AN ANALYSIS AND DESCRIPTION OF OUT-OF-HOSPITAL
POST DEATH DELIVERY SERVICES

A Project

Presented to the faculty of the Division of Social Work
California State University, Sacramento

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF SOCIAL WORK

by

Meghann Crane-Russ

SPRING
2013
AN ANALYSIS AND DESCRIPTION OF OUT-OF-HOSPITAL
POST DEATH DELIVERY SERVICES

A Project

by

Meghann Crane-Russ

Approved by:

____________________________, Committee Chair
Dr. Francis Yuen, DSW, Professor

____________________________
Date
Student: Meghann Crane-Russ

I certify that this student has met the requirements for format contained in the University format manual, and that this project is suitable for shelving in the Library, and credit is to be awarded for the project.

_______________________, Graduate Coordinator
Dale Russell, Ed.D., LCSW

Date

Division of Social Work
Abstract

of

AN ANALYSIS AND DESCRIPTION OF OUT-OF-HOSPITAL POST DEATH DELIVERY SERVICES

by

Meghann Crane-Russ

The purpose of this study is to research the needs, availability, and support services available to bereaved individuals of out-of-hospital deaths. This study included a purposive convenient sample of individuals who work with bereaved persons in a professional capacity, specifically law enforcement chaplains, bereavement group facilitators, and hospice social workers in the greater Sacramento area. Participants completed an online survey questionnaire which included questions about bereaved persons of out-of-hospital deaths specifically related to: needs, available services, where to access services, and barriers to serving that population. Study findings indicate that there is a disparity between the types of services available to bereaved persons of out-of-hospital deaths. Bereaved persons of sudden, unexpected, and traumatic deaths had access to fewer resources and were perceived to be more underserved by the current service delivery system than bereaved persons of expected death. Implications for social work practice include promoting awareness and advocacy for bereaved persons of out-of-hospital deaths. On a macro level the profession could examine whether there are
additional ways that social workers can support bereaved families of out-of-hospital deaths.

_______________________, Committee Chair
Dr. Francis Yuen, DSW, Professor

_______________________
Date
ACKNOWLEDGEMENTS

This research study is dedicated to my grandmother Nadine Atherton. The experience of her death was my inspiration and driving force to complete this project. I would like to thank my advisor Dr. Francis Yuen for his tireless guidance, encouragement, challenges, and for allowing me to pursue this topic. Special thanks to my professional contacts at the hospice agencies and law enforcement chaplaincy agencies who agreed to participate in this study and recruit additional participants. Thank you to my friends and family who supported me through this process. To my sweet Baylee Kaedence for being such a good girl for Daddy while Mommy was doing school work. Last but not least, I would like to thank Brian, my husband, rock, best friend, editor, and formatter, without you this study and entire experience would not be possible.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>vi</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>ix</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td>1-45</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1-12</td>
</tr>
<tr>
<td>Background of the Problem</td>
<td>2</td>
</tr>
<tr>
<td>Statement of the Research Problem</td>
<td>7</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>7</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>8</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>10</td>
</tr>
<tr>
<td>Justification</td>
<td>11</td>
</tr>
<tr>
<td>Delimitation</td>
<td>12</td>
</tr>
<tr>
<td>2. REVIEW OF THE LITERATURE</td>
<td>13-42</td>
</tr>
<tr>
<td>Prevalence of the Problem</td>
<td>14</td>
</tr>
<tr>
<td>Risk Factors</td>
<td>16</td>
</tr>
<tr>
<td>Professional Interaction and Death Notification</td>
<td>24</td>
</tr>
<tr>
<td>Follow-up Care for Suddenly Bereaved</td>
<td>30</td>
</tr>
<tr>
<td>Programs Supporting Suddenly Bereaved Persons</td>
<td>36</td>
</tr>
<tr>
<td>Conclusion</td>
<td>42</td>
</tr>
<tr>
<td>3. METHODOLOGY</td>
<td>44-45</td>
</tr>
<tr>
<td>Study Design</td>
<td>44</td>
</tr>
<tr>
<td>Sampling Procedures</td>
<td>45</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Page

1. Respondent Demographics ................................................................. 54
2. Services Offered .................................................................................. 56
3. Most Urgent Needs .............................................................................. 57
4. 5 Most Likely Places to Access Support ............................................ 60
5. Needs Versus Where Likely to Access Support .................................. 62
6. Barriers to Support .............................................................................. 63
7. Amount Underserved .......................................................................... 65
8. Reasons Why Underserved ................................................................. 66
9. Tests of Association Results ............................................................... 68
Chapter 1

INTRODUCTION

This year will mark the twelve year anniversary of my maternal grandmother’s death. She had suffered from asthma for many years, and one Sunday morning, on my Dad’s birthday, she had a severe asthma attack and died. She had tried to call my family, but this was before cell phones and unfortunately we were not at home when it happened. Later that afternoon we went to pick her up for birthday festivities, her door was unlocked and the County Coroner’s card was in the door. We later found out that she had called 911 and they were unable to save her. By the time we tracked her body down she had been a Jane Doe at the county’s morgue for most of the day. It was an awful way for my grandmother, let alone anyone, to end their life. We were not expecting my grandmother’s passing nor did we get to say goodbye and unfortunately it was a very traumatic experience for me and my family. Although my grandmother was a very important and special part of our family, our experience is not unique, as many people die suddenly and unexpectedly every day. My family was not offered any psychosocial support services by any of the officials involved, we did not receive any handouts on the grief process, we received no help or guidance in finalizing legal matters related to her will, nor did we receive any guidance in making funeral arrangements for her burial. Fortunately for my family we had an extensive support network of other family and friends in addition to being very connected in our church. With support we were able to cope, grieve my grandmother, and carry on.
Although my grandmother’s death was a fortifying experience for my family, we were very fortunate that everyone in my family was able to cope and move through the grief process despite a lack of professional psychosocial support. A number of factors contributed to my family’s resilience following my grandmother’s death. First of all, although my grandmother provided much emotional support to our family, she did not financially support our family, nor did she fill a primary supportive role in the day-to-day life of our family. As previously mentioned, we had a large social support network to help us through that challenging time and we had other primary relationships to sustain us. The sudden death of a loved one can pose many challenges if the deceased was the primary income earner of a family, the primary childcare provider, or filled any other essential roles within a family. The bereaved could also have a harder time adapting if they do not have a social support network. Therefore, it is important that families are offered and if necessary have access to professional psychosocial support services following a sudden death.

**Background of the Problem**

It is well documented in scholarly literature that the manner in which a death notification is presented and communicated affects the grief process (Olsson, 1997; Parris, 2012; Purves & Edwards, 2005; Stewart, Lord, & Mercer, 2001; Zalenski, Gillum, Quest, & Griffith, 2006). Poorly delivered death notifications can negatively affect the grief process, while well delivered death notifications can help the bereaved begin a healthy grieving process and predispose bereaved persons to accepting additional support. Also documented in scholarly literature are best practices for death notification
and care of suddenly bereaved persons in the emergency department setting. A basic search of three databases (PubMed, CINAHL Plus, and EBSCO Academic Search Premier) with the terms ‘death notification’ and ‘emergency’ returned 20 scholarly articles about best practices for death notification and support at the time of death to suddenly bereaved persons in the emergency department. The American Trauma Society also recommends best practices for death notification in emergency department. They recommend that an interdisciplinary team be present for the death notification and provide support in the time following the notification. The recommended team should include the treating physician, nurse, a social worker, and chaplain or other grief support staff. (Zalenski, Gillum, Quest, & Griffith, 2006). Other best practice recommendations include providing follow-up care and referrals for suddenly bereaved persons in the days and weeks following the death (Bishai & Siegel, 2001; LeBrocq, Charles, Chan, & Buchanan, 2003; Olsson, 1997; Parris, 2012; Purves & Edwards, 2005; Stone, Huggon, & Nayeem, 1999; Zalenski, Gillum, Quest, & Griffith, 2006). As evidenced through the literature, it should be expected that suddenly bereaved persons in medical settings receive acute grief and psychosocial support at the time of death. Although it is likely that some hospitals may not follow the recommended best practices, social workers and chaplains are routinely employed in emergency departments to provide psychosocial support. For that reason this study will focus exclusively on deaths that occur in out-of-hospital settings, as comprehensive psychosocial support is not as readily available to suddenly bereaved persons in those settings.
In an attempt to ascertain the extent of out-of-hospital deaths that occur each year, the Sacramento County Coroner’s Office was contacted on October 18th, 2012. This researcher was informed by a representative of that office that they do not track the number of out-of-hospital deaths that occur. When asked if there was any agency or national organization that kept track of out of hospital deaths, the Coroner’s Office representative stated that there was not, and this researcher was encouraged to contact Sacramento County Vital Records. Upon contacting Sacramento County Vital Records, also on October 18, 2012, this researcher was informed by a representative of that office that they do not track the number of out-of-hospital deaths nor do they know any agency that does. The lack of local data on this population, let alone national data, was disheartening.

Some programs do exist to support families of the victims of out-of-hospital deaths, such as hospice agencies and other specialized support programs. Hospice agencies specialize in providing not only medical care, but also comprehensive psychosocial support to patients and their families at the end of life. Medicare guidelines mandate that a social worker be assigned to all hospice patients. Hospice social workers can help families with various logistical tasks prior to a loved one’s passing including, but not limited to, final arrangements, arranging indigent burial, finding legal resources for a will or trust, finding financial resources, assistance with Family Medical Leave Act paperwork, and counseling support. Medicare guidelines also mandate that families be offered 13 months of free bereavement support following the death of their loved one. It is safe to assume that bereaved persons of out-of-hospital deaths that do not occur on
hospice face similar logistical challenges as those families on hospice. In the event of a sudden death, the family has an added disadvantage of not being able to plan or prepare for the death. Furthermore, families not connected to hospice usually do not have access to a social worker who specializes in support at end of life, nor are they offered free bereavement support services.

Some specialized support programs exist to support bereaved persons of traumatic deaths, such as homicide, violent crimes, suicide, and drunken driving accidents. Victims witness programs support families of victims of homicide and other violent crimes and are usually administered through the local district attorney’s office. As described on the Sacramento County District Attorney’s website, the Sacramento County Victim Witness Unit provides: crisis intervention and short-term counseling, court accompaniment, emotional support, and information during the court process. They also provide resource referrals, advocacy for victims within the criminal justice system, assistance in applying to the California Victim Compensation Program for reimbursement of crime related expenses (medical and dental, mental health counseling, wage or income loss, support loss for dependents of a deceased or disabled victim, and funeral and burial expenses) and assistance in obtaining emergency services (such as food, clothing, and shelter) (Sacramento County District Attorney, 2010).

Specialized support is also available for families of victims of suicide. Survivors of Suicide is a national umbrella organization with many local chapters. The Sacramento chapter, Friends for Survival, has a local help line and offers monthly support groups, education, and referrals to local resources for families bereaved by suicide (Friends For
Survival, 2012). Lastly, for families of victims of drunken driving accidents, Mothers Against Drunk Driving (MADD) offers comprehensive support. Per their website:

MADD victim services are free and available for as long as the victim survivor needs them. MADD Victim Advocates provide emotional support and information by phone or in person. MADD Victim Advocates may be able to help you with referrals, such as how to receive federal or state crime victims’ compensation funding, and can assist you in completing required paperwork. MADD Victim Advocates can provide a list of professional counselors skilled in working with crash victims/survivors. (MADD, 2012)

Similar to social work support for families of hospice patients, families who qualify for these programs receive comprehensive psychosocial support in the wake of their loved one’s sudden and traumatic death.

Unfortunately, no evidence of a nationwide support program for bereaved persons of sudden natural deaths could be found. A handful of individual locally-run programs were found that support families of sudden natural deaths, and these programs will be discussed further in Chapter Two. Psychosocial support at the time of death and immediately following can greatly affect bereavement outcomes, this topic will also be explored more in depth in Chapter Two. However, as evidenced by the previous discussion, the nature of psychosocial support to bereaved families varies greatly depending on the circumstances of the death. As mentioned previously, this is not a well-documented problem, and the lack of data and documentation of this problem potentially contributes to the lack of support programs available to bereaved families.
Statement of the Research Problem

The disparity among the type and availability of psychosocial support available to families at the time of death in out-of-hospital settings is starkly upsetting. The central problem is that the location of the death (in-hospital versus out-of-hospital) and the nature of the death (expected, traumatic, or natural) dictates the likelihood and type of support a family will receive. Furthermore, there has been relatively little attention drawn to this topic within academia or the field of human services, as evidenced by a lack of information and documentation regarding this disparity.

Purpose of the Study

The purpose of this study is to research the needs, availability, and support services available to bereaved individuals, specifically when death does not occur in a medical facility. This researcher hopes to document gaps in the service delivery system and subsequently document the needs of these populations. As discussed previously, after conducting a comprehensive search including internet sources, scholarly literature, and contacting local government entities, this researcher could find no evidence of any agency that tracks or publishes the number of out-of-hospital deaths. When a problem is not documented, it is rendered invisible. However, just because a problem is invisible, that does not mean it does not exist. The secondary purpose of this study is to illuminate this invisible problem and make public the existence and needs of this potentially underserved population.
Theoretical Framework

The goal of this study is to assess the types of assistance available to bereaved families in out-of-hospital settings. Many of the questions in the survey portion of this study focus on assessing needs and finding appropriate resources for the target population. Family Systems Theory and Crisis Intervention Theory served as the theoretical foundation of the survey questions and this study overall.

A death in the family can disrupt the family system as the role of the deceased member must be redistributed among other family members or to external sources of support. Family systems theory is used to determine family structure and to identify family dynamics, member roles, and relationship expectations. General systems theory was developed by Austrian biologist Karl Ludwig von Bertalanffy. Upon developing general systems theory Bertalanffy did not believe it could be applied to social systems, as he felt social systems were too complex for systems theory application. Dr. Murray Bowen developed family systems theory based on general systems theory and through studying families with a schizophrenic member (Greene, 2008). Basic tenets of the family systems theory include: social systems are comprised of interrelated interdependent and internally organized members who constitute a unit or a whole. All systems are contained within an external boundary that encompasses all the members of the system and everything outside the boundary of the system constitutes the system environment. Social systems are goal oriented, able to adapt, and if a member of the system changes, then the nature of the entire system changes. Finally, when imbalance occurs and the system and
the system structure adjust to reestablish balance, which is referred to as homeostasis. (Greene, 2008).

Through the application of Family Systems Theory, the role of the deceased family member can be assessed and described. General Systems Theory can also be applied in assessing external sources of support that can be accessed to support the family in lieu of the recent role change due to the death. The need for social service referrals can be assessed and supplied based on the needs of the individual family system and availability of environmental supports that are already in place.

Death can cause instability and disruption in one’s life, but the circumstances of an unexpected death can be even more debilitating. Consider a circumstance where a married father of two young children, who is the sole source of income for his family, dies of a heart attack in his sleep. His wife now becomes a single parent with no source of income. While in a state of mourning she is now faced with survival choices of paying the mortgage and needing to find employment and childcare. Not only must a family in this situation face the loss of a loved one, but they must also overcome the ensuing crisis caused by this life altering event.

