Office of Alcoholism and Substance Abuse Services

Clinical Response Following Opioid Overdose: A Guide for Managers

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Part I: Overview

Introduction

The opioid overdose death rate in New York State has grown exponentially over the past decade. Between 2010 and 2015, the age-adjusted rate of all overdose death per 100,000 residents doubled in size, from 5.4% to 10.8%. Correspondingly, the heroin overdose death rate increased five-fold between 2010 and 2015, from 1.0% to 5.4%.[1] Accidental drug overdose is currently the leading cause of injury-related death for people between the ages of 35-54, and the second leading cause of injury-related death for people ages 18-34.[2] The sharp upswing in overdose-related mortalities has created myriad issues for healthcare professionals, who have had to respond to this crisis in a short span of time.

While agencies, lawmakers, families, and communities throughout New York State contend with this public health crisis, professionals in the behavioral health field have encountered another growing issue: how do we respond to the emotional and psychological toll of this unprecedented death rate? How do we care for our patients during such a difficult time, many of whom have experienced the overdose death of a friend or peer? What are the best ways to support both staff and clients? While grief and loss have always been an aspect of therapeutic work, the opioid epidemic, and its attendant overdose rate, has created new dimensions and considerations for the staff members witnessing and responding to its effects.

This guide is intended to provide an overview of the primary issues that can arise when an organization must cope with the loss of a client to opioid overdose, from legal and regulatory issues, to addressing the issue with staff members and the client's peers. This document will also introduce clinical responses to grief and the grieving process, including specific considerations for behavioral health professionals.

The second part of this guide will provide some readily adoptable suggestions to assist agencies that are experiencing overdose deaths in their client population. It may be helpful for program managers to construct standardized protocols to respond to the issue of patient death within their agency. Clearly documented protocols provide a framework for the program, ensure consistency, and help minimize confusion and stress in the difficult period immediately following patient death. We will discuss the different considerations in greater detail throughout this document. At the end, you can find a template for the suggested protocols and additional resources for professionals, under the **Next Steps** subsection.

Opioid Overdose Prevention

Comprehensive opioid overdose prevention is always the first step in preventing future overdose deaths. While the current overdose death rate can be extremely disheartening for behavioral health professionals, it is critical that we continue to educate clients, communities, and other professionals on methods of preventing and responding to overdose. Prevention takes many forms, including: appropriate and accurate education about opioid overdose provided to vulnerable populations; Naloxone availability, training and proper utilization; and appropriate prescribing of, and adherence to, Medication Assisted Treatment plans for opioid-dependent patients. [3]

Grief and Loss in a Clinical Setting

Grief is a complex and unpredictable phenomenon. Grief, as distinguished from depression, can be defined as the emotional and psychological response to a significant loss. [4] Grief symptoms can include feelings of shock or disbelief, horror, numbness, intense sadness, increased anxiety and fear, anger, nihilism, and emotional withdrawal.[5] Grief symptoms can last anywhere from a few weeks to many years, and can include both psychological (e.g., sadness or anger) and behavioral components (e.g., sleeplessness, substance use). Some people additionally report acute somatic symptoms during periods of grief; including shortness of breath, stomach pain, headaches, and generalized joint pain.

The intensity of grief a person experiences may not correspond to the quality of their relationship with the deceased: in other words, some people may grieve very intensely after losing someone with whom they had a difficult or complex relationship. Conversely, other people may find that they cope quickly after losing someone with whom they had a strong and healthy relationship. Grief has few parameters and no set time limit. Grief is not inherently maladaptive; however, grief symptoms may become maladaptive over time if they are not addressed and treated as appropriate.

