**York County Overdose Fatality Review**

**ANNUAL REPORT**

January 1, 2023 – December 31, 2023

(Including data from previous years)

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Report Submission Date: May 13, 2024

## **Background**

The York County Overdose Fatality Review (OFR) Team was established by a joint initiative between the City of York Bureau of Health, the York Opioid Collaborative, and the County of York Offices of the Coroner and District Attorney. The City of York Bureau of Health received Overdose Data to Action (OD2A) funding in January 2020. Within the first two years of funding, York worked to build capacity with stakeholders interested in collaborating on the OFR Team. York County established its Overdose Fatality Review Team in 2021, with key community members involved and organizations represented.

The OFR Team affiliation agreement, confidentiality agreement, meeting confidentiality acknowledgment, roles and responsibilities, process and procedures, and other templates were finalized before the first case review on Tuesday, June 1, 2021. Stakeholders were recruited, processes and protocols were developed, confidentiality documents were developed, and 14 case review meetings were convened between June 2021 and December 2023. We reviewed two cases each bimonthly (one accidental and one suicide). During each case review, we identified improvement opportunities in our systems for helping people with substance use disorders and their families.

## **OFR Overview**

**Purpose and Objectives**

The purpose of this Team is to prevent overdose deaths. We accomplish this purpose by examining individual, organizational, and systems-level factors related to overdose deaths that occur in York County, Pennsylvania.

The OFR purpose is to:

* Develop an understanding of the causes and incidence of overdose deaths in York County.
* Identify risk factors and missed opportunities for prevention and intervention to make policy and programmatic recommendations to prevent future overdose deaths.
* Promote cooperation and coordination among agencies involved in the investigations of overdose deaths and/or provide services to families.
* Define effective localized strategies for coordinating services related to overdose prevention.
* Development and implementation of data-driven prevention and intervention strategies.
* Identify system gaps and innovative community-specific overdose prevention and intervention strategies.
* Develop plans for and recommend changes within the agencies represented on the team in law, policy, and practice to prevent overdose deaths.
* Inform public health and public safety of emerging trends in overdose events.

To fulfill the purposes of the York County Overdose Fatality Review Team, the Team objectives are to:

* Establish policies and procedures for sharing all available information on overdose decedents from local, county, and state government agencies and private entities (including medical examiner investigative records, behavioral health and somatic care treatment records, healthcare payer records, social service records, criminal justice history information, family, and social history, etc.) that maintain confidentiality.
* Conduct multidisciplinary, multi-agency reviews of available information to determine the incidence and prevalence of fatal overdoses and the factors that cause or are correlated with overdoses.
* Identify points of contact between deceased individuals and healthcare, social services, criminal justice, and other systems where prevention/intervention efforts could be implemented.
* Identify the specific factors that put individuals at high risk for overdose.
* Improve coordination and collaboration between member agencies/entities.
* Inform the development of comprehensive local overdose prevention and response plans and identify changes to statutes, regulations, and policies that generally support the implementation of prevention efforts.
* Assist with assessing overdose prevention activities' implementation, impact, and outcomes and developing best practices.

**Meeting Frequency and Structure**

Meetings were held bi-monthly in 2021-2022, with 4 meetings in 2021, 6 in 2022, and 4 in 2023. Two cases were reviewed each bi-monthly meeting, including one accidental drug-confirmed death case and one suicide death by drug case. In 2023, we shifted to quarterly meetings and reviewed three cases, including two accidental drug-confirmed death cases and one suicide death by drug case. A typical meeting will be two hours in length. Given the sensitive nature of the information shared and the need to build trusted relationships, the meetings are closed and not open to the public.

Lead Organization

Steering Committee

Governing Committee

York County OFRT

**Lead Organization – City of York Bureau of Health:** [Act 101](https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2022&sessInd=0&act=101) outlines categories of individuals who may be selected as a member of a death review team by its “lead organization.” In counties with a local health department, the local health department shall be the lead organization to oversee and coordinate the death review team in a form and manner as prescribed by the Pennsylvania Department of Health. The City of York Bureau of Health received funding through the Overdose Data to Action (OD2A) from January 2020 - August 2023 to support this initiative.