Howard Parad and Gerald Caplan, social work researchers at Harvard School of Public Health, along with Naomi Golan social work researcher at University of Haifa, Israel founded basic crisis intervention theory. They focused on delineating the nature of crisis stages, interventions, and strategies for crisis resolution. Rosemary Creed Lukton, a social work professor at Adelphi University developed the practice theory and skills for social work applications (Hepworth, Roony, Roony, Strom-Gottfried, & Larsen, 2010).
Basic tenants of this theory include: an orientation towards moving the client towards the future. The implementation of this theory also stresses employing timely yet limited intense intervention with high frequency within the duration to prevent a decline in functioning, and assists in identifying and alleviate affective, behavioral, and cognitive distortions as result of a traumatic event (Hepworth et al., 2010). Unexpected death is categorized as a traumatic stress crisis within this model. The crisis intervention model is focused on the present and does not dwell on pre-crisis personality dysfunction, although it does recognizes that it may need to be separately addressed.

The model employs intense short lived strengths based therapy with a focus on solutions to help through the crisis and restore psycho-equilibrium. All assigned tasks are focused on restoring equilibrium to the client’s life (Hepworth et al., 2010). The theory does not address any deeper psychological or behavioral issues that the crisis triggers. It is most effective for crises that happen as a result of a big event. The theory can be used to assess the most urgent needs and make appropriate referrals for suddenly bereaved families. Crisis intervention theory dictates how to best meet the needs of the client while in an acute crisis, whereas Family Systems Theory can be used to assess the overall needs of the client and what type of referrals sources are needed.

**Definition of Terms**

Operational definitions of terms used for remainder of this study will now be defined. “Out-of-hospital deaths” include any death that does not occur in a hospital, skilled nursing facility, or other medical facility. For the purpose of this study, the population will be split into three groups, bereaved families of traumatic death, sudden
death, and expected death. “Traumatic death” is defined as a death that occurs unexpectedly from a non-natural cause. Examples include: murder, suicide, fire, accidental death at the hand of another person, car accident including DUI, etc. “Sudden death” is defined as a death that occurs unexpectedly from a natural cause. Examples include: heart attack, stroke, aneurysm, appendicitis, meningitis, victim-caused accidental death (e.g., fall, electrocuted, drowning, drug overdose), etc. “Expected death” is defined as an anticipated death (cancer, Alzheimer’s/dementia, or any type of terminal illness).

Respondents of this study will include “law enforcement chaplains”, defined as community law enforcement chaplains in the greater Sacramento area. “Bereavement group facilitators”, defined as persons that facilitate community bereavement groups or bereavement groups sponsored by a hospice agency within the greater Sacramento area. Lastly, “hospice social workers”, defined as professionals who have a Master of Social Work degree and work for a hospice agency in the greater Sacramento area. For the remainder of this document the aforementioned terms should be interpreted by the reader using the above operational definitions.

**Justification**

As was mentioned previously, very little data exists that documents the disparity in psychosocial support services between out-of-hospital and in-hospital bereaved persons. This project is intended to research gaps in the out-of-hospital post-death service delivery system in the greater Sacramento area. Suddenly bereaved persons are more at risk for developing complicated grief and have worse bereavement outcomes than expectedly bereaved persons; this topic will be presented more in depth in Chapter two.
The profession of social work plays a pivotal role in supporting families on hospice and in providing bereavement support. That implies that there is a role for the profession in assisting suddenly bereaved persons as well. The intention of this study is to assess whether any of the aforementioned bereavement groups are underserved. Bringing attention to underserved populations can raise community awareness and potentially allow for further research and support of the underserved population. Bringing awareness to this topic can also pave the way for the profession of social work to address this issue.

**Delimitation**

This study does not aim to study the needs of bereaved persons when the death occurs in a hospital, nor in the event that a death occurs outside a hospital but the body is later transferred to a hospital. Deaths that happen in skilled nursing facilities, other medical rehabilitative centers, or other type of medical facilities will not be included in this study either. This researcher is not examining cultural differences related to the sudden death of a loved one. Specific medical interventions or types of treatment will not be examined in this study. Furthermore, grief and bereavement interventions beyond the recommendation that an individual seek bereavement support will not be discussed. Lastly, this study will not attempt to make recommendations regarding resolving any service gaps or needs that may be presented as a result of this study. The goal of this study is solely to present whether or not any underserved subpopulations of the target population exists.
Chapter 2

REVIEW OF THE LITERATURE

Grief and bereavement is a vast field of study with a significant amount of research pertaining to it. Research regarding the needs and services available to suddenly bereaved persons specifically for out-of-hospital deaths are limited. Many articles indicated that this is an important topic, but it has not attracted much attention from academic publications. An extensive search of databases including Social Service Abstracts, Academic Search Premier, PubMed(NCBI), CINAHL Plus, and Criminal Justice Abstracts using key words such as: death, sudden, bereave, trauma, support, services, out-of-hospital, pre-hospital, and EMS, only yields a net of 31 related articles. Some articles only partially relate to the topic at hand, but they are included as the results are generalized to the target population (e.g., needs for suddenly bereaved persons in the emergency department generalized to out-of-hospital settings). It will be clarified for the reader whenever this type of generalization is applied.

This chapter will examine multiple topics related to sudden bereavement and the services available to suddenly bereaved persons for out-of-hospital deaths. The chapter will begin with a discussion regarding the prevalence of out-of-hospital deaths, followed by a presentation of mental health and physical health risk factors for this population, next a description of other stressors and changes to social networks, and then a description of the impact of professional’s interaction and manner of death notification on suddenly bereaved persons. The immediate support needs of the suddenly bereaved and the importance of follow-up care from support services will be explored. Lastly, a
description of social service programs that exist, or were in existence, to support suddenly bereaved persons of out-of-hospital deaths will be presented. The research presented in this chapter shows that sudden bereavement can negatively affect the biological, psychological, and social areas of an individual’s life; however, as found through researching this topic, there are limited services available to meet the needs of this population in out-of-hospital settings.

**Prevalence of the Problem**

As described in Chapter 1, this researcher contacted the Sacramento County Coroner to ascertain the number of out-of-hospital deaths that occur annually in the greater Sacramento area. A representative of the coroner’s office explained that type of data is not recorded or maintained by their office. Upon being referred to Sacramento County Vital Records, a representative of that office informed this researcher that out-of-hospital deaths are not recorded or maintained by their office either.

Determining the number of out-of-hospital deaths that occur annually on a national basis was also a difficult task. A comprehensive search of the scholarly databases previously listed did not produce any data related to the number of out-of-hospital deaths that occur annually. A comprehensive internet search was also conducted using key words such as: out-of-hospital, death, annual, location of death, unexpected, sudden. Unfortunately this researcher was only able to locate a limited amount of published data somewhat related to out-of-hospital deaths. The Center for Disease Control (CDC) does publish an annual report on the total number of deaths that occur in a given year and leading causes of death. According to the CDC National Vital Statistics
Report Vol. 61, No. 6, the total number of deaths in United States in 2011 was 2,512,873. The CDC report does not specify where deaths occur or whether they were expected or unexpected deaths. Despite that limitation the causes of death most closely related to the definition of Sudden Death for this study, as described in Chapter 1 Definition of Terms, will now be presented: the leading cause of death in the United States during 2011 was diseases of the heart with 596,339 deaths, the fourth leading cause was Cerebrovascular diseases with 128,931 deaths, the fifth leading cause was accidents (unintentional injuries) with 122,777 death. There is no way to know where the deaths occurred or if they were sudden or expected. Deaths closely related to the definition of Traumatic Death for this study, also previously defined in Chapter 1, are as follows: the tenth leading cause of death in 2011 was intentional self-harm (suicide) with 38,285 deaths and assault (homicide) 15,953 deaths (Hoyert & Xu, 2012). Based on this information, it is not possible to determine where those deaths took place.

The CDC and the American Heart Association (AHA) do track out-of-hospital cardiac arrests. Neither agency publishes an exact number, but they do provide an annual estimate. According to the CDC “Approximately 300,000 Out-of-Hospital cardiac arrest events occur each year in the United States; approximately 92% of persons who experience an OHCA die” (McNally, et al., 2011, p. 2). The AHA reports that “Out-of-Hospital cardiac arrests (OOHCA) are a common, lethal public health problem that affects 236,000 to 325,000 people in the United States each year. If deaths due to OOHCA were separated from deaths due to other cardiovascular causes, OOHCA would be the third leading cause of death” (Nichol, et al., 2010, p. 710). The AHA also provides
an estimate on the number of out-of-hospital strokes that occur annually, “Every 4 minutes someone dies of a stroke. Stroke accounted for approximately 1 of every 18 deaths in US. Approximately 54% of stroke deaths occurred out of hospital” (Roger, et al., 2012, p. 70). As evidenced by the available data, it is difficult to statistically assess the breadth of out-of-hospital deaths that occur annually. Although the AHA provided estimates for out-of-hospital deaths, that information only accounts for two types of sudden natural death. Despite that lack of documented data on the prevalence of out-of-hospital deaths, the remainder of this chapter will illustrate the importance of supporting survivors of out-of-hospital deaths and why more attention should be brought to this issue.

**Risk Factors**

The effect of sudden death on bereavement was first documented by Erich Lindemann in his 1944 article *Symptomology and Management of Acute Grief*. He compared the grief reactions and symptoms of WWII military spouses to families of individuals who had been killed in the 1942 Boston Cocoanut Grove Fire. The Cocoanut Grove Fire was a fire that occurred in the Cocoanut Grove Nightclub in Boston that killed 492 people. Lindemann found that widows of WWII soldiers had less severe grief reactions because they had experienced preemptive grief in anticipation that their spouses would not survive the war. The widows did not appear grief stricken at the time of their spouse’s actual death whereas families of victims of the Cocoanut Grove Fire presented with severe and prolonged grief reactions (Carr, House, Wortman, Nesse, & Kessler, 2001). Kristensen, Weisæth, and Heir (2012) conducted a literature review of 140 articles
related to mental health after sudden death; based on their findings, they report that sudden loss causes relatives to have a more difficult time grasping the reality of their loved one’s death. Not only are suddenly bereaved persons more at risk for increased grief symptomology, they are also more at risk for a variety of mental health problems.

**Mental Health Risks**

Sudden bereavement has the potential to induce a number of mental health problems, including complicated grief, post-traumatic stress disorder (PTSD), and peritraumatic distress. Because sudden death is unexpected loved ones do not have time to experience preparatory or anticipatory grief (Carr, House, Wortman, Nesse, & Kessler, 2001; Parris, 2012; Purves & Edwards, 2005). Parris conducted a literature review of 100 articles pertaining to the needs of bereaved relatives following sudden traumatic death; he described anticipatory grief as a “period of adjustment and preparation for an expected death of a loved one” (2012, p. 141). A literature review of 28 articles related to initial needs of relatives following sudden and unexpected death was conducted by Purves and Edwards. They found sudden deaths are especially distressing because people are denied “any rehearsal opportunity and the biomechanical reaction to shock may overwhelm the bereaved to such an extent that they feel regressed and unable to function” (2005, p. 28). Expected deaths enables loved ones to prepare for the passing and to say goodbye to an individual. It also allows families to prepare ancillary arrangements such as financial or legal provisions or make final arrangements. Suddenly bereaved persons do not have an opportunity to complete ancillary arrangements prior to the death which can cause a crisis situation at the time of sudden death further complicating the grief process.
Sudden death also increases the risk for complicated and prolonged grief (Clements, DeRanieri, Vigil, & Benasutti, 2004; Hargrave, Leatham, & Long, 2012; Harrington & Sprowl, 2011; Parris, 2012; Stewart, Lord, & Mercer, 2001). Clements explains that deaths involving suddenness, among other risk factors, are more likely to cause complicated grief (2004). Shear, et al. completed a literature review of 157 articles related to complicated grief; they describe the symptoms of complicated grief:

Strong yearning for the person who died, frequent thoughts or images of the deceased person, feelings of intense loneliness or emptiness and a feeling that life without this person has no purpose or meaning. Complications also lead to dysfunctional thoughts, maladaptive behaviors, and emotion dysregulation, such as troubling ruminations about circumstances or consequences of the death, persistent feelings of shock, disbelief or anger about the death, feelings of estrangement from other people, and changes in behavior focused on excessive avoidance of reminders of the loss or the opposite, excessive proximity seeking to try to feel closer to the deceased, sometimes focused on wishes to die or suicidal behavior. (2011, p. 105)

Complicated grief can significantly impair a person’s ability to function. Because suddenly bereaved persons are at higher risk for complicated grief, it is important that some mechanism exists to screen suddenly bereaved persons for complicated grief. Out-of-hospital deaths lack the psychosocial support systems available to families in the emergency department; therefore it is unlikely that bereaved individuals at risk for
complicated grief are screened in the instance of out-of-hospital death despite their higher risk for complicated grief.

Another mental health problem suddenly bereaved persons are susceptible to is PTSD (Hargrave, Leathem, & Long, 2012; Kristensen, Weisæth, & Heir, 2012; Stewart, Lord, & Mercer, 2001; Zalenski, Gillum, Quest, & Griffith, 2006). According to Kristensen et al.:

In the DSM-IV witnessing death is one of the event criteria specified in the PTSD diagnosis and witnessing death has been consistently linked to PTSD after violent losses. But finding the deceased or being at the scene of the death has also been associated with PTSD symptoms. (2012, p. 84)

Screening suddenly bereaved persons for PTSD is important; however, similar to screening for complicated grief, it is a challenge to implement in out-of-hospital settings due to the lack of available psychosocial support systems.

Peritraumatic distress is an initial response to learning of a traumatic event, the response can include: fear, helplessness, and horror. It has been shown that peritraumatic distress is a precursor to PTSD. Hargrave, Leathem, and Long (2012) conducted a quantitative study of 125 persons who experienced the sudden death of a close family member or friend. The authors found that peritraumatic distress is also indicative of the potential development of complicated grief. Their findings imply “the initial reaction to learning of a sudden death may be implication in the development of both long-term trauma and grief reactions” (Hargrave, Leathem, & Long, 2012, p. 346). This indicates that increased support is necessary for suddenly bereaved persons at the time of death.
notification. This topic will be addressed further in a following section of this chapter. As presented through the aforementioned literature, suddenly bereaved persons are at heightened risk for developing mental health problems. Therefore, it is important that the survey tool for the study at hand assess if suddenly bereaved persons in out-of-hospital deaths are screened, referred, or able to access mental health support services.

**Health Risks**

In addition to mental health risks, suddenly bereaved persons have heightened physical health risks (Buckley, McKinley, Tofler, & Bartrop, 2010; Harrington & Sprowl, 2011; Stroebe, Folkman, Hansson, & Schut, 2006). Buckley, McKinley, Tofler, and Bartrop (2010) conducted a comprehensive literature review of 87 articles pertaining to cardiovascular risks in early bereavement. The authors found a large body of evidence that relates emotional stress to coronary heart disease (CHD) and acute cardiac events. Adverse psychosical factors such as depression, social isolation, and lack of quality social support were of similar order of risk for CHD as conventional factors such as smoking, dyslipidaemia, and hypertension. Buckley et al. explained “the risk of mortality for surviving spouses appears to be greatest in the immediate weeks following bereavement and to remain significantly elevated during the first six months” (2010, p. 232). They found no indicative evidence of a higher risk mortality among suddenly bereaved individuals. The authors did provide the disclaimer that population studied do not identify the nature of the spouses death, and therefore the mortality rate of suddenly bereaved is undifferentiated from the general populaiton of bereaved persons. A noteworthy finding regarding spousal mortality found spouses of patients who received
hospice care had significantly lower mortality rates during the first 18 months after their spouses death, compared to those who did not receive hospice care. This implies that social support at the time of death lowers the initial mortality risk for spouses. It can be correlated that suddenly bereaved persons who do not receive social support at the time of death are at heightened risk for CHD or mortality. This again signifies an urgent need for support to suddenly bereaved persons at the time of their loved one’s passing.

