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PROMISING PRACTICES AFTER A DEATH OR NEAR DEATH IN VAW SHELTERS

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Why This Guide

Deaths or near deaths in violence against women (VAW) shelters can occur for a variety of reasons including natural causes, accidental death, suicide and overdose. VAW shelters are also significantly impacted by deaths that occur in community, including women being killed by their partners. Regardless of where the death occurs, it is incredibly hard and traumatic on the organization and the staff. While deaths and near deaths in VAW are rare, the issue of deaths in community more broadly related to overdoses is intensifying and growing, and this has the potential to impact the VAW sector. This guide came from the need to acknowledge how difficult a death is and to provide support and a resource for staff.

From some of our interviewees for this project we heard that:

"The amount of women who are using is far higher than it's been. Easier access to more hardcore drugs. And they're coming in really young with the addictions, speaks to intergenerational trauma, our shelter is an indigenous shelter."

"Even now it is becoming more difficult to revive people with naloxone. Took 6 doses to revive someone the other night. It's been a lot more frequent in the last 2 years, particularly because of the types of drugs folks are using."

Additionally, death or near death that occurs in VAW shelters is particularly challenging for VAW advocates:

"The purpose of our entire existence is safety. If that is the reason for our existence then when someone dies (whatever the reason) automatically we go to we have failed, and there's an immense sense of shame."

"We are trying to protect women from all the stuff out there, and then it happens in here, the place that was meant to be safe"

What We Did

A group of Executive Directors of violence against women (VAW) shelters in Ontario, who had all experienced one or more deaths onsite, had been meeting together to share and learn. They felt that there was a need to have promising practices guiding document to help other shelters anticipate and prepare for a death onsite, and to open a broader conversation that would decrease the sense of shame and isolation many had felt when they experienced the death.

Louise Pitre Coaching & Consulting Inc. (LPCC) was hired to develop the guide. A review of the grey literature around death in VAW shelters was undertaken, as were interviews and focus groups with the following:

- Focus group with VAW Executive Directors who had experienced a death onsite.
- Focus group with VAW staff who had experienced a death onsite.
- Interview with Sue Browning, Registered Psychotherapist and Critical Incident Specialist and Trainer with Crisis Care Network.
- Interview with Marlene Ham, Executive Director of the Ontario Association of Interval and Transitional Houses.
- Interview with the Director of Shelters, Gordon Russell, from Mission Services.

- Interview with Amy FitzGerald and Asia McLean, Executive Director and Training Coordinator of BC Society of Transition Houses.
- Interview with Ilda Gizas, Program Supervisor, Ministry of Children, Community and Social Services.
- Crisis response data received from Teresa MacLennan, Executive Director, Barrie Shelter from training with Barrie Police and a Crisis Response Company.

The following promising practices emerged, and are divided as follows:

1. Practicalities in the Immediate Aftermath
2. Immediate Communications
3. Staff Supports
4. Briefing Sessions and Anticipated Reactions
5. In the Weeks/Months Following the Incident
6. Recommendations
7. Harm-Reduction as Death Prevention
8. A Concluding Thought
9. Resources

While the guide is targeted specifically for supporting the aftermath of a death in shelter, there is also value and guidance for those organizations who experience a death in the community in sections 2, 3, 4 and 5.

1. Practicalities in the Immediate Aftermath

Upon finding a deceased person in the shelter, suggested protocol:

1. Immediately DON PPE (eg face mask, face shield, gloves, gown).
2. Contact 911.
3. Scan the area for hazards.
4. If you suspect an overdose, administer Naloxone spray.
5. Inform co-worker of death in shelter OR contact On Call Supervisor (if single staffed).
6. Assess if the person has been deceased for a short or long time. If it's recent and you believe you can perform CPR, begin immediately. ONLY PERFORM CPR IF IT IS SAFE TO DO SO. If powders are present or blood around mouth, only perform chest compressions.
7. You may need to halt performing CPR if emergency services arrive.
8. In the event that performing CPR is not viable, close the door and secure the room. Staff can lock the door as they have main keys for each room.

