



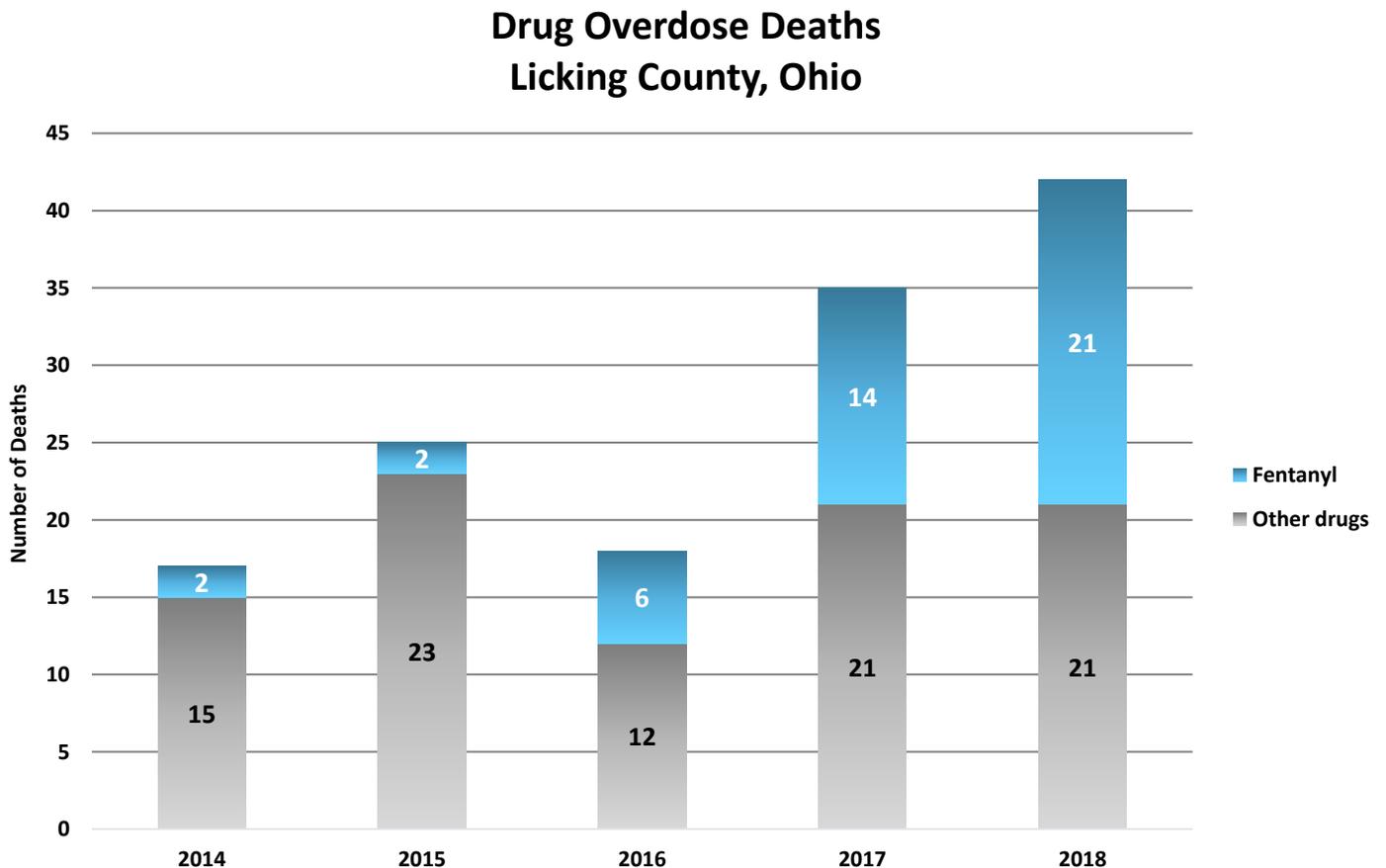
# DRUG OVERDOSE DEATH REVIEW

## 2018 SUMMARY

TOTAL OVERDOSE DEATHS		PRESCRIPTION DRUG DEATHS		FENTANYL DEATHS	
2017	2018	2017	2018	2017	2018
35	42 (+20.0%) ↑	19 (54.3%)	15 (-35.7%) ↓	14 (40.0%)	21 (+50.0%) ↑

