



From Data to Action:

The Volusia County Overdose Fatality Review

OCTOBER 2026



Acknowledgments

This report was made possible through the contributions and collaboration of the many organizations and individuals participating in the Volusia County Overdose Fatality Review. We extend our sincere appreciation to the Governing Board, Case Review Team, and community partners who have generously shared their time, expertise, data, and perspectives to advance this important work. We also gratefully acknowledge the Volusia County Opioid Abatement Funding Advisory Board for providing the funding that supports this initiative. Together, these contributions reflect a shared commitment to learning from overdose deaths, strengthening community systems, and preventing future loss of life.



Executive Summary

Overdose remains a significant public health concern in Volusia County. Although overdose deaths have declined from historic highs earlier in the decade, fatal and nonfatal overdoses continue to affect communities throughout the county. The drug environment also continues to evolve, with fentanyl, polysubstance use, and changing patterns of substance use contributing to ongoing risk.

The Volusia County Overdose Fatality Review (OFR) was established to look beyond aggregate statistics and better understand the lives and circumstances behind overdose deaths. The OFR brings together representatives from healthcare, behavioral health, public health, law enforcement, corrections, the courts, child welfare, recovery organizations, and other community systems to confidentially review selected fatalities. By bringing together information that would otherwise remain within separate systems, the OFR seeks to identify recurring patterns, gaps, potential intervention points, and opportunities to prevent future deaths.

Planning began in late 2024, with the inaugural Governing Board convening in May 2025 and the first Case Review Team meeting in July 2025. Since then, the team has reviewed 25 overdose deaths in depth, examining available information across the life course, including childhood experiences, behavioral and physical health, substance use and treatment, housing and family circumstances, criminal justice involvement, healthcare encounters, and recovery attempts.

The review identified opportunities to strengthen warm handoffs and follow-up at critical transitions; expand peer recovery and care coordination; intervene earlier with youth and families; improve treatment and diversion pathways; strengthen family education and support; improve cross-system coordination and information sharing; and reduce barriers and stigma associated with seeking help.

These findings point toward a broader principle for Volusia County: Every contact can be an opportunity for connection. The emerging **Open Door.**

Every Time. approach recognizes that a person may not be ready or able to engage with help at the first opportunity. Each subsequent encounter provides another opportunity to offer support and connection.

A central finding is that many individuals were not unseen by community systems—they were repeatedly visible. The challenge was converting those contacts into sustained engagement, coordinated intervention, and long-term stability. Critical transitions between systems, including discharge from healthcare or treatment and release from incarceration, were points at which connection and continuity could be lost.

Ultimately, the purpose of the OFR is not simply to understand the lives of people who have died from overdose. It is to use what is learned from those deaths to strengthen the community's response to the next person at risk and move from individual case review to coordinated community action.

Formation & Purpose of the Volusia County Overdose Fatality Review

Looking Beyond the Numbers. Why Volusia County Started an OFR

Overdose data can tell us how many people are dying, where deaths are occurring, which substances are involved, and how patterns are changing over time. Those data are essential for understanding the scope of the problem, but they cannot fully explain the circumstances that brought an individual to the point of a fatal overdose—or where opportunities to intervene may have existed along the way.

Overdose Fatality Review (OFR) provides a different and complementary perspective. Rather than examining overdose deaths only in aggregate, an OFR brings together information from multiple systems to reconstruct the experiences of individual people who died from overdose. The review considers factors across the life course, including substance use and treatment history; physical and behavioral health; adverse childhood experiences and other trauma; housing and social conditions; and interactions with healthcare, behavioral health, law enforcement, courts, corrections, child welfare, recovery organizations, and other community systems.

Confidential case reviews are designed to identify system gaps and community-specific opportunities for overdose prevention and intervention. Unlike population-level surveillance alone, case review can help communities identify agency- and system-level strengths, gaps, and opportunities that become visible when the pieces of an individual's story are considered together.

For Volusia County, the fundamental question became:

What can we learn from the lives of people who died from overdose that could help prevent the next death?

Although overdose deaths in Volusia County declined from the historic highs experienced during the COVID-era escalation of the overdose crisis, overdose remained a significant public health concern. In 2024, Volusia County's age-adjusted drug poisoning death rate was 33.4 deaths per 100,000 residents, compared with a Florida rate of 21.3 per 100,000. At the same time, the County was making substantial investments in prevention, treatment, risk reduction, recovery, and related services through opioid settlement funding. The need was not simply for more data, but for information capable of helping community leaders understand where interventions could have the greatest impact and how separate investments could contribute to a more coordinated continuum of care.

An OFR offered a mechanism for doing that. Its purpose is not to assign blame to an individual, family, provider, or system. Instead, it asks what can be learned when organizations that each hold only part of a person's story bring those pieces together.

This distinction is important. A hospital may know about an emergency department encounter. Law enforcement may know about an arrest or overdose response. A treatment provider may know about an episode of care. Corrections may know about a period of incarceration and release. Child welfare may hold information about experiences decades earlier. A family member may understand circumstances that appear nowhere in an institutional record. Viewed independently,

each represents one encounter. Viewed together, they can reveal a life trajectory—and potential opportunities for prevention that no single organization could identify on its own.

The Volusia County OFR was established to identify missed opportunities for prevention and intervention across health, social, and criminal justice systems and to translate those lessons into practical changes in policy, practice, collaboration, and community response.

