Mohave County Overdose Fatality Review

Annual Report 2022

Mohave County Department of Public Health

Overdose Data to Action Program

Mohave County Department of Public Health

Count On Us.

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Acknowledgements

The Overdose Fatality Review (OFR) team is comprised of key subject matter experts from a variety of local organizations. This report would not be possible without the work and dedication of its team members and the following agencies:

- Kingman Regional Medical Center
- Mohave County Sheriff's Office
- Mohave County Jail
- Mohave Substance Treatment Education & Prevention Partnership (MSTEPP)
- Mohave County Medical Examiner's Office
- Bullhead City Police Department
- Lake Havasu City Police Department
- Kingman Police Department
- MAGNET
- Mohave County Department of Public Health
- Arizona Department of Public Safety
- Mohave Mental Health
- Terros Health
- Southwest Behavioral and Health Services
- Kingman Aid to Abused People

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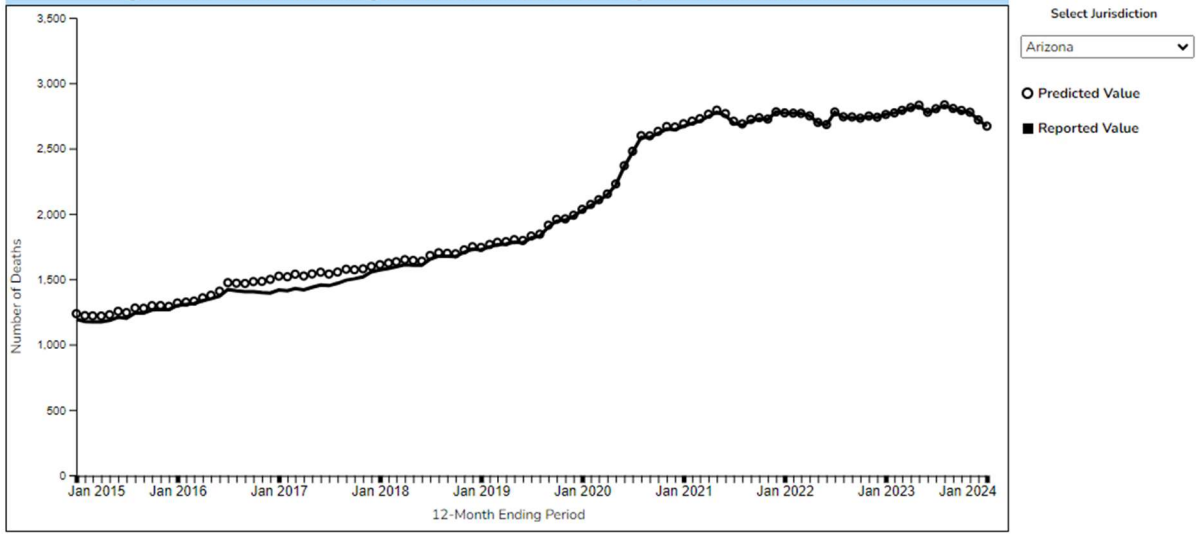
Introduction

During the past decade, the number and rate of drug overdose deaths in Mohave County has risen annually. In 2017, Governor Doug Ducey declared a public health state of emergency in response to the opioid epidemic leading to a heightened approach to addressing opioid misuse and abuse throughout the state. This led to the formation of locally based Overdose Fatality Review (OFR) teams in all counties across Arizona.

12 Month-ending Provisional Number and Percent Change of Drug Overdose Deaths

Based on data available for analysis on: June 2, 2024

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: Arizona



- New data shows overdose deaths involving opioids increased from an estimated 107,573 in 2021 to 109,413 in 2022.
- Overdose deaths from synthetic opioids (primarily fentanyl) and psychostimulants such as methamphetamine also continue to increase in 2022 compared to 2021.
- Drug overdose deaths involving psychostimulants such as methamphetamine are increasing with and without synthetic opioid involvement.
- Drug overdoses impact families, communities, workplaces, and the economy.
- **The drug overdose mortality rate per 100,000 in Arizona for 2022 is 25.8.**

www.cdc.gov

Mission

The mission of the Mohave County OFR Team is to conduct case reviews and gather data to report key trends found in local drug overdose fatalities. The team uses local professionals throughout the county to conduct a detailed review of the circumstances surrounding overdose fatalities. The major purpose of the program is to develop and implement data-driven recommendations for reducing preventable drug overdose deaths.

Methodology

Arizona Department of Health Services sent a list of 68 decedents who had drug overdose (prescription or illicit) listed as their primary cause of death in 2022 to Mohave County Department of Public Health. The Mohave County OFR team selected a sample size of 28 decedents whose cause of death was attributed to prescription or illicit drugs and who had either an accidental or undetermined manner of death.

Requests for records were sent to the medical examiner's office, medical facilities, behavioral health agencies, law enforcement, and emergency medical services. All records received by the OFR Team were reviewed to determine if additional records were needed to analyze deaths and contributing factors.

Using these records, a case narrative was created for each case to be reviewed by the OFR Team. Case reviews examined a person's demographics, psychosocial history, treatment history, medical records, crisis system encounters, and other prominent risk factors associated with drug overdoses.

