OVERDOSE FATALITY REVIEW WINNEBAGO COUNTY, WISCONSIN

ANNUAL REPORT 2018 - 2019

Overdose Deaths are Preventable

BACKGROUND

The increase in the number of overdose deaths in Winnebago County is striking, with only 3 deaths in 2001 and 24 deaths in 2018 (see graph below). Specifically, heroin and increasingly fentanyl have been the cause of many overdose deaths in Winnebago County. To help understand and address this growing problem, Winnebago County established a multidisciplinary, cross-sector Overdose Fatality Review Team in 2018.

PURPOSE OF THE OVERDOSE FATALITY REVIEW (OFR) TEAM

The purpose of this team is to prevent overdose deaths. The team accomplishes this purpose by examining individual, organizational and systems level factors related to overdose deaths that occur in Winnebago County. The reviews focus on systems level change to prevent future deaths and not on identifying fault in organizations or individuals connected to the death being reviewed.

DEVELOPING THE OVERDOSE FATALITY REVIEW TEAM

The Winnebago County Overdose Fatality Review Team was established in early 2018 after the Winnebago County Drug and Alcohol Coalition's Data Team wrote for and was awarded an Overdose Fatality Review grant from the Wisconsin Department of Justice and Wisconsin Department of Health Services on behalf of Winnebago County. As fiscal agent and project lead, the Winnebago County Health Department identified key partners and hired a consultant to facilitate this process. With training and support from the Medical College of Wisconsin technical assistance providers, together we developed our review process, established interagency agreements with each partner, and began reviews in May 2018.

Our partners represent local health departments, law enforcement, emergency medical services, the coroner's and district attorney's offices, human services, health care systems, mental health providers, treatment and recovery providers, schools, pharmacies, faith communities, department of corrections, local coalitions, and other impacted stakeholders.

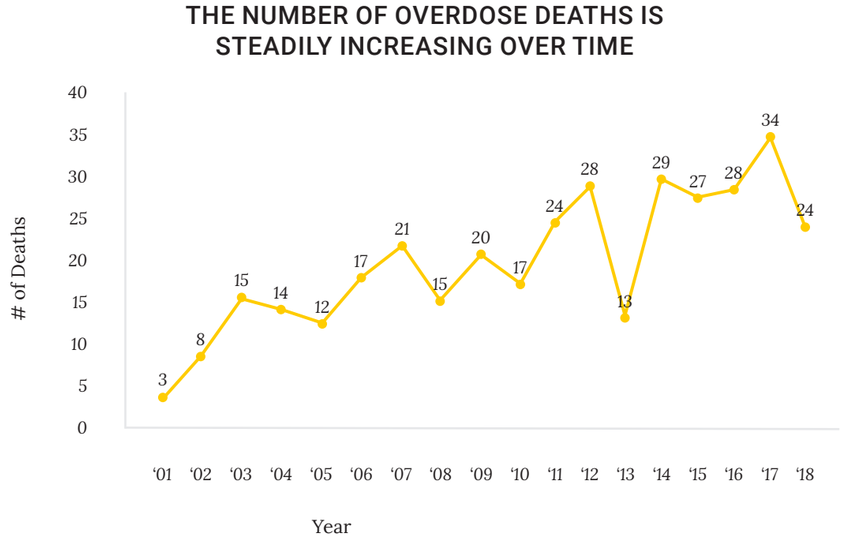
THE REVIEW PROCESS

The multidisciplinary, cross-sector team reviews two overdose deaths at each monthly meeting. The process involves each partner sharing information about the decedent's life and death, discussion of risk factors and circumstances surrounding each decedent, examination of system issues related to addiction and substance use, and identification of opportunities to influence policy and practice to prevent future overdoses and overdose deaths. Confidentiality is maintained through inter-agency memorandum of understandings (MOUs), signed agreements at each meeting, and de-identification of the decedent during the review meeting. The process is designed to maintain the highest levels of respect for the decedent, those impacted by the death, the partner agencies in the room, and the broader community.

