Supporting Providers After Drug Overdose Death

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As part of her outpatient experience as an adult psychiatry resident, Dr. Smith is co-leading a buprenorphine group with Dr. Jones. She is excited to have the opportunity for greater exposure to patients with addiction and is considering pursuing an addiction psychiatry fellowship. As part of her 6-month rotation, she starts working with Mr. A, a 26-year-old who was stabilized on buprenorphine and recently transitioned to the weekly buprenorphine group after finishing an intensive outpatient program. Mr. A has been engaged in treatment and is eager to restart full-time work in construction. He currently lives with his parents and would like to move out to live with his girlfriend. In reviewing Mr. A's intake note, Dr. Smith notices that Mr. A's mother came to his first appointment and that a full release of information is on file to share information with his parents. During Dr. Smith's first meeting with Mr. A, she discusses his support network with him. He notes that his parents are understanding, but he is reluctant to involve them in his treatment and emphatically states, "I am an adult."

Mr. A consistently attends his individual and group appointments. After a month in care with Dr. Smith, he reports that he found a full-time job. He will not be able to continue in group but would like to continue individual treatment with Dr. Smith. Mr. A subsequently cancels his next follow-up appointment on the same day as the appointment, because of a work conflict. Dr. Smith reschedules Mr. A's appointment and asks him to complete a toxicology screen before his next appointment. Mr. A does not show up at his next appointment, and Dr. Smith notices that he never completed his toxicology screen. She calls Mr. A's cell phone but is unable to leave a message because his voicemail is full. She leaves a message on his home telephone requesting a call back. Three days later, Dr. Smith receives a message from his mother letting her know that they found Mr. A dead from an apparent drug overdose.

Dr. Smith is devastated and experiences feelings of sadness, grief, and guilt. She contacts her supervisor for the rotation, Dr. Jones, about the death but is otherwise unsure how to proceed. She also questions whether she would like to pursue further fellowship training in addiction.

Dr. Jones is also sad to hear that Mr. A died, and he too experiences self-doubt about the management of Mr. A's care and worries that he should not have assigned the case to Dr. Smith. Dr. Jones meets with Dr. Smith to provide support by listening to her talk about the case. He also shares with Dr. Smith his experience after patient drug overdose deaths. Dr. Jones encourages Dr. Smith to reach out to Mr. A's mother to offer the opportunity to meet with them. Dr. Jones subsequently files an incident report and notifies the clinic director and Dr. Smith's training director of the death.

Mr. A's mother initially declines Dr. Smith's offer to meet. Drs. Jones and Smith decide to attend Mr. A's funeral. They are heartened to hear stories about Mr. A shared by his family during their eulogies. Although they both continue to feel self-doubt about the management of Mr. A's care and sadness about his death, the feelings are less intense. Dr. Smith slowly begins to feel less anxious about the patients with opioid use disorders whom she continues to work with as part of her rotation.

One month after Mr. A's death, his mother contacts Dr. Smith to meet. During their meeting, Drs. Jones and Smith and Mr. A's mother share their sadness about Mr. A's death. Drs. Jones and Smith discuss their experience working with Mr. A. They answer questions that Mr. A's mother has about medication for opioid use disorder and review his toxicology test results at her request. Mr. A's mother thanks them for taking care of her son and for meeting with her.

Two months after Mr. A's death, Drs. Jones and Smith participate in a small quality assurance and improvement meeting with the clinic leadership. The group reviews the case, offers support to both providers, and considers as a clinic the idea of developing a protocol of steps to follow after a patient overdose death.

Four months after Mr. A's death, Dr. Smith's rotation ends. Although she feels sad when she thinks of Mr. A's death, she is able to reflect on the death in the context of his opioid use disorder and the high mortality associated with the illness. She is motivated to continue to work with patients with opioid use disorder and begins working on her addiction fellowship applications.

See related feature: **CME course** *(p. 253)*

Substance use disorders are associated with substantial morbidity and mortality, including deaths due to drug overdose (1, 2). In 2016, 63,632 individuals in the United States died of drug overdose, which brought the total number of drug overdose deaths between 1999 and 2016 to 632,331 (3). Since the majority of drug overdoses involve opioids, a key component of the public health response to the opioid epidemic has been to increase access to evidence-based treatments for opioid use disorder (4).

