



# COPING WITH OVERDOSE FATALITIES

Tools for Public Health Workers

# TABLE OF CONTENTS

## CONTENTS

|  |    |
|--|----|
| <b>EXECUTIVE SUMMARY</b> .....                                     | 3  |
| INTRODUCTION .....   | 4  |
| Frontline Service Providers Need Locally Developed Strategies..... | 4  |
| Importance of Agency Preparedness and Leadership.....              | 5  |
| Effects of Responding to an Epidemic .....                         | 5  |
| Trauma and Trauma-Informed Organizations .....                     | 7  |
| TOOLS FOR SERVICE PROVIDERS .....                                  | 8  |
| Overview.....  | 8  |
| Five Core Actions .....  | 9  |
| Acknowledging the Death.....                                       | 11 |
| Processing Strong Emotions.....                                    | 13 |
| Making Connections.....  | 16 |
| Grief After an Overdose .....                                      | 18 |
| APPENDIX: Resources Available for Download .....                   | 20 |
| REFERENCES.....  | 21 |

# EXECUTIVE SUMMARY

The suggested tools and resources herein address the need for agencies to support frontline service providers following exposure to an overdose fatality. Frontline service providers may include any staff members that interact directly with populations that are at greater risk for experiencing overdose. The suggestions throughout the document should be implemented in keeping with agency-based policies and procedures for staff support. Introducing these strategies into the workplace can foster greater well-being among those staff members most vulnerable to trauma and distress.

The goal of these suggestions is to promote well-being in the workplace for those most vulnerable to trauma, stress and grief. To achieve this, outlined below are principles for agencies to incorporate into their organization, how to acknowledge death in the moment, approaches to coping with strong emotions, the importance of building a support system, and the process of grief.

The primary audience for this resource is staff working in substance use and overdose prevention programs contracted with the Massachusetts Department of Public Health.

The appendix offers helpful resources for review. Agencies may benefit from researching resources in addition to those provided in this document to meet unique staff needs.

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## Acknowledgements

Thank you to all the individuals who contributed to this report. Thank you to all the front-line program staff who are working to save lives.

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# INTRODUCTION

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## Frontline Service Providers Need Locally Developed Strategies

Frontline service providers in Massachusetts are exposed to thousands of overdoses each year,<sup>1</sup> 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](http://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.

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<sup>1</sup> 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.

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## 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,<sup>2</sup> 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,<sup>3</sup> but agencies should consider using a tool such as the Vicarious Trauma Organizational Readiness Guide<sup>4</sup> 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.

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<sup>2</sup> 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](https://bit.ly/trauma57).

<sup>3</sup> An example is the "Trauma-Informed Organizational Self-Assessment" from the Trauma-Informed Care Project, available at [bit.ly/TICassess](https://bit.ly/TICassess).

<sup>4</sup> A version customized for victim services organizations (which could be readily adapted for other agencies) is available at [bit.ly/vtorgreadiness](https://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](https://vtt.ovc.ojp.gov).

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## 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.<sup>5</sup>

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<sup>5</sup> It is beyond the scope of this document to address issues related to responding to the larger epidemic, but resources such as "Tips for Disaster Responders: Preventing and Managing Stress" (available from SAMHSA at [bit.ly/responderstress](https://www.samhsa.gov/2k16/2k16-disaster-response-tips)) provide practical examples of disaster response practices.

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## 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.

# TOOLS FOR SERVICE PROVIDERS

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## OVERVIEW

The key aspects of responding to people’s needs in the immediate aftermath of a fatality are listed below and then covered one-by-one in detail:

- Five core actions
- Acknowledging the death
- Processing strong emotions
- Making connections
- Grief after an overdose

Of course, coping with the aftermath of a fatality is not a linear, step-by-step process, and in fact, in the first minutes, hours, and days after a death, all of these issues overlap, repeat themselves, and play off of one another—so they must be addressed dynamically and fluidly.

