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# Supporting Providers After Overdose Death

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# Disclosures

- Dr. Yule has no relevant financial relationship(s) with ACCME defined commercial interests to disclose.
- Dr. Levin has no relevant financial relationship(s) with ACCME defined commercial interests to disclose.

*The content of this activity may include discussion of off label or investigative drug uses.  
The faculty is aware that it is their responsibility to disclose this information.*

# About our Work

- Dr. Yule currently has research funding from the American Academy of Child and Adolescent Psychiatry (AACAP) through the National Institute of Drug Abuse (5K12DA000357-17). She is a consultant to Phoenix House and the Gavin Foundation (clinical care). She represents AACAP on the PCSS Steering Committee.
- Dr. Levin currently holds a K24 DA DA029647. She is the PI of an RO1 DA 034087, a U54 DA037843, a H79 T1025937, Training Medical Dental Students in SBIRT, U79 T10124697. She also serves as the Medical Director for 2 SAMHSA supported national initiatives; a U79 TI026556, PCSS-MAT; and a U79 TI080816-0, Opioid State Targeted Response Technical Assistance (STR-TA)

# Target Audience

- The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication-assisted treatments.

# Educational Objectives

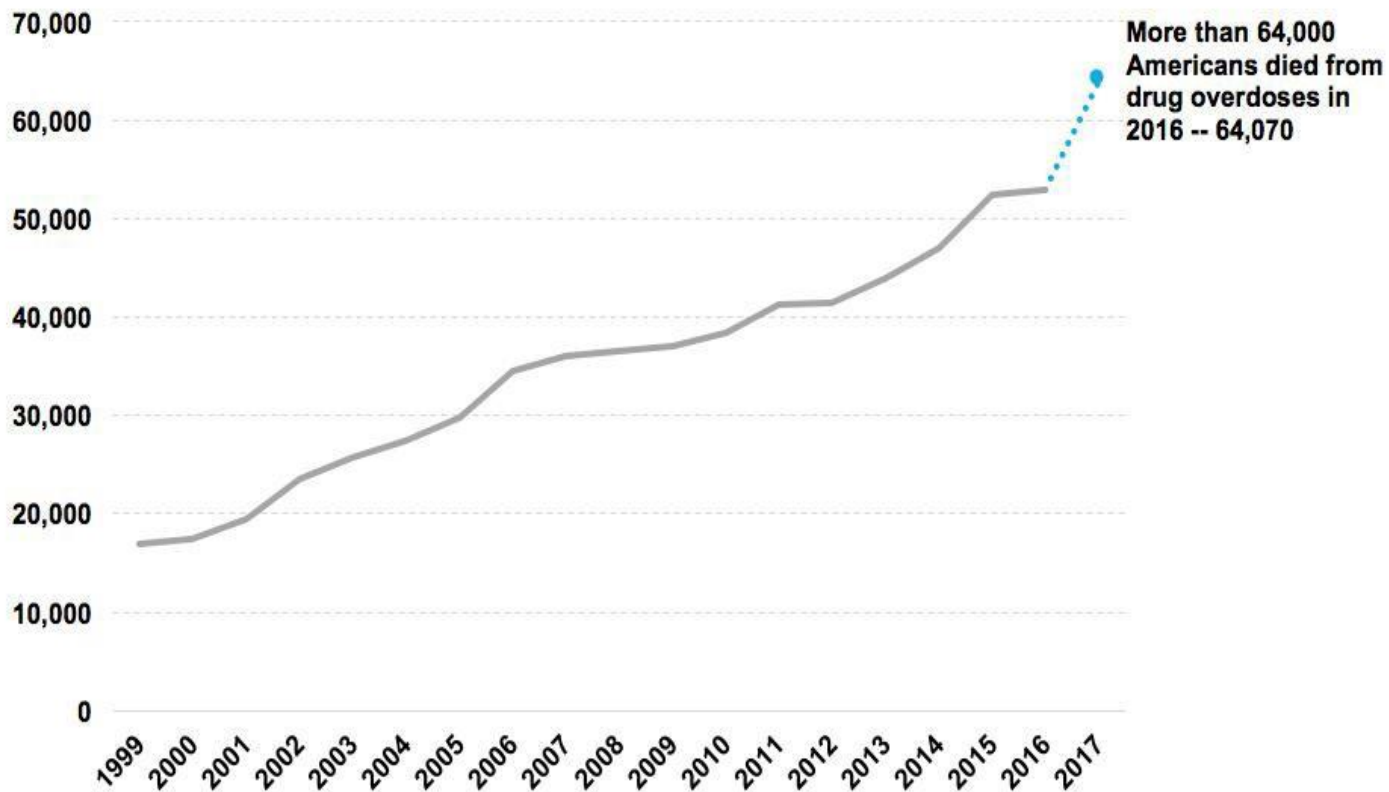
- At the conclusion of this activity participants should be able to:
  - Review therapeutic and legal issues to consider when working with families after an overdose death
  - Describe ways to care for themselves and support co-workers after an overdose death
  - Summarize possible quality, safety, and regulatory review procedures to follow after an overdose death

