

# Delaware Drug Overdose Fatality Review Commission

Rebecca Walker, PhD, JD, MSN

# Background

- Created by statute in 2016 - SB 174, by then Senator Hall-Long
- 16 Del. C. 47, § 4799
- Mission / statutory charge:
  - To examine the underlying facts and causes of deaths in Delaware resulting from overdoses of prescription opiates, fentanyl and heroin; and
  - to provide recommendations for consideration by the Governor and General Assembly in an effort to reduce the frequency of such overdoses.
- Statutory members:
  - The Attorney General, Secretary of DHSS and DSHS, Commissioner of DOC, the Division of Forensic Science, 2 members of the MSD, a representative of: the DNA, the Police Chiefs Asso., the FOP, the DHCA, 2 advocates from statewide nonprofit organizations, and the chairperson of each review team.
- Meetings are held quarterly for both the commission and the statutory review teams – all meetings are not open to the public.

# Reporting obligation

- Reports are to be submitted to the Governor's Office and to the Delaware General Assembly.
- 2017 report released to the above in July 2018 by then Attorney General Denn.
- 2018 report released from the Department of Justice to the above on June 24, 2019.

# New processes

- Effective July 1 2019 new process have been implemented for the review of cases and the development of recommendations.
- Review teams will present the review findings and recommendations to the commission, then the commission will aggregate and develop core recommendations to produce to the Governor's Office on a yearly basis.
- Review Team makeup
  - By county
  - Members include physicians, nurses, hospital and community care providers, law enforcement and DOC representatives, mental health providers, addiction care providers, advocates, members of the legal community, and members of the education community.

# 2018 Findings

- Cases were pulled through an odd-even selection criteria, where the toxicology findings met the statutory requirement (positive for fentanyl, heroin, and or prescription opiates).
- Case reviews were conducted in the county where the death occurred.
- Records reviewed by the teams included medical records, death records, community based treatment records, judicial records, law enforcement reports, and prescription and medication history records.
- Based on the review of the county teams, six findings with recommendations were released.

# Findings Continued

- Finding #1:
  - Seventy-nine percent of the overdoses reviewed occurred in a residential setting.
  - Of these, 93% occurred in locations where Naloxone was not available.
- Recommendation:
  - Promote efforts to improve community based access to Naloxone, and increase distribution opportunities from multiple agencies and/or targeted locations.
  - Continue Harm Reduction PSAs.
- Finding #2:
  - Of the cases reviewed, 50% of the individuals had at least one previous non-fatal overdose for which they were seen in an emergency department.
  - Of this group, 17.9% of the cases had a history of multiple non-fatal overdoses with documented treatment in a medical facility.
- Recommendation:
  - Support ED based initiatives to engage in treatment/testing, and promote naloxone distribution to overdose clients by either medical or law enforcement personnel.

# Findings Continued

- Finding #3:
  - Thirty percent of the cases reviewed had a history of being detained by DOC. Of this group, release dates were able to be confirmed for 70% of the deaths.
  - Of the 70% above, 50% suffered a fatal overdose within three months of their release, and of the remaining cases reviewed, 75% died from an overdose within 1 year.
- Recommendation:
  - Promote programs to engage care throughout detainment (MAT and Naltrexone), with Naloxone kits and connection with counseling services offered at the time of release.
- Finding #4:
  - Of the cases reviewed, 52% of the decedents had been treated in an ED within 3 months of the fatal overdose.
  - Of those treated, 25% had a documented history of mental health crisis intervention. In reviewing the crisis intervention touch points, these individuals had prior contact at either a voluntary mental health treatment center or hospital ED.
- Recommendation:
  - Promote workforce training to support effective care delivery to this population, as well as Naloxone access in the community.
  - Support expansion of sober living facilities, patient centered care and long term, dual diagnosis treatment either in the community or in-patient.

# Findings Continued

- Finding #5:
  - In review, 12.5% of the fatal overdose cases were active participants in a Medically Assisted Treatment (MAT) Program.
- Recommendation:
  - It is strongly recommended that all addiction treatment be coupled with Naloxone access and mental health / addiction counseling services.
- Finding #6:
  - Within three months of the fatal overdose, approximately 27% of the cases had some involvement with a law enforcement agency.
- Recommendation:
  - Continued support for law enforcement assisted diversion (LEAD) programs such as HERO Help and the Angel programs.



# Key takeaways

- Narcan access through multiple systems (private, public, judiciary, etc.).
- There are critical touchpoints (client and patient engagement).
- Expansion of programs and access (patient centric care, dual treatment).
- Collaboration (continued collaboration between agencies, organizations and jurisdictions - statewide).