OVERDOSE FATALITY REVIEW

Annual Report 2024

OAKLAND COUNTY
MICHIGAN
HEALTH DIVISION

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#25-132

Summary

This report is dedicated to those who have tragically lost their lives to overdose, and to the loved ones and communities profoundly impacted by these immeasurable losses. Overdose deaths are a critical public health issue, and we must continue to raise awareness and build collaborative efforts that can help prevent further tragedies.

We recognize the unwavering commitment of the many individuals across the county who contribute to our Overdose Fatality Review (OFR) team. These professionals are united in addressing overdose deaths as a community problem. Their willingness to step outside their traditional roles, examine the circumstances that contribute to these deaths, and work together to identify strategies for prevention makes these efforts possible.

Through their efforts, we gain a deeper understanding of the complexities surrounding overdose fatalities, and aim to honor the memory of those lost. Our collective goal is to strengthen community well-being by fostering a unified, informed approach to prevent future overdose deaths.

This report serves as a reminder that every effort counts in the fight to protect our communities. We remain committed to honoring those we've lost by progressing toward meaningful change to prevent future loss.

Resources

Crisis support (24 hours, 7-days a week): 988 (call or text)
Oakland Community Health Network Access Line: 248-464-6363
Oakland County Nurse on Call: 1-800-848-5533

Overdose Fatality Review Background

Overview and Purpose

In December 2023, an Overdose Fatality Review (OFR) team was established in Oakland County to enhance strategies for understanding and addressing the overdose crisis at the local level. We accomplish this purpose by examining individual, organizational, and systems-level factors related to overdose deaths that occur in Oakland County.

Key Objectives

Enhance understanding regarding trends of overdose in the local community	Identify missed opportunities for prevention and intervention	Implement innovative, community-specific overdose prevent strategies

In alignment with Michigan Public Act 313 of 2023, an act that provides for the review and prevention of deaths that occur from drug overdose in the state of Michigan, Oakland County's OFR is responsible for the following actions:

- Promoting cooperation and coordination among agencies involved in the investigation of drug overdose fatalities
- Identifying potential causes and incidence of drug overdose fatalities
- Recommending and planning for changes to prevent drug overdose fatalities
- Proposing potential changes to law, policy, funding, or practices to prevent drug overdoses
- In consultation with the Michigan Department of Health & Human Services (MDHHS), establishing and implementing protocols and procedures to carry out all processes of the overdose fatality review process
- Recommending prevention and intervention strategies, focusing on evidence-based strategies and promising practices and improving the coordination of services

Process Overview

Oakland County OFR meets monthly and consists of confidential reviews of individual overdose cases and community-level data to facilitate identification of prevention and intervention missed opportunities.

BEFORE

- Selection of case(s) for review
- Collection of data and information from partners

DURING

- Review of case-specific and community-level data
- Discussion of case circumstances and system gaps
- Identification of recommendations

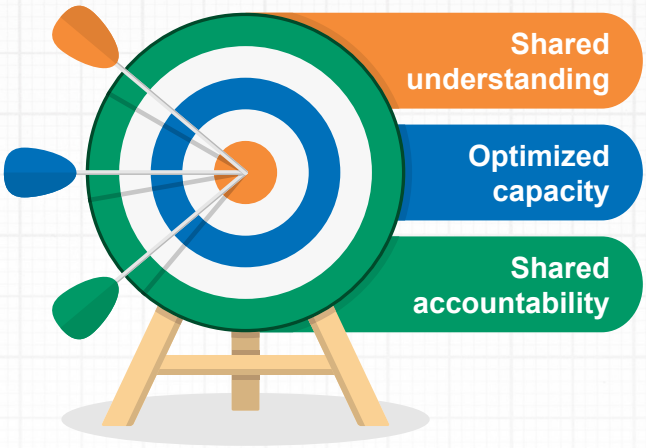
AFTER

- Recommendations provided to OFR subcommittees
- OFR subcommittees develop action plans for implementation

Overdose Fatality Review Background

Goals

The OFR process is driven by the following S.O.S (shared understanding, optimized capacity, and shared accountability) goals:



- Enhanced understanding of area agencies' roles and services
- Increased knowledge of community assets and needs, substance use and overdose trends, existing prevention activities, and system gaps
- Expansion of the community's overall capacity to prevent future overdose deaths by leveraging resources from multiple agencies and sectors.
- Advancement of a system-level approach to the overdose crisis throughout the community
- Continuous monitoring of local substance use and overdose death data
- Oversight of recommendation implementation activities
- Ongoing reinforcement of accountability for action

