

# Bereavement Care in Rural and Remote Communities of Australia

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Bereavement pertains to the state of having lost a loved one to death and the time period after. The expression is used interchangeably with the term, grief; which is descriptive in essence, often articulated as a series of psychological, physical, behavioural and emotional responses. Grief is also used more broadly than bereavement, incorporating other losses an individual may experience over a lifespan (Zisook & Shear, 2009). It cannot be disputed both terms appear with some inconsistency within literature; however this editorial will refer to bereavement as an emotional state experienced after a death and grief as a process.

The emotional and sometimes physical pain experienced after a death will be different for everybody; with no correct formulae on how to feel or what to do once a loss is experienced. Although similar responses will occur amongst individuals, no two experiences will be exactly the same, so comparisons are futile as factors such as personality, mental health, coping skills, support systems, the nature of the relationship with the deceased

person, the experience of illness, how the disease progressed and time frames will all play a contributing role (Australian Centre for Grief and Bereavement, 2015).

After a death, most individuals will draw upon their own resources and social supports and ultimately resume a new and different sense of normalcy in a time frame unique to them. Many individuals are unlikely to be receptive to outside professional help and will 'just take one day at a time' utilising their own strategies to deal with the emotional and sometimes physical reactions that can occur after a death.

However, in contrast, there will be some individuals who will feel an inability to cope with the onslaught of grief reactions that can occur after their loved one has died. These persons may therefore aim to pursue the assistance of a health professional, to validate their responses, develop coping strategies and gain new perspectives. If such individuals reside in a rural and remote district, then the availability of such a service may be more precarious and will depend largely

on a variety of factors, leaving the individual with the likelihood of yet another loss.

Furthermore, research has demonstrated that approximately 10% of bereaved persons will go on to develop a disorder known as Complicated Grief (Young et al., 2012). Complicated Grief is different to normal grief in that it consumes a person's every thought and is pervasive, leaving them unable to move forward (The Center for Complicated Grief, 2013). The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) defines Complicated Grief as a series of symptoms such as, a persistent yearning for the deceased, a marked difficulty accepting the death, feeling that life is meaningless or empty without the deceased, persistent bitterness or anger related to the loss, excessive avoidance of reminders of the loss and difficulty with positive reminiscing about the deceased (American Psychiatric Association, 2013, p. 577).

Assessing for Complicated Grief takes specific skill and expertise. Certain tools have been developed to help with the assessment process, with careful therapeutic interventions often required. Without appropriate support, persons suffering with complicated grief can be placed at psychiatric risk (Parkes, 2001). Individuals seeking general bereavement support, can also be left feeling vulnerable and at risk, if support is unavailable to them.

There is much evidence to suggest that people living with cancer who reside in regional and remote areas have inferior survival rates compared to their metropolitan counterparts. The further a person with cancer lives from larger treatment areas, the higher the risk of a poor treatment outcome (National Rural Health Alliance, 2012). Geographical location does not only impact survival rates, but will also influence bereavement care for family and friends after a death. Furthermore, "who" is in the community will play a significant role. The subsequent factors will enhance or diminish the bereaved person's experience:

- The availability and accessibility of health professionals
- The calibre of skills, interest and experience of the health professional in bereavement care
- Funding for resources and staffing

In many rural and remote communities, there is an

absence of available or accessible health professionals trained in psychosocial care to offer bereavement follow-up, leaving nurses to undertake this role. The literature states nurses face major barriers regarding psychosocial care in oncology, such as feelings of inadequacy related to a lack of knowledge and skill, particularly counselling skills; and having to assume tasks in which they do not feel vocationally prepared for (Kenny & Allenby, 2013; Rose and Glass, 2010; White, 2007; Hegney, McCarthy, Rogers-Clark & Gorman, 2002). In some rural districts, a social worker may outreach to the area, but is likely to be a generalist worker, so will perhaps be reluctant to accept referrals due to minimal education in loss and grief and limited exposure to this client group. In other instances, prominent health professionals in the community may not perceive the social worker to have the appropriate skills so will therefore not initiate a referral.

Furthermore, many community nursing services recognise the need for bereavement care, however, there are insufficient funds available to employ a health professional skilled in this area to undertake this role. There are some community nursing agencies where particular nurses have had an interest in bereavement care so have undertaken training in the area. This type of service provision is problematic in that it becomes about the person in the role rather than the role itself. If the nurse leaves the service, then the sustainability of the service may deteriorate.

In contrast, if a person lives within a catchment area of a hospice service that offers in-home nursing and psychosocial care, a different experience may ensue. High quality bereavement care can then be offered by skilled professionals, with home visits and bereavement group work being available to ease bereavement difficulties. Again, geographical location will therefore influence an individual's experience with bereavement. In Queensland, for example, there are a total of eight hospices, all of which are close to the eastern coastline or are situated in the southeast corner; not in rural and remote areas of the state.

The standard of quality care should not be about competent staffing and variations in competency depending on one's geographical location. Inequities of this kind in Australian rural and remote settings are unacceptable and clearly fail to meet both local and world standards (Lynch, 2012; Gwyther, Brennan & Harding, 2009). Current policies in some Australian states hardly reflect values such as clinical integrity, respect for persons, justice and beneficence as outlined by the National Health and Medical Research Council (NHMRC)

ethical framework document (2011). For psychosocial care, in particular bereavement care, to be universal for all communities, access to such support systems need to be in place, and funding should be allocated for the assured availability of skilled staff to address such issues. It may not be feasible to have a qualified bereavement counsellor physically located in every rural pocket of Australia; however, access to sufficiently trained staff, in some communicative form should be available to all, despite geographical location. It is imperative that the obvious need for bereavement services in rural and remote locations be given priority by those with responsibility for funding and service provision.

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