The intensity and duration of grief and bereavement symptoms can be compounded by numerous factors, including the age of the victim and the circumstances surrounding the death. Violent, traumatic, or unexpected deaths, or deaths where there is some ambiguity surrounding the intention of the victim (i.e., accidental overdose or suicide) have been shown to frequently result in stronger grief symptoms than anticipated or natural deaths.[6]

Opioid overdose can be particularly traumatic for the victim's counselors, friends, and family because it is, by its nature, a sudden and unanticipated death. As a result, people may be more prone to traumatic reactions. Additionally, many overdose victims suffer fatal overdose after a period of abstinence. The grief emotions their loved ones' experience is then further intensified by feelings of deep regret, disappointment, or even feelings of betrayal. Finally, while grief is often an isolating experience, people who lose someone close to them by overdose may also find less familial and community support and sympathy for their loss, owing to the persistent societal shame and stigma surrounding drug addiction and drug overdose deaths.[7]

Part II: Postvention

Introduction

When a program receives news of a client's passing, the agency staff must take on several different responsibilities: in addition to comforting and processing through the event with clients, the manager must also cope with their own emotions and reactions, as well as the emotions of their staff. Additionally, the program must review the death from an ethical and regulatory standpoint, and determine next steps. Finally, the agency may have to make programmatic changes in response to the death. This can all cause significant stress among behavioral health providers. At these times, it can be useful to have a "Response Roadmap" to help guide managers and supervisors in handling the situation. This section will focus on techniques and strategies to address the issue with the client's peers and other staff members.

First Response - Staff Debriefing

When the treatment provider is notified of a patient's death, management may find it helpful to conduct a staff debriefing. A staff debriefing after a significant incident can be an efficient and effective way for managers and administrators to address the news and gauge staff reactions.[8] The main purpose of a debriefing is to review the event and to have an open discussion with all involved staff members. The debriefing should take place as soon as possible after the program is notified of the death; ideally, within one business day of the notification. This also helps clarify staff roles and clearly delineates immediate actions to be taken. Additionally, a meeting gives staff an opportunity to openly discuss their feelings and reactions in a non-judgmental environment of their peers.

A debriefing can be conducted with all staff members who were directly involved in the patient's care. The debriefing can be extended on an invitational basis to all clinical staff, but management may find it more helpful to keep the initial debriefing small, with only the core clinical staff in attendance.

The basic format of a debriefing is straightforward: to review the event in a factual way; identify key factors in the patient's treatment episode; gauge staff reactions; and identify any immediate follow-up actions to be taken.

Some tips for conducting a successful debriefing include:

- Keep the conversation factual and the tone non-accusatory: it's important to not place staff members on the defensive.
- Ask open-ended questions: this encourages staff members to contribute more to the conversation.
- Keep things simple: debriefings answer the "who, what, when, where, why" of a patient death.
- Keep the meeting short: a debriefing should take between 30 minutes and an hour.

Working with Staff Members

Program staff members can have complex emotional responses to the news of a service recipient's overdose death; particularly if they were the client's individual counselor or case manager. A staff member who has lost a client to overdose may experience a range of emotions and reactions, including sadness, shock, self-blame, helplessness, disbelief, diminished confidence in their clinical skills or abilities, and anger. Some clinicians have self-reported feelings of numbness or dissociation when they have experienced multiple client deaths in their agency, particularly when these deaths occur within a short period of time.[9] Clinicians may replay their last interactions with the client, wondering if there were warning signs they failed to notice. They may feel upset or angry that their client was not forthcoming with them, or that the client did not utilize supports when they felt vulnerable to relapse.

Staff members may be hesitant to openly discuss their feelings with supervisors and managers. The staff member may question whether their feelings are in some way "unprofessional," or they may feel that they are "not allowed" to grieve. This reticence can stem from the long-standing, incorrect perception that clinician grief is a sign of enmeshment, codependency, and/or counter-transference.

However, the belief that clinician grief is a sign of unhealthy attachment or overinvestment in their patient has been demonstrated to be false.[10] Similarly, there is no empirical evidence that clinicians who experience grief reactions after the loss of a client are in some way acting outside the ethical standards of the profession.[11] Rather, grief emotions are simply a normal response to a significant loss, whether the relationship was personal or professional in nature.