From this, the team aims to identify missing gaps and opportunities for intervention. The outcome is 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 Mohave County.

There were four, two-hour reviews conducted by the Mohave County OFR Team. Case selection was limited to no more than 10 cases per review meeting. A total of 28 cases were reviewed.

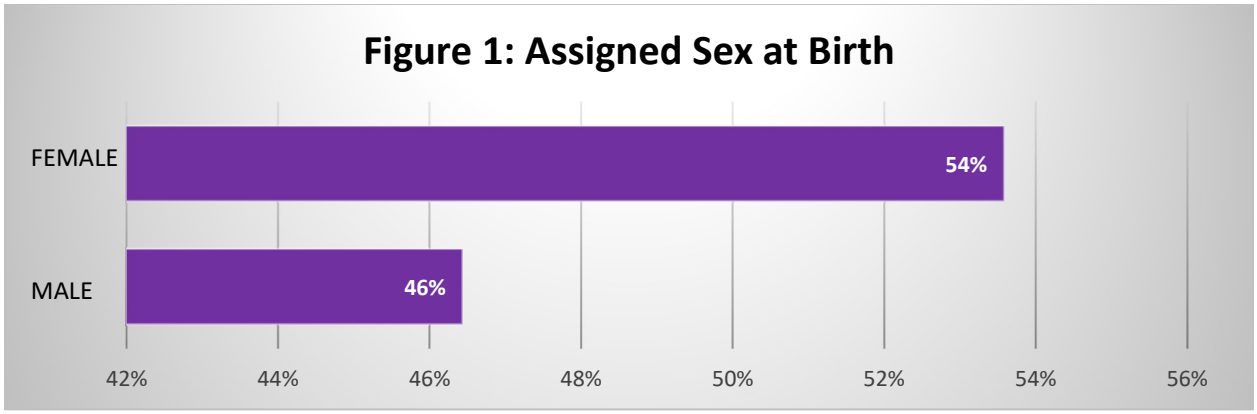
Data Sources

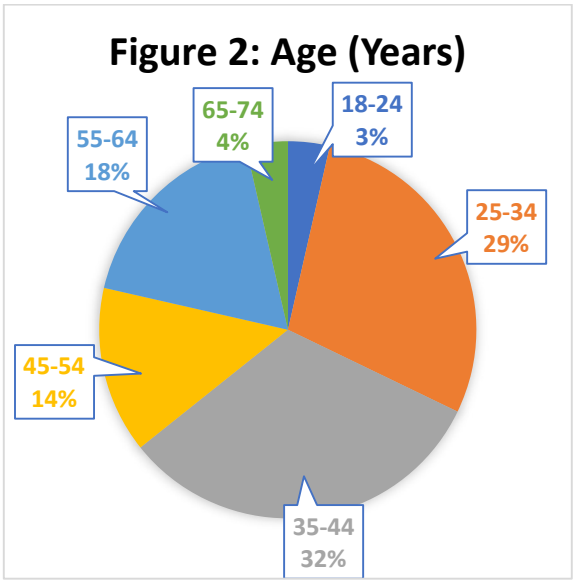
Mohave County Department of Public Health collects data from a variety of sources including medical examiner data, toxicology reports, Controlled Substance Prescription Monitoring Program (CSPMP), pharmacy data, hospital records, Arizona Health Care Cost Containment System (AHCCCS), first responders, law enforcement, and other health care agencies.

