

Overdose Fatality Review

MAY 2022

INTRODUCTION

Overdose fatality review (OFR) is a powerful tool used by local governments to identify system gaps and innovative community-specific overdose prevention and intervention strategies.¹ OFRs involve a series of confidential, individual death reviews by a multidisciplinary group which examines many aspects of a decedent's life, including drug use history, comorbidities, major health events, social-emotional trauma (such as adverse childhood experiences), encounters with the criminal justice system, and treatment history, to better understand and prevent missed opportunities for prevention and intervention in others.²

The groups performing OFRs are referred to by several names, including teams, boards, panels, committees, or commissions. This factsheet uses the term "team" because it reflects the ideals behind the purpose of an OFR; that is, a group of multidisciplinary individuals coming together to achieve a common goal of overdose prevention in a setting in which everyone offers a unique perspective to the case review process.³ "OFR is a useful model to analyze data and trends and garner interdisciplinary support to reduce the number of preventable deaths."⁴ By understanding what influences a fatal overdose, the review team can recommend changes in law and policy that will better allow the state, city, or county to prevent future overdose deaths.

ORIGIN OF OFR TEAMS

The concept of OFR is based on child death reviews, first established in 1978 in Los Angeles, California, and now found in almost every state.⁵ Originally developed to improve identification and prosecution of fatal child abusers, the role of child death reviews has evolved into a public health model of prevention through systemic reviews of child deaths from birth through adolescence.⁶ Child death reviews help jurisdictions understand the epidemiology and preventability of child death and provide a means of monitoring the effectiveness of prevention strategies.⁷ The American Academy of Pediatrics endorses child death reviews as a best practice and provides an effective model for other types of fatality review.⁸ Jurisdictions now use fatality reviews in a variety of situations, including fatalities related to mothers,⁹ fetuses and infants,¹⁰ traffic accidents, domestic violence,¹¹ suicide,¹² and homicide.

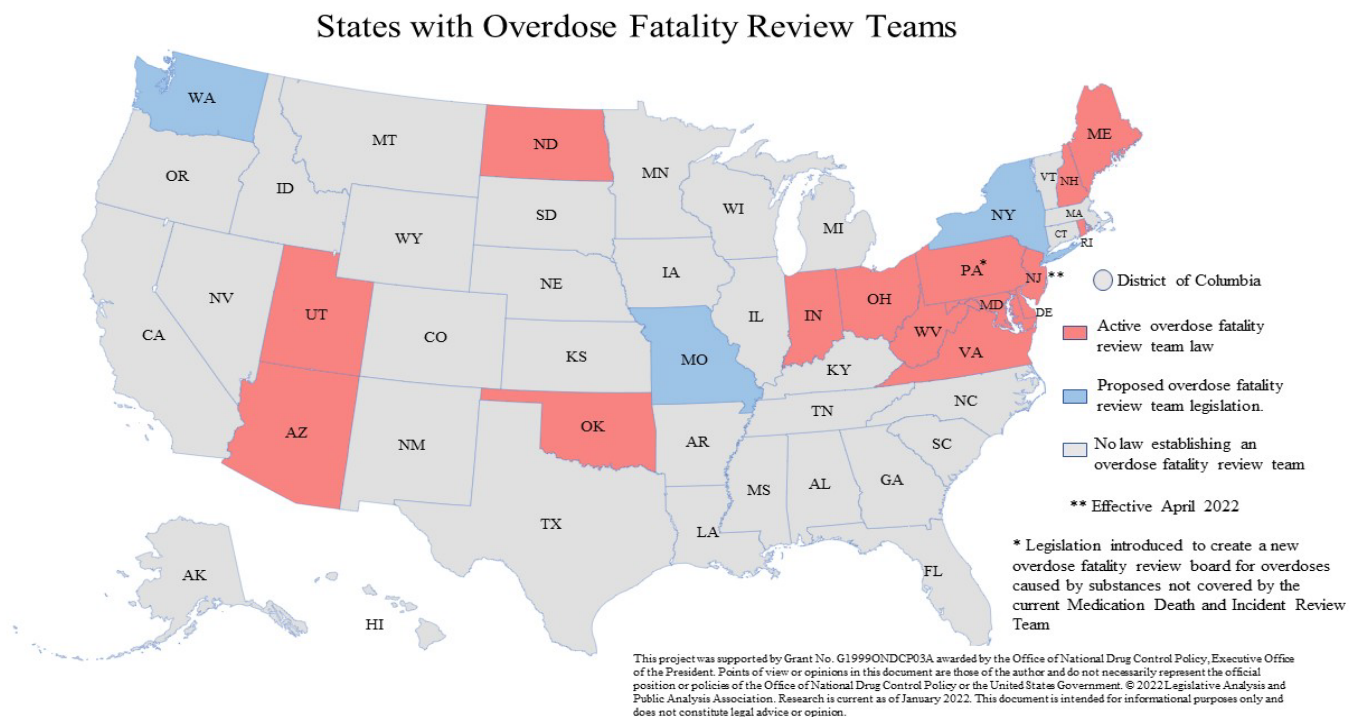
Maryland became the first state to establish an OFR in 2013 when it conducted an OFR pilot program in three counties.¹³ Maryland subsequently became the first state to authorize OFR teams via legislation in October 2014.¹⁴ According to public health researchers, "[a]s a result of their OFR program, Maryland reports improved care referral systems, enhanced services for diverse client needs, and increased knowledge within participating agencies of community resources available to assist at-risk populations."¹⁵ By reviewing overdose cases, OFR teams can make recommendations for local and state policies that better support people at risk for overdose. For example, in Maryland, several local OFR teams discovered that fatal overdoses frequently occurred in hotels and motels.¹⁶ Based on this information, the teams recommended that hotel and motel staff be trained in the use of naloxone.¹⁷

