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SPECIAL ISSUE

Reflections of volunteer counselors working remotely during the COVID-19 pandemic—Implications for policy and practice

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Abstract

Purpose: We reflect on our experience of running a remote volunteer counseling service, known as the Counseling Collective, to support patients and their families during the second wave of the COVID-19 pandemic in Cape Town, South Africa, and the learning and implications for practice and policy regarding the effective utilization of volunteers during a crisis or disaster context.

Background: The Beta SARS-Co-2 variant dominated the second COVID-19 wave which gained momentum in December 2020, as public sector health teams prepared to deescalate services over the South African summer season. The ferocity with which the wave hit the city soon made it clear that volunteers would be needed to assist with counseling services as the Beta variant caused serious disease, resulting in a significant upswing in hospitalisations and deaths.

Methods: Four counselors and a colleague with oversight responsibilities of the volunteers reflected on the service we provided. This was done with the benefit of hindsight a year after the activities of the Counseling Collective were wrapped up.

Lessons Learned: Virtual volunteers are a largely untapped resource in the South African health care system. Much is to be gained by using this underutilized resource to deliver patient-centred services, especially in times of crisis.

Conclusion: Networks of retired and self-employed health professionals, particularly nurses,—skilled volunteers—are a valuable resource and can be deployed for critical work using their versatile skillsets, in public health emergencies. Telephonic consultations are a useful modality for providing quality care and need to be built into the business of health services. Skills to conduct such consultations and for the provision of palliative care services need to be mainstreamed into the skillsets of health professionals.

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Policy and clinical relevance: Public health disaster plans should include a blueprint for the rapid recruitment and deployment of volunteer counselors to assist permanent staff in providing crucial patient-centred care.

KEYWORDS
bereavement, COVID-19, remote work, South Africa, volunteer counselors

INTRODUCTION AND BACKGROUND

The COVID-19 pandemic has had mental health and psychosocial consequences internationally, including for South African communities (De Man et al., 2022; Nguse & Wassenaar, 2021). Overwhelming COVID-19-related distress, such as fear of contracting the virus, related complications, social isolation, lack of income and disruption of daily routines have been reported (Menzies et al., 2020; Rahman et al., 2021). Complex family issues have become overt as family caregivers struggle to deal with uncertainty, multiple ill family members, unexpected loss, and specifically the fear of a family member dying alone (Galbadage et al., 2020; Wakam et al., 2020).

The COVID-19 pandemic has disrupted lives at every level. During the first and second waves, in particular, governments around the world imposed lockdown regulations (Briggs et al., 2021) restricting freedom of movement, and permitting only essential services to operate. In South Africa, the Disaster Management Act 57 of 2002 (Republic of South Africa, 2002) allowed for regulations specific to COVID-19. In March 2020 five alert levels, each with different restrictions were promulgated, and adjusted as the pandemic progressed and waned over 2 years. Restrictions over the first year of COVID-19 included banning alcohol and cigarette sales (Greyling et al., 2021), restrictions on travel and the entertainment and restaurant industries, which collapsed many businesses, with the consequent loss of jobs. Indeed, the pandemic for the South African population was yet another threat to a fragile economy, in a country affected by serial collective trauma (Naidu, 2020). All restrictions were lifted in June 2022 (Republic of South Africa, 2003, Regulation. 2190).

The pandemic resulted in sudden, often severe illness on a calamitous scale (Durrheim & Baker, 2020), predominantly affecting older people and those with comorbidities such as diabetes, chronic kidney disease and obesity (Adab et al., 2022), but many young, fit people were also severely affected and died. COVID-19 deaths were unlike death from other chronic diseases, such as chronic renal disease, cardio-vascular disease, tuberculosis, or HIV, which are often of longer duration, with slower deterioration, and death is often not unexpected. Consequently, trauma, loss, and grief became part of everyday life, affecting mental health and wellbeing (October et al., 2021). Throughout 2020, there were daily updates on the soaring numbers of infections and deaths. COVID-19 messaging via social media, with personal stories about being unable to contact loved ones in isolation or hospital and expressing the overwhelming fear of severe disease and death, permeated the initial waves of the pandemic (Hernández-Fernández & Meneses-Falcón, 2022; Menzies et al., 2020). Worldwide, health care workers, particularly nurses and doctors, faced enormous clinical and ethical challenges as they struggled to cope with the influx of ill patients needing treatment and care (Murat et al., 2021; Poortaghi et al., 2021; Setiawan et al., 2021; Sperling, 2021).

The pandemic in South Africa, the country ranked by the World Bank as the most unequal country in the world (The World Bank, 2022), with high levels of unemployment and unequal access to health care, exposed wide variations in social security and support (Nyasulu & Pandya, 2020; Van Ryneveld et al., 2022). Before the onset of the pandemic, the country's healthcare system was already under severe strain (Engelbrecht et al., 2021). Importantly, nurses are the foundation of primary care services in South Africa, and in 2015 comprised 77% of health professionals working in the public sector (World Health Organization & Alliance for Health Policy and Systems Research, 2017). The impact of Covid-19 on nurses was therefore profound, and they managed the almost a quarter of the over 200,000 Covid-19 patients admitted to hospital, who died in the first year of Covid-19—between March 2020 and 2021 (Jassat et al., 2021).

