Mohave County
Department of Public Health
Count On Us.

# OVERDOSE FATALITY REVIEW ANNUAL REPORT

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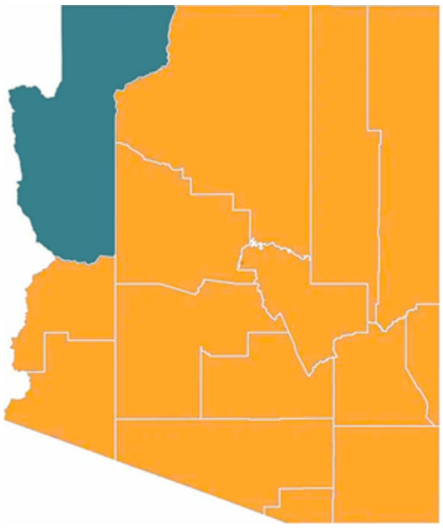

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# Acknowledgements

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- Southwest Behavioral and Health Services
- Tribal Action Planning Committee

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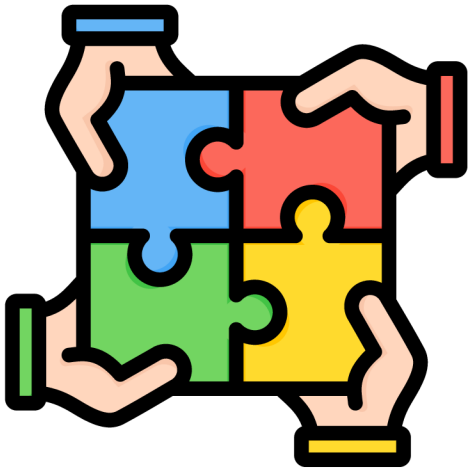

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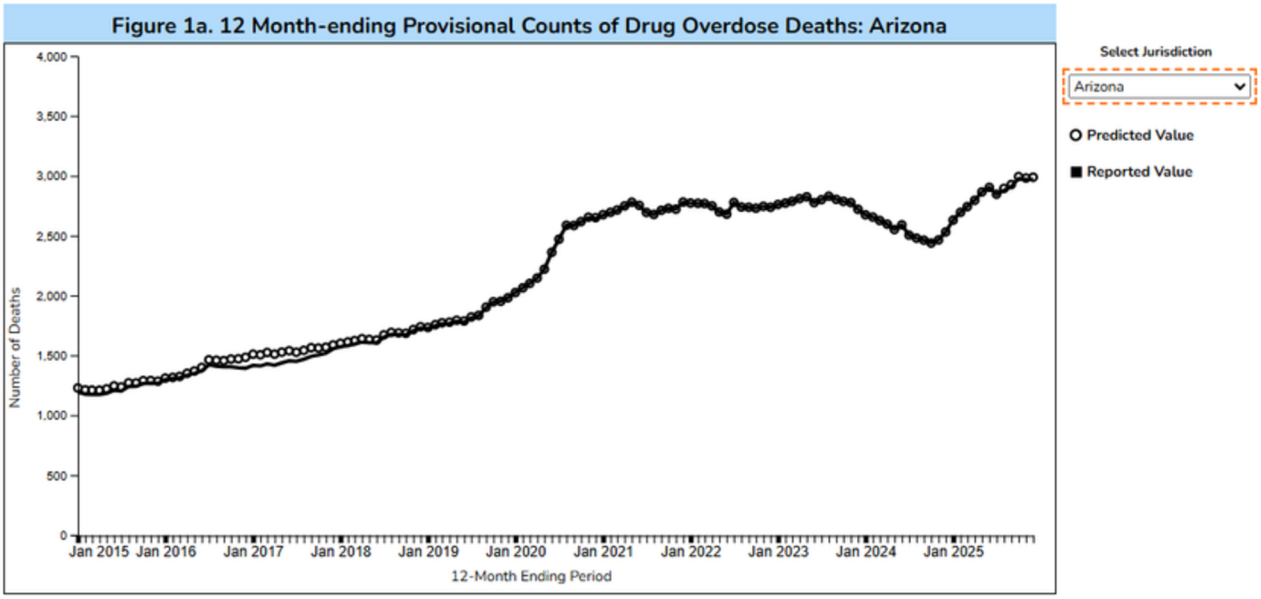
# Introduction

Over the past decade, Mohave County has experienced a steady annual increase in both the number and rate of drug overdose deaths. In response to rising opioid-related mortality statewide, Governor Doug Ducey declared a public health state of emergency in 2017. This action initiated a more coordinated statewide strategy to address opioid misuse and its impacts.

A key component of this strategy was the development of Overdose Fatality Review (OFR) teams in every county, including Mohave County. These teams bring together professionals from public health, behavioral health, medical services, emergency response, and social services to systematically review overdose deaths. Their purpose is to identify contributing factors, service gaps, and opportunities for targeted prevention efforts across Arizona.

## 12 Month-ending Provisional Number and Percent Change of Drug Overdose Deaths

**Based on data available for analysis on: May 3, 2026**




- Overdose deaths continue to be a significant public health concern in Mohave County, impacting individuals, families, and communities across the region.
- Similar to statewide trends, methamphetamine, fentanyl, and other synthetic opioids have become increasingly involved in overdose deaths in Mohave County over the past five years.
- Many overdose deaths reviewed by the Mohave County OFR Team involved complex contributing factors, including mental health challenges, substance use disorders, chronic pain, and barriers to accessing services.
- The drug overdose mortality rate per 100,000 in Arizona for 2024 is 32.6.

# Mission

The mission of the Mohave County Overdose Fatality Review (OFR) Team is to conduct case reviews and gather data to report key trends found in local drug overdose fatalities. The team uses local professionals throughout the county to conduct a detailed review of the circumstances surrounding overdose fatalities. The major purpose of the program is to develop and implement data-driven recommendations for reducing preventable drug overdose deaths.