In addition, the need for service providers on the scene to deal with the practical demands of an unfolding situation must be balanced against their need to cope with their own reactions to the impact of what has happened. It is essential that supporting helpers be a both/and proposition—not either/or—as issues such as those listed below demand attention:

- Taking care of vital job duties, including the urgent needs of clients
- Restoring order or cleaning up the scene, for example, after a resuscitation attempt
- Managing the crowd, including news media
- Informing others who have a need to know about the fatality

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## Five Core Actions

When preparing for, engaging in, or following up on issues related to the aftermath of a death, consider how these actions can be applied in the circumstances you face on behalf of the people you serve. Studies show that the following five core actions (Hobfoll et al., 2007) can be helpful to people who have been exposed to a traumatic event that involves loss of life:

### **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.
- Focus on basic needs (food, water, sleep, comfort, shelter, medical attention).
- Advise them on the risks of using alcohol, drugs, etc. to cope with distress.
- Protect their privacy (including from the media).
- Respond decisively to distress or danger (e.g., harm to self or others).

#### **Activities to promote calm**

- Be calm yourself (and compassionate, nonjudgmental).
- Dispense only information that you know is accurate.
- Listen with patience to whatever they want to share.
- Let them choose the pace and extent of talking about the death (if at all).
- Normalize intense emotions, troublesome thoughts, etc.
- Suggest calming practices (see “Coping Tools,” below).

#### **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.
- Encourage them to be in touch with key supportive people (family, friends, clergy, etc.).
- Give them “permission” to avoid unhelpful people and situations.
- Help them get professional support if they need it (see “Making Connections,” below).

### **Activities to promote hope**

- Express hopefulness in practical terms:
  - "As hard as this is, I believe we're doing a good job."
  - "I just believe in helping the next person if we can."
- Avoid platitudes ("This too shall pass) and predictions ("The situation is going to get better").
- Reinforce their gains, strengths, assets.
- Affirm that recovering from this distress is possible.
- If it is appropriate, say something about why you do the work you do, and invite them to share their reasons for doing the work.

### **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

### Exposure to fatalities

Service providers may experience a fatality at any time, which highlights the need to be attuned to the reality that confronting death is part of working on the front lines of the epidemic. For some people, this is a purely mental exercise, but for many, there is a spiritual element to being aware of the constant possibility of a fatality. Here are some of the ways that exposure to someone's death may occur:

- A person dying during a rescue attempt in which staff is directly involved<sup>6</sup>.
- Staff being informed by law enforcement or other officials that someone has died.
- Staff being told of a person's death (soon after the death or some period of time afterward) by a client, family member, or other source .
- Staff learning of a person's death when they resupply someone with naloxone
- A death being reported in the media or social media.
- Staff experiencing a death in their family, among their acquaintances or friends, and in their community.

### The Pause

Regardless of how exposure to a fatality happens, it is essential to acknowledge or announce the death with seriousness and respect—and to recognize the human dimension of the loss of life that has occurred. It is recommended that you consider the components of a practice called *The Pause* in developing procedures for how a death is acknowledged when someone dies in the workplace or how it is announced when a death occurs elsewhere. Components of The Pause to consider:<sup>7</sup>

- 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

In some cases where the deceased's body is at the scene—for example, with an unsuccessful resuscitation attempt or the discovery of a person who has died—the body not being handled properly has been an issue. This is ultimately under the purview of

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<sup>6</sup> This document primarily addresses responding to a fatality that occurs during a staff-involved resuscitation attempt, but everything covered herein can be modified for responding to any of the scenarios in this list.

<sup>7</sup> For more information about The Pause, please see the description at [bit.ly/deathpause](https://bit.ly/deathpause) and view the short video by its creator, nurse Jonathan Bartels, at [bit.ly/pausebartels](https://bit.ly/pausebartels). Depending on your workplace environment, The Pause may be expanded to include making space for people to respond to the personal or emotional weight of what has happened, but that may be better left for a time beyond when the death is acknowledged, as is outlined below in the section “Open dialogue.”

emergency medical services and law enforcement, but frontline service providers may benefit from the affirmation of a few basic principles:

- 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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## Processing Strong Emotions

### Normalize reactions

It is very important to convey the fact that it is normal to experience strong emotions in response to being exposed to a sudden death. You can discuss potential reactions in advance, for example, by pointing out that it can feel traumatic to be involved in or to witness a resuscitation attempt, especially when the outcome is that the person dies. Another natural—albeit distressful—aspect of coping with a fatality is having an empathic response to the shock, trauma, and grief other people are experiencing as the situation unfolds.