# Outline

- Background
- Clinical Relevance
- Case 1: Early Stabilization with Buprenorphine in Private Practice
- Case 2: Naltrexone Extended Release Lost to Follow-up in a Clinic Setting
- Case 3: Death after Discharge from Inpatient Hospitalization
- Conclusions

# Overdose deaths continue to increase despite increased awareness and resources directed to the opioid epidemic

## Total U.S. Drug Deaths



# Medication for opioid use disorders decreases overdose risk but some risk remains

## Buprenorphine

↓ rate of  
OD death  
by 70%  
when  
stabilized

## Methadone

↓ rate of  
OD death  
by 80%  
when  
stabilized

## Naltrexone ER

↓ OD in  
individuals  
treated  
with  
naltrexone  
vs control



Although most patients with opioid use disorders stabilize with treatment high rates of morbidity and mortality are associated with opioid use disorders. Providers need to be prepared for patient deaths.

# The family and provider experience after overdose death



A limited literature exists describing **family member's** experiences after an overdose death.



To our knowledge, the **provider's** experience after overdose death has not been studied, and no practice guidelines exist to guide providers after an overdose death.

# Similarities exist between suicide and overdose deaths

	<b>Suicide</b>	<b>Overdose</b>
<b>Timing of Death</b>	Sudden, Unexpected	
<b>Intentionality of Death</b>	Intentional	Often unknown intent, frequently assumed to be unintentional
<b>Stigma Associated with Death</b>	Significant social and moral stigma associated with self inflicted death that can isolate family and providers in grief	

Given the commonalities between deaths due to suicide and overdose we will reference the existing suicide literature to describe provider experience and practice guidelines for management.

# Overdose Deaths: The Family's Experience

- Drug overdose deaths are sudden. Families may or may not be aware of an individual's substance misuse or the risk of death associated with use.
- The bereavement process for families after an overdose is similar to death by suicide and more complicated than death due to other causes<sup>1</sup>
- Compared to parents whose child died of a natural or accidental death parents whose child died due to suicide or overdose were more likely to have:<sup>1</sup>
  - Complicated Grief—significant impairment due to prolonged grief symptoms
  - Post-traumatic Stress
  - Depression

# Overdose Deaths: The Family's Experience

- Significant stress is associated with substance use within families and families cope with this stress in different ways:<sup>1</sup>
  1. Putting up with the substance use
  2. Disengaging and distancing themselves with the individual
  3. Confronting the individual to make a change
- It is unclear what the implications of these different coping strategies are for families when a family member dies

# Overdose Deaths: The Provider's Experience

- No literature to date on provider's experience after overdose death
- The literature on provider's experiences after suicide death indicates providers are highly impacted by a patient's suicide
- Common emotions experienced after patient suicide:

Shock & Disbelief

Guilt, Shame, Fear of Blame

Self Doubt—looking for signs that would have indicated imminent suicide

# Overdose Deaths: The Provider's Experience

- Provider stress after a patient's suicide can reach levels comparable to a clinical population
- Among a random survey of 259 practicing psychiatrists 51% had a patient who completed suicide in their practice
  - 50% of respondents who had a patient complete suicide had stress levels in the weeks following the suicide that were comparable to stress levels of people seeking treatment following a parent's death.
  - Younger, less experienced psychiatrists were more impacted by patient suicide compared to older psychiatrists with greater clinical experience.