# Methodology

The Arizona Department of Health Services provided the Mohave County Department of Public Health with a list of 83 individuals whose primary cause of death in 2023 was attributed to a drug overdose involving either prescription or illicit substances. From this list, the Mohave County Overdose Fatality Review (OFR) Team selected a sample of 26 cases in which the manner of death was classified as accidental or undetermined.

To support the review process, records were requested from the medical examiner's office, healthcare providers, behavioral health agencies, law enforcement agencies, and emergency medical services. The OFR Team carefully reviewed all available records to identify any additional information needed to better understand the circumstances surrounding each death and the factors that may have contributed to it.

Using the collected information, a detailed case narrative was developed for each decedent. The multidisciplinary review process examined demographics, psychosocial history, treatment and service utilization, medical and behavioral health records, crisis system encounters, and other significant risk factors associated with overdose deaths.

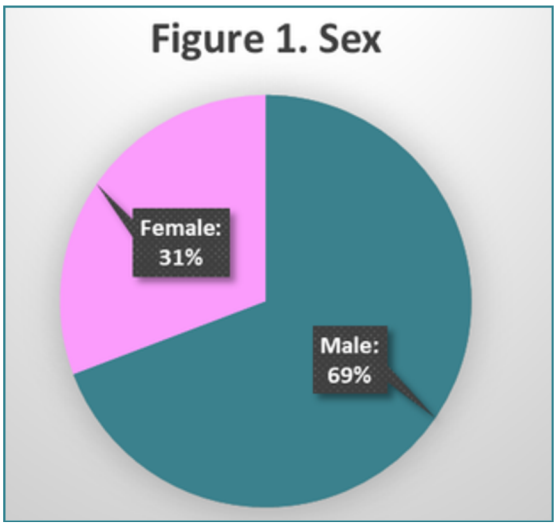
The purpose of these reviews is to identify gaps in services, systems, and supports, as well as opportunities for prevention and intervention. Findings from the review process are used to strengthen overdose prevention efforts, improve cross-system coordination and operations, inform local service providers and policymakers, and ultimately reduce overdose fatalities in Mohave County.

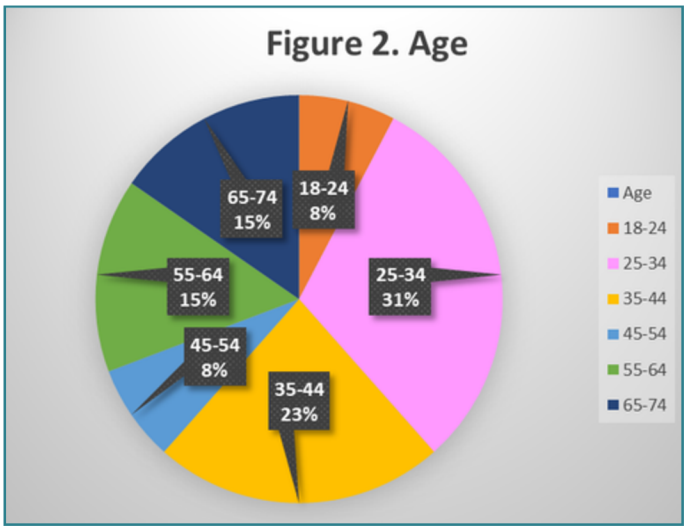
The Mohave County OFR Team conducted five review meetings, each lasting approximately two hours. To ensure thorough discussion and analysis, no more than seven cases were reviewed during a single meeting. In total, the team completed comprehensive reviews of all 26 selected cases.