Building the Volusia County OFR

Planning for the Volusia County OFR began in late 2024, when One Voice for Volusia started exploring the development of a local OFR through discussions with public health analysts from the Central Florida and North Florida High Intensity Drug Trafficking Areas (HIDTA). Early discussions focused on establishing the relationships necessary for meaningful case review, particularly with the Volusia County Medical Examiner's Office and the Volusia Sheriff's Office.

The planning team also examined established OFR practices from other communities. In April 2025, One Voice for Volusia was formally matched with an experienced New Jersey OFR through a national mentoring program and also learned from the OFR operating in Pinellas County. These peer relationships helped inform the proposed governance structure, case review process, confidentiality protections, data collection practices, and approach to translating case findings into recommendations. The national mentoring program was subsequently discontinued, but the local planning process continued.

Funding from the Volusia County Opioid Abatement Funding Advisory Board provided support for One Voice for Volusia to facilitate and coordinate the initiative. The original local framework envisioned two complementary functions: A Governing Board composed of organizational leaders with the authority to support participation and advance system change, and a Case Review Team composed of designated representatives able to locate, share, and interpret information relevant to individual cases.

The inaugural Governing Board convened in May 2025. Ten organizations initially committed to participation, representing healthcare, public health, behavioral health and substance use treatment, recovery, child welfare, law enforcement, the Medical Examiner, and drug intelligence/public health analysis. Each participating organization executed a Governance Agreement and designated representatives to participate in confidential case review.

The partnership continued to expand as the review process matured and the current OFR team includes contributors from fourteen (14) organizations.

AdventHealth	Halifax Health	Volusia County Corrections
Central Florida HIDTA	North Florida HIDTA	Volusia County Medical Examiner's Office
Community Partnership for Children	SMA Healthcare	Volusia Recovery Alliance
Department of Health in Volusia County	State Attorney's Office, 7 th Judicial Circuit	Volusia Sheriff's Office
Flagler Cares & One Voice for Volusia	Volusia County Community Services	

From Records to a Life Story

The first Case Review Team meeting was held in July 2025. Five overdose fatalities were selected from a list provided by the Medical Examiner. Before each review, available information was assembled from multiple sources, including Medical Examiner investigative and autopsy information, toxicology, Clerk of Court records, police reports, and other publicly available information. Team members reviewed their own agency systems to determine whether the individual had interacted with their organization and brought relevant information to the confidential review.

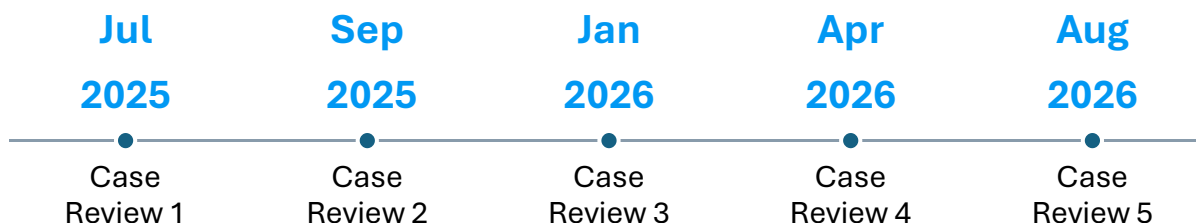
Confidentiality is central to the process. The Governance Agreement requires protections for case-specific information, designated organizational points of contact, and adherence to confidentiality requirements before a case can be reviewed. These safeguards allow organizations to examine sensitive information while keeping the focus on system learning and prevention.

During the review, the team reconstructs as much of the individual's life course as the available information permits. The discussion extends well beyond the circumstances immediately surrounding death. Reviewers consider childhood experiences, education, family circumstances, behavioral and physical health, substance use, treatment, housing, employment, criminal justice involvement, emergency and hospital care, periods of incarceration, recovery attempts, and other significant events.

Where possible, Volusia's process also incorporates Next of Kin interviews. These conversations can provide information that formal records cannot capture—family relationships, experiences of trauma or loss, attempts at recovery, barriers to care, and the family's perspective on what might have made a difference.

Work Completed to Date

Since the first review in July 2025, the Case Review Team has met approximately quarterly, reviewing five cases at each meeting. Twenty-five overdose deaths have now been reviewed in depth.



The work has evolved beyond individual case discussion. Information from successive reviews has been aggregated to identify patterns that recur across cases. The team has examined the relationship between overdose and early-life trauma, behavioral health, treatment history, housing instability, criminal justice involvement, critical transitions such as release from incarceration or discharge from healthcare, family involvement, changing drug supply, and repeated contact with community systems.

By July 2026, review of the first 20 cases had produced a set of initial themes and recommendations. One finding stood out across the cases: Many of the people whose deaths were reviewed were not invisible to the community's systems of care. They had repeatedly interacted with hospitals, behavioral health providers, law enforcement, courts, corrections, child welfare, treatment providers, and community organizations. Yet those contacts were often episodic, crisis-driven, or disconnected from one another.

The review therefore began to shift the question from “Did this person ever come into contact with help?” to “What happened after that contact—and did it lead to a sustained connection?” That distinction has become central to the OFR's work. Initial recommendations emphasize stronger warm handoffs at transition points, post-overdose and post-release engagement, peer and care coordination support, early intervention with youth, family education, improved treatment and diversion pathways, cross-system information sharing, outreach to high-risk environments, and a broader community approach to reducing stigma and encouraging help-seeking.

