*CLINICAL QUICKNOTES ON SUBSTANCE USE DISORDERS*

# Responding to Provider Trauma, Grief, and Loss Following Unintentional Lethal Overdose

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*Note to readers: QuickNotes are meant to provide a topic overview that can be digested in only 5-7 minutes. The authors and editors of this QuickNote feel that a more comprehensive review and lengthier QuickNote is required for this topic, given the prevalence and impact of unintentional overdose on clinicians and the relative paucity of currently available information. The next QuickNote will be the usual brief overview.*

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| **Quick Takes** |
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| • Opioid overdose deaths continue to be a major public health problem in the United States. |
| • Guidance on emotional support for providers after patient opioid overdose death is limited. |
| • Overdose death responses, like suicide, are associated with secrecy, shame and stigma. |
| • Stress levels after a death by overdose may impact clinical decision making. |
| • Overdose deaths create professional, emotional, and legal concerns in providers. |
| • Practitioners who have a patient die from unintentional overdose benefit from broad organizational support, especially the support of peers, self-care and psychotherapy. |

*Case Study:*

> *A mid-career physician presents to work at a substance use treatment facility to begin an expected day of clinical service. Upon opening email, he is immediately drawn to the subject titled "Patient death," and discovers that one of his patients with opioid use disorder (OUD) expired the previous day due to a suspected overdose. He immediately feels shocked, saddened and anxious. He reflects on the patient's treatment and wonders what he could have done differently, recalling that the patient was engaged in counseling, received monthly injections of extended-release naltrexone (XR-NTX), and had drug screens consistently negative for all tested drugs. But did he miss something? Did his treatment meet standards of care? How will his peers judge him? Is he at risk of facing litigation?*

The United States continues to be in the throes of an opioid crisis, with high numbers of unintentional overdose deaths. Recent reports find that the trend may be reversing, with a 12.7% reduction in overdose deaths nationally between May of 2023 and May of 2024 with an even greater reduction of 21.8% in Ohio over that same period.[1] Even with this improvement, tens of thousands of Americans still lose their lives to substance use disorders (SUDs) annually[2] contributing to trauma responses in families, friends, communities, and treatment providers.

Research on provider response to other unexpected deaths, such as suicide, is better developed and more frequently addressed in the literature compared to provider response to unintentional overdose death.[3,4] There is great overlap between death due to suicide and unintentional overdose, including their sudden and unexpected nature[5] and associated stigma.[3] Similar emotional reactions of families and providers are seen in both circumstances, and the findings and recommendations in response to suicide are extrapolated to unintentional overdose deaths in this QuickNote.

The reality remains that the stressors providers face in treating individuals with SUDs comes from the very work itself and providers must frequently manage "their own grief responses experienced at work—about work" for themselves.[6] According to recent studies the lack of self-care practices among providers can impact clinical outcomes and patient care,[7] further compromising the provider's role. When one considers the additional burden of losing patients by overdose, knowing where to turn for help during a critical incident is imperative.

While the literature regarding the response to families and others who experience the trauma of losing a loved one to overdose is limited,[8] it is even sparser regarding the effects on those who provide clinical care, except for a few articles on providers,[3,4,5] first responders,[9] and harm reduction workers.[10] Most providers of substance use treatment will experience a patient overdose death, and some will experience more than one.[4] The trauma of patient death due to overdose can impact the provider's clinical decision making,[7] and impact them in many other ways, leading to self-doubt, depression, ineffectiveness, "burnout," consideration of no longer providing treatment to patients with OUD, and thoughts of leaving the field altogether.[3,4]

*Case Continued:*

> *As the physician ponders the patient's death, the agency quality improvement (QI) director appears at his door and asks if he had heard about it. He acknowledges he did and was just reflecting on it. The QI director commiserates, and then informs him that he is expected to attend an initial morbidity and mortality review that morning at 10:00 AM. Immediately following this interaction, he is notified that his first patient of the day has arrived.*
>
> *The physician has a full schedule for the day, including two new evaluations, with no time allotted to attend the M+M. He proceeds with his first patient and despite being distracted, feels that he provided good care. He thinks that he may have pursued relapse risk factors in this patient more assertively than his typical practice and verifies that the patient has a naloxone kit and knows how to use it.*

The processes to address the administrative aspects of overdose death are well-defined.[5] While providers are dealing with the clinical aftermath and their personal emotions following an overdose death, both they and organizations they work for have obligations that must be met, such as clinical care of other patients and administrative processes. Often, healthcare organizations have specific QI activities that must occur in set time frames and are required to meet certification standards. These can be burdensome for clinicians involved in the patient's care, especially as they are dealing with their own emotional response to the event, additional patient care demands, and the responses of others involved with the care of the deceased patient.

