Bereavement Risk Assessment Tool (R)

Assessment Date	Assessed by	ID#	Patient / Deceased Name	Bereaved Name

Risk Indicators and Protective Factors

Comments

I. Kinship

- ☐ a) spouse/partner of patient or deceased
- ☐ b) parent/parental figure of patient or deceased

II Caregiver

- ☐ a) family member or friend who has taken primary responsibility for care

III. Mental Health

- ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)
- ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)

IV. Coping

- ☐ a) substance abuse / addiction (specify)
- ☐ b) considered suicide (no plan, no previous attempt)
- ☑ c) has suicide plan and a means to carry it out OR has made previous attempt
- ☐ d) self-expressed concerns regarding own coping, now or in future
- ☐ e) heightened emotional states (anger, guilt, anxiety) as typical response to stressors
- ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*
- ☐ g) declines available resources or support
- ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*

V. Spirituality / Religion

- ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress

VI. Concurrent Stressors

- ☐ a) two or more competing demands (eg single parenting, work, other caregiving)
- ☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness)
- ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement)
- ☐ d) significant other with life-threatening illness / injury (other than patient/deceased)

VII. Previous Bereavements

- ☐ a) unresolved previous bereavement(s)
- ☐ b) death of other significant person within 1 year (from time of patient's death)
- ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years
- ☐ d) death or loss of parent/parental figure during own childhood (less than age 19)

VIII. Supports & Relationships

- ☐ a) lack of social support/social isolation (perceived or real - eg housebound)
- ☐ b) cultural or language barriers to support
- ☐ c) longstanding or current discordant relationship(s) within the family
- ☐ d) relationship with patient/deceased (eg abuse, dependency)

IX. Children & Youth

- ☐ a) death of parent, parental figure or sibling*
- ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)
- ☐ c) parent expresses concern regarding his/her ability to support child's grief
- ☐ d) parent/parental figure significantly compromised by his/her own grief

X. Circumstances Involving the Patient, the Care or the Death

- ☐ a) patient/deceased less than age 35
- ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*
- ☐ c) distress witnessing the death OR death perceived as preventable*
- ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*
- ☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")
- ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")

XI. Protective Factors Supporting Positive Bereavement Outcome

- ☐ a) internalized belief in own ability to cope effectively
- ☐ b) perceives AND is willing to access strong social support network
- ☐ c) predisposed to high level of optimism/positive state of mind
- ☐ d) spiritual/religious beliefs that assist in coping with the death

Explanation of Risk Indicators and Protective Factors

I. a) This relationship is defined by the person him- or herself and may include those who are legally married or living common-law, same-sex partnerships, dating couples or an ex-spouse/partner still emotionally connected to the patient before the death.

I. b) This pertains to mothers, fathers, or guardians/relatives who have historically acted in a parental role to the person, regardless of the age of the child who has died (i.e., adult children as well as children less than age 19).

II. A person who has taken primary responsibility for the physical and emotional care of the patient or has organized the care. There may be more than one caregiver who provides this level of care, such as when family members take turns or when the patient's primary care is shared concurrently between two or more persons.

III. a) e.g., clinically diagnosed with major depression, schizophrenia, personality or anxiety disorders. If the illness is not currently manifesting (is managed well by medications), then a history of the illness is relevant only if the person has demonstrated previous susceptibility to relapse when under stressful conditions.

III. b) e.g., developmental disability, significant dementia, stroke or head injury affecting mental functioning, autism, or other mental disability that challenges the person's ability to cope.

IV. a) Includes the use of alcohol, street or prescription drugs or any other substance as a method of coping with the illness or death. Addictions to food, sex, or gambling may also be considered. Risk is indicated when the use of a substance or a patterned behaviour negatively impacts the ability of the person to cope or function.

IV. b) Some indication the person has thought about intentionally ending his or her life as a means to cope with the anticipated loss or the actual death. This does not include bereaved persons who question their ability to go on without the deceased or state life isn't worth living (although such statements warrant further exploration and assessment).