**Secondary Stressors**

As mentioned previously, suddenly bereaved persons are faced with the shock of their loved one’s death and may also be in crisis. In addition to grieving their loss, individuals are also faced with a number of secondary stressors. Stroebe, Folkman, Hansson, and Schut developed a risk factor framework for predicting bereavement outcomes. The authors explain:

The death of a significant person goes hand-in-hand with a number of changes in everyday life, even possibly some threatening features that also have an impact on adaption. Bereaved also have to deal with a wide range of such secondary stressors: including difficulties at work, legal issues arising from the deceased’s will, learning how to do tasks the deceased spouse had managed, or poverty due to the loss of the deceased’s income. Problems can extend to difficulties in social interactions, especially since the very person one would ordinarily turn to for support in such circumstances is missing, and because the bereaved person’s changed identity (2006, p. 2445).
After the sudden death of a loved one, individuals are faced with many challenges and need to have time to make arrangements for their new found circumstance. Breen and O’Connor conducted a qualitative study of 21 adults regarding changes to social supports after bereavement. Informants from the Breen and O’Connor study shared “an immediate concern following the death of their loved ones was getting paid time off work. However, decisions to return to work were significantly influenced by financial needs and most commenced work within a few weeks of death” (2011, p. 107). Lack of time and resources to handle the secondary stressors of the sudden death can lead to a crisis situation for suddenly bereaved persons.

Not only is it important to offer these suddenly bereaved persons assistance with bereavement and potential mental health difficulties, they need to be offered crisis intervention support at the time of the death.

Changes to Social Network

Kristensen et al. defines resilience after loss as “bereaved individuals showing a stable pattern of low distress over time and has been distinguished from maladaptive grief or the more traditional trajectory of recovery” (2012, p. 85). In their comprehensive literature review, Kristensen et al. found that data on resiliency specific to sudden loss was limited. The authors did note that interpersonal factors such as family support and social support can affect bereavement outcomes. Clements et al. (2004) explain that sudden traumatic death changes the family system causing a sudden and unexpected need to evaluate and change family roles and structure, which results in impulsive and disorganized attempts to regain homeostasis for the family unit. If the deceased played a
significant role in family functioning, whether financially, caretaking, or through emotional support, the family must reassign the roles previously held by the deceased. The process of reestablishing homeostasis to the family unit is also a vulnerability to crisis.

Breen and O'Connor (2011) conducted a study of recently bereaved family members regarding the changes in their family and social networks after bereavement. Although their study was in regard to general bereavement, for the purpose of this literature review, the results will be applied to suddenly bereaved persons. The key findings included that the initial tragedy of the death brought families together, yet many respondents reported eventual long term estrangement developed between respondent’s and their families. Death seemed to magnify relationship issues that were present before the death. Individuals had a difficult time getting support from family members, as other family members were also grieving. Lastly, support from a respondent’s social network was initially strong, but dwindled over time. Many individuals felt pressure from their social network to expedite and complete the grief process. Breen and Connor explained “most informants reported that the level of support from outside the immediate family dwindled relatively quickly over the days and weeks after the death, leaving them to grieve in isolation” (2011, p. 110). Ultimately, “informants reported that many relationships collapsed completely, including family relationships and long terms relationships with close friends” (2011, p. 112). Olsson (1997) studied suddenly bereaved families and the effects of loss on bereaved person’s primary social network. The author found bereaved spouses experienced support from family members more frequently than
bereaved adult children did. The author also reported “crisis reactions did occur regardless of family support but they lasted longer among relatives without family support at the hospital”. These findings can be generalized to out-of-hospital deaths as well. Unfortunately, families in out of hospital settings do not have access to the comprehensive psychosocial supports available in a hospital (e.g. physicians, nurses, social workers, and chaplains) that assist with crisis management and early bereavement interventions.

As is evident in the aforementioned literature, suddenly bereaved persons are particularly susceptible to a multitude of biological, psychological, and social stressors following the death of their loved one. Further compromising to this population is the lack of psychosocial support available in out-of-hospital deaths. In this study it will be important to assess whether the target population has adequate resources available to them to assist with bereavement and crisis management.

Professional Interaction and Death Notification

Bishai and Siegel (2001) are medical ethicists at John Hopkin’s University Bloomberg School of Public Health. They presented a case study whereupon a mother of two young girls who was pronounced deceased by EMS services in her home after CPR was initiated by the two daughters and then continued by EMS services. Upon pronouncement the EMS staff left the body in the home with the two daughters had to wait two hours until their father came home, following which the body was transferred to the medical examiner. Bishai and Siegel argued that upon a patient’s sudden death, the patient’s needs recede while the needs of the patient’s family remain present and actually
amplify. The authors advocate for transportation for resuscitation, even if futile, as it removes the body from a potentially chaotic situation to the hospital emergency room where a team can attend to family member’s urgent acute grief reactions and needs. As explained by Bishai and Siegel, paramedics do not receive systematic training in bereavement and grief counseling and therefore are inept to adequately handle family member’s acute grief reactions in the field. The authors explain that “family members are vulnerable to being harmed as a consequence of medical decisions made by or for a patient [which] compels us to give serious consideration to their interests when addressing the treatment of a patient” (2001, p. 384). Bishai and Siegel also argue that “this case illustrates that ignoring the interests of the family member botches the provision of medical care and leads to missed opportunities for healing” (2001, p. 387) and “although there is much to be said for a peaceful death with dignity in the home, where the patient can be surrounded by loved ones, sudden untimely death lends itself to neither peace nor dignity” (2001, p. 384). This case eloquently makes the argument for increased care and services for suddenly bereaved persons at the time of death. The authors argued that in this case the body should have been transferred to the emergency room for continued resuscitation, although futile. They argued that transportation to the hospital would have provided a support system for the family. However, transportation to the hospital for continued resuscitation it is not always possible, nor do families always want continued resuscitation attempts at the hospital. Unfortunately, as addressed by Bishai and Siegel, a sufficient level of support is not always available through emergency
medical service personnel, either due to lack of training, support, or not prioritized by personnel.

**Impact of Professionals on the Bereaved**

As was previously discussed, the circumstances of a death affect can affect the grief and bereavement process. Harrington and Sprowl conducted a qualitative study of 16 suddenly bereaved family members, the authors assert that the “care provided at the time of death can have a significant impact on later grief processes” (2011, p. 66). Janzen, Cadell, and Westhues (2004) conducted a qualitative survey of 20 suddenly bereaved parents regarding their interactions with professionals at the time of their child’s death. Although this study related specifically to suddenly bereaved parents the findings will be generalized to the impact of professional interactions with all suddenly bereaved persons. The authors argue that impactful professionals included not only doctors, but all healthcare professionals, clergy, funeral directors, and police. Janzen et al. found “professionals have a strong impact on bereaved parents at the time of sudden death” (2004, p. 157), it was noted that the impact can either be positive or negative. Respondents noted feeling a loss of control after the sudden loss. Professionals who were perceived as interfering with respondents’ attempts to gain a sense of control were viewed negatively, while those who supported respondents in regaining control were perceived as helpful. Janzen et al. elaborated that “feelings of control help reduce feelings of helplessness and powerlessness and lower rates of PTSD” (2004, p. 156). Olsson led a qualitative study of 60 suddenly bereaved participants regarding their interactions with staff members on a Coronary Care Unit. Related to interactions with professionals, she
found “in the vacuum of the loss, the interaction with staff members became very important. Some responses indicated a specific impact on the bereavement process, while other indicated a more general impact on personal feelings and attitudes” (1997, p. 125).

As is evident through the aforementioned articles, the way professionals interact with suddenly bereaved persons can greatly affect the grief process. Therefore, it is important that all types of professionals who come into contact with suddenly bereaved persons are knowledgeable and prepared to support this population.

Death Notification

Parris (2012) eloquently describes the importance of professional interaction at the time of death notification, “if the breaking of bad news is done badly, patients and their families may never forgive us; by contrast if we get it right they will never forget us” (p. 144). The death notification and the time immediately following is a pivotal time for suddenly bereaved persons. It is well documented that the manner in which a person is notified of their loved one’s death can significantly affect the survivor and can interfere with the long term resolution of grief (Bremer, Dahlberg, & Sandman, 2012; Zalenski, Gillum, Quest, & Griffith, 2006; Stewart, Lord, & Mercer, 2001; Smith-Cumberland & Feldman, 2006; Purves & Edwards, 2005).

Zalenski, Gillum, Quest, and Griffith conducted a literature review of 63 articles on how to best care for adult family members of unexpected cardiac death. They found: Competent empathetic death disclosure by hospital staff may prevent the mental and physical morbidity and mortality associated with bereavement. The need for
formal or intentional training in death disclosure to family members in the emergency setting has only been recently recognized. (2006, p. 1334)

Zalenski et al. further reported:

The American Trauma Society recommends that an interdisciplinary team of professional care for the family before, during and after the disclosure of a new death. Optimally, it would include the treating physician or nurse and a chaplain, social worker or other support staff with skill and expertise in the support of survivors in the setting of loss. (2006, p. 1335)

This recommendation emphasizes the importance of a competent team presenting a sudden death notification. The interdisciplinary team, as described by the American Trauma Society, is not feasible to implement in out-of-hospital settings. However, the recommendation implies a high level of support should be present to support families at the time of sudden death notification. Therefore, professionals in the field must be equally as prepared and competent in supporting suddenly bereaved persons as professionals in hospital settings.

Based on the findings of their literature review related to the initial needs of relatives following sudden and unexpected death, Purves and Edwards asserted:

There appears to be few studies on the initial needs of relative in pre-hospital areas and the response of pre-hospital practitioners. The needs of relatives and practitioners identified in the literature on EDs and hospital are applicable to pre-hospital environments and should be acknowledged. (2005, p. 28)
The available literature describing best practices in sudden death notification outlines that the notification should be presented in direct non-technical language specifically using the word death/dead to avoid confusion. Furthermore, families want to be notified of the death as soon as possible and want to be provided detailed information regarding the circumstances of the death and resuscitation attempts, lastly grief support at the time of death should be culturally and religiously appropriate (LeBrocq, Charles, Chan, & Buchanan, 2003; Parris, 2012; Purves & Edwards, 2005; Reigel, 2002).

**Out-of-hospital Death Notification**

Stewart, Lord, and Mercer conducted a needs assessment survey regarding death notification education for professionals who regularly perform this task. They found few resources exist to train professionals who typically provide out-of-hospital death notifications, including “law enforcement, victim advocates mental health, clergy, health care, and funeral directors” (2001, p. 222). Respondents to their study found it difficult to meet the emotional needs of families at the time of death and requested additional training on death notification. Purves and Edwards (2005) concluded “pre-hospital practitioners need more training on responding to the bereaved at the time of death” (p. 32). They also reported that in one study “paramedics spend an average of 27 minutes on scene with relatives” (p. 31).

Bremer, Dahlberg, and Sandman led a qualitative study of ten EMS professionals’ perceptions of their role in out-of-hospital cardiac arrests and death. They found “EMS personnel felt inadequate when responsibility was extended to caring for family members” (2012, p. 49). Although the EMS staff defined caring for bereaved families as
an important part of their job, it was not always recognized as such by their EMS organization. Smith-Cumberland and Feldman (2006) surveyed EMT’s attitudes toward death notification before and after a death notification education workshop. Although 77% of respondents agreed that their actions on scene affect the grief process of the family, 57% of respondents felt death notification was not part of their duties. They also found that EMTs who attended longer and more thorough death notification trainings were more comfortable and better prepared to provide death notification.

The literature presented suggests that a poorly delivered death notification can negatively impair the grieving process. As previously presented, suddenly bereaved persons are already at a heightened risk for difficult bereavement, complicated grief, and PTSD. Therefore suddenly bereaved persons who receive poorly delivered death notifications are twice as likely to experience challenges in the bereavement process. As the aforementioned literature suggests, out-of-hospital medical care providers lack adequate training to effectively provide death notification or support suddenly bereaved persons at the time of death. This implies that suddenly bereaved persons who receive death notification in out-of-hospital settings are predisposed to a multitude of risk factors that can negatively affect the grief and bereavement process. The survey tool for the study at hand must assess whether suddenly bereaved persons of out-of-hospital deaths receive the support they need to mitigate the aforementioned risk factors.

**Follow-up Care for Suddenly Bereaved**

Lensing (2001) wrote about the emerging need for professional support during bereavement. She described that, historically, people would have sought religious leaders
and institutions for bereavement support. Lensing explains this is not always a viable option as many people are no longer affiliated with religious organizations and they instead turn to mental health workers for support. In addition to religious support, Lensing expands “in the past extended families were close and neighborhoods provided a sense of cohesive bonding that helped people to cope with loss” yet if individuals do not live close to family “that sense of community may no longer exist to provide immediate support nor is the extended family available” (2001, p. 48). This argument supports the following research which outlines the importance of professional follow-up support services for suddenly bereaved persons. Based on the findings from his literature review Parris (2011) explains “it appears that many follow-up services for the bereaved have been developed in a somewhat haphazard way and whilst it is thought that the provision of follow-up is a good thing” (p. 149) he also explains “there is a constant message that the need for follow-up is greatest for those bereaved by sudden traumatic death” (p. 149).

An example of a program providing follow-up care to suddenly bereaved persons was developed by nurses in the emergency department of a 600 bed acute care hospital in the Midwest. The program provided a comprehensive bereavement program starting with a nurse informing the family of the death of their loved. The nurses facilitated viewing the body and provided space and time for any rituals which allowed families to start grieving. The nurses also provided help with initial contact to funeral homes and explained the hospital’s processes for the body postmortem. Families were also provided referrals to community based grief and bereavement services. Information was gathered from the families regarding risk factors predisposing them to complicated grief. Nurses
made follow-up calls to check on the status of the survivor and offer additional referrals if necessary at 1 week, 1 month and 2 months postmortem. Between 1985 and 1995 the program had 2,173 deaths, 83% were of natural causes. In survey of the program 92% of respondents ($n=156$) was very helpful (Williams & Frangesch, 1995).

Another program in a hospital in London provides telephone follow-up by support workers to next of kin four or five days after their relative’s death in the emergency department. The authors, Stone, Huggon, and Nayeem (1999), explain that families are informed about the follow-up call at the time of death and a support network assessment was accomplished before the family left. The authors conducted a survey of all families who received follow-up telephone calls during a six month period. They had a 39% response rate, with 97% of respondents reporting that the follow-up calls were helpful. Stone et al. reported “since the introduction of telephone follow-up, however, there has been no negative responses to phone calls” (1999, p. 109). These two programs illustrate that suddenly bereaved persons value follow-up support and find it helpful.