What to anticipate from Emergency Services Response

- Ambulance, police, and fire will all respond if a death has occurred.
- 1st priority will be to see if medical intervention is possible.
- Police will secure the scene for the Coroner.
- There will be an initial determination of cause of death.
- Once Police have determined if it is a criminal investigation, they will begin to interview the staff. Staff have the right to know if it's a criminal investigation or not.
- Police will advise next of kin and handle calling the coroner as well as the removal of the body.

A few guidelines from the police when dealing with different types of death

- If it is a hanging –it is important to know that a death by hanging does not occur quickly and can take some time, and the individual may be still moving/alive. If that is the case and you go to move them, note you may be surprised by how heavy they are. Note also that the "rope" can be cut but do not disturb the knot. How the knot has been tied will indicate if it was suicide or homicide.
- If it is an overdose, note that the administration of naloxone may result in the client suddenly waking up and being frightened. Back away and give them space. Be short with answers and watch for signs that they have stopped breathing. Naloxone can be administered again in an attempt to revive them.
- If the death involves a child- either as the deceased or as the child of the decease: allow the parent to remain with the child. While it may be ideal to support the child in moving to another area so the scene can be secured, in reality the child will not want to leave their parent. Stay with the child, support their crying and their touching their parent. This is an important time for them and needs to be handled with extreme sensitivity. If the child is agreeable to going with the staff, take them to a safe place and take your lead from the child – if do they want to talk, play with toys, call a family member. Offer drinks, snacks when appropriate.

Identify a point person—a manager is ideal—who can delegate or coordinate the following actions:

- Bringing in new staff, supporting staff who need to go home (when allowed, after they have provided what is needed to the police. Consider transportation support.).
- Identifying staff to support/situate other residents and keep them away from the incident.
- Filling out the SOR, notifying the police, managing any other external communication.
- Notifying other staff who aren't on shift.
- Arranging for external debrief person to come in.
- Arranging for outside professional cleaning service, if possible.

"Divvying up tasks was helpful. I realized you kick in differently and do stuff you never see yourself doing. We ended up taking all the sheets off the bed so that no staff would have to come in and see things. We were really relieved it was in the evening and it was dark so people wouldn't see the funeral home car outside of our location or see the person being taken out."

Another suggestion is to develop a Crisis Response Team. This team would be made up of staff who have additional training, can be called in and can support with the above actions.

Unanticipated challenges to consider:

- How to bring the body out of the building:
    - "physical limitations of the building create additional stressors…a stretcher can't fit in our elevator. We had to remove the body in a standing position. That was really hard."
    - "To bring the body out, we used emergency exit so that nobody would see it, created some problems because wasn't best place to bring somebody out. To think of all those things on the spot is difficult, you never know if you're it doing right, or if you're making things worse or triggering them. Make sure residents are in different location than body."
- Having what is needed on hand: "It was difficult having to run back and forth to get phone signal, didn't have everything they needed in the moment. We created emergency fanny packs so that anytime staff go out and do check-ins on any resident it has all the essentials, scissors, naloxone, which staff have said that has been quite helpful and beneficial."

Use of 'fanny packs' during wellness checks:

A few organizations pointed to the use of 'fanny packs' as a resource that is brought with staff when they do wellness checks. The pack is not intended to treat minor illness but rather to provide what is necessary in the case of a serious occurrence such as an overdose or death, and to help prevent the need to run back and forth to the residential office to grab what is needed to respond appropriately. The packs should include:

Regular band aides	Pen
CPR face shield x2	Flashlight
Gloves	Naloxone
Scissors (large enough to to be able to cut large rope)	List of room key codes (if applicable)
Hand sanitizer	Gauze

2. Immediate Communications

Guidelines for staff communication:

- Containment is not the goal. Transparency, early notification and supporting connection is best.
- Notify all staff on site and those coming in for shift.
- Appoint someone to take on calling staff, particularly those most impacted- who worked directly with the client. Use judgement in deciding whether to call all staff, weighing whether that will cause more distress while they are off or whether hearing it from a colleague will be more challenging.
- Support connection, staff talking to one another and to EAP/debrief session. Avoid asking staff not to talk about it to others, as having to sit with it without connection can compound the trauma.
- Within 12-24hrs, send out an all-staff email – likely a formality as many will have heard- but recognizing the pain and suffering the staff may be feeling, highlight supports available and debriefing options.