# Overdose Deaths: The Provider's Experience

- After a patient suicide the mental health professional's stress reaction is influenced by:
  1. The relationship to the patient
  2. Exposure to the suicide
  3. Support after the suicide
  4. Level of training
- Type of reactions among mental health professionals:

Low Impact	Moderately Impacted	Highly Impacted
<ul style="list-style-type: none"><li>• Had high support &amp; anticipated the suicide</li><li>• Were emotionally distant from the patient</li><li>• Had no contact with the patient around the time of death</li></ul>	<ul style="list-style-type: none"><li>• Were emotionally close to the patient</li><li>• Were responsible clinically for the patient</li></ul>	<ul style="list-style-type: none"><li>• Were emotionally close to the patient</li><li>• Lacked support after the patient's suicide</li></ul>



# Overdose Deaths: Recommendations for the Provider

- No guidelines exist to support providers after an overdose death
- Interventions conducted after suicide to support the bereaved are referred to as “postvention”
- General postvention guidelines:<sup>1</sup>
  - Seek support and avoid isolation
    - Outreach to colleagues and supervisors
    - Call malpractice insurance carrier for consultation
  - Prepare yourself for contact with family and consider outreaching to the patient’s family
  - Review case for quality assurance

# Case 1: Early Stabilization with Buprenorphine in Private Practice

## Setting:

- Dr. Smith works full time in private practice in a college town. She often sees young adults with substance use disorders in her practice. She became waivered to prescribe buprenorphine one year ago after attending a training at a national conference. She has several adult patients with opioid use disorders who are doing well on buprenorphine.

# Case 1: Early Stabilization with Buprenorphine in Private Practice

## Initial Presentation:

- John, a 21 year old male college student, presents to Dr. Smith's office with his parents. He has been using prescription opioids daily over the past three months. He began using heroin when he could not afford prescription opioids two weeks ago. One week ago he overdosed on heroin and was found by a roommate who called 911. John was very scared after the overdose and with his roommate's encouragement contacted his parents for help.

# Case 1: Early Stabilization with Buprenorphine in Private Practice

## Initial Presentation:

- John is hopeful he can finish the semester without having to go to a “program.” His parents are worried but are hopeful he can stabilize with buprenorphine since he is refusing to return home for local treatment and they would lose a substantial amount of money if he were to withdraw from his private school at this time.
- Dr. Smith agrees to a trial of buprenorphine with weekly individual therapy. John signs a full release of information for his parents to communicate with Dr. Smith.

# Case 1: Early Stabilization with Buprenorphine in Private Practice

## Course in Treatment

- John's opioid use stabilizes on buprenorphine 8 mg daily. He is engaged in therapy, completes regular toxicology screens, and is reporting things are going well.
- Leading up to finals John is less consistent with treatment. He appears very sleepy during a session but denies opioid use and reports he was up all night writing a paper. He reports he can not wait in line at the local laboratory to complete a toxicology screen because he has an exam later that day.

# Case 1: Early Stabilization with Buprenorphine in Private Practice

## Course in Treatment

- 4 days later Dr. Smith receives a call from John's parents letting her know that John was found dead by his roommate of an apparent overdose.
- Dr. Smith is devastated and wonders what she should have done differently. This is the first death in her practice, she is unsure what she should do next, and feels she does not want to prescribe buprenorphine anymore.

# Case 1: Early Stabilization with Buprenorphine in Private Practice

## Questions

- What can Dr. Smith do to support John's parents?
- Do confidentiality laws apply after death?
- What can Dr. Smith do to support herself?
- Is Dr. Smith's emotional reaction normal?

