Front Line Staff - Coping with Grief and Loss After a Suicide or Overdose Death

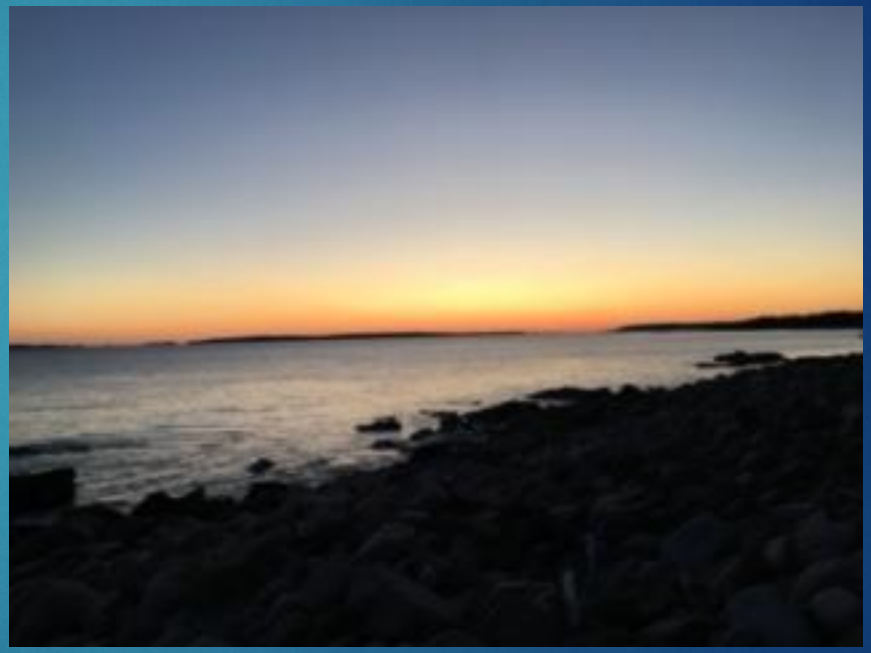
NH Behavioral Health Conference 2025

Ken Norton Franklin Cook

Objectives:

1. Understand the similarities and differences of grief and loss related to overdose deaths and suicide deaths
2. Validate the experience of many providers that an overdose or suicide death can have a profound professional and personal impact
3. Learn resources for supporting direct service professionals following an overdose or suicide death
4. Understand the importance of having a process in place to support staff after a suicide or overdose death

Acknowledgement



Acknowledgement and Introduction

- Special thanks to Nina Gutin and Vanessa McGann
- NAMI NH's Connect Suicide Prevention Program
- My own personal experience with suicide and suicide loss
  - Personally
  - As a clinician
  - As a Supervisor
  - Colleagues
  - Postvention response
  - Litigation

Ground Rules:

- Respect for diverse opinions
- Encourage sharing and discussion
- Oops! and Ouch! Rule
- Confidentiality?
  - What's said in the room stays in the room?
  - Non identifying information sharing?
  - No restrictions?
- Media?

Challenges to Presenting on This Topic

- As a society we rarely talk openly about death
- Death by suicide or overdose is even more taboo
- For clinicians/providers the issue is very difficult with challenges including, confidentiality, guilt, blame, and potential litigation
- Lack of clear research regarding the incidence and impact of suicide and/or overdose on Health Care Providers
- In place of lack of research I'll be using quotes from clinician survivors.

No Us and Them

- All of us have been touched by loss at some point in our lives.
- Visiting the topic of sudden traumatic loss can bring up personal experiences for us.
- We need to be sensitive to loss survivors, suicide attempt survivors, overdose survivors, people in recovery, or any of us at risk.
- If you find that the following information brings up painful emotions, take care of yourself and seek the support that would be helpful.
- YOU ARE THE EXPERTS!

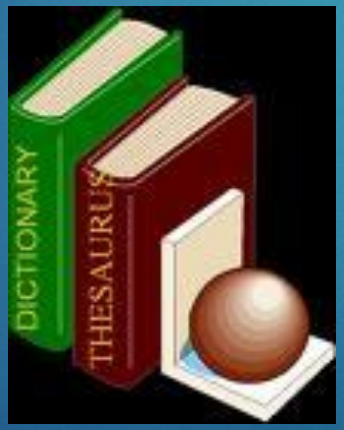
Person First Language

- **Terms to Avoid:**
- The Mentally Ill
- He's schizophrenic
- She's bipolar
- He's an alcoholic
- She's an addict

- **Terms to Use:**
- People with mental illness
- He has a schizophrenic disorder
- She has bipolar disorder
- He has an addictive disorder

Language – Suicide

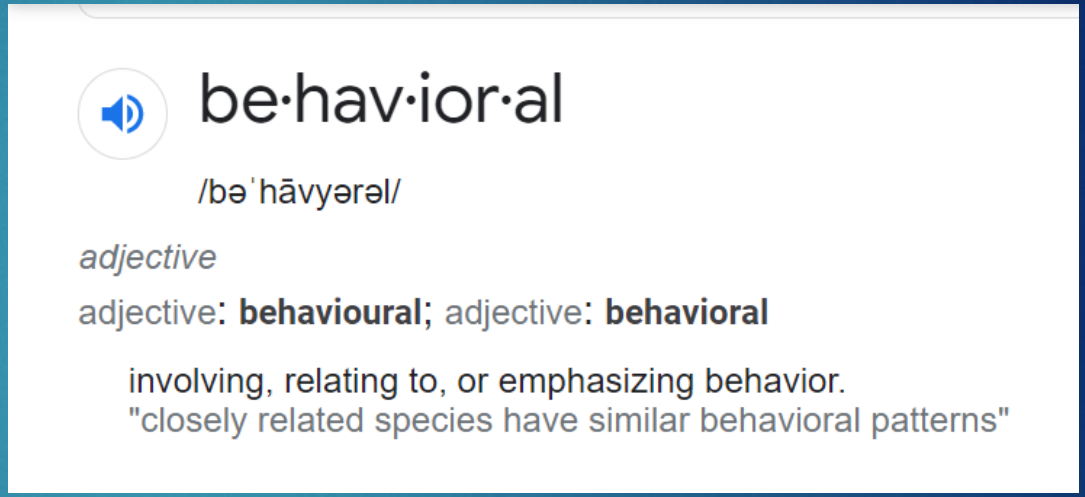
- **Terms to Avoid:**
- Committed suicide
- Successful suicide
- Chose to kill himself
- Threat



- **Terms to Use:**
- Took his/her own life
- Died as a result of a self-inflicted injury
- Died by suicide
- Died by own hand
- Lethal/non lethal
- Disclosed

Behavioral (Health?)

- Term is confusing
  - Used for mental illness/health
  - Used for substance misuse/addiction
  - Used for co-occurring disorders
  - Comes from Insurance Industry



be·hav·ior·al

/bəˈhāvyərəl/

adjective

adjective: **behavioural**; adjective: **behavioral**

involving, relating to, or emphasizing behavior.
"closely related species have similar behavioral patterns"

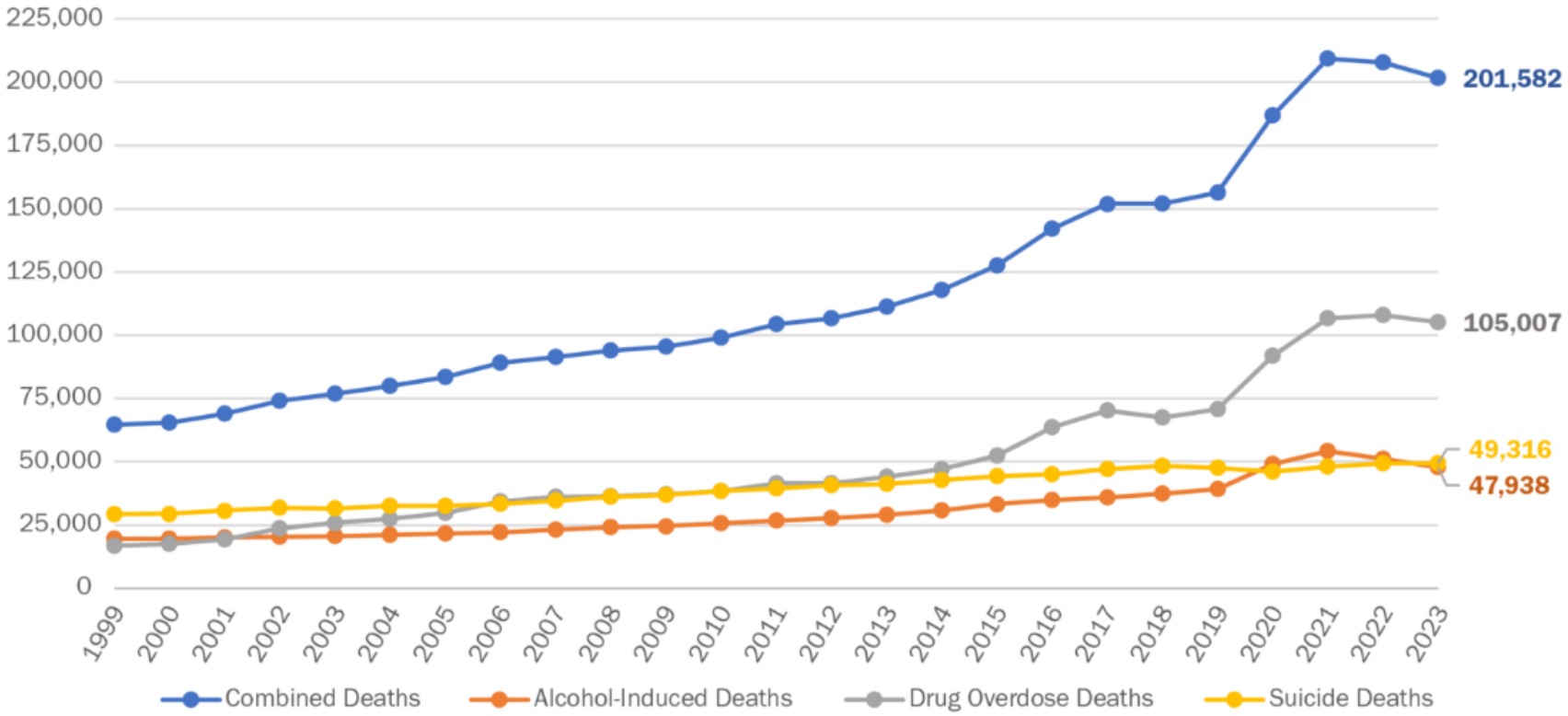
Reinforces negative attitudes and beliefs about mental illness and substance use

Who are Care Providers?