Unfortunately, some clinicians can recount experiences in which they lost patients to overdose (or other sudden death, as in suicide) and did not receive support from their employer or peers.[12] It is critical that staff members receive support from their supervisor or manager during the period after a patient's death. This support allows a person impacted by loss to explore and process their feelings and reactions in a safe setting. Furthermore, providing support to staff in the aftermath of a loss validates staff emotions and can bring the team closer together. Conversely, it is important that any clinical staff members experiencing grief symptoms do not try to ignore or suppress their feelings. Unresolved, unexplored grief is a contributing factor to staff turnover, compassion fatigue, vicarious traumatization, and burnout. [13]

When a clinician loses a client, they can also experience an episode of "twin bereavement;" in which the death impacts the clinician on not only a personal level, but a professional level as well. Losing a patient can have a negative effect on a clinician's professional identity and by extension, their clinical work.[14] The clinician may experience doubts or insecurities about their own competency, or may feel that the work is too sad or emotionally draining to continue. They may also be concerned that they are being judged by their co-workers. Again, these are normal reactions to stressful triggers. However, they do need to be addressed in a supportive and non-judgmental setting. A clinician who feels comfortable openly expressing self-doubt with their supervisor or manager is less likely to internalize these negative self-perceptions – and therefore, less likely to develop future problems.

When providing initial support to grieving staff members, do not try to "correct" statements that the staff member may express. Allow them to vent their feelings regarding the loss. It is important that managers working with grieving staff members and clients understand that the immediate effects of grief can result in irrational or illogical emotional responses, including: the belief that one could have prevented the death; the belief that one is in some way responsible for the death; and the belief that these feelings will always be present. Provide supportive statements and use active listening and reflection with staff members. Understand that grieving is a process and that the clinician may be working through the initial shock. The clinical staff member may need to take a few days off, or it may be necessary to reduce their caseload for a while until the staff member has had some time to process the loss.

It is important for administrators and program managers to consider the resources of their respective agency and the needs of their staff when constructing a response plan to overdose death. It may be necessary to look for other local resources for additional assistance with grief and trauma counseling. Some questions the manager may want to ask while developing their plan include:

- Does the agency have an EAP office? If so, what sort of counseling/crisis assistance does it provide?
- Are there any trained grief or trauma therapists available through the agency to work with staff? If so, can they attend staff debriefing and/or individual follow-ups with clinicians?
- What are the agency policies regarding time off for bereavement? Does the agency offer additional supports to clients or staff after an unexpected loss in the workplace?
- Are there any local resources available to professionals who are working with grief and loss? (Note: additional resources can be found at the bottom of this document, under the **Resources for Clinicians** subsection).

Self-Care for Clinicians

Professionals who encounter high levels of interpersonal stress and loss in their jobs are at an increased risk for mental health symptoms, vicarious traumatization, and compassion fatigue.[15] It is critical that people who work in the human services field, regardless of their credentials or professional role, are educated about and encouraged to practice self-care. Frequently, clinician self-care falls by the wayside when clinical staff members are busy, overwhelmed, experiencing stress in their personal lives, or have a negative perception that self-care practices are too involved or time-consuming.

Management can help promote staff self-care practices in their agency by integrating wellness into the agency culture. Managers and supervisors can first conduct an informal assessment of their agency's dedication to a healthy workforce. Managers may want to ask the following questions first, before determining next steps:

- Are staff members allowed or encouraged to use vacation time or personal time? Can staff members typically take time off when they have requested it?

- Does the organization offer time off for bereavement? Does this time off include any option for grieving the loss of a client?
- What is the turnover rate of the agency? What reason(s) do staff members provide for leaving the organization?
- Do staff members frequently work overtime hours, or past the 8-hour workday?
- Has the agency experienced an increase in client deaths in the past year? How has the agency responded in the past?
- Do staff members frequently experience colds or flus, or have there been complaints around feelings of exhaustion or overwork by staff?
- Are there any current activities at the agency designed to promote and strengthen staff morale (potluck lunches, recognition awards, etc.)?
- Are there current counseling options available for staff members struggling with personal issues (e.g., an EAP office)?
- Does the current organizational culture create a positive, supportive environment for staff members?