*Case Continued:*

> *After seeing his first patient of the day, a physician peer comes to his office and indicates that she heard about the patient death and lets him know that she would like to be of help to him. He shares that he is still reflecting on the situation, and that he feels overwhelmed with the death, the full schedule and the mandate to attend the M+M. She volunteers to help reduce his scheduled patients and arrange coverage for all patients scheduled during the M+M and the afternoon evaluations. She suggests that*

*they check-in during the day, and specifically touch base at lunch. He is appreciative and feels comforted by his peer's support as he enters the M+M*

Support and validation provided by clinician peers and colleagues is crucial during and after critical incidents like overdose death and is one of the experiences most highly valued by affected clinicians, with over 80% finding it "helpful" or "very helpful."[4] Regrettably, narratives of these vital conversations amongst providers regarding their own emotional struggles are limited,[3,5] with less than 30% of clinicians feeling "very well prepared" to support a colleague in these circumstances and only 23.1% receiving any postvention training.[4] Having conversations and utilizing colleagues as a resource to assist in these difficult moments is an aspect of support that providers respect,[3] although not "addressing the elephant in the room" remains all too frequent, and the silence in suffering through these losses may diminish the provider's passion for the work that lies ahead. Given the likelihood of overdose deaths and their impact on providers, organizations would be wise to provide staff and training in this area to help develop clinician skills to assist their colleagues.

Empathetic listening is important under these circumstances, but tangible help to relieve some of the conflicting obligations facing the involved clinician (such as providing patient coverage) is every bit as valuable and allows clinicians to provide full attention to activities that only they can address.

*Case Continued:*

*During the M+M, the patient's case history is reviewed. The patient had experienced OUD for at least a decade with multiple treatment experiences and relapses but had been stable and treatment adherent over the previous year. The physician recalls that at the end of his last medical appointment, the patient asked about discontinuing the XR-NTX. They had a brief discussion, and the physician indicated that relapse and lethal overdose are more common following medication discontinuation. He suggested that the patient continue the medication until they could discuss the issue in more depth at his next monthly appointment.*

*The patient did not show for his subsequent injection, then missed his next counseling appointment. The physician was not informed of this, and no follow-up steps were taken to check the patient's condition. There was no further contact with the patient before the agency became aware of his death. Based on the review of the case the agency decides to take immediate steps to identify all patients with recently missed appointments, assure that all of their treaters are aware of missed appointments and all identified patients are called to check on their well-being. A policy is established to perform these actions routinely going forward and a subsequent meeting is scheduled for more comprehensive discussion of these issues.*

*The physician suggests that the organization offer support to all providers involved in the patient's care. The agency leadership indicates that it has no formal process for this and suggests that employees contact the Employee Assistance Program or use the mental health benefit of their health plan. The physician also asks whether he should contact the patient's family and is told that he should ask the malpractice carrier for direction, and, if he contacts the family, should avoid saying anything that could subject him or the agency to an increased risk of litigation.*

Only half of clinicians whose patients have died by unintentional overdose find formal QI reviews to be helpful.[4] This is unfortunate and need not be the case. Clinical organizations can address QI and other administrative tasks and at the same time make a sincere effort to support providers. Ideally, QI reviews are learning experiences that focus on evaluating care provided and identifying areas for improvement without clinician

blame or discipline. Organizations should assure that the treating clinicians are available to attend the review and not "double booked" for both the review and clinical responsibilities.