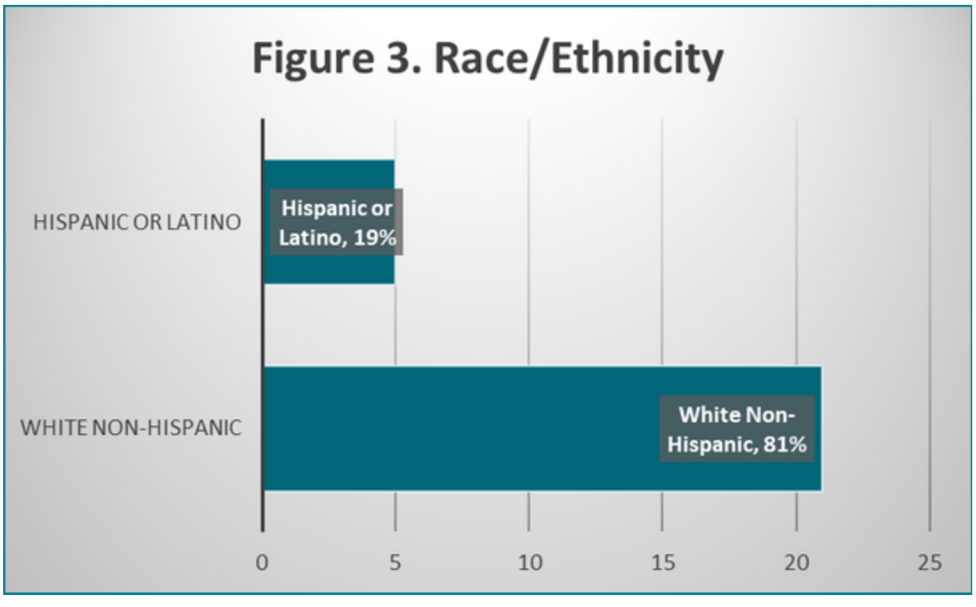
# DATA OVERVIEW

## Demographics

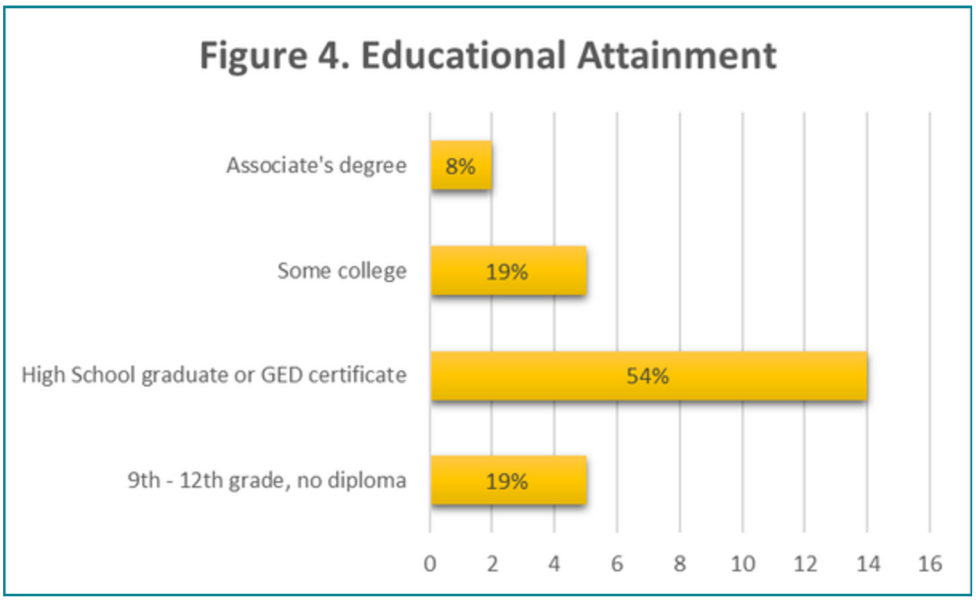
As illustrated in Figures 1–3, the majority of overdose fatalities reviewed by the OFR Team involved males, who accounted for 69% of decedents. Adults aged 25–34 represented the largest age group (31%), highlighting the significant impact of overdose deaths among individuals of working and family-building years. Most decedents were White (81%), reflecting the demographic composition of the reviewed cases. These findings help identify populations disproportionately affected by overdose mortality in Mohave County and inform targeted prevention and intervention efforts.

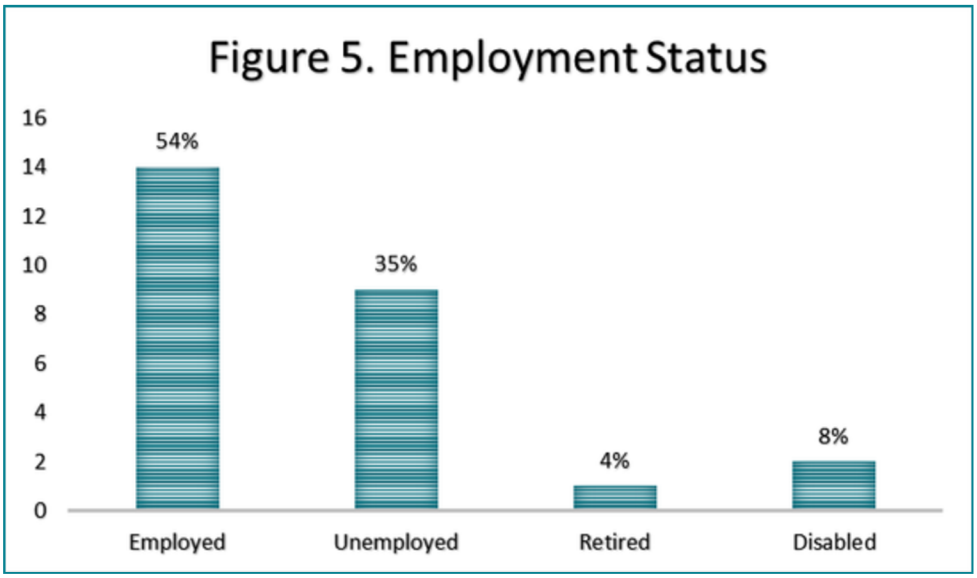


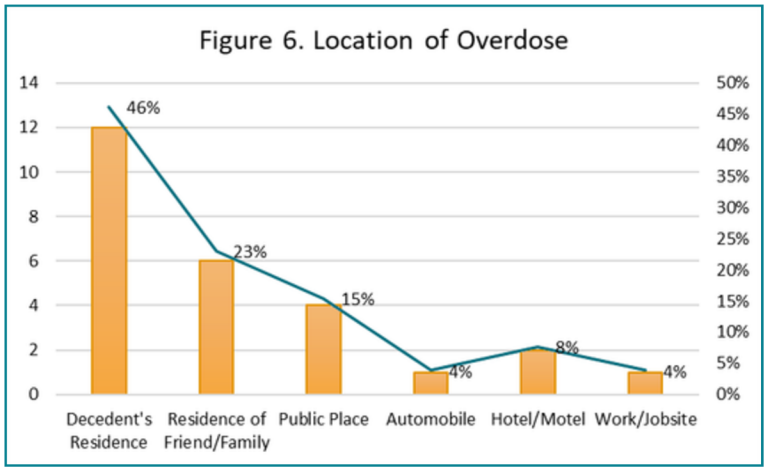
As shown in Figures 4 and 5, most decedents had completed at least a high school education, with 54% having earned a high school diploma or GED. Employment was also common among the reviewed cases, with over half of decedents (54%) employed at the time of death, compared to 35% who were unemployed. These findings underscore that overdose deaths affect individuals across a range of educational and employment backgrounds and are not limited to those experiencing economic instability.