### Coping tools

Here are some helpful approaches to processing strong emotions that feel overwhelming, which staff can be aware of in preparation for the eventuality of a death occurring:

- Step away from the scene:
  - Do this literally by physically going to a safe space.
  - “Stepping away” can create a sense of safety and calm even if:
    - You are able only to step back a short distance to remove yourself from the immediacy of the scene
    - You must step away only “in your mind” by moving your mental focus away from the intensity of the troubling scene
- Practice grounding or self-soothing techniques:
  - Breathing mindfully: Take three or four deep and deliberate breaths while concentrating on the awareness in your body that you are breathing (as air moves in and out, notice your chest and abdomen rising and falling).
  - Scanning your body:

#### **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” ...

- Visualizing a safe place:
  - Close your eyes.
  - Visualize a place, real or imagined, that is guaranteed to be a safe place for you.
  - Relax your body—and focus on keeping the scene in your “mind’s eye.”
  - Immerse yourself in being present in that place (imagine seeing, hearing, touching, smelling, tasting).
  - Stay in the scene for 5 or 10 minutes, relaxing your body as you picture it.
  - Slowly end the visualization.
- Practicing affirmative self-talk:



- Talking about it.
  - It can be calming to talk one-on-one in a safe space with a trusted person.
  - Exercise your power to choose whether you want to share your thoughts and feelings based on whether someone is available who can focus on listening to you and supporting you.

### **Open dialogue**

The effects of being exposed to fatalities should be a welcome and well-supported topic of discussion throughout your workplace culture. Whether sharing takes place in one-on-one conversations or among small groups of peers, whether it is informal or is a structured part of a meeting agenda, and whether supervisors are involved or not, opportunities for staff to discuss their experiences openly can be extremely helpful. Consider the following as you promote and support dialogue about grief, trauma, and loss:

- An essential requirement for all conversation is a safe space where people’s vulnerability, privacy, and confidentiality are protected.
- It is important to dispense only accurate factual information about any individual incident and about the epidemic overall.
- People should not be put in a position where they feel compelled to share about their feelings or experiences.
- The role of listeners, yourself included, should be primarily to listen—not to make judgments, give advice, or elicit details about what happened.
- Questions or guided facilitation may be appropriate if they focus generally on issues such as:
  - What meaning people’s experiences hold for them
  - How their experiences are shaped by their motivation or purpose for doing the work they do
- People should be validated for sharing all aspects of how they are doing, so they don’t feel confined to sharing only “positive” information: for example, they should be welcomed to talk about:
  - What is helping them cope and what they feel unable to cope with
  - What gives them hope and what they feel hopeless about
- Peer-to-peer support focused on coping with grief, trauma, and loss has high value so consider:
  - Dedicated time set aside for small group sharing on topics related to grief, loss, and trauma
  - A buddy system that pairs individuals with a partner for mutual help. Partners should focus on actions such as:
    - Listening to each other’s experiences
    - Understanding each other’s perspective
    - Helping each other speak up about needs and limitations
    - Encouraging each other with self-care and stress relief
    - Recognizing challenges and accomplishments
    - Acknowledging tough situations and the need for help

### **Clinical Supervision<sup>8</sup>**

- As per DPH regulations and RFR requirements, all program staff are expected to receive clinical supervision at a frequency consistent with their needs and work responsibilities. All programs must follow this requirement.
- Clinical supervisors are selected or adjusted based on an assessment of needs, qualifications, and fit with the workforce (with workers engaged in the decision).
- Confirming the capacity to provide back-up, on-call clinical support and/or supervision is expected of MDPH licensed and funded programs if clinical supervision is needed outside of scheduled sessions.

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<sup>8</sup> Supervision practices and policies can be strengthened by ensuring that they are guided by vicarious-trauma-informed principles of care. It is highly recommended that people delivering clinical supervision view the free online webinar *Trauma-Informed Supervision: What They Didn’t Teach Us in Graduate School*, available at [bit.ly/TIsupervision](http://bit.ly/TIsupervision). See additional guidance based on best practices in “Guidelines for a Vicarious Trauma-Informed Organization: Supervision,” available at [bit.ly/VTsupervision](http://bit.ly/VTsupervision).