After reviewing these questions, managers can determine what activities can be put in place to encourage clinician self-care and wellness. Therapeutic work is often inherently demanding, and clinicians greatly benefit from working at an organization that supports and recognizes the work that they do. Creating a positive organizational culture does not require huge shifts in protocols, or great financial investments on the part of management. Only a commitment to supporting staff and recognizing the difficulty in their jobs is required to effect organizational change.

Below are some ideas for managers to consider in promoting staff wellness in their agency:

- Setting aside time every month for staff members to meet for a potluck and discussion.
- Encouraging staff members to develop and maintain extracurricular activities outside of the workplace.
- Limiting the amount of overtime that staff can put in/hiring additional staff to help keep caseloads manageable.
- Placing caps on the patient population when there are staff shortages.
- Taking time to process upsetting and traumatic events with staff members (e.g., patient death).
- Empowering staff by using shared decision-making and encouraging feedback and input from staff.
- Advocating for staff members, particularly when there is a need for a change to agency protocols.
- Modelling wellness in their own role: delegating responsibilities, taking time off when needed, and not taking on the burden of "ownership" of an agency.

Self-care practices, at their core, do not have to be resource-intensive or difficult: they are simply about the consistent practices – physical, psychological, emotional, and spiritual – that promote

health and well-being in the individual. Self-care can encompass a wide range of activities, including:

- Eating a healthy diet
- Making sleep a priority
- Taking vacations or mini-breaks from work
- Seeing the doctor for any medical issues
- Exercise
- Journaling
- Having "down time" for enjoyable or restorative activities
- Maintaining supportive relationships with friends and loved ones

When people are grieving, it is important to encourage them to maintain healthy routines. People often feel unmotivated to take care of themselves when they are mourning a personal loss; however, a lack of self-care can result in physical or emotional exhaustion, worsening mental health symptoms, and immunosuppression, which can lead to more episodes of physical illness. [16] Daily self-care practices can also provide a sense of security and routine for people.

For more information on clinician self-care, clinicians are encouraged to watch, "**Year of Ethics: Self-Care and Counselor Wellness**" under the "Learning Thursday" Course Listing on the OASAS website. [17]

Interventions for Service Recipients

If a service recipient experiences a fatal overdose, it is important that the program responds appropriately and promptly towards the other service recipients. The program should directly address the loss, and allow the other service recipients time to process and explore their feelings. The overdose death of a peer can be extremely frightening and demoralizing to service recipients.

When the staff learns about the death of a client (whether opioid overdose is confirmed or suspected as the cause), they should arrange a time to speak about the death with the other clients in a group setting. If the clients present for a group session within the next day, this may be the best time to discuss news of the death and process client reactions. Otherwise, schedule a time to meet with service recipients as a group to openly process the event (note: this may be necessary in a residential or halfway house setting, if the service recipients typically attend treatment offsite).

Some key points for program staff in addressing a fatal overdose with the client population in a group setting:

- Discourage speculation – in a treatment milieu, it is common for there to be rumors and gossip surrounding a patient death among the service recipients. It is important that the staff does not encourage or validate any unsubstantiated rumors or provide any unnecessary details about the client's death.