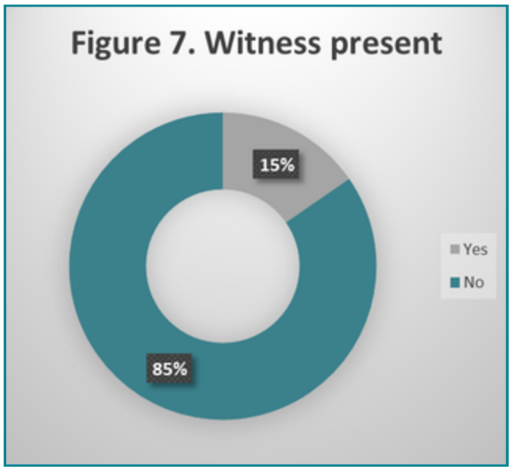


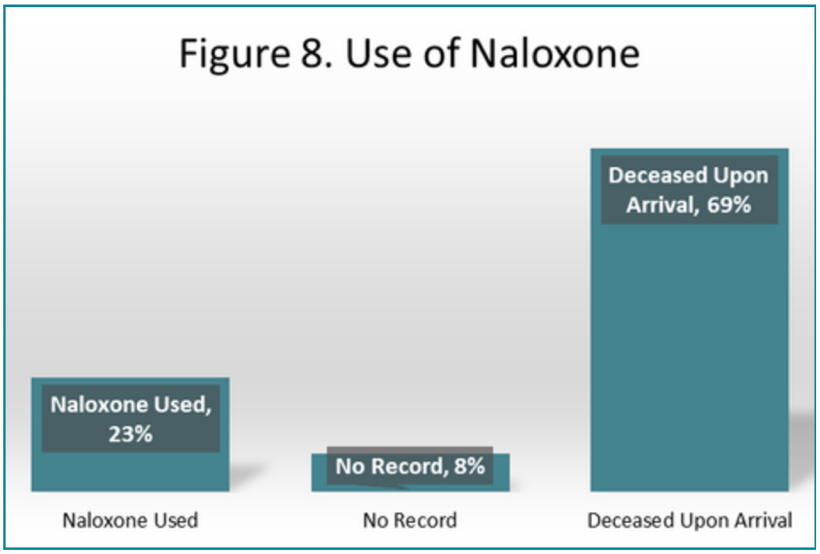



# Circumstances

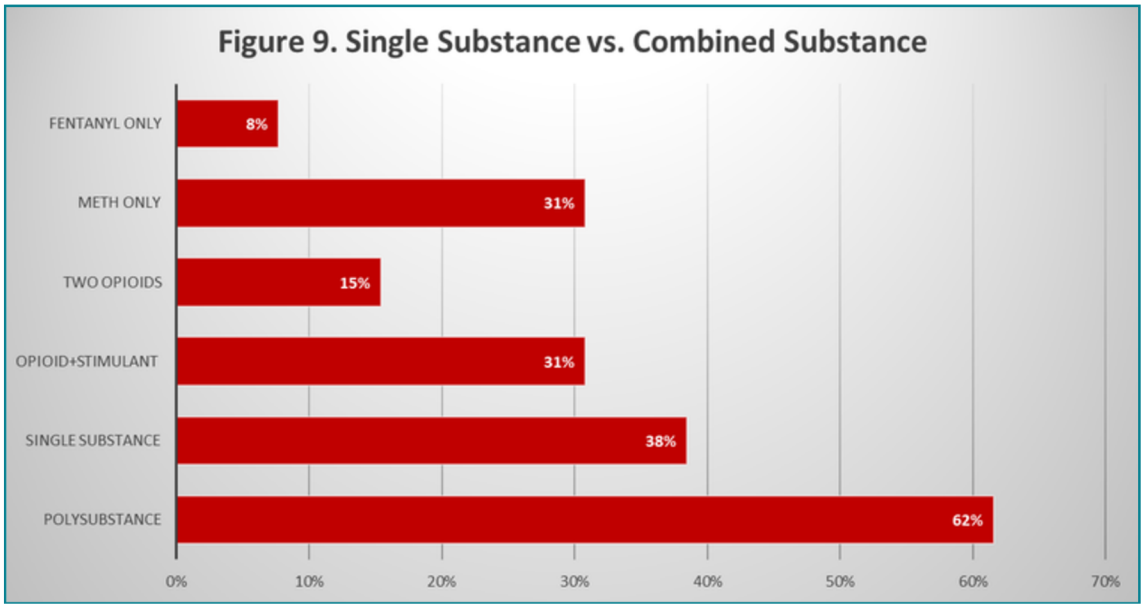
As shown in Figures 6–8, nearly half of fatal overdoses (46%) occurred in the decedent's own residence, while the remaining 54% took place in other settings, including the homes of friends or family members, motels, public locations, outdoors, or vehicles. A striking finding was that the vast majority of decedents (85%) were alone at the time of the overdose, compared to only 15% who had another adult present or nearby. This highlights the critical role that isolation can play in fatal overdose outcomes, as timely intervention is often unavailable. Naloxone was administered in 23% of cases by either emergency medical services or bystanders in an attempt to reverse a suspected overdose. However, in 69% of overdose deaths, the individual was determined to be beyond resuscitative measures when discovered. These findings underscore the importance of overdose prevention strategies that promote timely recognition of overdose symptoms, increase naloxone availability, and reduce the likelihood of individuals using substances alone.