One barrier to accessing treatment for individuals with opioid use disorder has been a shortage of both substance use treatment programs and providers who have undergone the additional training required to receive the Drug Enforcement Agency waiver that is needed to prescribe buprenorphine/naloxone, one of the medications approved by the U.S. Food and Drug Administration for the treatment of opioid use disorders (5). Furthermore, many of the providers who complete the waiver training never prescribe buprenorphine/naloxone (6) or only prescribe it for a small number of patients (6–8). Identified barriers to prescribing buprenorphine/naloxone include limited clinical time, insufficient office support, low reimbursement, and concern about medication diversion (6, 9, 10).

One possible barrier that may be contributing to low provider engagement in the treatment of opioid use disorder with buprenorphine/naloxone is the possibility of adverse patient outcomes, such as death due to drug overdose. Although treatment with buprenorphine/naloxone has been shown to decrease the risk for overdose (11, 12), individuals with an opioid use disorder are still at elevated risk for overdose relative to the general population. As we work to engage more providers in treating individuals with opioid use disorder, it is important that providers be prepared to cope with patient deaths due to drug overdose.

To our knowledge, the provider's experience after drug overdose death has not been studied, and no practice guidelines exist to guide providers after an overdose death. The family's experience after an overdose death has been characterized in a small but growing literature (13–15). For example, the response of parents whose child died from a drug overdose has been found to be similar to that of parents whose child died from suicide (13). Both groups of parents have higher rates of characteristics associated with more complicated bereavement, such as symptoms of complicated grief, depression, and posttraumatic stress, when compared with parents whose child died of natural causes (13).

Indeed, similarities exist between deaths from drug overdose and those from suicide, including the sudden and unexpected nature of the deaths as well as the social and moral stigma associated with self-inflicted deaths. Additionally, there has been increasing concern that many drug overdoses may have been suicides (16, 17). Opioid use is associated with serious thoughts of suicide and suicide attempts (18), and the number of intentional overdoses involving opioids doubled between 1999 and 2014 (19). It is unclear, however, to what degree intentional self-harm contributes to drug overdose deaths, because drug overdoses are classified as accidental or unintentional if there is no clear evidence of self-harm intent on the day of death (16, 20). Since there are similarities between deaths from drug overdose and from suicide, and some drug overdose deaths are suicides, we will reference the existing suicide literature to describe possible provider experiences and management strategies after a patient drug overdose death.

PROVIDER EXPERIENCE

Common emotions experienced by providers after a patient suicide include shock, disbelief, guilt, shame, fear of blame, and self-doubt (21–24). One survey of psychiatrists found that 50% of respondents who had a patient in their practice die of suicide had stress levels in the weeks following the suicide that were comparable to those of people seeking treatment following a parent's death (25). In that study and others, younger providers with less experience had higher levels of stress after a patient suicide when compared with older providers with more clinical experience (25, 26). Other factors associated with increased levels of provider stress after a patient suicide include having felt close to the patient, direct exposure to the suicide through seeing the deceased patient's body, and inadequate support after the suicide (26). Support after suicide is a variable that has been found in several studies and commentaries to influence providers' reactions. Clinicians in solo practices who were more isolated from colleague support were more likely to have increased symptoms of grief (23, 27). Another theme in the literature regarding provider experiences after patient suicide is the ways in which the provider's clinical practice is affected (22–24, 28–31). A study based on structured interviews of 20 therapists who had a patient suicide in their practice (29) found that 85% were much more direct in their assessment of suicidality after they had a suicide in their practice. Countertransference reactions described in the literature that can arise when continuing to work with suicidal patients include being overly protective and conservative in assessing risk, avoiding discussing suicidality, or avoiding patients at risk for suicide (22–24, 30).

In considering provider reactions after suicide and the similarities between suicide and drug overdose deaths, it follows that providers like Drs. Smith and Jones in the vignette are likely to experience similar emotional reactions. Now that medications are available to treat opioid use disorder and can be provided in less restrictive settings, such as office-based practices, in which providers may be in a small or solo practice, some providers may be relatively isolated after a patient drug overdose death. Providers who are working in a small or solo practice with individuals with opioid use disorder may benefit from being more deliberate in creating a peer supervision/support network for emotional support and supervision to increase awareness of countertransference reactions should a drug overdose death occur in their practice.