- Protect the client's privacy – understand that the confidentiality regulations continue to apply even after the death of a patient. Keep the group's focus on remembering the client and discussing feelings and reactions, rather than responding to questions regarding the circumstances of the patient's death (see the **Legal and Ethical Considerations** subsection for more information).
- Validate the feelings of the group – unexpected deaths, particularly when they are sudden, can evoke mixed reactions, including anger ("He was so stupid!") and contempt ("She had three kids! How can someone be so selfish?"). Clients may be fearful of "being next", or may exhibit signs of traumatic stress (particularly if they have witnessed or experienced an overdose in the past). Losing a peer to overdose can also cause clients to feel fatalistic or hopeless ("What's the point of all of this?") Allow the clients to express their emotions without judgement; however, gently redirect the conversation if clients begin to make irrelevant or potentially offensive statements. Discuss the nature of addiction and the importance of reaching out for help if someone is feeling vulnerable to relapse. Discuss the warning signs for relapse and how clients can identify their triggers. Emphasize that there is always help available when someone needs it.
- If any client appears to be especially impacted by the news, it is recommended that the program manager and the responsible clinical staff member speak with the client immediately after meeting with the group. It may be necessary to schedule an additional individual session with them, or to refer the client for additional mental health or grief counseling.
- When discussing an opioid overdose death, use descriptors like "toxic" or "poison" to describe the drug or drugs believed to have caused the service recipient's death. Avoid words like "potent" or "pure" in any description: these types of descriptors may unintentionally encourage other patients to seek out the batch of drug that caused the patient's overdose, believing that it will provide a stronger high. For example, if a client discovered that a brand of heroin was involved with the overdose death of a peer, they may feel compelled to track down the strain due to its perception of purity.
- If your program provides Narcan (naloxone) training and/or kits to service recipients, take the time to ensure that everyone has received the proper information and kit. Reinforce the importance of Narcan training, even if a client believes they will never need it. If your program is unable to provide Narcan training or kits onsite, make sure that all group members receive information about how to obtain Narcan locally. Narcan is available through prescription and over the counter in New York State.
- Where appropriate, identify risk factors for overdose and reinforce strategies to reduce the likelihood of overdose (e.g., adherence to MAT). Additionally, discuss the overdose risk factors, including poly-substance use, and the most vulnerable times for clients in programming (e.g., awaiting transfer between levels of care).
- Encourage clients who may feel at risk of recurrence of symptoms to talk to program staff. Do not use the client's death as a cautionary tale – this appears to encourage judgement and shaming of clients who relapse and may make other clients hesitant to approach staff members with concerns about their own risk for relapse.

- If there is group interest, a simple memorial or vigil for the deceased can be a good way to honor their memory and allow clients to openly grieve. Staff may encourage the other clients to read poems or make personal statements about their peer. The manager can set a date and time for any interested people to attend. A memorial can also provide some closure for staff who worked with the service recipient.

In addition to meeting with clients as a group, it is recommended that the program manager keep an "open door" policy for any clients who want to talk on an individual basis. Some clients may not feel comfortable sharing in the group setting, or may require time for additional processing. It may also be helpful for clinicians to "check in" with their clients about their reaction to the death in their next individual session.

Screening Tools and Clinical Interventions for Service Recipients

As we described earlier in the guide, grief responses are highly individualized, and influenced by many variables. However, there are some general guidelines for clinicians to help them assess the severity of grief in their client population. Mental health professionals generally separate grief into two main categories: typical and complicated grief. [18] When a person experiences typical grief, the grief feelings can be intense at the beginning, but usually lessen over time. The grieving person may experience feelings of sadness and loss in "waves", but the intensity of these emotions becomes more manageable as a person fully processes their loss. There is no set time frame for typical grief, and clinicians should refrain from advising or suggesting clients to seek closure from the loss.

Additionally, early grief often mimics the symptoms of Major Depressive Disorder – sleeplessness, loss of purpose, etc. – so it is important to regularly follow up with the client or clients on how they are coping, to provide an ongoing clinical picture and to apply interventions or additional services as needed.

In complicated grief, people will experience an intense and enduring sense of sadness and loss for the person who died. They may yearn to be with the deceased, or their feelings may be so intense that they interfere with the person's daily functioning. These feelings, left untreated, can persist for years and significantly impact a person's health and well-being. If a client continues to present as or self-report that they are experiencing intense and unabating grief symptoms, it may be advisable to screen them for complicated grief. This is especially important if the person intimates or states that they are having suicidal ideation or intent related to their grief. Complex grief symptoms can cause a person to develop clinical depression over time. (A note for diagnostic purposes: the DSM-5 excluded the "Bereavement Exception" from the Major Depressive Disorder (MDD) designation; in other words, people who experience prolonged and profound grief may be diagnosed with MDD secondary to loss, provided they meet the clinical criteria for the disorder).

There are a few simple clinical tools to assess for complicated grief, including the Brief Grief Questionnaire (BGQ), a 5-question self-assessment tool that assesses the severity of a person's grief. Other tools that can be used with clients are:

- **The Complicated Grief Assessment** – a self-assessment tool that measures grief symptoms over the preceding month based on 4 different criteria dimensions.
- **The Inventory of Complicated Grief** – a 19-question self-assessment tool with high consistency and reliability, that concerns the grief-related thoughts and behaviors of the client.