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## Making Connections

### Beyond initial reactions<sup>9</sup>

After people’s immediate reactions have been supported, ongoing dialogue and a commitment to helping providers cope with grief, trauma and distress from fatalities provide the foundation for addressing providers’ ongoing needs.<sup>10</sup>

Questions such as the following should be explored:

|   |
|---|
| <b>What professional support might be helpful?</b>  |
| <ul style="list-style-type: none"><li>○ Extra clinical supervision?</li><li>○ Counseling?</li><li>○ Religious or spiritual support?</li><li>○ Other resources specifically linked to people’s needs?</li></ul>  |
| <b>Are there obstacles to getting professional assistance?</b>  |
| <ul style="list-style-type: none"><li>○ People wanting to handle it themselves?</li><li>○ Not knowing of a referral to a specific resource that might be helpful?</li><li>○ Not believing that counseling is effective?</li><li>○ Practical issues such as access, cost, etc.?</li><li>○ Being affected by stigma about getting help?</li></ul> |
| <b>Are there adjustments needed in people’s work situation?</b>   |
| <ul style="list-style-type: none"><li>○ Assistance from other colleagues?</li><li>○ Reassignment from stressful tasks?</li><li>○ Help prioritizing tasks?</li><li>○ Time off?</li></ul>   |
| <b>Does anyone need help regarding their own substance use and recovery?</b>  |
| <ul style="list-style-type: none"><li>○ What counseling, peer help, or other support is available?</li><li>○ Is relapse prevention needed?</li><li>○ Is support needed because of family members who are actively using?</li></ul>  |
| <b>What about memorializing the deceased person?</b>  |
| <ul style="list-style-type: none"><li>○ Can staff who want to attend the funeral be accommodated?</li><li>○ Does your workplace maintain memorial activities for clients?</li></ul>   |

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<sup>9</sup> 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](http://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.

<sup>10</sup> An understanding of the signs and symptoms of vicarious traumatization can help you be aware of people’s needs. An overview of indicators—based on changes in people’s behavior, interpersonal interactions, personal values and beliefs, and job performance—is available from the American Counseling Association at [bit.ly/VTsigns](http://bit.ly/VTsigns).

## Self-help matters

Engaging in self-help activities can be very empowering to people who are distressed, and it is recommended that staff be encouraged to use the suggestions contained in the following two excellent resources:

- “Tips for Adults after Disasters” ([Psychological First Aid Field Operations Guide](#)): This handout, from the *Psychological First Aid Manual*, outlines self-help responses to issues such as:
- Menu of tools from PTSD Coach Online ([PTSD Coach Online](#)): These interactive, user-friendly tools from the VA’s National Center for PTSD can be used to help people with reactions to any kind of distress:

|                      |  |
|----------------------|--|
| <b>High anxiety</b>  | <b>Shame</b>                             |
| <b>Anger</b>         | <b>Feeling overwhelmed</b>               |
| <b>Fear</b>          | <b>Negative worldview</b>                |
| <b>Substance use</b> | <b>Changes in personal relationships</b> |

|                                       |   |  |
|---------------------------------------|---|--|
| <b>Be in the moment</b>               | <b>Change feelings by changing thoughts</b> | <b>Notice your thoughts and feelings</b> |
| <b>Deal with trauma reminders</b>     | <b>Change how you think about sleep</b>     | <b>Plan something enjoyable</b>          |
| <b>Identify your values and goals</b> | <b>Change negative thinking patterns</b>    | <b>Relax through visualization</b>       |
| <b>Relax through breathing</b>        | <b>Learn to be assertive</b>                | <b>Weigh the pros and cons</b>           |
| <b>Relax your body</b>                | <b>Learn to problem solve</b>               | <b>Write to reflect</b>                  |

## Self-care is fundamental

A commitment to ongoing self-care provides a foundation for using the tools and resources outlined in this document, which are focused on responding to the immediate aftermath of a fatality. To address self-care as an ongoing priority, it is highly recommended that you consider using a tool such as *Developing Your Self-Care Plan* ([bit.ly/doselfcare](http://bit.ly/doselfcare)), which provides excellent information on the topic, as well as step-by-step guidance and practical worksheets.