As is seen in Figure 1, the more transmissible and virulent Beta variant had a dramatic impact on the Western Cape at the end of 2020, causing a sharp upswing in severe disease and death and placing health services and health care workers under extreme pressure (Nyasulu & Pandya, 2020). Healthcare worker (HCW) infections followed a similar pattern to that of the general population in the Western Cape overall (Western Cape Government: Health, 2022). This increased the pressure on health care facilities as many HCWs were ill, in isolation, or in quarantine. In addition, after a grueling year, many were on annual leave, as December–January is the traditional holiday season in South Africa. These public health community nurse-based teams, operating on skeleton staffing, were exhausted, and needed recuperation time.

LOCKDOWN IN CAPE TOWN

In greater Cape Town, an urban area with a population of approximately 4.6 million people (Western Cape Government, 2020b), the COVID-19 pandemic had devastating effects on vulnerable groups in informal settlements, where variable sanitation infrastructure and many communal toilets, made social distancing impossible (Gibson & Rush, 2020). Despite a limited extra social grant for

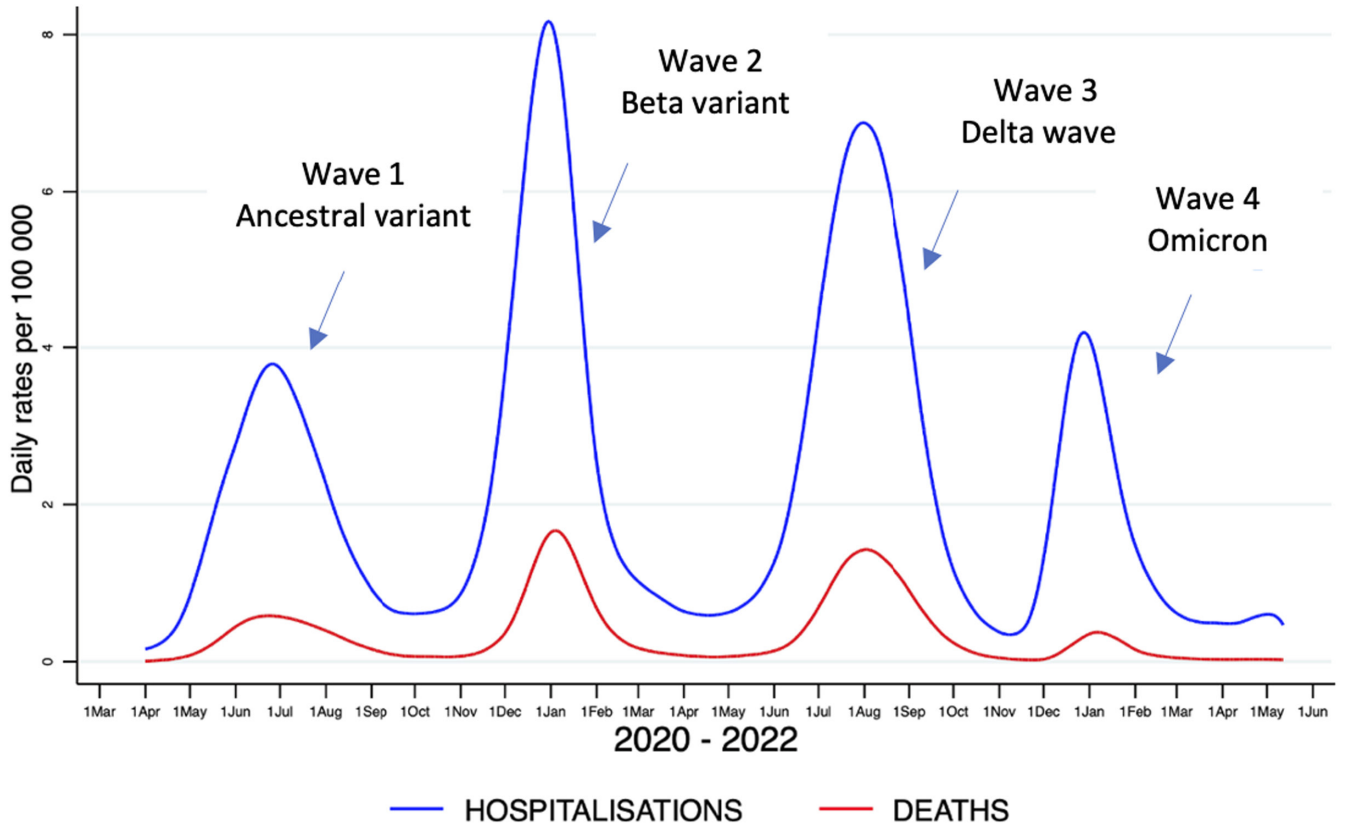

FIGURE 1 New daily hospitalisations and death rates per 100,000 in the Western cape 2020–2022

eligible persons, food insecurity was a particular challenge, as around 70% of economically vulnerable or disadvantaged South African communities obtain food supplies from informal traders, and lockdown prevented or severely limited access to these food sources (Battersby et al., 2016; Wegerif, 2020). Innovative responses to the crisis emerged from formal and non-formal structures. Examples of these included a rapid reorganization of the public primary health care services (Crowley et al., 2021), the implementation of home delivery of medication by community health workers (Mash et al., 2022), and the establishment of neighborhood-level community action networks (CANS), in which affluent suburbs developed collaborative relationships with vulnerable communities, working together to mitigate the effects of the pandemic and lockdown (Van Ryneveld et al., 2022).

