Nevada Opioid Center of Excellence
CASAT | School of Public Health

PARTICIPANT PACKET

Supporting Behavioral Health Providers

Recovery, Strength, and Postvention Strategies for Healing After Losing a Client to Suicide or Opioid Overdose

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Webinar | Wednesday, May 20, 2026 | 11:00 AM to 1:00 PM Pacific

Presented by the Nevada Opioid Center of Excellence (NOCE) at the Center for the Application of Substance Abuse Technologies (CASAT), University of Nevada, Reno School of Public Health, in partnership with the Suicide Prevention Resource Center (SPRC) Lived Experience Advisory Committee.

Featured Presenter

Bianca D. McCall, M.A., LMFT | National Best Practices Reviewer | SPRC Lived Experience Advisory Committee

Featured Voices in the Video Series

- Marlon Rollins, PhD, LPCC, LMHC | Suicide Loss Survivor
- Lisa St. George, MSW, CPRP, CPRSS| SPRC Lived Experience Advisory Committee
- Bianca D. McCall, M.A., LMFT | SPRC Lived Experience Advisory Committee
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Care notice. This packet contains material on mental health crisis, substance dependency, injury, suicide, and overdose. Please proceed with care. Take breaks. Step away from your screen. Ask for support. The depth of your engagement is your decision. Confidential support resources are listed on the final pages.

Agenda at a Glance

This webinar is co-facilitated. Breakout rooms will be assigned by the host. You will be returned to the main room for each video segment. Discussion rounds inside breakouts are timed by your breakout facilitator.

TIME	SEGMENT	FORMAT
11:00 to 11:05	Welcome, care contract, and webinar orientation	**Main room**
11:05 to 11:10	Series overview and PROMPT 1: Naming the loss in the room	**Main room**
11:10 to 11:15	VIDEO 1: Marlon Rollins on resilience and Root Cause Analysis	**Main room**
11:15 to 11:23	PROMPT 2: Culture, safe messaging, and honoring the client	**Breakout**
11:23 to 11:30	PROMPT 3: Confidence, emotional impact, and self-compassion	**Breakout**
11:41 to 11:45	VIDEO 2: Lisa St. George on peer connection	**Main room**
11:45 to 11:52	PROMPT 4: Collective support and the meaning of suffering	**Breakout**
11:52 to 12:00	PROMPT 5: Survivors remorse, lived experience, and healing	**Breakout**
12:03 to 12:07	VIDEO 3: Bianca McCall on workplace culture of preparedness	**Main room**
12:07 to 12:20	Storytelling, identity, vulnerability. PROMPT 6 (Vulnerability)	**Main + Breakout**
12:20 to 12:25	VIDEO 4: Anna Leiber on recovery and meaning making	**Main room**
12:25 to 12:30	PROMPT 7: Recovery, meaning making, the full story	**Breakout**
12:30 to 12:35	PROMPT 8: Blame, family reactions, the whole person	**Breakout**
12:35 to 12:55	RCA Activity: Sample scenario, Fishbone, Five Whys	**Breakout**
12:55 to 1:00	Debrief and close	**Main room**

Discussion Prompt Cards

Each prompt is sized for 5 to 10 minutes inside your assigned breakout room. Your breakout facilitator will time the rounds and bring everyone back to the main room. If a prompt activates strong emotion, you are permitted to step out. Crisis resources are on the final page.

PROMPT 1
After series overview, before Video 1

Naming the Loss in the Room

Round 1 (4 min, breakout) Introduce yourselves with one sentence: name, role, one type of loss your team has navigated in the last 24 months. Do not name a person. Name the type of loss.

Round 2 (2 min, pairs) One word for what you are bringing into this webinar today.

Round 3 (2 to 4 min, full webinar) Volunteers share their word in the chat or unmute. We witness. We do not analyze.

PROMPT 2
After Video 1

Culture, Safe Messaging, and Honoring the Client

Round 1 (3 min, breakout) How have your cultural experiences shaped your comfort with discussing suicide and overdose? What language did your family use. What language did your community avoid.

Round 2 (3 min, breakout) What language defaults do you hear in your team when communicating about a death? Name a specific phrase you would like to retire.

Round 3 (2 to 4 min, full webinar) Drop into the chat one safe messaging practice your team does well, and one you want to install before the end of the month.

PROMPT 3
After Video 1, second prompt

Confidence, Emotional Impact, and Self-Compassion

Round 1 (3 min, solo) Write one moment when you knew the protocol but could not feel confident executing it because emotional impact was running the room. Keep it private. Just write.

