Just Partnerships to Enhance Overdose Fatality Review

Introduction [00:00:05] Now, this is recording, RTI International Center for Forensic Science presents Just Science.

Voiceover [00:00:19] Welcome to Just Science, a podcast for justice professionals and anyone interested in learning more about forensic science, innovative technology, current research, and actionable strategies to improve the criminal justice system. In episode five, Just Science interviews Dr. Mallory O'Brien, Assistant Professor at the Medical College of Wisconsin, to discuss how partnerships can enhance Overdose Fatality Reviews. The National Violent Death Reporting System (NVDRS) is the only state-based reporting system that covers all types of violent deaths, including homicides and suicides. It pools more than 600 unique data elements from multiple sources into an anonymous, usable database. Dr. Mallory O'Brien uses her experience with NVDRS to improve the overdose fatality review process. Listen along as she discusses leveraging partnerships to enhance overdose fatality reviews, their impact on communities with substance abuse problems, and the historical context that led to fatality reviews in this episode of Just Science. This season is funded by the National Institute of Justice's Forensic Technology Center of Excellence. Here is your host, Paige Presler-Jur.

Paige Presler-Jur [00:01:33] Hello and welcome to Just Science. I'm your host, Paige Presler-Jur with the Forensic Technology Center of Excellence, a program of the National Institute of Justice. Our topic today is the critical importance of partnerships including medicolegal death investigators to overdose fatality review as part of a community strategy for innovative overdose prevention and intervention. We hope this discussion will provide ideas and guidance for communities such as those with the Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program funding to enhance their efforts to support implementation or expansion of data integration across agencies and systems to better identify target population needs and resource gaps, as well as improving program planning and decision making. Here to help us with the discussion is Dr. Mallory O'Brien, who consults on national overdose fatality reviews. Welcome, Mallory.

Mallory O'Brien [00:02:34] Hi, Paige. It's so good to be here.

Paige Presler-Jur [00:02:36] Mallory, according to your bio, you began your career studying injury epidemiology. Can you tell listeners a little more about what led you to intersecting with public health and public safety?

Mallory O'Brien [00:02:48] Certainly, I feel like it was a long time ago that I started working in this area, and I started working locally on a surveillance system, not a, like a criminal justice type surveillance system, but a public health surveillance system, to start tracking firearm injuries. So that was really my *entre* into this whole world. I am trained as an epidemiologist and so straddling the public health and public safety world has really been what I have done through my entire career. And interestingly, not only do I do that in my professional life, but in my personal life. My husband is a prosecutor, and so even at home, we're straddling public health and public safety.

Paige Presler-Jur [00:03:33] So what led you to your current national role supporting Overdose Fatality Review?

Mallory O'Brien [00:03:38] Well, as I mentioned, I started working locally on a surveillance system for firearm injuries. And that led me ultimately to the development of a incident

review process for homicides, again, locally. And I had been doing that for many years. At the time that I started overdose fatality reviews is when the overdoses were really starting to pick up. And so I was thinking about how do we apply a model that we knew was successful for reducing homicides - how do we take that and apply that to overdoses? And so from there, I created an overdose fatality review process for the state of Wisconsin, where we piloted in a couple of jurisdictions and expanded. And then I went to the national level working with the Bureau of Justice Assistance and the Centers for Disease Control on developing the National Overdose Fatality Review curriculum.

Paige Presler-Jur [00:04:37] I hope our listeners are ready to hear about the critical role that partnerships, including those with medicolegal death investigators, are to a multidisciplinary approach to conducting confidential reviews of fatal overdose cases to inform local overdose prevention planning. But first, I'd like to provide our listeners with the historical context that led us to fatality reviews. So, Mallory, can you tell us about the National Violent Death Reporting System or NVDRS?