OFR Partners

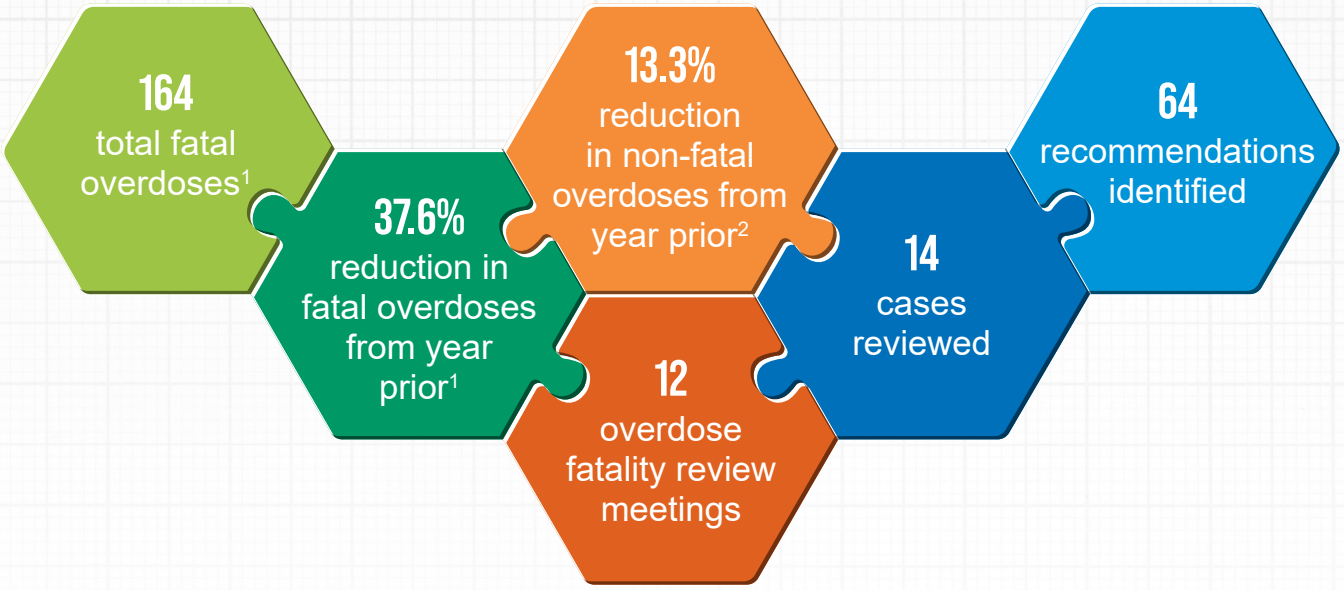
The Oakland County OFR process convenes a diverse group of multidisciplinary partners from numerous community sectors. The OFR team is united by the recognition of substance use as a chronic, treatable disease, an understanding that overdose deaths are preventable, and a shared commitment to continuous improvement.

Collaborating Partners Represent the Following Sectors and Agencies:

- Alliance of Coalitions for Healthy Communities
- Oakland County Medical Examiner
- Oakland County Harm Reduction
- Law enforcement
- Probation
- Oakland County Health and Human Services
- Oakland County Prosecutor's Office
- Face Addiction Now
- Emergency Medical Services partners
- Oakland County Board of Commissioners
- High Intensity Drug Trafficking Area
- Hospital partners
- Mental health providers
- Oakland County Pretrial and Justice Services

Data Trends and OFR Findings

Key Stats and Trends: 2024 at a Glance



Promising Trends and Ongoing Efforts in Reducing Overdoses

Recent data suggests a promising shift in overdose trends, with declines in both fatal and non-fatal overdoses in Oakland County in 2024. This progress is made possible by collaborative efforts from community partners and the unyielding commitment of many to identify key intervention points and remain resilient in the face of evolving challenges.

While these declines are encouraging, the work is far from over. Continued attention, resources, and support are essential to building on this progress. Not all populations and communities have equally benefited from the decreasing trends. Further progress is needed to more effectively engage at-risk populations with targeted outreach and support. Sustained efforts are crucial to ensure these positive trends continue and reach all members of the community. The Oakland County OFR team remains committed to ongoing collaboration and driving recommendations into actionable solutions to bolster this promising progress.

[1]Data Source: Oakland County Medical Examiner's Office. Deaths included in this report are those that occurred among individua ls who were pronounced deceased within Oakland County and were classified as overdose-related by the medical examiner based on investigations that include autopsies, toxicology reports, and other relevant findings. These deaths may involve prescription and/or illicit substances. All overdose deaths included in this report are classified as having an indeterminate manner of death due to limitations in ability to definitively determine whether these deaths were intentional or accidental.

