2025

Yuma County Overdose Fatality Review Report

Table of Contents

- Introduction
- Background
- Goals
- Yuma County OFR Team Members
- Methodology
- Summary of Data
- Commonalities
- Recommendations for Prevention
- Conclusion

Background

In April of 2017, Governor Doug Ducey declared a statewide opioid epidemic health emergency. In response to the declaration, Arizona Department of Health Services (ADHS) created a statewide Drug Overdose Fatality Review (OFR) program which supports local county OFR teams, as established under A.R.S. §36-198. This statute grants local counties the authority to request various records from entities such as law enforcement, medical facilities, and court system, with the purpose of reviewing the circumstances surrounding an overdose death. Consequently, the Yuma County OFR Team was established and held its first meeting in August of 2022. This report marks the completion of the third annual review.

Goals

The goal of the Yuma County Overdose Fatality (OFR) Team is to reduce preventable drug overdose deaths by participating in a local multidisciplinary team of professionals and community members to review the details surrounding drug overdose deaths. This collaborative effort with community stakeholders is accomplished by identifying overdose trends, identifying commonalities, developing a better understanding of the factors contributing to drug use, and making data driven recommendations based on our findings.

Yuma County OFR Team members

- Ryan Butcher; Public Relations and Community Engagement Coordinator, Yuma County Public Health Services District
- Benito Lopez; Epidemiologist, Yuma County Public Health Services District
- Cynthia Espinoza; Epidemiologist, Yuma County Public Health Services District
- Berenice Ortiz; Health Care Coordinator B.H.T. / P.S.S. , Transitional Living Center Recovery
- Cody Walden; Investigator, Yuma County Sheriff's Office
- Debbie White; Treatment Supervisor, Yuma County Adult Probation
- Dennis Gasgrow; EMS Training Captain,
- Irene Garcia; Health Educator,
- Jennifer Hulbert; Community Engagement Specialist
- John Abarca; Director of Operations
- Lauren Murphy, OFR Health Program Manager
- Maria Chavoya; Community Relations Representative III, Community Affairs
- Marisella Sanchez; Veteran Support Specialist, Community Medical Services
- Megan Barry, Trauma Program Manager, Onvida Health
- Roxanna Irra, Clinic Manager, Community Medical Services,
- Martha Dominguez, Sergeant/Detention Center, Yuma County Sheriff's Office
- Victoria Gonzalez, Health Services Manager, Yuma County Sheriff's Office

Methodology

Case Identification

Cases determined for review are identified by Arizona Department of Health Services. The Yuma County OFR Team determined specific case criteria for case selection. The team determined to select cases containing autopsy reports (including toxicology), where decedent was over the age of 18, and where the manner of the overdose death was not suicide. Since we were not able to review all overdose deaths we used our selected case criteria, chose cases with the most available information, and other statistical data provided by ADHS to select cases that embodied a true representative sample.

Records Requests

Records were requested and obtained from the medical examiner's office, health care agencies and hospitals, law enforcement, courts, correctional and behavioral health facilities. The team requested as many records as needed to conduct a thorough review, which varies case to case.

Develop Case Overview

Once sufficient records are obtained for a case, a case overview is developed utilizing a template provided by Arizona Department of Health Services. The case overview summarizes the pertinent details surrounding the case, and identifies criteria that is later entered into a data tool for use by Arizona Department of Health Services.

Case Reviews

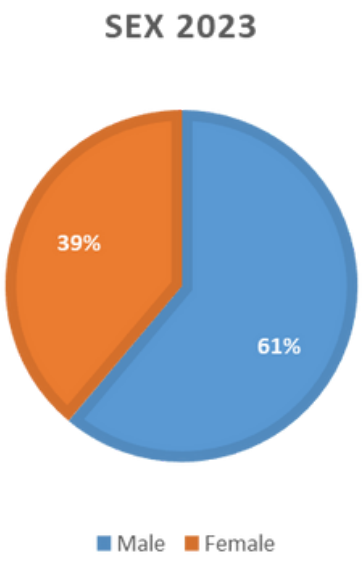
Meeting time and frequency were determined by availability of team members. Case reviews are done with intention of identifying system gaps and/or creating innovative local or state specific overdose prevention and intervention strategies.