Mallory O'Brien [00:05:07] Absolutely. For the development of the fatality reviews that I've been involved in, it really started for me with the National Violent Death Reporting System. I had worked with my colleagues at the Harvard Injury Control Research Center and the Centers for Disease Control on developing the National Violent Death Reporting System. And I'm sure many of the listeners, if not all of the listeners, are familiar with NVDRS because their information is paramount to be included in NVDRS. And one of the things that's awesome about the National Violent Death Reporting System is that it pulls information together from multiple sources on violent deaths. So it pulls information from the death investigation community, it pulls information from law enforcement, and it really allows state agencies and the Centers for Disease Control really to get a more complete picture of what's going on with violent deaths in their communities and across the United States. And so when you think about NVDRS, it's beginning to pull and link data sets. Now, the way the system works is that various providers share their information and it's entered into the National Violent Death Reporting System collection tool. What we tried to do when we were creating an incident review or fatality review process was really try and make that as person-centered as possible as opposed to report-centered. So instead of having a report go to the NVDRS data collection individual, it was having a person be part of a conversation from a particular agency. And so it was bringing people to the table as opposed to reports to the table. And what that did was it allowed for the expansion of agencies involved in the process. It involved in much more rapid review of the information because you could look at a case that happened last week or a month ago. You could start to begin to understand what occurred in that case and how that case might be similar to other cases and how you might start to think about prevention, intervention at a community level. And so that's really how we got from NVDRS to incident reviews, homicide overdose reviews. And I would be remiss if I did not mention that in addition to those fatality reviews, obviously there are child death reviews and fetal infant mortality reviews. And those reviews have been around for quite some time. And so as we were starting to think about homicide review back in 2005, 2004, we went and looked at the child death reviews as, you know, how are they doing it? What lessons can we learn from them as we begin to think about a homicide review, which then ultimately led to the development of the overdose fatality reviews.

Paige Presler-Jur [00:08:13] So it really sounds like the NVDRS impacted case and incident review as a whole. What recommendations resulted from these multidisciplinary conversations around case and incident review?

Mallory O'Brien [00:08:26] So if we're going to talk about homicide reviews, through that process, there was the development over a thousand different recommendations that ranged from small recommendations at an agency level to system wide change. And so some of those recommendations could look like a change in a local ordinance or another recommendation was looking at a state statute, a change in the state statute. Many of the recommendations revolve around information sharing and how to improve information sharing, because when you get to the core of a death, oftentimes someone didn't know something. And if that information would have been shared, it could have prevented that particular death. So you have recommendations that are around information sharing. There are also strategies that have been developed, strategies that are multidisciplinary. There are strategies that involve putting together teams that would address individuals that are returning to the community from prison, for example. These are homicide related examples. And then from the overdose fatality review side, there are recommendations that have come out at the local level that focus on locations where overdoses are occurring. For example, in hotels or motels, there are awareness campaigns about hotels and motels. There are enforcement kinds of activities that can occur. And there are other recommendations that look at, again, information sharing and partnership between, say, for example, child protection agencies and corrections where we know we have individuals that may be returning to the community from prison that also have contact with Child Protective Services to ensure that there is a continuum of care for that individual that's returning so that we don't see that next overdose - like ensuring that those agencies are communing among themselves and that the individual then is benefiting from whatever services are available from multiple agencies. So those are just a couple of examples of different types of recommendations that can come out of these reviews.

Paige Presler-Jur [00:10:46] And I feel like you touched on this in the recommendations, but can you tell us more about how post incident reviews became beneficial for both public health and public safety?

Mallory O'Brien [00:10:57] So when we started, and I would say this is true for both the overdose reviews and the homicide reviews, when we started these reviews, there wasn't a real strong relationship or partnerships between many of the agencies that sat around the table. And so some of the benefit was purely in bringing them together on a regular basis. And they started to network. They began to develop relationships of their own with their partners. So instead of wondering who should we go to, they had that person. And it might not be the right person in the agency, but they had someone that they could contact, that they had developed their own relationship with, that can help them move something through one of their agencies. So one is that they develop those relationships. Another is that they were able to develop some multidisciplinary responses - that they weren't just sitting siloed in their lane, but they were able to work with their partners in the development of those recommendations that led to change. And finally, I think one of the last things that has been so beneficial to both public health and public safety partners is the accountability, because as you do a review, part of what you want to do is you want to say, OK, what's happened since the last review? We made X, Y and Z recommendation, what's happened with those? So that there's this ongoing accountability through the process that ensures that change is happening, that action is being taken.

Paige Presler-Jur [00:12:34] I hope our listeners can sense how important cross discipline partnerships are for post incident reviews. So what is the first step towards a case review process and whose role is that?

