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BUREAU OF JUSTICE ASSISTANCE (BJA) DRUG COURT CLEARINGHOUSE/TECHNICAL ASSISTANCE PROJECT

FREQUENTLY ASKED QUESTIONS SERIES: Dealing With the Death of a Drug Court Participant

Subject: Dealing With the Death of a Drug Court Participant
From: BJA Drug Court Clearinghouse/Technical Assistance Project
Date: February 4, 2013

The following inquiry raises an issue which many programs have, unfortunately, had to confront: dealing with the death of a drug court participant.

Inquiry

Occasionally, we will have to deal with the death of a drug court participant. We were wondering if you could point us in the direction of any resources/publications that might be helpful to drug court teams as they cope with the grief of losing a client as well as resources for helping participants deal with this loss. We have resources for generally dealing with grief, but they don't deal with the additional complexities when a mental health professional is experiencing grief and loss about a client they had helped to treat or when a program participant is dealing with this situation. Any information you can provide and any experiences of other drug courts would be very helpful

To date, responses from 17 programs across 12 states, and an additional response from Jamaica have been received. Almost all programs noted the tremendous difficulties programs experienced when a participant died. The importance of maintaining professional composure among team members was stressed, as well as making sure both staff and other participants receive grief counseling as necessary and be able to express their grief. In most situations, counseling was either provided through program based groups or through referrals to community counseling providers or local hospitals. One respondent also encouraged other practitioners to understand that they "cannot take any credit for those who make it or for those who do not." Two of the responding programs indicated they had not experienced this situation.

It appears to be a common practice among programs to have grief debriefing sessions with both the team and participants after a death. Many programs also noted that judges and team members frequently attended funeral services and/or extended condolences to the families and friends of the diseased. Noted also, was the importance of recognizing the impact death has on participants with co-occurring disorders and the need for training on this issue to address the needs of all those effected.

RESPONSES

UNITED STATES

ARKANSAS

Donnie Scott, Advisor
Saline County Drug Court
Hot Springs, AK
Donnie.scott@arkansas.gov

As a professional we cannot take any credit for those who make it or for those who do not. This is not of our power. This is a lesson I had to learn early in my career.

CALIFORNIA

San Bernardino County

Debora Cima
Treatment Court Coordinator
Superior Court of California, County of San Bernardino
San Bernardino, CA
dcima@sb-court.org

Victoria Montgomery
Program Manager
Redlands Center for Change
Redlands, CA
vmontgomery@mhsinc.org

As Program Manager, I had to first make sure my staff was ok. We didn't want the staff to be falling apart in front of the clients. Although (in most cases) it is very shocking and sad when a client passes away, it happens, and it is important for us to be there for our clients, first and foremost, so my first concern was to make sure the staff was able to function in their positions. I surveyed them, and told them if they didn't feel well enough to work to take some time off.

None of my staff wanted/needed time off, and were able to help the group members process through this difficult time. We of course extended our deepest sympathies to the family of the deceased and continued to offer assistance to them should they need referrals, etc. I also personally called the family members whenever possible to follow up.

We also had the support of our Home Office (a crisis intervention team) when one of our clients suddenly committed suicide. This was very helpful. As they were not personally involved with the client, they were able to come in and make sure staff was healthy and help us process the grief with our clients.

Unfortunately, death, dying and grieving is a part of life that we deal with frequently in recovery, and I feel that more trainings should be offered for counselors in the areas of grief, loss and death. I believe that people don't think about it until someone in the program passes away, and then counselors are ill prepared.

Karen O'Rear
Program Manager
Victor Valley Center for Change
Victorville, CA
korear@mhsinc.org

This is an issue that none of us want to face but we have to remember that we are role models in every aspect of the process. For myself, I deal with the issue of what could I have done…maybe I should have…if I had to do it over I would have…and then I realize that it isn't about me or what I did or didn't do. It is about the friends and family that are left behind. Empathy and compassion! We deal with the client's in a group and then follow up in an individual session. Then the next few groups we deal with memories and sadness and bring the clients back to the positive impact and the fun times that were shared with the individual. We have a local hospital that we will refer the clients to for free grief counseling and a crisis center with counselors on duty 24 hours a day, seven days a week.

Believe me, the same that is done with the clients, the staff pulls together and does the same processing because it is a heart-breaking tragedy and we have to be ready to help the clients heal. We have a company that provides services for employees also.

Santa Clara County

Judge Stephen Manley
Santa Clara County Superior Court
San Jose, CA
smanley@scscourt.org

We have one or more deaths each month and many are tragic. We have outstanding grief counseling programs in our county.

This inquiry highlights a major issue that is often not given enough attention -the loss of a family member or close friend has a profound effect on the mentally ill and those addicted. Every treatment court should have a grief program in place as much a part of the overall program as relapse prevention or aftercare. It is also important to note that a participant will not necessarily immediately benefit from these programs and coercion or mandates are not wise. Patience is important.