*\*Prescription drug deaths include all types of prescription medications. Fentanyl is not included in the totals.*

Figure 1: Drug Overdose Deaths for Licking County, Ohio (2014 – 2018)



## DRUG DEFINITIONS

**Prescription Non-Opioids** – any non-opioid drug that is legally prescribed by a medical professional to a patient. Patient maintains drugs in a sealed bottle with appropriate labeled information on the bottle during the prescribed timeframe.

**Documentation must exist within case reviews to be considered under this definition and the drug must have contributed to the death.**

**Prescription Opioid** - opioid based drugs used to treat pain that require a prescription from a medical professional. Patient maintains drugs in a sealed bottle with appropriate information on bottle during the prescribed timeframe.

**Documentation must exist within case reviews to be considered under this definition and the drug must have contributed to the death.**

**Illegal Drugs** - possession of a prescription drug (**all types**) but the possessor does not have a legal prescription for that drug. Or the prescription drug is not in a labeled bottle/original container. **\*Fentanyl is included under “illegal drugs” because in some cases fentanyl can be prescribed for extreme pain.**

**Illicit Drugs** - drugs that are illegal to make, sell, or use.

## CASE COMPARISON FOR EACH DEFINITION

DEFINITIONS	CASES		PERCENT CHANGE
	2017	2018	
Prescription Non-Opioid	12 (34.3%)	3 (7.1%)	↓ 79.3%
Prescription Opioid	8 (22.9%)	2 (4.8%)	↓ 79.0%
Illegal Drugs	17 (48.6%)	25 (59.5%)	↑ 22.4%
Illicit Drugs	12 (34.3%)	28 (66.7%)	↑ 94.5%

*\*Table is comparing the percent of cases matching each definition in comparison to 2017 –2018*  
*\*Due to polydrug use, overdose cases may fit a combination of drug definitions*

## DRUG OVERDOSE DEATH CLASSIFICATIONS

**Class 1** – Overdose cases involving patients taking prescription medications appropriately, but organs are not metabolizing drugs as they should.

**Class 2** – Overdose cases where patients are not compliant with their prescription medications. Several scenarios fit under this class. Patients can be “selective” with when to take their medications. Investigations have revealed patients not taking their prescription medications at all and then deciding to take an abundance resulting in an overdose. Other scenarios involve patients consuming too many prescription medications or consuming with alcohol resulting in an overdose. Patients with a diagnosis of Schizophrenia or a major depressive disorder seem to be at a higher risk for non-compliance.

**Class 3** – This class of cases have documentation of a diagnosis for chronic pain and prescription medications are used to treat such pain. Chronic pain can result from accidents, sports injuries, cancer, complications from surgery, or conditions associated with aging.

**Class 4** – This class of cases involves linking some type of “trauma” experienced by the case resulting in depression. Cases with a diagnosis of “depression” were also included in this class because it’s not always clear from the information reviewed what was causing each case to be depressed. Based on some of the information, assumptions can be made about the traumatic experience resulting in depression. Examples of traumatic experiences include the death of a loved one, post traumatic stress (military service), divorce, abuse, or loneliness. Traumatic experiences vary for everyone so evaluating each case is important for understanding what led to someone’s drug use/addiction.

## CASE COMPARISON FOR EACH CLASS

TYPE	CASES		PERCENT CHANGE
	2017	2018	
Class 1	2 (5.7%)	1 (2.4%)	↓ 57.9%
Class 2	3 (8.6%)	6 (14.3%)	↑ 66.3%
Class 3	7 (20.0%)	5 (11.9%)	↓ 40.5%
Class 4	15 (42.9%)	14 (33.3%)	↓ 22.4%
No Class	8 (22.9%)	16 (38.1%)	↑ 66.4%

*\*Table is comparing the percent of cases matching each type in comparison to 2017–2018*

## CONCLUSIONS/RECOMMENDATIONS

### Drug Definitions

The same drug definitions established in 2017 were used again for this summary of 2018 drug overdose deaths. Fentanyl is still being labeled an “illegal drug” as it can be obtained by a prescription for extreme pain. If a valid prescription is identified during an overdose death review, it will be listed under the “prescription opioid” definition.

Reviewing the “definitions” table, some significant findings were seen in comparison to the 2017 report. Prescription non-opioids decreased by **79.3%** along with prescription opioids by **79.0%**. With the implementation of OARRS and other protocols for dispensing narcotics, availability of these drugs may be down resulting in a decline in deaths involving these drugs. In contrast, illegal drug deaths increased by **22.4%** and illicit drugs increasing by **94.5%**. Prescription drugs may now be harder to obtain resulting in cases to resort to illicit drugs.

The proportion of fentanyl related deaths increased by **25%** compared to 2017 statistics. Out of all the fentanyl related deaths, **71.4%** of deaths also had a contributing illicit drug in their system. This suggests that cases may have purchased an illicit drug without knowing it was laced with fentanyl.

### Overdose Classifications

Several classifications created in 2017 were down significantly in 2018 and this was due in part to not being able to classify several of the cases. Around **38%** of cases were not classified because they either didn’t fit the criteria or not enough information was available to identify any risk factors. A majority of unclassified cases had documented histories of drug abuse but no other details indicating what was causing the drug abuse. One third of cases reported in 2018 had documented “trauma” which could explain their addiction and eventual deaths.

The percent of Class 2 cases increased by **66.3%** in 2018 and a possible explanation for this could be due to the implementation of OARRS. With providers limiting the amount of medications being prescribed, patients may feel the need to hold on to the medications and only use them during a significant event. The event may trigger overconsumption of the suspect medication or a drug interaction may occur resulting in an overdose.

### Recommendations for each class:

**Class 1:** Recommend routine lab screenings to see how organs are metabolizing drugs. Conduct screenings after any adjustment is made to prescription drug regimen.

**Class 2:** Prior to refilling prescriptions, conduct lab screenings and assessments to see if patients are taking medications as prescribed. If a medical condition is diagnosed, a health aid may be required to validate compliance of prescription drug use. Also, screen for alcohol to prevent lethal combinations with prescription drugs. Promote drug disposal if prescription medications are past their recommended dates.

**Class 3:** Patients with chronic pain need to be encouraged/offered treatment not involving prescription drugs. Improve insurance coverage for physical therapy and alternative medicine treatment.

**Class 4:** Education, awareness, and support groups need to be offered throughout the county addressing trauma. Multiple cases with charted depression were seen amongst 2018 cases as well as cases who seemed to be “alone”. Several of these cases were not classified because there was no one to contact in their lives to gather information. These findings continue to support the idea of needing social networks to help prevent addiction and overdose deaths. Community focus groups addressing trauma could be a low-cost intervention to help reduce depression and loneliness.

**Notes on several unclassified cases:**

- Two overdose deaths occurred at Legend Valley during the Lost Lands Festival. Both cases were out of state residents so establishing a history was not possible.
- Three overdose deaths involved cases staying at local motels with very little information regarding their histories. Cases seemed to have tendencies of staying at these locations in order to do drugs. Two overdose deaths occurred at the Knight’s Inn Motel in Heath, Ohio.
- Two overdose deaths occurred at truck stops in Hebron, Ohio along Interstate 70. Both cases stopped at these locations to rest and were present with one other person when their overdoses occurred. One of these cases fit the criteria for Class 1.
- Single case involving an individual with developmental delay cognitive, learning disability, and mental equivalency of a 13-year old. Case consumed large quantities of alcohol in parent’s basement and overdosed. Could be considered an outlier and was not classified.