Guidelines for other clients/residents:

- Use judgement to determine when to tell other residents. Some may need to know sooner as they are observing the events.
- Assign certain staff to support residents and children in processing in the moment, and in the following days. If possible, this staff support should be from another team (eg outreach) or those who have not directly worked with the client who has passed away.

> "The clients that were there really struggled, police in the building which are never there, coroners, ambulance attendants, a lot of activity when there typically isn't, as well as men in the house which there aren't usually. We had all of our residents go on our main floor. By the time they were done it was 2am, this happened at 10pm."

Other communications:

- Contact MCCSS Program Supervisor
- Contact Board Members – in particular, it was noted that in smaller communities this is important to do very soon after.

3. Staff Supports

- For those who were directly involved with the incident, once cleared by the police, allow them to go home for a day or two with pay. Many agencies noted that staff directly involved often needed more extended time off (weeks).
- Arrange for EAP or other provider to come onsite, same day or next, if possible, to:
    - Meet with staff individually. Have this provider return a few days later and perhaps multiple times.
    - Provide a group debrief – determine whether the critical incident debriefing happens right away or do staff need, for example, time to sleep? Depends on peoples' needs, sometimes need it in the moment.
    - Important that this person work from an ARAO feminist lens and have expertise in trauma. Consider providing this support over Zoom if someone local cannot approach it from this perspective. Consider if appropriate to bring in culturally relevant supports.
- Recognize that staff all have different needs: some benefit from group process, some need time off, and some need something different. All supports should be voluntary and offered at a few different times.
- Ask staff what they need: some need to smudge, others to have a Minister come in.

    "Continue touching base every so often. Feelings don't always manifest right away. Need to keep checking in."
- In the following weeks and months, some found it helpful to have a manager walk with impacted staff down the hallway and into the room, helping to change the narrative in their mind. Simply sitting with the staff in the room.
- The sensory experiences of dealing with a dead body- the smell, touch, sounds- can be jarring and are what will stay with staff. Acknowledging this, that it will be the sensory triggers that will sit with the staff long after the event. All reactions to this are normal, and that over time they should lessen but to notice if they don't, as that is a good cue to get more support.

4. Briefing Sessions and Anticipated Reactions

"Could I have done more? Why does this keep happening? Frustration and anger. Despondent. Fearful. These are all feelings that came up."

Things to keep in mind:

- Offer a briefing within 24-48hrs.
- Offer a few briefing sessions, for example over different shifts and after a period of time
- These should last 45min-1hr.
- Failing to provide briefing sessions can result in staff anger at the organization, focusing on what the organization should have done, anger at leadership.
- The purpose is not for people to get over it but to, over time, demonstrate healthy adaptive behaviours like being able to express their feelings without getting emotionally flooded, organizing themselves to for example plant tree or have a little service.
- Don't make everyone attend. We encourage you to attend. Not mandatory.
- It is helpful to gather people together, in person or virtually, and helpful for them all to have same info. We need to tell you that this happened, this is what we know (minimizes rumours).

For a long time, the “critical incident stress management and debriefing model” or Mitchell Model, was widely used. It involves sitting in a circle, each person being required to speak and say what was the worst part of the event for them. The research on this approach is clear that it is not helpful and can lead to vicarious trauma, when people who know more details share those with those who know less. The language of ‘debriefing’ comes from this model. Other language that can be used includes briefing, small group gathering or intervention/support after the incident.
When considering which external clinician to bring in, ask: what is the focus of their support?

