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OVERDOSE FATALITY REVIEW TEAMS LITERATURE REVIEW

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Abstract: *States and localities across the United States have implemented overdose fatality review teams to address the impact of the opioid crisis on their communities. Overdose fatality review teams are designed to increase cross-system collaboration among various public safety, public health, and social service agencies; identify missed opportunities and system gaps; and develop recommendations for intervention efforts in hopes of preventing future overdose deaths. However, limitations in peer-reviewed research on the effectiveness of overdose fatality review teams limit the understanding of their usefulness. This article provides a review of literature on overdose fatality review teams, including goals, recommendations, and information sharing protocols, as well as considerations from other fatality review teams.*

A Review of Literature on Overdose Fatality Review Teams

By Jacquelyn Gilbreath, MSW and Jessica Reichert, MS

Abstract: *States and localities across the United States have implemented overdose fatality review teams to address the impact of the opioid crisis on their communities. Overdose fatality review teams are designed to increase cross-system collaboration among various public safety, public health, and social service agencies; identify missed opportunities and system gaps; and develop recommendations for intervention efforts in hopes of preventing future overdose deaths. However, limitations in peer-reviewed research on the effectiveness of overdose fatality review teams limit the understanding of their usefulness. This article provides a review of literature on overdose fatality review teams, including goals, recommendations, and information sharing protocols, as well as considerations from other fatality review teams.*

Introduction

Opioid-related deaths in the United States increased six-fold between 1999 and 2018, with two of every three overdose deaths involving opioids.[1] The impacts of the opioid crisis have been well documented in recent years. For instance, researchers have identified the health impacts of opioid use to include malnutrition, infectious disease, and adverse mental health outcomes and the social impacts to include an estimated loss of employment of tens of thousands of people with opioid dependency, undermining economic growth.[2] The crisis also impacts children through abuse and neglect, foster care involvement, parental incarceration, and homelessness.[3] Additionally, the criminal legal system has experienced a toll from the opioid crisis with increases in the number of opioid-related cases in courts, 63% of people admitted to jails reporting drug use or dependence, and 12% of people admitted to jails reporting regular opioid use.[4]

Communities have established fatality review teams to collaborate among relevant stakeholders to address preventable deaths including child and elderly fatalities, domestic violence-related deaths, and overdose deaths. Overdose fatality review (OFR) teams have been implemented across the country as a means to address the opioid crisis.[5] OFR teams unite representatives from various public safety, public health, and social service agencies to review fatalities related to overdoses in their communities and to identify missed opportunities and system gaps in hopes of preventing future overdose deaths. This article explores the history and process of OFR teams, goals, recommendations, and deliverables of teams, information sharing protocols, and considerations from other fatality review teams.

OFR Team Goals

OFR teams are jurisdictional, multi-agency, multidisciplinary teams that share data and information related to local overdose cases. OFR teams often operate within counties or regions with an interdisciplinary group of public health, social service, criminal justice, and treatment provider agency representatives, members of the public and other stakeholders needed to share resources and review overdose cases.[6]

OFR team goals are to identify patterns in drug overdose cases, improve data accuracy related to overdose deaths, enhance service coordination, and provide recommendations to policies and programs.[7] Additional OFR team objectives include:

- Establishing policies to gather and share information on overdose deaths from public health, public service, and law enforcement agencies and any other organization that has knowledge about the overdose fatality case.
- Conducting reviews of the information gathered to determine fatal overdose trends and factors related to the overdose.
- Identifying opportunities for intervention and prevention implementation for individuals at high-risk for overdose.
- Developing prevention and response plans though the identification of changes in laws and policies.
- Improving cross-system coordination and collaboration.
- Assisting with the implementation, assessment, and development of best practices of prevention efforts.[8]

OFR Team Development

Maryland was the first state to implement OFR teams.[9] Maryland chose one city and two counties in 2013 to pilot OFR teams. Teams were created based on the child fatality review model and implemented to analyze fatal opioid overdose cases. In child fatality reviews, multidisciplinary teams assess whether child deaths could have been prevented and develop recommendations to assist in the prevention of future deaths.[10] Initially, Maryland's OFR teams were designated as medical review committees, established in local health departments. In 2014, however, legislation was passed supporting a broader framework for OFR teams that strengthened confidentiality protections for team members and the sensitive data shared among team members.[11]

States create OFR teams in a variety of ways.[12] For instance, the New Hampshire Drug Overdose Fatality Review Committee was created in 2016 through an executive order by the governor. The Unintentional Pharmaceutical Drug Overdose Review Panel in West Virginia was created via legislative approval from the state Bureau of Public Health's Commission of the Fatality and Mortality Review Team.[13] Teams in Cook, DuPage and Kankakee counties operate without a legislative mandate. Some teams advocate for staff funding to address capacity limitations.

The manner in which OFR teams review overdose data and cases also vary. The quality of the review process depends on the availability of data and information on interactions that the team has with the decedent. OFR teams may consider also reviewing near death overdoses to find additional prevention opportunities that could be missed by focusing solely on fatality cases.