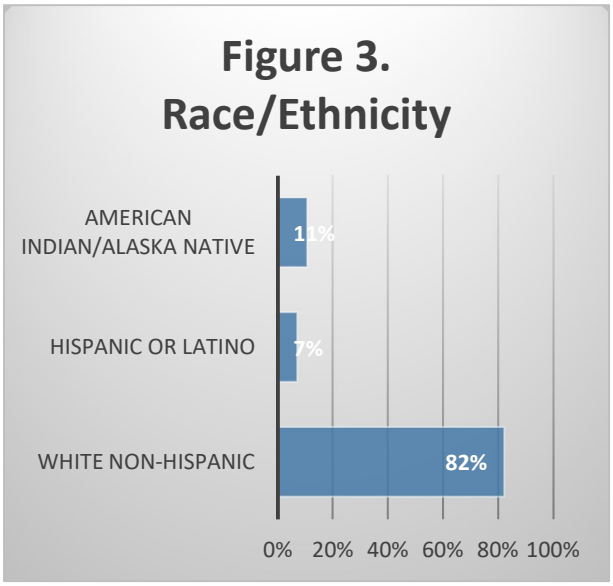
Data Overview

Demographics

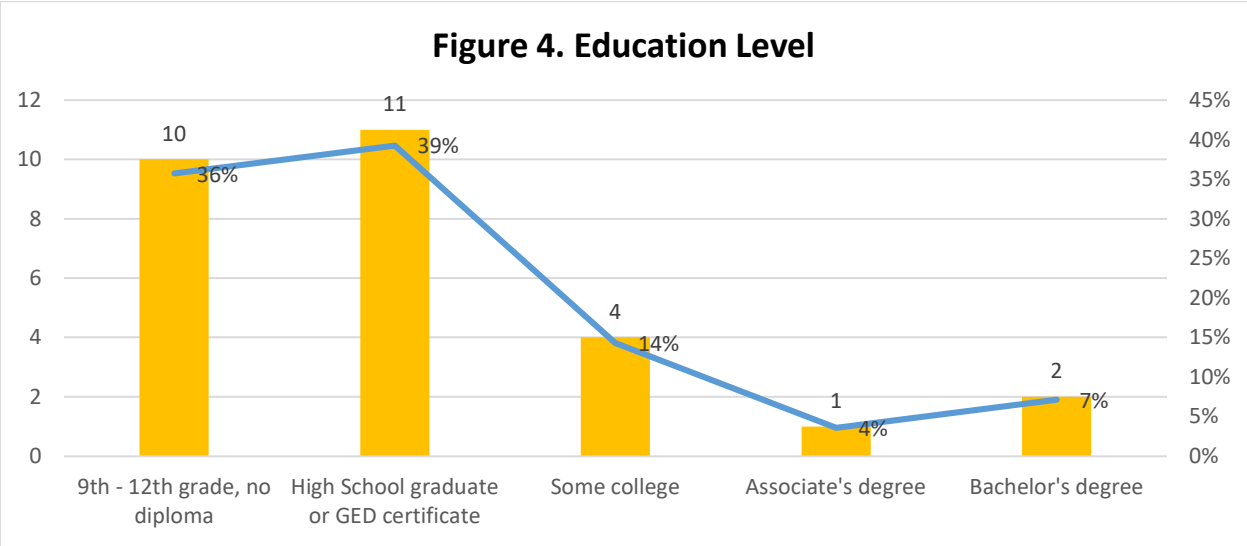
As shown in figures 1-3, more than half of the 28 decedents were female (53.5%). Most of the decedents were in the 35-44 age range (32%) and were white (82%). Additionally, only one of the decedents in our sample had prior military service (4%).

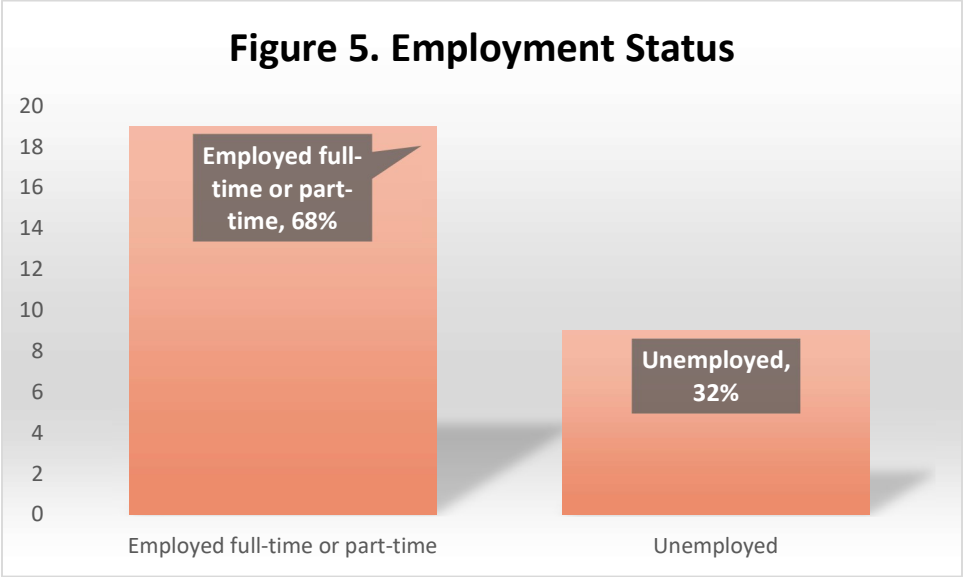






As shown in figures 4 and 5, the majority of decedents in our sample either graduated High School or received a GED certification (39%). Thirty-six percent of decedents had some high school education but did not obtain a diploma or GED. Furthermore, 68% of the decedents were employed compared to 32% that were unemployed.