# Working with families after an unexpected drug overdose death

- It is important to offer the option to meet with family members since families may feel isolated by stigma as they grieve.
- When providers do not respond to family outreach they may seek information to help them understand their loss through litigation.<sup>1</sup>
- In a survey of 26 therapists of patients who committed suicide 73% saw the patient's relatives after the suicide.<sup>2</sup>
  - Therapists expected anger and criticism from families
  - In the majority of cases relatives were not critical of the therapist and expressed gratitude for the help provided



# Communication with Families After a Patient's Death

- If a patient's family was not part of their treatment but it was clear that their family knew they were in treatment, outreaching with a phone call or condolence card are ways to recognize the patient's death and communicate a willingness to support family members in the initial grieving process.
- Condolence cards have been identified as a way to help families and physicians cope with a patient's death.<sup>1</sup>

# Communication with Families After a Patient's Death

- Communication with families should focus on addressing family member's feelings and not on the clinical details of the case.<sup>1</sup>
  - Many states have apology statutes that prohibit expressions of sympathy from being admissible as evidence of an admission of liability in civil action.<sup>2</sup>

# Communication with Families After a Patient's Death

- Providers can consider attending the patient's funeral
  - A limited literature exists which suggests funeral attendance after a patient suicide helps families and providers mourn and work through the suicide.<sup>1,2</sup>
  - As noted by primary care providers, Drs. Arroll and Falloon,<sup>3</sup> funeral attendance is a gesture of respect to the deceased that is appreciated by families.
  - When a provider attends their patient's funeral this also allows family members to follow up with the provider to discuss their experience surrounding the death which may help the family member process their grief.

# Patient Confidentiality After Death

- If families want to know details of the case it is important to consider that the Health Insurance Portability and Accountability Act (HIPAA) continues for a period of 50 years after the date of death of an individual.
- If the patient did not sign a comprehensive release of information providers are limited in what they can disclose about the details of the case unless a family member is the legal executor of the patient's estate.
- If there is not a legal executor identified at death families can petition the court to become a legal executor.

# Peer Support for Families

- Families with similar losses may be an important source of support for families grieving an overdose death.
- Peer support resources for families after an overdose death:
  - Grief Recovery After Substance Passing (GRASP) is a peer led organization specific to families whose loved one died due to substance use.
    - Meetings in 34 out of 50 states
    - [www.grasphelp.org](http://www.grasphelp.org)
  - Compassionate Friends is a large national peer led organization that supports parents whose child has died regardless of the cause.
    - 660+ meeting locations around the United States
    - [www.compassionatefriends.org](http://www.compassionatefriends.org)

# Support for the Provider

- It is important for providers to also seek support for themselves and to review the events leading to the patient's death
- Colleague support is important<sup>1-5</sup>
  - Helpful: When colleagues shared their own experience with the suicide of a patient.<sup>6</sup>
  - Not helpful: Premature reassurance that the clinician had done nothing wrong.<sup>1,2</sup>

# Support for the Provider

- Practice setting may impact the provider's experience
  - Providers in solo practices have a greater sense of responsibility, loss, and psychological distress after a patient's suicide.<sup>1</sup>
  - Providers who work in hospitals and/or more public settings where the suicide is more common knowledge are often offered increased support by colleagues who are aware of the situation.<sup>2</sup>
  - Providers who are less socially integrated into their professional network are more impacted by patient suicide.<sup>3</sup>

# Support for the Provider

- Providers need to be aware of possible countertransference reactions towards patients with substance use disorders following an overdose death
- After completed suicides it is not uncommon for providers to experience countertransference reactions toward patient's with suicidal ideation
  - After patient suicide 23% of providers were anxious or reluctant to accept suicidal patients in their practice.<sup>1</sup>
  - Providers were also more vigilant about the possibility of suicide and more thorough in assessment of risk for suicide.<sup>1-3</sup>



# Support for the Provider

- Opioid use disorder specific support and mentorship:  
PCSS is focused on provider education and training for prescribing opioids and opioid use disorder treatment. The PCSS mentorship program can also be used as a resource for provider support.