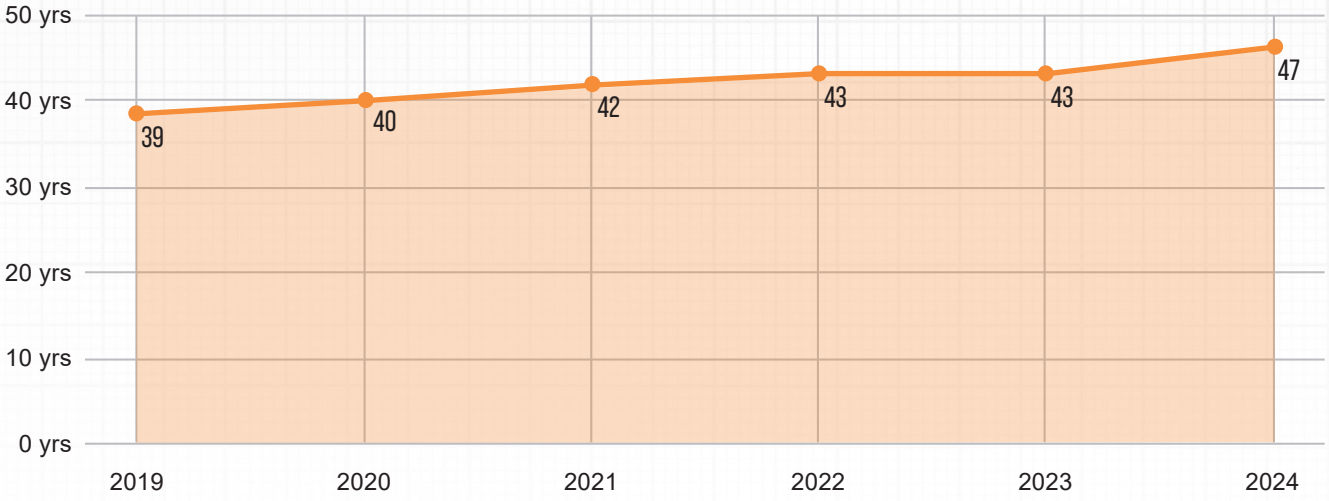
[2]Data Source: Biospatial Emergency Medical Service data using the "Overdose (MI)" syndrome which is based on criteria provided by the Michigan Department of Health and Human Services (MDHHS). Results were restricted to non-fatal, transport data.

Data Trends and OFR Findings

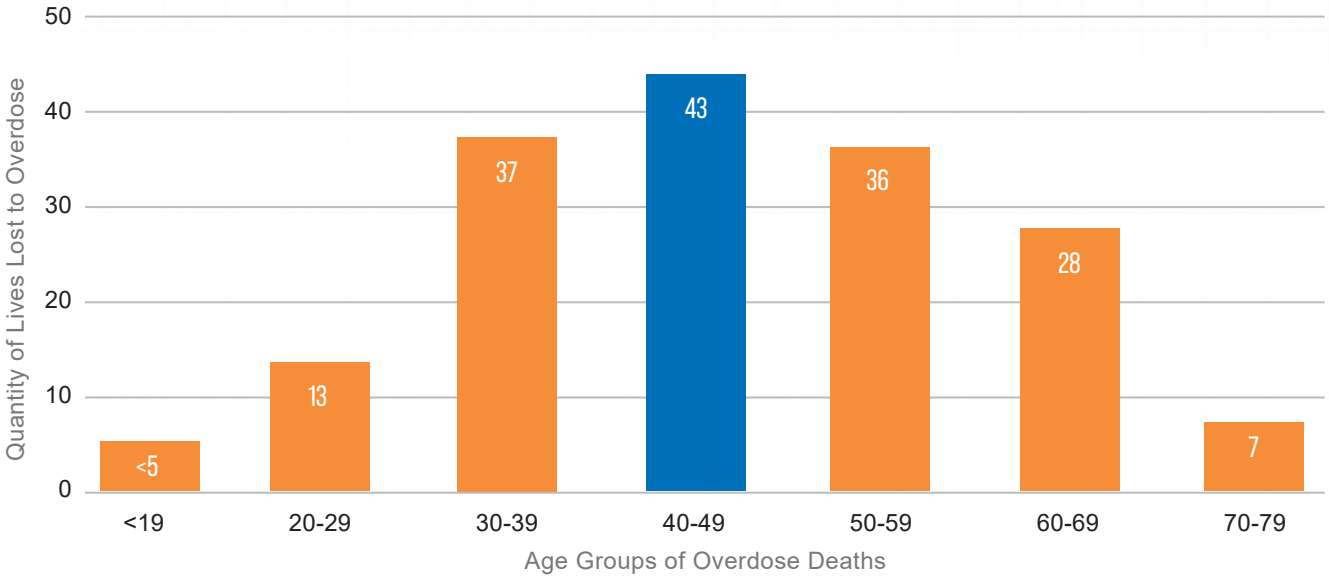
Age-Related Trends Among Oakland County Overdose Deaths

The median age of overdose deaths increased by 4 years overall from 2023 to 2024. While median age has been increasing gradually since 2019, the increase from 2023 to 2024 is the most substantial single-year increase that has occurred in the past 6 years. In 2024, individuals in their 40s made up the largest age group who experienced a fatal overdose. This differs from prior years in which individuals in their 30s were the predominant age group for fatal overdoses in Oakland County.