Mallory O'Brien [00:12:46] If you think about a review, generally the reviews are hosted by the public health entity in the community. So you'll have public health or potentially a medical examiner or coroner's office taking the lead. Generally, those are the two lead agencies in a overdose fatality review process. They will coordinate all of the agencies. They will get the data use agreements in place. They will start looking at the data. But what's key in actually starting a case review is that death certificate, is that information from the medicolegal death investigation. So from the medical examiner, coroner, death investigator, that is what starts the process. So the way we recommend a case review begins is what do we know from the medical examiner, coroner. That includes the death investigation, the scene information that would have been gleaned through the death investigation, the toxicology - all of that information is where we start. And that is so critical. It's so critical to have the participation of someone from the medical examiner's office, the coroner's office or death investigator. I have been in multiple reviews across the country. And when the medical examiner, coroner is not present, oftentimes there's a void because not only can they provide the information on the investigation, oftentimes they are in the best position to explain the toxicology. What does this drug interaction mean? If there's X drug and Y drug, how could they interact? They are really in the best position to be answering all of those questions. The other part of the key role that the medical examiner coroner's office plays in the case review process is that the way you want to start out a case review, every meeting should start out with data. So what do we know about what's going on in our community? And the most up to date data, the best data to be looking at deaths is from the medical examiner coroner's office. So it's really key that there is representation and participation by the ME, coroner, or death investigator, because not only do they provide that awesome information on the scene in the death investigation, but they are the ones that have the best information on the deaths that are occurring in the community.

Paige Presler-Jur [00:15:21] Thank you for getting us through that history of post incident review and talking to us about the roles that start the process. We're looking forward to hearing even more about overdose fatality reviews or OFR. Can you start with defining OFR for our listeners?

Mallory O'Brien [00:15:37] Absolutely. So OFR or overdose fatality review is a way that we can start to better understand what is going on with the overdoses, specifically the fatal overdoses in a community. So it's allowing for multiple disciplines to come together to share their information, whatever that might be, on the decedent involved in the overdose, so that ultimately, new innovative prevention and intervention strategies can be developed to reduce the number of overdose deaths, not only locally, but nationally. In short, it's a multidisciplinary team that comes together on a regular basis to better understand the nature of overdoses, specifically fatal overdoses, to develop those intervention and prevention strategies.

Paige Presler-Jur [00:16:33] And what positive impacts can OFRs have on communities battling the substance use disorder crisis facing our nation?

Mallory O'Brien [00:16:40] There's a couple of ways that OFRs can impact communities. One is it provides much more detailed data than, for example, the medical examiner can provide because it allows for communities to not just look at one sector and how one sector responded to an individual involved in an overdose, but multiple agencies. So it first allows the community to have much better information on what transpired leading up to an overdose. And then secondly, it provides opportunities, again, as I mentioned, to develop those recommendations that lead to those prevention and intervention strategies. Some of

the strategies that are developed may be unique to the community or those strategies might be going on somewhere else in the country. They don't have to reinvent the wheel, but they can think about going to, for example, one of their TTA providers, because we know that with many of these federal grants that folks have across the country, there is also TTA provision. I can't stress enough using that TTA provider, training and technical assistance provider. They can provide so much guidance on ways to combat overdose, ways to work better with your partners. And as I'm saying that, there is also extensive resources for overdose fatality review. There is on the Institute for Intergovernmental Research website, there is a COSSAP resource page. I just encourage everybody to use the technical assistance opportunities that are available to them.

Paige Presler-Jur [00:18:23] You have explained to us how the death certificate is the foundation to a post-mortem OFR which really highlights the critical importance of a medicolegal death investigator in being a multidisciplinary partner. What, then, does participation in an OFR provide to them?

Mallory O'Brien [00:18:41] So it's important because, as I mentioned, the information they provide is critical to the process. It's the starting point of the case reviews. What does the death investigator get out of it? Well, it's participating in the process. It's being part of the solution. It's being part of the development of those prevention and intervention strategies to reduce the number of deaths that are occurring in their communities. But I can also give you other examples where there were benefits to the medical examiner or coroner in participating in the reviews. It led to opportunities for them to receive additional funding for things that they needed in their offices. For example, I know there was one medical examiner's office that was part of an overdose fatality review team that needed assistance with toxicology. So there was a grant that was written and part of it included additional staff for the medical examiner's office. In that same proposal, there was the addition of the social worker to be working with the families of the victims. So there are benefits financially as well as being part of the solution. The other thing I think it brings to the medicolegal death investigator is the opportunity to learn more about how others are interacting with the overdose victims prior to the event. That is one of the things that I've seen happen over and over again is individuals go into these reviews and into these multidisciplinary teams thinking they know what another agency does and how they can or should be interacting with that agency. And oftentimes there's way more opportunity than they understand. And so coming together on a regular basis, as I mentioned, develops those relationships. But it also allows them to see how they can expand their interactions and relationships and how they can be part of more of what's going on in their community.

Paige Presler-Jur [00:20:49] What are some challenges of successful overdose fatality reviews that you'd like to highlight for our listeners?