Volunteering during the pandemic

In South Africa, telephonic case and contact tracing (hereafter referred to as C&CT) was initially done by public health responders (such as nurses and doctors), supported by the deployment of community health workers for uncontactable cases (Nachega et al., 2021). In Cape Town, to support the C&CT effort, volunteers were recruited and grouped into teams, called "pods", under the leadership of provincially employed health professionals. Teams of volunteers included retired mental health nurses, social workers, psychologists, health sciences students, and provincial administrative employees. The trained volunteers, using a calling script, telephonically contacted persons who had received a positive COVID-19 diagnosis, advised on isolation and quarantine, and referred severely ill persons to the health facilities for assessment and further management.

It became increasingly evident that this measure could not effectively contain infections due to factors such as overcrowded households, increasingly difficult access to basic foods, long queues at public health and welfare facilities, and lack of adherence to social distancing measures. However, the support given to cases and contacts was appreciated and it soon became evident that good case management should become the primary focus. Prolonged lockdowns had affected the mental health of individuals and families, with psychosocial risk factors such as increased domestic violence, including the targeting of pregnant women (Abrahams et al., 2022), and loss of employment (Posel et al., 2021). Mental health and social support services struggled to respond adequately to the psychosocial support needs of the population affected by COVID-19.

The emergence of spontaneous volunteering, "involving unplanned voluntary behaviour by unaffiliated members outside formal management arrangements" (Yang, 2021, p. 2) has been a feature of the pandemic and is not unique to the Cape Town context. The use of volunteers in medical settings in Cape Town is well established but has been limited mainly to well-coordinated in-person support to patients by reputable non-profit organizations. The speedy

mobilization and deployment of volunteers to help in a crisis was a feature of the provincial pandemic response.

The role of volunteer health care professionals during the pandemic has been reported in many countries and many professions. Nurses, nursing students and retired nurses volunteered not only as frontline workers but in supporting roles (Al Gharash et al., 2021; Chung et al., 2021; Lee et al., 2022; Wagner et al., 2021).

In this paper, we focus on the experience of coordinating a rapidly assembled remote volunteer counseling service that became known as the Counseling Collective and provided patient-centred care to families affected by the second wave of the COVID-19 pandemic in Cape Town. We discuss the operational issues, the range of concerns addressed, our reflections on the experience and the implications for future policy.

The authors (two mental health nurse practitioners, two clinical social workers and a public health medical specialist) were all involved in COVID-19 C&CT, case management, and the establishment of the Counseling Collective, comprising volunteers, the majority of whom were mental health nurses. We recognized the potential usefulness of sharing our experiences more widely as a means of informing policy and practice in similar contexts. The process began with written reflections that were shared via email. Key areas were grouped into themes for discussion. Regular online meetings were used to workshop issues and helped us to make sense of our shared experiences as members of the Counseling Collective.

THE COUNSELING COLLECTIVE

The Counseling Collective had its genesis in the voluntary C&CT groups, which worked telephonically, from the onset of the pandemic in 2020 to support public sector health services. In December 2020, as the peak the COVID-19 second wave gained traction, it became clear that complex cases and newly bereft families needed more time and expert help than the busy C&CT volunteers could accommodate.

Appropriately qualified volunteers who were already active in the C&CT teams were approached to form a separate team, which quickly assumed the name of the "Counseling Collective". Mental health professionals (mental health nurses, social workers, and psychologists) and lay counselors joined the Counseling Collective, which operated for approximately 3 months. Lay counselors, trained and employed in the non-governmental sector, are often first-line counselors in primary care settings, and are mostly involved in pre-and post-test HIV counseling and emotional wellness services (Jansen van Rensburg, 2008). Volunteers were predominantly middle-class professionals with access to online communication tools. It was the willingness of volunteers to help in a crisis and their access to digital communication tools that made their deployment possible. All cases referred were managed virtually, through telephone calls, WhatsApp calls and virtual conferencing using online platforms from the counselor's home, which were funded by the Western Cape Health Department, thus limiting the costs to the person being counseled. Most cases were one-on-one, however, there were opportunities for working with more than one family member and even family groups via video conferencing. Connection with C&CT teams using these methods enabled counselors to access information rapidly from other volunteers or health professionals when required.

Referrals to the Counseling Collective were done mainly by inserting case information from a central secure online platform case spreadsheet to a counselor referral spreadsheet. Each entry had columns for identifiers, contact numbers, brief referral notes and the counselor's summary after each contact. All counselors kept confidential case notes. Counselors offered their time as they could, within the constraints of their private practice or other work commitments. The backbone of the initiative was a group of senior counselors, mainly mental health nurses and social workers, with a wealth of professional experience, many of whom had retired. The group was coordinated by three of the co-authors, on a roster basis, who also assisted with counseling.