- Similarities/differences between Mental Health and Substance use fields
- Mental Health - Clinician focused hierarchy/treatment focused
- Substance use – lived experience - people in recovery
- Who provides supervision?
- What is availability of training?
- Who and what is training directed toward
- First Responders
- Faith Leaders
- Teachers

Alcohol/Drug/Suicide Mortality

Figure 1: Annual Deaths from Alcohol, Drugs, and Suicide in the United States, All Ages, 1999–2023



Source: TFAH analysis of National Center for Health Statistics data.[6]

NH 10 Leading Causes of Death 2023

	<1	1-4	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Short Gestation --	Unintentional Injury --	Suicide --	Unintentional Injury 39	Unintentional Injury 127	Unintentional Injury 162	Malignant Neoplasms 141	Malignant Neoplasms 486	Heart Disease 2,514	Malignant Neoplasms 2,990
2	Sids --	Influenza & Pneumonia --	Malignant Neoplasms --	Suicide 24	Suicide 35	Malignant Neoplasms 36	Unintentional Injury 133	Heart Disease 320	Malignant Neoplasms 2,312	Heart Disease 2,988
3	Congenital Anomalies	Cerebrovascular	Diabetes Mellitus	Malignant Neoplasms --	Malignant Neoplasms --	Heart Disease 33	Heart Disease 109	Unintentional Injury 110	Chronic Low. Respiratory Disease 665	Unintentional Injury 1,021
4	Maternal Pregnancy Comp. --	Heart Disease	Heart Disease --	Congenital Anomalies	Heart Disease --	Suicide 32	Suicide 35	Chronic Low. Respiratory Disease 72	Cerebrovascular 558	Chronic Low. Respiratory Disease 748
5	Bacterial Sepsis	Homicide --		Heart Disease --	Diabetes Mellitus	Liver Disease 20**	Liver Disease 32	Liver Disease 70	Alzheimer's Disease 491	Cerebrovascular 617
6	Respiratory Distress --			Homicide --	Liver Disease --	Diabetes Mellitus 12**	Cerebrovascular 19**	Diabetes Mellitus 48	Unintentional Injury 446	Alzheimer's Disease 499
7	Atelectasis			Diabetes Mellitus	Covid-19	Homicide --	Diabetes Mellitus 15**	Suicide 43	Diabetes Mellitus 295	Diabetes Mellitus 376
8	Circulatory System Disease			Hernia	Cerebrovascular	Covid-19	Chronic Low. Respiratory Disease	Cerebrovascular 35	Covid-19 231	Covid-19 252
9	Hematological Disorders			Influenza & Pneumonia	Chronic Low. Respiratory Disease	Congenital Anomalies	Nephritis --	Septicemia 20**	Parkinson's Disease 212	Liver Disease 230
10	Intrauterine Hypoxia			Liver Disease	Congenital Anomalies	Septicemia --	Pneumonitis	Nephritis 17**	Nephritis 186	Suicide 221
	Maternal Hypertensive Disorders			Nephritis	Homicide --		Septicemia --			
	Neonatal Hemorrhage			Septicemia --						
	Unintentional Injury --									


Postvention
Prevention

Health Care Providers As Survivors of Suicide Loss

- Clients/Patients/Service Users/Consumers
- Family member
- Friend/Loved one
- Colleague
  - Combination

Is Suicide an Occupational Hazard?

- "The most profoundly disturbing event of a professional career" (Hendin Et. Al 2000).
- "There are two kinds of clinicians, those who have had patients commit suicide and those who will." (Simon 1998).
- First Responders – exposure to suicide deaths/higher rates of suicide

Frequency (? Data)

- As many as 1 in 5 people who die by suicide were in treatment at time of their deaths
  (Luoma Et al 2000)
- Fully one in six psychiatric patients who die by suicide die in active treatment with a healthcare provide (Bongar 1991)
- Approximately 50% of those who die by suicide in America will have seen a mental health provider at some time in their life. (US DHHS 1999)
- Interns, residents and other novice clinicians have been found to experience higher rates of suicide among their clients than more seasoned clinicians. (B. Bongar 1991)

Frequency II

- Estimates are:
  - 51% of psychiatrists will lose a client to suicide
  - 22% of psychologists will lose a client to suicide (Chemtob, Hamada et al 1988)
    - A. Spruch-Feiner et all 2022)
  - 31.5% of psychologists reported loss of a client(s) (Finlayson 2017)
  - Nurses who treat patients at risk are likely to have a patient suicide during their careers (Collins 2003)
  - 15,000 Clinician Survivors (Weiner 2005)

Clinicians & Suicide Loss

- 2022 NY State Survey Found:
  - 57% Psychiatrists
  - 467% of psychiatry trainees
  - 36% Nurses and nurse practitioners
  - 30% psychologists
  - 20% masters-level social workers and menta health counselors
  - 19% other mental health professionals
    (A. Spruch-Feiner et all 2022)

  - 15,000 Clinician Survivors (Weiner 2005)

Suicide Grief/Bereavement

- Reaction to a suicide death is unlike other grief.
- Studies indicate grief reactions to suicide are often complicated and last longer than other deaths
- Reactions may include intense feelings of
  - Shame
  - Anger
  - Guilt
  - Regret
  - Self-Blame
  - Rejection
  - Bewilderment

The person who dies by suicide dies a single death, but their family/friends are left to die a thousand deaths……

(unknown)

WHY?????

For people bereaved by suicide, grief is often combined with a persistent search for an answer or explanation.

Intentionality?

For Health Care Providers, that search for answers can have professional and legal implications

Health Care Providers Grief/Bereavement

Health Care Provider reactions are very similar to those experienced by family members: In addition, providers may experience

- Shock/disbelief
- Humiliation
- Isolation
- Loss of professional confidence
- Fear of lawsuits
- Replay last interaction over and over

Health Care Providers Grief/Bereavement Including PTSD

Impact may rise to level of post traumatic response such as:

- Intrusive thoughts
- Hyper arousal/hyper vigilance
- Difficulty concentrating/sleeping
- Dissociative response
- Up to a third may experience severe distress for more than a year

Health Care Providers Professional Impact (cont)

- Trouble trusting clients
  - 77% of clients who died by suicide denied suicide intent in their last communication with therapist (Fawcett 2008)
- Impact may be more severe for providers with less experience
- Some seek positions with lower risk population
- Some leave profession entirely

One Clinicians Experience

"It was very difficult to cope while helping others cope with the same experience. I had no energy and could not bounce back out of my crying spells and depression. Anxiety was taking over as well. I was getting outpatient therapy myself, but it didn't seem to help me. I felt so alone because I had no other colleagues who had experienced a client suicide to talk to, to validate my reaction; hence I concluded I must be over-reacting. I felt so much guilt and shame for failing these parents who trusted us to help their daughter. I felt the worst at about 4 months after the death as I wasn't getting better, and I was no longer allowed to "take my time" as administration had first told me. I was being pressured to take in new clients. I felt overwhelmed, scared, and helpless. I developed my own suicidal thoughts due to feeling without options to make my life better. I eventually checked myself into inpatient treatment, which turned out to be my lifesaver."

Posted to Amer. Association of Suicidology

"Tyranny of Hindsight"

Sins of omission or commission

- Jordan and Baugher 2016

"What should I have said that I didn't, or shouldn't have said that I did? Could I have done more or did I do too much? This seems to be a part of the grieving process. I think it's especially intense in a situation where you have direct responsibility for helping the person get better."

Dr. Brown – The Atlantic 2019

“Twin Bereavement”

Plakun and Tillman

- Providers often experience both a personal loss as well as a professional loss

“I went to the funeral,” he says quietly. “I stood for the entire service … it was completely packed with people just standing and so I was thinking, as I was listening to this service, that I was the only person in that room who had that particular relationship with that woman. Everybody else knew her in some different way. They were friends, they were family, they were relatives, maybe they knew her in the congregation and I was the only one who had been working with her, seeing her the day before, trying to prevent this. I felt unique and not in a very flattering way.” Dr. Brown – The Atlantic 2019

After a Suicide - Dialectic

- "First is the acceptance that suicide happens and is quite common,"
- "It happens….it's part of our work….we just need to accept it……"
- If we don't examine and learn what may have prevented a suicide death how will we learn and prevent future deaths?
- Accountability, especially at the systems level, is critical for reducing the incidence of suicide
- "People describe feeling not only battered by loss but battered by the people and profession they thought would support them,"

R. Clay 2022

Professional/Societal Expectations

"*The suicide death of a patient in active treatment is commonly taken as prima facie evidence that the therapist, somehow or another, has mismanaged the case,*" and thus the clinician often faces unwarranted blame and censure from colleagues and supervisors - Jobes and Maltsberger 1995

"*We're the only (medical) profession where it's not expected that someone will die from that which we are treating them for…..*"