Mallory O'Brien [00:20:55] Some of the challenges that I've seen - one, obviously, is the lack of participation. If you're missing one of those key players in the review process, you're often missing that chunk of information. And the value in doing these is really that multidisciplinary information sharing. And again, I've said this before, but it's really the only place I've seen where there is this real information sharing that occurs between all of the partners that allows for that development. So if you think about the world of medicolegal death investigation, it's as we talked about, it's the scene investigation, it's the investigation of the body, it's the toxicology. But with the other partners, you learn their interactions with behavioral health, with law enforcement, with prosecution, with the court, so they may have been part of a drug court, with corrections. You may learn about their education. You may learn about their prescription drug monitoring data. You may learn about their prior

hospitalization. And without one of those pieces of information, you may be missing a huge opportunity to prevent future overdose deaths. What I've said is, if you can get three or four of those main agencies to start participating and sharing information, you can accomplish a lot. But the more you can bring to the table, the better your outcomes will be. So it's participation and information sharing. If you don't have it, it's hard to continue the process. Another area that I think is really important and can be a challenge is the development of those recommendations and the implementation of those recommendations. If there isn't action being taken at those case reviews, people are not going to want to come back. So that's a challenge. From the medicolegal death investigation, again, as I've worked with jurisdictions across the country, the challenges in terms of the amount of time that they have, especially today. There are so many different types of deaths that are occurring in communities that are really pulling the medical examiner, coroner in different directions, that just having the time to be able to devote to an overdose fatality review can be a challenge. And, you know, the other is the cost. Sometimes we see in some of the smaller jurisdictions that even the cost of doing an autopsy or toxicology can be a barrier because they don't have the funds to actually do the autopsy or the toxicology. One additional, I think, challenge to an overdose fatality review is ensuring that the data is accurate in terms of are we capturing all of the overdose deaths? In some jurisdictions, I've seen where the numbers seem really low based on what we would expect, based on, for example, EMS data. And so the concern becomes, are all of the overdose cases correctly coded as an overdose? And so that is a challenge. If we're not looking at all of the right cases or we have an undercount of those overdose deaths, that can be a challenge. And then the second part of that is that often leads to the cause of death being accurately coded is the toxicology. And some of the issue there is that jurisdictions just don't have the funds to do all of the toxicology that's required. And in some cases, it takes a long time for the toxicology to come back if they are doing it. And so there's often a real time lag between when the death occurs and when the toxicology is back for the coding of the cause of death. So those are a couple of challenges that can interfere with the success of an overdose fatality review from the death investigation side.

Paige Presler-Jur [00:25:09] It's really insightful to hear about the importance of partnerships and incident reviews. Can you share examples of how incident reviews led to recommendations and reductions of harm within communities?

Mallory O'Brien [00:25:23] Paige, that's an excellent question. Let me first start by saying that from the homicide review process, there was an evaluation that was conducted by a couple of my colleagues - one at the Harvard School of Public Health and the other at the Kennedy School of Government at Harvard. So, again, thinking criminal justice and public safety, that was included in the evaluation component. And that evaluation showed that in the districts that participated in the review, there was a fifty-two percent decrease in the monthly counts of homicide compared to a nine-point-two percent decrease in the districts that did not participate in the review. Now, obviously, that's a statistically significant decrease and that led then to the expansion of the homicide review citywide. And that is why I personally believe and others believe that if you do this process right, you can make a substantial difference in the type of incidents that you're reviewing. So that's an example of, statistically, of how those homicides were reduced in a community. When we think about overdose fatality reviews and the reductions, I think it's too early to tell. Overdose fatality review is a relatively new process that's being implemented, again, in multiple jurisdictions. But I think it's too soon to be looking at it from an evaluation perspective. There are efforts underway both to begin to look at the success of the OFRs. There are ways that you can take a look at an overdose fatality review and say, is this successful? So what are some of those that aren't looking at the reductions but at the success of the

process? And that is, are you having partners continually show up, prepare, and participate in the reviews? Are you able to develop recommendations? Are those recommendations that you're developing, are they actually being implemented? Are you taking action based on the recommendations that are being developed? Are you seeing these partnerships strengthened and people develop those relationships? If you can say yes to all of those, you're on the road to success. You're on the road to actually getting those reductions that you're seeking.

Paige Presler-Jur [00:27:47] How can jurisdictions build capacity to create sustainable OFR partnerships?