IV. c) The person has thought about suicide as a way to cope with the anticipated loss or actual death, has considered a plan, and has the means to carry it out. An example would be a plan to overdose with a narcotic that is sufficiently at hand. This also pertains to thinking about killing oneself AND having made one or more attempts in the past.

IV. d) The person is unsure of his or her own ability to cope prior to or after the death. An example would be someone who feels unprepared, emotionally, mentally or practically, to cope with daily aspects of living.

IV. e) This refers to a long-standing disposition or personality style that is prone to emotional volatility (as opposed to one or two episodic demonstrations under stress). e.g., the person remains angry, bitter, or feels excessively guilty with regard to diagnosis, treatment, or negative outcomes such as the death itself; or the person is typically in a state of agitation or anxiety (but not with a diagnosed anxiety or personality disorder – see Mental Health); or appears unusually sensitive to stressful circumstances and typically responds in a highly emotional manner.

IV. f) The person describes yearning, pining or longing for the deceased often, and to a distressing degree that disrupts daily functioning. This may or may not be accompanied by persistent, disturbing thoughts (e.g., “I should have done more” or “he suffered horribly at the end”) or rumination on visual images of the circumstances of the death or of the deceased. Since these experiences may occur initially for some bereaved people after the death, it is the persistence and uncontrollable nature of these thoughts over several months that constitute risk.

IV. g) A person who, as a general practice, tends not to demonstrate trust in other people and, when dealing with difficult situations, either avoids asking for help or consistently declines assistance that is offered.

IV. h) A person describes feeling numb and unable to access their feelings around grief and loss, although they expect to be able to do so. Also, persons who have trouble intellectually accepting the death and who continue to live as if the deceased were still alive. The lack of emotional expression or lack of intellectual acknowledgement of the death must be acknowledged by the person him or herself and continue for more than 3 months.

V. The person’s core belief system or world view is significantly challenged by the illness or death. For example, the person may believe life is empty or meaningless and the future holds no prospect for fulfillment without the person who died. This often occurs after sudden or traumatic deaths, or multiple losses and may result in a loss of normal functioning and in difficulty in making decisions. As this is not an unusual circumstance in early bereavement, it is the persistence and impact on daily life that reflects true risk.

VI. a) Multiple competing demands that are persistent and significant. e.g., single parenting, working, other caregiving.

VI. b) This includes having restricted access to financial resources due to low or interrupted income; unavailability of practical support such as childcare or transportation; or a physical health challenge which further strains a person’s ability to cope (e.g., pain, blindness, cancer treatments, or post-operative rehabilitation).

VI. c) e.g., retirement, loss of a job, a recent move to a new home or the end of a significant relationship.

VI. d) A family member or friend, other than the current patient/deceased, who has an illness or injury that could be life-threatening (e.g., recent cancer diagnosis, stroke or motor vehicle accident).

VII. a) One or more previous deaths to which the person continues to have a strong emotional response, or in which the current situation “reawakens” or compounds former feelings of grief. There is no time limitation regarding this unresolved loss.

VII. b) Previous death of a close relative or friend that has taken place within one year of the current patient's death.

VII. c) Occurrence of multiple previous deaths of family, friends, work colleagues, or acquaintances within the past 3 years (approximately).

VII. d) Loss of a parent or other person who acted in a parental role when the person was still a child (age less than 19). This pertains to both the death of a parent as well as an unexpected or unexplained absence when the person was a child, such as a parent's unexplained disappearance or abandonment.

VIII. a) A perceived or actual lack of support available to provide emotional, informational or tangible support. This could also refer to someone experiencing disenfranchised grief from a stigmatized loss (e.g., death of a secret lover; a gay or trans-gendered partner or death from AIDS, alcoholism or suicide. Moreover, there is not only a lack of validation of the loss, but also knowledge that support is being intentionally withheld because of the stigma. In some instances, isolation may be the person's choice or usual style of coping, or may be due to an inability to mobilize out of the home.

VIII. b) A lack of support for a member of a particular culture (defined as a religious, ethnic or distinct social group) whose beliefs and practices around death and grief do not align with the mainstream culture. If support is not available from within that culture, there could also be barriers to grief or social support because the person does not speak or easily understand the local primary language.