**Steering Committee**: York County Coroner's Office, York County District Attorney's Office, York Opioid Collaborative, and City of York Bureau of Health

* **Chair:** Pam Gay, York County Coroner's Office
* **OFR Facilitator**: Dr. Matthew Howie, WellSpan Health
* **OFR Coordinators**: Samantha Zahm, City of York Bureau of Health & Brittany Shutz, York Opioid Collaborative
* **OFR Data Manager**: City of York Bureau of Health

A screenshot of a computer

Description automatically generated with medium confidence**Committee Members/Partner Agencies** – As of January 2023, 15 primary team members represented 13 different organizations.

**Committee Members/Partner Agencies**

City of York Bureau of Health

Person with Lived / Living Experience

UPMC in Central PA

WellSpan Health

WellSpan Philhaven, Behavioral Health

York County Children, Youth & Families

York County Coroner’s Office

York County Department of Emergency Services, 911 Communications

York County District Attorney’s Office

York County Human Services

York County Prison

York County Probation Department of Adult Services

York Opioid Collaborative

York/Adams Drug & Alcohol Commission

York/Adams Mental Health – Intellectual & Developmental Disabilities (MH-IDD)

## **Methodology of the Review Process**

The York County OFR team is a multidisciplinary team with members who can share case-level data about the decedent and/or contribute to analyzing available data as a subject matter expert. Currently, it is not feasible to review every overdose death in our community. An OFR is a systematic process used to examine the underlying causes of overdose fatalities in real time and problem-solve. This process includes:

1. **CASE SELECTION & GATHER DATA:** Identify cases, gather records, and examine the Coroner’s Office Reports

* Identifies 2-3 cases based on case selection criteria.
* Recruit guest members based on the York County Coroner’s Office Death Investigation Report.
* Accessing records of the deceased via record request letter\*
* Secure email sent to team members with Coroner’s Office Death Investigation Reports (4-weeks prior).
  + For virtual meetings: send out Zoom registration information.
* Prepare PowerPoint presentation with compiled data into detailed case notes and other visuals.
* 2-week Meeting reminder email sent to members.
* Agendas and other meeting materials prepared – printed/emailed to members.

1. **REVIEW CASES:**  In-depth case reviews by multi-disciplinary partners to examine case information and identify contributing factors and critical takeaways.
2. **MAKE RECOMMENDATIONS:** Collectively identify changes within and across existing programs and systems designed to prevent and reduce overdose.
3. **CHANGE SYSTEMS:** Actionable recommendations to strengthen these programs and systems. Every interaction with a part of the system is an opportunity for intervention.

**Case Selection Criteria**

York County Coroner Pam Gay began performing autopsies on each individual who overdosed in 2014. The Coroner and District Attorney, David Sunday, spent months persuading York County's 23 police departments, many of which rarely handle significant investigations, to treat every overdose like a crime scene. These efforts were aided in part by a 2011 change in Pennsylvania state law that demoted drug delivery, resulting in death (DDRD) from a murder charge to a first-degree felony. DDRD charges increased 356% statewide in Pennsylvania from 2015 to 2019. York is one of the highest counties with the highest percentage of [DDRD offenses](https://www.pacourts.us/news-and-statistics/news/news-detail/1040/drug-delivery-resulting-in-death-charges-in-pennsylvania). Under current law, prosecutors have five years to charge a person who provided a drug that led to a fatal overdose.

Our case criteria determined include the following inclusion and exclusion criteria described below:

* **INCLUDE:** Drug overdose deaths where the death certificate AND/OR the coroner or medical examiner report indicates that acute drug toxicity was directly the cause of death.
  + All drug overdose deaths of unintentional or undetermined intent should be included.
* **INCLUDE:** Manner of death[[1]](#footnote-1) —deaths where the manner of death is accident, suicide, or undetermined related to drugs.
  + The manner of death is the circumstance that led to the cause of death. The Commonwealth of Pennsylvania recognizes five manners of death—Homicide, Suicide, Accident, Natural, and Undetermined.
* **EXCLUDE:** Age of decedent under 21 years old—excluded cases are being reviewed by the local child death review team under the Public Health Child Death Review Act[[2]](#footnote-2)
* **EXCLUDE:** Cases under active investigation and litigation—exclude cases that would hinder the progress of an active investigation or criminal proceeding
  + Accidental cases are reviewed by the York County District Attorney’s Office to exclude these cases.

## **The Opioid Epidemic and Addiction Crisis in York County, Pennsylvania**

Every community member should have the chance to live a healthy life. Knowing who lives here helps us determine how to serve our community best and what extra support might be needed. Factors like age, race and ethnicity, sex, languages spoken, immigrant population, veterans, and disabilities are all essential to understanding our community's unique needs.