Psychiatrist- NH Hospital Grand Rounds 2010

Loss of a family member

"I've thought many times about leaving the mental health field after losing my 26 yr. old son to suicide in 2001. It's a shame to realize that some people who actually work in the mental health field don't have a better understanding of how to be supportive to a co-worker who has lost someone to suicide. I'm not saying that they didn't try, but I certainly felt alone and that I was an imposition to continue to work in the field while being so "needy" myself and so easily triggered. I had to stop working for several months. For me, the trigger was: don't give me anyone who is suicidal or has a history of being suicidal. I can't handle being responsible for them. When I went back full time at the agency I had been employed at when my son died, I was told that I would have to start doing the crisis on call work after an initial adjustment period. I did the pager when my turn came up for several months, and whenever I had it, I was a wreck, and when I had to deal with suicidal clients either in the daytime or through the pager, it set me back tremendously - to the point where I had to take time off almost each time. I finally begged and pleaded for them to allow me to still work there but not do the crisis on call work. I told them I was willing to take a cut in pay and demotion or whatever. They finally worked with me, but I still always had a lot of guilt about not taking my turn with the pager. I should add that I was really close to many of my co-workers, and they were supportive in many other ways. It took me years to work through it…." *Post to AAS list serve*

Professional/Legal Implications

- Incident/sentinel report forms
- Notification of Insurance Carrier
- Psychological Autopsy
- Complaints before professional licensing boards
- Suicide malpractice is the leading cause of legal action against all behavioral healthcare providers, regardless of discipline (Gutheil 1991)

My Personal Malpractice Experience

- Patient was on 48 hour pass from State Hospital
- Severely Injured in jump from a parking garage
  - Suicide or intentional self injury?
- Suit filed 2 years and 11 months after incident
- 14 people personally named (11 State Hospital)
- Process dragged on for years – Interrogatories, depositions, expert witnesses
- State $ettled out 3 years later - 6 months before trial
- Jury trial lasted 8 days
- Verdict for the Defendants

Zero Suicide: Promoting a "Just" Culture

- Goal of suicide as a "never" event
- Foundational belief that suicide deaths are preventable
- Commitment to education, training and evidence based practices
- Data and continuous quality improvement driven
- Non shaming/blaming atmosphere

Private Practitioners

- Extreme isolation
- Confidentiality/shame may prevent discussing with colleagues
  - Discussions with colleagues may be "discoverable" if wrongful death suit is brought forward
- No back up to cover caseload/emergencies
- Loss of income if they take time off

Family Perception of Clinicians

- 39% reported clinician had contacted them
- 48% believed the clinician was withholding information
- 74% who were not contacted tried to contact clinician
- Clinicians who were seen as grieving and who answered questions were less likely to be sued

(Peterson Et Al 2002)

- 50% of families of patients who died by suicide consider the fatal outcome to be a clear-cut case of malpractice (cams-care.com)

Organizational Impact

- Staff turn over
- Staff burnout
- Increased risk of medical errors
- Litigation
  - Financial impact
  - Reputational impact
    - Negative Media Coverage

Gary Larsen

Postvention Planning

- Promote a climate of well being and support for all staff (EVERY DAY!)
- Provide Postvention Training to staff and supervisors
- Have comprehensive written postvention protocols
- Protocols ground everyone as to what to expect and do.

Protocols Should Include

- Confirmation of death
- Steps for immediately securing medical record
- Notification of impacted clinicians and staff
- Notification of other clients (eg. residential settings)
- Structured debriefing for impacted staff
- Communication with family (if indicated)
- Adjustment of caseload/on call for primary clinicians
- Supervision and other supports (ongoing)
- QI/risk management activities

Supports After a Suicide

- Disaster Behavioral Health Response Team
- Employee Assistance Program or referral
- Time Off / Bereavement Leave?
- Caseload Review (focus on high risk people)
- Frequent/ongoing supervision and support
- Peer Support
- Refer/provide info for Coalition of Clinician Survivors

Attending the Service and Other Professional Concerns

- Does the family know the person was in treatment?
- Have you had previous contact with the family?
- What does the family understand or expect about information/confidentiality?
- Does sending flowers, a card, etc. violate confidentiality?
- Does your presence at a public event reveal that the person was in treatment?
- Are you doing this for yourself, the family, and/or survivors who are your clients?

Post Traumatic Growth

- Research demonstrates that working through traumatic experiences can produce growth
- Post traumatic growth can occur both personally and professionally following a suicide death
- Must be open to change and willing to discuss stressful event

Post Traumatic Growth II

- Appreciation of life.
- Relationships with others.
- New possibilities in life.
- Personal strength.
- Spiritual change.

Self-Care Skills - Postvention

- Talk openly about self-care and role model self-care as well as providing support to others.
- Review and encourage self-care skills with staff and clients.
- Remember that the healing process will take months and years, and that people grieve in different ways.
- Seek out EAP, ongoing supervision and/or private counseling
- Make a commitment to stay with the process for the long run.

Resource Info:

- Coalition of Clinician Survivor https://www.cliniciansurvivor.org/
- Clinicians As Survivors (handout) New York State https://www.preventsuicideny.org/wp-content/uploads/2020/02/Clinicians-as-Loss-Survivors.pdf
- Responding to Grief, Trauma, and Distress After a Suicide US National Guildelines https://theactionalliance.org/resource/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines
- NAMI NH Connect Program (Postvention training) www.theconnectprogram.org

Resource Info II:

- The impact of Suicide On Professional Caregivers: A Guide for Managers and Supervisors https://omh.ny.gov/omhweb/suicide_prevention/omh_postventionguide.pdf
- Uniting for Suicide Postvention (Veteran's Administration)

  https://www.mirecc.va.gov/visn19/postvention/providers/
- Suicide Prevention Resource Center Videos https://sprc.org/resources/supporting-behavioral-health-providers-creating-postvention-strategies-for-healing-after-losing-a-client-to-suicide/
- Suicide Prevention Resource Center Fact Sheet https://sprc.org/wp-content/uploads/Supporting-Behavioral-Health-Providers-Fact-Sheet.pdf

Contact Information

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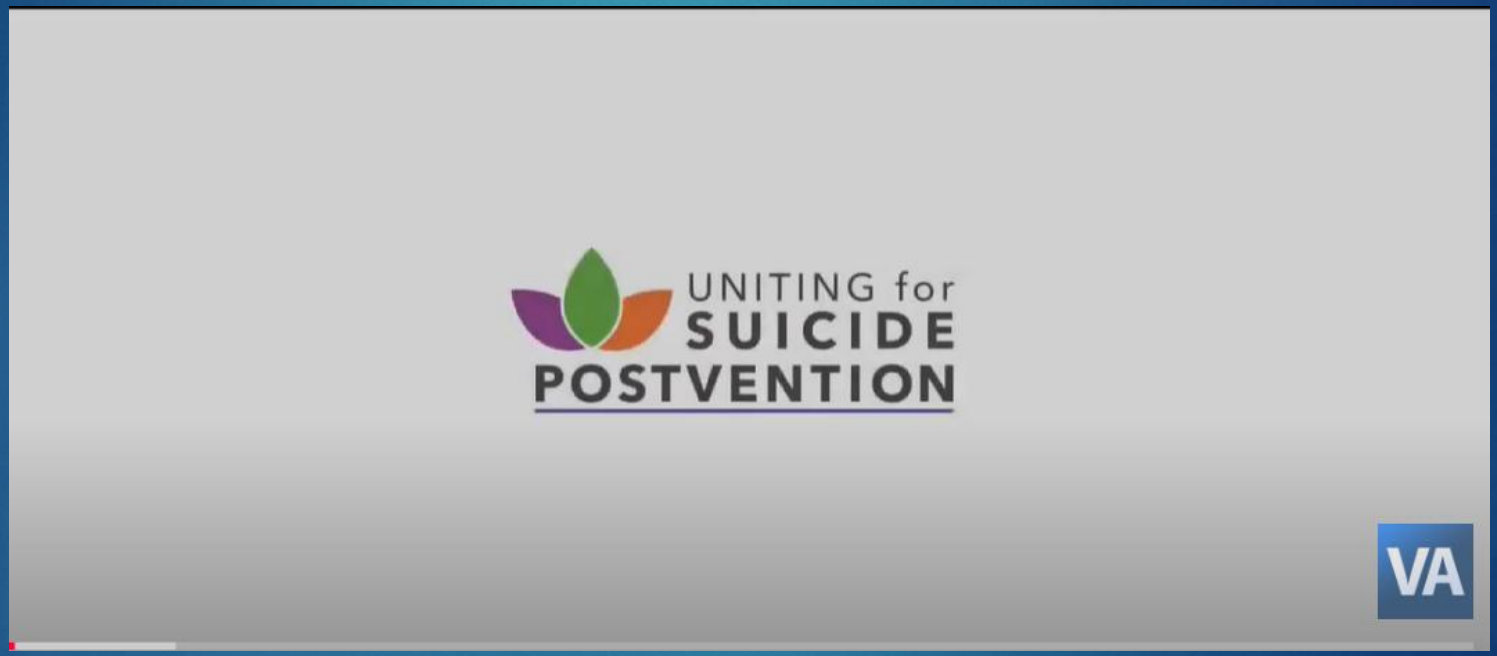
Importance of Supervision and Support



https://www.youtube.com/watch?v=nOukW-jSIAw

Frontline Staff — Coping with Grief and Loss After a Suicide or Overdose Death

NH Behavioral Health Summit
December 8-9, 2025 -– Manchester, NH

If you would like a PDF of this slideshow, please text me at **617-398-0243**:

- Your name
- Your organization or affiliation
- Your email address

Franklin James Cook
Owner, Peer Support Community Partners
Director, SADOD Community Peer Grief Support Programs

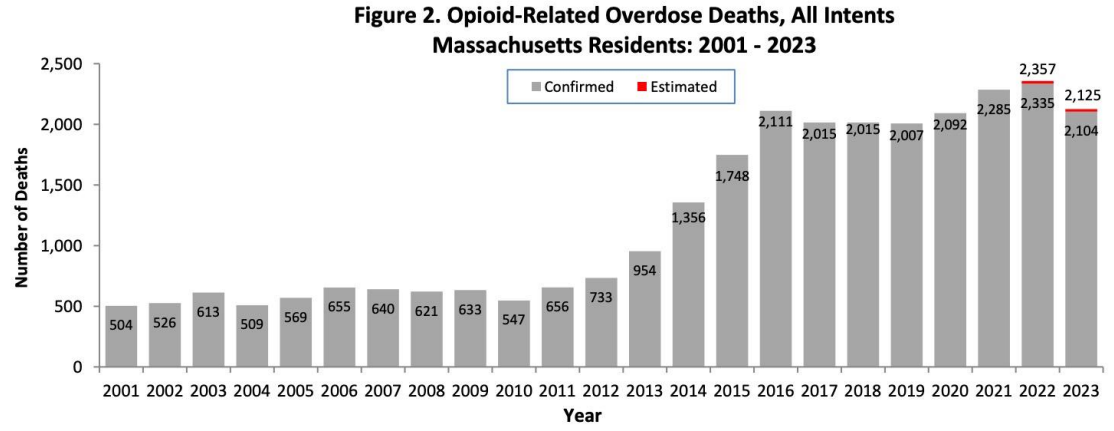
Tools for Frontline Service Providers

COPING WITH OVERDOSE FATALITIES

Tools for Public Health Workers

The fatalities that are occurring as part of the epidemic have the potential to cause distress similar to what is faced by workers responding to natural disasters and other catastrophes that result in mass casualties.