Median Age at Death: Slow Increase Over Time



Overdose Deaths by Age Group: People in their 40s Have the Highest Quantity of Deaths



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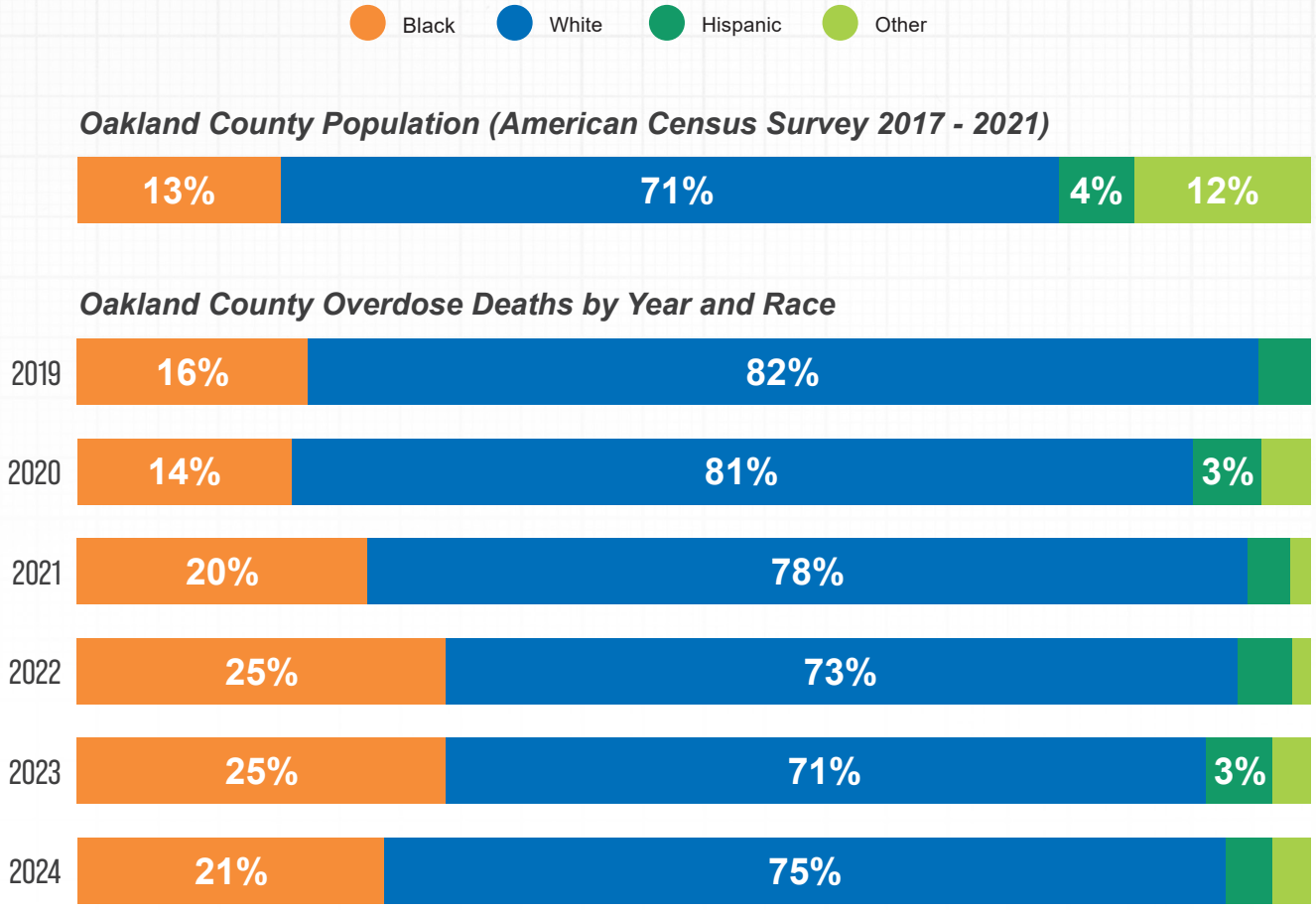
Data Trends and OFR Findings

Race-Related Trends in Oakland County Overdose Deaths

From 2023 to 2024, overdose deaths increased among White individuals and decreased among Black individuals. Although the decline in Black overdose deaths is promising, racial disparities persist. Black individuals make up 13% of Oakland County's population, yet represented 21% of overdose deaths in 2024.

Overdose Deaths by Race/Ethnicity from 2019 - 2024



Data Source: Oakland County Medical Examiner's Office. Deaths included in this report are those that occurred among individuals who were pronounced deceased within Oakland County and were classified as overdose-related by the medical examiner based on investigations that include autopsies, toxicology reports, and other relevant findings. Race/ethnicity data is initially determined by the Medical Examiner investigator and finalized by the funeral home before being listed on th e death certificate.

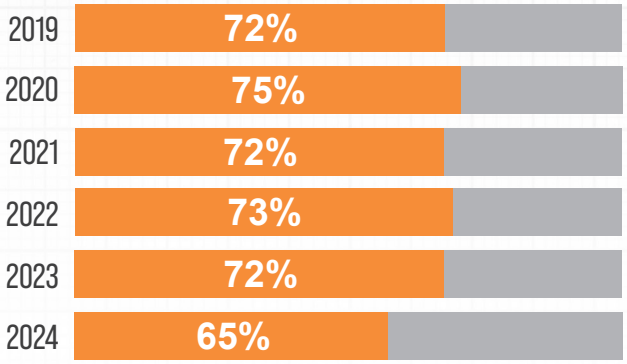
Data Trends and OFR Findings

Monitoring substance-related trends in Oakland County is essential for guiding OFR efforts. As the landscape evolves, these trends play a key role in informing initiatives.