Summary of Data

Yuma County 2023

SEX

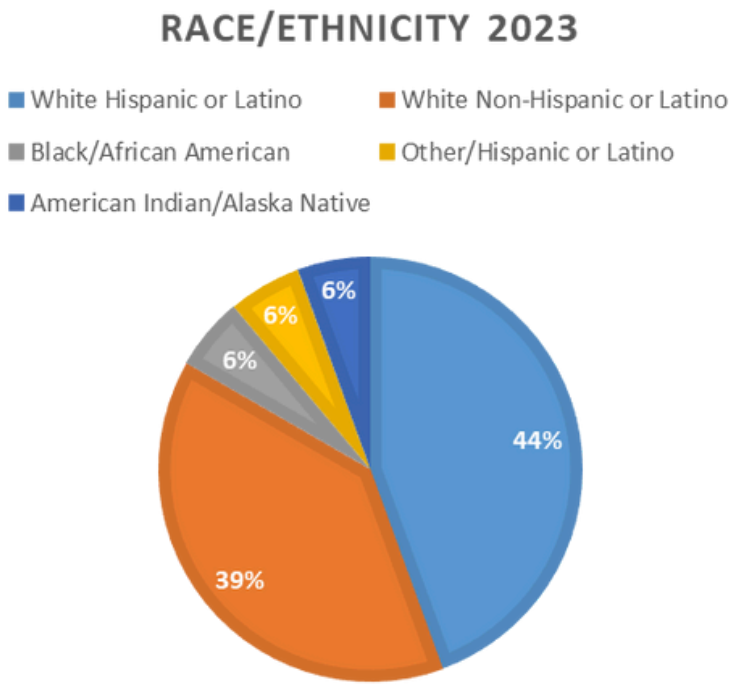
The majority of the 18 overdose fatalities reviewed belonged to males (11 cases), and the remaining cases (7 cases) belonging to females.



RACE/ETHNICITY

Comparing race/ethnicity among the 18 overdose fatalities reviewed were as followed:

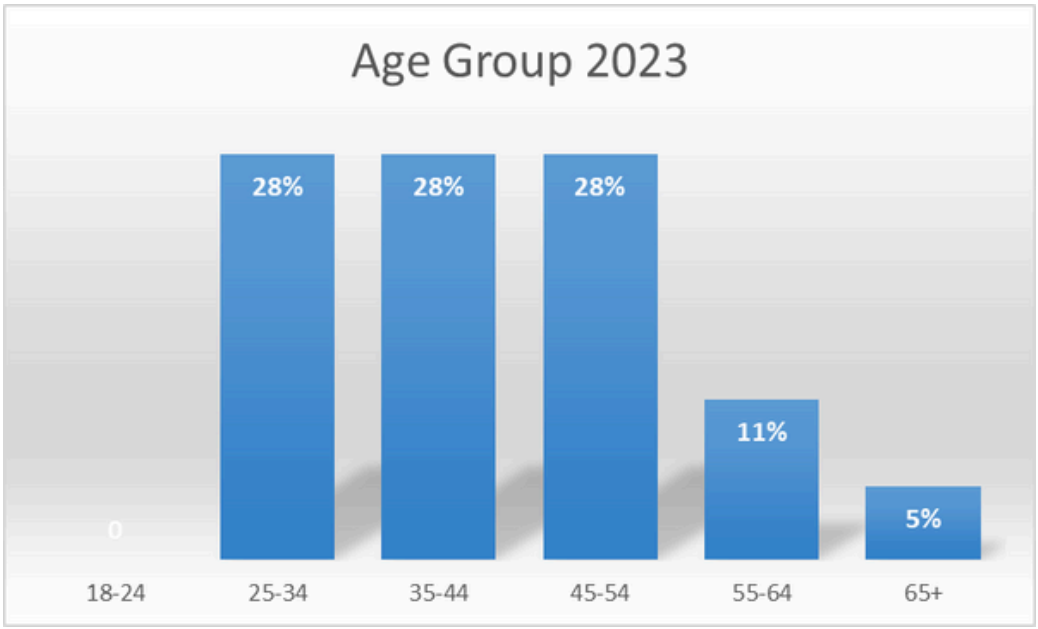
- White Hispanic or Latino (8)
- White Non-Hispanic or Latino (7)
- Black/African American (1)
- Other/Hispanic or Latino (1)
- American Indian/Alaska Native (1)