1



Effects of Responding to an Epidemic

Because the number of deaths from opioid overdoses truly represent an epidemic, several overarching ideas can be helpful in responding to providers' distress.

First, service providers' experiences of loss potentially exist in two domains, both as individual losses and as part of the larger epidemic. Helpers will be affected by the death of the individual person who died, based on their relationship and the role they played in helping the person. In addition, they will be affected by how this death resonates with them as being part of the ongoing loss of life in the context of the epidemic. Keeping this general idea in mind is essential in all supportive interactions because people are likely to have needs around grief, trauma, or distress in both domains.

Second, the fatalities that are occurring as part of the epidemic have the potential to cause distress similar to what is faced by workers responding to natural disasters and other catastrophes that result in mass casualties. The casualties from the epidemic are happening one at a time over a span of time instead of during a single disaster incident, but the high number of inter-related deaths (see footnote 1) can take a collective toll on service providers.[5]

DSPs Need Locally Developed Strategies

INTRODUCTION

Frontline Service Providers Need Locally Developed Strategies

Frontline service providers in Massachusetts are exposed to thousands of overdoses each year,[1] which is causing some workers to suffer from significant distress, grief, and/or trauma in the aftermath of deaths among the people they serve. The tools and resources in this document are for the benefit of workers delivering prevention, treatment, harm reduction, or other social welfare or health services directly to people who are actively using drugs and are at high risk of dying by an overdose. The focus of the suggestions outlined is on helping providers cope with the effects of fatalities from the opioid epidemic.

Services throughout Massachusetts are delivered by a variety of agencies with different organizational structures and capacities for supporting their staff, and the suggested tools are designed as a starting place for the local development of customized procedures, programs, and policies that can be applied in response to circumstances commonly faced in local settings. The footnotes and other references point to expert sources and authoritative information to help develop and deliver support for frontline providers who are exposed to overdose fatalities (all resources referenced that are available online for download are also listed in Appendix A).

For a comprehensive guide written from a clinical perspective on service providers' needs after a fatality, see *Clinical Response Following Opioid Overdose: A Guide for Managers* at bit.ly/oasasguide. The document—from the New York Office of Alcoholism and Substance Abuse Services (OASAS)—also includes information on topics such as assisting clients and family members after a death.

[1] In 2017, there were nearly 2,000 opioid overdose fatalities (MDPH, February 2018) and about 20,000 rescues (usually involving the administration of naloxone, or Narcan) (MDPH, May 2018), the combination of which represents the total number of life-or-death situations that occur.

4

The fatalities that are occurring as part of the epidemic have the potential to cause distress similar to what is faced by workers responding to natural disasters and other catastrophes that result in mass casualties.

APPENDIX: RESOURCES AVAILABLE FOR DOWNLOAD

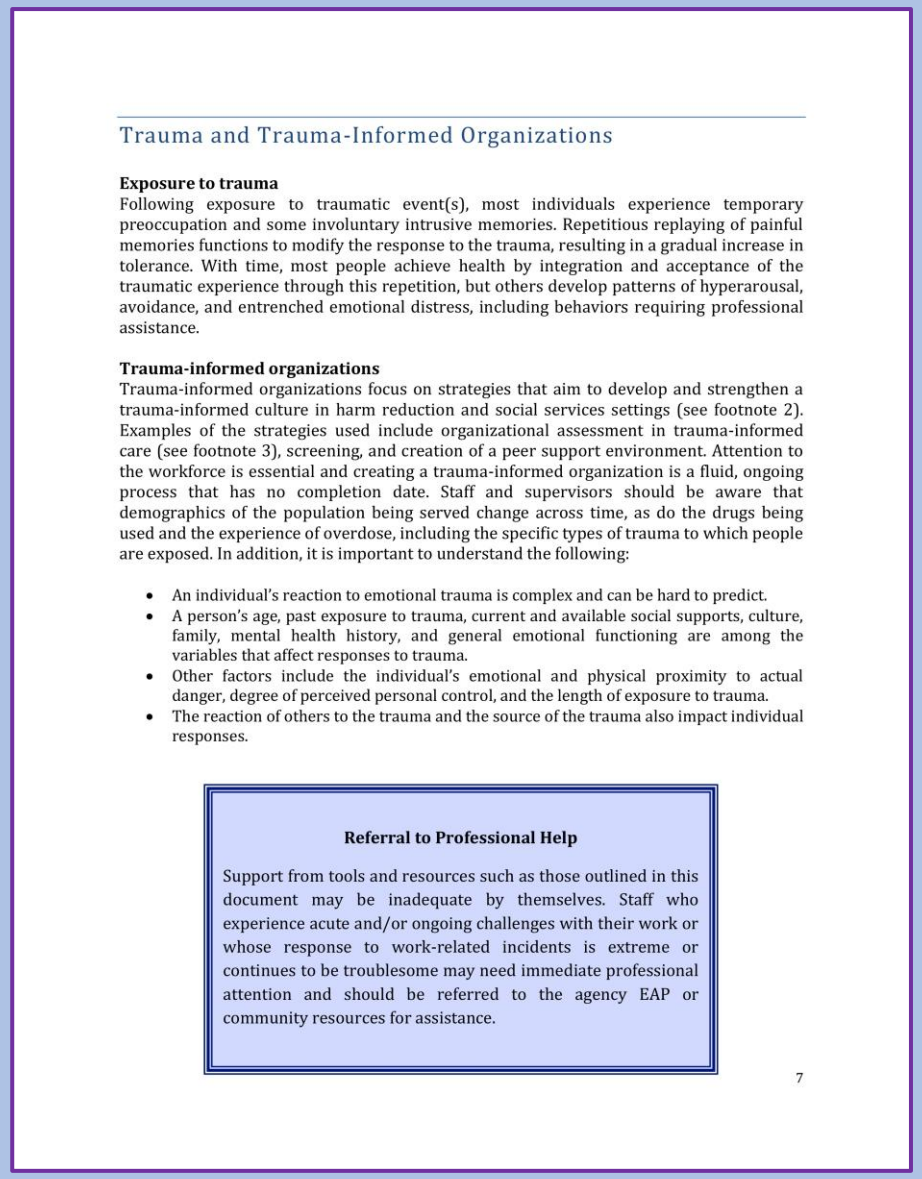
In preparing this document, the resources listed below were identified as being among the most helpful and authoritative tools and references available on the topics covered. Each resource is available as a free download at the Bitlink listed.

- *Clinical Response Following Opioid Overdose: A Guide for Managers,* from the New York Office of Alcoholism and Substance Abuse Services (OASAS): bit.ly/oasasguide.
- "Coping with Grief from a Substance-Use Death," from SADOD (Support After a Death by Overdose): bit.ly/sadodprimer.
- "Guidelines for a Vicarious Trauma-Informed Organization: Supervision," from the Vicarious Trauma Toolkit, U.S. Department of Justice, Office for Victims of Crime: bit.ly/VTsupervision
- *Developing Your Self-Care Plan,* from the University at Buffalo School of Social Work: bit.ly/doselfcare
- The Pause: See bit.ly/deathpause and bit.ly/pausebartels
- *PTSD Coach Online,* from the VA's National Center for PTSD: bit.ly/tools4ptsd
- "Tips for Adults after Disasters," from the *Psychological First Aid Manual:* bit.ly/pfatipsadults
- "Tips for Disaster Responders: Preventing and Managing Stress," from SAMHSA (Substance Abuse and Mental Health Services Administration): bit.ly/responderstress
- *Trauma-Informed Care in Behavioral Health Services - TIP 57,* from SAMHSA (Substance Abuse and Mental Health Services Administration): bit.ly/trauma57.
- "Trauma-Informed Organizational Self-Assessment," from the Trauma-Informed Care Project: bit.ly/TICassess
- *Trauma-Informed Supervision: What They Didn't Teach Us in Graduate School,* from Relias and the National Council for Behavioral Health: bit.ly/TIsupervision
- "Vicarious Trauma," from the American Counseling Association: bit.ly/VTsigns
- *Vicarious Trauma Organizational Readiness Guide,* from the Vicarious Trauma Toolkit, U.S. Department of Justice, Office for Victims of Crime: bit.ly/vtorgreadiness

SADO.D Support After a Death by Overdose

PeerSupport COMMUNITY PARTNERS

Are You “Trauma-Informed”? Is Your Organization



Trauma and Trauma-Informed Organizations

Exposure to trauma

Following exposure to traumatic event(s), most individuals experience temporary preoccupation and some involuntary intrusive memories. Repetitious replaying of painful memories functions to modify the response to the trauma, resulting in a gradual increase in tolerance. With time, most people achieve health by integration and acceptance of the traumatic experience through this repetition, but others develop patterns of hyperarousal, avoidance, and entrenched emotional distress, including behaviors requiring professional assistance.