Round 2 (3 min, pairs) Without sharing the story, share what you learned about yourself. What did you wish your organization had offered within the first 72 hours after a loss?

Round 3 (2 to 4 min, full webinar) Name one postvention support that is readily available to you. Name one that is not but should be. Be specific about who would authorize it.

PROMPT 4
After Video 2

Collective Support and the Meaning of

Suffering

Round 1 (4 min, breakout) When Lisa names suffering as something that overcame the person, what shifts in your interpretation of responsibility? Where does the reframe help. Where does it not.

Round 2 (4 min, breakout) Design a standing healing community for providers in your region. Who is in it. How often does it meet. Where does it meet. Who funds it. Be concrete.

Round 3 (2 min, full webinar) Share one thing your organization could do in the next 30 days. Funded. Owned by a named person.

PROMPT 5
After Video 2, second prompt

Survivors Remorse, Lived Experience, and Healing

Round 1 (3 min, solo) How have your personal experiences shaped the way you would process a client death? You do not need to share unless you choose to.

Round 2 (3 min, pairs) Name a culturally grounded or family centered healing practice from your lineage that could strengthen team postvention. Examples: ancestral remembrance, communal meals after loss, storytelling, music, prayer, somatic movement, time at the water.

Round 3 (2 to 4 min, full webinar) One practice your team can pilot. Name it. Date it.

PROMPT 6
After Video 3, before Video 4

From Vulnerability to Compassion in Postvention

Round 1 (3 min, pairs) Name a moment when a supervisor or colleague was vulnerable about a client loss in front of you. What did that model? If you have never witnessed it, name that too.

Round 2 (3 to 5 min, full webinar) What is one structural permission your organization could grant in the next 60 days to make vulnerability safer after a death? Examples: 72-hour and 30-day debrief windows, paid clinical processing time, blame-free supervision protocols, a peer-led postvention pod, six and twelve month check-ins.

PROMPT 7
After Video 4

Recovery, Meaning Making, and the Full Story

Round 1 (3 min, solo) How have client deaths shaped your sense of identity in this work? Most honest version, not the job-interview answer.

Round 2 (3 min, pairs) What support helped you regain clarity, purpose, and confidence after a difficult clinical loss?

Round 3 (2 to 4 min, full webinar) One support to add to your organization's playbook at 30 days, 90 days, and 365 days.

PROMPT 8
After Video 4, second prompt

Blame, Family Reactions, and the Whole Person

Round 1 (3 min, breakout) Without naming a case, describe a moment you feared family blame or organizational scrutiny after a client death. What did you do with that fear. What did your organization do.

Round 2 (3 min, breakout) What practices help you remember the client as a whole person? Photos. Anniversaries. Naming rituals. Treatment review with a strengths lens. Letters that never get sent.

Round 3 (2 to 4 min, full webinar) One commitment your team will make to the families of clients lost in the next 12 months. Specific. Reasonable. Willing.

Root Cause Analysis Activity

Postvention is prevention. A Root Cause Analysis is not a fault-finding process; it is a learning process aligned with SPRC postvention guidance, the 2024 National Strategy for Suicide Prevention, and the Joint Commission, CMS, and VHA frameworks for sentinel-event review.

Your task

1. In your assigned breakout room, designate three roles: a timeline lead, a Fishbone lead, and a Five Whys lead. Spend two minutes assigning.
2. Read the sample scenario silently (5 minutes). Mark moments on the timeline that feel clinically significant.
3. Complete the Fishbone Diagram (10 minutes). Identify contributing factors across the five categories. Breadth, not perfection.
4. Complete the Five Whys (5 minutes). Select one factor from your Fishbone. Ask why five times. Land on a system, not a person.
5. Identify one corrective action and one lesson learned. We will share themes in the main room at close.

Sample Scenario: Client M

This scenario is fictional. Any resemblance to actual persons or cases is coincidental. It is composed to mirror the clinical patterns that the SPRC fact sheet, the CDC OD2A literature, and the SAMHSA Overdose Prevention and Response Toolkit recommend agencies review.

Client profile

- Client M is a 34-year-old non-binary client, recently relocated to Northern Nevada from a tribal community in the Western US.
- Presenting concerns at intake six months ago: opioid use disorder, history of two prior overdoses (both reversed with naloxone in community), unresolved grief from the loss of a sibling to overdose two years prior, intermittent suicidal ideation, no prior attempt documented.
- Engaged in outpatient services at a community behavioral health agency. Plan included weekly individual therapy, twice-weekly buprenorphine appointments via telehealth, and optional weekly peer support.
- Insurance: Medicaid managed care. No private therapist. No family support local. Lived alone in studio apartment.