**Importance of Follow-up Support**

The literature review on the needs of relatives following sudden death by Kristensen et al. reported “A recent meta-analysis confirmed that treatment interventions effectively reduce symptoms of prolonged grief disorder” (2012, p. 87). Stroebe, Folkman, Hansson, and Schut developed a criteria to assess risk factors in bereavement and they assert “it is critical to identify those persons who are likely to suffer from the more severe consequences of bereavement, because professional help needs to channeled to those who need and will benefit from it (2006, p. 2441). As reported by Zalenski et al.
in their literature review “more research is needed to assess and to find ways to improve immediate care of the surviving family of unexpected cardiac death victims” they also assert that research is needed to improve “methods of referral for services for prevention of psychological and cardiovascular morbidity during bereavement” (2006, p. 1333). All of the aforementioned authors emphasize the importance and benefit of follow-up care for suddenly bereaved persons. This too underscores the importance of assessing follow-up care services for suddenly bereaved persons in out-of-hospital deaths through the study at hand.

Recommendations for Follow-up Care

The aforementioned articles describe the importance and benefit of follow-up support services for suddenly bereaved persons. The following articles will describe best practices in providing follow-up care to suddenly bereaved persons. Purves and Edwards (2005) reported on a study from their literature review that showed “relatives can identify their ‘grief needs’, and they want healthcare professionals to support and comfort them in death situations” (p. 30). The authors reported findings from another study, citing “follow up is an integral part of care for bereaved relatives, so support workers in their study called relatives between four and five days after the death of their loved ones and asked how they were coping” (p. 31). Breen and O'Conner (2011) studied the changes to family and social networks after bereavement; they recommend “strengthening of current services available to bereaved” (p. 113). Misconceptions about follow-up care for bereaved individuals were described by the authors as follows:
First services assume that people who require help are aware they need help, are willing and able to seek help, and trust the services and are able to afford them, while those who do not ask for help do not need it. However, these assumptions fail to take into account the notion that the very experience of grief reduces the likelihood of recognizing a need, asking for and receiving help, and being able to find a suitable service. (p. 113)

This description emphasizes that follow-up care must be initiated by support staff as opposed to an individual having to seek out support services. Additional recommendations include those of Parris, who emphasizes that bereavement care should provide “accurate information and knowledge appropriate to the cultural and religious needs of the bereaved” (2012, p. 143). Harrington and Sprowl (2011) conducted a qualitative study regarding the experience of 16 suddenly bereaved family members. Respondents reported “providing a business card or bereavement resources with the invitation to call the care provider was not helpful during the initial hours post-notification. A follow-up call or visit was identified as potentially more supportive”, this finding can be generalized to out-of-hospital deaths as well (2011, p. 73). As reported by Olsson (1997) “emotional support was the only supportive function that was fully appraised as supportive during acute crisis reactions while informational support could only be appreciated partially” (p. 122). Additional findings included “the timing issue often required the information to be repeated sometime after the loss in order to be more supportive” (p. 123). Lastly, Olsson stressed the importance of support at the time of death citing “a supportive interaction at the hospital can help prepare the way for
professional intervention as well as for continued support from the informal network or from self-help groups” (1997, p. 127). In addition to studying whether services exist for suddenly bereaved persons in out-of-hospital deaths, it is important that the survey tool for the study at hand assess whether follow-up care providers are following the aforementioned best practices.

**Out-of-hospital Follow-up**

Many of the aforementioned articles regarding follow-up discussed hospital based programs or assessed suddenly bereaved persons in hospital settings. As mentioned previously in the section regarding death notification, hospitals have psychosocial support staff such as social workers and chaplains to provide support at the time of death notification and follow-up support services. However, psychosocial support services are not integrated into the out-of-hospital medical systems of care. This point addresses the research question of the study at hand: where do suddenly bereaved persons for out-of-hospital deaths receive psychosocial follow-up support services and how are they referred? Zalenski et al. cite physicians as a possible source; however, they note family members were unlikely to visit their physician after a sudden death as they were preoccupied with “care for other survivors, funeral arrangements, and estate matters” (2006, p. 1334). A study conducted by Wiles, Jarrett, Payne, and Field (2002) explored factors affecting physician bereavement referrals. The qualitative study used semi-structured interviews and had 50 participating physicians. Wiles et al. found referrals to bereavement services by respondents were rare, and counseling was not offered to all bereaved people. Furthermore, respondents did not feel that absent or delayed grief posed
a threat to patients. It can be extrapolated from these correlated studies that suddenly bereaved persons are unlikely to seek bereavement care from their physicians and even if they did physicians do not accurately assess the need for bereavement care. This indicates that other referral sources need to be available to suddenly bereaved persons in out-of-hospital settings.

As previously described, follow-up care is important for mitigating challenges in the bereavement process. Follow-up care is especially important to suddenly bereaved persons for out-of-hospital deaths as they are at increased risk for difficulties in the grief process. None of the aforementioned articles described the importance of services beyond bereavement care for suddenly bereaved persons, such as crisis intervention. Another aforementioned challenge is many suddenly bereaved persons struggle with secondary stressors such as making final arrangements, financial, legal, and other logistical arrangements. Yet none of the articles found for this literature review addressed the importance of providing ancillary services to suddenly bereaved persons; if left unresolved the aforementioned secondary stressors can contribute to a crisis for the suddenly bereaved person. It can then be concluded that in addition to follow-up bereavement services, suddenly bereaved persons would benefit from crisis intervention services as well.

Programs Supporting Suddenly Bereaved Persons

Suddenly bereaved persons of out of hospital deaths are faced with a number of challenges. They are more at risk for complicated bereavement, PTSD, other mental and physical health factors, and may also need crisis intervention support services. Ideally,
support programs for suddenly bereaved persons for out of hospital deaths would address both bereavement and crisis intervention needs. The need for follow-up is important as many suddenly bereaved persons cannot effectively digest large amounts of information or resources at the time of death. It is important that follow-up happen in the time after the initial death notification. This section of the literature review will present various programs that support suddenly bereaved persons of out-of-hospital deaths.

**Grief Counseling: A Funeral Home- Based Model**

Riordan and Allen (1989) describe a grief counseling program developed by a funeral home near Atlanta, Georgia. It was initially developed as a free grief counseling program for its clientele, but it was later opened up to the wider community. Families were notified of the service at the time funeral arrangements were made. Riordan and Allen explained that the specific program elements were designed to complement existing community resources. The authors described the goal of the program as, “to help the client regroup the resources that may seem estranged because of the client’s perception of hopelessness” (Riordan & Allen, 1989, p. 424). The program format is as follows:

Individual counseling initially takes the form of brief interventions surrounding the early bereavement period rather than the funeral itself. After the initial contact with client families, four additional contacts are made during the next year. Two and one-half moths after the funeral, a letter and brochure are sent reviewing the services and stating the intention of the counselor to call shortly for follow up contact. (Riordan & Allen, 1989, p. 424)
Most participating clients enrolled in counseling two months after the death, and the individual counseling frequently lasted for 8-12 sessions over a 2-3 month period. A four-week structured grief support groups was offered in addition to referrals to individual specialty groups, medical, financial, religious or other counseling resources takes place during group sessions. Within the programs first two years, 200 clients received either individual or group counseling. The program has received positive feedback from participants and expressed their appreciation for the available services (Riordan & Allen, 1989). Unfortunately, this program is no longer in operation.

**Intervention Following a Sudden Death: The Social Work-Medical Examiner Model**

Kintzle and Bride (2010) describe a nine month pilot program in Iowa City, Iowa in which a social worker was embedded into the county medical examiner (ME) team. The ME investigates all death that affects public interest, which the article defined as sudden, unexpected, violent, suspicious or unattended within their jurisdiction. The program was designed to assist families of victims of unexpected death, because according to the authors “survivors of sudden death have an increased susceptibility to the development of complicated grief reactions” (Kintzle & Bride, 2010, p. 221).

Because the ME is mandated to investigate all sudden deaths they come into contact with a large majority of suddenly and traumatically bereaved people. The social worker was integrated into the ME team to provide crisis intervention, bereavement support and education regarding the ME investigation process at the time of death. During subsequent visits, the social worker provides grief and bereavement services along with referrals to community resources. The social worker provides follow-up calls to the families 10 days,
6 weeks and 3 months after the death to assess the family’s needs and provide additional resources if necessary (Kintzle & Bride, 2010). This program is still in operation today, however, the social workers involved in this program are employed on a volunteer basis (Johnson County Medical Examiner).

**Westchester Crisis Counseling Program**

The American Journal of Public Health highlighted a program established in 1980 in Westchester County New York. The county Department of Mental Health founded a program to provide crisis counseling to suddenly bereaved families in Westchester County. The program supported bereaved families of victims of suicide, homicide, accident, or illness. The objectives of the program, as outlined in the article included:

1) identify families of individuals who died by suicide, homicide, accident or unexpected for other reasons: 2) reach out to them in a supportive way; 3) assist them in coming to terms with death 4) create a County service program to meet these objectives. A special family support team was formed to make direct contact with the family members and offer them assistance at no charge. (American Journal of Public Health, 1987, p. 739)

A staff member of the Department of County Mental Health contacted the Medical Examiner Office weekly to obtain information about suddenly bereaved persons and obtain the contact information for next of kin. A letter would be sent to the family by the program explaining services, followed by a telephone call from a staff member. The authors report that the program had been widely accepted:
Between 1980 and December 1985, 563 referrals have been received from the Westchester County Medical examiner. Of that number 170 individuals have accepted help from the staff of Community Service Center and 69 have accepted a referral to another agency. Thus 42.5 percent of the people contacted accept help.


The authors reported that individuals who declined shared that they appreciated that the service existed and some who initially declined requested help 6-12 months later. Unfortunately, no evidence of the program’s current existence could be located.

**The Analyst at the Morgue: Helping Families Deal with Traumatic Bereavement**

Sklarew, Handel, and Ley (2012) report on the Wendt Center for Loss and Healing RECOVER program in Washington DC. The program provides crisis support and bereavement intervention to families of sudden death identifying loved ones at the Office of the Chief Medical Examiner. Established in 1999, the authors report the program has assisted more than 10,000 families. Support begins with a grief counselor meeting the family at the morgue whereupon the grief counselor assists the families through the identification process and provides emotional support. The grief counselor attempts to address all questions and provides referrals to support services in the community. The authors report that the goal of the program is to “lessen the possibility of developing a complicated grief reaction that might result in deep depression and interfere with normal functions, like the ability to work, develop and maintain relationships and love” (Sklarew, Handel, & Ley, 2012, p. 151). The program also offers follow-up support: “Staff call next of kin one month after their visit to the OCME [Office of the
Chief Medical Examiner] and quarterly for a year to offer individual and group psychotherapy for children and adults” (Sklarew, Handel, & Ley, 2012, p. 151). The staff also assesses the need for referrals: “If more professional services are needed and requested, the RECOER counselor will refer the client(s) to assist the family with issues such as housing relocation, financial assistance, work-related needs, mental health counseling referrals, and issue with children, and teens among others” (Sklarew, Handel, & Ley, 2012, p. 151). This program is still in operation today and, according to their website, services 2,500 individuals annually (Wendt Center for Loss and Healing, 2011).

The aforementioned programs are all excellent examples of comprehensive programs that support suddenly bereaved persons for out-of-hospital deaths. An interesting commonality is the role of the coroner/medical examiner in accessing suddenly bereaved persons. All of the programs highlighted the importance of providing crisis intervention and referrals to resources that assist with secondary stressors, in addition to providing grief services. This approach is consistent with the findings of this chapter regarding the support suddenly bereaved persons need following their loved ones death, specifically crisis intervention and grief support. Despite a comprehensive search for support programs for suddenly bereaved persons for out of hospital deaths, the four programs presented were the only programs found to offer this type of support.

Furthermore, two of the four programs presented are no longer in existence. Although the Iowa City program provides social work support, the social workers must volunteer their time which indicates a lack for funding for psychosocial support to suddenly bereaved persons. The presented programs are examples of the type of programs that should exist
to assist suddenly bereaved persons, yet the scarcity of programs to support suddenly bereaved persons for out-of-hospital deaths is disheartening.

Conclusion

This chapter addressed a multitude of risk factors and challenges suddenly bereaved persons of out-of-hospital deaths face as a result of their loved ones death. Sudden death robs an individual from being able to experience anticipatory grief or say goodbye to their loved one. The suddenness of the death also puts the bereaved individual at risk for complicated grief, PTSD, peritraumatic death, cardiac events, and mortality. Suddenly bereaved persons are exposed to a number of secondary stressors related to the death such as making final arrangements and handling any necessary legal and financial matters. Individuals also experience significant changes to their family system and social networks after a sudden death as well. The aforementioned factors illustrate the risk that the target population of this study is exposed to.

The manner in which professionals conduct themselves and interact with suddenly bereaved persons can have a significant impact on the grieving process. Furthermore, the manner in which a person is presented with the notification of their loved ones sudden death can also impact the grief process. Literature was presented that outlined best practices for death notification and care of suddenly bereaved persons at the time of death. A number of articles were cited describing the lack of training EMS and out-of-hospital medical providers receive on death notification and grief support. Suddenly bereaved persons of out-of-hospital death are thereby more at risk for receiving a poorly delivered death notification and subsequently have even more risk for complications to
the grief process. Many articles cited the need for increased training for out-of-hospital medical providers on death notification and grief support.

Due to the high level of risk factors suddenly bereaved persons of out-of-hospital deaths are exposed to it is imperative that follow-up support services are offered. A number of articles presented the importance and positive effects of follow-up care for suddenly bereaved persons. It was also explained that comprehensive follow-up care should include grief support and crisis intervention services. Best practices for follow-up care were also presented. Four programs that provide comprehensive support for out-of-hospital sudden deaths were described. However, as was mentioned previously two of the four programs listed are no longer in operation. Because suddenly bereaved persons have so many risk factors associated with the grief process it is important to assess whether appropriate support programs are available. This study will assess professional’s knowledge of the needs of this population and knowledge of available resources for this vulnerable population.
Chapter 3

METHODOLOGY

This chapter will describe the research methodology employed in this study. The survey design will be presented first, followed by a description of the sampling technique. Next, the data collection procedure will be outlined followed by a detailed explanation of the survey instrument. Data analysis techniques will be discussed, concluding with a discussion of the measures employed to protect human subjects. The methodology employed for this study was chosen specifically to provide the most detailed and accurate data available through secondary professional respondents while preserving the anonymity and confidentiality of participants.

Study Design

Social work research studies commonly use one of the following research designs: exploratory, descriptive, or explanatory. Exploratory research is used to gather general information on a topic when there is little current knowledge or research available. Descriptive studies are used to gather detailed or specific information about a topic or population, on which some current data exists. Explanatory studies aim to provide a causal explanation or relationship between variables related to the topic being studied (Dudley, 2011). This study will employ a descriptive research design using a cross-sectional key-informants/experts survey. Because the study aims to assess detailed information about a particular population, i.e. needs and available services to out-of-hospital bereaved persons, a descriptive research design was deemed most appropriate. Descriptive studies are especially effective at accurately ascertaining detailed information
about the target population. There are some limitations of descriptive studies, specifically related to validity. Internal validity is more difficult to control for, as independent and dependent variables are not included or accounted for in descriptive studies. Because descriptive studies are not randomized, external validity is not possible and generalization is limited. Despite the limitations, given the nature of the research question, a descriptive design is most appropriate for this study.