Trauma-informed organizations

Trauma-informed organizations focus on strategies that aim to develop and strengthen a trauma-informed culture in harm reduction and social services settings (see footnote 2). Examples of the strategies used include organizational assessment in trauma-informed care (see footnote 3), screening, and creation of a peer support environment. Attention to the workforce is essential and creating a trauma-informed organization is a fluid, ongoing process that has no completion date. Staff and supervisors should be aware that demographics of the population being served change across time, as do the drugs being used and the experience of overdose, including the specific types of trauma to which people are exposed. In addition, it is important to understand the following:

- An individual’s reaction to emotional trauma is complex and can be hard to predict.
- A person’s age, past exposure to trauma, current and available social supports, culture, family, mental health history, and general emotional functioning are among the variables that affect responses to trauma.
- Other factors include the individual’s emotional and physical proximity to actual danger, degree of perceived personal control, and the length of exposure to trauma.
- The reaction of others to the trauma and the source of the trauma also impact individual responses.

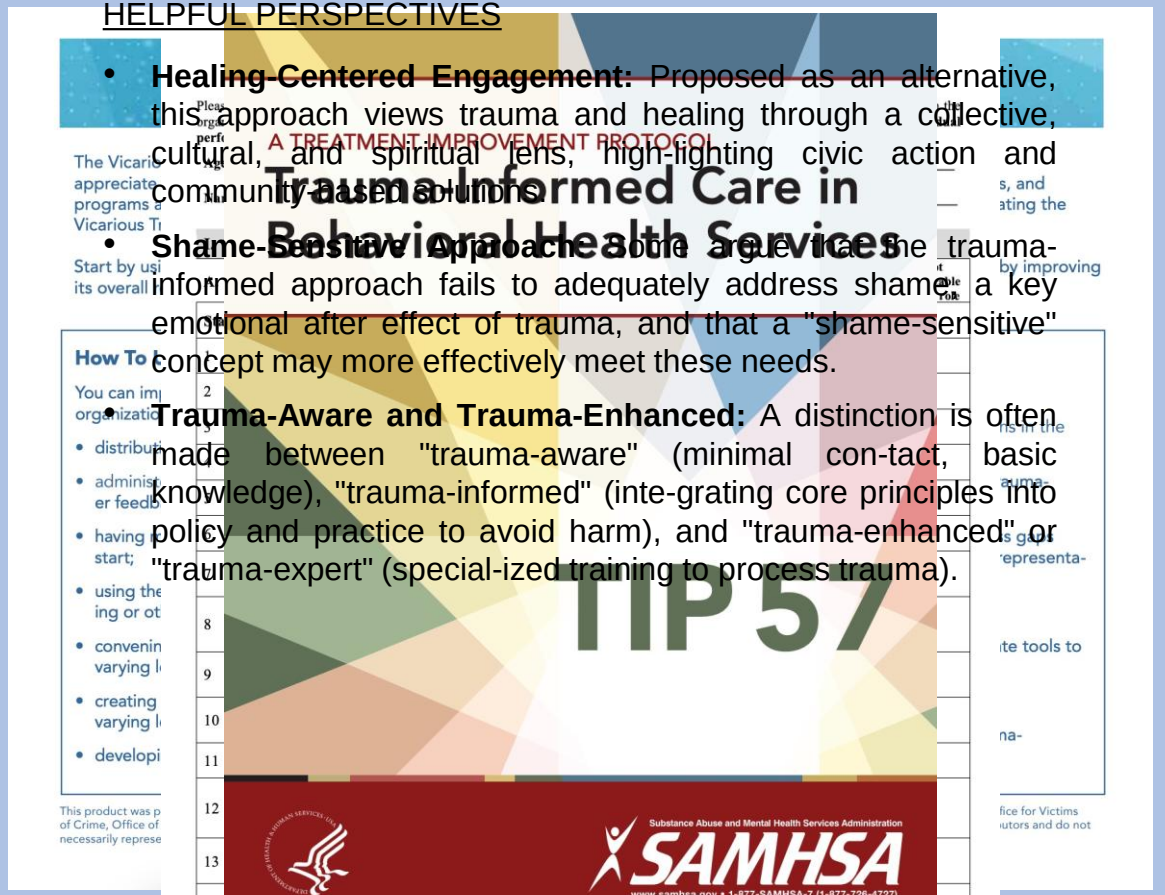
Referral to Professional Help

Support from tools and resources such as those outlined in this document may be inadequate by themselves. Staff who experience acute and/or ongoing challenges with their work or whose response to work-related incidents is extreme or continues to be troublesome may need immediate professional attention and should be referred to the agency EAP or community resources for assistance.

7

HELPFUL PERSPECTIVES

- **Healing-Centered Engagement:** Proposed as an alternative, this approach views trauma and healing through a collective, cultural, and spiritual lens, high-lighting civic action and community-based solutions.
- **Shame-Sensitive Approach:** Some argue that the trauma-informed approach fails to adequately address shame, a key emotional after effect of trauma, and that a "shame-sensitive" concept may more effectively meet these needs.
- **Trauma-Aware and Trauma-Enhanced:** A distinction is often made between "trauma-aware" (minimal con-tact, basic knowledge), "trauma-informed" (inte-grating core principles into policy and practice to avoid harm), and "trauma-enhanced" or "trauma-expert" (special-ized training to process trauma).



15	How to develop safety and crisis prevention plans.						
16	What is asked in the intake assessment.						
17	How to establish and maintain healthy professional boundaries.						

Principles of Disaster Response

Five Core Actions

1. **Promote safety**
2. **Promote calm**
3. **Promote connectedness**
4. **Promote hope**
5. **Promote self-efficacy**

Activities to promote safety

- Ensure that there is a safe space for them to be.
- Communicate and demonstrate your interest in their safety.
- Foc
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Activities to promote calm

- Be calm yourself (and compassionate, nonjudgmental).
- Dispense only information that you know is accurate.
- Lis
- Let
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- Sug

Activities to promote connectedness

- Remember that your sincere attentiveness to them strengthens connectedness.
- Create opportunities for peers who have had similar experiences to be together.
- En
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Activities to promote hope

- Express hopefulness in practical terms:
  - "As hard as this is, I believe we're doing a good job."
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Activities to promote self-efficacy

- Engage them in decisions, planning, taking action.
- Focus on the immediate next step.
- Encourage small, achievable, incremental steps.
- Don't over-manage the situation.
- Understand their needs from their point of view (don't assume).
- Avoid being critical.

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Acknowledging the Death

The Pause

- Stop for a moment and intentionally create a space for service providers to acknowledge that the person has died.
- Through affirmation, silence, and/or other respectful means, honor the person who died, the life they led, and the people they touched.
- Express gratitude for the efforts that were made to help the person and to prevent the death.

The Deceased's Body

- The body of a deceased person should be treated with dignity and respect.
- It should be handled gently and with solemnity.
- It should be shielded from public view.
- The deceased person's belongings should be properly accounted for.
- Family members' need to view the body and take part in its disposition should be accommodated.

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Coping Techniques, Grounding, Self-Soothing

- Step away from the scene, literally or mentally
- Breath mindfully
- Visualize a safe space
- Affirmative self-talk

The Body Scan

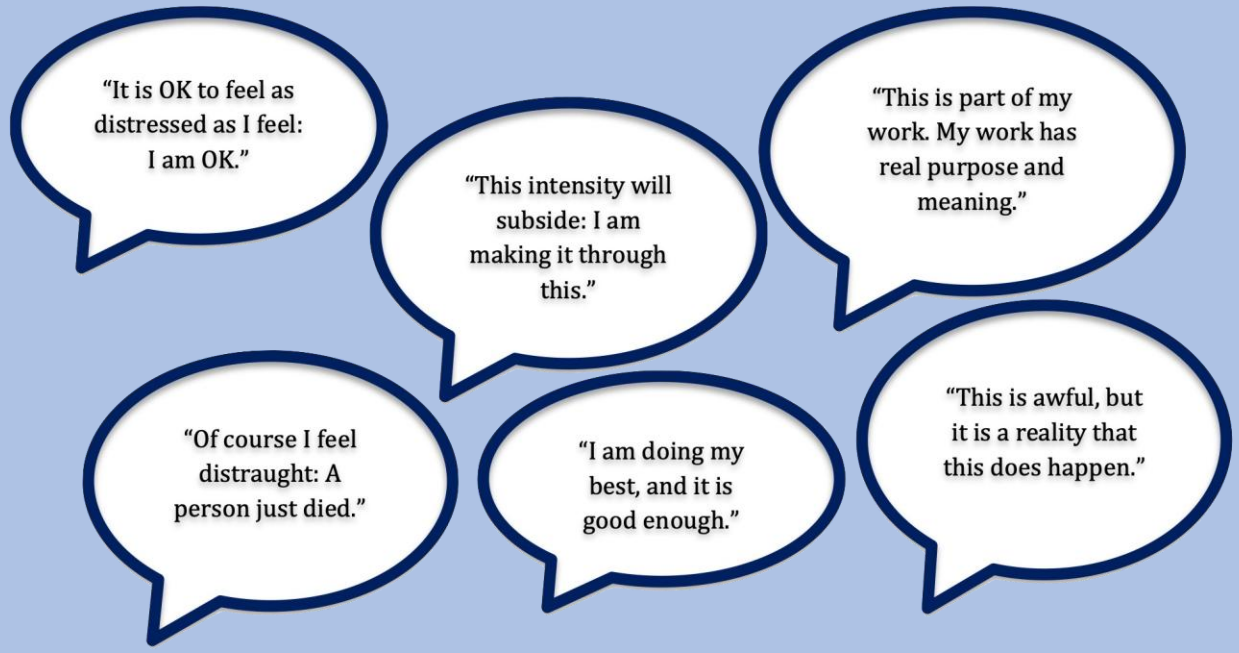
Sit in a chair, relax and be still

↓

Begin at the soles of your feet, take notice, and say to yourself, "I notice the soles of my feet touching the floor."