LEGISLATIVE EFFORTS

As of March 2022, there are approximately 170 operational OFR teams spread throughout 32 states.¹⁸ Although an OFR team may operate in a state without statewide authorizing legislation, having enacted legislation in place provides several benefits as compared to independently established OFR teams.

First, statutory language can directly provide an OFR team with access to information generally protected from disclosure. Without legislation addressing access to such information, an OFR team—and the individuals and entities from whom it requests information—are constrained by their own (or local) attorneys’ interpretations of the confidentiality provisions of: (1) the Health Insurance Portability and Accountability Act (HIPAA), governing “protected health information;” (2) 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2, governing the disclosure of substance use disorder treatment records; and (3) any other federal, state, or local confidentiality laws pertaining to information sought by the team. This may result in an entity’s unwillingness to share information with an OFR team due to unduly restrictive interpretations and/or confusion caused by varying conclusions among jurisdictions.

Figure 1



Second, OFR legislation helps to enhance the legitimacy of OFR teams, especially in areas where some community members may be reluctant to establish a team on their own. Finally, legislation promotes uniformity and consistency among the local teams within the state. To assist states in establishing statewide legislation for OFRs, LAPPa created the Model Overdose Fatality Review Teams Act, which is available [here](#).

OFR-related statutes in place around the country establish or authorize OFR review teams on the state level, local/county level, or a combination of both.¹⁹ (Figure 2). Additionally, some state laws apply only to OFRs reviewing fatalities involving certain drugs. This “substance of focus” of an OFR law can range from overdoses involving any substance, to overdoses involving only opioids, to overdoses involving only “FDA-approved medications for treatment of opioid use disorder.”²⁰ (Figure 3).