Two other observations that may help:

First, I think that if a drug court is concerned about this issue, an important resource is local hospitals. Physicians and nurses treat many terminal patients in hospitals. I have noted that doctors and nurses often become very close to patients particularly when they are repeatedly in and out of the hospital with a chronic and reoccurring illness that is terminal. They must deal with this issue on a daily basis, and may well have staff willing to make a presentation and offer advice to a drug court team.

Second, I have repeatedly noted that as a field we need to recognize that in comparison to 10 years ago, we are often working with clients who have co-occurring disorders that go far beyond our typical discussion of treating mental health and substance abuse. I have a very large number of participants who, in addition to substance abuse and mental health, suffer from seizure disorders, diabetes, Hepatitis C., MRSA, HIV, cancer, liver failure, strokes, heart conditions, etc., that often end with death at a relatively early age. We need to expand our horizons.

In my programs we often expend far more effort in trying to obtain medical care for a co-occurring disorder client than in placing them in substance abuse and/or mental health treatment.

COLORADO

Doug Hanshaw
Problem Solving Court Coordinator
Seventh Judicial District
Montrose, CO
Doug.hanshaw@judicial.state.co.us

I think specific to the provider/practitioner, supervision is a good place to start. There should be a supervisory relationship in place whether they work for an agency or a solo practice. For the broader team, I suggest bringing in a therapist with some training in this area.

Critical Incident Stress Management is a formal model that includes de-briefing. The CISM structure is Defuse (almost immediately assure them of their safety and normality of the response), Debrief (process the incident within 72 hours), and Follow up (by a therapist within a week). The research on CISM is not very encouraging.

In my former job at the regional mental health center we used critical incident de-briefing and follow-up in our communities for suicides and trauma deaths. To debrief we used one or two master's level clinicians depending on the issue and the number of people affected. The simplest form is to offer voluntary participation both to attend and to participate. I think some people might want to debrief individually, others in a group. Group participants sit in a circle and take turns talking about what they experienced (senses) what they thought (interpretations) and what they felt (including the pain of prior losses or trauma). This process is best done by someone from outside the program. It may open the door to referrals to counseling for some participants.

There is often additional training in related areas depending on your state. Here in Colorado I went through a mental health first responder course that included training in crisis management and how to integrate with a local disaster incident commander. The emphasis was on first responder safety and preventing secondary incidents on-site. We also have a one-day training called mental health first aid that is about how to recognize people with psychiatric conditions, prevent escalation, and refer to treatment. Getting this kind of training can help normalize these situations and our reactions to them in my opinion, as well as increase the odds of staying safe and being part of the solution in a crisis.

I think the attitude with which we approach our work every day is at least as important as how we manage the death and loss and grief that are part of the landscape. Early on I decided not to take much credit for my patients' successes, nor much blame for their relapses and other behaviors. Showing up and doing my best is all that I can do, and people are going to chart their own course in life with or without my consent. It is up to us to have good boundaries, good supervision, good self-care, and the ability to move on from loss so we don't miss all the good that our career of service offers. We also need to know when to reach out for help.

Here is a resource I found while researching DEC issues:

The National Child Traumatic Stress Network offers additional resources for clinicians and other professionals working with families and communities where violence or disaster has occurred, including online training opportunities http://learn.nctsn.org/course/category.php?id=3.

Other resources on its Web site include a video to train police for when they are responding to a situation of domestic violence that includes children

http://www.nctsn.org/nctsn_assets/acp/dv/NCTSN_DV_rev1.htm#.

Barbara Pevny, MA, LPC
Family Court Therapist
Southern Ute Tribal Court
Ignacio, CO
bpevny@southernute-nsn.gov

In situations as these, I have used grief/trauma and loss debriefing sessions with colleagues along with education around the normal stages of grief. Debriefing the incidents leading up to such a loss and the check-ins offered to a client appears to help professionals learn more about their own limitations in treatment, their sense of attachment to outcomes of a client, and the inevitable facts of not always knowing the totality of the outer and inner life of a client. As colleagues we also can debrief whether there was a systems breakdown that needs further consideration or repair and acknowledgment that professional support systems are not enough for clients and that more family/friends support is needed to truly engage clients to maintain their sobriety and their hope

MICHIGAN

Marcia Kane, MA LPC, CCJP
Drug Court Caseworker
Berrien County Trial Court
St. Joseph, MI
mkane@berriencounty.org

We have had several overdose deaths in our community recently, including a Drug Court participant, and had these same questions.

MINNESOTA

Judge Leland Bush
Lyon County District Court
Marshall, MN
Leland.bush@courts.state.mn.us

We have not ever had that experience.

MISSOURI

D. Craig Hogg, Counselor
Adair County Drug Court
Kirksville, MO
Craig.hogg@courts.mo.gov

I recommend the workbook titled "Good Grief." The author is Cecil W. Fike from Fike Press. We use it in our "grief" group and it is very thorough and helpful.