From Review to Action

The ultimate purpose of an OFR is not simply to understand the past. It is to use what is learned from past deaths to change the conditions encountered by the next person at risk.

OFRs are intended to move communities from case review to system improvement—using multidisciplinary data to identify gaps and develop community-specific prevention and intervention strategies.

For Volusia County, the first year of review has pointed toward a central conclusion: The challenge is often not the absence of system contact, but the difficulty of turning repeated contacts into sustained engagement, coordinated intervention, and ongoing support.

That conclusion is shaping the OFR's emerging **Open Door. Every Time.** initiative. The concept recognizes that recovery does not necessarily begin during the first—or even the fifth—interaction with a system. Instead, every emergency department visit, law enforcement encounter, release from jail, treatment episode, community-service interaction, conversation with a family member, or other point of contact can become another opportunity to offer information, support, connection, and hope. The proposed initiative seeks to make recovery resources consistently available across community settings and reinforce a shared expectation that every encounter matters.

Twenty-five lives cannot represent every person who dies from overdose in Volusia County. But examined carefully and respectfully, those lives can reveal patterns that aggregate statistics alone cannot. The measure of the OFR's value will ultimately be whether what is learned from the lives already lost helps the community respond differently to the next person at risk.

Understanding the Data

The following graphs draw from several data sources to describe overdose deaths and incidents in Volusia County. Each source captures a different aspect of overdose activity and has its own geographic basis, reporting timeframe, and limitations. As a result, counts and trends may differ across sources and should not be interpreted as directly interchangeable.

Florida Department of Health – Florida CHARTS Public Health Data

Florida CHARTS provides population-level public health data, including mortality and nonfatal overdose indicators derived from vital statistics and healthcare data. Mortality data are generally reported based on the decedent's county of residence rather than the location where the death occurred. These data provide a standardized source for examining long-term trends and comparing Volusia County with Florida and other jurisdictions. However, finalized public health data typically have a reporting lag and therefore may not reflect the most recent overdose activity.

Volusia County Medical Examiner Data

Medical Examiner data provide detailed information about deaths investigated by the Volusia County Medical Examiner's Office, including cause and manner of death and toxicology findings. These data are based on deaths occurring within the Medical Examiner's jurisdiction and may therefore include individuals who were not Volusia County residents. This source provides more detailed and timely information about the circumstances and substances associated with local overdose deaths than is generally available through aggregate public health data.

Volusia Sheriff's Office – Emergency Response Data

Emergency response data provided by the Volusia Sheriff's Office reflect overdose-related incidents recorded through the county's centralized emergency response system. These data are based on the location of the incident rather than the individual's county of residence and may therefore include nonresidents who experience an overdose within Volusia County. Because these records are available relatively quickly, they provide the most current view of local overdose activity; however, they represent emergency response records and should not be considered equivalent to finalized mortality or public health surveillance data.

Overdose Fatality Review Case Review Data

OFR data are derived from the individual overdose deaths selected for multidisciplinary case review. Cases are examined in greater depth using information from multiple sources to identify recurring circumstances, system interactions, potential intervention points, and opportunities for prevention. Cases were not selected using a scientific or statistically representative sampling methodology and, in some instances, were selected in part based on the availability of information for review. Accordingly, OFR findings should be interpreted as patterns and themes identified among the cases reviewed and not as estimates of the prevalence of those characteristics among all overdose deaths in Volusia County.

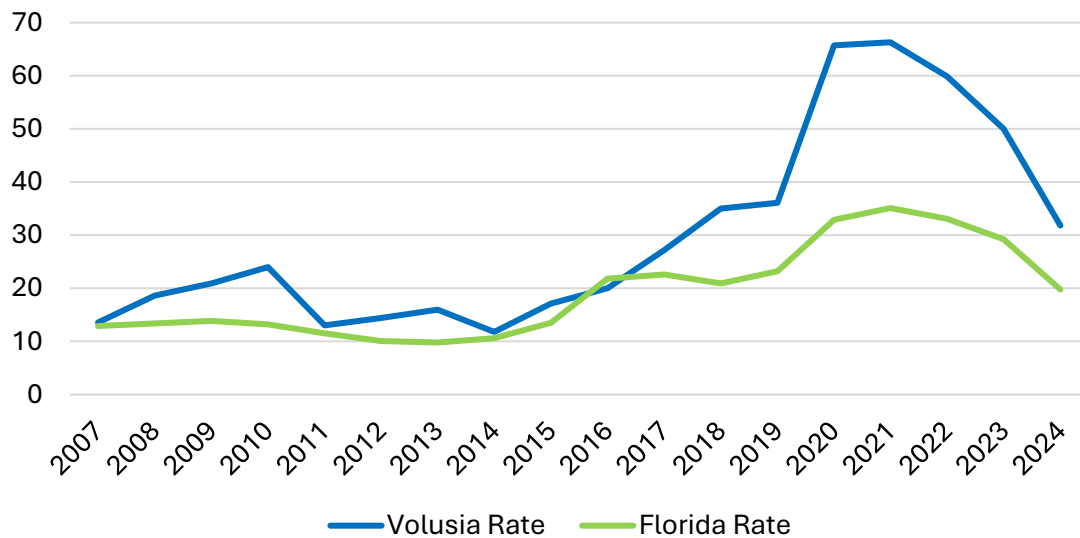
A Summary of Overdose in Volusia County

The Long-Term Picture: Overdose Trends in Florida & Volusia County

Trend & Comparison: Overdose Deaths

Age-adjusted Deaths From Unintentional Injury by Drug Poisoning, Rate Per 100,000 Population