(Note: these tools can be located under the **Resources** subsection).

If a client appears to be suffering from complicated grief as identified by any of these self-assessment tools, it may be necessary to refer that client for additional therapeutic services (ideally, a therapist who specializes in bereavement issues). While the clinician can broach the topic of grief and loss with the client, be aware that bereavement-related disorders are generally considered to be a subspecialty of trauma-related disorders, and that clinicians who do not have specific training in grief counseling should refrain from providing therapy to the client about their grief.

Intervention for Family Members

Family member reactions to a client's death may differ greatly, depending on many factors, including: the cultural and religious background of the family; the gender roles in their family and community; the family's resources and outlets for expressing grief; their knowledge and understanding of addiction; and the quality and nature of their relationship to the deceased. These grief reactions may be further complicated by a lack of acknowledgement and support for overdose deaths by the family's friends or community. Finally, grief responses can be highly impacted by the family member's perception of addiction and overdose.

Family members may struggle with intense ambivalence after their loved one has died, often stemming from feelings of shame or guilt related to their loved one's use; possible feelings of relief that their loved one is no longer in pain; or from the perception that they "failed" as a parent. Across the nation, family members of overdose victims still struggle to find community and therapeutic support for their grief. [19] Drug overdose death remains stigmatized: in a 2011 study, researches contrasted the mental and emotional after-effects for parents who had lost a child to drug overdose or suicide, when compared to parents who had lost a child to natural or accidental causes unrelated to overdose or suicide. The findings showed that the parents who lost children to overdose or suicide were consistently more troubled by lasting grief and mental health symptoms than the parents who had lost children to other causes. This data suggests that the stigmatization of drug addiction caused further isolation and shame in parents coping with their child's death, leading to more prolonged grief and mental health symptoms. [20]

Working with families following a patient death can be a particularly sensitive undertaking for clinicians and managers. It is important that managers, in collaboration with their agency's administration and available legal counsel, determine guidelines or protocols for agency staff to follow in these cases. Be aware that these cases are not typically "one size fits all", and may need to be considered on a case-by-case basis. There are numerous factors to consider when

developing standards for agency staff. Some general guidelines and ethical considerations have been provided below.

Suggestions and Issues for Consideration:

- Extend condolences to the family if they contact the agency to report the passing.
- Unless the client was in a residential level of care and it is necessary to contact the family to notify them of the passing, it is generally not advisable to contact the family without an invitation. In many cases, the family will contact the clinician to notify them of the passing. Be aware that families are experiencing their own grief process and may not be receptive to the counselor's attempts to reach out, even when they are well-meaning.
- Keep the patient's information confidential. Do not disclose any information related to the person's treatment episode to the family, even if they ask for additional information.
- Provide community resources and additional supports for family members struggling with grief (see list under **Resources for Families)**.
- If a staff member wants to attend a memorial service for the deceased, first discuss the matter in clinical supervision. The decision to attend a funeral should be always made with the foreknowledge and approval of the staff member's supervisor and/or manager.
- Always be cognizant and respectful of the family's wishes. In some cases, the family may invite the primary clinician to attend the memorial or funeral service for the deceased. If the family contacts the agency and the staff member would like to attend the service, it is always advisable to ask for permission from the family of the deceased prior to attending. Any staff member who attends a memorial or funeral service must not disclose they were the deceased person's substance use counselor.

Part III: Additional Considerations

Legal and Ethical Considerations

In addition to navigating their own emotional responses, as well as the responses of their clients, program staff members may have questions or concerns regarding the increasingly complex legal and regulatory considerations in the behavioral health field. They may not know whether they are permitted to reach out to the family of the deceased, or what to do if an oversight agency decides to investigate the death.

What Do the Regulations Say?

To properly guide staff members, it is important to understand how the regulations surrounding confidentiality and death reporting requirements intersect. We have provided relevant excerpts from different federal and state sources that outline the current standards and expectations for behavioral health agencies.