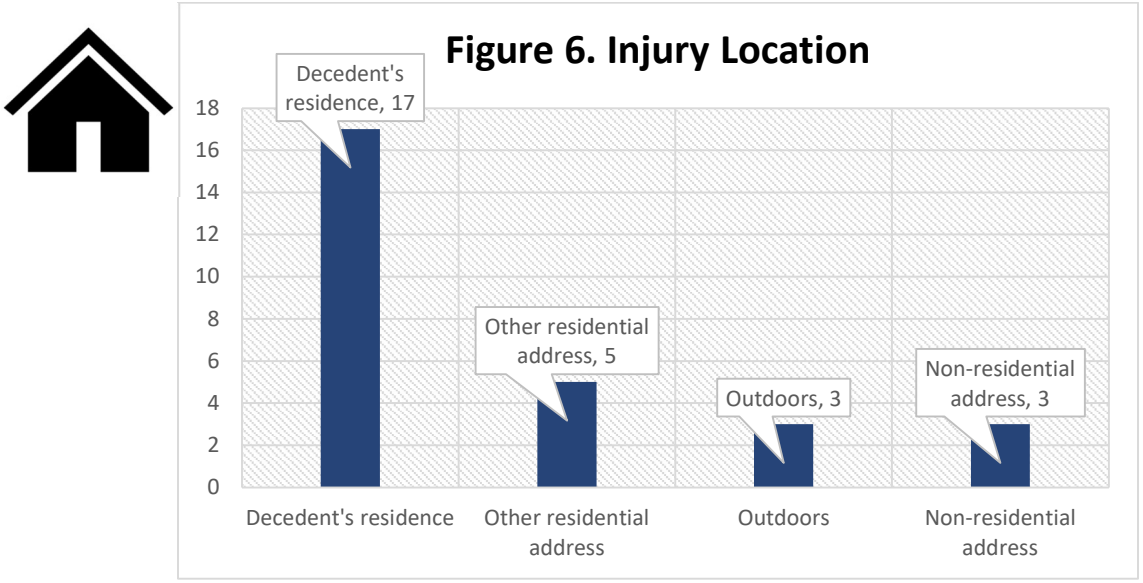


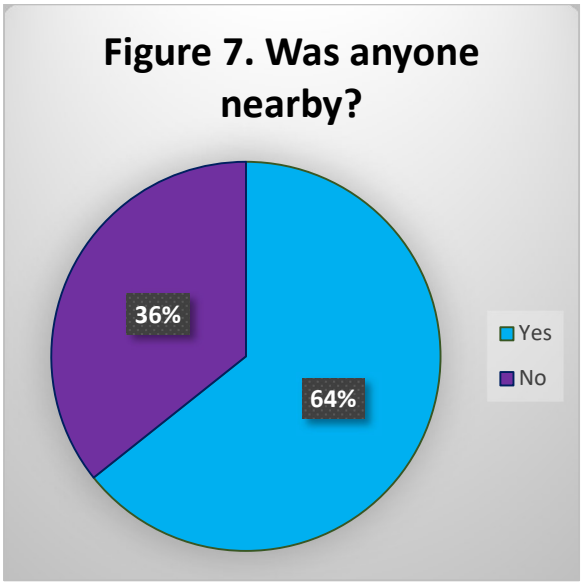


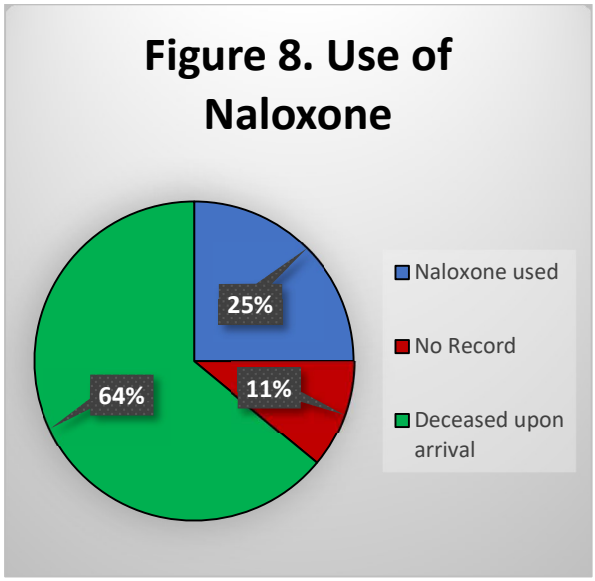
Circumstances

Most of the fatal overdoses occurred at the decedent's place of residence (61%, Fig. 6). In 39% of the cases, the overdoses occurred in another residential location such as the home of a friend

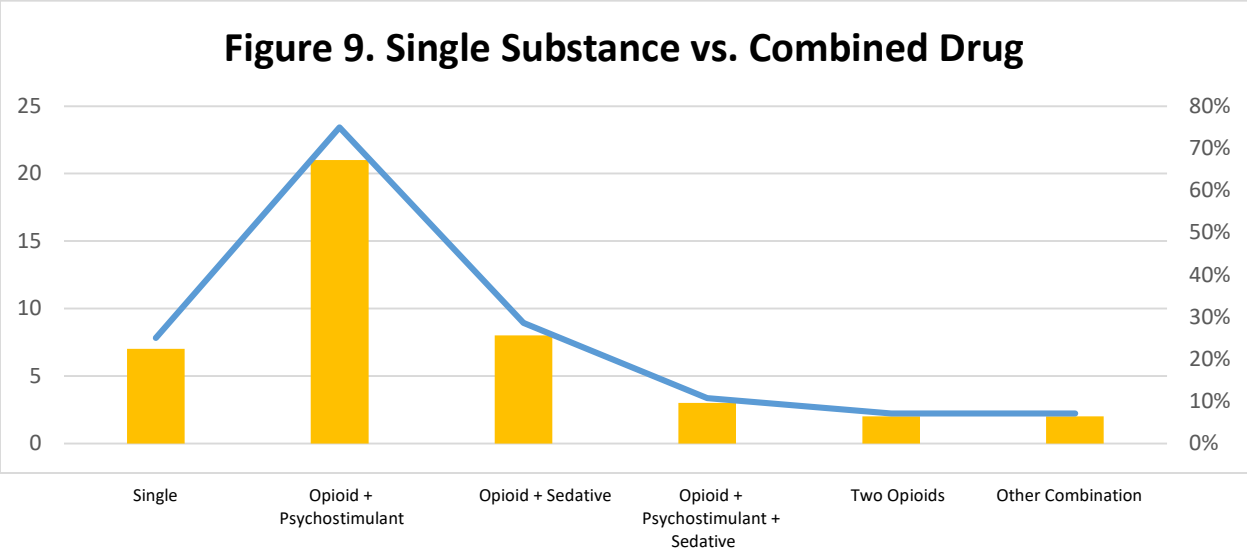
or family member or a public place, outdoor, hospital, or an automobile. More fatal overdoses occurred with other adults present or nearby at the time of death compared to when a decedent was alone (64% vs. 32%, Fig. 7). Naloxone was administered to 25% of decedents (Fig. 8) either by EMS or a bystander. Naloxone was administered to resuscitate from suspected overdose.