York County, Pennsylvania, is an urban county with a total population of 461,058 people, according to the U.S. Census[[3]](#footnote-3). While York County is predominantly White (82%), the City of York predominantly has a population of people of color (62%).

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Trends in Overdose Fatalities in York County, Pennsylvania

In recent years, more people have died in York County, Pennsylvania, by drug overdoses – primarily due to opioid and substance misuse – than by traffic incidents. Reports of opioid overdoses and other substance misuse-related deaths in York County are astonishing. According to annual reports issued by the York County Coroner, overdoses are one of the top causes of traumatic death in the county consistently is accidental drug overdoses. On average, nearly 15 Pennsylvanians died from a drug overdose every day in 2021[[4]](#footnote-4).

The overdose death rate in York County per 100,000 population increased 37.41% from 22.6 in 2013-2015 to 33.0 in 2017-2019. In addition, the overdose death rate in York County per 100,000 population was 43.09% higher in 2017-2019 than the overdose death rate nationwide.

**Age-Adjusted Rate of Drug Overdose Deaths per 100,000**[[5]](#footnote-5)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **2013-2015** | **2014-2016** | **2015-2017** | **2016-2018** | **2017-2019** |
| York County | 22.6 | 26.4 | 23.9 | 28.9 | 33.0 |
| Pennsylvania | 20.4 | 23.8 | 31.7 | 40.7 | 40.1 |
| United States | 14.9 | 16.9 | 19.3 | 20.7 | 21.3 |

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# Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

In York County, drug overdose deaths were slowly on the decline from 2017 to 2019 (12.73%). However, the opioid epidemic has not gone away, and in fact, it has only gotten worse because of the COVID-19 pandemic in 2020, causing increased social isolation and barriers to treatment, complying with prolonged mitigation measures like shelter-in-place orders to limit the spread of this infectious disease. Among the impacts was a sharp increase of 32.48% in overdose deaths in York County from 2019 to 2020, when the COVID epidemic swelled. Drug overdose deaths spiked to an all-time high in 2020 in York County. After the uptick in 2020, drug overdose deaths decreased by 37.90% from 2020 to 2021. The figure on the next page shows total drug overdose death counts in York County by year.

**Any Drug Overdose Death Estimates by Year in York County, 2012 – 2022**

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# Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

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Description automatically generatedOpioids continue to be an important driver of drug overdose death, however, increases in other substances contributing to death validates we are dealing with a poly-substance use epidemic. Preliminary estimates show that of the 946 total drug overdose deaths identified between 2017 to 2022, 89.11% (843) were confirmed to involve an opioid in York County with an 8.85% increase from 2017 to 2022.

Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

The most common combinations of drugs contributing to death remains fentanyl only with 46.11% in 2017 and 40.00% in 2022. Stimulant involvement includes overdoses of any prescription stimulant medication, such as

methylphenidate, or illicit stimulants, such as cocaine and methamphetamine contributing to death and increased by 45.72% compared to 2017 to 2022. In 2017, 27.54% (46) involved any stimulant. For comparison, 43.85% (57) involved any stimulant in 2022.

**Drug Classes Contributing to Cause of Death for the 130 Overdose Deaths in York County, 2022**

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# Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

**Drug Classes Contributing to Cause of Death for the 167 Overdose Deaths in York County, 2017**

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# Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

Despite relatively equal populations of males (49.7%) to females (50.3%) in York County according to the U.S. Census Bureau, there was a disproportionately higher number of overdose deaths among males in York County. 70.00% of drug overdose deaths occurred amount males.

Chart, line chart

Description automatically generated**Demographic Trends for Sex by Rate of Death per 10,000 in York County, 2012 – 2022**

Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

**Demographic Trends for Race & Ethnicity by Rate of Death per 10,000 in York County, 2012 – 2022**

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# Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

The figures above show the rate of overdose deaths per 10,000 population in York County by race and ethnicity. While York County is predominantly white, we have seen a significant increase of overdose deaths in populations of people of color over the past five years.

The figure below shows the majority of drug overdose deaths in 2022 occurred among those 35–44 years old (6.1 deaths per 10,000 population), followed by those 25–34 years old (5.8 deaths per 10,000 population).