The small group of volunteer counselors dealt with 258 cases, with over 80% being referred by case and contact tracers and 20% through word-of-mouth referrals. The focus was bereavement counseling, but counselors also provided support to people with severe emotional and/or mental health responses to the pandemic. Of the total number of cases dealt with during the Second Wave, approximately 70% were related to bereavement and the remaining were people experiencing complicated reactions to the COVID-19 illness experience. Counselors also assisted with the debriefing of C&CT managers, some of whom experienced secondary trauma.

REFLECTIONS ON THE WORK OF THE COUNSELING COLLECTIVE

The Counseling Collective was responsible for responding to a wide range of concerns that were predominantly linked to persons who had died from COVID-19. Some issues required short-term brief interventions of a more practical nature, such as sharing information on funeral procedures during the lockdown and facilitating contact with hospital personnel for information on a relative's health status. Few cases were, however, straightforward, as the pandemic complicated already difficult social situations. These more complicated issues required intensive, in-depth therapeutic intervention that focused on grief and bereavement after the loss of a loved one. As indicated in Figure 2, this complex work concentrated on three main areas: firstly, as shown by the inner circle of circumstances around the COVID-19 related death, secondly the middle circle referring to grief responses to the COVID-19 related death, and finally the outermost circle of socio-economic implications of a COVID-19 related death for the remaining family (Figure 2). These three areas are illustrated as concentric rather than separate circles, as one aspect typically had implications for another.

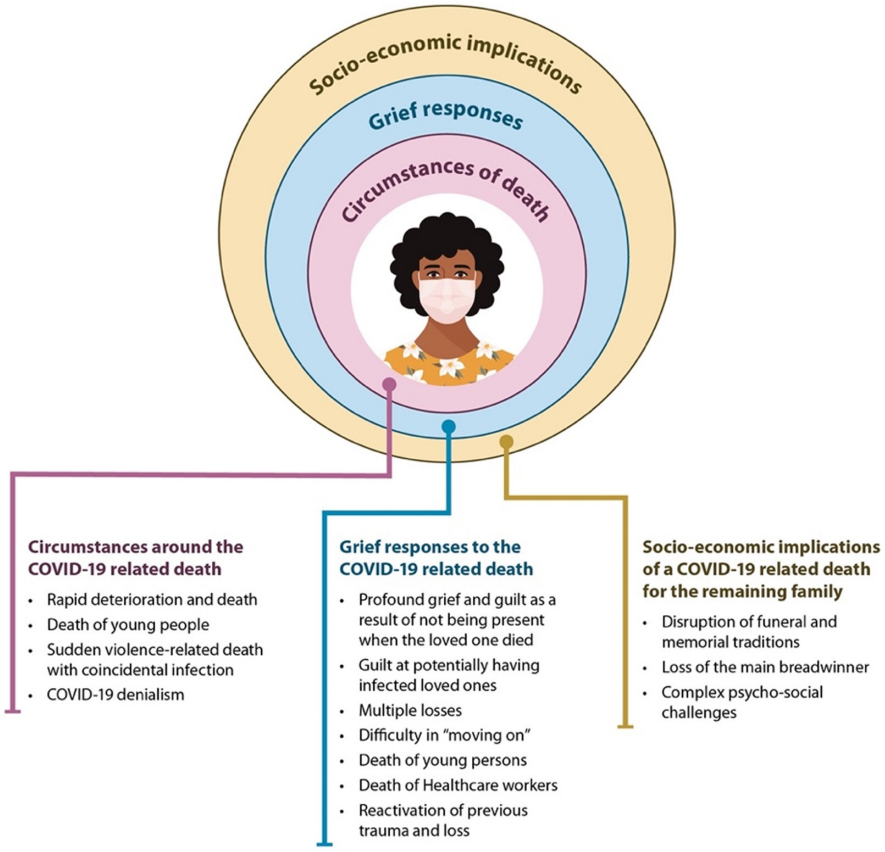

FIGURE 2 The nature of complicated cases managed by the Counselling Collective

Circumstances around the COVID-19-related death

Numerous cases of deaths related to COVID-19 were associated with particularly challenging circumstances. As illustrated by the inner circle in Figure 2, these circumstances often exacerbated the grieving process, leaving loved ones feeling confused and angry.

Rapid deterioration and death

In many cases, the deterioration of a loved one from the initial diagnosis of COVID-19 to death was extremely rapid, whether at home or in hospital. Families were left completely unprepared and emotionally traumatized by the unexpected and sudden loss of their loved one. Questions of "could I or should I have done something differently" were often shared with counselors. In some instances, this was after a loved one died at home, in an ambulance, or even in a private vehicle en route to the hospital. A counselor reflects:

> A mother died in the arms of her daughter, son at the wheel, as they drove through the hospital gate. Once they found parking, they sat with the dilemma of what to do with their "dead on arrival" mother. The daughter ran around asking random people what to do and eventually, a porter assisted them. The mother had been reluctant to be admitted to the hospital as she believed that people who were admitted were doomed to die. The children grappled with the irony of this and their guilt about not having acted sooner to get her help when it was obvious that she was having severe breathing problems.