Through the process of reviewing overdose deaths, the OFR team develops system-level recommendations to prevent future overdose deaths. The Recommendations and Monitoring Action Team works with partners to develop an action plan for the implementation of recommendations and reports back to the OFR team on progress.

PARTNER AGENCIES

Addiction Medical Solutions of Wisconsin (AMS)
Aging and Disability Resource Center (ADRC)
Appleton Police Department
Apricity
Ascension
Aurora Medical Center of Oshkosh
City of Menasha Health Department
City of Menasha Police Department
City of Oshkosh Fire Department/Emergency Medical Services
City of Oshkosh Police Department
Community Church
Fox Crossing Police Department
Gold Cross Ambulance Service
Hometown Pharmacy
Lake Winnebago Area Metropolitan Enforcement Group
Neenah Joint School District
Neenah Police Department
Northeast Wisconsin Mental Health Connection
Nova Counseling Services
Omro Police Department
Oshkosh Area School District
Partnership Community Health Center
Samaritan Counseling Center of the Fox Valley
Solutions Recovery, Inc
ThedaCare
ThedaCare Behavioral Health
United States Attorney's Office
University of Wisconsin Oshkosh Police Department
Village of Winneconne Police Department
Winnebago County Coroner's Office
Winnebago County Health Department
Winnebago County Human Services Department, Behavioral Health
Winnebago County Safe Streets Committee (Criminal Justice Coordinating Committee)
Winnebago County Human Services Department, Child Welfare
Winnebago County Office of District Attorney
Winnebago County Sheriff's Office
Winnebago County Sheriff's Office – Jail
Wisconsin Department of Justice - Division of Criminal Investigation
Wisconsin Department of Corrections




Serenity Gardens at Nova Counseling

DATA ON ALL 2018 OVERDOSE DEATHS IN WINNEBAGO COUNTY

In 2018, there were 24 overdose deaths in Winnebago County.

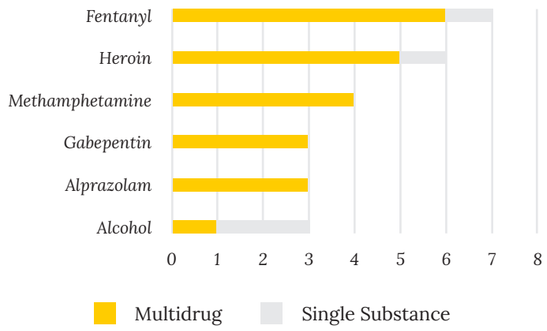
SEX: 15 Males, 9 Females

AGE RANGE: 21-84

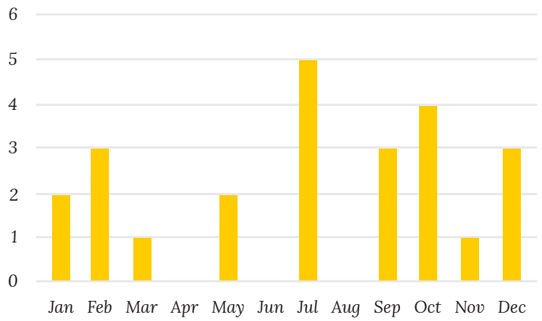
RACE: In 2018, all overdose deaths in Winnebago County occurred among Caucasian individuals. Substance use can and does affect individuals of all races and ethnicities.

GEOGRAPHIC LOCATION OF DEATH: 12-Oshkosh, 7-Neenah, 3-Menasha, 2-Rural/Small Communities

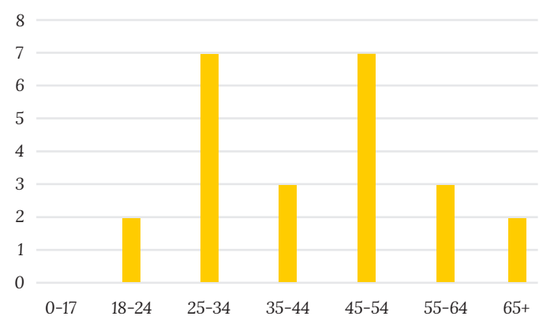
IN 2018, FENTANYL HAD A ROLE IN 7 OVERDOSE DEATHS



IN 2018, THE MAJORITY OF OVERDOSE DEATHS OCCURED IN THE SECOND HALF OF THE YEAR



IN 2018, THE MAJORITY OF OVERDOSE DEATHS OCCURRED AMONG INDIVIDUALS AGED 25-54



EMERGING THEMES FROM REVIEWED DEATHS

NARCAN ADMINISTRATION:

Most of the decedents were found dead on scene, some were administered Narcan/naloxone by EMS/fire department and/or law enforcement.