TRAINEE EXPERIENCE

As noted earlier, younger providers with less clinical experience are likely to be more affected by patient suicide. A survey of residents (28) found that exposure to a completed suicide during their training had an impact on their emotional health and on their view of the profession, and it increased their awareness of the medicolegal aspects of psychiatry. One finding from that study that is concerning is that trainees were reluctant to use formal support, such as employee assistance programs, because of concerns about confidentiality and insurance. Another survey of trainees (32) found that 27% felt unable to ask for help after a patient suicide despite the fact that all had a supervisor to contact in an emergency and that the majority felt that someone was available to help. Although most training programs (70%) have a clear requirement that a supervisor be notified after a patient suicide, program directors may be involved less often; surveys of chief residents and program directors found that only 32% to 66.5% of programs recommend or require that the training director be notified in a timely manner (33, 34).

Few training programs have written protocols to guide trainees and educators on steps to take to support trainees after a patient suicide. In a national survey of chief residents (34), training programs that had written protocols to follow after a patient suicide were found to be more likely than programs without written protocols to have implemented procedures to support trainees, such as timely notification of the program director, process sessions, therapy or counseling, and emergency leave. An example of a training program protocol, created by the National Capital Consortium psychiatry residency in response to an increased rate of military suicides, has been described in detail (35). Written protocols on procedures to follow after adverse events such as a patient suicide or drug overdose death may help programs better support trainees. Additionally, because residents may struggle to reach out for support after a suicide or drug overdose death, it is important that training directors be notified of such adverse events, as Dr. Jones notified Dr. Smith's training director in the vignette. This allows the training director to reach out to the trainee and to monitor the impact of the death on the trainee over time, since supervisors like Dr. Jones may not work with individual trainees longitudinally.

In studies in which residents and training programs were surveyed about training on suicide, most (91% to 94%) reported that formal teaching on suicide risk factors was provided (33, 36). However, training in postvention—interventions to support the bereaved after suicide—was less common and existed in only 25% to 47% of programs (33, 36). Several postvention curricula have been described in the literature (37–39). These programs have been well received by residents and were found to be associated with improved knowledge on how to cope with a patient suicide (37, 38) as well as increased self-competence in how to manage the emotional, clinical, and medicolegal issues that arise after patient suicide (37). As the field of psychiatry works to increase trainee interest and training experiences in addiction psychiatry, the literature suggests that it is important for training programs to develop or strengthen postvention curricula to support trainees after suicide and drug overdose deaths.

INTERACTING WITH FAMILIES

Concern from family members or close friends is often the catalyst that leads individuals with substance use disorders to engage in treatment, and social support is a key component to helping patients sustain change. At the point of initial treatment engagement, providers should encourage the patient to involve a support person in their care. At a minimum, this would include a release of information, allowing information to be shared between the provider and the support person should concerns arise. Opening lines of communication between the provider and the support person can be important if the patient is struggling in treatment.

After an adverse outcome such as death from drug overdose, providers may assume that families will blame them, and they may feel reluctant to reach out to or meet with the patient's family. One study in which therapists of patients who died by suicide were surveyed (24) found that most therapists expected anger and criticism from families. However, as in the case of Drs. Smith and Jones in the vignette, when these therapists met with families, most of the relatives were not critical of the therapist and expressed gratitude for the help provided. If a provider is contacted by a family after a patient drug overdose death, it is important to respond. In a review of litigation after suicide, Gutheil (40) noted that families were sometimes motivated to file a malpractice suit to access information to help them understand their loss when providers were not responsive to family members' attempts to contact them.

If a family member was part of the patient's treatment, it is important for providers to offer the option to meet with family members, since families may feel isolated by stigma as they grieve. If a patient's family was not part of their treatment but it was clear that the family knew that the patient was in treatment, reaching out with a telephone call or a 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 one way to help families and physicians cope with a patient's death (41). When interacting with family members, providers need to be aware that the confidentiality provisions of the Health Insurance Portability and Accountability Act continue after the death of the patient. If it is unclear whether a patient's family knew that the patient was engaged in substance use treatment, it is important to honor the patient's confidentiality and not contact the family until this can be elucidated.