Situations in which there was rapid deterioration and death of a patient resulted in severe emotional turmoil and survivor guilt for some family members. Counselors played an important role in creating opportunities for families to make sense of how little control they had over the situation and the suddenness of the loved one's final moments.

Death of young people

Although most COVID-19 related deaths were seen in older persons, younger people also fell victim to the virus. Counselors found these cases particularly challenging and reaching out to families was often left to the mature, more experienced counselors. A counselor reflects:

> My heart sank whenever I saw young, deceased cases on the list. I worked for some months with a family whose young adult daughter had died. We used

> online family meetings to explore their immense grief. It was clear from the outset that there was great potential for productive work and their commitment to the counselling process touched me deeply. It was a privilege to work with them. The contact started before the drive-by memorial for their daughter and I was invited to attend the touching and dignified online funeral service. My early involvement as the family counsellor set a foundation on which we built over the months and as one important milestone after another passed—the first week, the first month, what would have been the daughter's birthday, visits to the grave, and remembrance rituals over Christmas.

These cases often required longer-term support over many months to help families through the grieving process. These cases often carried great emotional resonance for the counselors concerned and necessitated the need for peer debriefing amongst counseling team members.

Sudden violence-related death with coincidental infection

The Western Cape province has a high prevalence of violent crime (Kelly et al., 2021). Challenges for the counselors included young adult family members who died due to violence and tested positive for COVID-19 post-mortem. Counselors had to inform family members of this diagnosis and the quarantine protocols associated with this. A counselor reflects:

> This family was not amenable to counselling and one brother was particularly hostile. His rage was amplified as the post-mortem diagnosis had complicated an already heart-breaking situation, as the deceased was an innocent victim. The COVID-19 diagnosis would significantly increase the cost of repatriating the body to a neighbouring country.

These violence-related deaths with coincidental COVID-19 infections were a stark reminder of how violence, mistrust of authority, the pandemic and socio-economic factors coexist and intersect particularly in low-income communities. This makes managing such situations more complex.

COVID-19 denialism

Conspiracy theories, the promotion of alternative treatments and distrust of the government control measures served to increase the lack of acceptance of the cause of severe illness and death. It was extremely difficult for COVID-19 denialist families to process the loss of a loved one who had contracted the virus and subsequently died. A counselor reflects:

> An extended family lost their beloved matriarch to COVID-19 pneumonia soon after admission. I worked with five of the siblings at different times. The COVID-19 diagnosis was not seen as evidence that the virus exists, rather their anxiety was heightened and their explanations for what happened became progressively more elaborate and distressing. Despite health care workers' explanations about their mother's cause of death, the adult children were convinced that their mother had been administered a lethal injection or died from neglect. I realized that I needed to focus my efforts on calmly reinforcing the information available and providing a safe space to talk about their loss rather than engaging with conspiracy theories.

It was important for counselors to remain non-judgemental and supportive regardless of the family belief system. While disbelief and denialism are often part of the grieving process, COVID-19 denialism complicated families' responses and made the task of supporting and counseling more challenging. Rumor, stigma, conspiracy theories and COVID-19 denialism have implications for communities' health. Persons who follow misinformed advice and resist preventive behavior endanger themselves and others (Douglas, 2021; Islam et al., 2020; Romer & Jamieson, 2020). This complicated sense-making system is used by groups who feel marginalized and cannot relate to the highly complex COVID-19 information environment. Counselors who rely on counterarguments as their primary therapeutic tool do so at their peril. Douglas (2021, pp. 272–273) argues that counterarguments rarely succeed in correcting misinformation and recommends rather talking about the greater good and the importance of our collective care for one another. When trying to communicate crucial public health information, Douglas (2021) advocates for the use of "trusted messengers" who are relatable and mirror the groups and communities who are suspicious of authority.

Grief response to the COVID-19 related death

While the process of grieving reflected the more universal experience of grieving, certain issues stood out as specific to the pandemic and cases managed by the Counseling Collective. As illustrated by the middle circle in Figure 2, these grief responses took many forms.

Profound grief and guilt as a result of not being present

COVID-19 lockdown regulations did not permit families to visit loved ones once they had been admitted to hospital, and families were unable to be with their loved ones during their final moments. Many family members were left with feelings of guilt and deep sadness for themselves and concerned that their loved ones were alone and

feeling abandoned in their final moments. Some looked to hospital staff for answers as to what had happened, and what their loved ones had experienced in their final moments. A counselor reflects:

> … a young woman who wept over the phone as she tried to make sense of her father's death and how she had not even been able to talk to him in the days before his death. She was concerned about whether he had been alone, whether anyone had brought him water or pain medication, and whether he knew how much he was loved.

Counselors were able to connect families with hospital staff who were able to answer some of their questions, but a great deal of emphasis was on listening and empathizing with families as they grappled with their pain.

Guilt at potentially having infected loved ones

In the second wave, COVID-19 spread rapidly through families and communities. After the death of older family members, young adults and teenagers were often consumed with guilt at the prospect of having brought COVID-19 into the home after going to a party or gathering. A counselor reflects:

> A young woman lost her father, a pastor who would have officiated at her upcoming wedding. She had attended a party, become infected and transmitted the virus to her father, who died soon after becoming ill. She had lost her faith in herself and God which complicated the grief process. She required support for months after his death.