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## Grief After an Overdose

Here is a summary of important issues related to grief after an overdose that can help inform assistance offered to bereaved people.<sup>11</sup>

### Grief in general

Grief involves several tasks, but they do not unfold in any particular order, and every person will experience grief in their own way over the course of their lifetime. The tasks of grief (adapted from Worden, 2009):

### Key questions

After someone dies from substance use overdose, the answers to three commonly asked questions may contribute to survivors' experiences of grief:

- "Why did this person die from substance use?"
- "Did the person intend to die?"
- "Was the death preventable?"

### Key emotions

A death from substance use can cause survivors to experience troublesome thoughts and strong feelings such as:

### Key factors

Other factors that come into play when someone dies from substance use may have a profound impact on the bereaved:

- Stigma: Negative judgments about the character of people affected by substance use can cause survivors to be mistreated or isolated.
- Disenfranchised grief: Survivors' grief can be treated as insignificant because, for example, the deceased's behavior is seen as contributing to their death.
- Trauma: Survivors may experience trauma from being involved in situations ranging from taking part in a resuscitation attempt to being exposed to media coverage of the death.

### **Tasks of Grief**

**Facing the reality of the loss**

**Coping with the pain of grief**

**Living in a world without the deceased**

**Engaging in the next phase of life**

**Exploring enduring connections with the deceased**

### **Key Emotions**

**Shock**

**Guilt**

**Abandonment**

**Disbelief**

**Hopelessness**

**Numbness**

**Confusion**

**Unfairness**

**Rejection**

**Anger**

**Fear**

**Failure**

**Shame**

**Blame**

**Helplessness**

**Relief**

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<sup>11</sup> This information is from the handout "Coping with Grief from a Substance-Use Death," available at [bit.ly/sadodprimer](http://bit.ly/sadodprimer).

### **Influence of substance use**

Even before the death, coping with substance use may begin to influence what happens to the bereaved after the death occurs:

- Dynamics of addiction: Relationships can be affected by shifting roles, crises, intense emotions, a negative world view, unmanageability, etc.
- Caregiver effects: Caring for a person at risk of overdose can affect caregivers similarly to how caring for the terminally ill affects them.
- Ambiguous loss: Sometimes, a person using substances is utterly absent psychologically in a way that resembles an actual death.

## 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](https://bit.ly/oasasguide).
- “Coping with Grief from a Substance-Use Death,” from SADOD (Support After a Death by Overdose): [bit.ly/sadodprimer](https://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](https://bit.ly/VTsupervision)
- *Developing Your Self-Care Plan*, from the University at Buffalo School of Social Work: [bit.ly/doselfcare](https://bit.ly/doselfcare)
- The Pause: See [bit.ly/deathpause](https://bit.ly/deathpause) and [bit.ly/pausebartels](https://bit.ly/pausebartels)
- *PTSD Coach Online*, from the VA’s National Center for PTSD: [bit.ly/tools4ptsd](https://bit.ly/tools4ptsd)
- “Tips for Adults after Disasters,” from the *Psychological First Aid Manual*: [bit.ly/pfatipsadults](https://bit.ly/pfatipsadults)
- “Tips for Disaster Responders: Preventing and Managing Stress,” from SAMHSA (Substance Abuse and Mental Health Services Administration): [bit.ly/responderstress](https://bit.ly/responderstress)
- *Trauma-Informed Care in Behavioral Health Services - TIP 57*, from SAMHSA (Substance Abuse and Mental Health Services Administration): [bit.ly/trauma57](https://bit.ly/trauma57).
- “Trauma-Informed Organizational Self-Assessment,” from the Trauma-Informed Care Project: [bit.ly/TICassess](https://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](https://bit.ly/TIsupervision)
- “Vicarious Trauma,” from the American Counseling Association: [bit.ly/VTsigns](https://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](https://bit.ly/vtorgreadiness)

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