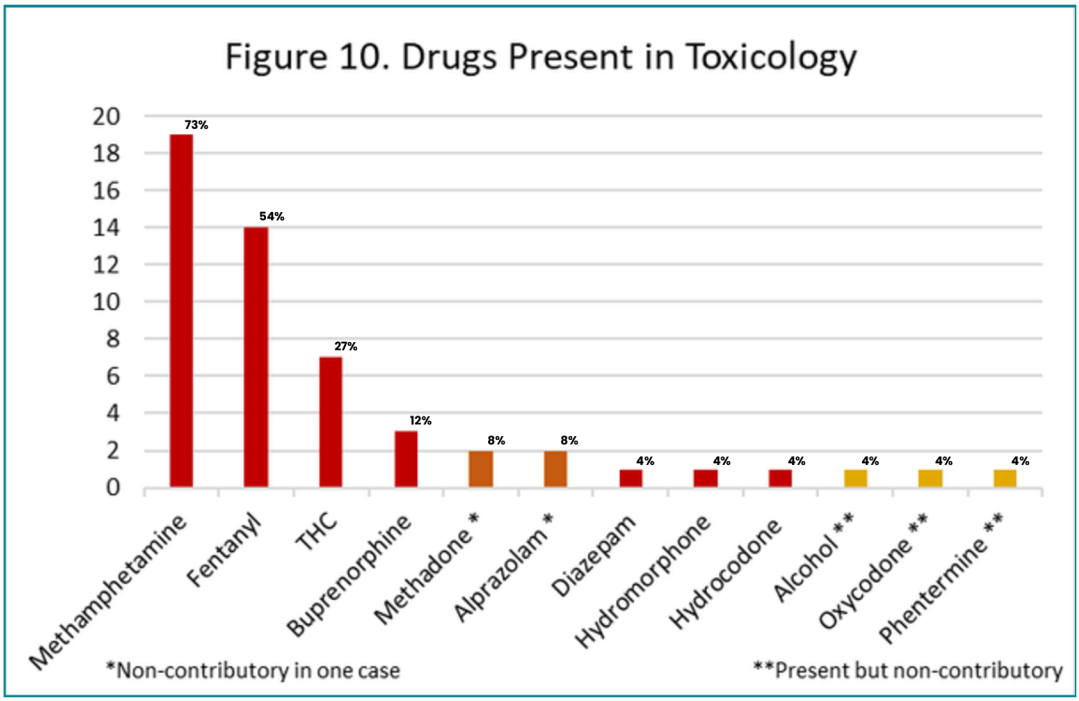


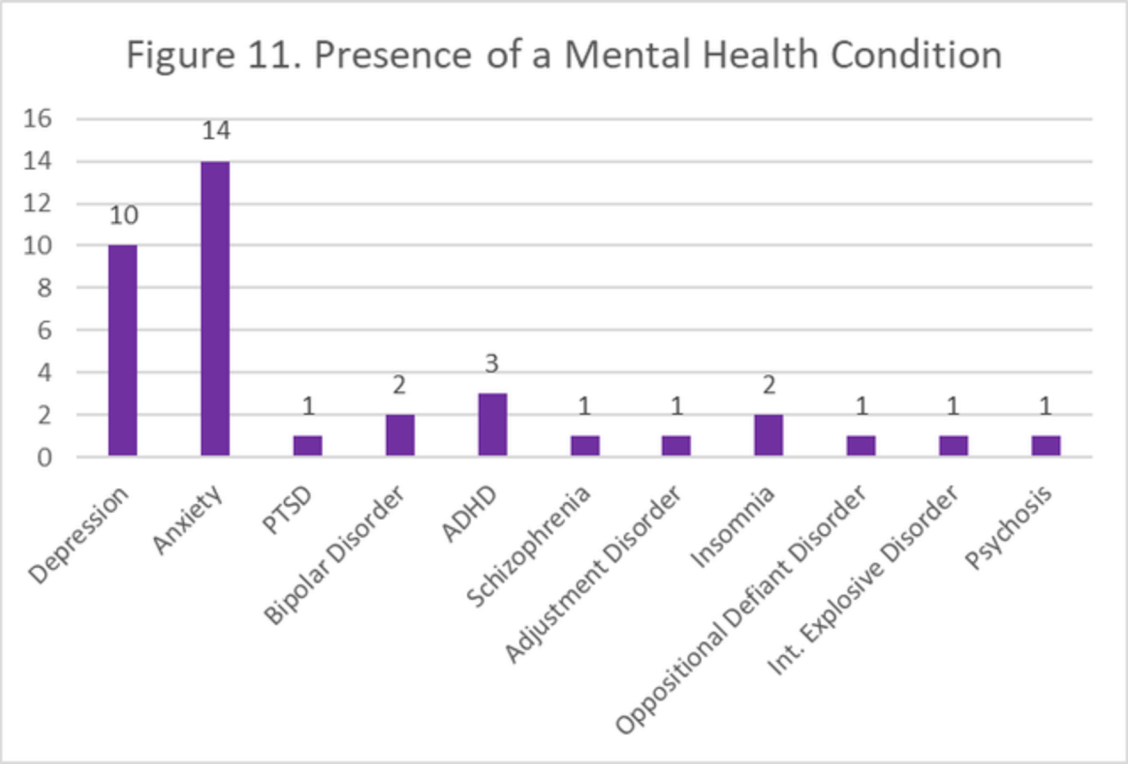
As shown in Figures 9 and 10, polysubstance use was a common factor in overdose fatalities, with 54% of decedents having two or more substances listed as a cause of death. Nearly one-third of cases (31%) involved a combination of opioids and psychostimulants, most commonly fentanyl and methamphetamine. Methamphetamine was the substance most frequently identified in the reviewed overdose deaths, present in 73% of cases, followed by fentanyl in 54% of cases. The findings also indicate a continued shift in local substance use patterns, with methamphetamine appearing more frequently in overdose deaths while heroin and other opioids were identified less often than in previous years. These trends highlight the growing complexity of overdose risk and the increasing prevalence of stimulant involvement in fatal overdoses.