Summary of Data

Yuma County
2023

AGE



Among the 18 overdose fatalities reviewed, the distribution of age (by age groups) was as described in the six age categories:

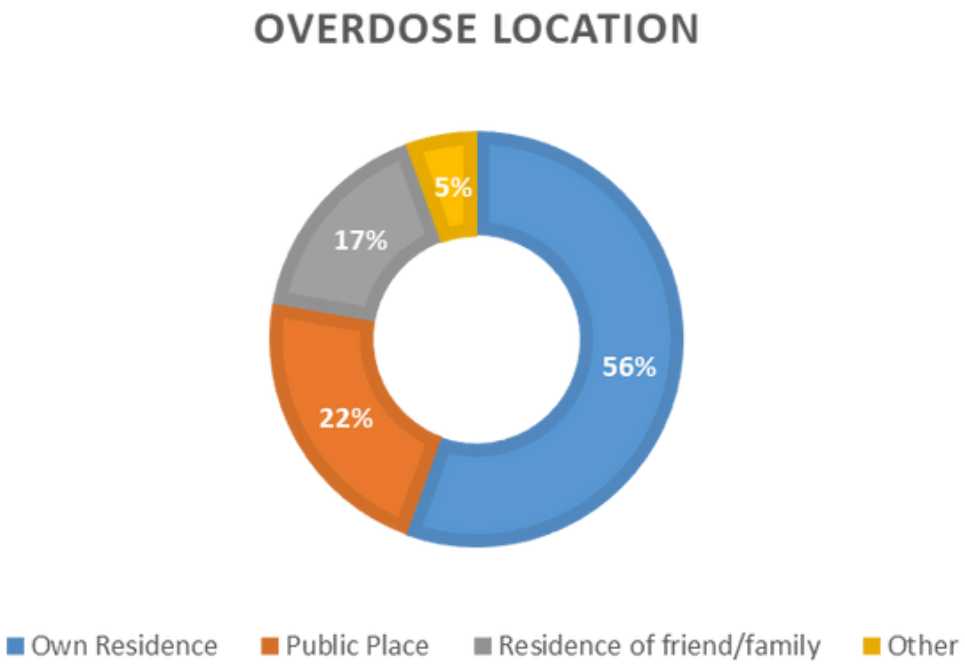
- 18 – 24 years old = 0 cases
- 25 – 34 years old = 5 cases
- 35 – 44 years old = 5 cases
- 45 – 54 years old = 5 cases
- 55 – 64 years old = 2 cases
- 65 years & older = 1 case

- It is important to note that there were cases in every age category except 18-24. Cases with the most sufficient records were selected for reviews. The age categories are not reflective of all cases, but only those selected for reviews.