↓

Move your attention slowly up your body, taking notice at each stop along the way and saying to yourself things like:
"I notice my butt sitting on the chair" … "I notice my back being supported" … "I notice my arms at my sides and my hands in my lap" … "I notice my chest moving with each breath" … "I notice the temperature of the air on my face" … "I notice the weight of my head" …



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Talking and Listening with Each Other

- Provide a safe space and protect people's vulnerability, privacy, and confidentiality.
- Share only accurate information about any individual incident and about the epidemic overall.
- Do not put anyone in a position where they feel compelled to share about their feelings or experiences.
- It is best to avoid making judgments and giving advice.

- Questions or guided facilitation may focus generally on:
  - What meaning people's experiences hold for them
  - How their experiences are shaped by their motivation or purpose for doing the work they do

- Validate all experiences, including both "positive" and "negative":
  - What is helping them cope and what they feel unable to cope with
  - What gives them hope and what they feel hopeless about

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Making Connections

What professional support might be helpful?
○ Extra clinical supervision? ○ Counseling? ○ Religious or spiritual support? ○ Other resources specifically linked to people's needs?
Are there obstacles to getting professional assistance?
○ People wanting to handle it themselves? ○ Not knowing of a referral to a specific resource that might be helpful? ○ Not believing that counseling is effective? ○ Practical issues such as access, cost, etc.? ○ Being affected by stigma about getting help?
Are there adjustments needed in people's work situation?
○ Assistance from other colleagues? ○ Reassignment from stressful tasks? ○ Help prioritizing tasks? ○ Time off?
Does anyone need help regarding their own substance use and recovery?
○ What counseling, peer help, or other support is available? ○ Is relapse prevention needed? ○ Is support needed because of family members who are actively using?
What about memorializing the deceased person?
○ Can staff who want to attend the funeral be accommodated? ○ Does your workplace maintain memorial activities for clients?

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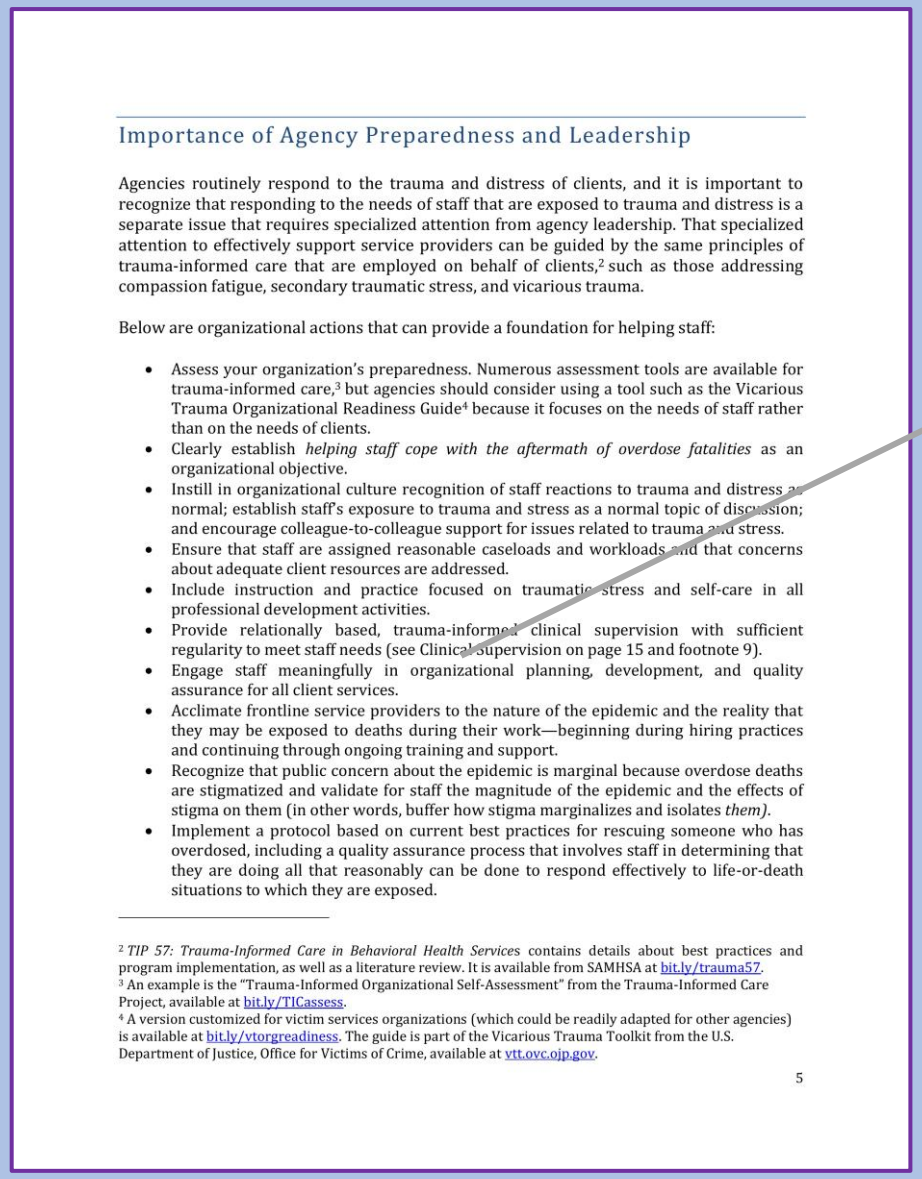
Agency and Industry Leadership Challenges



Importance of Agency Preparedness and Leadership

Agencies routinely respond to the trauma and distress of clients, and it is important to recognize that responding to the needs of staff that are exposed to trauma and distress is a separate issue that requires specialized attention from agency leadership. That specialized attention to effectively support service providers can be guided by the same principles of trauma-informed care that are employed on behalf of clients,[2] such as those addressing compassion fatigue, secondary traumatic stress, and vicarious trauma.

Below are organizational actions that can provide a foundation for helping staff:

- Assess your organization's preparedness. Numerous assessment tools are available for trauma-informed care,[3] but agencies should consider using a tool such as the Vicarious Trauma Organizational Readiness Guide[4] because it focuses on the needs of staff rather than on the needs of clients.
- Clearly establish *helping staff cope with the aftermath of overdose fatalities* as an organizational objective.
- Instill in organizational culture recognition of staff reactions to trauma and distress as normal; establish staff's exposure to trauma and stress as a normal topic of discussion; and encourage colleague-to-colleague support for issues related to trauma and stress.
- Ensure that staff are assigned reasonable caseloads and workloads and that concerns about adequate client resources are addressed.
- Include instruction and practice focused on traumatic stress and self-care in all professional development activities.
- Provide relationally based, trauma-informed clinical supervision with sufficient regularity to meet staff needs (see Clinical Supervision on page 15 and footnote 9).
- Engage staff meaningfully in organizational planning, development, and quality assurance for all client services.
- Acclimate frontline service providers to the nature of the epidemic and the reality that they may be exposed to deaths during their work—beginning during hiring practices and continuing through ongoing training and support.
- Recognize that public concern about the epidemic is marginal because overdose deaths are stigmatized and validate for staff the magnitude of the epidemic and the effects of stigma on them (in other words, buffer how stigma marginalizes and isolates *them)*.
- Implement a protocol based on current best practices for rescuing someone who has overdosed, including a quality assurance process that involves staff in determining that they are doing all that reasonably can be done to respond effectively to life-or-death situations to which they are exposed.

[2] *TIP 57: Trauma-Informed Care in Behavioral Health Services* contains details about best practices and program implementation, as well as a literature review. It is available from SAMHSA at bit.ly/trauma57.
[3] An example is the "Trauma-Informed Organizational Self-Assessment" from the Trauma-Informed Care Project, available at bit.ly/TICassess.
[4] A version customized for victim services organizations (which could be readily adapted for other agencies) is available at bit.ly/vtorgreadiness. The guide is part of the Vicarious Trauma Toolkit from the U.S. Department of Justice, Office for Victims of Crime, available at vtt.ovc.ojp.gov.

5

- Clearly establish helping staff cope with the aftermath of overdose fatalities as an organizational objective.
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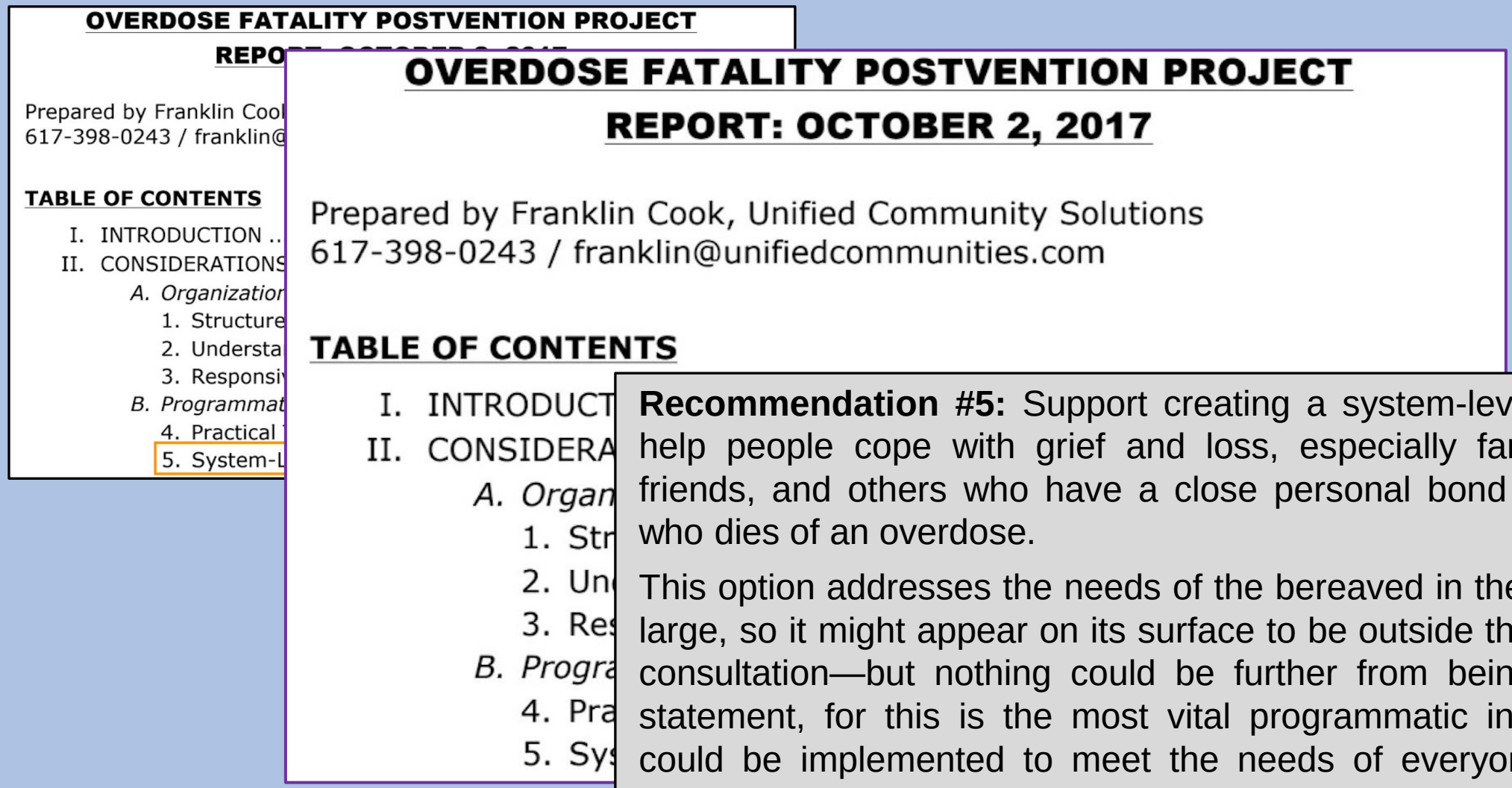
Genesis of the SADOD Project