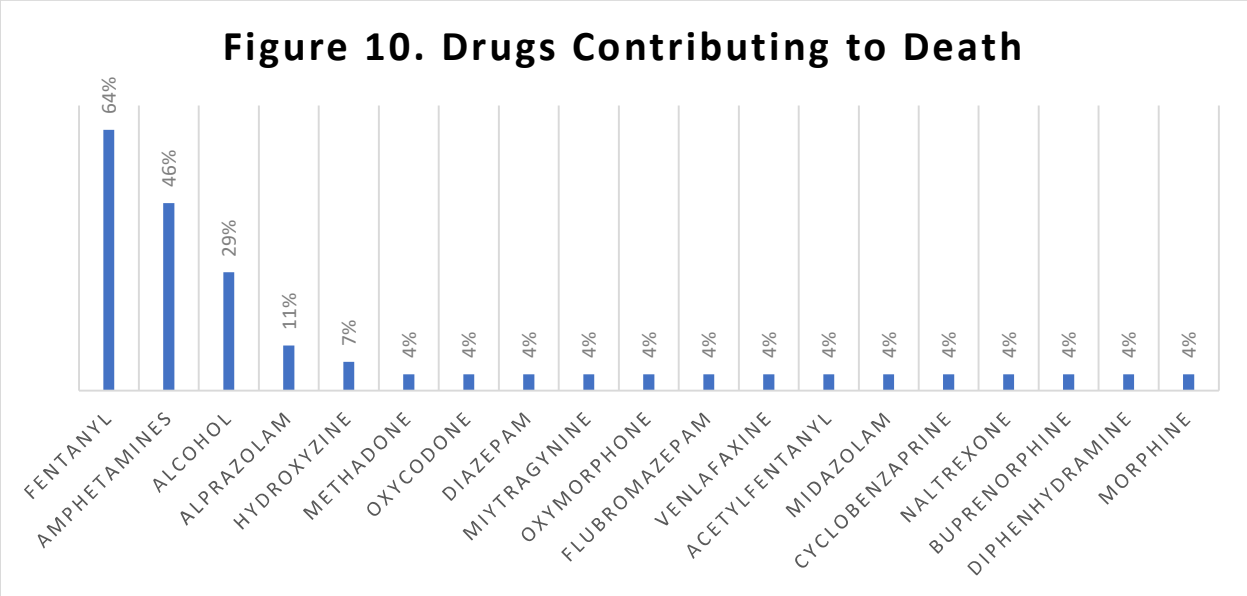






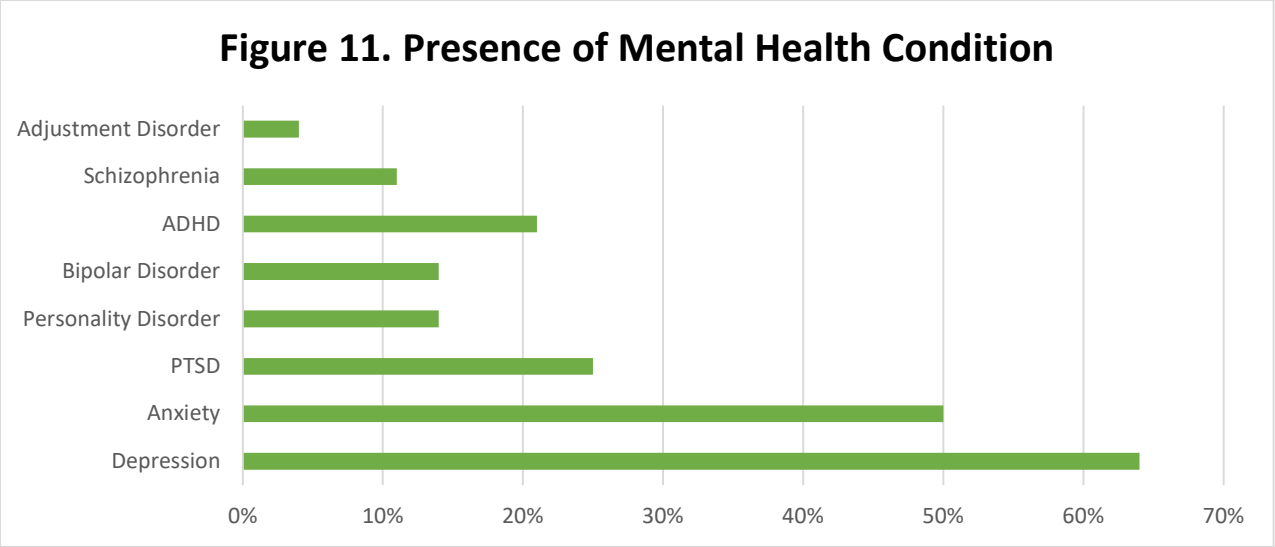
In 75% of the cases, a combination of two or more substances were listed as a cause of death (Fig. 9). Twenty-nine percent of cases involved a combination of opioids and psychostimulants most frequently methamphetamine and fentanyl (Fig. 9). Fentanyl was the most frequently found substance in the overdose deaths reviewed, present in 64% of cases, followed by amphetamines (46% Fig. 10). There was an increase in the presence of fentanyl, while other substances such as heroin and other opioids decreased in 2022 compared to 2021.