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# Case 2: Naltrexone Extended Release Lost to Follow-up in a Clinic Setting

## Setting:

- Dr. Kelly works in a free standing multidisciplinary clinic where he provides medication management including naltrexone extended release and co-leads groups for individuals with opioid use disorders.

## Initial Presentation:

- Jane, a 34 year old female with opioid use disorder moderate presented to clinic after treatment in a short term residential program. She enrolled in the intensive outpatient treatment program and was prescribed naltrexone extended release by Dr. Kelly.

# Case 2: Naltrexone Extended Release Lost to Follow-up in a Clinic Setting

## Course in Treatment:

- After graduating from the intensive outpatient treatment program Jane started a weekly recovery group led by Dr. Kelly and a resident. Jane also started a short term vocational program to help her restart work.
- Jane was an active participant in group and reported high motivation and confidence in her ability to be abstinent from prescription opioids.
- Jane restarted retail work part-time three months after presenting to clinic. After two months on the job she increased to full-time due to increased demands at work around the holidays.

# Case 2: Naltrexone Extended Release Lost to Follow-up in a Clinic Setting

## Course in Treatment:

- Jane began frequently cancelling group due to last minute scheduling changes at work. With the holidays Jane's naltrexone extended release injection was rescheduled and she missed this appointment. When Dr. Kelly tried to reach Jane to discuss the missed injection appointment he was unable to leave a voicemail since her voicemailbox was full.
- Dr. Kelly sends an outreach letter to Jane's home. Several days later Jane's mother called Dr. Kelly to let him know that Jane died of an overdose one week ago.

# Case 2: Naltrexone Extended Release Lost to Follow-up in a Clinic Setting

## Questions:

- What can Dr. Kelly do to support staff members and his group co-leader, the resident, who knew Jane?
- Who does Dr. Kelly need to notify regarding Jane's death?

# Supporting Other Staff Members

- Try to inform staff after an overdose death in a timely manner and in person if possible.
- Avoid blame, allow staff to support one another, and to express their emotions.<sup>1</sup>
- Emotional support should be provided in a way that respects individual's adaptive styles and avoids undue focus on emotional responses and personalities.<sup>2</sup>

# Supporting Trainees: The Trainee Experience

- 31% to 69% of psychiatry residents experience patient suicide during training.<sup>1</sup>
- Younger and less experienced clinicians are impacted more by patient suicide than older clinicians with more experience.<sup>2,3</sup>

# Supporting Trainees: The Trainee Experience

- Residents may have difficulty asking for help.
  - 27% of trainees found themselves unable to ask for help after a patient's suicide despite most trainees feeling someone was available to help.<sup>1</sup>
  - Trainees were reluctant to use available employee assistance programs due to concerns regarding confidentiality and insurance coverage.<sup>2</sup>



# Supporting Trainees: Recommendations for Supervisors

- Since some residents have difficulty asking for help consider notifying the program's training director directly to inform them of the patient's OD death and the trainee's involvement with the case.
- Trainees should be told repeatedly throughout training that they should contact their supervisor and training director after an adverse patient outcome.

# Teaching Psychiatry Trainees about Postvention

- Postvention, how to respond after a suicide, is taught in 25 to 49% of psychiatry training programs.<sup>1,2</sup>
- Training program postvention requirements and recommendations:<sup>2</sup>
  - Most require a supervisor be notified after a patient suicide
  - Most require or recommend a postmortem meeting for quality assurance assessment
  - Some encourage trainees to have supervisory sessions to assess and process the emotional impact of the patient suicide

# Quality Assurance/Improvement after an Overdose Death

- File an incident report within your organization.
- The existing literature is mixed on the impact of QA/QI or psychological autopsy review after a suicide.
  - A psychological autopsy can facilitate learning, improve care of patients in the future, and help bring closure for the treating psychiatrist.<sup>1</sup>
    - For the 20 out of 74 trainees who had an administrative inquiry after a patient suicide all of them found it helpful.<sup>2</sup>
  - Care needs to be taken to ensure the review is not shaming or a “witch hunt.”<sup>3</sup>
  - Avoid conducting the review immediately after the death since this can compound provider doubt.<sup>4</sup>
- QA/QI meetings are privileged

# Case 3: Death after Discharge from Inpatient Detoxification

## Setting:

- Dr. Adams works in a large inpatient detoxification unit

## Initial Presentation:

- Bill, a 42 year old male with opioid use disorder severe was admitted for inpatient detoxification from opioids.