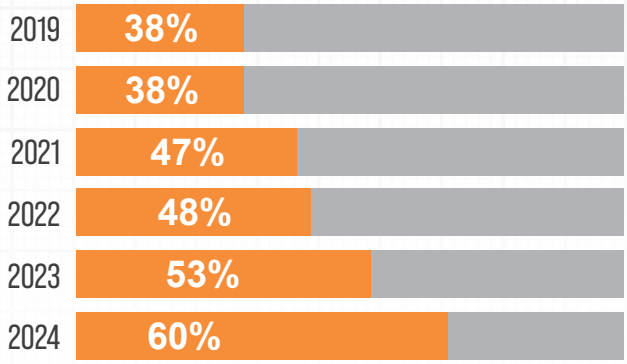
Fentanyl-Related Trends Among Oakland County Overdose Deaths

Percentage of overdose fatalities with fentanyl or fentanyl analogues present in toxicology decreased in 2024. While 72% of fatal overdoses in 2023 had fentanyl or its analogues present in toxicology, this dropped by 7% to 65% of the 164 overdose fatalities in Oakland County in 2024.

Percentage of Deaths with Fentanyl or Fentanyl Analogues Present in Oakland County by Year, 2019 - 2024



Percentage of Deaths with Cocaine or Benzoylecgonine Present in Oakland County by Year, 2019 - 2024



Cocaine-Related Trends Among Oakland County Overdose Deaths

Overdose fatalities involving cocaine or its metabolite, benzoylecgonine, have steadily increased over the past six years. While 53% of overdose fatalities in Oakland County had cocaine or its metabolite present in 2023, this increased to 60% in 2024.

Additional Substance-Related Trends Among Oakland County Overdose Deaths

- The percentage of overdose deaths with both fentanyl (or its analogues) and cocaine (or its metabolite) present in toxicology increased in 2024
- Deaths with xylazine present in toxicology decreased from 2023 to 2024
- Although fatalities with fentanyl or fentanyl analogues present decreased, they continue to be present in the majority of local drug-related deaths.

Data source: Oakland County Medical Examiner's Office. Deaths included in this report are those that occurred among individuals who were pronounced deceased within Oakland County and were classified as overdose-related by the medical examiner based on investigations that include autopsies, toxicology reports, and other relevant findings.

[1]Deaths are classified as having fentanyl or fentanyl analogues present if any substances within this classification are present in toxicology findings. Fentanyl analogues include acetylfentanyl, para-Fluorofentanyl, and carfentanil. This also includes presence of the fentanyl metabolites, 4-ANPP or norfentanyl, in toxicology results.

[2]Deaths are classified as having presence of cocaine or its metabolite, benzoylecgonine in toxicology findings. Deaths that have benzoylecgonine present in toxicology without the presence of cocaine is an indicator of recent cocaine use.

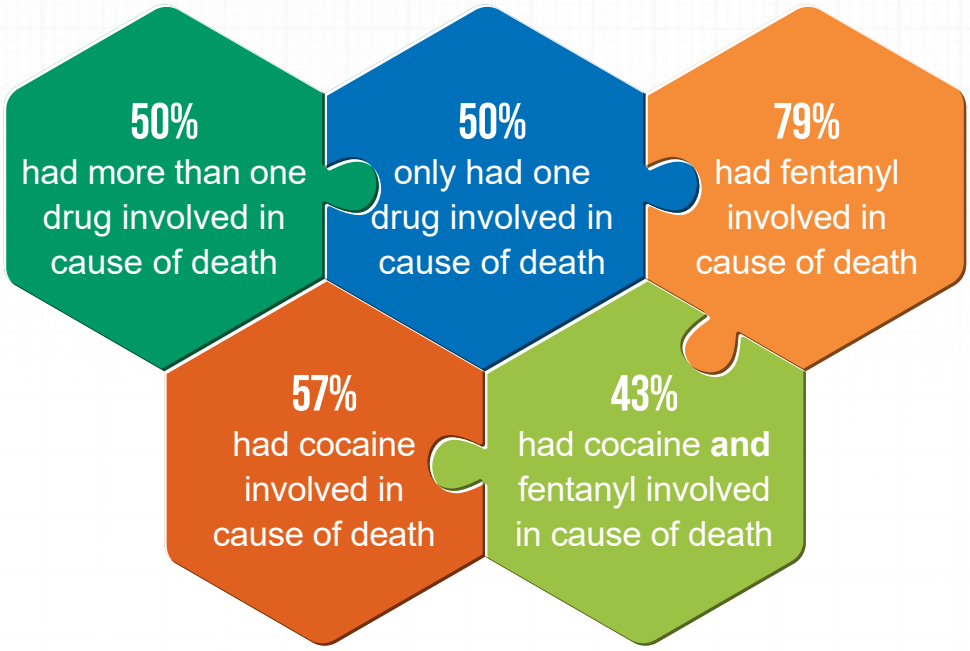
Data Trends and OFR Findings

In-depth reviews of individual overdose cases reveal additional insights that enhance our understanding of the local overdose crisis, building upon knowledge gained from community-level data. Summary information for the 14 overdose fatalities reviewed by the OFR team in 2024 is included below.