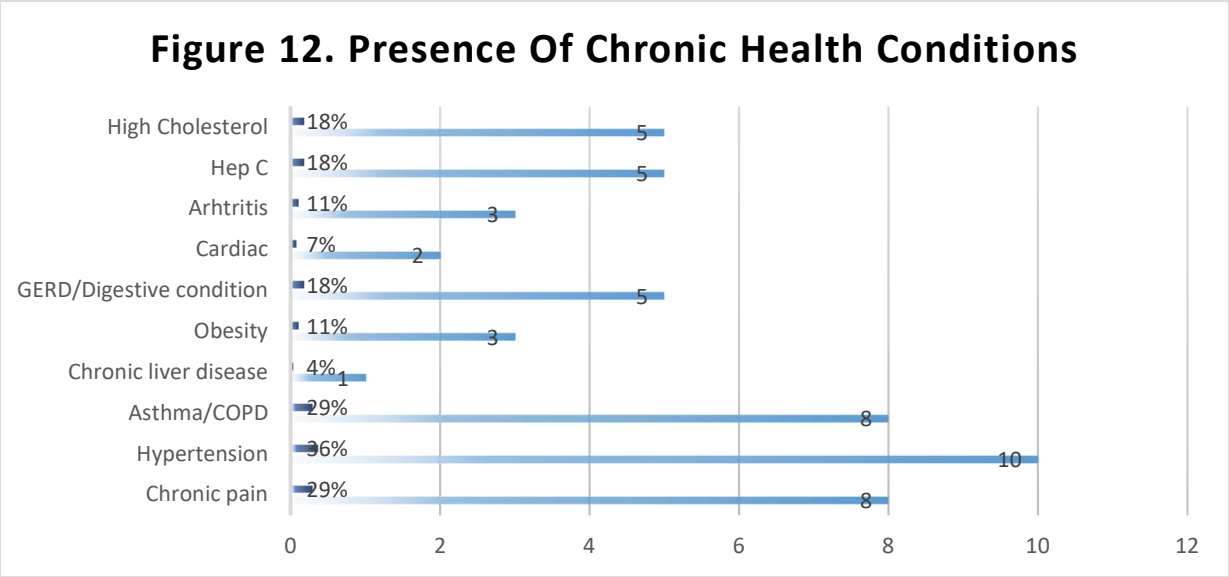




Contributing Factors & Commonalities

Multiple commonalities were noted to be shared among the sample of decedents. Commonalities are defined as shared attributes, circumstances, or life events shared by cases. They provide insight into risk factors and offer opportunities for intervention.





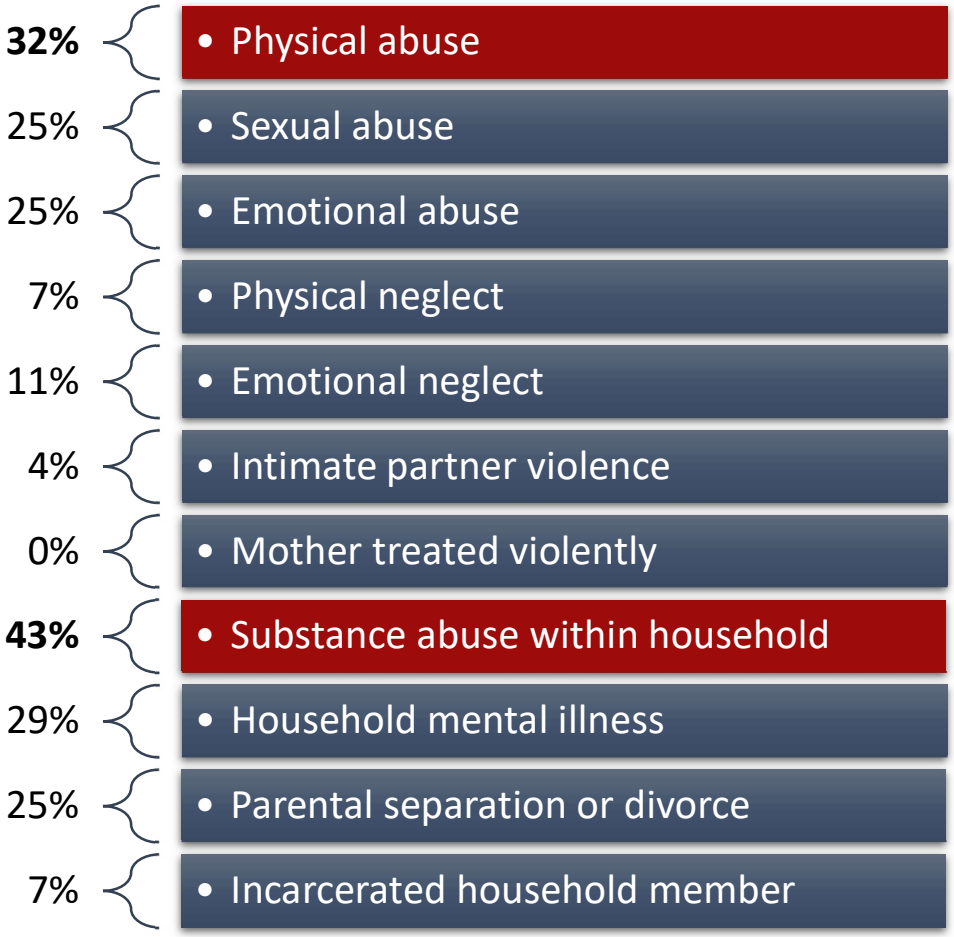
Many of the decedents had a mental health disorder (79%) or a chronic health condition (71%, Figure 11 & 12). Depression (64%) and anxiety (50%) were the most prevalent mental health diagnosis. The most common health conditions were hypertension (36%), chronic pain (29%), and asthma/COPD (29%). These numbers have the potential to be higher due to data limitations. Other attributes include (Table 1):