Summary of Data

Yuma County
2023

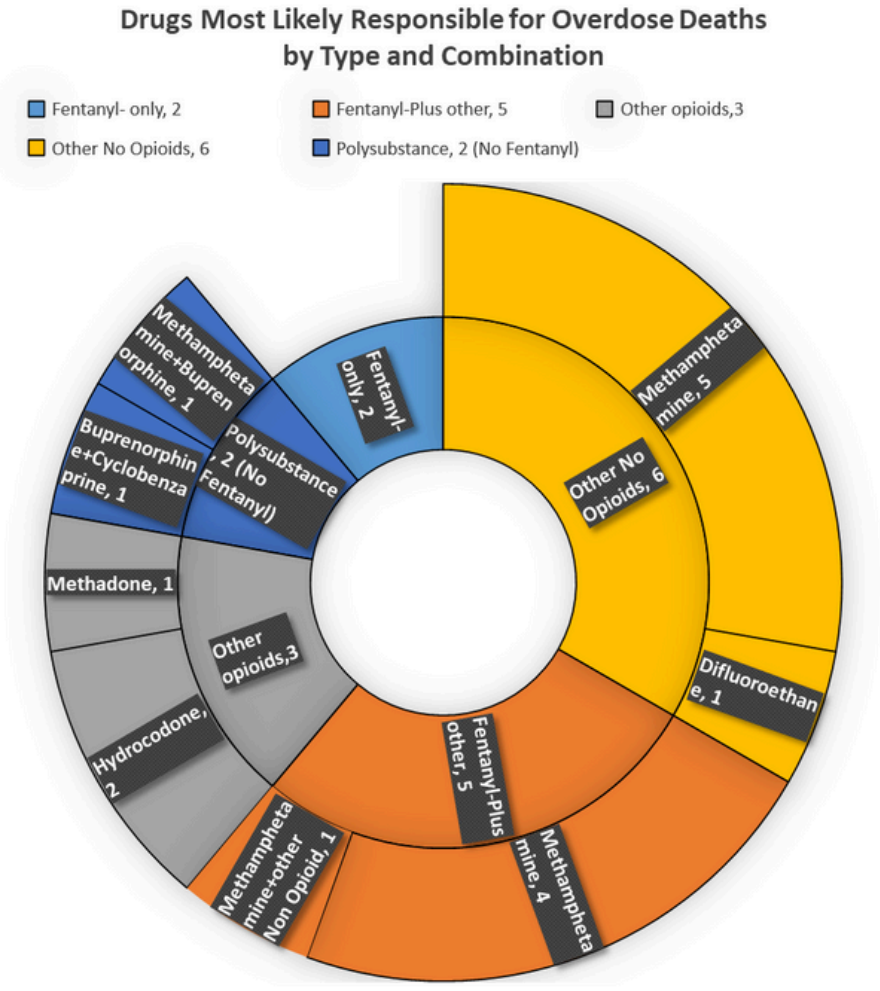
LOCATION



The most frequent injury location for fatal overdoses was the decedent's residence (10). The second most frequent location were public places (4), followed by residential addresses belonging to someone other than the decedent (3). There was one location, listed as other (1), that did not fit any of these criteria.

Summary of Data

Yuma County
2023



All substances were identified through toxicology reports and analyzed during Overdose Fatality Review (OFR) meetings and by the team lead. This graph does not display every substance detected; instead, it highlights those most likely responsible for the overdose deaths.

In some cases, the cause of death is clear, either a single drug is present in the toxicology report, or the responsible substance is listed on the death certificate. In more complex cases, the team conducted a detailed analysis of the toxicology findings, including an assessment of the concentration of each substance detected. Interpretive comments from NMS Labs were also used to distinguish between therapeutic and potentially lethal levels.

For deaths involving multiple substances, the same reference materials were used both to rule out substances unlikely to have contributed and to hypothesize which drug combinations most likely caused the fatal overdose.

Summary of Data

Yuma County
2023

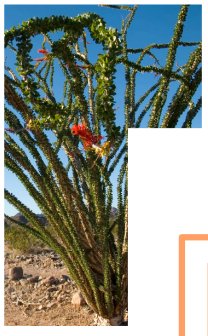
Polysubstance use continues to be the most common trend observed, with 11 of the reviewed cases involving multiple substances that contributed to the overdose death. Among the 7 cases with only one contributing substance, methamphetamine was most frequently involved, appearing alone in 5 cases. Fentanyl was the sole substance in only 2 cases.

Fentanyl was involved in 7 of the overdose deaths. In 2 of these cases, fentanyl was the only substance contributing to the fatality, while the remaining 5 were polysubstance cases. Among those, methamphetamine was the most frequently co-occurring substance. The average fentanyl concentration detected in toxicology reports was 19.6 ng/mL, ranging from 2.6 ng/mL to 83 ng/mL.