OVERDOSE FATALITY POSTVENTION PROJECT

REPORT: OCTOBER 2, 2017

Prepared by Franklin Cook, Unified Community Solutions
617-398-0243 / franklin@unifiedcommunities.com

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5. Sys

Recommendation #5: Support creating a system-level response to help people cope with grief and loss, especially family members, friends, and others who have a close personal bond with someone who dies of an overdose.

This option addresses the needs of the bereaved in the community at large, so it might appear on its surface to be outside the scope of this consultation—but nothing could be further from being an accurate statement, for this is the most vital programmatic intervention that could be implemented to meet the needs of everyone affected by overdose deaths, including direct care providers.

SADO.D. Support After a Death by Overdose

PeerSupport COMMUNITY PARTNERS

Support After a Death by Overdose is a statewide project funded by the Massachusetts Bureau of Substance Addiction Services. SADOD programs and services are available only in Massachusetts.

Peer Support Community Partners is a private, for-profit company that manages the SADOD project. PSCP's mission is to establish Peer Grief Support nationally as a field of practice in its own right.

SADOD Serves Three Populations

- An online portal for each population
- Targeted resources & programs
- All three populations overlap

SADOD.ORG — Peer Grief Support After any Drug-Alcohol-Related Death
Accidental Overdose – Suicide – Homicide – Medical Condition – Other Accident

SADO.D. Support After a Death by Overdose

PeerSupport COMMUNITY PARTNERS

Community Peer Grief Support Programs

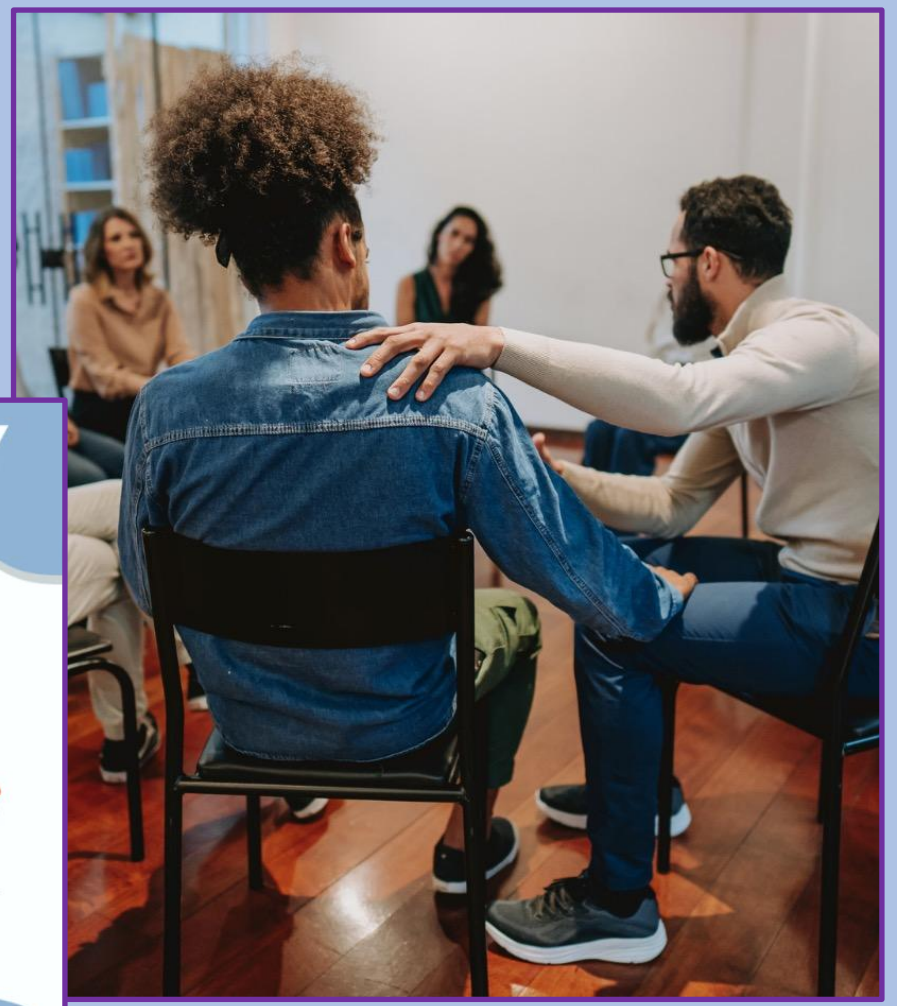
Request Help

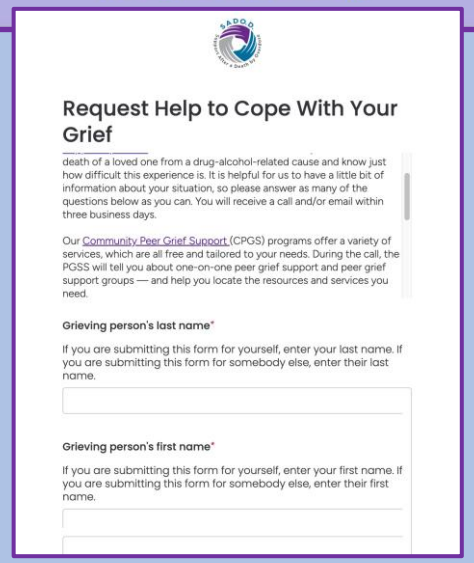
SADOD's Community Peer Grief Support Programs

SADOD and our partner The Sun Will Rise offer peer grief support to people grieving the drug-alcohol-related death of a loved one or of someone they feel close to. Our trained staff and volunteers are peer grief helpers, people who themselves have suffered a death from substance use and now support other grieving people. Please use the Request Help form to contact us.

All of our services are free and confidential, and we will mail a free grief support booklet to any Massachusetts address.

peergriefsupport.org





Request Help to Cope With Your Grief

death of a loved one from a drug-alcohol-related cause and know just how difficult this experience is. It is helpful for us to have a little bit of information about your situation, so please answer as many of the questions below as you can. You will receive a call and/or email within three business days.

Our Community Peer Grief Support (CPGS) programs offer a variety of services, which are all free and tailored to your needs. During the call, the PGSS will tell you about one-on-one peer grief support and peer grief support groups — and help you locate the resources and services you need.

Grieving person's last name*

If you are submitting this form for yourself, enter your last name. If you are submitting this form for somebody else, enter their last name.

Grieving person's first name*

If you are submitting this form for yourself, enter your first name. If you are submitting this form for somebody else, enter their first name.