See guidelines below on best practices for briefing sessions:

Briefing sessions should include the following:

- The focus should not be on an expert coming in to lead the process but someone holding space, someone who can reign in any oversharing of detail with good facilitation skills, and who uses a more psychoeducational approach: sharing info on what to expect on a range of emotions and coping skills (things to avoid and watch for), and provide space to share reactions and responses, not information and details.
- They should normalize a range of reactions and emotions: Numb, might judge myself for feeling numb cause someone else is crying all the time (for them could be a trigger to what had already happened), angry, guilt, range of emotions is normal, based on who we are as individuals and what history we bring into these moments. No right or wrong. Don’t judge yourself or another.
- They should remind staff of helpful coping strategies: watch how much you’re drinking water, do not under eat, get to bed at decent time, a little exercise, journal or talk to close friend about what you’re feeling. Give space for people to share their coping strategies: think of another moment in your life, what did you do that was helpful.

Briefing sessions should be accompanied by a separate meeting with the leadership team. The clinician should ask leadership if they know anyone who was particularly close to this person or anyone who is struggling with suicide or overdose themselves, be they staff and residents. This helps prepare them for the holding the briefing sessions.

Remember that organizations also have trauma, not just individuals. Say a shelter has had more than 2 deaths or has undergone a big organizational restructuring and then experienced an overdose. This will intensify the experience for staff. Knowing the traumas of the organization is important for knowing how high risk the staff and clients are for being impacted by this.

5. In the Weeks/Months Following the Incident

- If the resident has not died (eg an overdose that was managed through naloxone and CPR), consider what staff supports are needed if they return to shelter.
- Consider whether you have a role in supporting the family of the deceased. "We were very closely connected to this woman and her family is up North so we facilitated all of the funeral arrangements because there was no way for them to be able to do it. It was at the very beginning of covid, so no one could really attend. We also helped with expenses."
- Consider how staff would like to mark the event- some agencies held a memorial on site with residents and staff, other staff and resident's family were able to stream it.
- Consider asking staff what was done well, what was missed and what else they needed in that moment. Do this after some time has gone by, and people are feeling ok.

At the 6 month or 1 year mark:

- Consider bringing in someone to run a debrief.
- Consider what would be meaningful for staff in terms of honouring the individual who has passed. For example, a memorial, the planting of a tree, the creating of some form of art piece.

For many agencies, this was also the time when the room was re-opened. Things to consider:

- Re-decorate and shift the layout.
- Ensure that all clients who were living at the shelter at the time of the incident have departed before re-opening the room.

6. Recommendations

1) Build onsite deaths into the organization's emergency response framework.
2) Connect with nearby sister shelters and identify what pieces they could support in managing (Eg providing staffing, providing counselling supports for clients if agency staff are too close, coordination pieces, support for the ED and managers).
3) Work with Ministry to align the funding model to support shelters in adequately responding to the increase in overdose deaths. Depending on needs of shelter, the resources could support moving away from single-staffing, adding an addictions and mental health counsellor to the in-house team of support staff, or other needs identified by the shelter.
4) Work in collaboration with the Ontario Association of Interval and Transition Houses to develop a province-wide advocacy and reporting strategy that will document the increase in and impact of overdose deaths.
5) Implement robust harm-reduction practices (see section below).

7. Harm-Reduction as Death Prevention

Many interviewees pointed to the link between death prevention and robust harm reduction practices. Within the sector there is a spectrum of implementation. Below we provide a few guideposts on what a robust harm reduction practice entails and how to go about implementing it.

"It is one thing for a shelter to say they support harm reduction but then to use a don't ask don't tell approach with women using alone in their room, afraid of judgement, there is more risk of overdose".

Why harm reduction?

As one of our interviewees so succinctly put it:

"The reality is we are in an opioid crisis right now and women are using illicit drugs. We know that trauma and substance use go hand in hand. To expect residents to not use at all is only setting someone up for failure."