Methamphetamine contributed to 11 overdose deaths. It was the only substance involved in 5 cases and part of a polysubstance combination in 6 others. In 5 of those 6 polysubstance cases, fentanyl and/or other opioids were also present. The additional opioids found in combination with methamphetamine included buprenorphine. The average methamphetamine concentration detected was 1,517 ng/mL, with a range from 26 ng/mL to 7,100 ng/mL.

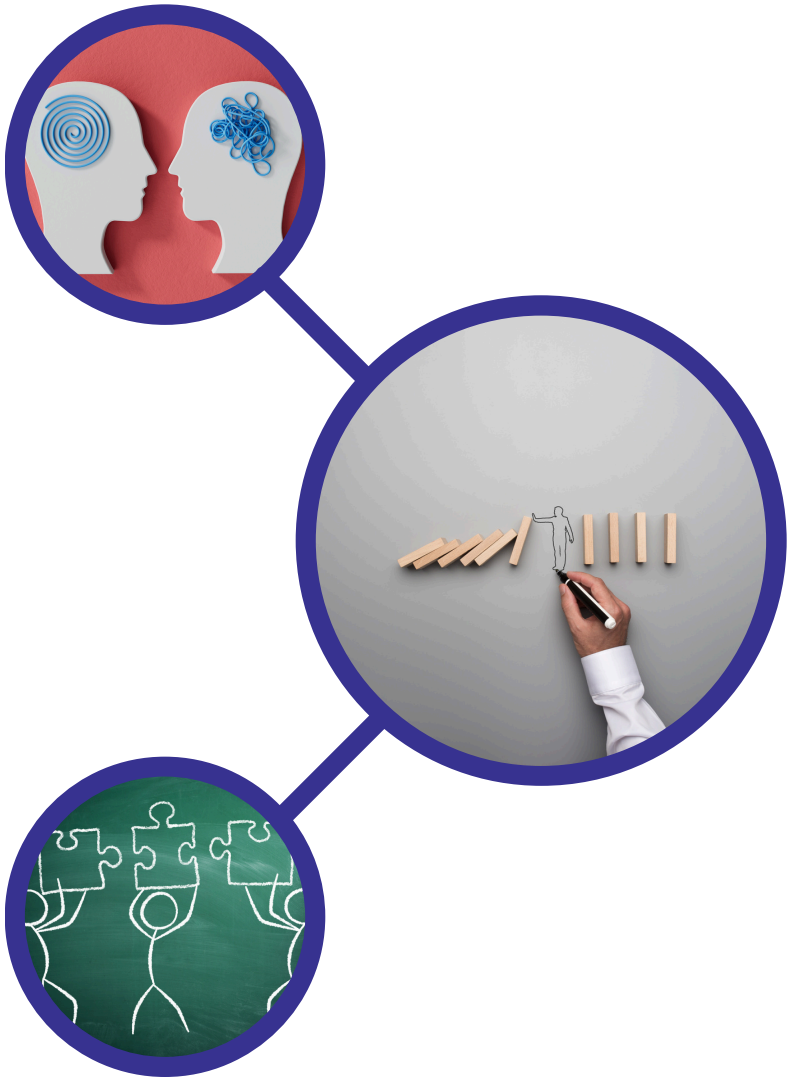
Other opioids were present in 5 cases and included hydrocodone (2 cases), methadone (1 case), and buprenorphine (2 cases). Additionally, two overdose deaths were identified in which extreme heat was a significant contributing factor.

Not represented in the graph are common prescription medications found in polysubstance cases, outside of those involving methamphetamine and fentanyl. These cases included antidepressants, benzodiazepines, and antipsychotics. While these medications may have contributed to the overdose in some capacity, their toxicity levels were typically below lethal thresholds.



Commonalities

Commonalities are shared attributes, circumstances, or life events that are analyzed during each case review. The commonalities shared among decedents do not indicate causation, but are opportunities to investigate common behaviors, circumstances and shared experiences that may provide insight into possible interventions.