Figure 2

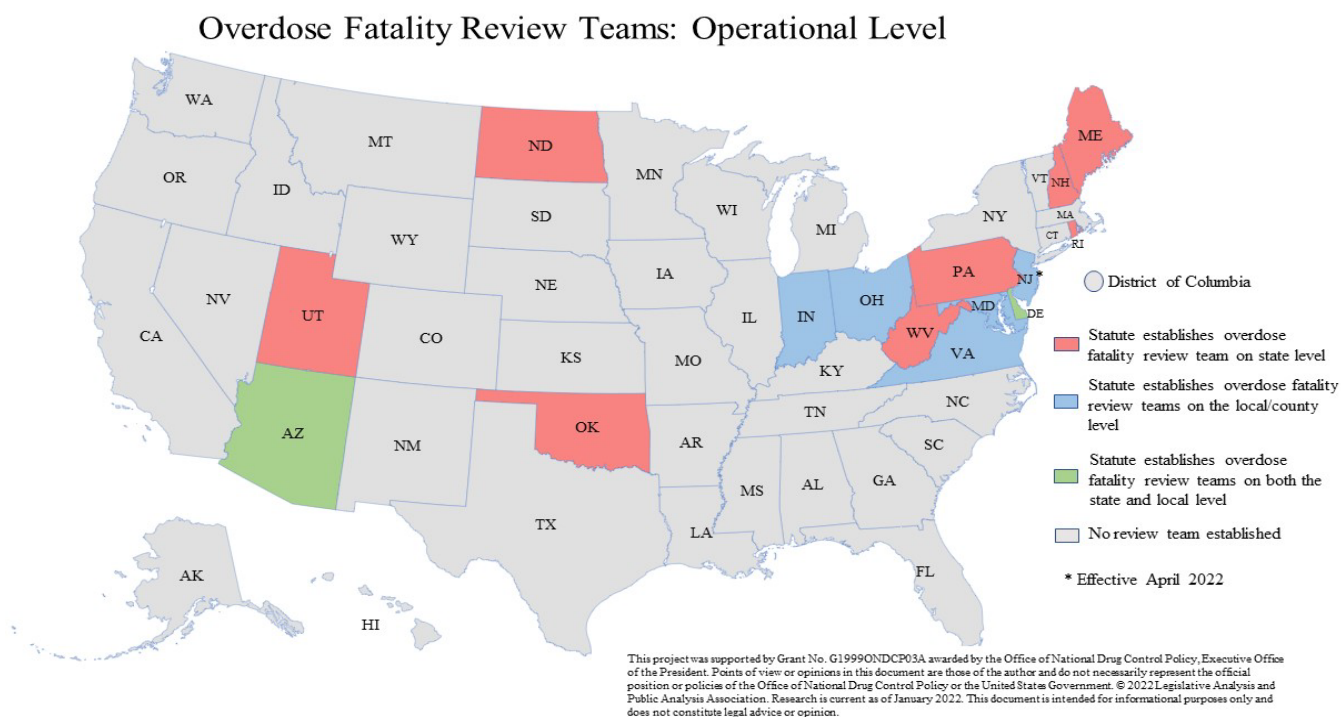
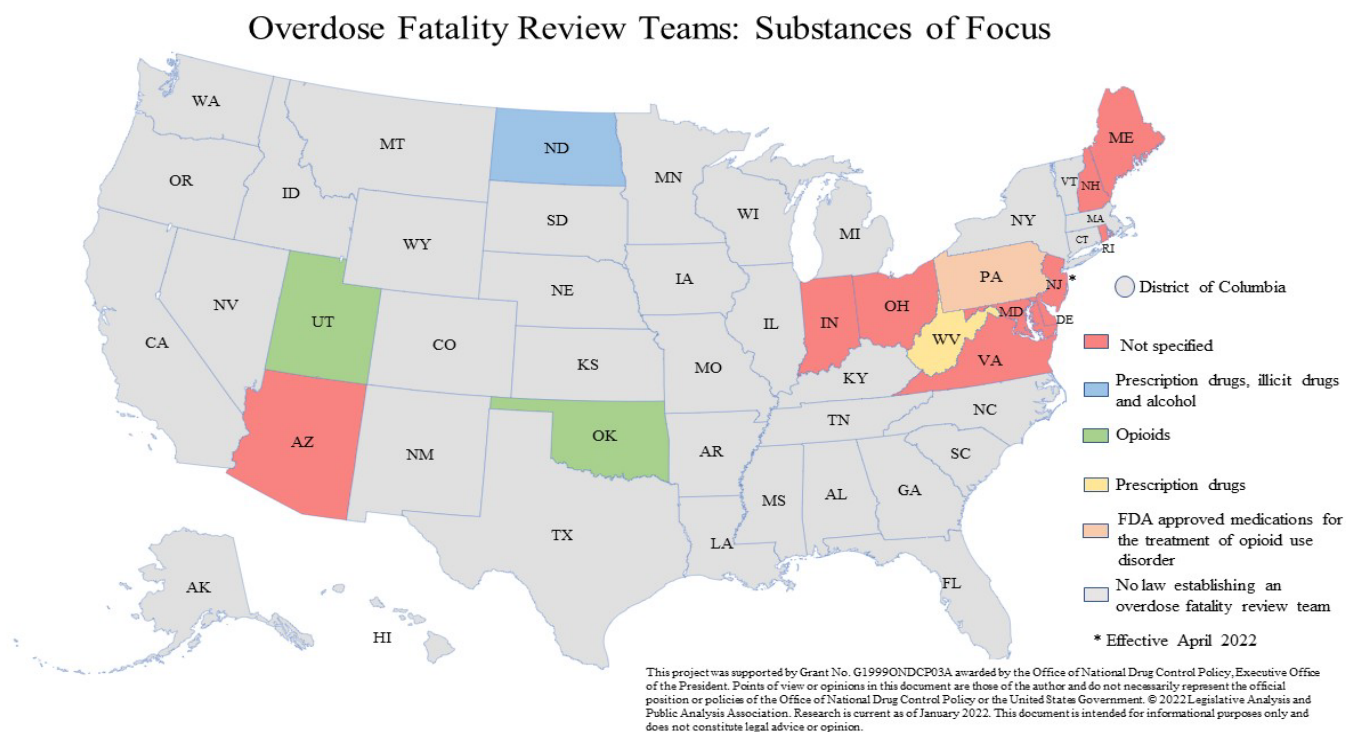