Source: Florida Department of Health, Bureau of Vital Statistics; <https://www.flhealthcharts.gov/>



Counts: Volusia Overdose Deaths

Volusia County Deaths From Unintentional Injury by Drug Poisoning, Counts Per Year

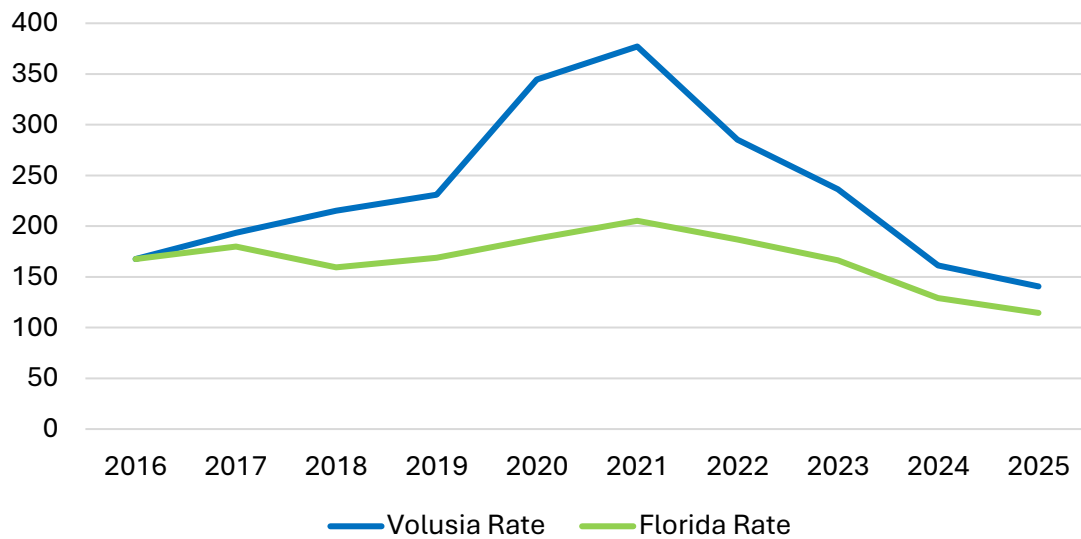
Source: Florida Department of Health, Bureau of Vital Statistics; <https://www.flhealthcharts.gov/>

Year	Count
2024	168
2023	274
2022	302
2021	330
2020	316
2019	171
2018	160
2017	123
2016	92
2015	78
2014	54
2013	76
2012	62
2011	60
2010	104

Trend & Comparison: Non-fatal Overdose

Non-fatal Emergency Department Visits for Drug Poisoning

Source: Florida Agency for Health Care Administration; <https://www.flhealthcharts.gov/>



Counts: Volusia Non-fatal Overdose

Volusia Non-fatal Emergency Department Visits for Drug Poisoning

Source: Florida Agency for Health Care Administration; <https://www.flhealthcharts.gov/>

Year	Count
2025	850
2024	959
2023	1,378
2022	1,636
2021	2,127
2020	1,884
2019	1,246
2018	1,147
2017	1,016
2016	870

A More Current Look at Overdose in Volusia County Local Surveillance Data | 2025–August 2026

State and county public health datasets offer important context for understanding longer-term overdose trends but often have significant reporting delays. To present a more current picture of overdose activity in Volusia County, this report also draws on emergency response data collected by the Volusia Sheriff's Office, offering timely insight into recent overdose patterns and emerging trends.

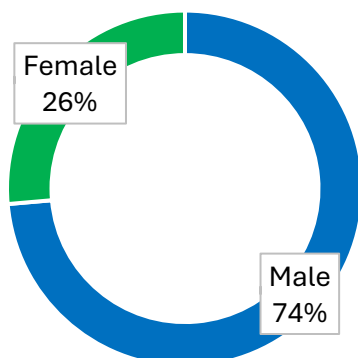
This dataset includes all of 2025 and January through August 2026. The following graphs use either the full available dataset or, where noted, January through August data for both years to provide an equivalent and accurate year-to-year comparison. Of note is that the visuals represent fatal, non-fatal, and combined data sets.

Fatal Overdose Deaths, by Gender

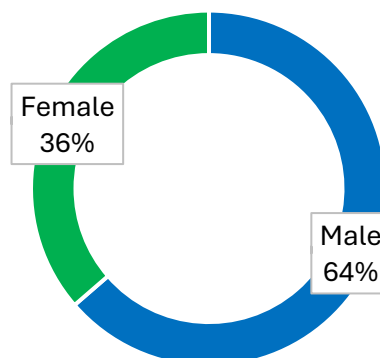
Full Data Set | Comparison of January to December, 2025 to January to August, 2026

Source: Volusia Sheriff's Office

2025 Fatal Overdose Deaths,
By Gender



2026 Fatal Overdose Deaths,
By Gender



Non-fatal Overdose Deaths, by Gender

Full Data Set | Comparison of January to December, 2025 to January to August, 2026

Source: Volusia Sheriff's Office

	2025	2026
Male	54.6%	52.2%
Female	44.6%	46.4%
Unknown	0.9%	1.4%

Fatal and Non-fatal Overdoses, by Race

Full Data Set | Comparison of January to December, 2025 to January to August, 2026