Table 1. Other Attributes

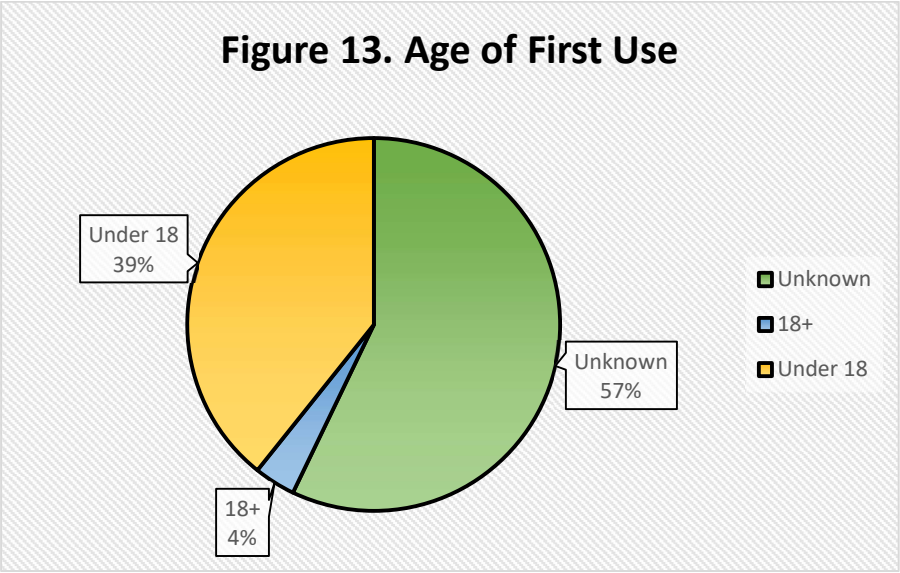
32%	Had a history of suicide ideation.
27%	Had a history of suicide attempts.
18%	Had a history of self-directed violence/injury.
29%	Had behavioral health signs or symptoms in the past 30 days.
64%	Had a behavioral health diagnosis within the past year.
18%	Recent incarceration release (past year).
36%	Had a history of incarceration at any point in their lifetime.
18%	Were homeless or had inadequate housing.

In 2022, we were able to obtain ACEs risk factors from 19 out of 28 decedents (68%). Table 2 shows the percentage of ACEs risk factors, the highest being 43% of decedents had substance abuse within their household growing up, as well as 32% of the decedents experienced physical abuse during their childhood. Additionally, Figure 13 shows the percentage of the decedents' age of first use of any substance, (at least 39% under the age of 18).

Table 2. ACEs Risk Factors



*More than one risk factor may have been identified for each decedent.



Controlled Substance Prescription Monitoring Program (CSPMP)

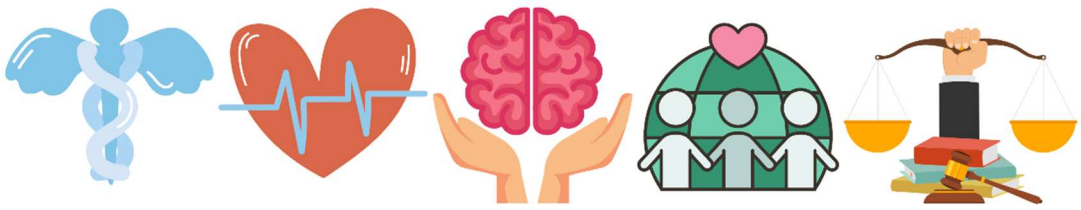
Of the 28 cases reviewed, more than half (68%) of the decedents had a history in the CSPMP. Six out of 19 of those with a CSPMP history had active prescriptions at the time of death, with only two of those having prescriptions that matched the drugs in the cause of death (Table 3).