Janota et al. (2018), report that in Indiana, case discussions start with the circumstances leading up to the death and then move backward through the person's life.[14] If the team determines it has sufficient information on the decedent to answer questions related to the case before them, it develops a timeline, collects additional historical information about the decedent, and identifies gaps in services and missed opportunities for intervention. The team also identifies risk factors

based on the individual's experiences. Lastly, the team identifies efforts that could have prevented the overdose. These efforts inform their recommendations for the reduction of future overdose deaths.[15]

OFR teams may consider following the national guidance from *Overdose Fatality Review: A Practitioner's Guide to Implementation* by the U.S. Bureau of Justice Assistance's Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) on the development and implementation of their program.[16] The guidance recommends that a lead agency provides administrative support to OFR teams with three key leadership roles:

- Facilitator: facilitates meetings, recruits and builds relationships with members, orients new members.
- Coordinator: gathers and shares case information with team, manages meeting logistics, reviews reports from team.
- Data manager: enters case information into database, analyzes data, writes data reports.

OFR Team Recommendations

Generating recommendations for community overdose prevention and intervention efforts is the cornerstone of the OFR team process. OFR teams should have an effective and efficient process for developing recommendations and putting those recommendations into action in their communities. Heinen and O'Brien (2020) outlined steps for OFR teams to build a plan to generate recommendations.[17] The authors recommend teams create a collaborative process among stakeholders throughout the fatality review to ensure cross-agency responses that reduce information silos and foster more innovative prevention recommendations. Additionally, initial recommendations should be documented in OFR team meeting minutes and all data discussed in the meetings (e.g., related cases, implementation strategies, level of prevention, etc.) should be entered into a fatality review database.[18] It may also be beneficial for OFR teams to develop subcommittees to focus on the implementation of recommendations and maintain momentum.

Although there are no peer-reviewed studies of OFR teams, there is some evidence to indicate they can provide data on overdose fatalities and develop recommendations for prevention.[19] For instance, an analysis of the recommendations of Maryland OFR teams from 2015 to 2016 developed a unique data collection method for strategic planning, coalition building, and developing community responses.[20] Other types of review teams that have been studied (e.g., child fatality, domestic-violence fatality) can provide insight to OFR teams on effective fatality review strategies (summarized later in this article). Maryland Department of Health and John Hopkins University researchers found the local overdose fatality review teams in Maryland to be effective at understanding the opioid crisis, increasing cross-system collaboration and coordination of interventions, and informing overdose prevention planning.[21] OFR teams can discover system gaps and policy issues by applying a person-centered approach to the data provided by substance use service agencies. Local OFR teams often earn a faster recommendation turnaround times than national agencies, allowing local authorities to quickly respond to emerging drug and overdose trends.[22] Team recommendations can inform local and state policy, identify unmet needs, and enhance cross-system partnerships.[23]

The multi-agency and multidisciplinary nature of OFR teams results in wide-ranging recommendations. Recommendation types including the following:

- Systemic, addressing a gap, weakness, or problem within or across systems.
- Agency-specific, addressing a service gap or failure.
- Research, with recommendations to research a topic or issue area.
- Fatality review quality assurance, to strengthen or improve the OFR process.
- Population specific, with interventions to reduce a specific opioid risk factor.[24]

Maryland OFR team recommendations to prevent opioid fatalities fell under the following themes:

- Underserved populations (e.g., veteran resources, support for children of overdose patients)
- Standardization of services (e.g., shelter services, oversight of pain management clinics)
- Information sharing amongst agencies on the OFR team (e.g., statewide police database, emergency room notification of overdoses to courts)
- Law enforcement interventions (e.g., police with mental health focus, law enforcement outreach with peers)
- Criminal justice reforms (e.g., judicial education, treatment referrals post-release from jail)
- Harm reduction (e.g., syringe service program, naloxone education)
- Integrated care (e.g., peer support counselors, Prescription Drug Monitoring Programs)
- Prevention education (e.g., education and outreach to youth, fentanyl education and outreach)[25]

Many OFR teams implement recommendations within existing services and programs; however, implementation varies based on the jurisdiction's available resources. Annual reports produced by teams can influence policy change as they often summarize priority recommendations and are shared with media, policymakers, city councils, and the public.[26] OFR teams also create a sense of coalition in communities as team members work toward the common goal of overdose prevention.

OFR Team Information Sharing Protocols

To gather information across agencies, OFR teams develop information sharing protocols. Data sharing and individual agency representation are often permitted through legal agreements between institutions.[27] Some information is protected via state statute and the Health Insurance Portability and Accountability Act. In Arizona, Delaware, Maryland, Pennsylvania, and West Virginia, OFR teams are protected from subpoena and all information collected is confidential through their respective state statutes.[28]

COSSAP's *Overdose Fatality Review: A Practitioner's Guide to Implementation* recommends the following:

- A team member, such as a data manager, should review all relevant federal, state, and local laws that affect data protections and privacy laws. Agencies should sign interagency data sharing agreements and all team members should review and sign confidentiality agreements.
- Files should be organized and saved securely and with restricted access.
- The meeting notetaker should consistently enter accurate meeting notes into the OFR database after each meeting.
- The OFR database stores case information and team recommendations.[29]

Other Review Team Considerations

Because evidence to support the work of OFR teams is limited, it may be beneficial to explore other types of fatality review teams. The framework of OFR teams was modeled after child fatality review (CFR) teams; therefore, their principles may be useful to OFR teams. Domestic violence fatality review (DVFR) and elderly fatality review teams also may provide insight.

