and District Attorney. The City of York Bureau of Health received Overdose Data to Action (OD2A) funding in January 2020. Within the first two years of this funding, York worked to build capacity with stakeholders interested in collaborating on the OFR Team. York County established its OFR Team in 2021 in partnership with key community members and representation from various key organizations.

The team finalized the affiliation agreement, confidentiality agreement, meeting confidentiality acknowledgment, roles and responsibilities, process, procedures, and various templates before the first case review on June 1, 2021. Stakeholders were recruited, processes and protocols were developed, and confidentiality documents were created. Between June 2021 and December 2023, 14 case review meetings were convened, during which the team reviewed two cases bimonthly—one accidental and one suicide. In each case review, the team identified opportunities for improvement in their local systems aimed at assisting individuals with substance use disorders and their families.

Fatality Review Process

Currently, it is not feasible for the team to review every overdose in its local jurisdiction; therefore, a systematic process is used to examine and investigate the underlying causes of overdose fatalities and work on practical solutions:

1. Case selection and gather data
2. Review cases
3. Make recommendations
4. Change systems

Case Inclusion Criteria

- Drug overdose deaths where the death certificate and/or the coroner or medical examiner report indicates that acute drug toxicity was directly the cause of death.
- Drug overdose deaths of unintentional or undetermined intent.
- Deaths where the manner of death is accident, suicide, or undetermined related to drugs.

- The manner of death is the circumstance that led to the cause of death. The Commonwealth of Pennsylvania recognizes five manners of death – Homicide, Suicide, Accident, Natural, and Undetermined.

Case Exclusion Criteria

- Decedents who were under the age of 21 years, as these cases are reviewed by the local child death review team under the Public Health Child Death Review Act.
- Cases under active investigation and litigation.

Results/Findings and Analysis

From June 2021 to December 2023, 31 total cases were reviewed. Of these cases, 19 were accidental and 12 were suicide by drug. Among all cases reviewed, the average age was 40 years.

Characteristics of overdose fatalities:

- Males (11) and females (8)
- Majority white (17), one Hispanic, and one bi-racial
- Average age of decedent at the time of death was 33 years.
- Majority of the people who died from an accidental drug overdose were never married or single (68.4%).
- Majority of people who died from a drug overdose died in their own home - 15 (78.9%) occurred at residence, 2 (10.5%) at a motel, 1 (5.3%) at a friend's residence, and 1 (5.3%) at a family's residence.
- In over 50% (12) of reviewed cases, mixed substance toxicity was reported as the cause of death, with fentanyl and/or morphine being present in all fatalities except one.
- Over 80% of the decedents were not born in Pennsylvania (16), with the majority birth state being Maryland, followed by Florida, New York, and Connecticut.

Characteristics of suicide by drug fatalities:

- Males (5) and females (7)
- Majority white (11) and one Black.
- Average age of decedent at the time of death was 52 years.
- Majority of people who died from suicide by drugs died in their own home – 11 (91.7%) occurred at residence and 1 (8.3%) occurred at parent's residence.

Table 3. Year of Death of cases Reviewed by Year by the York County Suicide and Overdose Death Review Team

Year	Total
2014	1
2015	0
2016	1
2017	6
2018	9
2019	1
2020	3

2021	5
2022	2
2023	3
Total	**31**

The team identified the following themes from the deaths that were reviewed:

- History of trauma
- Mental health and/or substance use disorder history
- Resource navigation
- Naloxone access
- Bereavement support services

Barriers

The team identified barriers to effective case review. Before the passage of Act 101 of 2022, the team faced significant barriers due to limited access to case records. However, since the legislation was enacted in November 2022, the main barrier has shifted to how agencies interpret and understand the legislation. Some agencies lack requisite knowledge on the law related to the release of records, which prohibits agencies from releasing information until further interpretation of the law. Additionally, some agencies' interpretation of the legislation continues to impede receiving records.

In York County, there are ongoing challenges in receiving medical records from certain providers. Furthermore, since York County borders Maryland, many decedents who overdosed in York County either resided in Maryland, were former residents of Maryland or received treatment in Maryland and vice versa. The lack of access to records across state lines has also been identified as a barrier, given the county's proximity to the Maryland border.