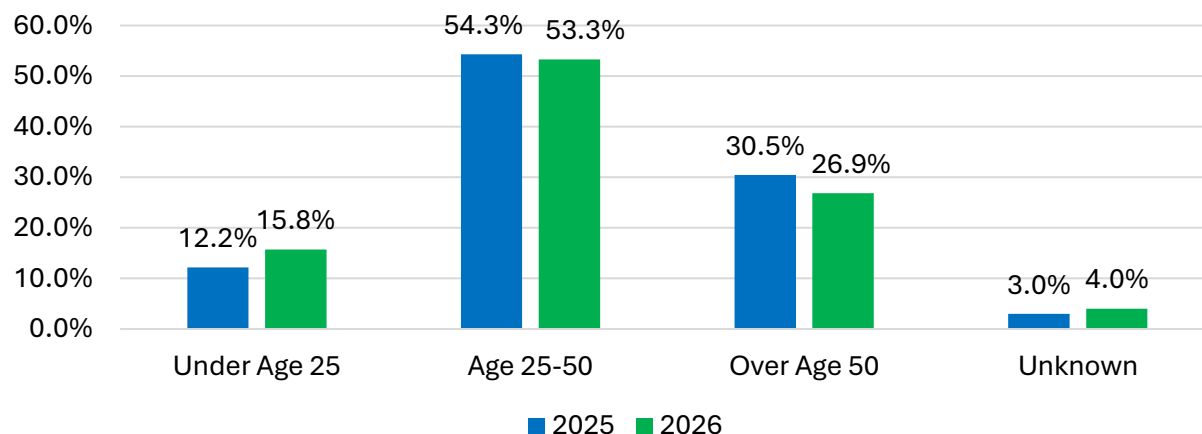
Source: Volusia Sheriff's Office

	Fatal Overdose Deaths		Non Fatal Overdoses	
	2025	2026	2025	2026
White	89.6%	89.1%	63.9%	74.6%
Black	9.7%	10.9%	8.5%	8.6%
Other	0.7%	0.0%	0.5%	0.0%
Asian	0.0%	0.0%	0.2%	0.2%
Indian	0.0%	0.0%	0.2%	0.2%
Unknown	0.0%	0.0%	26.6%	16.4%

Fatal and Non-fatal Overdoses, by Age Groups

Full Data Set | Comparison of January to December, 2025 to January to August, 2026

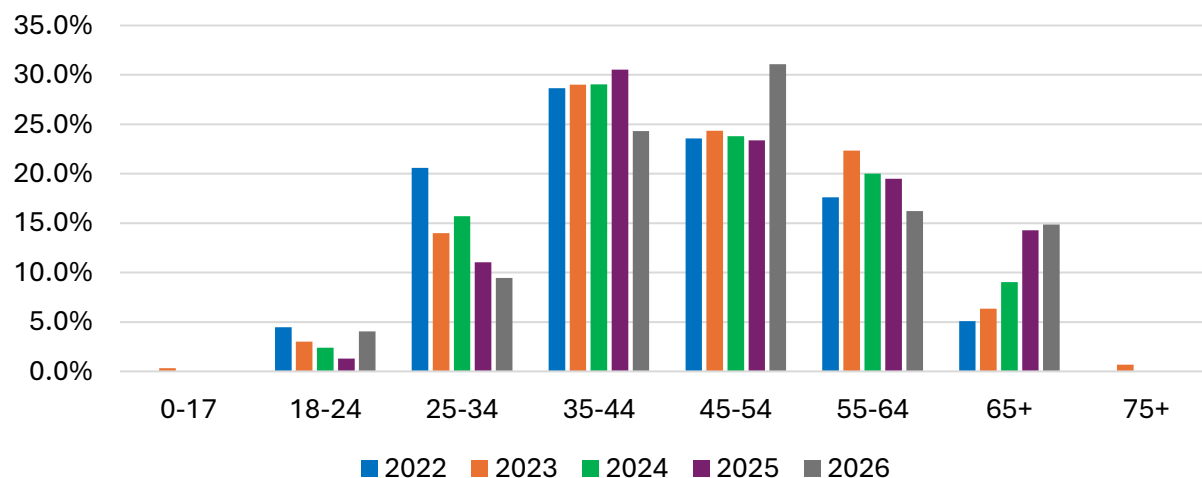
Source: Volusia Sheriff's Office



Fatal Overdose Deaths, by Age Bracket

All Overdose Deaths for 2022-2025, January to June 2026

Source: Volusia County Medical Examiner



Combined Fatal and Non-Fatal Overdoses, by City

Full Data Set | Comparison of January to December, 2025 to January to August, 2026

Source: Volusia Sheriff's Office

	2025		2026 (January - August)	
City	Count	Percent of Total	Count	Percent of Total
Daytona Beach	380	34.9%	207	29.9%
DeLand	129	11.8%	105	15.2%
Ormond Beach	107	9.8%	75	10.8%
Port Orange	105	9.6%	50	7.2%
Deltona	76	7.0%	66	9.5%
New Smyrna Beach	53	4.9%	28	4.0%
Holly Hill	46	4.2%	36	5.2%
Orange City	41	3.8%	28	4.0%
Edgewater	39	3.6%	21	3.0%
South Daytona	31	2.8%	28	4.0%
Daytona Beach Shores	27	2.5%	13	1.9%
DeBary	21	1.9%	10	1.4%
Oak Hill	11	1.0%	4	0.6%
Pierson	6	0.6%	6	0.9%
Lake Helen	5	0.5%	3	0.4%
DeLeon Springs	4	0.4%	7	1.0%
Enterprise	3	0.3%	1	0.1%
Osteen	2	0.2%	2	0.3%
Ponce Inlet	2	0.2%	1	0.1%
Astor	1	0.1%	1	0.1%
Mims	1	0.1%	0	0.0%
Total	1,090	100.0%	692	100.0%