# Contributing Factors & Commonalities

Several common characteristics emerged across the reviewed overdose fatalities, providing valuable insight into factors that may increase overdose risk and identifying opportunities for prevention and intervention. Commonalities are defined as shared attributes, circumstances, or life experiences observed among multiple cases. As shown in Figures 11 and 12, a substantial majority of decedents (69%) had a documented mental health disorder, while nearly one-quarter (23%) had a chronic health condition. Anxiety (54%) and depression (38%) were the most frequently identified mental health diagnoses, underscoring the strong connection between behavioral health challenges and overdose risk. Among chronic health conditions, hypertension (23%) and diabetes (23%) were most commonly reported. It is important to note that these figures may underestimate the true prevalence of both mental and physical health conditions due to incomplete records and other data limitations. Additional shared characteristics identified through the review process are summarized in Table 1 and further illustrate the complex and interconnected factors contributing to overdose fatalities in Mohave County.



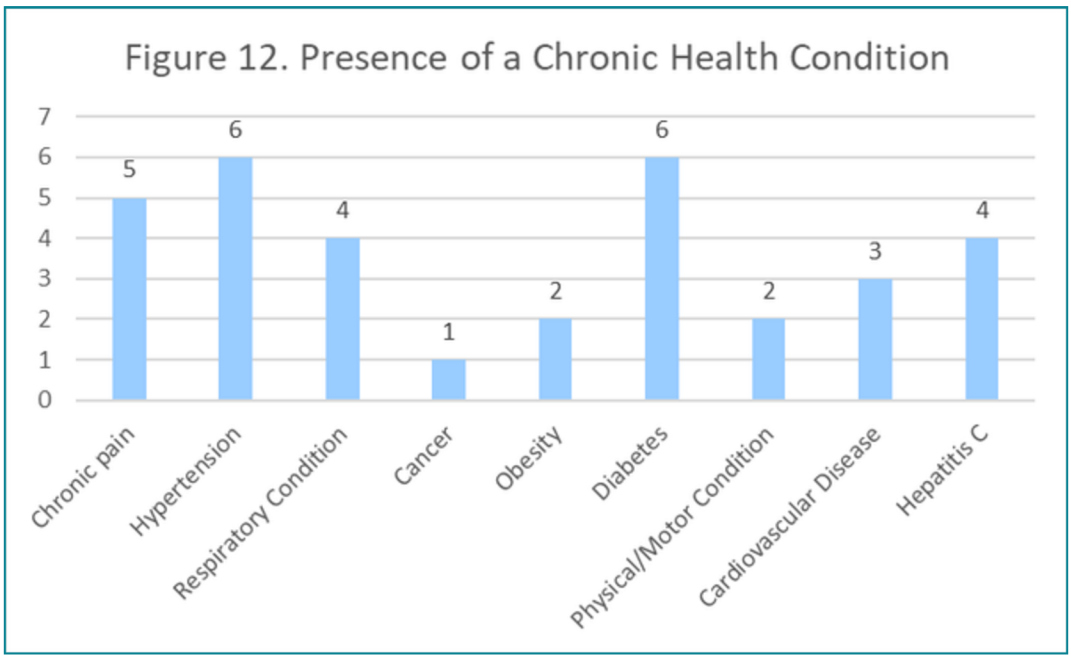
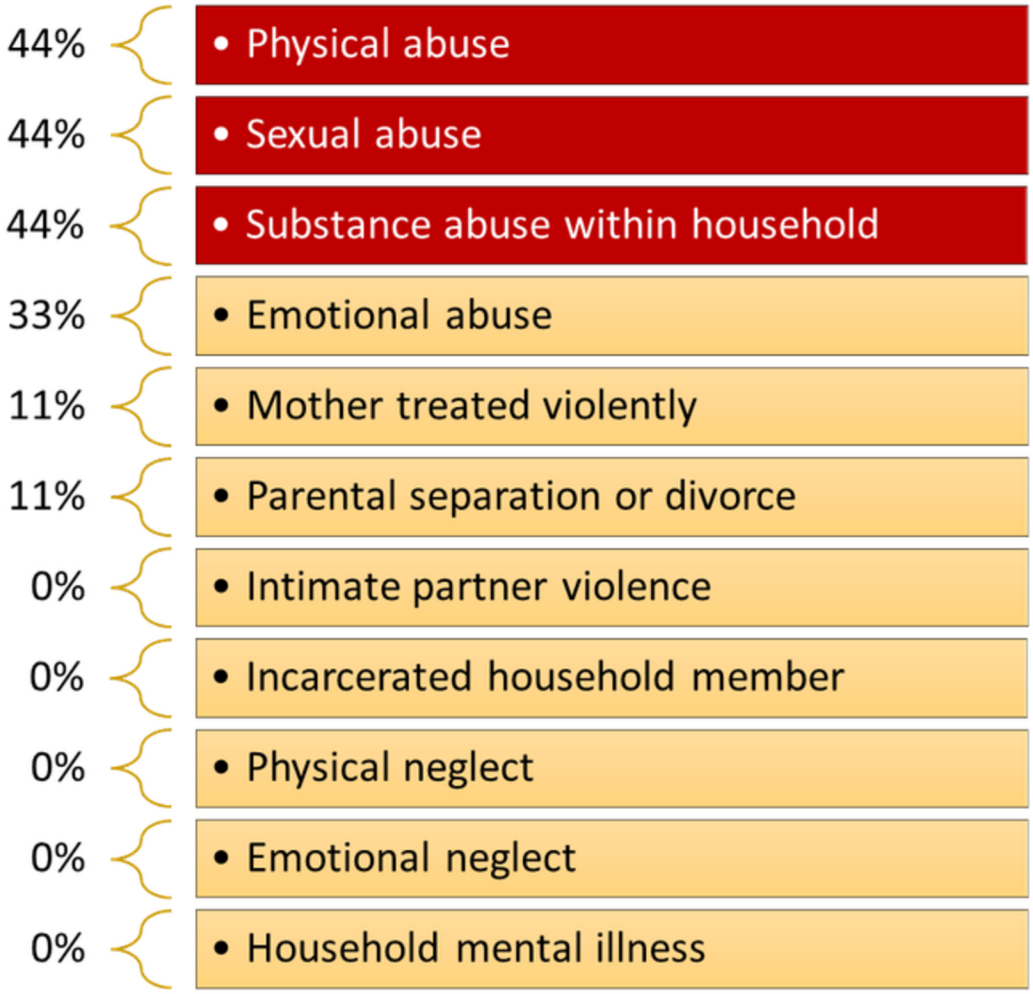