Federal Regulations:

Under the Code of Federal Regulation 42 Part 2.15, release of information is allowed when there are laws that require the notification of death to regulatory bodies to permit inquiry into the cause

of death (e.g., the Justice Center). Otherwise, it is necessary to obtain consent from the executor or spouse of the deceased patient prior to releasing any information about the patient.

HIPAA protections typically cover the patient for a period of 50 years after their death (HHS). The HIPAA Privacy Rule states that disclosures following a patient's death may be made under the following circumstances:

1.To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct

2.To a family member or other person who was involved in the individual's health care or

payment for care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the deceased individual that is known to the covered entity.

If there are any questions or issues that require clarification regarding confidentiality and disclosures following a patient death, agencies should first consult with their attorney. If there are further questions, please email: legal@oasas.ny.gov

State Regulations:

New York State Justice Center Reporting Requirements

If a client suffered a fatal overdose (or passed away from other causes) while actively engaged in treatment or on the program premises, then the death is considered a significant incident and must be reported to the Justice Center's VPCR hotline, regardless of the level of care the service recipient was engaged in. This standard applies to inpatient, outpatient, halfway house, and residential levels of care. The death reporting forms may be found here: https://www.oasas.ny.gov/jc/vpcr/index.cfm

If the client passed away within 30 days of discharge from an inpatient or residential treatment facility (whether the discharge was successful or non-routine), then the death must be reported to the NYS Justice Center as described above. However, if the client passed away within 30 days of discharge from an outpatient treatment facility, then there is no mandate to report the event to the Justice Center. (It is important to note that, while there is no mandate, there is also no prohibition on reporting a death if the staff member feels it is necessary to do so.) For more information, please refer to the following link and select Part 836: Operating Regulations

The Justice Center may choose to investigate the death of a client. If the Justice Center decides to investigate, they will notify the program of the pending investigation. If a staff member is named as the subject of the investigation, the Justice Center will also notify the staff member, typically in the form of a letter sent to the person's residence.

It is often helpful to meet with a staff member to address any questions they may have about a Justice Center investigation. Investigations are often quite stressful for all involved staff members, so it is important to emphasize that an investigation should not be construed as an accusation of misconduct on the part of the staff member. Clinical staff members may exhibit significant fear

and anxiety towards being interviewed by the Justice Center, or being named as the subject of a Justice Center investigation. In response, managers may need to arrange ongoing meetings with the involved staff member(s) to offer support and clarification as appropriate.

More information on Justice Center investigations can be found at: www.justicecenter.ny.gov or by calling 518-549-0200 during normal business hours (M-F, 9:00 a.m.-5:00 p.m.)

Guide to Families in the Legal and Ethical Context

The loss of a client can create a difficult situation for clinicians, who may want to reach out to the loved ones of the deceased while adhering to the strict confidentiality standards that govern behavioral health treatment. The federal regulations governing patient confidentiality after death do not expressly prohibit the clinicians from contacting the family of a deceased patient; however, there are strict rules governing the kind of information that can be released. All staff members should be aware that no medical records can be released to the family after a patient's death unless the family member is an Executor to the deceased's estate. Privacy regarding the patient's treatment should always be maintained, even if the patient previously signed a release form for their family. Clinicians should refrain from discussing any personal aspects of the client's treatment. As mentioned above, clinicians should also be aware of the family's wishes prior to attending any funeral services.

Next Steps

This sample protocol is intended to provide a template for administrators and program managers to design a standardized response to a crisis event. These protocols are modifiable for different programs and can be adjusted depending on time constraints and patient and/or staff needs.

Agency Protocol - Response to Patient Death
1. Incident Management: Upon news of patient death: Notify appropriate departments (e.g., Quality Assurance) and follow all reporting requirements (e.g., the Justice Center). Additionally, assemble staff members as soon as possible for notification.
2. Staff Debriefing: Contact the agency's EAP office, internal crisis team, or local crisis team and request a grief counselor to meet with directly impacted staff members. If not all staff members are present at the debriefing, ensure that everyone is notified of the passing as soon as possible.
3. Schedule a time to meet with the responsible clinical staff member individually.
4. Set a time to discuss the event with directly impacted service recipients (either in a group session or informal group meeting). Allot adequate time to discuss the loss. (If applicable): arrange a date and time to hold a memorial for the deceased open to all service recipients and staff.