Trend By City, Combined Fatal and Non-Fatal Overdoses

Average per month, 12 highest cities

Full Data Set | Comparison of January to December, 2025 to January to August, 2026

Source: Volusia Sheriff's Office

City	2025 Average Per Month	2026 Average Per Month	Trend
Daytona Beach	31.7	25.9	↓
DeLand	10.8	13.1	↑
Ormond Beach	8.9	9.4	↑
Port Orange	8.8	6.3	↓
Deltona	6.3	8.3	↑
New Smyrna Beach	4.4	3.5	↓
Holly Hill	3.8	4.5	↑
Orange City	3.4	3.5	—
Edgewater	3.3	2.6	↓
South Daytona	2.6	3.5	↑
Daytona Beach Shores	2.3	1.6	↓
DeBary	1.8	1.3	↓

Combined Fatal and Non-Fatal Overdoses, by Location Type

Full Data Set | Comparison of January to December, 2025 to January to August, 2026

Source: Volusia Sheriff's Office

	2025	2026
Residence	60.9%	67.6%
Business	19.5%	15.6%
Intersection/Roadway	6.1%	6.6%
Healthcare Facility	2.7%	4.2%
Parking Garage	2.5%	0.9%
Woods	1.5%	0.4%
Park	1.5%	0.9%
First Responder/County Gov.	1.4%	1.4%
School/Daycare	0.8%	0.6%
Shelters/Halfway Houses	0.8%	0.6%
Homeless Camp	0.7%	0.3%
Beach	0.6%	0.4%
Churches	0.5%	0.1%
Vacant Building	0.3%	0.0%
Waterway	0.1%	0.3%
Cemetery	0.1%	0.0%
Food Bank/Non-Profit	0.1%	0.0%

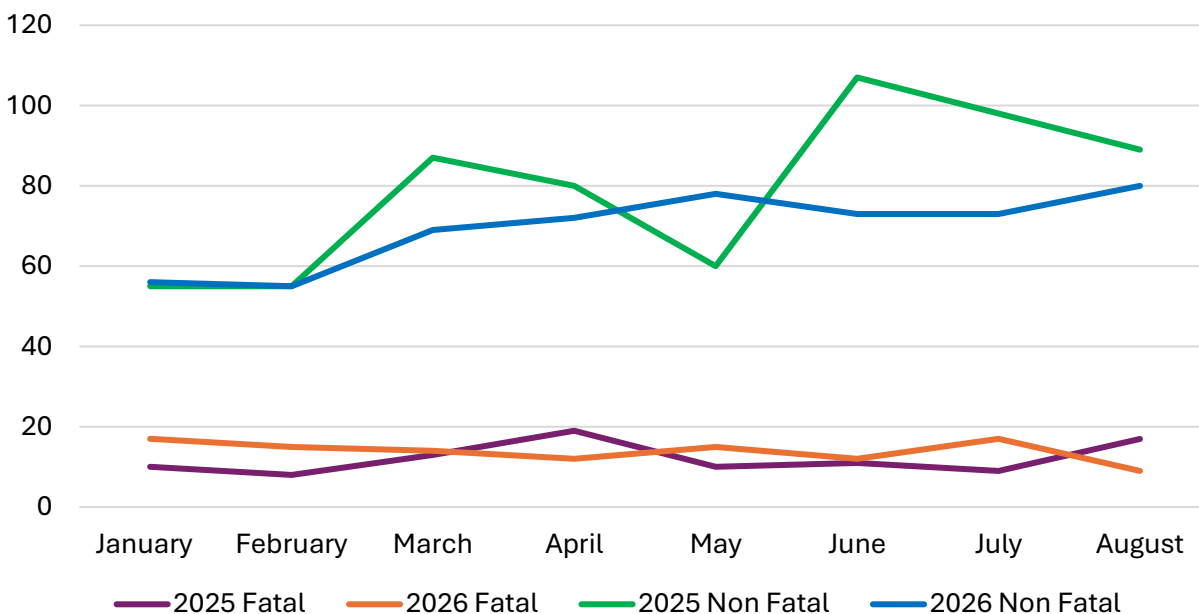
Business Detail

	2025	2026
Gas / Convenience	19.2%	19.0%
Hotel	45.1%	43.8%
Store	9.4%	15.2%
Restaurant	7.0%	7.6%
Pharmacy	0.9%	3.8%
Financial	1.4%	0.0%
Bar	1.4%	1.9%
Fast Food	9.9%	1.9%
Entertainment Venue	1.4%	1.9%
RV/MH/Campground	0.5%	0.0%
Service	0.9%	4.8%
Transportation/Term.	0.9%	0.0%
Library	0.9%	0.0%
Dealership	0.5%	0.0%
Construction	0.5%	0.0%

Comparison of Fatal and Non-fatal Overdose Occurrences, By Month

Full Data Set | Comparison of January to December, 2025 to January to August, 2026

Source: Volusia Sheriff's Office



Based on Volusia Sheriff's Office data through August 2026, fatal overdoses are projected to exceed 2025 totals, potentially marking the first annual increase since 2021.