**Sampling Procedures**

This study included a purposive convenient sample of individuals who work with bereaved persons in a professional capacity. Professionals that were contacted to participate in this study included law enforcement chaplains, bereavement group facilitators, and hospice social workers in El Dorado, Placer, Sacramento, and Yolo counties. Professionals from four law enforcement chaplaincy agencies, eight hospice agencies, and one general bereavement organization were contacted to participate. If a bereavement program was associated with a hospice agency, then the participant was asked to provide information about both the bereavement program and hospice services. With the expectation of having at least 20 respondents, this research project intentionally over-sampled and reached out to seven primary contacts who were asked to forward to the survey onto colleagues at their agency, it is unknown how many individuals received an invitation to participate. At the closure of the survey a total of 26 completed questionnaires were received.

Qualified professional respondents were referred by professional or personal contacts or found via publicly available contact information on their affiliate agency
website. For example, the Sacramento Hospice Consortium website was utilized in obtaining contact information for potential participants, as the email addresses of their members is published on the website. Employing a snowball sampling technique, this researcher asked primary agency contacts to provide the contact information of other potential participants within their agency. This researcher was contacted directly by a number of participants referred by the primary agency contact. An alternative option was also provided in that primary contacts could send the survey to other members of their organization to protect the anonymity of their agency colleagues. Professionals that agreed to participate were informed that they were representing themselves and not their affiliated agency.

**Data Collection Procedures**

An online questionnaire was used to obtain the opinions of professionals who come into contact with out-of-hospital bereaved persons. Potential participants who agreed to partake in the survey were emailed a link to the survey, which was hosted by SurveyMonkey.com. For the participants whom this researcher had an email address, a direct link to the survey was sent via email to each individual participant. Some initial agency contacts preferred not to have colleagues contact this researcher directly. In those cases, this researcher sent an email containing the link to the survey to the agency contact who then forwarded the email to their colleagues.

The survey was available for six weeks after it was initially sent out to participants. An email reminder was sent to participants three weeks and one week before
the survey closed. Following the close of the survey a ‘thank you’ email was sent to participants and a thank you card was sent to all participating agencies.

**Instruments**

The design of the questionnaire was guided by the intent of the study and informed by the current literature. It is not a standardized instrument and has not been thoroughly vetted for validity and reliability of applications beyond this study. Unfortunately, no standardized surveys exists that measures the desired variables for this study; so a survey specifically for this study was developed.

The survey questionnaire (see Appendix A) consisted of 15 multiple choice and open-ended questions. The operational definition of each type of death scenario (traumatic, sudden, and expected) was defined at the beginning of the survey. Participants were asked questions regarding the services offered by their affiliated agency, as well as basic information regarding their professional experience. Subsequent questions addressed participants’ professional opinions of the needs, type of support available, and barriers to support of each bereavement group. A Likert scale was included to assess which group participants felt was the most underserved. Lastly, participants were asked their professional opinion regarding what barriers exist in serving the group they feel was the most underserved, and how to improve access or services that underserved groups. The last question provided an opportunity for participants to include any additional information or thoughts they wanted to add.
Data Analysis

The study collected both qualitative and quantitative data; however, a majority of the survey questions were quantitative. Qualitative data was analyzed using a word processing program to ensure that respondent’s exact wording is recorded. Quantitative data was analyzed using descriptive statistics. Because the study is not explanatory in nature and did not employ an intervention of which the results were measured, only appropriate inferential were applied to the dataset.

A fellow second-year Masters of Social Work colleague agreed to do an independent analysis of the qualitative data. The colleague has completed the same level of coursework and has similar experience and background as well as understanding of ethical considerations in research as this researcher. Therefore, the colleague was considered by this researcher to be a reliable source for qualitative data analysis. The results of the colleague’s completed data analysis were compared with this researcher’s results to ensure inter-rater reliability of the qualitative data.

This researcher used the SPSS program to aid in the statistical analysis of the quantitative data. Quantitative data was downloaded directly from Surveymonkey.com into the SPSS program, thereby limiting the possibility of human error in data transcription. This researcher independently verified the downloaded data against the raw data on the Surveymonkey.com website to ensure accuracy of transcription. SPSS was used to assess descriptive measures and data trends. Because respondents were asked to identify their professional role, this researcher evaluated whether each profession held a
differing assessment of the problem. All other unexpected yet remarkable findings were also presented in the data findings.

**Protection of Human Subjects**

The Protocol for the Protection of Human Subjects was submitted to the California State University, Sacramento Division of Social Work Human Subjects Committee on August 31, 2012. The Protocol was approved as exempt research on September 25th, 2012. A number of precautions were taken to protect the anonymity of participants to ensure exempt status. First and foremost, this researcher chose to survey professionals who come into contact with bereaved persons of out-of-hospital deaths instead of surveying that population directly. Professionals are expected to be reasonably knowledgeable about the needs of the populations they work with, and they should be able to provide detailed information about the needs of the population based on their professional experience. Furthermore, because the professionals work with the population in a helping role, they are able to share what resources they provide to out-of-hospital bereaved persons. Given the experience and expertise of the professionals targeted for this study, it was determined that descriptive and accurate data could be obtained from professionals in lieu of contacting out-of-hospital bereaved persons directly.

A number of measures were put in place to protect the anonymity of the study participants. Firstly, participants were sent an introductory email outlining confidentiality measures, individual/agency anonymity, and a statement regarding voluntary participation. The survey did not contain any questions that could identify participants or participating agencies. Surveymonkey.com was chosen as the vehicle to collect data due
to their robust security features. Data collection was encrypted to ensure that data could not be decoded or linked to respondents. The highest level of data encryption was used, within the limits of availability and feasibility.

Informed consent was to be obtained by participants as a precursor to the survey. Upon following the link to the survey, a statement of consent was presented to participants. Participants had to indicate that they had read the statement of consent and agreed to it before being able to begin the survey, thereby providing their implied consent. Implied consent was appropriate for this project because the research only focuses on the participants’ professional knowledge on the subject matter and the survey/questionnaire did not seek to obtain any identifying information about the individual participant or their affiliated agency. A copy of the consent form is included in Appendix B. All collected data was downloaded using an encrypted secure channel to the researcher’s personal computer. The data on this researcher’s computer was only accessible to this researcher and the computer was password protected. Data will be properly disposed of at the completion of this project or by June 1, 2013.

**Summary**

This chapter provided a detailed description of the research methodology employed for this study. Being as the research question seeks to gain more specific and detailed information about a particular population, a descriptive research design was chosen. To limit the level of risk to human subjects associated with this study, key informants/experts were selected to be surveyed instead of directly surveying the target population. This chapter also provided a detailed explanation of the inclusion criteria for
the selection of the survey participants. A description of the survey tool was included, along with a presentation of the data collection and analysis techniques. Lastly, a report of the measures taken to ensure protection of human subjects was presented. The methodology employed throughout this study will provide protection of participants while ensuring detailed and impactful data can be collected.
Chapter 4

RESULTS

This purpose of this study was meant to research and document the needs of bereaved persons of out-of-hospital deaths. In addition to documenting needs, the study was also meant to document any gaps in service for the previously defined death types: traumatic death, sudden death and expected death. The data for this study was obtained through an online survey created by this researcher and distributed through Surveymonkey.com. Snowball sampling was used to access as many potential respondents as possible. Seven individuals were contacted directly regarding participation in this study. They were asked to forward the survey onto colleagues and other professionals who work in grief/bereavement services, law enforcement chaplaincy, hospice, or other related fields. The total number of potential respondents that received an invitation to participate is unknown. The survey was open for six weeks; upon closing the survey there was a total of 26 respondents. After examining the raw data, only 23 surveys were sufficiently complete to be included in data analysis.

The focus of this chapter is to present the data and analysis as it relates to the research question. General findings consisting of demographic information of respondents will be presented first. Specific findings will be presented in five sections. The first section will present the data related to the type of support respondents’ agencies provide for each death type. Section two will include the data regarding the needs of each death type. Section three will present data regarding where bereaved persons of each death type can access services. Next, section four will include barriers respondent’s face
in providing services to each death type. Lastly, section five will consist of data regarding which death type is the most underserved and why. Each section will include any relevant quantitative and qualitative data as well as analysis and comparison between death types when applicable.

**Overall Findings**

Professionals from a total of four hospice agencies and three law enforcement agencies were asked to participate in this study. Respondents were not asked to identify which specific agency they were affiliated with, but they were asked to specify what type of agency they were affiliated with. Of the 23 total respondents there was a fairly equal distribution between hospice agencies and Law Enforcement Chaplaincy (LEC) agencies. Respondents were also asked to report their number of years of experience in the field of grief/bereavement or crisis support. They were also asked to rate their knowledge of local grief/bereavement or crisis support services. The three death types were defined at the beginning of the survey and made available throughout the survey for the respondents to reference. Respondents were asked to identify which death types their agency supports as defined by the provided definitions. The specific data relating to respondent demographics can be seen in Table 1.
Table 1

Respondent Demographics

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>11</td>
<td>47.80%</td>
</tr>
<tr>
<td>LEC</td>
<td>12</td>
<td>52.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years Experience</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5 years</td>
<td>11</td>
<td>47.80%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>3</td>
<td>13.00%</td>
</tr>
<tr>
<td>10+ years</td>
<td>9</td>
<td>39.10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-Rated Knowledge</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some Knowledge</td>
<td>10</td>
<td>43.50%</td>
</tr>
<tr>
<td>Very Knowledgeable</td>
<td>11</td>
<td>47.80%</td>
</tr>
<tr>
<td>Extremely Knowledgeable</td>
<td>2</td>
<td>8.70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Death Type Agency Serves</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>16</td>
<td>69.60%</td>
</tr>
<tr>
<td>Expected</td>
<td>4</td>
<td>17.40%</td>
</tr>
<tr>
<td>Traumatic/Sudden</td>
<td>3</td>
<td>13.00%</td>
</tr>
</tbody>
</table>

Specific Findings

The survey asked respondents to answer the same four questions related to the needs and available services for each death type. Although the four questions on the survey were grouped by death type, the resulting data from each question will be presented together. This will allow for a clearer comparison to be drawn between the needs and available services for each death type. Tests of association were applied to the data and the results will be presented below. The Fishers Exact Test was selected as the most appropriate test for association because the sample size was so small. The test can be used on 2x2 contingency tables with expected values of 5 or less per cell. When analyzing data for larger contingency tables the Mantel-Haenszel Test for Linear Association was used as that test can also be applied for tables with expected values of 5 or less per cell. For the duration of this chapter the type of test used along with level of
significance will be specified. Table 9 provides a complete list of the test of association results, it can be found at the end of this section.

Respondents were asked to list the type of support they offered to bereaved persons of each death type, this data can be viewed in Table 2. Using Fishers Exact Test (p<.1) there was association between the type of support offered to traumatic death type and the agency type. Bereavement Support groups were associated with hospice agencies with a p =.000, whereas crisis intervention and spiritual support was associated with LEC agencies both with a p = .000. In regards to sudden death, as with traumatic death, there was an association between the type of agency and services offered. Using the Fisher’s Exact Test (p<.1), it was found that hospice agencies were associated with offering bereavement support groups with p = .003. Whereas LEC were associated with providing crisis intervention with p=.002 and spiritual services p=.010. In the case of expected death, there was also an association between hospice agencies and bereavement support groups, using Fisher’s Exact Test (p<.1), the result was p=.001. However, unlike sudden and traumatic death types, there was no association found between crisis intervention services and spiritual services and LEC. This indicates that hospice agencies provide that type of care to expectedly bereaved persons but not to suddenly bereaved persons or traumatically bereaved persons.

There were other types of support offered to this group through hospice, including, legal advice and financial planning. Also noted was the number of agencies providing mental health services and case management increased for expected death. This data confirms what was described in Chapter One, that hospice agencies have
comprehensive psychosocial support to provide to patients and families. However, hospice services are only available when the death is anticipated, which, per the definition of this study, would be in the case of expected death.

Table 2

*Services Offered*

<table>
<thead>
<tr>
<th>Services Offered</th>
<th>Traumatic N</th>
<th>Percent</th>
<th>Sudden N</th>
<th>Percent</th>
<th>Expected N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement Support Group</td>
<td>11</td>
<td>20.80%</td>
<td>11</td>
<td>20.40%</td>
<td>12</td>
<td>17.40%</td>
</tr>
<tr>
<td>Case Management</td>
<td>2</td>
<td>3.80%</td>
<td>3</td>
<td>5.60%</td>
<td>6</td>
<td>8.70%</td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>14</td>
<td>26.40%</td>
<td>14</td>
<td>25.90%</td>
<td>14</td>
<td>20.30%</td>
</tr>
<tr>
<td>Financial Planning</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>1</td>
<td>1.40%</td>
</tr>
<tr>
<td>Legal Advice Services</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>1</td>
<td>1.40%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>1</td>
<td>1.90%</td>
<td>2</td>
<td>3.70%</td>
<td>5</td>
<td>7.20%</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>3</td>
<td>4.30%</td>
</tr>
<tr>
<td>Pediatric Bereavement Support</td>
<td>4</td>
<td>7.50%</td>
<td>5</td>
<td>9.30%</td>
<td>7</td>
<td>10.10%</td>
</tr>
<tr>
<td>Spiritual Support</td>
<td>14</td>
<td>26.40%</td>
<td>13</td>
<td>24.10%</td>
<td>16</td>
<td>23.20%</td>
</tr>
<tr>
<td>Suicide Prevention Support</td>
<td>7</td>
<td>13.20%</td>
<td>6</td>
<td>11.10%</td>
<td>4</td>
<td>5.80%</td>
</tr>
</tbody>
</table>

This question also allowed respondents to indicate ‘other’ and provide an open-ended description of other types of support their agency offers to each group. The data collected from this question was analyzed using the qualitative analysis technique of word counting. In the case of traumatic and sudden death the four out of five qualitative responses, three LEC-affiliated respondents and one hospice-affiliated respondent, mentioned offering referrals. In the case of expected death the most frequently mentioned type of support was individual counseling, and only hospice respondents mentioned that type of support. Again the qualitative data illustrates that hospice agencies have a wide range of services for persons of expected death. Although LEC and hospice provide
referrals to traumatic and suddenly bereaved persons, they do not offer the same type of
direct support that hospice does to expectedly bereaved persons.

The next question asked respondent’s to indicate the five most urgent needs of
bereaved persons of each death type, these needs are presented in Table 2.

