

## **Understanding Overdose and Suicide Fatality Reviews**

When a community loses someone to an overdose or suicide, the impact reaches far beyond one family. Friends, schools, coworkers, and neighbors are all affected. While we can never undo these tragedies, our community is working to learn from them. One way this happens is through a process called an *Overdose and Suicide Fatality Review (OSFR)*.

The Meigs County OSFR is a community-based effort to understand the complex circumstances that led to a death and to identify ways to possibly prevent similar losses in the future. It is *not* an investigation and *not* about assigning blame or judgment. Instead, it focuses on learning, understanding, and prevention. By looking at the bigger picture—what supports were available, what barriers existed, and where help may have been missed—an OSFR board can take a deeper dive.

An OSFR review process brings together a diverse team of professionals from multiple sectors of a community. Review boards may include members representing healthcare, public health, emergency response, law enforcement, social services, mental health providers, and more. Each member offers a different perspective when reviewing the fatality, which helps the team understand how systems and services connect in real life.

The review team carefully and respectfully looks at information related to the person's life and death, such as interactions with healthcare and social histories. The focus is on trends and systems, not on judging individuals or families. All reviews are highly confidential.

The goal is not to focus on an individual's choices, but to ask important questions, such as: Were there warning signs that could have been addressed earlier? Were services accessible and coordinated? Did gaps in support exist? How can the community respond better in the future?

Overdose and suicide often share common challenges, including mental health struggles, substance use, trauma, isolation, or difficulty accessing care. Reviewing them together helps the community recognize risk factors and then discuss prevention efforts that look at root causes, not just symptoms.

The most important part of a fatality review is what comes next. Findings are used to guide recommendations that could potentially lead to change. Examples of this could include expanding access to mental health and substance use support, improving crisis response, strengthening prevention programs in schools and neighborhoods, increasing support and education for families and caregivers, and even building stronger connections between local organizations.

Overdose and suicide fatality reviews honor lives by learning from them. They remind us that prevention is possible and that communities play a powerful role in caring for each other.

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