Treatment team

- Primary clinician: 11 months post-licensure, no prior client death. Caseload approximately 38 active clients.
- Prescriber: Telehealth-only, contracted, sees clients across three states.
- Peer specialist: Available in scheduling, not assigned by default at intake.

- Supervisor: Two clinical supervisors over the past six months due to organizational turnover.

Timeline of the last 90 days

- Day -90: Routine session. Client M reports two weeks abstinent. Anniversary of sibling's death is in three weeks. Clinician notes increased grief, no SI endorsed. Safety plan reviewed, updated copy in chart.
- Day -76: Sibling's death anniversary. Client M no-shows individual session and buprenorphine appointment. No outreach documented for 48 hours. Standard reminder text sent on day -74.
- Day -73: Client M returns. Reports one slip on opioids over the weekend. Naloxone refill discussed. Peer specialist offered, declined by client. Buprenorphine continued. Safety plan reviewed verbally, no documented update.
- Day -60: Client M misses prescriber telehealth visit, citing connectivity. Reschedule is set for two weeks out due to prescriber's limited availability. No bridging dose protocol documented.
- Day -56: Client M attends individual therapy. Discloses passive suicidal ideation tied to grief and 'feeling like a burden.' Clinician completes C-SSRS, ideation positive without plan or intent. Safety plan re-reviewed. Lethal means counseling discussed. Naloxone confirmed in home. Peer specialist offered again, declined.
- Day -55 to -45: Three sessions held. Theme: ambiguous grief and identity dislocation. No SI endorsed in last two sessions. Clinician documents 'stable.' Supervision occurs once in this window, focused on caseload audit, not on Client M.
- Day -44: Client M misses individual session. Outreach text sent same day. No call. Voicemail not full.
- Day -42: Client M arrives at next session. Reports 'rough week.' Returned to opioid use. Used alone. Did not call peer or clinician. Clinician completes new C-SSRS, ideation positive, plan and intent denied. Safety plan updated in chart. Naloxone reviewed. Family contact not updated (none listed).
- Day -35: Prescriber visit held. Buprenorphine continued. No coordination note between clinician and prescriber regarding the slip on day -42. EHR does not push alerts across the two specialties.
- Day -21: Client M attends individual therapy. Emotional but engaged. Speaks about 'wanting to do right by my sibling.' Safety plan reviewed. Clinician feels session was strong.
- Day -10: Client M no-shows individual session and peer support outreach call. Standard text reminder sent. No phone outreach by clinician (caseload load high, organizational policy is one text and one voicemail before disengagement workflow at 14 days).
- Day -3: Building manager performs welfare check after neighbor reports concern about smell. Client M is found deceased. Manner of death listed by coroner as accidental overdose, fentanyl-contaminated heroin, with elevated benzodiazepine co-presentation.
- Day 0 (today): Agency convenes initial debrief. Primary clinician is offered three days off and a referral to EAP. Supervisor sends a team-wide email summarizing the death in two sentences. No formal RCA scheduled. No outreach to client's tribal community of origin.

Initial framing questions for your team

- Is this a suicide loss, an overdose loss, or both? Why does that framing matter for postvention?
- What contributing factors do you see across communication, policies, training, care planning, and culture?
- What postvention infrastructure should be activated within the first 72 hours, within 30 days, and within 6 to 12 months?
- How will the agency engage Client M's tribal community of origin in culturally appropriate notification, with consent and dignity?
- Where does the primary clinician need support? Where does the supervisor need support? Where does the agency need to change its system?

Fishbone Diagram Worksheet

Map contributing factors across the categories below. Add as many factors as your breakout room can name in 12 minutes. Breadth, not perfection.

Communication	Policies	Training	Care Planning	Culture

Optional categories to consider beyond the five headers: Equipment and information access. Documentation and handoff. Workforce capacity. Insurance and access barriers. Cultural and community context. Family and natural supports. Pharmacology and continuity of MAT. Crisis response infrastructure.

Five Whys Worksheet

Select one contributing factor from your Fishbone. Ask why, five times, until you reach a root condition. The discipline is to land on a system, not a person. If your answer at any level is a person's name, ask why again.

Contributing factor selected	
Why #1	
Why #2	
Why #3	
Why #4	
Why #5 (Root cause)	
Proposed action plan	

Suicide and Opioid Overdose Postvention Crosswalk

The SPRC video series is built around suicide loss. NOCE has integrated opioid overdose loss into the curriculum because postvention skills, evidence base, and dignity practices transfer. Use this crosswalk as a reference when adapting your agency's postvention plan.