5. Immediately following the group session with service recipients, follow up with adversely impacted individual clients as needed.
6. Have appropriate clinical staff (counselors, therapists, and/or case managers) follow up with all clients on their caseload in their next individual session on their reaction to the death. Discuss any concerns or observations in the next treatment team meeting.
7. If applicable): retrain service recipients on Naloxone administration and provide a kit or prescription for Naloxone.
8. (If applicable): management can reconvene to review the agency response and determine if there are necessary revisions or additions to agency policy, or other procedural changes in the organization.

Additional Resources

Resources for Clinicians

Grief Assessment Tools and Resources

- **The Center for Complicated Grief -** https://complicatedgrief.columbia.edu/professionals/complicated-grief-professionals/overview/
- **The Complicated Grief Assessment** – www.npcrc.org/files/news/complicated_grief_assessment.pdf
- **The Inventory of Complicated Grief** – www.goodmedicine.org.uk/files/assessment,%20traumatic%20grief,%20tahoma.doc

Online resources for staff members coping with grief symptoms include the following:

- **Grief Counseling Resource Guide: A Field Manual** – this guide is for professionals working with grieving clients and is appropriate for behavioral health workers of different disciplines. https://www.omh.ny.gov/omhweb/grief.org
- **Clinician Survivor Task Force –** for therapists and clinicians who have lost a client to suicide. http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm
- **Zubin Institute –** for behavioral health professionals who are coping with the death of a client. http://www.zurinstitute.com/clients_death_resources.html

Resources for Families

Online resources for grieving family members include the following:

- **GRASP (Grief Recovery After Substance Passing)** – a support group with chapters around the country, specifically designed for those grieving an overdose death. http://grasphelp.org/
- **Broken No More** – a website with forums, articles and resources for people grieving substance abuse death. Broken No More is also working to change the stigma around addiction. http://broken-no-more.org
- **Mom's Tell** – a website that provides information about substance use treatment, legislation and policy issues, in memory of the many people who have lost their lives to overdose. The organization was founded by a group of mothers who lost their children to overdose. http://momstell.org/
- **Learn2Cope** – this website has resources available for online/in-person meetings for families of people struggling with addiction, and has resources available for people who are grieving the loss of a loved one. https://www.learn2cope.org/
- **The Brendon Project –** this website allows family members to post stories and photos of their loved ones who have lost their lives to overdose. https://www.thebrendonproject.com/
- **What's Your Grief –** this website addresses all subjects related to grieving, including educational materials, trainings, and community support. This website can be used by both families and behavioral health professionals. https://whatsyourgrief.com/about/
- **Grief –** this website has a lot of resources, workshops, and educational materials for people dealing with grief. The website is suitable for both families and professionals. https://grief.com/
- **The Grief Toolbox –** this website offers resources, articles, and community support groups. https://thegrieftoolbox.com/

Footnotes

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[12] http://www.apa.org/gradpsych/2008/11/suicide.aspx

[13] Price, D. M., & Murphy, P. A. (1984). Staff burnout in the perspective of grief theory. *Death Education*, *8*(1), 47-58. doi:10.1080/07481188408251381

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[16] http://www.apa.org/helpcenter/stress-body.aspx

[17] https://www.oasas.ny.gov/testportal/LTcourses.cfm

[18] http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/complicated-grief.aspx

[19] https://www.drugrehab.org/coping-stigma-grieving-overdose-death

[20] Feigelman, W., Jordan, J. R., & Gorman, B. S. (2011). Parental Grief after a Child's Drug Death Compared to other Death Causes: Investigating a Greatly Neglected Bereavement Population. *OMEGA - Journal of Death and Dying*, *63*(4), 291-316. doi:10.2190/om.63.4.a

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