Counselors needed to reassure young members of the family and help them to work through their feelings of guilt and grief. Referrals to therapists able to engage in longer-term therapy were made where possible. As this is a limited service in the public sector, for persons with limited social means, referrals to non-profit mental health organizations were made.

Multiple losses

As COVID-19 infections surged, multiple family members became infected and very ill, and many died. The multiple losses that families endured were extremely difficult. A counselor reflects:

> One family I worked with had lost three members within a week, two other family members were in intensive care and the contact person was ill. The support was limited to a few brief sessions as illness overcame this family. I was left not knowing if they had survived, with a sense of helplessness as the situation was beyond anyone's control.

COVID-19 decimated many families. The loss of multiple family members meant those who were grieving were battered by loss and grief from many angles. Family members who would have been sources of support were no longer there to help navigate the bereavement process. This meant that counselors had a significant role in supporting those who remained to be able to support other family members while also making space for their grief.

Difficulty in "moving on"

Many who had lost loved ones described how they struggled to return to work and other activities. The prospect of having to repeat the news of a loved one's death, seeing pity in the eyes of friends and colleagues, or hearing well-meaning words of advice was overwhelming. The pandemic and lockdown gave more time to grieve but also isolated people from their usual support structures. A counselor reflects:

> … a young mother lost her husband to COVID-19. It was only the need to care for her children that had her getting up each day and going through the motions of living. Her grief came in waves and often unpredictably. While friends, extended family and colleagues returned to their lives, she described how alone she felt, particularly in those quiet late-night moments when her grief felt most real.

Counselors provided a space for talking through the challenges of managing day-to-day activities and navigating good and bad days. The listening ear offered by the counselors was often what those who were grieving needed most.

Death of healthcare workers

COVID-19 put enormous pressure on the healthcare system. Health care workers were overwhelmed by the ever-increasing numbers of patients needing care, and the risk of becoming infected themselves and/or infecting their families. A counselor who dealt with many health workers and their families reflects:

> I counselled the family of a much-loved nurse, who became very ill with COVID-19. The hospital staff were devastated by her loss. I had been the person who had initially discussed the implications of her diagnosis with the nurse, communicated with her during her initial hospitalisation, and then with her family when she died. I felt privileged to be a small part of this family's journey but have never even seen their faces.

HCWs and their families were often torn between the pressure of their commitment to the care of their patients and the loss of connection with their families (Fernandez et al., 2020). As reported in other studies (Rabow et al., 2021; Smeltzer et al., 2022), grieving had to be put on hold, and caused fear and anxiety for HCWs, as they grappled with new ways of caring and communicating with their patients and families, and even became proxy families for their patients.

The reactivation of previous trauma and loss

For many people, the loss of a loved one to COVID-19 triggered memories of previous trauma and losses. A counselor reflects:

> I worked with a family who had lost a daughter to cancer 3 months before their second daughter died from COVID-19. They were completely overwhelmed by grief with the mother, father and remaining daughter moving between stages of complete disbelief to anger. In their grief, they had to rely on one another for comfort as no one was allowed to visit them and they were not allowed to go out. Their faith, while usually strong, was questioned with disbelief at the extent of their loss. The phone calls with me became a space for talking through their individual and shared thoughts and feelings.

In cases of previous trauma and loss, the bereavement process is further complicated with layers of grief (Diolaiuti et al., 2021). The counseling process was a safe space to share stories of loss and grief, and counselors supported individuals and families through their current loss but also helped to contextualize this within previous losses and trauma.

Socio-economic implications of a COVID-19 related death

The pandemic and lockdown regulations had ripple effects beyond the bereavement process for many individuals and families. As illustrated by the outermost circle in Figure 2, the death of a loved one was often compounded by existing psycho-social challenges and the loss of income. Time-honored funeral and memorial traditions were also disrupted because of lockdown regulations. Losses were therefore felt on multiple levels from the personal to the socio-economic.

Disruption of funeral and religious traditions

The strict rules undertakers and the public were subjected to, including wrapping the deceased in plastic before burial (a practice phased out as more about the illness was understood), caused severe anguish in a country where most communities have specified traditions in disposing of their dead. It was difficult for people not to be able to follow their rituals, such as the washing of their loved ones, dressing their dead in traditional or religious regalia or having open coffins. A counselor reflects how one of the counselors helped a family navigate this difficult time:

> One of our counsellors with a sensitive understanding of tradition and rituals facilitated a compromise for a deceased pastor who could not be dressed in clerical robes and organised to have the robes placed in the coffin to be buried with the body.

There were strict limits on the number of people who could attend memorial services and "after tears parties" (a ritual gathering for mourners after the burial of a loved one to collectively reminisce and remember the life of the deceased; Lukhele, 2016) were forbidden. As a counselor reflects:

> Many families and friends opted to show their love and support for families of loved who had died by participating in a drive-by where they would remain in their cars. Pastors and other religious leaders also took to performing services outdoors with limited numbers of parishioners in attendance and chairs set far apart to avoid any potential spread of COVID.