- January to August 2025: 97 Fatal Overdoses
- January to August 2026: 111 Fatal Overdoses

Summary of Cases Reviewed by the Overdose Fatality Review Case Review Team

Case Selection and Data Limitations. Twenty-five cases were selected for OFR review. Case selection was not entirely random and was influenced, in part, by the availability of information about the decedent, including law enforcement and criminal justice records. As a result, individuals with criminal justice system involvement may be overrepresented in the cases reviewed. The characteristics of the cases reviewed, including demographics and system involvement, may differ from patterns reflected in broader overdose surveillance and mortality data. Findings should therefore be interpreted as patterns and themes identified within the reviewed cases and should not be considered representative of all individuals who die from overdose in Volusia County.

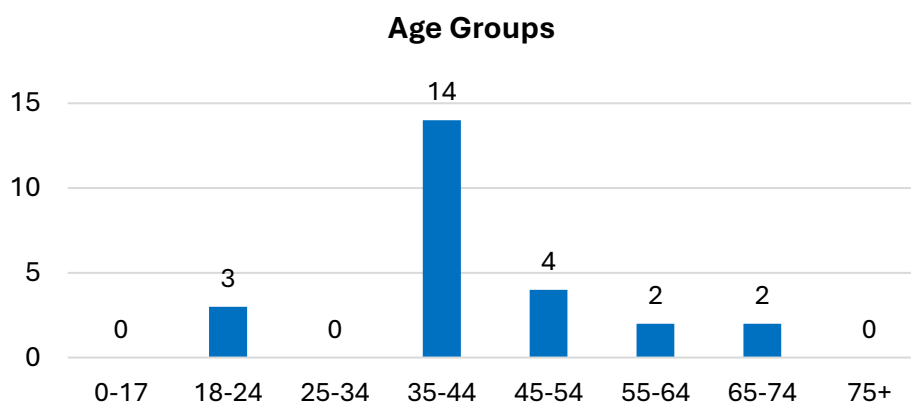
Demographics of Descendants

Gender

- 58% Female
- 48% Male

Race

- 92% White
- 8% Black



City of Overdose Death

Region	City	Count
East Volusia	Daytona Beach	6
	Edgewater	1
	New Smyrna Beach	2
West Volusia	DeBary	1
	DeLand	5
	Deltona	6
	Orange City	4
		25

Location of Death

- Residence: 13
- Hospital: 7
- Hospice: 1
- Outside of a Residence: 1
- Public golf course: 1
- Tent on private property: 1
- Transient camp: 1

Cause of Death

- Mixed Drug Toxicity: 68%
- Fentanyl: 88%

Housing Status when Death Occurred

- **6** (24%) Staying with Friend or Family
- **10** (40%) Living in Own Home
- **5** (20%) Unhoused/Living in Tent
- **4** (16%) Unknown

**One of the residences was a known drug house. Two individuals living with family and friends had a history of homelessness.*

Law Enforcement Contact

- **8** (32%) had LEO contact or juvenile justice involvement as minors
- **23** (92%) had LEO contact and involvement in the criminal justice system as adults
- The average number of contacts with LEO was **11.2**

**Common offenses: drug offenses, assault/battery, theft/shoplifting, domestic violence, burglary, probation violation, prostitution, possession of narcotics or paraphernalia, trespassing*

Involvement in the Child Dependency System

- **32%** were involved as children (victims)
- **52%** were involved as adults
- **25%** were involved as both children & adults
- **10 of 13** women were involved as adults

Behavioral Health History

- **40%** had a known or reported diagnosis (Bipolar, Schizophrenia, Major Depressive Disorder, PTSD, OUD, PTSD, Adjustment Disorder)
- **44%** had contact with crisis system (Baker Act, Marchman Act, Detox)
- **36%** experienced a previous overdose

**Other service history: medication management, outpatient psychiatric services, state hospital, mental health court (out of county), inpatient treatment, jail-based peer recovery services. Three individuals had evidence of self-harm*

Other Notes

- 3 individuals died shortly after leaving treatment or incarceration
- 3 had a history of self-harm

Initial Themes, Conclusions and Recommendations,

The following summary was created by One Voice for Volusia staff and reviewed and approved at the August 2026 OFR Case Review Team meeting.

Core Themes

Repeated System Contact Without Sustained Engagement. Individuals touch multiple systems, including law enforcement, hospitals, child welfare, courts, and behavioral health. Engagement was often crisis-driven, short-term, or incomplete, with little continuity of care across systems.

Sustainable engagement was a key challenge that emerged from the review process, where services and treatment were offered but not pursued or required. Stigma around behavioral health support was a frequent assumption of the board that emerged with each case reviewed. An opportunity to explore how best to help individuals with varying levels of engagement seeking should be considered.

Critical Transitions. Deaths frequently occurred shortly after release from incarceration, hospital discharge, or other major transitions. Warm handoffs, medication continuity, and follow-up support may have been absent.

Co-Occurring Mental Health and Substance Use Disorders. Mental health challenges, self-harm, trauma, and substance use frequently coexisted.

Early Life Trauma and Child Welfare Involvement. Many individuals experienced childhood abuse, neglect, domestic violence, truancy, or child welfare involvement, suggesting long-term impacts of adverse childhood experiences.