Chart, line chart

Description automatically generated**Demographic Trends for Age by Rate of Death per 10,000 in York County, 2012 – 2022**

Source: Pennsylvania ODSMP – [Drug Overdose Surveillance Interactive Data Report](https://www.health.pa.gov/topics/programs/PDMP/Pages/Data.aspx)

Additional detailed findings are available on the [Drug Overdose Surveillance Interactive Data Report](https://public.tableau.com/app/profile/pennsylvania.pdmp/viz/PennsylvaniaODSMPDrugOverdoseSurveillanceInteractiveDataReport/Contents).

## **Trends in Suicide Deaths in York County, Pennsylvania**

The Pennsylvania Violent Death Reporting System[[6]](#footnote-6) (PAVDRS) is a state-level surveillance system funded through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). The PAVDRS program collects data on all suicides, homicides, undetermined deaths, and accidental firearm deaths occurring in Pennsylvania.

Chart

Description automatically generatedFirearms were the most common method of death by suicide, accounting for 48% of all suicide deaths from 2016-2018[[7]](#footnote-7) in York County. The most common method of suicide was suffocation, including hangings at 29%, followed by poisoning at 21%, including drug overdose. The figure below shows the leading cause of suicide deaths by sex from 2016-2018.

The suicide rate in York County per 100,000 population increased 18.41% from 14.3 in 2011-2015 to 17.2 in 2015-2019. This is 21.94% higher than nationwide suicide rates in 2015-2019.

**Age-Adjusted Suicide Rate per 100,000[[8]](#footnote-8)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **2011-2015** | **2012-2016** | **2013-2017** | **2014-2018** | **2015-2019** |
| York County | 14.3 | 15.3 | 16.9 | 17.8 | 17.2 |
| Pennsylvania | 13.1 | 13.4 | 14.0 | 14.3 | 14.5 |
| United States | 12.7 | 12.9 | 13.2 | 13.6 | 13.8 |

In York County, males were 3 times more likely to die by suicide than females. The rate of suicide is highest among middle-aged white men.

* In 2019, York County had 75 suicide deaths (58 males and 17 females), which occurred at a rate of 16.7 suicide deaths per 100,000 people. In 2019, York County averaged more than 1 suicide death every week.
* In 2018, York County had 92 suicide deaths (69 males and 23 females) at a rate of 20.5 suicide deaths per 100,000 people. Approximately 8 suicide deaths occurred every month in 2018 in York County.
* In 2017, York County had 90 suicide deaths (69 males and 21 females) at a rate of 19.2 suicide deaths per 100,000 people. Approximately 7 suicide deaths occurred every month in 2017 in York County.

## **Data & Findings from Case Reviews**

York County Overdose Decedent Data, June 2021 – December 2023

**31 Total Cases: 19 accidental & 12 suicides by drug were reviewed June 2021 – December 2023**

**19 Accidental Drug Overdose Fatalities**

* **Sex =** Males (11) and Females (8)
* **Race =** White (17), Hispanic (1), and Bi-racial (1)
* **Average age of decedent at the time of death =** 33 years

Majority of the people who died from an accidental

drug overdoses were never married or single (68.4%).

In addition, the majority of people who died from a drug overdose,

died in their own home. Of the 19 accidental overdose fatalities

reviewed, 15 (78.9%) occurred at Residence, 2 (10.5%) at a Motel,

1 (5.3%) at Friend’s Residence, and 1 (5.3%) at Family’s Residence.

In over 50% (12) of the 19 accidental overdose fatalities reviewed, mixed substance toxicity was reported as the cause of death, with fentanyl and/or morphine being present in all fatalities except one.

Over 80% of the people who died from a drug overdose were not born in Pennsylvania (N=16), with the majority birth state being Maryland, followed by Florida, New York, and Connecticut.

**12 Suicide by Drug Fatalities**

* **Sex =** Males (5) and Females (7)
* **Race =** White (11) and Black (1)
* **Average age of decedent at the time of death =** 52 years

The majority of people who died from suicide by drugs

died in their own home. Of the 12 suicide fatalities

reviewed, 11 (91.7%) occurred at Residence and

1 (8.3%) occurred at Parent’s Residence.