Rituals are part of the fabric of family and community life, associated with birth, childhood, adulthood and finally death (Imber-Black, 2020). The inability to practice familiar or traditional mourning rituals was for many people, perhaps one of the greatest causes of distress (Carr et al., 2020). This was compounded by the stigma of possible contagion surrounding a COVID-19 related death (Walsh, 2020) and the strict protective measures required for the management of the deceased (Republic of South Africa, Department of Health, 2020). Counselors had to step into these spaces to assist and support families in finding ways of mourning within this complex context.

Loss of the main breadwinner

Most of the cases that were supported by the Counseling Collective had limited financial resources and where the family breadwinner was lost to COVID-19, the ripple effects were immediate and extreme. A counselor reflects:

> An elderly gentleman lost his wife rather suddenly and her sister died shortly afterwards. He was left as the sole carer for his grandchildren as their parents were unreliable. He had no access to basic provisions and the situation became very fraught as he

> had to reapply for the social grant which added to his stress. This was at a time when social services were severely strained. It required much persistence on my part and from one of the team leaders to facilitate access to food parcels and assistance in obtaining the grant.

The role of counselors required flexibility and networking in supporting cases. Information about government and non-profit organizations and volunteer groups such as CANS was shared between counselors so that referrals could be made, and appropriate resources could be accessed.

Complex psycho-social challenges

Some bereaved individuals had existing mental health issues which were exacerbated by loss and fear. Several cases had complicated, long-standing problems of addiction, mental health challenges, criminality, violence, and sexual abuse. In some instances, relationships that were strained beforehand forced reconciliations but in others, the divide deepened. A counselor reflects:

> I reached out to the family of a young man, a substance user with severe cardiac damage, who had died after contracting COVID-19. It was hard to reach them emotionally as the family was divided and unable to reconcile even after the loss.

In these instances, counselors often took on the role of family counselor to assist families in navigating a way forward. Counselors also engaged with employers, helping them to understand the psychosocial impact of the crisis and that those who survived COVID-19 infection were not malingering and might need sick leave beyond the isolation period required.

LEARNING FROM OUR EXPERIENCE

Counselors offered services in the context of a deep crisis over the 3-month period of the second wave in Cape Town. We recognize that each person's name on referrals signified immeasurable heartbreak, and was a microcosm of the difficult, complex living contexts faced by many in Cape Town.

Adaptability

The Counseling Collective service offered during the period of crisis was only possible due to the flexibility and adaptability of not only the counselors, but also the health services, who were willing to engage, collaborate, refer, and take referrals from the volunteers. This is not the norm for a public sector health service but was achieved through trusting relationships, built over the pandemic and before. A feature of the South African mental health care sector is its interdisciplinary approach which optimizes the commonalities between disciplines with the aim of offering a coordinated service. This undoubtedly contributed to the flexible, harmonious approach taken by our volunteers and health care staff drawn from different professional backgrounds.

Virtual volunteers

The core group of leaders and volunteers used their personal and professional networks to assemble the counselors, and all signed confidentiality undertakings before starting work. These prior trusted relationships together with the swiftness with which the Counseling Collective was created, and the urgency of the need meant that there was little opportunity for counselor screening, orientation, and training. As the group settled into a rhythm, periodic virtual meetings were held to discuss cases and strategies and provide support. Most were highly experienced and were able to draw on prior experience to offer appropriate support and interventions. However, there were instances of volunteer counselors who found professional boundaries more difficult to negotiate in the context of this crisis and required close management and support from the coordinators.

Impact on counselors

Counselors often felt humbled by the stories that were shared and listened to. These included love stories of long marriages, sweet memories of how they met, their love, good times and more challenging times, great loneliness at the passing of their life partner, the shock and grief and the burden of not being able to follow religious and cultural customs of burial. The gratitude and appreciation from individuals and families were deeply moving and unexpected, as the counseling interventions felt to many counselors like a drop in the ocean. Layers and layers of hardship, pain and loss were shared, but also memories of joy. Many families, despite being financially stressed, were able to laugh and seemed to find comfort in sharing their stories. Just creating time to listen made a difference. The psychosocial support was clearly valuable and appreciated. Counselors received messages from the people they had counseled months later to express their thanks or let the counselor know how they were doing.

Support for volunteers

There was informal mutual support for Counseling Collective volunteers through regular meetings. Team members also offered formal support and debriefing for C&CT volunteers, mostly students over this time. Although most counselors had a wealth of experience, the unremitting day-to-day bereavement counseling took its toll. While there were many positive accounts as volunteers stepped up to the

challenge, counselors also experienced secondary trauma, as they listened to and worked with grieving individuals and families.

Secondary trauma experienced by counselors is often processed long after the exposure to griefwork. Volunteer counselors need support to minimize the risk of secondary trauma. Although coordinators supported the volunteers individually and collectively, more could have been done, and been incorporated into the routine of these initiatives.

Networks of referral support structures

For many people in Cape Town, resources are scarce whether it is as basic as food and adequate shelter, or counseling and psycho-social support services. Cases requiring more support than the Counseling Collective was able to offer were linked with community networks providing food and other material support. Persons who requested or required long-term care and support were referred to faith-based organizations and non-profit mental health organizations for further psychological support.