Cases Reviewed Through OFR: Demographic Information

- The median age of the cases reviewed was 38 years, with 50% of the cases being in their 30s and 36% aged 40 years or older at the time of their passing
- 64% of cases reviewed were male and 36% were female
- 64% of cases were White and 29% were Black or African American
- 64% were single (never married), 29% were divorced, and 7% were married
- 79% of cases reviewed were employed at the time of their passing
- 64% of cases were high school graduates or received higher education

Cases Reviewed Through OFR: Substance-Related Trends



Cases Reviewed Through OFR: Additional Insights

- 80% of cases reviewed experienced a fatal overdose at a residence and 20% experienced a fatal overdose at a hotel or motel
- Multiple cases reviewed were known to have experienced co-occurring substance use disorders and mental health conditions
- Several of the female cases reviewed were known or suspected to be victims of human trafficking

Progress & Next Steps

Translating OFR Recommendations into Action: PHAST Subcommittees

Public Health and Safety Team (PHAST) is a framework created by the Centers of Disease Control and Prevention (CDC) that aims to assist local jurisdictions in reducing overdose deaths through increased collaboration and coordination across sectors. OFR and PHAST are complementary frameworks guided by the same principles and processes.

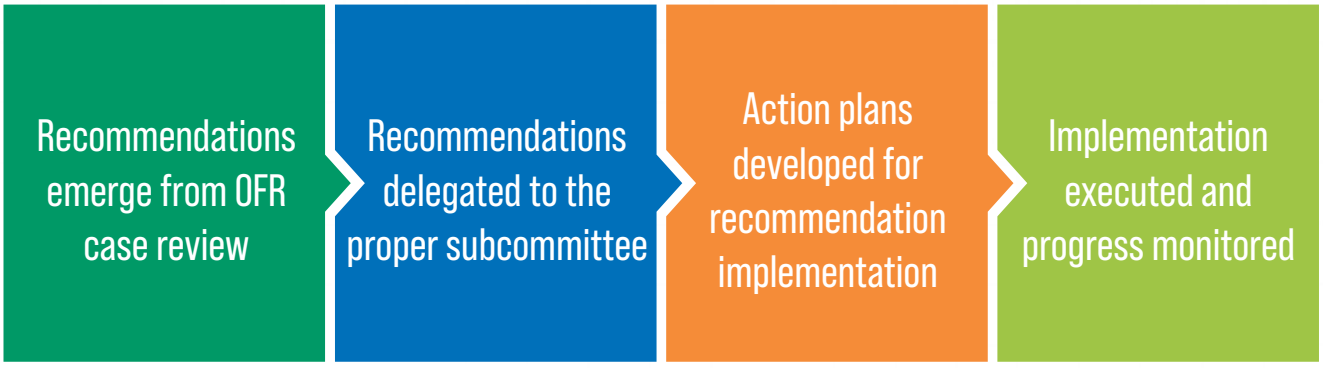
The PHAST model has been integrated into the Oakland County OFR, public health and public safety subcommittees were established in fall of 2024 as an extension of OFR efforts to advance this framework in the community and continue bridging gaps among sectors. Public health and public safety subcommittees meet monthly, as well as jointly on a quarterly basis to align efforts.

PHAST Subcommittee Goals

- Facilitate coordinated and data-driven action based on OFR recommendations
- Ensure that recommendations that emerge from the OFR are implemented into action
- Develop, oversee and evaluate short-term and long-term action plans for recommendation implementation

PHAST Subcommittee Responsibilities

The subcommittees leverage the expertise of partners and stakeholders in public health and public safety to transform OFR recommendations into actionable strategies. The key focus of the subcommittees to develop and implement targeted initiatives that address the gaps and needs identified through OFR.



Progress & Next Steps

Recommendation Themes

Below lists the number of recommendations grouped by themes, highlighting the key focus areas that have emerged from Oakland County Overdose Fatality Review meetings in 2024.

See Appendix A for all recommendations.

Recommendation Progress Highlights

Coordinated efforts have begun addressing the 64 recommendations from Oakland County's first year of Overdose Fatality Review meetings. Collaboration between the OFR team and PHAST subcommittees supports evidence-based, data-driven actions. Below is an overview of key progress area.

1. Expanding Collaborative Strategies and Bridging Connections

One area of success has been the expansion of collaborative approaches and increased coordination within the Substance Use Disorder (SUD) space. Ongoing OFR efforts have fostered stronger partnerships and collective action.

Related recommendations:

- Improve data sharing practices across organizations
- Increase buy-in for data sharing through awareness of OFR
- Enhance inter-organization collaboration to streamline resource access

Implementation progress:

- Broadened OFR membership to incorporate additional perspectives
- Enriched information acquired for OFR case reviews to improve insights obtained and strengthen recommendation development
- Improved communication among partner agencies for better coordination
- Cultivated new partnerships and collaborations among agencies

Progress & Next Steps

2. Advancing SUD Support Throughout the Justice System

Case reviews revealed frequent justice system touchpoints, leading the OFR team to facilitate ongoing discussions to improve SUD support.