Commonalities

- 14 of 18 had never been married or were divorced
- 14 of 18 diagnosed with substance use disorder (SUD)
- 11 of 18 overdosed within close proximity (shouting distance) to known bystander
- 10 of 18 released from an inpatient rehabilitation facility within past year
- 11 of 18 had substance misuse in past 30 days
- 11 of 18 had substance misuse in past year
- 9 of 18 started using before 18 years of age
- 8 of 18 history of prior overdose
- 12 of 18 diagnosed with anxiety disorder
- 14 of 18 diagnosed with mood disorder
- 14 of 18 had behavioral health encounter in past year

Commonalities

- 12 of 18 had healthcare visit in past 90 days
- 8 of 18 had financial problems in past 90 days
- 9 of 18 had history of homelessness
- 7 of 18 had at least 3 adverse childhood experiences
- 4 of 18 had at least 5 adverse childhood experiences
- 7 of 18 experienced substance misuse within household as a child; most common ACE
- 11 of 18 had chronic pain; chronic pain most common chronic condition

Recommendations for Prevention

Introduction

The Arizona Department of Health Services has provided a list of standardized prevention recommendations for use by local teams. These can be adopted as they are or tailored to generate custom recommendations. The ADHS Overdose Fatality Review Data Collection Tool will aggregate these local recommendations, although teams are free to adjust them to suit their specific jurisdictions. While there is no strict limit on the number of recommendations, it is suggested to prioritize and limit them to three or fewer.

Healthcare

- Enhance capacity and coverage of mental health services (e.g., long-term case management). (5%)
- Increase patient-specific education of overdose risk associated with age, comorbid conditions, prescription medications, and the use of other substances. (5%)
- HC Improve care coordination by connecting to social support resources such as housing, employment, insurance, transportation, etc. (11%)

Crisis Response

- Increase funding for crisis response teams that offer alternatives to incarceration. (5%)
- Improve care coordination by connecting to mental health and substance use services (e.g., transport/referral to treatment). (11%)

Recommendations for Prevention

Community/Public Health

- Improve support for individuals with past childhood or adult trauma (e.g., domestic violence, sexual assault, loss of a loved one). (33%)
- Improve support for families who have a loved one with a substance use disorder (e.g., community events, connection to support groups, written materials). (33%)
- Increase education and awareness of overdose prevention and harm reduction strategies (e.g., naloxone, fentanyl test strips, HIV/HEP C testing). (5%)
- Develop social work/case management resources for children directly involved in overdose deaths to identify and treat behavioral health illnesses related to the death (e.g., PTSD from a parent's overdose death). (11%)

Criminal Justice

- 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. (11%)
- Enhance capacity of drug courts to divert a greater number of individuals with a substance use disorder from incarceration. (5%)

Recommendations for Prevention

Yuma County Custom Recomendations

- Enhance capacity and coverage of mental health services; specifically, the Assertive Community Treatment (ACT) Model. (5%)
- Improve care coordination prerelease through funding for jail liaison positions. (11%)
- Mental health first aid training as a crisis response for family members, friends and peers. (5%)
- Expand mental health and substance use services for incarcerated individuals. (11%)
- Provide MAT/SUD/BH/TRAUMA services for professionals, such as telehealth. (5%)
- Increase access to residential treatment for mental health and substance use disorders. (5%)
- Broaden initiatives that offer comprehensive care management services for individuals at high risk of incarceration, as well as those with past convictions (e.g., registered sex offenders) that hinder their access to certain services. (5%)
- Increase training on mental health crisis intervention and Title 36 procedures for law enforcement, with a focus on better utilization of crisis intervention services. (5%)
- Expand access to alternative housing options for individuals with prior offenses, ensuring eligibility for those who may otherwise be excluded from traditional sober living facilities. (5%)

Recommendations for Prevention

Yuma County Custom Recomendations

- Develop social work/case management resources for children directly involved with the criminal justice system to identify root causes for violent/delinquent behaviors (e.g., domestic violence in home, learned behavior from bad parents/family). (5%)
- Improve access to social support resources such as transitional housing with live in peer support with 24/7 availability for peer support services/accountability. (5%)
- Improve support for families, specifically minors, who have a loved one with a substance use disorder (e.g., community events, connection to support groups, written materials). (5%)
- Develop strategies to increase accountability for parents of troubled youth to ensure they take an active role in addressing their child's behavior (e.g., structured family programs, legal responsibilities, or community-based initiatives). (5%)
- Improve education for families on the process and available resources of continuous care. (5%)
- Develop social work/case management resources for parents whose children are struggling with SUD to identify and treat behavioral health illnesses. (5%)