Table 3. History of Controlled Substance Prescriptions

Characteristic	CSPMP, N (%)
History of prescription(s)	19 (68%)
Active prescription(s) at time of death	6 (21%)
Prescription(s) match drug(s) in COD	2 (7%)

Prevention Recommendations

The Mohave County OFR Team identified prevention recommendations for each of the 28 fatalities reviewed. Table 4 summarizes our recommendations for the sample along with the standardized recommendations.



Prevalence of Prevention Recommendations by Base		
Healthcare	#	%
Enhance capacity and coverage of mental health services (e.g., long-term case management).	2	7%
Enhance capacity and coverage of substance use disorder treatment (e.g., long-term treatment).	4	14%
Improve access to primary care services that include substance use disorder screening, harm reduction education, Medication Assisted Treatment, and referral to treatment.	8	29%
Establish protocols for emergency department and inpatient hospital discharge instructions to include naloxone distribution, connection to peer recovery specialists, case management, and treatment services.	10	36%
Increase patient-specific education of overdose risk associated with age, comorbid conditions, prescription medications, and the use of other substances.	14	50%
Improve care coordination by connecting to social support resources such as housing, employment insurance, transportation, etc.	8	29%
Criminal Justice		
Decrease stigma related to mental health and substance use disorders for incarcerated patients in an effort to increase the number of patients utilizing the available services.	0	0%
Improve care coordination post-release by performing a warm hand-off to substance use disorder treatment, medical care, and mental health services as well as providing social support resources such as housing, employment, insurance, transportation, etc.	7	25%
Increase naloxone distribution from correctional setting post-release.	0	0%
Increase training on evidence-based overdose prevention for corrections health and custody staff.	2	7%
Enhance capacity of drug courts to divert a greater number of individuals with a substance use disorder from incarceration.	0	0%
Crisis Response		
Improve care coordination by connecting to mental health and substance use services (e.g., transport/referral to treatment).	8	29%
Enhance universal training on evidence-based overdose prevention for first responders (EMS, Fire, Law Enforcement, etc.).	0	0%
Increase funding for crisis response teams that offer alternatives to incarceration.	1	4%
Community/Public Health		
Improve access to social support resources such as housing, employment, insurance, transportation, etc.	6	21%
Increase education and awareness of overdose prevention and harm reduction strategies (e.g., naloxone, fentanyl test strips, HIV/HEP C testing).	9	32%
Improve support for individuals with past childhood or adult trauma (e.g., domestic violence, sexual assault, loss of a loved one).	8	29%
Improve support for families who have a loved one with a substance use disorder (e.g., community events, connection to support groups, written materials).	16	57%
Develop social work/case management resources for children directly involved in overdose deaths to identify and treat behavioral health illness related to the death (e.g., PTSD from a parent's overdose death).	8	29%
Fatality Review (if information missing or inadequate)		
Promote best practice for drug-related death investigations.	0	0%
Promote the utilization of the ADHS State Lab comprehensive toxicology testing.	0	0%
Recruit new members to offer valuable insight at the community, system, or policy level.	1	4%

Specific Prevention Recommendations for Mohave County

The top five recommendations (see below) were identified and shared with a variety of community partners to improve and enhance services in Mohave County.

Healthcare

1. Increase patient-specific education of overdose risk associated with age, comorbid conditions, prescription medications, and the use of other substances. (50%)
2. Establish protocols for emergency department and inpatient hospital discharge instructions to include naloxone distribution, connection to peer recovery specialists, case management, and treatment services. (35%)
3. Improve access to primary care services that include substance use disorder screening, harm reduction education, Medication Assisted Treatment, and referral to treatment. (29%)

Community/Public Health

4. Increase education and awareness of overdose prevention and harm reduction strategies (e.g., naloxone, fentanyl test strips, HIV/HEP C testing. (32%)
5. Improve support for families who have a loved one with a substance use disorder (e.g., community events, connection to support groups, written materials). (57%)

Conclusion

With the help of local stakeholders, Mohave County completed its third year of case reviews and created the OFR Annual Report. Deaths that occurred in 2022 were reviewed for this report. The OFR's key recommendations are to increase patient-specific education of overdose risk associated with age, comorbid conditions, prescription medications, and the use of other substances; improve access to primary care services that include substance use disorder screening, harm reduction education, Medication Assisted Treatment, and referral to treatment; establish protocols for emergency department and inpatient hospital discharge instructions to include naloxone distribution, connection to peer recovery specialists, case management, and treatment services; increase education and awareness of overdose prevention and harm reduction strategies (e.g., naloxone, fentanyl test strips, HIV/HEP C testing); and improve support for families who have a loved one with a substance use disorder (e.g., community events, connection to support groups, written materials). The OFR findings and recommendations confirm the importance of collaboration and integrated care that identifies and takes advantage of multiple support services that engage individuals at risk of overdose.

The OFR team is committed to the ongoing analysis that identifies both gaps and prevention opportunities. The Mohave County Department of Public Health and the OFR Team is committed to playing a positive role in reducing overdose deaths and encouraging healing among individuals who suffer from Substance Use Disorder and their families by promoting evidence-based overdose prevention strategies identified by the Centers for Disease Control and Prevention (CDC).