



# Developing a person-centered bereavement care service for health professionals with diverse communities

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## Background

### Bereavement

- multi-faceted (emotional, cognitive, physical, spiritual, behavioural), natural response to death and dying<sup>1,2</sup>
- adaption is associated with family and community connection, peer support, spiritual beliefs and practices, and access to practical support<sup>1,2</sup>
- complicated grief or Prolonged Grief Disorder (PGD) (~9.8%)<sup>3</sup> → risk factors include background, treatment-related, and death related factors<sup>3,4</sup>

### Bereavement care and services

- facilitate adjustment to death<sup>5,6</sup> and can reduce immediate distress & long-term morbidity, mortality and health service usage<sup>2,5,7</sup>
- needs to be offered to all bereaved across hospitals and community-based services; and to those bereaved by acute and chronic diseases

### Australian hospital context

- most common place of death → bereavement support is integral
- evidence-based bereavement care is not routinely provided or delivered by trained staff<sup>5,9</sup>
- currently no psychosocial model of bereavement care that is applicable to diverse communities<sup>5</sup>

## Nepean Blue Mountain Local Health District (NBMLHD)

Provides health care to ~350,000 residents (incl. Indigenous, culturally and linguistically diverse, socioeconomically disadvantaged communities)<sup>10</sup>

Requires an evidence-based bereavement model of care that identifies all aspects of bereavement incorporates recommendations for their diverse communities



## Aim

**Develop a bereavement model of care that identifies all aspects of bereavement processes and is appropriate for diverse communities.**

**Data to inform the bereavement model of care will be collected across three phases:**

1. Systematic review
2. Interview study
3. Resource review

## Systematic review

**Aim:** To identify international models of care and implementation factors of relevance to the Australian context

### Findings:

#### Stepped care

- Routine provision of universal level of care; specialist services for individuals at high risk of complicated grief

#### Care provided across the death and dying continuum

Care provided by a range of staff/volunteers across the health service

#### Culturally and linguistically diverse communities

- accepting and responsive to individual cultural, spiritual, religious beliefs, values and approaches to death and dying
- enable individuals from different cultural, language, religious, and spiritual communities to engage in care provision

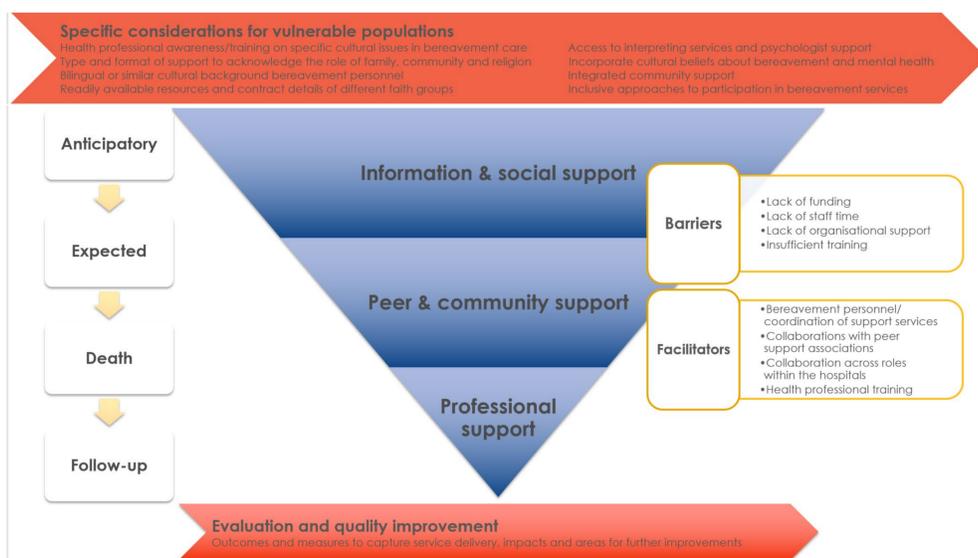


Figure 1: Preliminary stepped care model of bereavement care based on systematic review findings

## Interview study (ongoing)

**Aim:** to explore current practice, gaps in services and barriers to a stepped care model of bereavement care in the NBMLHD.

### Demographics and clinical experience of prospective interviewees

Ten staff/volunteers have provided expressions of interest to be interviewed (100% female, neither Aboriginal or Torres Strait Islander origin, English spoken first as child and do not speak any other languages; 90% born in Australia; 50% employed full time; mean age = 54.2 years)



Figure 2: Prospective interviewees current role in NBMLHD



Figure 3: Bereavement care setting

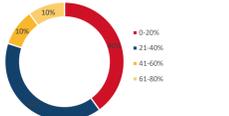


Figure 4: Percentage of practice devoted to bereavement care

Mean years working in bereavement care = 12.6

Table 1: Bereavement services provided

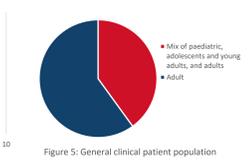


Figure 5: General clinical patient population

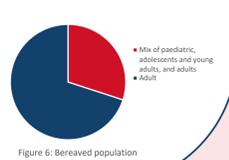


Figure 6: Bereaved population

## Resource review (ongoing)

**Aim:** to determine if current resources are evidence based and meet the special considerations for diverse populations.



## Conclusion

This preliminary bereavement stepped care model requires further development and tailoring to NBMLHD diverse communities based on results of the interview study and resource review.

The bereavement clinical pathway developed from this research will be implemented into practice within NBMLHD and future research will involve an evaluation of the model to determine key implementation outcomes for feasibility, acceptability, and adherence.

The results of this research will inform development of a brief education resource to build capacity for health professionals and volunteers that covers identified knowledge gaps.

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