There were no decedents that had Narcan/naloxone present at the time of death.

The majority of decedents were alone at the time of overdose and would not have been able to administer Narcan/naloxone.

LOCATION OF INCIDENT:

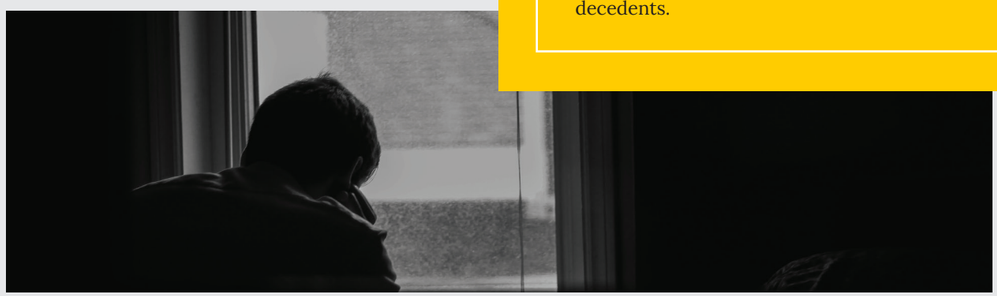
All overdose incidents that lead to death occurred at a place of residence (decedent's home, relative's home, or a friend's home).

In Winnebago County, overdose deaths occurred in homes, not in public places.

HISTORY WITH CRIMINAL JUSTICE SYSTEM:

Half of the decedents were on community supervision in the last year, many of them were on community supervision at the time of death.

The Criminal justice system is an important touchpoint because some were able to access services (such as substance use treatment) through probation and parole.



MENTAL HEALTH:

Nearly all of the decedents had mental health as a factor, very few were being treated for those illnesses.

HISTORY OF SUBSTANCE USE:

The majority of decedents had a known history of substance use; many of which had a history of opioid use.

All decedents either had a mental health concern or history of substance use; many had both.

EARLY EXPERIENCES

Many decedents had witnessed significant substance use by other members in their household when growing up.

Many decedents had documented substance use at an early age (Age: 10-15).

Early substance use (starting before 14 years old) is a risk factor for serious substance use disorders in the future.

Marijuana and alcohol were the two most common first used substances among the decedents.

RECOMMENDATIONS

In January 2019, the OFR team discussed recommendations based on themes that came out of the thirteen cases that had been reviewed up to that point. A Recommendations and Monitoring Action Team was developed shortly after that meeting. This action team created a list of 11 recommendations for the OFR team to work on based off the January discussion, which were then approved by the OFR team. The Winnebago County Drug and Alcohol Coalition (WCDAC) is an important partner in this process, providing infrastructure and capacity for implementing many key recommendations building community will and interest.

1. Create a referral-to-help card that partners can share with at-risk individuals and their loved ones.
Many reviewed cases could have offered referral to help through partner touchpoints. New community resources have been established that streamline referral to substance use treatment and recovery support. Each touchpoint serves as an opportunity for intervention.

2. Support the launch of the Law Enforcement Addiction Assistance Program (L.E.A.A.P.) in Oshkosh.
Cases show that law enforcement agencies trained on referral and integrative partnerships with treatment providers increase the speed of access to services and connecting people to treatment.

3. Leverage chaplain services in overdose related incidents.
Chaplains and faith based organizations serve as another touchpoint for those struggling with addiction and those that have overdosed. Partners want to explore ways these groups can leverage their services as another resource and as a point of referral for community members.