Mallory O'Brien [00:27:52] There is a whole toolkit that's available for overdose fatality reviews and the development of those partnerships, and that is, again, at the cossapresources.org. There is a practitioner's guide for implementation. There are many template documents that you can easily lift and change to meet your needs. Some of those include confidentiality agreements. They include information sharing agreements across agencies. They include data collection tools. They include template PowerPoints. There are also webinars that have been recorded that you can take a look at and check out and share with your partners. For example, OFR 101. There's a couple of other webinars that you might want to take a look at. And then there's also a way that you can ask for TTA and that would be through using again at the cossapresources.org. You can request TTA, training and technical assistance on overdose fatality reviews and someone will respond to you quickly. It might be someone at IIR or it might be somebody in the field. There are BJA peer mentor sites that might reach out and help you, or there are Centers for Disease Control peer-to-peer TTA providers. So there's lots of opportunity for people to come in and assist your jurisdiction in developing the process and the partnerships. In addition, when COVID hit and we realized that people were not going to be able to meet in person anymore, we created some tools for virtual OFRs. And so there is even information on what platforms to be considering, how you ensure the confidentiality - all of that is included. You know, I always try and look for the silver lining, and what are some of the positives that you take away from the work that we're doing? So for me, looking at these deaths, I'm always looking for, well, how can we prevent the next one? But in this case, thinking about how we've gone to a virtual OFR is really beneficial for many jurisdictions. Some of the OFRs that are occurring in the more rural jurisdictions may continue to do them beyond COVID because it really eases people's time. There's not the huge travel to get to the case review. The one downside, obviously, is there's a lot that can be gained from being in a room with other individuals and as a facilitator, sometimes it's hard to read the room if you can't see someone fidgeting or them kicking their, you know, their feet under the table and whatnot. But I think in the long run, for some jurisdictions, they may continue to do the virtual meetings because it just is easier for everybody. But that's one of the benefits, I think, that we've seen is that it allows more jurisdictions to actually do the reviews in a timely fashion.

Paige Presler-Jur [00:30:57] And what are ways you would suggest to our listeners on how to think creatively to support building partnerships to enhance data integration across their agencies?

Mallory O'Brien [00:31:06] One example that I gave you earlier around a recommendation, I think is a really good example. Because the medical examiner's office, coroner's office was engaged in the process, they were able to purchase some new equipment that was necessary for the toxicology. The grants that a medical examiner or coroner can be involved in could leverage resources from buying equipment to actually

paying for staff time. And so all of that leads to that data integration across agencies. It allows potentially for more rapid information exchange, but certainly it allows for stronger partnerships.

Paige Presler-Jur [00:31:55] We're running near the end of our time together. Are there any final thoughts you'd like to share with our listeners?

Mallory O'Brien [00:32:01] My final thoughts for listeners is to really encourage participation in the overdose fatality reviews. One of the huge advantages to doing these case reviews and bringing people to the table - if you think about reviewing a report, I can review a police report and I've reviewed enough that I have a good understanding of what I'm reading and what's going on in the case. But by having an individual from, say, a police agency reviewing the report and sharing that information, oftentimes there's so much that's not known to me because I don't do police work. And so having a police officer kind of read between the lines of what's in a report is so valuable because that information is not gleaned from a report. It's only because you have people in the room that can share that information and their experience. So whether it's a law enforcement officer or it's a medical examiner, being able to go beyond what's in the report is so important to understanding the incident itself. Not only is it so key to the success of the reviews that you have a medical examiner or coroner or a representative from your office participating because of the valuable information that's gleaned through the death investigations that are completed by our officers. But it's also a way to really strengthen those partnerships across the community and to be involved in the solution.

Paige Presler-Jur [00:33:37] I'd like to thank our guest today for sitting down with Just Science to discuss the creation of sustainable overdose fatality review partnerships, including the critical importance of the participation from the medicolegal death investigation community, as a strategy for innovative overdose prevention and intervention. Thank you, Mallory.

Mallory O'Brien [00:33:57] Thanks, Paige.

Paige Presler-Jur [00:33:58] If you enjoyed today's conversation, be sure to like and follow Just Science on your podcast platform of choice. For more information on today's topic and resources in the forensic field, visit forensiccoe.org. I'm Paige Presler-Jur and this has been another episode of Just Science.

Voiceover [00:34:19] Next week, Just Science interviews Tim Black of the White Bird Clinic in Eugene, Oregon, about the CAHOOTS program, an initiative that provides mental health first response for crises involving mental illnesses, homelessness, and substance abuse disorder. Opinions or points of views expressed in this podcast represent a consensus of the authors and do not necessarily represent the official position or policies of its funding.