For Loss Survivors: Family, Peers, and Providers

SUICIDE LOSS POSTVENTION	OPIOID OVERDOSE LOSS POSTVENTION
Validate the provider. Avoid blame. Honor the client as a whole person. Support for 6 to 12 months minimum (SPRC).	Same validation arc. Add explicit stigma-reduction protocols. Address ambiguous loss and disenfranchised grief from drug-related death (Templeton et al., 2018; O'Callaghan and Lambert, 2024).
Coalition of Clinician Survivors at the University of Washington offers structured peer support.	Hazelden Betty Ford grief and addiction research; eight-session Grief Support Model for overdose bereavement using ambiguous loss framework.
Safe messaging guidance from SPRC and the National Action Alliance.	Add naloxone education for family survivors. Discuss continued access to MAT for surviving peers. CDC OD2A next-of-kin social workers can support.
Structured debrief windows at 72 hours, 30 days, 6 months, 12 months.	Add anniversary trauma planning. Anniversary of sibling, parent, or partner death is a documented high-risk window for surviving peers in OD bereavement literature.

For Attempt Survivors and Overdose Survivors

SUICIDE ATTEMPT FOLLOW-UP	OPIOID OVERDOSE SURVIVOR FOLLOW-UP
Safety planning intervention. Caring contacts. Lethal means counseling. C-SSRS at every visit.	MINI screening for OUD post-naloxone reversal. ED-initiated buprenorphine where indicated (SafetyNet). Outpatient warm handoff. Naloxone education at discharge.
Lived experience peer support, including SPRC Lived Experience Advisory Committee resources.	Peer Intervention to Link Overdose Survivors to Treatment (PILOT). Trained peer specialists deploy motivational interviewing to reduce repeat overdose.
Long-term clinical engagement and integrated care.	Continuity of MAT through transitions. Anticipate withdrawal during reversal and titrate naloxone per 2025 American Heart Association guidance.

For Providers: Occupational and Organizational

CLINICIAN AFTER CLIENT SUICIDE LOSS	CLINICIAN AFTER CLIENT OVERDOSE LOSS
Occupational death trauma research: approximately one in three behavioral health providers exposed to a client death. Elevated PTSD symptom prevalence.	Same exposure profile. Often higher acuity in providers with personal recovery history. Confidential occupational health pathway needed.
Moral injury independently associated with provider suicidal ideation in high-stress occupations (2025).	Same evidence applies. Stigma magnifies moral injury in overdose loss. Acknowledge openly inside debrief structures.
Root Cause Analysis as a postvention learning tool. Joint Commission, CMS, VHA frameworks.	Same framework. Add MAT continuity, overdose education, and harm-reduction policy review categories to the Fishbone.

Resource Sheet

Curated resources for postvention planning, provider support, and overdose response. Bookmark this page or save the PDF.

SPRC and National Suicide Prevention

- SPRC Fact Sheet: Supporting Behavioral Health Providers (the fact sheet that companions this series)
- SPRC: Provide for Immediate and Long-Term Postvention
- 2024 National Strategy for Suicide Prevention
- After a Suicide: A Toolkit for Workplaces

Provider Support and Professional Recovery

- Coalition of Clinician Survivors (University of Washington)
- AFSP I've Lost Someone (for personal loss support)

Opioid Overdose Postvention and Prevention

- SAMHSA Overdose Prevention and Response Toolkit (PEP23-03-00-001)
- CDC Overdose Data to Action (OD2A)
- CDC OD2A Linkage to Care Case Studies
- CDC OD2A Post-Overdose Outreach (Public Safety Settings)
- Hazelden Betty Ford: Grief and Addiction Research

Crisis and Same-Day Support

- 988 Suicide and Crisis Lifeline. Call or text 988. Spanish, ASL, LGBTQ+, and Veterans subnetworks available.
- SAMHSA National Helpline. 1-800-662-HELP (4357). 24/7, free, confidential, English and Spanish.
- Crisis Text Line. Text HOME to 741741.
- Substance Use Treatment Locator. FindTreatment.gov.
- Nevada 2-1-1. For local Nevada referrals to housing, food, behavioral health, and recovery services.

Connect with NOCE

Thank you for participating in this webinar. The Nevada Opioid Center of Excellence (NOCE), housed at the Center for the Application of Substance Abuse Technologies (CASAT) within the University of Nevada, Reno School of Public Health, supports clinicians, agencies, and communities across Nevada with postvention planning, training, and resources for substance-related and suicide-related loss.

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