As an approach to save lives, a robust harm reduction approach is key.
Harm reduction practices are important for any organization working with populations who are at increased risk of substance abuse. These populations include women with experiences of violence, who have a higher risk of witnessing or experiencing an overdose.[1] Furthermore, substance use is a common coping strategy for women with experiences of violence.[2] Given the level of toxicity and unpredictability found in the unregulated drug supply, women who use substances are at an increased risk of overdose.[3] Therefore, it is important to have harm reduction strategies in place to reduce this risk. Furthermore, not only are harm reduction practices necessary to reduce risk, but they also align with feminist anti-oppressive principles.[4] "Feminist VAW work is all about helping women access safety from violence and it is also about supporting women to understand themselves, to reconnect them with their capacity to make informed choices by providing information and resources and supporting change as directed by the women themselves."[5] This is all encompassed in the work of harm reduction, as outlined further below.

What is harm reduction?

A set of practices aimed at minimizing the negative consequences associated with drug use[6], including the following:

- Meeting people where they are at with their drug use
- Reducing existing barriers for folks and their drug use.

[1] BC Society of Transition Houses (December 2020). "Overdose Prevention and Response Guidelines: For Transition Houses, Second Stage Houses, and Sage Homes", p.2
[2] Ibid.
[3] Ibid.
[4] OAITH. (2013). "Harm Reduction in VAW Shelter: Realities of Service."p.4.
[5] Ibid, p.16.
[6] "Principals of Harm Reduction." National Harm Reduction Coalition https://harmreduction.org/about-us/principles-of-harm-reduction/

How to implement harm reduction?

General Guidelines

- Advocates of harm reduction practices encourage giving women as much autonomy as possible when it comes to their drug use. It is important to understand that women are experts in their own lives and have generally figured out what works for them regarding their drug use.
    - Examples: If a woman has been prescribed a drug by a medical professional, allow woman to administer drug herself. (This promotes autonomy.)
- Have open and honest conversations with women about their drug use. It is important to talk with women, as not knowing women are using is one of the biggest risk factors of an overdose. Furthermore, you can't always know someone is using by looking at them.
- "Keeping that very open/non-judgmental relationship, we also have to straddle that line there, ask that you don't use drugs, but if you do please let us know, not so we can discharge you but just to make sure you're ok and have someone check in on you."
- Work with women to create safety plans related to drug use.
- Encourage residents to use safely.[7]
    - Discuss overdose prevention with residents.
    - Ask residents how they would like to be supported.
    - Make harm reduction supplies available to residents.
    - Talk to residents about the availability and location of naloxone.[8]

Policies

- Policies should reflect practice.
- Should be fluid. Be prepared to update them as practices of harm reduction change.
- Develop policy for substance use and one for responding to on site overdoses.[9]
- Interviewees pointed out that some policies say you can't use illicit/illegal onsite. "This then shuts down relationship building with residents who are using those drugs because they have nowhere else to use them. Ideal scenario would be to have women let us know when they're using illicit drugs so we can know and check in on them. This is a big change."

For more information on harm reduction see section 9 below for resources.

8. A Concluding Thought

"I appreciate the need for best practices, but I hope I never have to get good at it, don't want this to become common place. Everyone does the best with what they have in the moment. These situations are all so different. There's nothing that can really fully prepare you, or answer all the questions."

[7] BC Society of Transition Houses (December 2020). "Overdose Prevention and Response Guidelines: For Transition Houses, Second Stage Houses, and Sage Homes", p.11
[8] Ibid, p.12
[9] Ibid, p. 10-11

9. Resources

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OAITH. (2013). "Harm Reduction in VAW Shelter: Realities of Service." http://www.oaith.ca/assets/files/Harm%20Reduction%20%20Report,%20April%202013,%20final.pdf

"Principals of Harm Reduction." National Harm Reduction Coalition https://harmreduction.org/about-us/principles-of-harm-reduction/

Webinar: "Harm Reduction and Overdose Prevention in Transition Houses, Second Stage Houses and Safe Homes" March 18th, 2021. Hosted by BCSTH. Speakers: Asia McLean and Janice Abbott from Atira Women's Resource Society https://www.youtube.com/watch?v=82jD4jV4tbo

West Coast Leaf (2020). The Overdose Crisis isn't Gender Neutral. http://www.westcoastleaf.org/2019/08/07/the-overdose-crisis-gender/