Related recommendations:

- Incorporate input from formerly incarcerated individuals
- Develop strategies for enhanced law enforcement interagency collaboration
- Improve “flagging” of SUD concerns during justice involvement

Implementation progress:

- Developed a survey to identify opportunities for improving support for recently incarcerated people, particularly post-release
- Guided conversations among law enforcement to bridge gaps in coordination
- Held ongoing discussions on the need for a unified ‘flagging’ approach by law enforcement agencies to support connection to resources

3. Strengthening Approaches to Coordination of Services

An important insight from OFR case reviews is that while many areas of Oakland County are well-resourced, there is a significant need to improve the coordination of resources to optimize efficiency, care coordination, and service delivery.

Related recommendations:

- Address areas of disconnect between the judicial system, peer support, and other support services
- Develop and distribute a consolidated, streamlined resource flyer
- Increase awareness of the Oakland County Crisis Response Unit throughout the county

Implementation progress:

- Discussed need for communication among key partners and began conversations to reduce barriers
- Convened key partner agencies to begin curating a simplified list of vital resource access points
- Distributed information about the Crisis Response Unit to stakeholders throughout the county
- Identified specific needs for service coordination & conceptualized strategies targeting existing needs

Next Steps and Future Directions

Emphasis will be placed upon advancing key initiatives, refining practices, and fostering new collaborations to address emerging needs. Future actions may include the following:

- Selecting cases for review that align with identified needs, such as those from rural areas, older adults, and individuals experiencing housing instability
- Exploring partnership opportunities with law enforcement touchpoints commonly identified in cases
- Refining OFR practices to improve the review process and facilitate recommendation implementation
- Expanding connections with additional sectors to enhance collaboration
- Strengthening efforts to improve resource coordination and reduce silos

Appendix A: All Recommendations

Theme: Education and Training
Increase targeted education about fentanyl in drug supply
Learn about best practices for next-of-kin interviews and consider implementing
Improve trauma-responsive approach in district courts
Encourage providers to ask about supplement use and anticipate potential drug interactions
Facilitate human trafficking training for law enforcement officers in Oakland County to improve understanding of identifying trafficking scenarios and supporting victims
Connect human trafficking unit with Oakland Community Health Network for crisis training (tentatively to be combined with law enforcement training)
Implement comprehensive training and education on the root causes substance use disorders for first responders to improve understanding, compassion, and response effectiveness
Develop targeted initiatives to address burnout among first responders and co-responders, especially in relation to responding to substance use disorder-related calls and recurring responses to the same community members
Enhance substance use-related educational support for all elementary and middle school students, focusing on mainstreaming efforts and ensuring that resources are comprehensive and inclusive of students with individualized learning needs
Provide widespread education to clarify the distinctions between neurodevelopmental disorders and mental health conditions, especially to providers and first responders, to reduce stigma and improve approaches to care

Theme: Communication
Increase communication with neighboring jurisdictions about drug supply concerns
Define language around polysubstance use, sobriety, and recovery
Evaluate strategies for communication (regarding areas such as Overdose Fatality Review awareness, drug supply trends, bad batch alerts, etc.)
Address stigma related to medication for opioid use disorder within the courts, recovery communities, providers, and the broader public

Appendix A: All Recommendations

Theme: Harm Reduction

Standardized naloxone training through the county, aligning education and marketing
Provide a way for individuals to reach out for help following Narcan utilization
Increase access to harm reduction services in all areas of the county and enhance access education
Harm Reduction clinic to implement release of information and a safety net for clients who receive inpatient care
Include the jail admission question: “Have you received Narcan and did it work?“
Provide naloxone at release (moderate impact when given to a target group, high impact when included in property box for everyone)
Enhance harm reduction capacity and knowledge around return to use, including training for providers and law enforcement

Theme: Support for Justice-Involved Individuals

Coordinate continuous care for medication for opioid use disorder programs within correctional settings
Improve “flagging” of substance use disorder concerns during justice involvement for other issues, including a red flag system in Courts and Law Enforcement Management Information System for increases in law enforcement encounters
Improve early identification and supportive action for substance use disorder among justice-involved individuals
Address areas of disconnect between the judicial system, peer support, and other support services in the community
Increase awareness of the Oakland County Sheriff’s Office Crisis Response Unit throughout the county by presentations to outpatient counselors at Meridian Health Services and staff at the Prosecutor’s Office
Facilitate the implementation of a universal in Courts & Law Enforcement Management Information System code among law enforcement agencies in the county to enhance tracking of drug-related cases
Ensure all overdoses responded to by law enforcement create a report to optimize tracking of overdose cases and help facilitate the work of the Oakland County Sheriff’s Office Crisis Response Unit

Appendix A: All Recommendations

Theme: Outreach and Collaboration
Connect to local support networks
Enhance inter-organization collaboration to streamline support and resources
Conduct outreach at hotels and motels
Improve access to supportive housing and reduce barriers to housing for individuals with substance use disorder, leveraging partnerships to increase vetted sober living homes
Have emergency medicine representation at Overdose Fatality Review meetings
Add prosecutor and judge to Overdose Fatality Review team membership
Incorporate input from formerly incarcerated individuals
Enhance coordination between schools and law enforcement when a crisis arises
Develop strategies for enhanced interagency collaboration and data sharing among all local law enforcement agencies
Connect with local treatment providers to facilitate discussions and reminders surrounding the importance of compassionate care for those experiencing SUD
Evaluate opportunities to build up resource connection across county lines to streamline systems and minimize duplication of services