Among the 31 fatalities reviewed, the average age was 40 years old of age:

* 20-29 years old = 9 cases
* 30-39 years old = 7 cases
* 40-49 years old = 8 cases
* 50-59 years old = 3 cases
* 60+ years old = 4 cases

Among the 31 fatalities reviewed, the year of death:

* 2014 = 1 case
* 2016 = 1 case
* 2017 = 6 cases
* 2018 = 9 cases
* 2019 = 1 case
* 2020 = 3 cases
* 2021 = 5 cases
* 2022 = 2 cases
* 2023 = 3 cases

**Barriers to an Effective Case Review**

Some barriers to an effective case review have been identified during case reviews. Before Act 101 of 2022 was passed, a significant barrier was limited access to case records. Since legislation passed in November 2022 to aid in the efforts, the barrier to accessing records has transitioned to agencies’ interpretation and understanding of the legislation. Some agencies lack knowledge and education on the law to release the records, so it prohibits agencies from releasing information until further educated. Additionally, some agencies’ interpretation of the legislation continues to impede receiving records. There continues to be difficulty in York County receiving medical records from certain providers. Similarly, since York County borders the Maryland line, many decedents either resided in Maryland and overdosed in York County, were past residents of Maryland, or received treatment in Maryland or vice versa. The impact of not having access to records across state lines when being a bordering county to the Maryland state line has also been identified as a barrier.

York County does not have a Next-of-Kin interview process, which also creates limitations regarding effective reviews. Additionally, due to the prosecution of DDRD in York County, case selection is limited until clearance is received from the District Attorney’s Office. Although reviews do not interfere with the investigation and are preventative in nature, this continues to impact the timeframe in which cases are reviewed. Many cases are not reviewed until at least two to three years after death unless the case is a suicide by drug overdose or there is no potential for prosecution in the next five years. When cases are reviewed so long after the death, it is difficult to make appropriate recommendations as there have been significant changes since the time of the overdose death, and they may not be reflective of current trends.

**Recommendations Based on Barriers**

Eliminating barriers to help OFR teams be more effective and preventative in nature, as intended in the design of OFR, is essential. As a result of the barriers York County faces, the following recommendations are made. Educational materials or bulletins from the state are provided to different types of agencies based on confidentiality guidelines and the release of records to create uniformity in understanding the legislation. For example, the Department of Drug and Alcohol Programs released a bulletin explaining and detailing Act 101 so that treatment facilities understood they could release records despite 42 CFR. Similar bulletins for other agencies would be helpful to share with agencies to educate them. Similarly, all counties in Pennsylvania handle case review selection differently, and the understanding of whether a review impacts the active investigation of a DDRD case is left up to counties to determine and interpret. OFR is similar in nature to Child Death Review, and these reviews are not delayed due to interference with an active investigation; the legislature for OFR is vague in that the reviews must not interfere with an active investigation; many counties interpret this as an OFR may not be conducted while there is still an open investigation. OFR is not intended to focus on the investigation of the death; it is to look at the gaps and missed opportunities before the death to prevent future overdoses. Clear guidelines from the state for the District Attorney’s Office in all counties are recommended to improve uniformity in proceeding with OFR during an active DDRD investigation. Additionally, guidance and direction on sharing data and receiving records from bordering states are essential to improve recommendations. On a local level, York County is working to establish a Next-of-Kin interview process to incorporate into OFR to help gather additional data regarding the decedent that other agency records cannot provide or fill in the gaps.

**Recommendations Resulting from Case Review**

A picture containing table

Description automatically generatedAfter a review of overdose-related data, the OFR team develops recommendations to prevent future overdoses and overdose deaths. Recommendations are then shared to be implemented by OFR partners and community agencies. Recommendations to date have focused on communication, information and resource sharing, training, referrals to services, naloxone distribution, and education opportunities. The recommendations generated during the case review meetings are taken to the following Public Health and Safety Team (PHAST) meetings for feedback and support. In addition to recommendations, the OFR team has identified emerging themes during reviews and recurring themes to aid in generating recommendations.

**Themes from Deaths Reviewed**

* History of Trauma
* Mental Health and/or SUD History
* Resource Navigation
* Naloxone Access
* Bereavement Support Services

Table

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**Dissemination Efforts**

The 2023 Annual Report for York County was published on the City of York Bureau of Health website[[9]](#footnote-9)The published report contained a review from June 2021 to May 31, 2023. The public can view this annual report. Additionally, printed copies were published to distribute to OFR team members, agencies, and other community stakeholders.