Table 3

<table>
<thead>
<tr>
<th>Most Urgent Needs</th>
<th>Traumatic</th>
<th>Sudden</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Percent</td>
<td>Rank</td>
<td>N</td>
</tr>
<tr>
<td>Bereavement Support Group</td>
<td>15</td>
<td>12.80%</td>
<td>(2)</td>
</tr>
<tr>
<td>Childcare Services</td>
<td>1</td>
<td>0.90%</td>
<td></td>
</tr>
<tr>
<td>County Financial Assistance</td>
<td>4</td>
<td>3.40%</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>22</td>
<td>18.80%</td>
<td>(1)</td>
</tr>
<tr>
<td>Estate Planning</td>
<td>3</td>
<td>2.60%</td>
<td></td>
</tr>
<tr>
<td>Financial Planning</td>
<td>2</td>
<td>1.70%</td>
<td></td>
</tr>
<tr>
<td>Funeral Home</td>
<td>12</td>
<td>10.30%</td>
<td>(3)</td>
</tr>
<tr>
<td>Hospice</td>
<td>1</td>
<td>0.90%</td>
<td></td>
</tr>
<tr>
<td>Legal Advice</td>
<td>10</td>
<td>8.50%</td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>12</td>
<td>10.30%</td>
<td></td>
</tr>
<tr>
<td>Private Practice Therapy</td>
<td>3</td>
<td>2.60%</td>
<td></td>
</tr>
<tr>
<td>Specialized Support</td>
<td>15</td>
<td>12.80%</td>
<td>(2)</td>
</tr>
<tr>
<td>Spiritual Services</td>
<td>15</td>
<td>12.80%</td>
<td>(2)</td>
</tr>
<tr>
<td>Suicide Prevention Services</td>
<td>2</td>
<td>1.70%</td>
<td></td>
</tr>
</tbody>
</table>

An association was found between agency types and perceived needs of traumatic
death type. Using Fisher’s Exact Test (p<.1), LEC-affiliated respondents indicated
bereavement support as a need more than hospice-affiliated respondents with p=.071.

Another association was found, using the same test and level of significance, that
hospice-affiliated respondents listed mental health services as a need more than LEC-
affiliated respondents with p=.009. Lastly, LEC-affiliated respondents indicated spiritual
services as a need more than hospice with p=.071. No association was found when years
of experience and knowledge were compared against perceived needs.
An association was found between agency type and perceived need for the sudden death type. Using Fishers Exact Test (p<.1), LEC-affiliated respondents indicated Spiritual Services as an urgent need more than hospice respondents with p=.001. Using Mantel-Haenszel Test for Linear Association (p<.1), an association was found between respondents who rated themselves as being some/very knowledgeable of local grief/bereavement or crisis services and listing Funeral Home as an urgent need with p=.008. No association was found between the type of support selected and years of experience.

An association was found between agency type and perceived needs for the expected death type. Using Fisher’s Exact Test (p<.1), an association was found: LEC-affiliated respondents indicated ‘Crisis Intervention Services’ as a need and hospice respondents did not indicate that as a need with p=.045. There was also an association between agency type and indicating ‘Mental Health Services’ as a need; hospice-affiliated respondents more frequently listed ‘Mental Health Services’ as a need than LEC-affiliated respondents, with p=.024. A possible explanation for the discrepancy in reported needs by agency type is that expectedly bereaved persons are not the target population for LEC agencies, so those respondents might not be as familiar with the needs of expectedly bereaved persons. No association was found between years of experience/knowledge and perceived needs.

It was also noted that each death type shared similar urgent needs; however, the needs were ranked differently depending on the type of death. Mental health services were rated much higher for traumatic death, at 10.3%, than for sudden death, which was...
at 6.1%. This data conflicts with current research described in Chapter Two, specifically that survivors of sudden death are at a high risk for developing mental health problems after the death of a loved one. Furthermore, crisis intervention services was listed as the most urgent need for traumatic death type but only the third most urgent need for sudden death type. This data also conflicts with the scholarly literature presented in Chapter Two, which indicates that a sudden death can cause an acute crisis of a family, despite the circumstances of the death. Therefore, such as in the case of traumatic death type, crisis intervention should be just as important for the sudden death type. Although Spiritual Services was listed as a top five need that number may be skewed due to the all of the participating LEC agencies having a focus on religious services as well as crisis intervention.

There was not an overwhelming consensus among qualitative data regarding needs. The most notable responses for needs of traumatically bereaved included accessing support from church, referral to Victim Compensation, and referral to corner. There was only one qualitative response for additional needs of suddenly bereaved persons, which was education on coroner proceedings. Likewise, there was only one qualitative response for additional needs of expectedly bereaved persons, which was grief education.

The next question asked respondents to rank the five most likely places bereaved persons of each death type would access services. The data from this question can be viewed in Table 4.
Table 4

*5 Most Likely Places to Access Support*

<table>
<thead>
<tr>
<th>Likely to Access Services</th>
<th>Traumatic N</th>
<th>Percent</th>
<th>Rank</th>
<th>Sudden N</th>
<th>Percent</th>
<th>Rank</th>
<th>Expected N</th>
<th>Percent</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement Support Group</td>
<td>19</td>
<td>19.20%</td>
<td>(2)</td>
<td>18</td>
<td>20.50%</td>
<td>(1)</td>
<td>20</td>
<td>21.70%</td>
<td>(1)</td>
</tr>
<tr>
<td>Case Management Agency</td>
<td>2</td>
<td>2.00%</td>
<td></td>
<td>2</td>
<td>2.30%</td>
<td></td>
<td>4</td>
<td>4.30%</td>
<td></td>
</tr>
<tr>
<td>Childcare Services</td>
<td>1</td>
<td>1.00%</td>
<td></td>
<td>1</td>
<td>1.10%</td>
<td></td>
<td>1</td>
<td>1.10%</td>
<td></td>
</tr>
<tr>
<td>County General Assistance</td>
<td>1</td>
<td>1.00%</td>
<td></td>
<td>2</td>
<td>2.30%</td>
<td></td>
<td>3</td>
<td>3.30%</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>20</td>
<td>20.20%</td>
<td>(1)</td>
<td>17</td>
<td>19.30%</td>
<td>(2)</td>
<td>8</td>
<td>8.70%</td>
<td>(4)</td>
</tr>
<tr>
<td>Estate Planning</td>
<td>1</td>
<td>1.00%</td>
<td></td>
<td>3</td>
<td>3.40%</td>
<td></td>
<td>5</td>
<td>5.40%</td>
<td></td>
</tr>
<tr>
<td>Financial Planning</td>
<td>1</td>
<td>1.00%</td>
<td></td>
<td>3</td>
<td>3.40%</td>
<td></td>
<td>7</td>
<td>7.60%</td>
<td>(5)</td>
</tr>
<tr>
<td>Homicide Support Network</td>
<td>5</td>
<td>5.10%</td>
<td></td>
<td>1</td>
<td>1.10%</td>
<td></td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>7</td>
<td>7.10%</td>
<td></td>
<td>10</td>
<td>11.40%</td>
<td>(4)</td>
<td>19</td>
<td>20.70%</td>
<td>(2)</td>
</tr>
<tr>
<td>Legal Advice</td>
<td>4</td>
<td>4.00%</td>
<td></td>
<td>4</td>
<td>4.50%</td>
<td></td>
<td>4</td>
<td>4.30%</td>
<td></td>
</tr>
<tr>
<td>MADD</td>
<td>3</td>
<td>3.00%</td>
<td></td>
<td>1</td>
<td>1.10%</td>
<td></td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Other Support Group</td>
<td>9</td>
<td>9.10%</td>
<td>(5)</td>
<td>14</td>
<td>15.90%</td>
<td>(3)</td>
<td>16</td>
<td>17.40%</td>
<td>(3)</td>
</tr>
<tr>
<td>Suicide Prevention Services</td>
<td>3</td>
<td>3.00%</td>
<td></td>
<td>3</td>
<td>3.40%</td>
<td></td>
<td>2</td>
<td>2.20%</td>
<td></td>
</tr>
<tr>
<td>Survivors of Suicide</td>
<td>11</td>
<td>11.10%</td>
<td>(4)</td>
<td>4</td>
<td>4.50%</td>
<td></td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Victims Witness Assistance</td>
<td>12</td>
<td>12.10%</td>
<td>(3)</td>
<td>5</td>
<td>5.70%</td>
<td>(5)</td>
<td>3</td>
<td>3.30%</td>
<td></td>
</tr>
</tbody>
</table>

An association was found between agency type and where traumatically bereaved persons would access services. Using the Fisher’s Exact Test (p<.1), LEC-affiliated respondents more frequently indicated crisis intervention services with p=.093. Using Mantel-Haenszel Test for Linear Association with p<.1, respondents with 6 or more years of experience indicated that traumatically bereaved persons would access Survivors of Suicide support with p=.082. Using the same test and significance level, an association was found between self-rated experience level and where traumatically bereaved persons would access services. Respondents who rated themselves very and extremely knowledgeable indicated that traumatically bereaved persons would access Victim Witness Assistance with p=.007.
Using Fisher’s Exact Test (p<.1), an association was found with agency type and where suddenly bereaved persons would access services. LEC-affiliated respondents were more likely to report crisis intervention as a service suddenly bereaved were likely to access with p=.059. No other association was found with agency type. Associations were not found between years of experience or knowledge of resources and the most likely places suddenly bereaved persons would access services.

No associations found were between where expectedly bereaved persons would access services with agency type, years’ experience, or knowledge.

There was a slight difference between where each bereaved persons of death type would access services, see Table 5. For example, crisis intervention was listed first for traumatically bereaved, at 20.2% and bereavement groups second at 19.2%. Whereas bereavement support groups were listed first for suddenly bereaved persons at 20.5% with crisis intervention second at 19.3%. Expectedly bereaved had bereavement support group first at 21.7% and hospice agencies second at 20.7%. Upon comparing the top five needs with the top five places most likely to access support, traumatic death and expected death were best matched, whereas sudden death was not as well matched. Specifically, hospice and victims witness assistance were listed as the fourth and fifth most likely place suddenly bereaved persons would access services. This implies that respondents may not have clearly understood the definition for sudden death, being as sudden death was defined as a death with less than 24 hours’ notice and of a natural cause. Although in rare cases these persons might be admitted to hospice for less than 24 hours that may not be the case for most sudden deaths. Furthermore, because sudden death was defined as
death from a natural cause, they would most likely not be eligible for victims witness assistance. The mismatch between perceived needs and where suddenly bereaved persons can access services also illustrates a gap between what this group needs and what is available. Respondents misinterpreting death type definitions will be explored more thoroughly in Chapter Five.

Table 5

*Needs Versus Where Likely to Access Support*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Needs</th>
<th>Access Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Traumatic Death</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Crisis Intervention Services</td>
<td>Crisis Intervention Services</td>
</tr>
<tr>
<td>2</td>
<td>Bereavement Support Group</td>
<td>Bereavement Support Group</td>
</tr>
<tr>
<td>3</td>
<td>Spiritual Services</td>
<td>Victims Witness Assistance</td>
</tr>
<tr>
<td>4</td>
<td>Specialized Support</td>
<td>Survivors of Suicide</td>
</tr>
<tr>
<td>5</td>
<td>Funeral Home</td>
<td>Other Support Group</td>
</tr>
<tr>
<td></td>
<td><strong>Sudden Death</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Bereavement Support Group</td>
<td>Bereavement Support Group</td>
</tr>
<tr>
<td>2</td>
<td>Funeral Home</td>
<td>Crisis Intervention Services</td>
</tr>
<tr>
<td>3</td>
<td>Crisis Intervention Services</td>
<td>Other Support Group</td>
</tr>
<tr>
<td>4</td>
<td>Spiritual Services</td>
<td>Hospice</td>
</tr>
<tr>
<td>5</td>
<td>Specialized Support</td>
<td>Victims Witness Assistance</td>
</tr>
<tr>
<td></td>
<td><strong>Expected Death</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Bereavement Support Group</td>
<td>Bereavement Support Group</td>
</tr>
<tr>
<td>2</td>
<td>Funeral Home</td>
<td>Hospice</td>
</tr>
<tr>
<td>3</td>
<td>Hospice</td>
<td>Other Support Group</td>
</tr>
<tr>
<td>4</td>
<td>Spiritual Services</td>
<td>Crisis Intervention Services</td>
</tr>
<tr>
<td>5</td>
<td>Crisis Intervention Services</td>
<td>Financial Planning</td>
</tr>
</tbody>
</table>

There was some qualitative data related to where bereaved persons of each death type would access services. The most notable responses for traumatic death type were church, law enforcement, and victim advocates. For sudden death type, the most common response was seeking a chaplain. The qualitative data for where expected death survivors would seek services included church/religious provider and private practice therapist.
The last question respondents were asked about each death type was regarding barriers their agency faces in serving each death type, as seen in Table 6.

Table 6

Barriers to Support

<table>
<thead>
<tr>
<th></th>
<th>Traumatic</th>
<th></th>
<th>Sudden</th>
<th></th>
<th>Expected</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>Not Target Population</td>
<td>10</td>
<td>34.50%</td>
<td>7</td>
<td>35.00%</td>
<td>4</td>
<td>33.30%</td>
</tr>
<tr>
<td>No Contact with this Population</td>
<td>6</td>
<td>20.70%</td>
<td>4</td>
<td>20.00%</td>
<td>1</td>
<td>8.30%</td>
</tr>
<tr>
<td>Not Referred to My Agency</td>
<td>5</td>
<td>17.20%</td>
<td>4</td>
<td>20.00%</td>
<td>5</td>
<td>41.70%</td>
</tr>
<tr>
<td>Not Eligible for Services at My Agency</td>
<td>2</td>
<td>6.90%</td>
<td>1</td>
<td>5.00%</td>
<td>1</td>
<td>8.30%</td>
</tr>
<tr>
<td>No Agency Funding</td>
<td>6</td>
<td>20.70%</td>
<td>4</td>
<td>20.00%</td>
<td>1</td>
<td>8.30%</td>
</tr>
</tbody>
</table>

There was an association between agency type and barriers to service. The most significant association was hospice affiliated respondents reporting that traumatically bereaved persons were not their agency target population. Using Fisher’s Exact Test (p<.1), resulted in a p-value of p= .001. Hospice affiliated respondents also were associated with selecting no contact with traumatically bereaved persons. Using the same test and significance level resulted in a p-value of p= .059. No association was found between self-rated knowledge and barriers. Years’ experience was not tested against barriers for any death type as it was not considered an independent variable in this case.

There was a partial association between respondents’ agency type and one barrier to supporting suddenly bereaved persons: specifically, respondents affiliated with hospice agencies responded that no contact was a barrier to this group and LEC respondent’s responded that it wasn’t a barrier. Using a Fisher’s Exact Test (p<.1) resulted in a p-value of p=.037. No other associations were found based on agency type, or knowledge.
No association was found between barriers to serving bereaved persons of expected death and agency type, knowledge of the field, or years of experience. A greater number of respondents answered the question regarding barriers for traumatic and sudden death types than expected death, traumatic n=29, sudden n=20, and expected n= 12. The most frequently cited barrier for both traumatic and sudden was Not Target Population, which was associated with hospice-affiliated respondents, which confirms what was described in Chapter One. Three LEC-affiliated respondents and one hospice-affiliated respondent reported facing barriers in serving all death types. Four LEC-affiliated respondents reported no barriers to any death type. This may be because each individual agency may differ in which population they are able to provide services to.

Qualitative data was also collected regarding barriers agencies face in providing services to each death type. The number one barrier reported by LEC-affiliated respondents to providing services to traumatically bereaved persons was lack of referrals from law enforcement. Other barriers included their agencies are not well known by public, refusal of services from survivors. Hospice-affiliated respondents reported limited funding was the biggest barrier to supporting traumatically bereaved persons. There was no qualitative data regarding barriers to serving suddenly bereaved persons. Qualitative data was also reported for expected death type. The number one barrier to serving expectedly bereaved persons reported by hospice-affiliated respondents was no access to this population if the deceased was not on hospice services. LEC-affiliated respondent’s biggest reported barrier was not being contacted for this death type.
Respondents were asked to rate the extent to which they thought each death type was underserved, see Table 7.

