NSW Health
Pathology

Proactive case management of suicide bereaved persons

NSW Health Innovation Symposium

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Overview of DOFM - Newcastle

- Department of Forensic Medicine-DOFM – role in Coronial process
- Expanding State-Wide Service
- Rural and Remote Tertiary Referral Unit
- Geographically covers 75% State NSW
- Provides Coronial Services for over 60 Coroners/ Local Area Commands
- Currently >1500 admissions annually to DOFM
- Approx 15% of admissions reported as suicide
- Forensic Counselling Unit

Forensic Counselling Unit

- Forensic grief counsellor is often first point of contact for relatives and friends
- One of the first responders for early identification and referral
- Knowledge base, skills and experience in short to medium term therapeutic work
- Initial research project (data mining, lit.review, survey) based on existing evidence/literature and practice-based knowledge

  – needs / barriers / support utilised / effectiveness of support
- Proactive case management model implemented, trialled, modified

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Incidence of suicide

- Suicide is leading cause of death with over 2,300 deaths attributed to intentional self-harm in 2010
- 600 suicide deaths in NSW 2010 (M=456)
  - caution in suicide numbers
- Of 2010 admissions to NDFM 105 cases or 9.9% classified as suicide – 2012 expanded services with suicide as cause of death more than double 2010 numbers (now 15.6% of admissions are reported to be suicide)
- 33% higher rate of suicide in rural areas than major cities

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Bereavement by suicide

Published suicide bereavement research reports that anywhere from 6 to 100 individuals are bereaved by every suicide

(Cerel and Campbell, 2008; Crosby and Sacks, 2002)

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Bereavement by suicide

"The suicide bereaved must not only attempt to cope with the death of someone close to them, but most do so in a likely context of shame, stigma, guilt, blame, and confusion about the responsibility for the death, all of which are frequently associated with bereavement after this type of death"

(Jordan and McIntosh, 2010; xxvii)

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Risks/needs relating to suicide bereavement

- The Hidden Toll: Suicide in Australia Report of the Senate Community Affairs (2010)
  - Bereaved by suicide well–known at risk sub-population group
  - Loss of a friend, family member or peer group to suicide as tipping point (LIFE Framework, 2010)
  - “That Commonwealth, State and Territory governments together with community organisations implement a national suicide bereavement strategy”

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Risks/needs relating to suicide bereavement

- Five-fold increased suicide risk in those bereaved by suicide, when compared to population (Suicide Prevention Australia, 2009)

- Queensland Suicide Register reported 8.2% of all suicide deaths listed on register had exposure to suicide of another.
  - Of this group 59.8% had exposure to suicide of family member

- Both the amount of help available and the quality of professional bereavement support provided were unsatisfactory and damaging (Wilson and Marshall, 2010)

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Survey results – concerns

Table 1

Frequency of respondents indicating sometimes or often to concerns for people bereaved by suicide

Concern type	*Sometimes or often n/N (%)*	
Obtaining services	17/34	50%
Legal or financial	22/35	63%
Difficulty talking about what happened	23/37	62%
Difficulty sharing grief within family	16/38	42%
Coroners process	15/34	44%
Heightened concern for other family members	28/38	74%
Social isolation or withdrawal of family and friends	22/38	56%
Shame/stigma/embarrassment	15/37	41%
Intense sadness	34/37	92%
Anger at others	23/38	61%
Confusion or questions of why	34/37	92%
Distressing thoughts or images	32/38	84%
Complicated relationship with person who died	16/38	42%
Guilt	27/38	71%
Relief	7/38	18%

Note: N represents the number of respondents that responded to each question. n represents the number of respondents that reported sometimes or often.

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Survey results – barriers

Table 4

Frequency of moderate to high difficulty in obtaining services

Barrier Type	*n/N (%)*	
Lack of information about where to find resources	15/37	41%
Personal financial concerns	16/36	44%
Coroners process	9/36	25%
Lack of time	9/36	25%
Lack of energy to seek help	18/36	50%
Distrust of professionals	9/37	24%
Unavailability of resources	11/36	31%
Reluctance to ask for help	17/36	47%
Concern about what others will think of me	7/36	19%
Travel time or distance	8/36	22%
Fear that talking about it will only make things worse	7/37	19%

Note: N represents the number of respondents that responded to each question. n represents the number of respondents that reported agree or strongly agree.

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Support for suicide-bereaved

- "Bottom-up approach"
- Jordan and McIntosh (2010: 116) "hard-won wisdom …wisdom to which clinicians, program administrators, and researchers should pay careful attention"
- Maple, Edwards, Plummer and Minichiello (2010)

  "Understand the immediate and long-term needs of those who are affected and …understand the complex and traumatic bereavement these [families] are faced with" (p247)

- *"Please listen to people in how they wanted to handle things and to have more follow up"* (DOFM survey respondent)

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Recommendations

- “One size does not fit all”

- Limitation of contact us ‘as and when required’ model, beyond the initial and often intensive provision of information and support

- Active Postvention Model
  - Proactive outreach

- Our results and the comments of participants suggest to us that the ideal program of support services would allow for “multiple points of access” to multiple types of services (Jordan and McIntosh, 2010)

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Recommendations

“Offer details of support services at staggered times as I was not ready to approach services when received info and have never followed up since.”

“a gentle push…more knowledge of support and follow up to see if we accessed (services)."

(a need for) "ongoing support…point families in the right direction for help. Keep in contact with them."

“We were very happy with the support from The Forensic Medicine Team. They gave such wonderful, caring support to our family. Even calling 6 months later to seek assistance it was never a problem and they were so willing to help. They made us realise that suicide was not our fault.”

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DOFM Proactive case management model

- Based on needs analysis and existing evidence-base and models of best-practice
- Research embedded into model (with UNE, Ethics-approved) to evaluate, and contribute to evidence-base – appropriate and therapeutically-useful tools
- Individualised, flexible, timely, specialised, integrated, collaborative, comprehensive, client-centred response to suicide bereavement
- Telephone, online, face-to-face support, ongoing as needs require and as needs change over time

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DOFM Proactive case management model

- **Challenges** – extent of need within limited resources and existing caseload; practitioner-researchers; data collection; equity of service in regional/rural areas; limited community-based bereavement services to refer onto; raising awareness

- **Opportunities**
  - e.g. Support After Suicide Program (SASP)(DOFM Glebe);
  - Keeping Connections Childhood Bereavement Program (see poster – *Award Finalist*);
  - Regional/rural support – training / integration / clinics/ partnerships / use of technology (e.g. Telehealth)

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Questions…

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