**Appendix A**

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Description automatically generated2023 York County Overdose Demographic Data – January 1, 2023 – December 31, 2023**

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Figure 2. 2023 Decedent Sex

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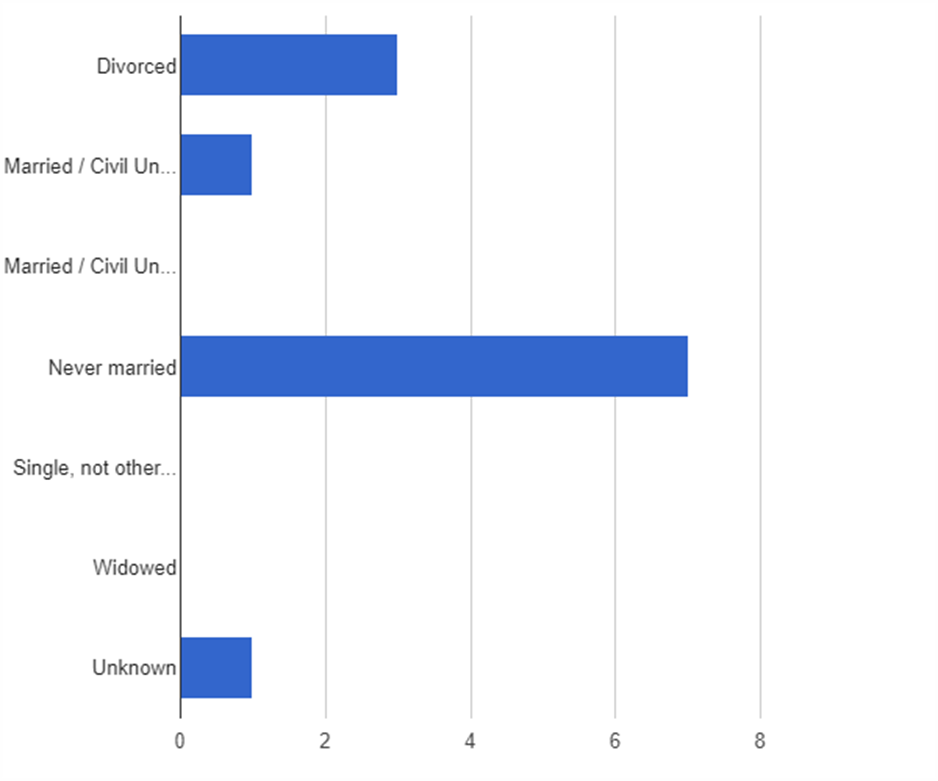
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Figure 4. 2023 Decedent Children Under the Age of 18

Figure 3. 2023 Decedent Race

Figure 5. 2023 Decedent Marital Status

1. PA Laws Empowering, Defining and Limiting the Power of the Coroner, <http://www.pacoroners.org/Laws.php> and Death Investigation: A Guide for the Scene Investigator <https://www.ojp.gov/pdffiles/167568.pdf> [↑](#footnote-ref-1)
2. 11 Pa. Stat. § 2150.20 [↑](#footnote-ref-2)
3. [U.S. Census Bureau](https://www.census.gov/quickfacts/yorkcountypennsylvania), Population Estimates Program (PEP), updated annually (estimate July 1, 2022) [↑](#footnote-ref-3)
4. <https://www.health.pa.gov/topics/Documents/Programs/PDMP/Pennsylvania%20Overdose%20Data%20Brief%202021.pdf> [↑](#footnote-ref-4)
5. <https://www.health.pa.gov/topics/HealthStatistics/HealthyPeople/Documents/current/county/su-03-drug-overdose-death-rate-lhi.aspx> and [NCHS Data Brief, Number 457, December 2022 (cdc.gov)](https://www.cdc.gov/nchs/data/databriefs/db457-tables.pdf#1) [↑](#footnote-ref-5)
6. [https://www.health.pa. gov/topics/programs/violence-prevention/Pages/VDRS.aspx](https://www.health.pa.gov/topics/programs/violence-prevention/Pages/VDRS.aspx) [↑](#footnote-ref-6)
7. <https://www.health.pa.gov/topics/Documents/Programs/Violence%20and%20Injury%20Prevention/2016-2018%20PAVDRS%20York%20County%20Suicide%20Fact%20Sheet.pdf> [↑](#footnote-ref-7)
8. <https://www.health.pa.gov/topics/HealthStatistics/HealthyPeople/Documents/current/county/mhmd-01-suicide-rate-lhi.aspx> and <https://www.cdc.gov/nchs/data/databriefs/db464-tables.pdf#1> [↑](#footnote-ref-8)
9. <https://www.yorkcity.org/city-services/departments/economic-and-community-development/bureau-of-health/substance-abuse-prevention/> [↑](#footnote-ref-9)