VIII. c) There is an observed pattern of conflict or communication breakdown between one or more family members and may limit primary social supports. This can result in differing opinions regarding caregiving practices, decision-making on behalf of the patient, or with an issue after the death such as a dispute over the estate.

VIII. d) Pertains to the person's relationship with the patient/ deceased. This includes someone who felt ambivalent within the relationship or was the recipient or provider of verbal, emotional or physical abusive. He or she may also have been emotionally or physically dependent on the patient/deceased.

IX. a) Pertains to a bereaved child less than age 19 (or age of majority) who has lost a parent, parental figure (e.g., a grandmother who was involved in the upbringing of the child); or the loss of a brother or sister.

IX. b) One or more indications of an exaggerated expression of grief are exhibited by the child, reflected by a heightened intensity and frequency of otherwise normal manifestations of grief. e.g., extreme or persistent sleep difficulties, refusing to eat, bed wetting, headaches, stomach aches, emotional distress, separation anxiety, fear that others will also die, death fantasies, learning difficulties (including difficulty concentrating), feelings of responsibility for the death, developmental regression, explosive emotions, acting out, extreme shyness, disinterest in play, overdependence, or demand for attention.

IX. c) Refers to a parent/parental figure who is concerned about his/her child's exposure to dying/death or is unsure how to differentiate between normal and potentially problematic expressions of grief in children. The parent is likely unsure as to how to support the child and is looking for guidance.

IX. d) A parent or other person in the home who has responsibility for the child but exhibits behaviours that place both the adult and child at risk. e.g., parent with a serious addiction to drugs or alcohol, severe depression, suicidal ideation or excessive anger.

X. a) The belief that children and young adults are not supposed to die marks the death as exceptional, tragic and unfair.

X. b) The bereaved person perceives the death as sudden and unexpected which has left the him or her mentally and/or emotionally unprepared, resulting in shock or disbelief. Because a lack of preparedness for the death may be difficult to assess, it may be easier to look for evidence of preparedness such as when the person has considered life without the patient or has shown a readiness to “let them go”, even if only to end the patient’s suffering.

X. c) The person has observed disturbing elements of the death resulting in strong reactions of fear, helplessness or anger. Distressing events may include witnessing severe pain, a collapse, drowning, choking, delirium or bleeding. This also refers to a death that is perceived as preventable (e.g., someone killed by a drunk driver or the belief that incompetent medical care caused the death).

X. d) The nature of the death was traumatic, violent, or otherwise atypical. e.g., motor vehicle accident, fall, industrial accident, homicide and suicide, or a natural disaster such as a flood or hurricane. Unexplained death refers to a situation where the cause of death was not identified. This may also include situations when someone disappears and death is assumed without evidence of a body.

X. e) The person attributes blame to the health care system or a specific health care provider regarding diagnosis, care of or death of the patient. Anger is the primary expression of grief and may serve as a barrier or obstacle to the person accepting receiving support.

X. f) The person attributes significant blame to the program of care that provides bereavement services or to a specific staff member who provided what is believed to be “poor” or “incompetent” care. This is particularly significant if the action in question was seen as a contributor to the patient’s death. Whether or not this is a result of misinformation or a misperception by the person, his or her anger and blame may result in declining follow-up support from the program. Assigning the highest risk level to this circumstance alerts our hospice palliative care program to the need for timely contact with the bereaved person in order to provide accurate information and demonstrate responsiveness to the concern.

XI. a) The person believes he or she can cope effectively with most negative external events and takes responsibility for his or her response to them. He or she may also have had previous successful experiences in coping with loss and death.

XI. b) The person believes that helpful support is readily available from family, friends, or community before and after the death and demonstrates a willingness to use it.

XI. c) Throughout much of life, the person has demonstrated genuine hopefulness for the future and tends to look for the positive aspects of a situation or a "silver lining".

XI. d) Evidence of spiritual or religious beliefs that either help make meaning of the loss, facilitate problem-solving or access to social support, lessen negative emotional experiences related to the death or provide a means of maintaining connection to the deceased.