## Bill's past history:

- 4 prior detoxification admissions.
- He was recently asked to move out of his parent's home after he was found stealing from parents and has been sleeping on friend's couches.
- He works intermittently in construction and has struggled with chronic lower back pain.

# Case 3: Death after Discharge from Inpatient Detoxification

## Course in Treatment:

- Bill receives buprenorphine 16 mg during the initial assessment period. He reports he has been experiencing recent anxiety about family and financial stressors and requests a benzodiazepine prescription.
- Dr. Adams worked with Bill during previous admissions and strongly recommends maintenance buprenorphine or methadone treatment. Dr. Adams encourages participation in groups on the unit to build Bill's coping skills to manage anxiety.

# Case 3: Death after Discharge from Inpatient Detoxification

## Course in Treatment:

- Bill's family visits the unit and meets briefly with the case manager. The family is hopeful that the patient can be discharged to longer term residential treatment.
- Bill does not want to have a family meeting but signs a release of information allowing his treatment team to discuss his discharge plan with them.

# Case 3: Death after Discharge from Inpatient Detoxification

## Course in Treatment:

- Bill requests continued detoxification off of buprenorphine and declines referrals to buprenorphine or methadone maintenance treatment. Bill reports he does not want to take a daily medication.
- Bill requests referral to an intensive outpatient program after discharge that he previously found helpful. He declines a referral to residential treatment or a sober living house because he is worried about his financial stressors and wants to quickly return to work.
- Bill's case manager leaves a message for Bill's family with the details of the intensive outpatient program.

# Case 3: Death after Discharge from Inpatient Detoxification

## Course in Treatment:

- Two days after Bill's discharge Dr. Adams receives a call from Bill's family letting him know that Bill was found dead after an apparent drug overdose. Prescription opioid and benzodiazepine pills were found with the patient.
- The family requests to meet with Dr. Adams. When he meets with the family they express frustration that Dr. Adams did not refer the patient to residential treatment and did not start the patient on buprenorphine.
- Dr. Adams feels guilty about Bill's death and is afraid Bill's family may sue him for malpractice.



# Case 3: Death after Discharge from Inpatient Detoxification

## Questions:

- What should Dr. Adam's say to Bill's family?
- What should Dr. Adam's next steps be?

# Communicating with a Contentious Family

- When communicating with families remember that patient confidentiality laws continue after death. It is important to review the patient's chart for details of the release of information before speaking to the family.
- Express sadness but do not make self-incriminating or self-exonerating statements since this can cause additional stress to the family<sup>1</sup>
- A family may deal with their grief by pursuing litigation<sup>2</sup>
  - For malpractice to be present the plaintiff needs to prove there was a dereliction of duty by the provider that directly caused damages.
  - Completed suicides are the leading cause of malpractice litigation in mental health.

# Other Notifications to Consider after Patient OD Death

- Consider contacting your malpractice insurance carrier regardless of whether or not there was a contentious interaction with the deceased family.
- Notify medical records that a patient is deceased.
- Investigate state agency reporting requirements.

# Conclusions

- Providers who are working with patients with opioid use disorders need to be prepared for overdose death
- After an overdose death providers are obligated to:
  - 1. Support the patient's family after their loved one's death
  - 2. Support themselves and others who worked with the deceased patient to minimize the psychological trauma associated with the patient's sudden death.
- As a field there is a need for increased:
  - 1. Research on the impact of overdose death on families and providers.
  - 2. Formal training on coping with unexpected patient death (suicide, overdose) in residency training programs and continuing medical education.

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# PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medication-assisted treatment.**
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

**For more information visit:**

**[www.pcssNOW.org/mentoring](http://www.pcssNOW.org/mentoring)**



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A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

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Addiction Technology Transfer Center	American Society of Pain Management Nursing
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