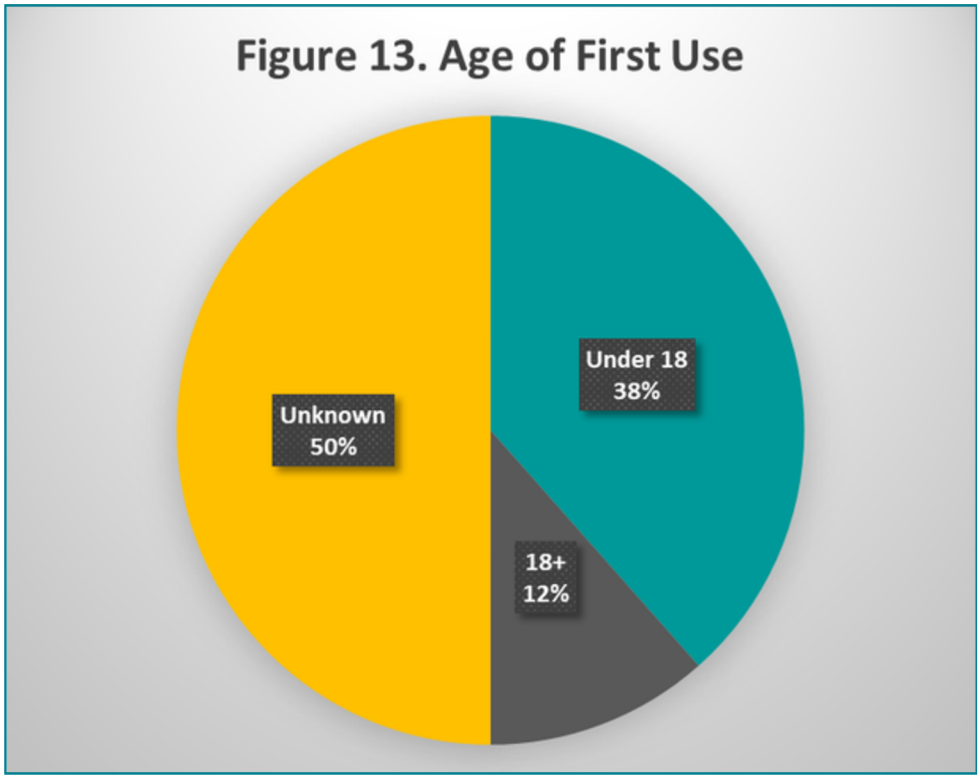

**Table 1. Other Attributes**

| | |
|---|---|
| 88% | SUD Diagnosis |
| 73% | History of homelessness |
| 73% | History of incarceration |
| 69% | Mental health condition |
| 46% | Released from jail within 12 months of death |
| 38% | Previous non-fatal overdose |
| 27% | History of suicide attempt, ideation, or self-injury |
| 23% | Homeless/unstable housing at time of death |
| 23% | Chronic health condition |
| 19% | Victim of violence |
| 12% | Completed residential treatment within 12 months of death |

In 2024, the OFR Team was able to obtain information related to Adverse Childhood Experiences (ACEs) for nine of the 26 decedents reviewed (35%). Although limited, the available data revealed a high prevalence of childhood trauma and difficult family dynamics among those cases. As shown in Table 2, the most commonly identified ACEs risk factors were physical abuse, sexual abuse, and exposure to substance misuse within the household, each reported in 44% of cases with available data. Figure 13 further highlights the early onset of substance use among many decedents, with at least 38% initiating substance use before the age of 18. These findings reinforce the long-term impact of childhood adversity on health and substance use outcomes and underscore the importance of early intervention, prevention, and trauma-informed approaches to care.

**Table 2. ACEs Risk Factors**






## Controlled Substance Prescription Monitoring Program (CSPMP)

Of the 26 overdose fatalities reviewed, half of the decedents (50%) had a history documented in the Controlled Substances Prescription Monitoring Program (CSPMP). Among those with a CSPMP history, nine individuals had active prescriptions at the time of death. However, only three of those cases involved prescriptions that corresponded to the substances identified in the cause of death (Table 3). These findings suggest that while prescription medication histories were common among decedents, most overdose deaths were not directly linked to medications that were actively prescribed to the individual at the time of death. This highlights the evolving nature of the overdose epidemic and the increasing role of non-prescribed and illicit substances in fatal overdoses.

**Table 3. History of Controlled Substance Prescriptions**

| Characteristic | CSPMP, N (%) |
|---|---|
| **History of prescriptions** | 13 (50%) |
| **Active prescriptions at time of death** | 9 (35%) |
| **Prescriptions match drugs in COD** | 3 (12%) |

# Prevention Recommendations

Following the review of 26 overdose fatalities, the Mohave County Overdose Fatality Review (OFR) Team developed prevention recommendations aimed at addressing the factors and system gaps identified throughout the case review process. These recommendations reflect opportunities to strengthen prevention efforts, improve access to services, enhance cross-system collaboration, and reduce future overdose deaths. Table 4 summarizes the recommendations generated from the reviewed cases and aligns them with standardized OFR recommendation categories to support implementation and ongoing quality improvement efforts.