Table 7

*Amount Underserved*

<table>
<thead>
<tr>
<th></th>
<th>Traumatic</th>
<th></th>
<th>Sudden</th>
<th></th>
<th>Expected</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>4.30%</td>
<td>0</td>
<td>0%</td>
<td>6</td>
<td>26.10%</td>
</tr>
<tr>
<td>Small</td>
<td>6</td>
<td>26.10%</td>
<td>6</td>
<td>26.10%</td>
<td>7</td>
<td>30.40%</td>
</tr>
<tr>
<td>Some</td>
<td>8</td>
<td>34.80%</td>
<td>8</td>
<td>34.80%</td>
<td>1</td>
<td>4.30%</td>
</tr>
<tr>
<td>Large</td>
<td>3</td>
<td>13%</td>
<td>4</td>
<td>17.40%</td>
<td>2</td>
<td>8.70%</td>
</tr>
</tbody>
</table>

No association was found between agency type and which group respondents felt was most underserved. Because this question was a scaling question, respondents could rate how underserved they thought the death types were in comparison of each other. In an attempt to find an association, this researcher extracted the most underserved death type reported by each respondent. That data was then tested against agency affiliation, however no association was found. The extracted data was compared against years of experience and self-rated knowledge with no associations found. When comparing the frequency tables it is notable that no respondent marked Sudden Death as ‘None’ for amount underserved. Furthermore, expected death type was indicated to be the least underserved, whereas traumatic death and sudden death types were very similar in the amount respondents felt they were underserved. Overall, the sudden death type was perceived to be slightly more underserved than the traumatic death type. This data confirms what was discussed in Chapter One and Chapter Two, bereaved persons of sudden death are more underserved than bereaved persons of expected death and
bereaved persons of traumatic death. Although traumatic death was perceived to be very close to sudden death in the level that population is underserved.

Respondents were also asked to indicate what factors contributed to the most underserved death type being underserved, as shown in Table 8.

Table 8

*Reasons Why Underserved*

<table>
<thead>
<tr>
<th>Reason</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Public Awareness</td>
<td>9</td>
<td>28.10%</td>
</tr>
<tr>
<td>Low Professional Awareness</td>
<td>7</td>
<td>21.90%</td>
</tr>
<tr>
<td>Funding</td>
<td>6</td>
<td>18.80%</td>
</tr>
<tr>
<td>No Available Services</td>
<td>5</td>
<td>15.60%</td>
</tr>
<tr>
<td>Accessibility</td>
<td>3</td>
<td>9.40%</td>
</tr>
<tr>
<td>Need Not Significant</td>
<td>2</td>
<td>6.30%</td>
</tr>
</tbody>
</table>

No association was found between reasons why underserved, agency type, years’ experience, or self-rated knowledge level. Again in an attempt to find an association, this researcher extracted the most underserved death type reported by each respondent and compared it reasons why underserved with agency type, years’ experience, and self-rated knowledge. No association was found between any of the aforementioned variables.

Respondents provided a wealth of qualitative answers regarding what could be done to improve services to the group that was most underserved. Two LEC-affiliated respondents and two hospice-affiliated respondents provided feedback about how service could be improved for bereaved persons of traumatic death. Their recommendations were focused on improving the integration between law enforcement/first responders and grief/bereavement and crisis support services. Qualitative data regarding ways to improve services for bereaved persons of sudden death was collected from three LEC-affiliated
respondents and three hospice-affiliated respondents. The recommendations for improving services to suddenly bereaved persons included increased hospice funding to support suddenly bereaved persons, low-cost individual grief counseling, better integration between law enforcement/first responders and grief/bereavement support services, and increased public awareness of this population. There was limited qualitative data regarding improving services to expectedly bereaved persons, it included increased awareness of hospice to ensure more time sensitive referrals. Two themes are present among the recommendations for all the death types, improve integration between law enforcement/first responders to increase referrals to grief/bereavement and crisis support services as well as increased public awareness regarding services available to bereaved persons of out-of-hospital deaths.
### Table 9

**Tests of Association Results**

<table>
<thead>
<tr>
<th>Death Type</th>
<th>Agency Offered Support</th>
<th>Agency Type *</th>
<th>Years Experience**</th>
<th>Self-Rated Knowledge**</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>Bereavement Support</td>
<td>Hospice</td>
<td>LEC</td>
<td>6 to 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>Crisis Intervention</td>
<td></td>
<td></td>
<td>p=.000</td>
</tr>
<tr>
<td>T</td>
<td>Spiritual Services</td>
<td></td>
<td></td>
<td>p=.000</td>
</tr>
<tr>
<td>S</td>
<td>Bereavement Support</td>
<td></td>
<td></td>
<td>p=.003</td>
</tr>
<tr>
<td>S</td>
<td>Crisis Intervention</td>
<td></td>
<td></td>
<td>p=.002</td>
</tr>
<tr>
<td>S</td>
<td>Spiritual Services</td>
<td></td>
<td></td>
<td>p=.010</td>
</tr>
<tr>
<td>E</td>
<td>Bereavement Support</td>
<td></td>
<td></td>
<td>p=.001</td>
</tr>
</tbody>
</table>

**Most Urgent Need**

| T          | Bereavement Support     |               |                    | p=.071   |     |      |      |          |
| T          | Mental Health Services  |               |                    | p=.009   |     |      |      |          |
| T          | Spiritual Services      |               |                    | p=.071   |     |      |      |          |
| S          | Spiritual Services      |               |                    | p=.001   |     |      |      |          |
| S          | Funeral Home            |               |                    | p=.008   |     | .008 |      |          |
| E          | Crisis Intervention     |               |                    | p=.045   |     |      |      |          |
| E          | Mental Health Services  |               |                    | p=.024   |     |      |      |          |

**Likely Access Support**

| T          | Crisis Intervention     |               |                    | p=.093   |     |      |      |          |
| T          | Survivors of Suicide    |               |                    | p=.082   | .082|      |      |          |
| T          | Victims Witness         |               |                    | p=.007   | .007|      |      |          |
| S          | Crisis Intervention     |               |                    | p=.059   |     |      |      |          |

**Barriers to Support**

| T          | Not Target Population   |               |                    | p=.001   |     |      |      |          |
| T          | No Contact              |               |                    | p=.059   |     |      |      |          |
| S          | No Contact              |               |                    | p=.037   |     |      |      |          |

---

*Fishers Exact Test (p<.1)  **Mantel-Haenszel Test for Linear Association (p<.1)

### Summary

The purpose of this study, as stated in Chapter One, was to document needs and support services available to bereaved persons of out-of-hospital deaths. This study also
meant to document any gaps in the service delivery system and document the needs of those underserved by the current system. The scope of this study was limited to the greater Sacramento area; therefore the resulting data is only applicable to services available within that area. By surveying professionals who work in the field of grief/bereavement and crisis intervention, sufficient data was collected to illustrate the needs of bereaved persons of out-of-hospital deaths and document gaps in the service delivery system. As described in Chapter One, in the case of expected death, bereaved persons have access to a wide range of support services through hospice agencies. Furthermore, those services are offered by the hospice agency, which prevents bereaved persons from having to be referred out for services such as case management or mental health support. Traumatic death and sudden death types are not as well supported by the current service delivery system. Although LEC agencies offer crisis intervention services and spiritual support services, many of the other needs of this population as described in scholarly literature presented in Chapter Two are not met by the services offered by LEC agencies. Fortunately, respondents provided a wealth of ideas regarding how to improve services for bereaved persons underserved by the current delivery system which will be discussed further in Chapter Five.
Chapter 5

DISCUSSION

This study was inspired by the researcher’s experience with the sudden natural death of a loved one. Although that experience was fortifying in many ways it wasn’t until many years later, after witnessing the type of support that can be afforded to bereaved persons, was it apparent how different that experience could have been. The circumstance of every death is just as unique as the person who is leaving this world as a result of it. The needs of the bereaved loved ones that are left behind are also unique. Every person experiences grief differently and has needs for support during the grief process; however, the nature of the death should not dictate the services available to the bereaved. This study was not intended to criticize hospice, hospitals, or any other institution that provides support to bereaved persons who qualify for services. This study was intended to shed light on the disparity between the types of support available to some bereaved persons as compared to others. The primary goal of this study was to document the needs and available services to bereaved persons of out-of-hospital deaths. This was achieved by surveying professionals who work in agencies that provide support to bereaved persons of out-of-hospital deaths in the greater Sacramento area, specifically hospice and law enforcement chaplaincy (LEC) agencies.

The needs of bereaved persons of out-of-hospital deaths as described through the professional opinion of respondents were successfully documented through the course of this study. Death types were classified and defined for respondents to investigate whether the type of death influenced the services available to the bereaved, see Chapter One,
“Definition of Terms,” for definitions. Respondents were asked to rate the five most urgent needs of each death type. The needs ‘Crisis Intervention’, ‘Bereavement Services’, ‘Funeral Home’, and ‘Spiritual Services’ were noted as a top five need for all death types but they were ranked differently for each death type. In the case of traumatic and sudden death there was an association between the agencies and type of services offered: LEC agencies offered crisis intervention services and hospice agencies offered bereavement services. That association was only partially present for expected death. Also in the case of expected death, bereavement services were associated with hospice. There was not an association between LEC agencies and crisis intervention services for the expected death type, which indicates that both hospice agencies and LEC agencies offers crisis intervention services to expectedly bereaved persons. In the qualitative data, both types of respondents indicated that they offer referrals to all death types; however, it is unclear how and to where those referrals are made.

It was interesting that ‘Spiritual Services’ was listed as such an urgent need for each death type, as there was no scholarly data which concurs with that. The emphasis given to spiritual needs was associated with the LEC agencies’ respondents; all three LEC agencies are faith based organizations. If ‘Spiritual Services’ were removed from the top five most urgent need list, then ‘Mental Health Services’ would be included as a top five most urgent need for all death types. The literature in Chapter Two clearly emphasized the mental health risks for bereaved persons of sudden and traumatic death, including: Post Traumatic Stress Disorder, Complicated Grief, and Peritraumatic Stress. A few respondents reported providing mental health services, but it varied by death type:
one respondent for traumatically bereaved, two respondents for suddenly bereaved, and five for expectedly bereaved. In all cases, the respondents that reported providing mental health services were hospice-affiliated. The aforementioned information shows a disproportionate amount of mental health services available to expectedly bereaved persons as opposed to suddenly and traumatically bereaved. That disproportion is concerning because, as the scholarly literature cited in Chapter Two showed, suddenly and traumatically bereaved persons are more prone to mental health problems following the death of a loved one than expectedly bereaved persons. In the qualitative data about agency offered services, respondents of both types reported providing referrals to all death types. However, respondents did not specify where those referrals are to, so it may be possible that agencies refer to mental health services, but this survey did not provide conclusive evidence of that. Mental health services were described as a need for suddenly and traumatically bereaved persons by both scholarly literature and respondents to this survey, yet the data from this survey shows little support is currently available to meet this need.

The scholarly literature in Chapter Two described challenges faced by suddenly bereaved persons, including: health risks and secondary stressors such as financial strain, legal issues, childcare issues, changes to social network, and more. The literature also emphasized the importance of follow up care for suddenly and traumatically bereaved persons. The aforementioned needs were not highly rated by respondents for any death type. Furthermore, only one respondent reported offering services related to secondary stressors; one hospice-affiliated respondent reported providing ‘Legal Advice Services’
and ‘Financial Planning’. In regards to follow-up care, Centers for Medicare & Medicaid Services (CMS) mandates that all hospice providers provide follow-up care and bereavement services to all families of hospice patients for up to one year following the death of the patient (Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS), 2010). It was not clear from the collected data the extent or length of time LEC agencies provide care or if they follow-up with clients after initial care is provided. However, each of the websites for participating LEC agencies describes their services as short-term crisis intervention assistance. Agency representatives whom this researcher spoke with when doing preliminary research for this study also described services as short-term crisis intervention. It would be necessary to get a more thorough description from LEC agencies regarding the length of time clients are supported as well as what type of follow-up care is provided. With the data from this survey it is not possible to definitively determine whether adequate follow-up services are available to meet the needs of suddenly and traumatically bereaved persons.

It was interesting to compare the indicated needs versus where respondents felt bereaved persons would access services as displayed on Table 14, Needs Versus Where Likely to Access Services. The needs and where likely to access services were well aligned for traumatic and expected death types, but not for sudden death. Two of the places respondents indicated suddenly bereaved persons would access services, ‘Victims Witness Assistance’ and ‘Hospice’, suddenly bereaved persons, as defined by this survey, are not eligible to access services. It appeared that respondents had a difficult time deciphering between the different death types. It was especially important to this
researcher to distinguish between traumatic and sudden death. That distinction was important because of the specialized support services available to traumatically bereaved persons such as Victims Witness Assistance, Survivors of Suicide, Mothers Against Drunk Driving, etc. (see Chapter One for a more detailed description of services for these agencies). However, the distinction between sudden death (unexpected from a natural cause) and traumatic death (unexpected from a non-natural cause) may have confused respondents as evidenced by some responses related to sudden death type. For example, respondents indicated suddenly bereaved persons could access services from Victims Witness Assistance, but the definition of sudden death stated the death was from a natural cause. Therefore, those families could not access Victims Witness Assistance because the death was not a result of a crime.

In retrospect, it may have been clearer for respondents if there was just a distinction between unexpected death and expected death. Overall, traumatic death type and sudden death type were perceived as underserved by respondents. Based on the data collected from this study and as the aforementioned discussion suggests, sudden and traumatic death are not afforded the breadth of services available to expectedly bereaved persons, whereas expectedly bereaved persons seem to be well served by the current service delivery system. This conclusion confirms the assertion made by this researcher in Chapter One.

Respondents of both types reported similar barriers to serving suddenly and traumatically bereaved persons. The most prominent barrier reported by LEC-affiliated respondents was a lack of referrals by law enforcement. They also indicated needing
better integration between LEC agencies and law enforcement/first responder agencies. Hospice-affiliated respondents reported that the biggest barrier to supporting the aforementioned death types was limited funding. Although CMS mandates follow up care and bereavement support to hospice families, they do not mandate hospice agencies provide community bereavement support. Many of the hospice agencies in the greater Sacramento area vary on whether community support is provided and, if so, the extent the support is provided. That variation is probably true on a national basis as well, but that is just conjecture and has not been researched. Many respondents provided suggestions on improving services; their recommendations centered on improving integration between law enforcement/first responders with crisis intervention services and bereavement services. This would enable more referrals of suddenly and traumatically bereaved persons to support services. Increased funding to hospice agencies to provide services to the community was suggested by multiple respondents as well. Lastly, respondents of both types indicated that free or low-cost long-term counseling services should be made available to suddenly and traumatically bereaved persons. Ultimately, it would be up to individual agencies to research and implement the various recommendations; however, it is unknown whether the motivation or means exist to do so.