York County does not have a Next-of-Kin interview process, which also creates limitations on effective case reviews. Additionally, due to the prosecution of drug delivery resulting in death in York County, case selection is restricted until clearance is received from the District Attorney's Office. Although reviews do not interfere with the investigation and are intended to be preventative, this continues to impact the timeframe in which cases are accessed and reviewed. Many cases are not reviewed until at least two (2) to three (3) years after the death unless the case involves a suicide by drug overdose or there is no potential for prosecution within the next five years. When cases are reviewed so long after the death, it becomes challenging to make appropriate recommendations, as there have been significant changes since the time of the overdose death, and the circumstances may not be reflective of current trends.

Recommendations

The York County Suicide and Overdose Team recognizes that eliminating barriers is crucial to help the team be more effective and preventative in nature, as intended by the design of death review teams. In light of the challenges faced by York County, the following recommendations for state agencies were proposed:

- Provide educational materials or bulletins to different agencies based on confidentiality guidelines and the release of records to create uniformity in understanding Act 101 of 2022.
- Establish clear guidelines for county District Attorney's Offices to improve uniformity in proceeding with suicide and/or overdose death review during an active drug delivery resulting in death investigation.
- Establish guidance and direction on sharing data and receiving records from bordering states.

Based on case review, the York County Suicide and Overdose Death Review Team made the following recommendations in their 2023 report:

- Create a referral-to-help card that partner agencies can share with at-risk individuals and their loved ones.
- Crisis Intervention should follow-up after certain patient encounters.
- Offer training and support to first responder agencies in York County. Naloxone distribution to Motels/Hotels.
- Naloxone distribution to patients via health care system.
- Grief support and resources – more grief support for surviving family members, especially children, especially something goes beyond support groups.
- Post Overdose Response Strategy – expanding linkages to care for those who do not go to the hospital post-overdose.

Local Progress

The team has implemented several activities as a result of the recommendations, please see their full report for additional details. The York County Suicide and Overdose Death Review Team's 2023 report is available here: https://www.yorkcity.org/wp-content/uploads/2023/09/York-County-OFR-Annual-Report-2023-WEB.pdf .

Statewide Progress and Resources

The primary purpose of death review is to identify risk factors that contributed to death and missed opportunities for intervention to develop recommendations to prevent future overdoses. There were several commonalities across the four teams who conducted case reviews in CY2023, including opportunities to:

- Improve coordination of care across systems.
- Increase access to and knowledge of harm reduction tools like naloxone and drug testing supplies.
- Reduce stigma and improve knowledge about overdose and response.
- Improve access to the data available to death review teams.

The Department of Health has reviewed the death review team's CY2023 recommendations and will continue to collaborate with state and local partners to implement, improve, and expand programming in response to recommendations. The following initiatives are related to death review team recommendations and are examples of work that is already underway by Commonwealth agencies. Please note, this is not an exhaustive list of the efforts that have been implemented to end the overdose and suicide epidemic in Pennsylvania.

- Access to harm reduction tools:
    - The Department of Health administers a training program, the First Responder Addiction and Connection to Treatment (FR ACT) program, to ensure first responders, public safety professionals, and their agencies have the tools necessary to respond to and fight the overdose epidemic. Training is offered free of charge and is available in all 67 counties in Pennsylvania. The program includes information about naloxone leave behind and examples of how to implement.
    - The Department of Health has published several resources about how to use and access naloxone, resources are available here: https://www.pa.gov/agencies/health/programs/opioids/naloxone.html
    - The Department of Health also maintains naloxone standing orders for both the public and first responders. For more information, visit: https://www.pa.gov/agencies/health/programs/opioids/naloxone.html
    - The Department of Drug and Alcohol Programs implements the Pennsylvania Overdose Prevention Program (POPP). POPP provides free harm reduction and overdose prevention supplies to groups throughout Pennsylvania. POPP offers naloxone and test strips to check drugs for xylazine and fentanyl. For more information, visit: https://www.pa.gov/agencies/ddap/overdose/overdose-prevention-program.html
    - As part of a Lethal Means Safety and Violent Injury Prevention Initiative, the Department of Health provided funding to three (3) healthcare systems to implement a Safe Firearm Storage program in three (3) counties. The program provides gun locks, gun safes and lethal means safety education to those with a firearm(s) in the home. The initiative focused on the Suicide Prevention, Veteran Firearm Safety, and Children & Adolescent Firearm Safety.