4. Explore the feasibility of police and EMS/fire departments mapping drug overdoses and interactions to provide intervention for help and improve access to services and referrals.
Knowing where overdoses occur, not only overdoses that result in death, will improve responses and services offered to individuals so that future overdoses can be prevented.

5. Ensure lifesaving Narcan/naloxone distribution and training in Winnebago County through the public health department and community partners.
None of the cases reviewed had Narcan/naloxone available at the time of overdose and there are no free Narcan/naloxone distribution sites in Winnebago County.

6. Promote the need for those that use substances to carry Narcan/naloxone, even for those that do not plan to use opiates, through Public Service Announcements and local trainings.
Several decedents used substances that were laced with Fentanyl and did not have Narcan/naloxone available because they did not intend to use opiates.

7. Expand overdose prevention and Narcan/naloxone training for individuals and organizations who interact with those that may use drugs (i.e., new first responders, staff in faith communities, library staff, bus drivers, teachers, etc.). Work with those that provide CPR training services to incorporate Narcan/naloxone training into their standard service.
While most overdose deaths in Winnebago County occurred in a private residence, overdoses themselves happen in a variety of locations. Equipping our community with lifesaving Narcan/naloxone and training will reduce overdose deaths. Additionally, there has been the increase of opiod use and Fentanyl being mixed into common drugs where the user has no intention of using opiates. Expanded and universal training on how to administer Narcan/naloxone is needed across our region.

8. Work with local pharmacists to establish best practices and processes when using the Wisconsin Prescription Drug Monitoring Program (PDMP) when prescriptions are distributed.
Some cases had prescription histories that fell outside of recommended ranges, such as long-term prescriptions, high doses, and/or large quantities prescribed. Pharmacists checking the PDMP will add a second layer of review and referral before distribution.

9. Support statewide policy that allows peer support for substance use to be a billable service covered by insurance and medical assistance.
Peer support is effective in improving access to needed services and in promoting long-term recovery. Currently peer support is only a billable service in Wisconsin under mental health; this recommendation would expand the policy to include support for those with substance use disorders.

10. Create a regional (cross-county) response team to work with those identified as high-risk for overdose; similar to a crisis intervention team.
Many overdose fatalities in our community experienced common events; they had a previous overdose and/or they recently lost a close friend/family member to an overdose. A crisis intervention team can work to offer services and referrals to those at high risk of overdose to prevent an overdose death from occurring.

11. Expand and adapt the Law Enforcement Addiction Assistance Program (L.E.A.A.P.) regionally based on successes and learnings from the Oshkosh and Appleton programs.
Law enforcement agencies in smaller and rural communities do not have the capacity to sustain a L.E.A.A.P. style program. Additionally, people living in our community and the services they need to access are regional. A regional approach will improve coordination and referral to services.

CALL TO ACTION AND CONTACT INFORMATION

There are many ways to get involved in preventing overdose deaths and reducing substance use.

IMPLEMENT THE RECOMMENDATIONS IN YOUR ORGANIZATION

The success of the Overdose Fatality Review Team depends upon the willingness of partner organizations and the broader community to respond to what we are learning and implement change. If you believe you can implement any of the recommendations in your organization, we would love to support you in doing that. *You can contact our facilitator at jskolaski@co.winnebago.wi.us or winnebagodac@gmail.com to express interest and learn more.*

GET INVOLVED WITH THE WINNEBAGO COUNTY DRUG AND ALCOHOL COALITION

The coalition provides infrastructure and capacity for implementing many key recommendations, builiding community will, and strengthening collaboration across our community. There are four action teams (Data, Communications, Prevention/Awareness, and Treatment/Recovery) that work towards preventing and reducing substance use in Winnebago County. *Visit www.winnebagodac.org or email winnebagodac@gmail.com to learn more and get involved.*

SUPPORT THE WORK OF OVERDOSE DEATH PREVENTION WITH YOUR RESOURCES

This work, the work of the review process and the implementation of recommendations that stem from the review process, requires resources. Those resources come in many forms (e.g., time, data, knowledge, and money). Please consider how you may be able to contribute your resources to the work of the Overdose Fatality Review Team and the broader community work around overdose death prevention and substance use reduction.