The most discouraging finding of this study was the lack of information on this topic. Despite an exhaustive search, this researcher was unable to find any entity that tracks out-of-hospital deaths on a local or national level. It was quite clear based on this study, despite its small scope, that there is a disparity between the types of services available to bereaved persons of out-of-hospital deaths. Although some services are
available to sudden and traumatically bereaved persons, they are not as comprehensive or easy to access as hospice is to expectedly bereaved persons. Ultimately, there needs to be increased attention and research on this topic. Both public and professional awareness of this topic must be increased to ensure that the needs of all out-of-hospital bereaved persons are met.

**Implications for Social Work**

This researcher hopes that this study will bring awareness to the profession about the differences in support services available to bereaved persons of out-of-hospital death. As mentioned before, this researcher could not find any entity that tracks out-of-hospital deaths and there is very little research on this topic. The lack of information provides an opportunity for social workers to further research this topic and increase awareness. Currently there are social workers employed in hospitals who support bereaved persons in that setting, with crisis intervention, bereavement referrals, and other types of referrals. There are also social workers employed in hospice who provide case management and support prior to death as well as continued support after death. In both cases established institutions employ social workers and a system for social workers to provide support to bereaved persons. On a macro level the profession should examine whether there are ways that social workers can support bereaved families of deaths that do not occur in a hospital or on hospice. Many respondents stated that enhancing integration with law enforcement/first responders would make it easier to access suddenly and traumatically bereave persons of out-of-hospital deaths. Social workers are already integrated with law enforcement through the justice system in the sub-specialty of forensic social work. The
profession could push for integrating social workers into areas of law enforcement and with first responders who come into contact with suddenly and traumatically bereaved persons. Social workers could also provide training to law enforcement and first responders on grief and bereavement interventions, supporting suddenly and traumatically bereaved persons, and how to refer to additional support services. Lastly, social workers who are providing support to suddenly and traumatically bereaved individuals should become knowledgeable about the risk factors of this population. There are many opportunities for the field of social work to ensure that all bereaved persons of out-of-hospital deaths have access to support services despite the nature of the death.

**Recommendations**

The scope of this study and sampling technique prevent results from being generalized. Therefore, this study should be replicated on a larger scale and using methods that allow it to be generalized for the larger population. It may be that the results of this study are unique to greater Sacramento area, however, that cannot be disproven until the study is replicated on a larger scale. Other professionals who come into contact with bereaved persons of out-of-hospital deaths should also be interviewed regarding their professional opinion on the needs of that population. This topic also needs to be researched through direct contact with bereaved families. It would be best to start with a qualitative study to learn about experiences of families after a sudden or traumatic death. It would be beneficial to ask families where they accessed services, if they felt the services they accessed met their needs, and, if not, what type of services would be helpful. It would also be interesting to compare the experiences of bereaved families of
sudden and traumatic death with those of bereaved families of expected death who had access to hospice services. Lastly, it is important to determine the scope of this problem. The number of out-of-hospital deaths that occur annually should be recorded along with the cause and location of death.

**Limitations**

This study was limited by the geographical region of the included agencies and the limited number of agencies who participated. This study did not include all hospice and LEC agencies in greater Sacramento area. Because many of the questions were multiple choice, respondents could not describe in detail the services their agency provides to each death type. The data collected is based on the perspective of professionals who work in the field of grief/bereavement and crisis intervention, bereaved persons of out-of-hospital deaths were not directly contacted for this study. Therefore, the needs described in this study might differ from the needs described by actual bereaved persons of out-of-hospital deaths. The small sample size and snowball sampling method that was employed prevent the results of this study from being generalized to the larger population.

**Conclusion**

The purpose of this study was to determine if bereaved persons of out-of-hospital deaths were underserved. Ultimately, the results of the study showed that there are differences between the extent of support afforded to expectedly bereaved persons than that afforded to suddenly and traumatically bereaved persons. Hopefully this study will shed light on the fact that the current service system for out-of-hospital bereaved persons is not effectively serving everyone. Many feasible recommendations were made by
respondents to improve this system. In order to initiate change the aforementioned disparity in available services must be brought to the attention of professionals in the field of grief/bereavement and crisis intervention, as well as the attention of the public. The circumstances of a death should not dictate the services available to the bereaved.
Appendix A

Human Subjects Protocol Approval

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

TO: Meghann Crane-Russ
FROM: Committee for the Protection of Human Subjects

Date: 9/25/12

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “An Analysis and Description of Out-of-Hospital Post Death Delivery Services.”

__X__ approved as __X__ EXEMPT __ NO RISK ____ MINIMAL RISK.

Your human subjects approval number is: 12-13-001. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Maria Dinis, Jude Antonyappan, Teahsha Bankhead, Serge Lee, Kisun Nam, Maura O’Keefe, Dale Russell, Francis Yuen.

Cc: Yuen
Appendix B

Statement of Informed Consent

Consent to Participate in Research

You are being asked to participate in a thesis research which will be conducted by Meghann Crane-Russ, a Master of Social Work student at California State University, Sacramento. The study aims to gain a better understanding of the services needs and availability of services for bereaved families of victims of out-of-hospital death.

You will be asked to complete one questionnaire with several questions related to your work with bereaved persons and your agency’s work with bereaved persons. The questionnaire may require about 30 minutes of your time.

This research project is intended to research gaps in service in the out-of-hospital post-death service delivery system in the greater Sacramento area. Bringing attention to underserved populations can raise community awareness and potentially allow for further funding, research, and support of the underserved population.

Your responses on the questionnaire will be anonymous and will be kept confidential to the degree permitted by the technology used. However, no absolute guarantees can be given for the confidentiality of electronic data. If you complete the survey anonymously after submission, I will be unable to remove anonymous data from the database should you wish to withdraw it. As sole researcher for this project, I will be the only person who has access to the survey answers. You will not be required to provide any personally identifying or agency identifying information in any part of the questionnaire. The data from the questionnaire will be destroyed as soon as it has been transcribed, tabulated, and is no longer needed. Until that time, all data will be stored in a secure location. The names of the participating agencies and the participants will not be published as part of this project.

You will not receive any compensation for participating in this study.

Some of the items in the questionnaire may seem saddening, as the topic of the research is related to death and bereavement services. You do not have to answer any question if you do not want to.

If you have any questions about this research, you may contact Meghann Crane-Russ at (XXX)-XXX-XXXX or by email mc4542@saclink.csus.edu or her thesis advisor Dr. Francis Yuen at fyuen@csus.edu. Your participation in this research is entirely voluntary. By completing this survey, you are agreeing to participate in the research. Click NEXT if you agree to participate.
Appendix C

Survey Questionnaire

(The final questionnaire will be in Survey Monkey format)

This survey aims to assess the services needs and availability of services for bereaved families of out-of-hospital deaths. Please carefully read the three death scenarios below and refer to them for the remainder of this survey.

Traumatic death: a death that occurs unexpectedly from a non-natural cause. Examples: murder, suicide, fire, accidental death at the hand of another person, car accident including DUI, etc.

Sudden death: a death that occurs unexpectedly from a natural cause. Examples: heart attack, stroke, aneurysm, appendicitis, meningitis, victim caused accidental death (fall, electrocuted, drowning, drug overdose), etc.

Expected death: an anticipated death (cancer, Alzheimer’s/dementia, or any type of terminal illness)

1. Please indicate what type of agency you are affiliated with:
   A. General bereavement group
   B. Hospice
   C. Law enforcement chaplaincy
   D. Other ________________________

2. Does your agency distinguish between different types of death?
   Yes  No

3. Despite whether your agency distinguishes between different types of death, to the best of your ability, based on the aforementioned death scenarios definitions, please indicate which type of death scenario your agency serves?
   A. Traumatic
   B. Sudden
   C. Expected
   D. If more than one, please list ____________________
   E. None of the above

4. Please describe your role within your agency:
5. How long have you been involved in the field of bereavement/crisis support?
   A. Less than 1 year
   B. 1-5 years
   C. 6-10 years
   D. 10+ years

6. How knowledgeable are you of bereavement/crisis support services in the greater Sacramento area?
   A. No knowledge
   B. Limited knowledge
   C. Some knowledge
   D. Very knowledgeable
   E. Extremely knowledgeable

The questions for the remainder of this survey are about your professional interactions and agency interactions with bereaved individuals/families that experience a loss due to one of the abovementioned types of out-of-hospital deaths. Please answer the following questions in regards to bereaved individuals/families and not the actual victims/deceased.

Despite whether your agency distinguishes between different types of death, to the best of your ability, based on the following death scenarios definitions, please use them in answering the following questions:
   Traumatic death: a death that occurs unexpectedly from a non-natural cause. Examples: murder, suicide, fire, accidental death at the hand of another person, car accident including DUI, etc.
   Sudden death: a death that occurs unexpectedly from a natural cause. Examples: heart attack, stroke, aneurysm, appendicitis, meningitis, victim caused accidental death (fall, electrocuted, drowning, drug overdose), etc.
   Expected death: an anticipated death (cancer, Alzheimer’s/dementia, or any type of terminal illness)

7. Please indicate the type of support your agency offers to each group? Check all that apply:
   A. Traumatic:
      - Bereavement support group
      - Pediatric bereavement support groups
      - Other type of support group (please specify) __________________________
      - Crisis intervention support
      - Mental health services
      - Case management services
      - Suicide prevention services
      - Spiritual services provider
Legal advice services
Financial Planning services
Other: ______________________
We do not offer services to this group

B. Sudden:
Bereavement support group
Pediatric bereavement support groups
Other type of support group (please specify) _________________
Crisis intervention support
Mental health services
Case management services
Suicide prevention services
Spiritual support services
Legal advice services
Financial Planning services
Other: ______________________
We do not offer services to this group

C. Expected:
Bereavement support group
Pediatric bereavement support groups
Other type of support group (please specify) _________________
Crisis intervention support
Mental health services
Case management services
Suicide prevention services
Spiritual support services
Legal advice services
Financial Planning services
Other: ______________________
We do not offer services to this group

D. We do not support any of the aforementioned groups

8. In your professional opinion, please indicate what specific types of support each group needs? Check the 5 MOST URGENT NEEDS:
A. Traumatic:
Bereavement support group
Pediatric bereavement support groups
Other type of support group (please specify) _________________
Crisis support providers
Funeral home
Hospice agency
Mental health service provider
Suicide prevention services
Spiritual services provider
Private practice therapist
Specialized support program (i.e. victim’s witness, Mothers Against Drunk Driving, Survivors of Suicide)
County financial assistance programs
Childcare providers
Legal advice services
Estate planning services
Financial Planning services
Other:

B. Sudden:
Bereavement support group
Pediatric bereavement support groups
Other type of support group (please specify) _________________
Crisis support providers
Funeral home
Hospice agency
Mental health service provider
Suicide prevention services
Spiritual services provider
Private practice therapist
Specialized support program (i.e. victim’s witness, Mothers Against Drunk Driving, Survivors of Suicide)
County financial assistance programs
Childcare providers
Legal advice services
Estate planning services
Financial Planning services
Other:

C. Expected
Bereavement support group
Pediatric bereavement support groups
Other type of support group (please specify) _________________
Crisis support providers
Funeral home
Hospice agency
Mental health service provider
Suicide prevention services
- Spiritual services provider
- Private practice therapist
- Specialized support program (i.e. victim’s witness, Mothers Against Drunk Driving, Survivors of Suicide)
- County financial assistance programs
- Childcare providers
- Legal advice services
- Estate planning services
- Financial Planning services
- Other: ________________

D. The type of death does not affect the needs of the bereaved family

9. To the best of your professional knowledge, indicate where each group would most likely access support services? Check 5 MOST LIKELY:

   A. Traumatic:
      - Community bereavement support group (please specify sponsor organization) ____________
      - Other type of support group (please specify organization) ________________
      - Crisis Intervention services provider (please specify organization) ____________
      - Hospice agency (please specify organization) ____________________________
      - Case management services (please specify organization) ________________
      - Suicide prevention services (please specify organization) ________________
      - Victim and Witness Assistance/Volunteers in Victim Assistance
      - Mothers Against Drunk Driving
      - Homicide support network
      - Survivors of Suicide
      - County financial assistance program (General Assistance)
      - Free/low cost:
        - childcare resources (please specify organization) ________________
      - legal advice services (please specify organization) ____________________________
      - estate planning services (please specify organization) ________________
      - financial planning services (please specify organization) ________________
      - Other: ____________________________
B. Sudden:
☐ Community bereavement support group (please specify sponsor organization) __________
☐ Other type of support group (please specify organization) __________
☐ Crisis Intervention services provider (please specify organization) __________
☐ Hospice agency (please specify organization) __________
☐ Case management services (please specify organization) __________
☐ Suicide prevention services (please specify organization) __________
☐ Victim and Witness Assistance/Volunteers in Victim Assistance
☐ Mothers Against Drunk Driving
☐ Homicide support network
☐ Survivors of Suicide
☐ County financial assistance program (General Assistance)
☐ Free/low cost:
☐ childcare resources (please specify organization) __________
☐ legal advice services (please specify organization) __________
☐ estate planning services (please specify organization) __________
☐ financial planning services (please specify organization) __________
☐ Other:_____________________

C. Expected:
☐ Community bereavement support group (please specify sponsor organization) __________
☐ Other type of support group (please specify organization) __________
☐ Crisis Intervention services provider (please specify organization) __________
☐ Hospice agency (please specify organization) __________
☐ Case management services (please specify organization) __________
☐ Suicide prevention services (please specify organization) __________
☐ Victim and Witness Assistance/Volunteers in Victim Assistance
☐ Mothers Against Drunk Driving
☐ Homicide support network
☐ Survivors of Suicide
☐ County financial assistance program (General Assistance)
☐ Free/low cost:
  ☐ childcare resources (please specify organization)
  ☐ legal advice services (please specify organization)
  ☐ estate planning services (please specify organization)
  ☐ financial planning services (please specify organization)
  ☐ Other:_____________________

D. There are no support services available to the aforementioned groups

10. In your professional opinion, please indicate what barriers your agency and other crisis/bereavement support agencies face in accessing or servicing each group? Check all that apply:

A. Traumatic:
   ☐ Not client base
   ☐ No way for agency contact this type of client
   ☐ This type of client not referred to agency
   ☐ Not eligible for services through agency
   ☐ No agency funding to support this type of client
   ☐ Other __________________

B. Sudden:
   ☐ Not client base
   ☐ No way for agency contact this type of client
   ☐ This type of client not referred to agency
   ☐ Not eligible for services through agency
   ☐ No agency funding to support this type of client
   ☐ Other __________________

C. Expected:
   ☐ Not client base
   ☐ No way for agency contact this type of client
   ☐ This type of client not referred to agency
   ☐ Not eligible for services through agency
   ☐ No agency funding to support this type of client
   ☐ Other __________________
D. There are no barriers to services for the aforementioned groups

11. Do you feel that any of the aforementioned groups are underserved? If so please indicate to what extent:

<table>
<thead>
<tr>
<th></th>
<th>To a large extent</th>
<th>To a moderate extent</th>
<th>To some extent</th>
<th>To little extent</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. In regards to the group whom you feel is the MOST underserved, please indicate why?
   A. Accessibility of the group
   B. Funding
   C. Availability of services
   D. Level of need not significant
   E. Other ________________________________

13. In regards to the group whom you feel is the MOST underserved, in what ways do you think services could be improved for them?

14. Are there any additional thoughts or information you would like to add?
References


doi:http://dx.doi.org.proxy.lib.csus.edu/10.1521/psyc.2012.75.1.76