Child Fatality Review Teams

CFR teams review child fatalities to inform recommendations aimed at preventing future child deaths. As part of the child fatality review process, teams define "preventability." Dufree et al. (2002) found that most states use a single definition of preventability:

> a preventable death is "one in which, with retrospective analysis, the team determines that a reasonable intervention (e.g., medical, educational, social, legal, or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances, or resources available" (p. 621).[30]

Identifying preventable deaths, however, does not imply predictability. OFR teams may consider operationalizing terms, such as prevention and intervention, at the outset of the team's creation to assist in communication among team members and the development of recommendations.

The National Center for Fatality Review and Prevention identifies additional purposes and values of childhood reviews as the following:

- The death of a child is a community responsibility.
- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- A death review requires multidisciplinary participation from the community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe, and protected.[31]

These purposes may inform the goals of OFR teams. For instance, OFR teams may decide it is necessary to include representatives from community organizations or community members on their team if they agree that "an overdose death is a community responsibility." Additionally,

OFR teams may consider including team members that interacted with the person whose case is being reviewed to ensure comprehensiveness.

Rimsza et al. (2002) identified CFR team limitations that may be informative to OFR teams.[32] One limitation centered around the difficulty and complexity of determining and implementing effective prevention strategies. For example, effective prevention strategies often involve proactive interventions across many systems and stakeholders. This may require complex coordination of programs and services, which can be challenging. Additionally, with limited funding, CFR teams typically depend on volunteers to facilitate the team's work. CFR teams have indicated that the successful implementation of team recommendations can be difficult as social and cultural institutions must be ready to accept and implement new processes.[33]

To address these limitations, Rimsza et al. (2002) recommended extending child fatality reviews to include deaths attributable to any external cause (e.g., motor vehicle, firearm, poisoning) for a more comprehensive list of cases that may offer additional opportunities for prevention.[34] The authors also recommended establishing federally funded national program to standardize data collection practices and encourage national data resource sharing, assist states in development of authorizing legislation, and identify funding sources for state and local teams.[35]

Domestic Violence Fatality Review Teams

DVFR teams reviews domestic violence-related deaths to develop strategies for prevention and accountability for the person who perpetrated violence. Of note is the involvement of family members of decedents of domestic violence fatalities, providing teams a better understanding of the complex lives of people who experience and perpetrate violence.[36] Family insights inform teams of the relationships between those who experience violence and those who perpetrate violence, patterns of abuse, and potential areas for intervention.[37] Many OFR teams do not involve family members; however, teams may consider integrating family interviews into their review processes to gain a better understanding of the life of the person who died from an opioid overdose.

Websdale (2012) found that DVFR teams recognize that domestic violence fatalities are community problems, not just criminal justice problems.[38] Multi-agency, multidisciplinary teams create a diverse set of perspectives to better understand the worldview of the person who experienced violence. This diversity can create tension, especially when those with differing perspectives are in professions that have traditionally been at odds with one another (such as advocates and prosecution). However, the tension is often de-escalated as team members contribute their professional expertise to the case, allowing others to recognize the value each person brings to the team. Using dialogue, rather than pre-established, hierarchical power, may be a useful strategy to ease tensions within OFR teams.

U.S. Bureau of Justice Assistance
Comprehensive Opioid, Stimulant, and Substance Abuse Program
Overdose Fatality Review Resources

BJA offers the following funding and resources for OFR teams:

Overdose Fatality Review: A Practitioner's Guide to Implementation

Overdose Fatality Review training and technical assistance request

Overdose Fatality Review peer mentor opportunities

Overdose Fatality Review tools

Conclusion

OFR teams aim to prevent future overdose deaths by identifying patterns, improving data accuracy, enhancing service coordination, and providing recommendations to inform policies and programs. The review processes and recommendations of each OFR team vary based on their goals and the data available to them. To develop effective recommendations, teams must develop information sharing protocols for implementation. The work of other fatality review teams may inform OFR team goals, development, and recommendations. While research is limited, OFR teams have shown promise in terms of understanding opioid overdoses in communities, increasing cross-system coordination of interventions, and informing overdose prevention efforts.

The lack of rigorous research limits what is known on the usefulness of OFR teams on overdose prevention. Without more methodologically rigorous research study designs, knowledge of the teams' effectiveness will continue to be insufficient. More rigorous research and data collection is needed to determine the efficacy of and improve upon OFR teams.

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