PeerSupport COMMUNITY PARTNERS

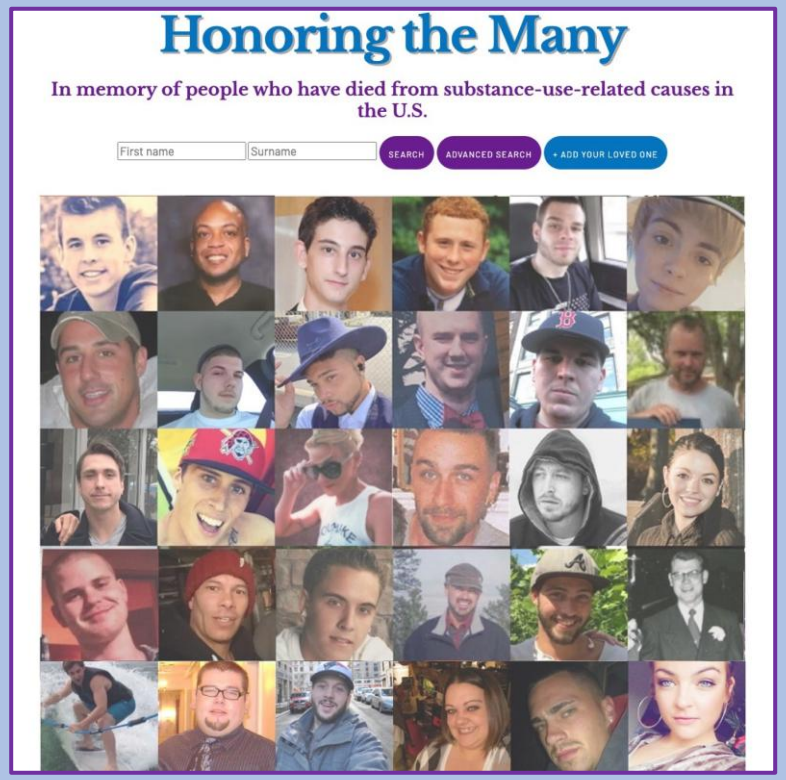
Community Peer Grief Support Programs

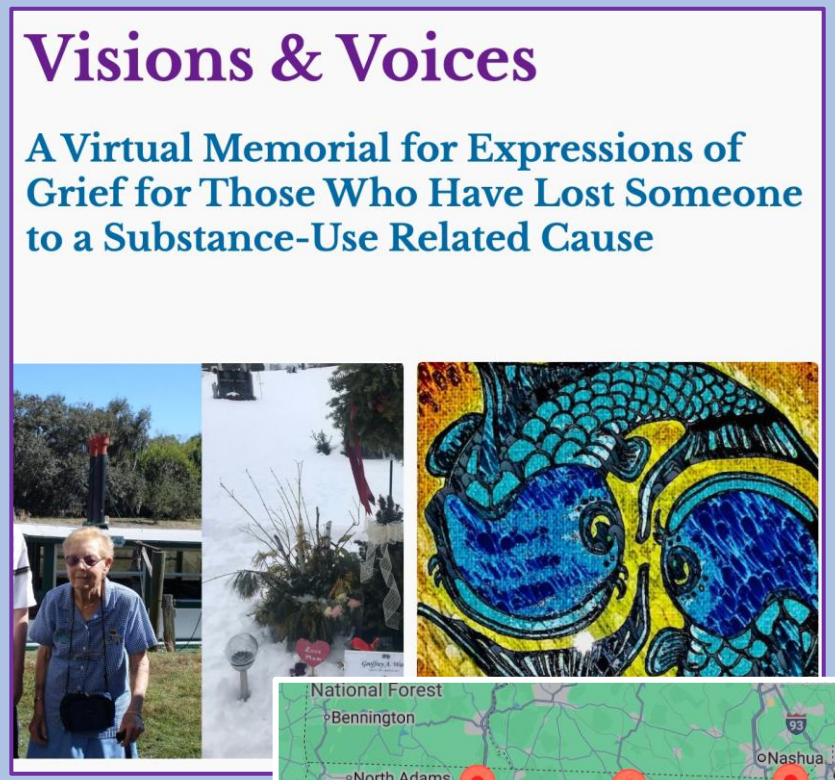
THE SUN WILL RISE
— FOUNDATION —

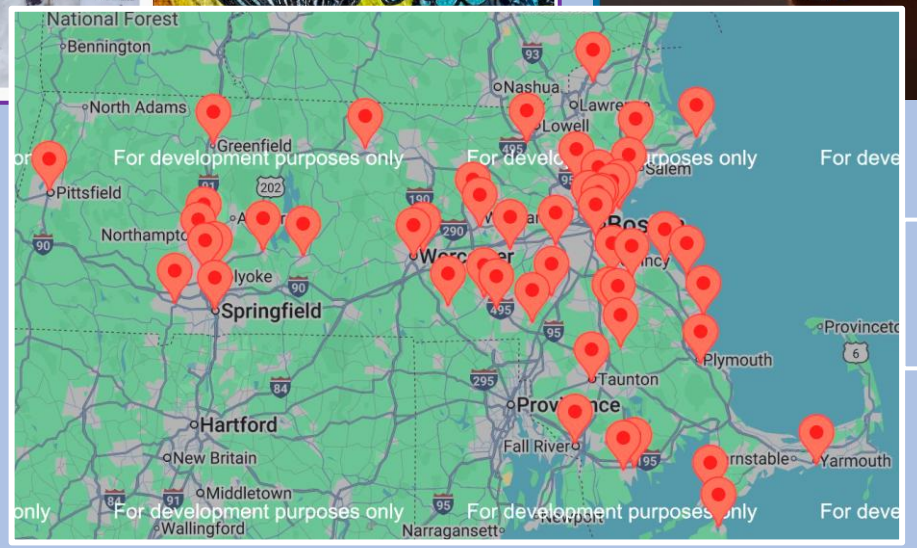
Hosts 45+ free Peer Grief Support Groups (with trained Peer Grief Helpers) for adults 18+, who are grieving a death from drug-alcohol-related causes.

Hosts dozens of activities for the bereaved in Massachusetts.

Community Peer Grief Support Programs







IOAD Online Directory

SADO.D. Support After a Death by Overdose

Peer Grief Support

VOICES

November 2025

PeerSupport COMMUNITY PARTNERS

Direct Service Provider Programs

Peer Grief Support Groups

- Monthly support group
- Easy access
  - No registration
  - Drop in anytime
- Begins with a brief ritual
  - Emphasis on safe space
  - Open discussion & sharing
- Ends with a moment of mindfulness

Creating Space for Connection

Even if formal systems don't exist, providing time and space for workers to gather and talk is valuable in itself.

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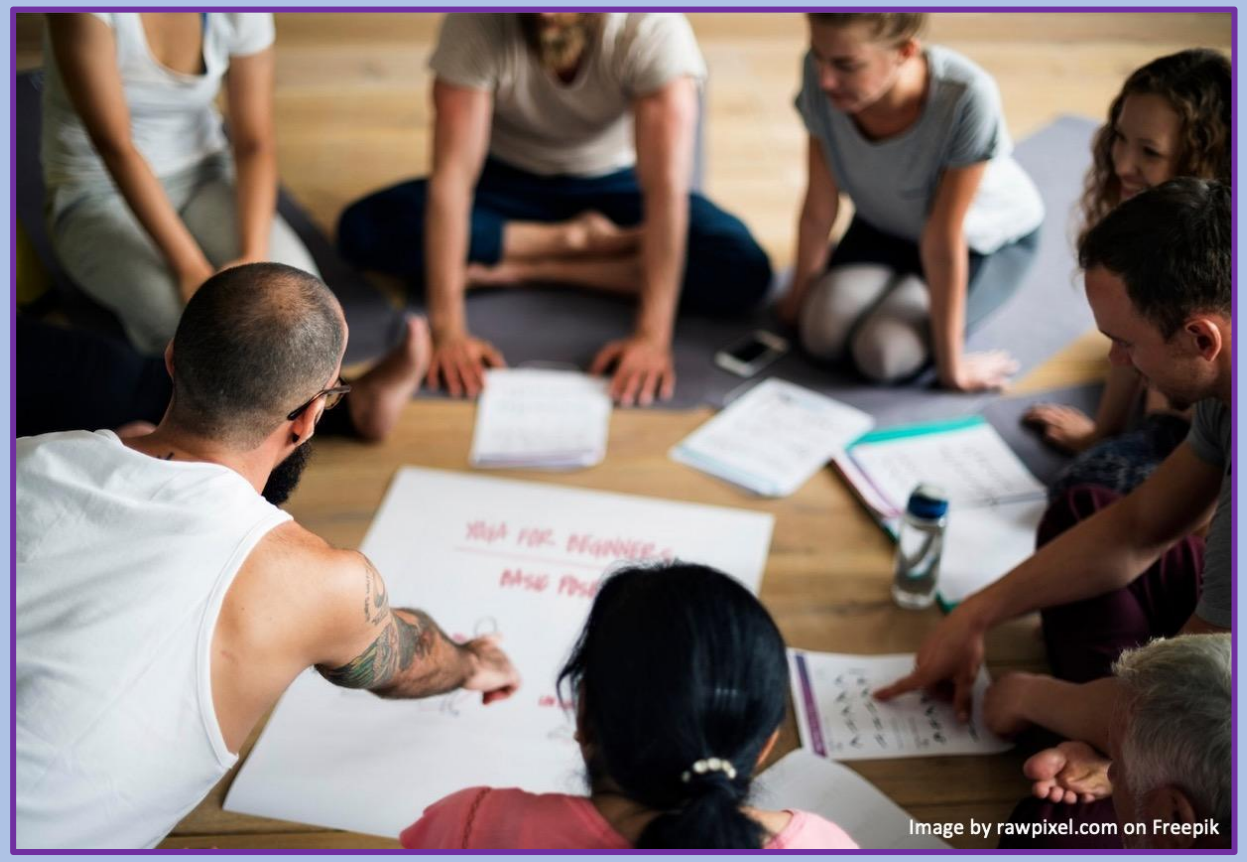
Direct Service Provider Programs

Training - Technical Assistance

- Twice-monthly trainings
- Focuses on coping with work-place grief, trauma, distress
- Emphasizes collaboration with employers to meet their training and TA needs
- Encourages being proactive
- Recommendations for work-force support



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Trainings Offered by SADOD

GRIEF & GRIEF SUPPORT

- **SADOD Overview:** Introduces SADOD's full range of peer grief support services.
- **Being Grief-Informed:** Teaches helpful skills to support grieving participants or coworkers.
- **Good Grief:** Offers practical tools to help with the emotional and psychological toll of overdose work.
- **Grief & Loss for DSPs:** Explores grief issues of DSPs and provides education, tools, and resources.
- **Remembering Those We've Lost:** Invites participants to remember and to share expressions of grief.

SPECIAL TOPICS

- **Harm Reduction Yourself**: Encourages DSPs to apply harm reduction principles to their own lives.
- **Advocacy for DSPs**: How advocacy restores agency. Covers strategy, messaging, and policy events.
- **Post-Incident Conversations:** Emphasizes adaptive approaches in conversations after crises.
- **Working with Families:** Equips DSPs to help family members and loved ones affected by substance use.
- **Nervous System Education for DSPs:** Focuses on self-regulation, and Includes guided practices.

MANAGEMENT

- **Supporting Direct Care Staff:** Explores practical ways to support staff well-being, manage challenges, and sustain morale in demanding environments.

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Annual Overdose Awareness Day Vigil — Gloucester, Massachusetts

Franklin James Cook

Owner, Peer Support Community Partners
Director, SADOD Community Peer Grief Support Programs

If you would like a PDF of this slideshow, please text me at **617-398-0243**:

- Your name
- Your organization or affiliation
- Your email address

franklin@unifiedcommunities.com ~ 617-398-0243