We recommend that agencies proactively establish a process to respond to sudden unexpected deaths that is shared with clinical staff and includes their input during development in order to have pre-planned and mutually understood actions that meet the needs of all concerned (Table 1). Specific postvention programs for professionals following a patient suicide have been developed and may be considered for adaptation to lethal overdose postvention.[11]

Table 1. Recommendations for Agencies in Responding to Sudden Unanticipated Deaths

- Develop processes following sudden unexpected deaths.
  - Actions to support affected clinicians.
  - QI activities with timeline and purposes.
- Train staff on agency approach following sudden unanticipated death.
- Train staff on postvention.
  - Postvention approach to families.
  - Postvention approach to clinician peers.
- Following the event:
  - Mobilize resources to support and assist the involved clinician(s).
    - Peer clinicians.
    - EAP, if needed.
    - Outside therapists with expertise in postvention/trauma response.
  - Arrange coverage for patients to allow time for affected clinicians to reflect, receive support, participate in review activities.
  - Set the tone that clinical review activities are focused on quality improvement—not blaming or accusing.
  - Have regular check-ins in the following weeks with affected staff to support recovery process.
  - Offer time-off, if possible/desired.
  - Provide support—emotional and clinical as providers resume or continue clinical duties.
  - Encourage routine provider self-care and self-care in response to adverse events.

*Case Continued:*

> *After this physician's emotion-laden morning, the peer physician seeks him out, bringing food and drink. She shares her own experience with the overdose death of a patient, the emotions she experienced and the process of recovering. She affirms to her colleague that he is a caring and capable physician whom she respects. She also shares that she found value in receiving support from a peer, practicing self-care and eventually pursing individual therapy following her patient loss experience.*

Support of peers is highly valued by those who have experienced traumatic loss of a patient.[4] In this case, the peer was able to share personal experience of the challenges and recovery from patient death, acknowledging both her current feelings and identifying a hopeful path to recovery. During stressful periods such as this, affected clinicians will sometimes forget to take care of basic needs such as eating or drinking. Offering such resources is another tangible demonstration of support and modelling of self-care.

*Case Continued:*

> *That afternoon, the physician contacts the malpractice carrier, who did not object to him contacting the family, but affirms the agency's advice to avoid any self-implication in such a discussion. He discusses*

*his conundrum with his peer, who indicates that in a similar circumstance she contacted the family who was appreciative. The physician contacts the family, hoping to be helpful, but also having some trepidation about an angry response. He felt gratified when the family thanked him for caring for their son and said that the year he was in treatment at the agency was the best he had experienced in the previous ten year period.*

There is no consensus about contacting a patient's family following a sudden unexpected death. Many clinicians fear that family contact will elicit a negative reaction from them, but this is not common, occurring in only 5-6% of cases.[4] To the contrary, family members frequently *expect* outreach from clinicians and may see a lack of outreach as tacit acknowledgment of culpability. Families are experiencing the same flood of emotions as the clinician, and sharing grief can be helpful to both. However, the clinician should not see the family as a source of support. When offering support and sympathy to family members, the clinician should not express responsibility or guilt about the patient's death. Additionally, providers should recall that confidentiality extends beyond death. This alone should not dissuade the provider from speaking with the family, but clinical details should not be shared unless a release of information to family member(s) was signed by the patient during treatment, or a family member is designated as executor or administrator of the patient's estate.[5,12,13]

*"The traditional, legalistic approach to risk management is to avoid or minimize family contact after a patient suicide [or death due to unintentional overdose]* to reduce the threat of litigation. However, compassion over caution is likely a better approach. Avoidance of family contact increases distrust, animosity, and litigation, whereas compassionate contact reduces the likelihood of litigation."* [13]

*-Simpson, 2022*
*(Mr. Simpson is legal counsel to psychiatric plaintiffs in malpractice litigation)*

**Bracketed words added by QuickNote authors with permission of Mr. Simpson*

*Case Continued:*

*That afternoon, the physician choses to see a few patients, and, although it is difficult and he found himself second-guessing his approach at times, he feels that the treatment rendered was good. He discusses a few of the clinical situations with his peer as a "double check" and his approach is affirmed by her.*

The decision to continue to see patients in the immediate period following unexpected patient loss is an individual one. Some clinicians find that continuing to treat patients is helpful, while others feel that a break from patient care is needed for their personal well-being and coping. Consulting with peers and supervisors is important in making that decision. If the clinician is distracted and unable to concentrate on clinical issues, they clearly should suspend patient care activities.