MONTANA

Brenda Desmond
Standing Master
4th Judicial District Court
Missoula, MT
bdesmond@mt.gov

We once lost a youth to suicide in our youth drug court. We brought in a grief counselor who specialized in post-suicide counseling for the other participants following the next court session. We also encouraged the other participants to go to the funeral if they wished. The court coordinator and one judge attended the funeral. Very difficult event.

Janet Meissner
Executive Director
Alliance for Youth
Eighth Judicial District Drug Court
Great Falls, MT
Janet_meissner@gfps.k12.mt.us

Montana's Eighth Judicial District unfortunately has experienced deaths of three participants over the course of our 8 year program tenure. The Team and participants utilized normal counseling/grief therapy avenues. We have dedicated drug court activities to the deceased participants. This is truly a difficult and challenging situation.

NEW HAMPSHIRE

Robert Gasser
Drug Court Coordinator
Grafton County Drug Court
North Haverhill, NH
ragasser1@yahoo.com

I think it depends on the circumstances; in New Jersey (where I served as prosecutor in a local drug court) I had an older (65) client pass away from natural causes and I accompanied the Judge and others to the church services. Here in Grafton, someone we released from the program to ordinary probation because his cognitive skills were not sufficient to do the program, committed a new crime and then committed suicide. We honor him with a picture on our wall with his child.

NORTH DAKOTA

Marilyn Moe
State Drug Court Coordinator
North Dakota Supreme Court
Bismarck, ND
mmoe@ndcourts.gov

Unfortunately, North Dakota Juvenile Drug Court has dealt with two participants who committed suicide. In the first case, the team was devastated and I offered counseling for the team; the judge, however, refused to let me bring someone in. The court never gained its confidence back and we eventually closed it because of lack of referrals. There were other reasons for it closing but the prosecutor told me that he felt the team just never got it back after that. In another scenario, the participant committed suicide and one of our trackers was the one who found him and had to tell the mother. I insisted this time on bringing in a counselor who was not affiliated with the treatment providers on the team and who was experienced in grief counseling. The team met one evening for dinner, and processed the whole situation with the grief counselor. There were lots of tears, lots of discussions and all very thankful for the chance to process it together.

TEXAS

Georgia Kimmey, Attorney at Law
Coordinator
Angelina County Drug Court
Lufkin, TX
gkimmey@angelinacounty.net

In Angelina County, we have had three participants die within about a five year span. Our program is eight years old. All were recent graduates in their second year of the program (aftercare). Two died

in car accidents, and one on a motorcycle. In two of them, alcohol was a component, and in the other, marital problems contributed to reckless driving. Our team was shocked and saddened by all of them. We attended the three funerals. After the last one, for the graduate who died on a motorcycle, his mother came to court one night and spoke about how Drug Court had really helped her son, how everyone in the program needed to take it seriously and stay sober for life, and how fleeting our chances are to correct mistakes we've made. It was unexpected and very touching. Our Judge makes a habit of telling each new participant, that there only two ways they can get out of drug court, unless they graduate of course – prison or death. There are only two things you can be certain about when it comes to a life devoted to drugs and alcohol – prison or death.

VIRGINIA

Leslie Pryor
Probation and Parole Officer
Richmond Adult Drug Treatment Court
Richmond, VA
Leslie.pryor@richmondgov.com

We've had to deal with the death of a participant several times here in Richmond, Virginia. As one might expect, there is no formula for dealing with grief. As you noted, the death of a client can be difficult on a professional as well. Often times, staff, participants and other members of the team will attend the funeral services of a participant and we also try to process and discuss the loss in our treatment groups. We have a few books that we often share with clients about death as we deal not only with clients dying but their family members and significant others.

WASHINGTON

Marcy Brown, MA, CDP
Treatment Court Coordinator
Thurston County Family Court
Tumwater, WA
brownm@co.thurston.wa.us

I'm sorry but I don't have anything here. Am looking forward to what folks have as a response.

INTERNATIONAL

JAMAICA

Dr. Myo Kyaw Oo
Program Manager
Drug Court Treatment and Rehabilitation Program
Kingston, Jamaica
myokyawoo@yahoo.com

Regarding dealing with the loss due to death of clients, we so far had two clients die recently over the past 11 years. One of the decedents was already in the programme and one was in the process of entering. We do not have any formal protocol to deal with the grief for the remaining clients as well as staff.. Both the legal and treatment team members had a sort of ventilation session during a pre-court meeting ,and during the actual session, we recognized the departure of these individuals with a minute of silence. Some members attended the service to show support to the grieving members of the family.

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We welcome any additional information and/or perspective readers may have on this topic.

BJA Drug Court Clearinghouse and Technical Assistance Project
Justice Programs Office, School of Public Affairs
American University
4400 Massachusetts Avenue NW, Brandywine, Suite 100
Washington D.C. 20016-8159
Tel: 202/885-2875Fax: 202/885-2885
e-mail: justice@american.edu Web: www.american.edu/justice