Theme: Treatment
Investigate policies on refusal of service at treatment facilities and crisis centers and engage in conversations with stakeholders to determine how policies may be adapted
Establish a no barrier/low barrier/no turn away location for treatment
Advocate at the state level for changes to the existing reimbursement structure and improved funding for treatment centers to reduce barriers for readmission
Address differences in accessibility of intensive outpatient treatment programs
Address the need for integration and alignment of the Oakland County Crisis Response Unit with medication for opioid use disorder programming

Appendix A: All Recommendations

Theme: Resource and Support Access
Develop and distribute a resource flyer
Increase access to case management
Improve conditions and oversight/support at “informal” housing solutions for people with substance use disorder and returning citizens
Equitable resource allocation throughout the county
Support proactive prevention for children with family history of substance use disorder, particularly those involved in child placement system
Improve family services and research evidence-based prevention for children impacted by substance use disorder among parents and caregivers
Address aftereffects of overdose on loved ones
Improve mental health and substance use disorder support for postpartum parents (including fathers) with history of substance use disorder
Hire Family Advocate at the Oakland County Medical Examiner’s Office
Assess options for providing support to patients with neurological conditions
Promote recovery friendly workplace initiatives and minimize employer barriers to inpatient treatment
Address gaps in the availability of long-term programs for individuals with substance use disorders
Enhance resources and support for those facing co-occurring domestic violence and substance use, including among crisis response, peer support, and housing services
Generate strategies for expanded 24/7 access to warm lines and peer support for victims of human trafficking beyond the volume of calls the crisis team has the capacity to handle
Investigate support options for human trafficking victims that are low barrier and available to those who are intoxicated or don’t have family support

Appendix A: All Recommendations

Theme: Resource and Support Access – Continued
Develop a connection between the Oakland County Sheriff's Office Crisis Response Unit and Medical Examiner's Office to provide support following an overdose death
Increase awareness of the Michigan Health Professionals Recovery Program, especially within the courts, including ability to self-refer into the program
Investigate options for supporting victims of sexual or physical assault in reporting and throughout the duration of court processes
Invest in development and expansion of sober living infrastructure throughout the county that is accessible and well-supported
Investigate and implement strategies to support adults with co-occurring neurodevelopmental disorders and substance use disorders, ensuring that integrated care addressing both is available and accessible

Theme: Data
Develop strategies for collecting additional data on Naloxone usage (i.e. QR code on boxes)
Testing & epidemiologic surveillance for legal & illegal emerging drugs of concern (including nitazenes)
Improve data sharing practices across organizations and counties
Increase buy-in for data sharing through awareness of Overdose Fatality Review
Determine options for gaining access to Emergency Medical Services records for Overdose Fatality Review cases
Explore age-related trends to identify potential factors contributing to the rising median age at death and evaluate trends in co-contributors to mortality among older adults

Appendix B: Technical Notes

How are "Oakland County" Deaths Defined?

Each overdose death can be identified by county in at least three ways:

- Medical Examiner (ME) Jurisdiction: Where the decedent was pronounced dead. This might be a hospital that they were brought to after overdosing in another location.
- Incident County: The county where the incident (the overdose) occurred. They may or may not have died or been pronounced dead in the same county.
- Residence: Where the decedent lived at the time they died. This information is not included in this report, as cases are investigated by an ME office based on location of death rather than residence at time of death. Oakland County residents who died in other jurisdictions would be investigated by a different ME.

  These may be different. One decedent could have lived in Macomb County, overdosed in Wayne County, and been pronounced in Oakland County. During 2023, Oakland County began conducting investigations for decedents pronounced in Macomb and Lapeer County.

  This report focuses primarily on deaths that occurred within the Oakland County Medical Examiner Jurisdiction. Note that as of 2023, Oakland County also serves as the medical examiner for Lapeer and Macomb counties. Data from these jurisdictions were excluded from analyses unless explicitly stated otherwise.

How was race/ethnicity determined for cases included in this report?

Race/ethnicity data is initially determined by the ME investigator and finalized by the funeral home before being listed on the death certificate. Data in this report should be considered preliminary and may differ from race/ethnicity listed on death certificate. In late 2023, the Oakland County ME and Oakland County Health Division established a plan to validate race/ethnicity data by cross-referencing with death certificate data. Collecting and reporting on accurate race/ethnicity data is an essential part of identifying and addressing health inequities and we are working to improve our practices in this area.

How was gender determined for cases included in this report?

Gender as presented in this report is determined based on the gender listed on the decedent's legal identification card. Our data team acknowledges the importance of affirming gender identity and identifying gender-based inequities. We are working to improve our practices in this area and to develop standards for collection of additional information related to gender identity as well as sexual orientation.