Figure 3



KEYS TO SUCCESS

Regardless of the operational level or substance of focus, all OFRs should be composed of a variety of members from multiple agencies and multiple disciplines. OFR team members customarily include law enforcement, emergency responders, health care providers, public health workers, social services workers, medical examiners, and others.²¹ Effective OFR teams typically have 15-35 members.²² Moreover, having a diverse membership allows an OFR team to properly explore the systems with which a person came in contact throughout his or her lifetime to identify opportunities where improvements to such systems, policies, or services might help prevent future overdose deaths.²³ The perspectives and input of the members will be valuable even if the individual or organization did not have direct contact with the decedent.²⁴

Each OFR case review relies on the quality of the data available to the local team, which is often contingent on the amount of interaction the decedent had with various systems.²⁵ Information that OFR teams consider critical to a case review includes medical records, substance use disorder treatment records, medical examiner reports, criminal justice records, and social services records. Using these records, an OFR can piece together a timeline of services offered to the decedent, including whether sufficient referrals were generated, if gaps in service existed, and what missed opportunities were present. Additionally, information may be gathered on family members related to the decedent to further look at the social determinants of health that influenced the decedent's behavior. An OFR may also wish to interview surviving family members to hear their stories and perspectives that may assist with the team's investigation into the death.²⁶

CONCLUSION

The purpose of an OFR is not to assign blame to a particular person or entity for failing to prevent an overdose death but instead to determine what the gaps in the system are and to address those gaps to prevent overdose deaths in the future. OFRs can help states and local jurisdictions determine what factors and characteristics may lead to a possible overdose. By understanding what influences a fatal overdose, the OFR can recommend changes in law and policy that will better allow the state, city, or county to prevent future overdose deaths.

¹ Melissa Heinen and Mallory O'Brien, "Overdose Fatality Review: A Practitioner's Guide to Implementation," BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program, July 2020

https://www.cossapresources.org/Content/Documents/Articles/Overdose_Fatality_Review_Practitioners_Guide.pdf.

² *Id.*

³ Erin Hass, *et al.*, "Local Overdose Fatality Review Team Recommendations for Overdose Death Prevention," *Health Promotion Practice* 20 (Sept. 2018): 554, <https://doi.org/10.1177/1524839918797617>.

⁴ Andrea Janota, *et al.*, "Indiana Drug Overdose Fatality Review," IUPUI Richard M. Fairbanks School of Public Health, October 2018, <https://fsph.iupui.edu/doc/research-centers/overdose-fatality-review-20181010.pdf>.

⁵ Hass, *supra* note 3, at 561.

⁶ Cindy W. Christian and Robert D. Sege, "Child Fatality Review," *Pediatrics* 126 n. 3 (Sept. 2010): 592, <https://publications.aap.org/pediatrics/article/126/3/592/66138/Child-Fatality-Review>.

⁷ *Id.*

⁸ Hass, *supra* note 3, at 561.

⁹ See "Enhancing Review and Surveillance to Eliminate Maternal Mortality," Centers for Disease Control and Prevention, last modified November 10, 2021, <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html>.

¹⁰ See "Fetal and Infant Mortality Review," The National Center for Fatality Review and Prevention, accessed February 24, 2022, <https://ncfrp.org/fimr/>.

¹¹ See "Review Teams," National Domestic Violence Fatality Review Initiative, last modified March 2021, <https://ndvfri.org/review-teams/>.

¹² See OHIO REV. CODE ANN. §§ 307.641 through 307.6410 (West 2022).

¹³ Hass, *supra* note 3, at 561.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.* at 556.

¹⁷ *Id.* at 561.

¹⁸ E-mail from Melissa Heinen, Senior Research Assoc., Institute for Intergovernmental Research, to Stephanie Noblit, Legislative Attorney, Legislative Analysis and Public Policy Ass’n (Mar. 2, 2022, 18:04 EST) (on file with LAPPa).

¹⁹ See *Overdose Fatality Review Boards: State Laws*, LEG. ANALYSIS & PUB. POLICY ASS’N (Feb. 2021), <http://legislativeanalysis.org/wp-content/uploads/2021/02/OFR-State-Laws-Final.pdf>.

²⁰ *Id.*

²¹ Janota, *supra* note 4.

²² Heinen, *supra* note 1, at 6.

²³ *Id.*

²⁴ “Recruit Your OFR Members,” BJA’s Comprehensive Opioid, Stimulant, and Substance Abuse Program, last visited Sept. 30, 2020, <https://www.cossapresources.org/Tools/OFR/Recruit>.

²⁵ Janota, *supra* note 4.

²⁶ *Id.*

ABOUT LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPa) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

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