Conclusion

Over the past three years, the Yuma County Overdose Fatality Review Team has strengthened its process into a more collaborative, data-driven effort focused on driving meaningful change. This third annual report reflects both ongoing challenges and new opportunities for improvement. In previous years, identified gaps led us to engage new partners in key areas for this review year, helping deepen our understanding of specific issues and strengthen the quality of our recommendations. As a result, the team has become more effective and efficient in its review process. This growth contributed to an increase in the number of cases reviewed—from ten last year to eighteen this year, and allowed for more comprehensive analyses. The team maintained the same case selection criteria used in the previous year, ensuring the cases reviewed were representative of all overdose deaths occurring in 2023.

Identifying the drug most likely contributing to each death was done in one of two ways. In some cases, the cause was clear from a single drug found in the toxicology report or listed on the death certificate. For more complex cases, the team conducted a detailed review of toxicology results, taking into account substance concentrations and interpretive comments from NMS Labs to distinguish between therapeutic and potentially lethal levels. Our findings show that fentanyl remains a major concern in our community, linked to 39% of overdose deaths reviewed this year. However, for the first time since this team was formed, methamphetamine emerged as the leading factor, involved in 61% of cases. It's also important to note that other opioids (not fentanyl) were present in five polysubstance overdose deaths and likely contributed alongside other substances, but was not the drug solely responsible based off toxicity results.

Methadone overdoses have been a recurring trend in Yuma County in recent years and have continued into this year, with another fatality attributed to methadone toxicity. Additionally, two more overdose deaths occurred in which buprenorphine was the drug responsible. In all three cases, toxicology reports indicated drug levels consistent with the NMS Laboratory's defined lethal limits. Each individual had received the medication through a Medication-Assisted Treatment (MAT) provider or physician, with a multiple-day supply prescribed in each instance.

Conclusion

In identifying barriers to care, the team recognized two key themes. The first centered on the need to expand support for addressing adverse childhood experiences (ACEs), which often contribute to substance use disorders and mental or behavioral health challenges later in life. Two of the most frequently used recommendations this year focused on increasing support for individuals with histories of childhood or adult trauma and enhancing services for families with a loved one affected by substance use disorder. Of the fifteen custom recommendations developed, six specifically addressed components related to supporting individuals and families impacted by SUD and ACEs. These issues, when left unaddressed, frequently lead to more serious outcomes. Our team found that 39% of decedents had experienced at least three adverse childhood experiences (ACEs), and an equal percentage reported growing up in a household where substance misuse occurred, making it the most common ACE. Ultimately, 78% of decedents were diagnosed with a substance use disorder (SUD). In addition, 67% had an anxiety disorder, and 78% had a mood disorder. A common thread among many of these individuals was a history of significant trauma in childhood or young adulthood that was never adequately addressed. These findings reinforce what is already well established, individuals who experience trauma are at greater risk of developing substance use disorders and mental health conditions later in life.

The second theme highlighted the need for improved care coordination services for individuals involved in the justice system. Three of the most frequently identified recommendations focused on strengthening care coordination both before and after release from incarceration. This includes implementing warm hand-offs to connect individuals to substance use disorder treatment, medical and mental health care, and vital social support services such as housing, employment, health insurance, and transportation. The team also recommended funding for jail liaison positions to help facilitate care coordination and continuity of services prior to release.

Conclusion

These findings highlight the critical need for early intervention, trauma-informed care, and stronger systems of support, both within the community and at key transition points such as release from incarceration. By addressing the root causes of substance use and mental health challenges, and strengthening care coordination for high-risk individuals, we have an opportunity to prevent future overdose deaths and promote long-term recovery and stability. Continued collaboration among healthcare providers, justice system partners, and community organizations will be essential in turning these insights into impactful action.

"This publication was made possible by grant number H79TI087838 from SAMHSA. The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS."