

DELAWARE DRUG OVERDOSE FATALITY REVIEW COMMISSION ANNUAL REPORT

2024 Annual Report

Overview of Sample

The Delaware Drug Overdose Fatality Review Commission (DOFRC) is charged under Delaware Code Title 16, § 4799, to review opioid overdose deaths in the State of Delaware. In 2022, there were 549 overdose deaths recorded in the state of Delaware, marking a 6.6% increase from 2021. Additionally, the total number of overdose deaths has been declining. In 2023, there were 527 overdose death, representing a 1.8% decrease from the previous year. In 2024, this number further declined to 338 deaths, a 36% reduction compared to 2023. This report examines a sample of 103 cases of fatal overdoses that occurred in 2022. Sampling was done systematically by reviewing the cases of odd months (e.g., January-01, March-03, etc.) reported on odd days (e.g., 01, 03, 05, etc.) and the cases reported on even days of even months. Case information is collected from law enforcement, local medical and rehabilitation treatment providers, the Department of Correction, and public health records. Any data on each decedent collected within the last five years is requested from these organizations via subpoena. Our research team then quantifies all information to provide the analysis found in this report.

Before engaging with our recommendations based on the 2022 data, it is essential to address some limitations in the current sample. As noted in previous reports, the data presented is not reflective of all overdose deaths in the state of Delaware. Due to the systematic nature of our data collection, we do not review every overdose death. Additionally, information collected is limited to the five years preceding the overdose death, which means that the data lacks informative historical content for each decedent. Another limitation arises from the primary sources utilized for data collection – the organizations subpoenaed cannot provide a holistic picture of each individual's life course and use history. Notably, data from Christiana Care was unavailable for this report and the 2022 dataset, which further limits the completeness of the overall information.

In previous years, a handful of overdose deaths have been excluded due to no additional information being available outside of the official death certificate. Five cases were excluded from analysis each year in the 2019, 2020, and 2021 data. Notably, for the 2022 data, 58 cases are excluded due to missing information, which presents a significant limitation to the data presented in this report. It is possible that

the missing data may reflect individuals not coming into contact with the various touchpoints from which we collect data. This may suggest that those struggling with substance use may be increasingly unlikely to seek medical care, addiction treatment services, and may also have reduced contact with law enforcement agencies.

Despite these limitations, the current sample (n = 103) remains robust enough to conduct the analysis needed for this report. Within this sample, 52.4% of overdose deaths occurred in New Castle County, 35% in Sussex County, and 12.6% in Kent County. Throughout 2022, overdose deaths most frequently occurred on Thursdays, Saturdays, and Tuesdays, respectively. Figure 1 (below) demonstrates the distribution of reported cases per day of the week:

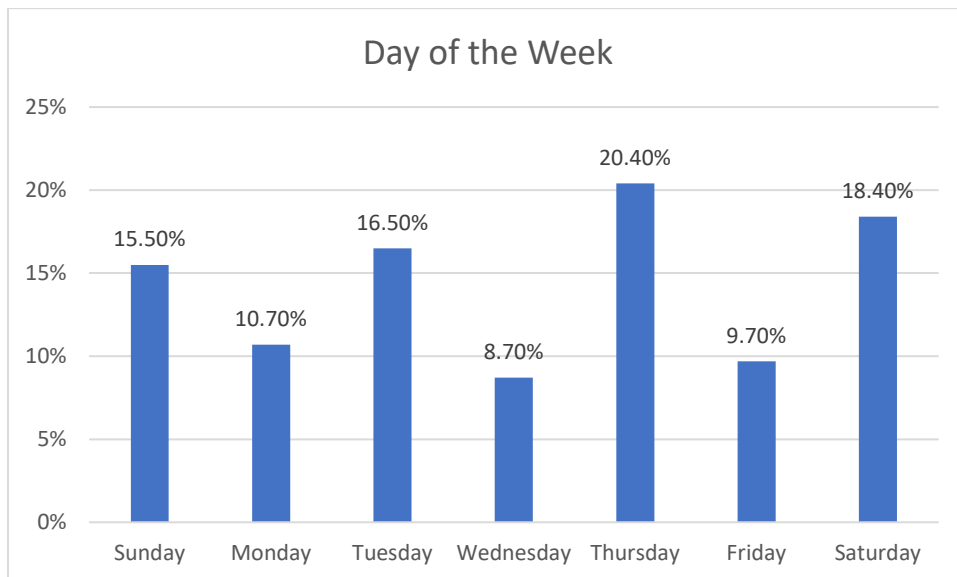


Figure 1: Day of the Week When Death Occurred

Figure 2 (below) outlines the location of overdose deaths. Overdose deaths occurring within the decedent's own home represented 37.9% of our sample, while 62.1% occurred outside of the decedent's own residence. Fatal overdoses outside of the decedent's residence often occurred at a family members residence/property, the residence/property of another, or at motels/hotels.

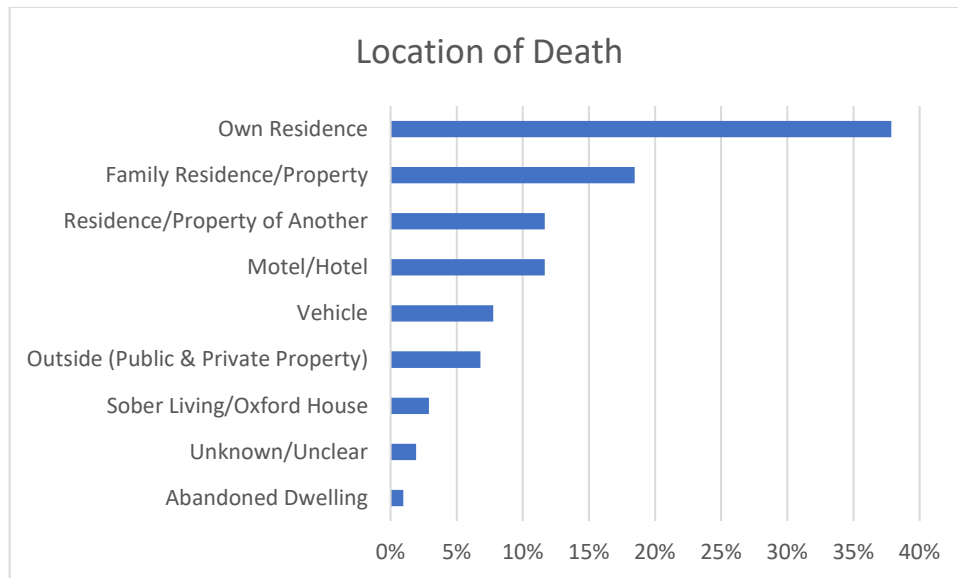


Figure 2: Location of Death

Decedents were most frequently discovered by their family (27.2%), significant other (22.3%), or friend(s) (19.4%). Figure 3 below highlights the relationship of those who discovered the decedent:

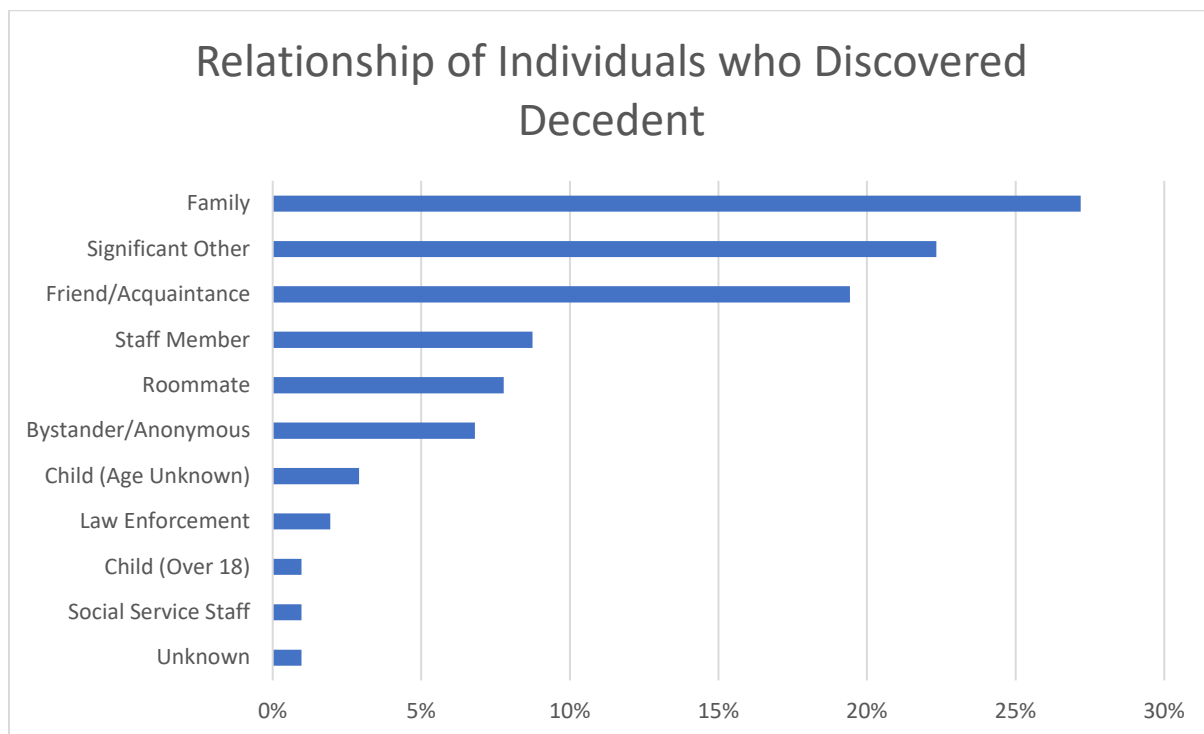


Figure 3: Relationship of Individuals who Discovered Decedent

Decedent Demographics

The average decedent in our sample was a 42-year-old single white male. Most decedents had a high school diploma, worked in construction/extraction occupations, and had no prior military experience. Most individuals who died from a fatal overdose in 2022 had fentanyl in their system at the time of death (91.8%). Table 1 below outlines demographic data from our sample:

<i>Variable</i>	<i>Percentage</i>
Age	
Mean = 42.5	
Sex	
Male	68%
Female	32%
Race	
White	65%
Black	31.1%
Latino/a	2.9%
Biracial	1%
Marital Status	
Single/Never Married	66%
Married	8.7%
Divorced	16.5%
Widowed	1.9%
Missing Data	6.8%
Veteran Status	
Never Served	89.3%
Previously Active Duty	1.9%
Missing Data	8.7%
Education	
Grade School	1%
Some High School	13.6%
High School Diploma/GED	56.3%
Some College	8.7%
Associate's degree	1.9%
Bachelor's Degree	3.9%
Trade School	1.9%
Missing Data	12.6%
Occupation	
Management	1.9%
Business and Financial Operations	1%
Computer and Mathematical	1%
Art, Design, Entertainment, Sports, and Media	1%
Healthcare – Practitioners and Technical	1.9%
Healthcare Support	6.8%
Food Preparation and Serving Related	12.6%
Personal Care and Service	2.9%
Building/Ground Cleaning and Maintenance	1%

Sales and Related	6.8%
Office and Administrative Support	2.9%
Farming, Fishing, and Forestry	1.9%
Construction and Extraction	21.4%
Installation, Maintenance, and Repair	3.9%
Production	3.9%
Transportation and Material Moving	5.8%
Self Employed	1%
Homemaker	3.9%
Disability/Public Service	2.9%
Unemployed	1.9%

Table 1: Demographic Information

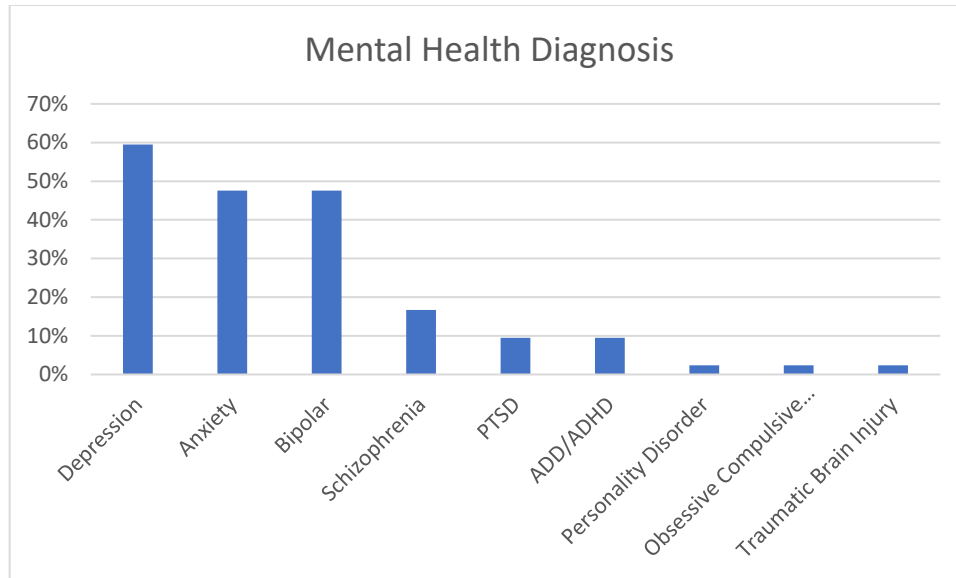
We have developed the following recommendations based on our analysis of data collected from death certificates, medical records, legal records, and treatment history. We specifically propose the following recommendations to combat the morbidity and mortality of Delaware's opioid crisis:

1. *Expand the continuum of care, resources, and follow-ups for individuals with a mental health and substance use disorder (SUD) dual diagnosis.*
2. *Improve law enforcement training for mental health and SUD dual diagnosis.*
3. *Trauma sensitivity training for Law Enforcement and Healthcare Providers.*
4. *Increase access to shelters for unhoused individuals.*
5. *Broaden Naloxone distribution.*

Recommendation 1: Expand the continuum of care, resources, and follow-ups for individuals with a mental health and substance use disorder (SUD) dual diagnosis.

Dual diagnosis commonly refers to individuals who are diagnosed with substance use disorder (SUD) and a mental health disorder. According to the National Institute of Drug Abuseⁱ, “35% of adults aged 18 and over in the U.S. who have another mental disorder also have a substance use disorder”.

Within our sample, **40.8% of decedents had a dual diagnosis**. An individual was classified as having a dual diagnosis if the data indicated that they had a diagnosis for a mental health disorder at any point prior to their death. Figure 4 highlights the diagnoses of decedents with a mental health disorder:



Of decedents with a mental health diagnosis, 47.6% received mental health services. Notably, only 41.5% previously received or had an active prescription for mental health medications, 7.1% were reported as receiving counseling services, and 11.9% previously sought treatment through psychiatric services (e.g., Rockford, Meadowwood). These findings highlight a gap in access to appropriate care for individuals with dual diagnosis.

To address these disparities, we recommend two changes across mental health and SUD services. The first is to incorporate integrated treatment and broaden the continuum of care for individuals with a dual diagnosis. Integrated treatment refers to treating both mental health and substance use disorders concurrently rather than treating them separately. Grounded in evidenced-based practices, integrated care has been shown to improve outcomes for individuals with a dual diagnosisⁱⁱ. The Substance Abuse and Mental Health Services Administration (SAMHSA)ⁱⁱⁱ outlines six steps for establishing integrated treatment practices:

- 1: Create a vision by clearly articulating evidence-based practice principles and goals. Designate a staff person to oversee your Integrated Treatment initiative.
- 2: Form advisory groups to build support, plan, and provide feedback for your Integrated Treatment initiative.

- 3: Establish program standards that support implementation. Make adherence to those standards part of licensing criteria.
- 4: Address financial issues and align incentives to support implementation.
- 5: Develop a training structure tailored to the needs of different stakeholders.
- 6: Monitor fidelity and outcomes to maintain and sustain program effectiveness.

Given the limited utilization of mental health services received by decedents in our sample, we recommend implementing the practices in all healthcare, behavioral health, and substance use treatment facilities in Delaware.

Further, we recommend expanding the continuum of care for all individuals who are involved in mental health or substance use services. At times, SUD and mental health treatment may be fragmented and disjointed – a continuum of care approach focuses on ‘filling the gaps’ in services and care. In other words, healthcare providers collaborate across all stages of a patients’ care journey. The Division of Substance Abuse and Mental Health’s (DSAMH) implementation of the web-based behavioral health care coordination platform, DTRN360, this year aims to support and enhance this collaborative approach. Importantly, this includes implementing additional follow-up care and services for individuals receiving SUD or mental health treatment. Our second recommendation is to strengthen follow-up services statewide to ensure individuals receive sustained support throughout their recovery journey. In alignment with the continuum of care, we advocate for the provision of ongoing access to resources and personalized assistance following initial treatment or intervention. This approach recognizes that recovery is not a singular event but a long-term process that requires consistent, compassionate support, and a whole-person approach. For instance, individuals discharged from mental health or substance use disorder (SUD) treatment could benefit from being connected with a dedicated caseworker. This caseworker would assist in navigating essential services such as housing, outpatient treatment, and healthcare, thereby fostering stability and promoting long-term recovery outcomes. While certain supportive services such as housing remain limited across the United States, including in Delaware, the broader system of care continues to expand. However, patients may still struggle to navigate the multiple levels of care available

to them. Expanding care navigations initiatives, such as DSAMH's Substance Use Disorder Care Navigator Program, could help address the challenge by improving access, coordination, and continuity of care.

Recommendation 2: Improve law enforcement training for interacting with individuals with a dual diagnosis.

In line with our first recommendation, we suggest implementing additional training for law enforcement in responding to calls from individuals with a dual diagnosis. Of the 40.8% of decedents with a mental health diagnosis, 57.1% of decedents had previously been arrested by law enforcement, 19.5% were recorded as having drug-related contact with law enforcement that did not result in an arrest, and 26.8% were recorded as having non-drug related contact with law enforcement that did not result in an arrest. We believe that, equipped with proper training and resources, law enforcement can better identify mental health or substance use-related emergencies and behaviors to help facilitate appropriate care for individuals in need of help and support.

We recommend that law enforcement agencies improve their response to individuals experiencing drug-induced psychosis, mental health crises, or recurrent drug-related offenses by partnering with diversion programs designed to address these complex needs. Specifically, we encourage departments to join forces with the Delaware State Police and DSAMH's Police Diversion Program, or to adopt diversion models similar to New Castle County's HERO Help Program. These initiatives provide structured pathways for individuals to access treatment and recovery services, rather than being funneled into the criminal justice system. Recognizing that determining appropriate care often falls outside the traditional scope of policing, we further recommend that the state fund training to help law enforcement identify when individuals would be better served by healthcare professionals. Such collaborative approaches not only improve outcomes for vulnerable populations but also support public safety in a more sustainable and humane way.

Recommendation 3: Trauma informed training for Law Enforcement and Healthcare Providers.

As discussed in our previous reports, a robust body of literature demonstrates that trauma significantly increases the likelihood of substance use.^{iv,v,vi,vii,viii} Across all decedents, 3.9% of decedents had a reported diagnosis of PTSD and 23.3% had a history of experiencing one or more traumatic events. In line with our recommendation of integrated care above, we suggest additional trauma informed care training for law enforcement officers and health care professionals to help facilitate appropriate care for individuals with a history of trauma.

Decedents in our sample frequently were in contact with law enforcement and health care providers. Regarding interactions with law enforcement, 51.5% of decedents had previously been arrested by law enforcement, 14.7% were recorded as having drug-related contact with law enforcement that did not result in an arrest, and 26.5% were recorded as having non-drug-related contact with law enforcement that did not result in an arrest. Regarding interactions with health care providers, 24.86% of all ER visits by decedents were use related, and 13.6% of decedents were seen 30 days preceding their death. Given the frequency of interactions people who use drugs have with law enforcement and health care providers, we recommend increased trauma-informed care training for these two groups.

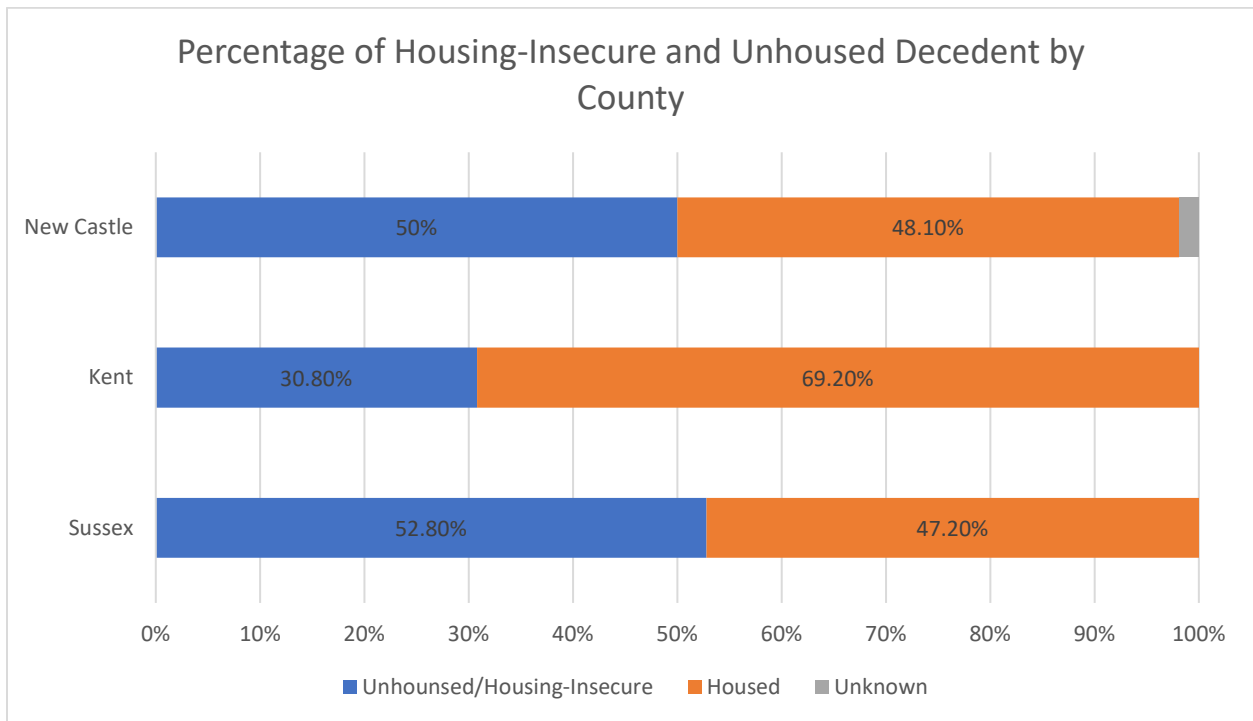
Trauma-informed care entails an approach that acknowledges and recognizes the multitude of ways that trauma can impact individuals. SAMHSA provides the following practices, commonly referred to as the “Four Rs” framework, for trauma-informed care in health care and law enforcement settings:

A program, organization, or system that is trauma-informed ***realizes*** the widespread impact of trauma and understands potential paths for recovery; ***recognizes*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and ***responds*** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively ***resist re-traumatization*** (p. 9).^{ix}

We recommend that health care providers and law enforcement organization across the state implement the trauma-informed approaches and training outlined by SAMHSA – a guide can be found [here](#)^x.

Recommendation 4: Increase access to shelter services for unhoused individuals.

Almost half of the decedents in our sample were identified as housing-insecure or unhoused. Following the parameters of our previous reports, housing-insecure individuals are defined as any individuals age 25 or older with no identified residence. In the 2022 data, **48.5% of decedents were identified as housing-insecure or unhoused.** Figure 5 (below) represents the percentage of decedents in each county who were identified as unhoused or housing-insecure, indicating that the majority of unhoused or housing-insecure individuals were in New Castle and Sussex County. Importantly, only 10.2% of decedents identified as unhoused/housing-insecure previously received treatment/services through a shelter. Of decedents identified as unhoused/housing insecure in Sussex County, 5.3% previously received treatment/services through a shelter compared to 10.2% in New Castle County and 0% in Kent County.



Given the limited utilization of shelter services across all three counties, coupled with the significant number of decedents identified as housing-insecure or unhoused, we recommend expanding the availability of shelter and supportive services for this population statewide. Addressing housing instability

is a critical component of reducing vulnerability and improving health outcomes. Additionally, we urge all relevant stakeholders to review our previous reports highlighting the effectiveness of housing-first models and emphasizing the urgent need to enhance housing services, particularly in Sussex County. (See [DOFRC 2023 Annual Report](#)). However, a recent Executive Order issued by the Trump Administration prohibits the use of Housing First models. As a result, this recommendation may face implementation challenges, as federal agencies such as the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS) will be restricted from funding programs that utilize Housing First approaches.

A potential explanation for the limited utilization of services may reflect larger systemic hurdles that have historically served as barriers for people who use drugs to access treatment and care. One significant and persistent barrier is the lack of reliable public transportation in Kent and Sussex counties. Research consistently shows that inadequate transportation is a critical obstacle for individuals seeking care, follow-up services, or supportive resources. To help address this challenge, the Delaware Division of Substance Abuse and Mental Health (DSAMH) offers free transportation through a program called RoundTrip, available to uninsured patients receiving services from state-contracted providers. Through the Delaware Treatment Referral Network (DTRN), providers can schedule rides with rideshare companies for their clients' treatment and medical appointments. Patients with Medicaid may access similar transportation through ModivCare. This initiative, funded through State Opioid Response (SOR) funds, provides over 21,500 rides annually. While this service represents a significant step forward, there is a clear opportunity to strengthen and expand it, particularly to meet the needs of rural and underserved communities. Additional strategies the State of Delaware and its partners may consider include: (1) Providing dedicated shuttle services connecting high-need communities in Sussex County with treatment hubs in Georgetown, funded by the State of Delaware; (2)

Establishing partnerships with ride-share companies and non-profit organizations to provide vouchers or subsidized rides for medical and treatment appointments; and (3) Integrating transportation support into existing case management and care navigation programs. These measures could help ensure that individuals are not denied access to life-saving treatment and recovery support simply because they lack transportation.

Recommendation 5: Broaden Naloxone distribution.

The widely reported nationwide decrease in overdose deaths in 2024 has been partially attributed to Naloxone distribution, which prior reports from this Commission have repeatedly stressed as a priority and which remains one of the most powerful tools available to combat overdose deaths (Chimbar & Moleta, 2018; Naumann et al., 2019). Unfortunately, no state yet distributes the amount of Naloxone needed to achieve community saturation.^{xi,xii,xiii}

The Division of Substance Abuse and Mental Health (DSAMH) and multiple local organizations have significantly expanded the availability of Naloxone throughout the state in recent years. However, in our sample, only 9.7% of decedents were reported as having Naloxone available on scene at the time of death, and only 5.8% had a reported history of having Naloxone in their house/possession. This signifies a slight increase from our last report for Naloxone available on the scene at the time of death (previously 8.3%), but a slight decrease in the number of individuals with a reported history of Naloxone in their house or possession (previously 7.5%). Despite these changes, the numbers remain low. We recommend implementing additional efforts to broaden Naloxone distribution and availability throughout the state.

First, we recommend that emergency departments expand take-home Naloxone efforts. Delaware is actively working to expand access to naloxone (Narcan) through partnerships between emergency departments and the DSAMH. Between April and August 2024, a total of 527 Narcan kits were distributed through emergency departments. Continued expansion of this initiative is a key goal to ensure life-saving interventions are more widely available at critical points of care. Take-home Naloxone dispensed in Emergency Room settings has been shown to improve access compared to pharmacy

dispensed Naloxone^{xiv}. In our sample, 30.1% of decedents had a recorded nonfatal overdose. **Of those with an overdose history, 44.4% experienced a nonfatal overdose less than three months before their death.** As stated in our last report, “providing individuals with naloxone following these events as they are discharged from medical services may help reduce the number of fatal overdoses.” (p. 18).^{xv} Second, we recommend state-level investment in providing more Naloxone vending machines. In Delaware, the DSAMH currently operates five such harm-reduction vending machines strategically located across the state, in partnership with local non-profits. These machines are stocked with essential supplies, including Naloxone kits, Xylazine test strips, Deterra drug deactivation bags, wound care kits, items to support physical and dental hygiene, and other self-care tools. They are accessible at the following locations:

- 2713 Lancaster Ave, Wilmington, DE 19805
- 24 Brookhill Drive, Newark, DE 19702
- 698 S. Bay Road, Dover, DE 19901
- 769 E. Masten Circle, Milford, DE 19963
- Springboard Pallet Village, 411 Kimmey Street, Georgetown, DE 19947

We strongly encourage the state to support and expand this program to ensure broader access to harm-reduction tools in underserved and high-risk communities. Expansion of these vending machines represents a cost-effective, low-barrier intervention that can save lives and complement the state’s broader public health and treatment strategies. Public health vending machines have been shown to greatly reduce opioid overdose deaths in the areas they are established.^{xvi} Lastly, we echo our prior recommendations to provide fentanyl test strips when distributing Naloxone in hospital setting and improve access by making Naloxone more available in public spaces (see [DOFRC 2023 Annual Report](#)).

ⁱ Substance Abuse and Mental Health Services Administration. (2024). *2023 National Survey on Drug Use and Health*. <https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables>

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- ^x Substance Abuse and Mental Health Services Administration. (2023). *Practical Guide for Implementing a Trauma-Informed Approach*. SAMHSA Publication No. PEP23-06-05-005. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023. <https://library.samhsa.gov/sites/default/files/pep23-06-05-005.pdf>
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Delaware Drug Overdose Fatality Review Commission Contact

Julia Lawes, MS., Executive Director

Office of the Attorney General

Julia.Lawes@delaware.gov

302-577-8901

302-420-1559 (cell)

Delaware Drug Overdose Fatality Review Commission Members

- Erin Booker, Chair, New Castle County Regional Review Team Chair
- Joanna Champney, MS., Director, Division of Substance Abuse and Mental Health
- Dr. Rebecca Walker, Deputy Director, DPH, Director Clinical & Science Operations
- Kathleen Jennings, Delaware Attorney General
- Rebecca King, MSN, RN, Delaware Nurses Association Representative
- Chief Ken McLaughlin, Ocean View PD, Police Chiefs of Delaware Representative
- Lt. Sakinah Slayton, New Castle County PD, Fraternal Order of Police Representative
- Lt. David Hake, DSP, Troop 7
- Paul Shavack, Chief of Staff, Delaware Department of Correction
- Dr. Manonmani Antony, Medical Society Representative

Report compiled and written by Delaware OFR staff Julia Lawes, M.S., Dr. Joshua Stout, and Mary McGee