*Case Continued:*

*His peer checks on him again before he leaves for the day, offers him a ride home (which he declines) and calls him during the evening. Over subsequent weeks, they converse frequently, and he begins a self-care regimen of exercise, healthy eating, and quiet reflection that was lacking in his life for a long time. Eventually, he decides to seek psychotherapy and finds it helpful. He continues to be a respected and valued physician in the agency and community.*

Table 2. Recommendations for Provider Self-Care Practices*[14]

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| ● Biological<br>○ Good sleep hygiene<br>○ Balanced nutrition<br>○ Consistent physical activity<br>○ Deep breathing<br>○ Yoga<br>○ Do not use alcohol/drugs as a coping mechanism | ● Spiritual/Social<br>○ Spiritual practices<br>○ Time with family and friends<br>○ Time for hobbies/other interests |
| ● Mental/Emotional<br>○ Take breaks<br>○ Avoid isolation—plan time with support system<br>○ Daily mindful activities like walking<br>○ Meditation<br>○ Relaxation<br>○ Self-compassion and self-forgiveness<br>○ Psychotherapy | ● Professional<br>○ Agency response and support for self-care<br>○ Support from peers<br>○ Reduce caseload to support coping and self-care<br>○ Limits and boundaries between professional and personal lives |

*Adapted from source

Table 3. Barriers to Self-Care Practices

- Historical pressures for professionals to cope regardless of circumstance. (Maintaining "Professional endurance and composure").[15]
- Time pressures. "It's traumatizing and then there's nothing for workers to deal with that trauma. You just have to go back to work".[10]
- Stigma surrounding patients with SUDs and the providers who treat them.[16]
- Lack of relief/support for clinical and other stressful work responsibilities.[16]
- Lack of standardized agency practice guidelines for overdose death response.[3]

The sudden unexpected death of a patient due to suicide or overdose is traumatic and most SUD clinicians will experience it at some point in their careers. With good organizational support, support of clinician peers, prioritization of self-care practices, and treatment with behavioral health professionals (when indicated) affected clinicians can gain perspectives that will help mitigate the impact of the trauma, help them maintain good functioning in their daily professional and personal lives, avoid excessive self-blame and burnout, and assist them in continuing to serve their patients with high levels of professionalism and empathy.

| Resources for Providers Coping with Sudden Unexpected Patient Death |
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| • Ohio State Medical Association Well Being Resource Center https://www.osmawellbeing.org/care |
| • Ohio Professionals' Health Program: Supporting Ohio's Healthcare Professionals https://www.ohiophp.org |
| • American Psychological Association All providers-focus: identification-early intervention https://www.apaservices.org/practice/ce/self-care |
| • American Psychiatric Nurses Association APNA: Well, Being Initiative https://www.apna.org/resources/well-being-initiative |
| • HEAR (Healer Education, Assessment & Referral): Proactive, preventive program for all health care workers https://pubmed.ncbi.nlm.nih.gov/29300216/ |
| • American Medical Association (AMA): Physician/health care provider well-being https://www.ama-assn.org/ |

| Upcoming Trainings on Substance Use Disorders |
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| • Ohio Alcohol and Substance Use (AUD/SUD) ECHO. Northeastern Ohio Medical University. First and third Fridays of every month. |
| • Substance Use Deflection Initiative ECHO. Northeastern Ohio Medical University. Second Wednesday of every month. |
| • Ohio Substance Use Disorders Center of Excellence. Multiple trainings and learning communities on various topics, with in-person and virtual trainings available. |
| • American Society of Addiction Medicine. Multiple trainings in Addiction Medicine in various formats. |
| • Providers Clinical Support System (PCSS). Multiple trainings on substance use disorders in various formats. |

*At the SUD COE, we are committed to bringing you resources and trainings that meet your needs in providing care to patients with substance use disorders. Please let us know what suggestions you have for improving Clinical QuickNotes, or topics that you would like addressed by clicking QUICKNOTES_feedback.*

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*This QuickNote is an overview only and is not intended to be the sole resource for provider support after opioid overdose death. The reader is encouraged to seek additional support from sources listed in "Additional Resources on Self Care for Providers"*