- Access to Data:
    - The Department of Health maintains a robust overdose surveillance program and publishes several data products to help inform state and local overdose prevention efforts. For more information, visit: https://www.pa.gov/agencies/health/healthcare-and-public-health-professionals/pdmp/data.html and https://www.pa.gov/agencies/health/healthcare-and-public-health-professionals/pdmp/resource-library.html
    - The Bureau of Justice Administration's Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) provides resources and technical assistance to overdose fatality review teams via the Institute for Intergovernmental Research (IIR). The Department of Health frequently recommends local teams contact IIR for support in implementing best practices for case review. For more information, visit: https://www.ofrtools.org/
    - The Substance Abuse and Mental Health Services Administration (SAMHSA) provides resources and technical assistance to Suicide fatality review teams via the Service Members, Veterans, and their Families (SMVF) Technical Assistance Center. The Department of Health frequently recommends local teams contact SAMHSA for support in implementing best practices for case

review. For more information, visit: https://www.samhsa.gov/smvf-ta-center/suicide-mortality-review

- Education and Stigma Reduction:
    - From April to June 2024, the Department of Health implemented a media campaign in three counties to raise awareness of prescription drug misuse amongst Gen Z audiences and their parent/caregivers. The campaign was placed in counties where data showed opioid dispensations, emergency department visits, and any drug overdose deaths for individuals aged 15-24 were highest.
    - The Department of Drug and Alcohol Programs has implemented a stigma reduction campaign, *Life Unites Us*. This people-forward, research-driven campaign launched in September 2020 and utilizes social media to spread stories of individuals in recovery, their family members, and allies who support those with SUD. For more information about the campaign, visit: https://lifeunitesus.com/
    - In 2024, the Department of Health distributed over 50,000 wound care kits to organizations across Pennsylvania. These kits included necessary supplies to care for xylazine-associated wounds, information about how to use the supplies, and access to care resources. Additionally, the Department of Health collaborated with the Philadelphia Department of Public Health and the Center for Forensic Science Research and Education to implement trainings for clinicians and non-clinicians on best practices for caring for individuals with xylazine-associated wounds. Recordings of the trainings are available at no cost and may be used to fulfill various professional training requirements:
        - Non-clinical training: https://forensiceducation.cfsre.org/product?catalog=Caring_for_People_with_Xylazine_Associated_Wounds_Training_for_Non_Clinicians
        - Clinical training: https://forensiceducation.cfsre.org/product?catalog=Caring_for_People_with_Xylazine_Associated_Wounds_Training_for_Clinicians
    - The Department of Health continues to update overdose response language to include the importance of rescue breathing and reminders that the goal of overdose response is to restore breathing and that individuals may not immediately regain consciousness.
    - From May 2024 through July 2024, the Department of Health implemented a 3-month statewide suicide prevention communications campaign to raise awareness of the 988 Crisis Text Line. Ads were placed on billboards and bus shelters, convenience store digital screens, posters in grocery stores, etc., as well as Digital/Social media ads. The campaign generated nearly 156.2 million impressions and over 133,443 clicks.
    - The US Department of Health and Human Services led a federal Multiagency group to develop the "*2024 National Strategy for Suicide Prevention and Federal Action Plan*". This 10-year, comprehensive, whole-of-society approach to suicide prevention that provides tangible recommendations for addressing gaps in suicide prevention. For more information, visit: http://hhs.gov/nssp

- Linkage to care:
    - The Department of Health recently awarded funding to four harm reduction organizations and three community-based organizations to implement or expand local organization's use of navigators to connect individuals to services, treatment options, and overdose prevention education. For more information, visit: https://www.pa.gov/agencies/health/newsroom/shapiro-administration-invests--3-2-million-to-bolster-overdose-.html
    - The Department of Health also awarded funding to one (1) county Mental Health/Autism/Developmental Program and one (1) Healthcare System to implement a suicide prevention pilot program in two (2) counties. The initiative is aimed at Identifying and supporting individuals at risk by reducing factors that increase risk and increasing factors that promote resilience among disproportionately affected populations. Grantees are required to implement evidence-based suicide prevention programming and education services as per CDC's guidelines. For more information on CDC's "*Suicide Prevention Resource for Action*", visit: https://www.cdc.gov/suicide/resources/prevention.html
    - The Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS) oversee several suicide Prevention programs in the Commonwealth including the Commonwealth's 988 Crisis Text Line call centers as well as the federally funded Garrett Lee Smith Suicide Prevention Grant Projects. For more information, visit: https://www.pa.gov/agencies/dhs/resources/mental-health-substance-use-disorder/suicide-prevention.html