When communicating with families, providers should focus on addressing the family members' feelings about the patient's death to help support the family's grieving process

(42). If a full release of information is on file for a family member, as there was for Mr. A's parents in the vignette, or the family member is the legal executor for the patient, a provider can answer specific questions about a patient's course in treatment. In states with apology statutes, providers can express sadness and sympathy without fear of malpractice, since expressions of sympathy are not admissible as evidence of an admission of liability in a civil lawsuit (43). When communicating with a contentious family, it is important to avoid self-incriminating or self-exonerating statements, since this can cause additional stress to the family (42).

Providers can also consider attending a patient's funeral after a drug overdose death, as Drs. Smith and Jones did. Surveys of providers who experienced a suicide in their practice found that funeral attendance was relatively uncommon, with rates ranging from 2% to 14% of providers (21, 28, 31, 44). The literature does suggest, however, that funeral attendance after a patient suicide can help families and providers mourn and work through their grief after suicide (24, 31, 45, 46). As noted by two primary care providers (47), funeral attendance is a gesture of respect to the deceased that is appreciated by families. Furthermore, they describe experiences where their funeral attendance allowed family members to follow up with the providers to discuss their experience surrounding the death, which may help family members process their grief. In a commentary describing the psychiatrist's role after patient suicide, Kaye (46) described feeling welcomed by a patient's family at the funeral and finding it helpful to learn more about the patient through other people's memories.

SUPPORT FOR PROVIDERS

As noted earlier, it is important for providers to receive support from colleagues after a drug overdose death. After a patient suicide, providers have found it helpful to discuss the case with colleagues and to hear other providers' experiences with patient deaths from suicide (48). This can also be helpful after an overdose death, as in the example of Dr. Jones listening to Dr. Smith discuss Mr. A's case and sharing his experiences after patient overdose death. Although it may be tempting to provide reassurance to a provider after a patient's drug overdose death, premature reassurance that a provider did nothing wrong after a patient's suicide has not been shown to be helpful (23, 24). In addition to colleagues, a provider's family and friends have been identified as a source of support after a patient suicide (28, 31). While patient confidentiality regulations limit what information can be shared, providers can still disclose that an unexpected death occurred and can discuss their emotions about the death with family and friends.

If a provider is working within a treatment system, it is important to file an incident report after a patient drug overdose death, as Dr. Jones did in the vignette. A quality assurance and improvement meeting after the incident report can be helpful to facilitate learning, improve patient care, and bring closure to the provider who treated the deceased patient (46). Quality assurance and improvement meetings are confidential, and the content that is discussed in the meeting is privileged information that cannot be subpoenaed in a malpractice lawsuit. Care needs to be taken to be sensitive to the timing and tone of the quality assurance and improvement meeting to avoid shaming the provider or worsening provider doubt (49).

Providers working in a small or solo private practice should consider contacting their malpractice insurance carrier regardless of whether there was a contentious interaction with the deceased patient's family.

RECOMMENDATIONS FOR THE FUTURE

Providers who work with patients with opioid use disorders need to be prepared for a drug overdose death in their practice. Providers should consider their practice setting, develop a protocol of steps to take after a patient drug overdose death, and identify and strengthen their support system. It is important that providers seek support for themselves after a patient drug overdose death to minimize the psychological trauma associated with the death. They also need to be prepared to support colleagues who worked with the deceased patient, as well as the deceased patient's family.

The larger health care system also has a role to play in supporting providers by creating a culture that supports routine reviews of adverse outcomes to identify opportunities for change and improvement. For providers in private practice, this may involve incorporating quality improvement and assurance discussions into peer supervision, or perhaps establishing opportunities for consultation with local psychiatric societies. There could even be a role for incentives from malpractice insurers or health insurers to provide discounts or greater reimbursement, respectively, for providers who incorporate into their practice quality assurance and improvement projects or reviews after adverse events.

There is a need for increased research on the impact of drug overdose deaths on providers and families. Formal training in postvention needs to be strengthened in residency training programs as well as in continuing medical education, particularly when education on evidence-based practices for the treatment of opioid use disorder is being provided. Finally, we would all benefit from discussing adverse events more regularly, so that no one is worrying alone about a past event or the possibility of a future adverse event. Provider distress after an adverse patient event is particularly relevant in the current era of increasing rates of provider burnout, since distress after an adverse patient event can be a contributing factor (50). We need to do better with supporting one another and to work together collectively as a field to identify ways to improve our practices and system of care as we care for patients at risk for adverse events such as unexpected death.

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