Housing Instability and Location of Residence Prior to Death. A significant number of decedents were homeless, transient, living in temporary arrangements, or residing in environments where substance use was prevalent. Known drug houses, encampments, and unstable housing situations were recurring factors across multiple cases.

Polysubstance Use and Changing Drug Supply. Fentanyl was frequently combined with methamphetamine, cocaine, benzodiazepines, or novel substances, creating unpredictable overdose risk.

Family Involvement. Families played both protective and enabling roles and often did not have knowledge of how to effectively respond to substance use issues. Of the family interviews completed, all expressed a desire to help but did not know where to seek support or how to help.

Missed Opportunities for Early Identification. Truancy, juvenile justice involvement, shoplifting, behavioral issues, and early substance use were common warning signs.

Specific Findings

Criminal Justice Involvement Findings. The case selection process intentionally involved the selection of cases with some public criminal justice involvement. The extent of that involvement often began with low-level offenses such as truancy, shoplifting, possession, or probation violations. Many individuals experienced repeated arrests, incarceration, or diversion opportunities but were unable to successfully pursue sustained treatment. Post-incarceration periods emerged as particularly high-risk. Criminal justice systems represented one of the most consistent points of contact.

Autopsy and Toxicology Findings. Fentanyl was the dominant substance involved in overdose deaths. Most deaths involved polysubstance use, commonly combining fentanyl with methamphetamine, cocaine, benzodiazepines, or synthetic substances. Emerging substances such as xylazine and fentanyl analogs were also identified.

Many individuals had significant underlying health conditions, including cardiomegaly, hypertension, COPD, hepatitis C, obesity, and cardiovascular disease. These conditions likely increased vulnerability to overdose and fatal complications.

Circumstances of Death. Deaths frequently occurred in homes, encampments, known drug houses, hotels, or hospitals. Many individuals were not alone when they overdosed, although some were alone in a room. Several individuals had recently used substances after periods of incarceration, hospitalization, treatment, or sobriety, suggesting reduced tolerance and increased overdose risk. Many decedents had interacted with hospitals, law enforcement, courts, or treatment providers shortly before death, indicating missed opportunities for intervention.

Overall Conclusions

These deaths were not isolated or unpredictable events. Across the twenty-five cases, individuals were repeatedly seen by healthcare systems, behavioral health providers, law enforcement, child welfare agencies, and community organizations. The primary challenge was not lack of contact but lack of sustained engagement, coordination, and intervention.

The findings suggest that the most effective future strategies will focus on coordinated care, post-overdose and post-release engagement, integrated behavioral health services, family involvement, early intervention, risk reduction, and stronger cross-system collaboration.

A central conclusion emerging from these reviews is that individuals were not hidden from systems; they were repeatedly visible. The challenge was that systems often responded independently rather than collectively, allowing critical opportunities for intervention to be missed.

Equally important is recognizing the perspective of individuals experiencing substance use disorder. People may not recognize the severity of their substance use, may be reluctant to seek help, or may not be ready to accept treatment when it is offered. Fear, stigma, previous experiences, and competing needs can also influence willingness to engage. Effective intervention must account for these realities by building trust, meeting people where they are, and offering repeated opportunities for support and connection. A person who declines help today may be ready to accept it tomorrow.

Recommendations

- Create a “No Wrong Door and No Wrong Exit” system with warm handoffs at every major transition point.
- Expand post-overdose and post-release outreach using peer recovery specialists and care coordinators.
- Strengthen school-based and youth-focused early intervention strategies.
- Target outreach to high-risk environments such as encampments & known drug-use locations.
- Naloxone distribution is strong in Volusia County, but it is a bystander tool and should be accompanied with education beyond overdose response to include additional risk reduction and connection pathways to individuals with substance use disorder.
- Develop structured family engagement and education programs.
- Improve criminal justice diversion and treatment pathways.
- Enhance cross-system data sharing and risk identification.
- Shift from viewing non-compliance as individual failure toward understanding system retention challenges.
- Explore stigma reduction around seeking help from systems of care, targeting youth in their teens and continuing the message through all age groups, with a goal to create a social norm that readies individuals for a “No Wrong Door and No Wrong Exit” response.

Open Door. Every Time. A Community Recovery Engagement Initiative

Open Door. Every Time. is a community-wide initiative designed to make every interaction with a person affected by substance use an opportunity to offer support, resources, and a pathway to recovery.

People often encounter healthcare, behavioral health, law enforcement, corrections, social services, faith communities, and other organizations multiple times before they are ready to seek help. **Open Door. Every Time.** is built on a simple principle: Every encounter matters. Every conversation matters. Every opportunity for connection matters.

Community partners will be equipped with consistent, accessible recovery information that can be offered in hospitals, jails, courts, treatment and recovery settings, schools, faith communities, outreach programs, and other locations—not only when someone appears ready for treatment.

Materials will include:

- A centralized guide to local treatment, recovery, peer support, behavioral health, crisis, and harm reduction resources.
- Information available in multiple formats, including print materials, QR codes, and a brand-neutral website.
- Hope-centered messaging that reduces stigma and encourages help-seeking.

The initiative asks community partners to move beyond assumptions about who is “ready” for recovery and instead consistently offer information, encouragement, and opportunities for connection.

You never know which conversation will open the door to recovery. Every conversation matters. **Open Door. Every Time.**