## Table 4. Prevalence of Prevention Recommendations

| Healthcare | | |
|---|---|---|
| Strengthen and integrate behavioral and primary healthcare systems by expanding the capacity and coverage of long-term mental health and substance use disorder treatment services. | 5 | 19.23% |
| Promote whole-person care by increasing provider capacity, requiring ongoing training in life-saving overdose prevention and response services, OUD screening, and ensuring effective, evidence-based management of chronic pain. | 8 | 30.77% |
| Increase tailored education to patients on overdose risk that considers patient-specific factors, including chronic pain, age, comorbid conditions, prescribed medications, and concurrent substance use. | 15 | 57.69% |
| Implement standardized hospital discharge protocols that include naloxone distribution, connection to peer recovery, treatment services, coordinated referrals, and active family involvement for continued care. | 7 | 26.92% |
| Improve care coordination for overdose prevention by integrating evidence-based strategies, trauma-informed care, and stigma reduction into EMS/FD responses. | 2 | 7.69% |
| **Criminal Justice** | | |
| Enhance the capacity and resources for diversion and deflection programs to reduce the incarceration of individuals with substance use disorders and mental health needs. | 9 | 34.62% |
| Implement standardized screening for substance use disorders and mental health needs for all incarcerated individuals and increase access to medication for opioid use disorder (MOUD) and mental health services during incarceration. | 10 | 38.46% |
| Increase naloxone distribution upon release from correctional facilities, managed by healthcare staff, and improve post-release care coordination through warm hand-offs to continue services. | 2 | 7.69% |
| **Community/Public Health** | | |
| Reduce stigma for people who use drugs, those who are incarcerated, and the unhoused population by providing ongoing stigma and trauma-informed education and training for healthcare professionals, custody staff, public health professionals, and the community. | 10 | 38.46% |
| Strengthen multi-system care coordination across healthcare, criminal justice, and social services to ensure individuals and their families have seamless access to essential supports including housing, employment, insurance, transportation, mental health care, substance use treatment, and medical services. | 10 | 38.46% |
| Expand universal access to naloxone by installing clearly marked naloxone distribution stations including vending machines, wall mounts, and gravity fed boxes in high-trafficked public areas such as transit stations, libraries, schools, parks, jails, and community centers. | 3 | 11.54% |
| Increase training and education for community members to recognize signs of overdose and substance use risk to respond effectively, while also expanding awareness of community-based prevention, treatment, recovery resources, and life-saving overdose prevention and response services. | 11 | 42.31% |
| Enhance support for families affected by substance use through trauma-informed services to help navigate a loved one's substance use disorder and access to grief resources following an overdose death. | 9 | 34.62% |
| Improve support for individuals with a history of childhood or adult trauma (e/g., overdose death of a parent, domestic violence, sexual abuse) by expanding resources to address related behavioral health needs. | 6 | 23.08% |
| **Fatality Review** | | |
| Promote best practices for drug-related death investigations. | | 0.00% |
| Promote the utilization of the ADHS State Lab comprehensive toxicology testing. | | 0.00% |
| Enhance and broaden fatality review committees by incorporating diverse community representation including agencies such as Veteran Affairs, active-duty military, family and child services, housing and Tribal organizations. | 1 | 3.85% |

# Specific Prevention Recommendations for Mohave County

The top five recommendations for Mohave County were identified and shared with community partners (see below) to support ongoing efforts to improve and enhance services in local communities.

1. Increase tailored education to patients on overdose risk that considers patient-specific factors, including chronic pain, age, comorbid conditions, prescribed medications, and concurrent substance use. (58%)
2. Increase training and education for community members to recognize signs of overdose and substance use risk to respond effectively, while also expanding awareness of community-based prevention, treatment, recovery resources, and life-saving overdose prevention and response services. (42%)
3. Implement standardized screening for substance use disorders and mental health needs for all incarcerated individuals and increase access to medication for opioid use disorder (MOUD) and mental health services during incarceration. (38%)
4. Reduce stigma for people who use drugs, those who are incarcerated, and the unhoused population by providing ongoing stigma and trauma-informed education and training for healthcare professionals, custody staff, public health professionals, and the community. (38%)
5. Strengthen multi-system care coordination across healthcare, criminal justice, and social services to ensure individuals and their families have seamless access to essential supports including housing, employment, insurance, transportation, mental health care, substance use treatment, and medical services. (38%)

# Conclusion

The Mohave County Overdose Fatality Review Team's examination of 26 overdose deaths highlights the complex and multifaceted nature of overdose mortality in our community. The findings demonstrate that overdose deaths are often associated with a combination of factors, including mental health conditions, polysubstance use, chronic health conditions, adverse childhood experiences, social isolation, and barriers to accessing care and support services.

The review identified several recurring opportunities for intervention. These include improving patient-centered education regarding overdose risk, increasing community awareness and overdose response training, expanding access to substance use and mental health screening and treatment within correctional settings, reducing stigma through trauma-informed practices, and strengthening coordination among healthcare, behavioral health, criminal justice, and social service systems. Together, these strategies have the potential to address underlying risk factors and improve access to lifesaving resources for individuals and families affected by substance use.

Overdose deaths are preventable. By implementing the recommendations identified through this review process, Mohave County can strengthen its prevention and response efforts, improve outcomes for individuals at risk, and build a more coordinated system of care. Continued collaboration among community partners, service providers, public health professionals, policymakers, and individuals with lived experience will be essential to reducing overdose deaths and promoting health, recovery, and resilience throughout Mohave County.