LESSONS FOR FUTURE POLICY AND PRACTICE

Many insights were gained from this experience which have implications for policy and planning for managing disruptors in health systems. These include the roles of volunteers, particularly those with scarce skillsets, the implications for ethical practice, the power and place of telephonic consultations, enhancing the communication skillsets of health professionals, as well as the mainstreaming of palliative care services.

Volunteerism is part of the whole of society approach

The COVID-19 pandemic has given substance to the mantra of "health is everyone's business". The responsibility of managing the poor health of individuals and populations cannot be and is not the sole responsibility of health services and health systems. Mitigating the consequences of poor health, severe disease and death is the responsibility of government, private and community actors, requiring a whole of society approach (World Health Organization, 2020). Government departments often make mention of this approach, and contracts non-profit organizations to deliver specified services. Entrusting unpaid volunteers to deliver services is rare but was implemented during the COVID-19 pandemic. An example of such a partnership is the Counseling Collective, which was initiated by skilled volunteers, who saw the gap in services and understood the urgent need for mental health support for grieving families, hit hard by the COVID-19 second wave in Cape Town. It was enabled by mutual respect and trusting relationships built up over the previous months where the Counseling Collective's leadership had worked voluntarily in C&CT, in a context where many, particularly mental health nurses, had prior engagement with provincial health services earlier in their careers. These nurses were not only able to respond to mental and emotional counseling needs but also provided assistance to persons with illness related queries.

Governance and accountability

In times of crisis, the standard protocols for the protection of the patient and the counselor may be disregarded in the urgency to provide a service. This, however, leaves the patient vulnerable and the volunteer counselor open to challenge or even litigation. Although confidentiality agreements were signed by all counselors, a clear protocol for volunteer counseling services during disasters is needed and must be formulated. During the period of operation, guidelines were developed through discussion and feedback, and these prepared new counselors for their roles. Such guidelines should be available for use at the onset of a crisis or disaster and regularly updated. A formal Memorandum of Agreement between the service provider and volunteers should be completed.

In principle, we agree with McKee and McKee (2008, pp. 94–97) who argue that there should be no difference in the way virtual volunteers are recruited, managed, or dismissed compared to the process followed in dealing with on-site volunteers. Although volunteers signed confidentiality agreements, more attention should have been paid to screening prospective volunteers, making sure that they sign codes of conduct, and that they are championed through training and support groups. In addition, volunteers who prove to be unsuitable for the task at hand cannot be ignored and must be managed.

McLennan et al. (2016) identify five strategies that enable a successful volunteer initiative, which characterized the functioning of the Counseling Collective. Firstly, the need for flexible volunteering strategies must be identified; followed by harnessing spontaneous volunteering; the building of capacity to engage digital (and digitally enabled) volunteers; tapping into employee and skills-based volunteering, and finally co-producing community-based disaster risk reduction.

Telephonic consultations

The pivotal role of telephonic consultation with patients and their families during the COVID-19 pandemic demonstrates opportunities for the development of telehealth services as an important patient management modality. This includes the difficult work of bereavement counseling by skilled practitioners.

South Africans commonly use cellular phones for communication, and according to the Stats SA household survey 97.7% of Cape Town households had access to cellular phones in 2018 (Statistics South Africa, 2018, p. 56). Many people, however, change phone numbers frequently when providers offer less expensive 'pay-as-you-go' rates, which necessitates changing phone numbers. The transition from telephonic C&CT to telephonic management of counseling services was effortless, as prior spreadsheet lists of cases

housed in secure spreadsheets and the use of communication channels such as WhatsApp had become routine. Clients were referred by C&CT colleagues who had already made telephonic contact which ensured numbers used were functional. Challenges in making contact remained however, due to poor reception, lack of access to airtime or data, incorrectly captured mobile phone numbers and the use of multiple mobile phones/numbers. Similar challenges of economic and disparities have been reported by Pickell et al. (2020). There was distrust with respect to answering calls from numbers, especially if they appeared to be official. A system for updating health service users' phone numbers is crucial to address if this patient management modality is to be mainstreamed.

Cultural competence, understanding religious diversity and language challenges

Wherever possible the counseling team endeavored to use the home language of the family being counseled and to be sensitive to cultural differences. Cape Town has three official languages and is highly complex culturally and religiously. A manual issued by the Western Cape Government (2020a) to assist first responders in managing COVID-19 fatalities in the context of a broad range of cultural and religious practices and observances demonstrates the depth and breadth of understanding required by people tasked with helping affected families. Cape Town is home to people of the Christian, Muslim, Hindu, Jewish, Baha'i, and African traditional faiths. Counselors, therefore, have to work hard to gain a deep understanding of diversity to work with sensitivity and not unwittingly offend families at a time when they are in crisis. Mature counselors typically have a good working knowledge of customs in the Christian, Muslim, Jewish and Hindu communities. Despite a good working knowledge of differences, it was nevertheless necessary for team members to rely on each other in finessing delicate situations around death rituals and customs. The differences between charismatic African and traditional Christian churches required a deeper understanding than a mere "working knowledge" and this is where team members were able to guide each other. Language presented us with another challenge as there were not enough counselors proficient in isiXhosa (one of the three official provincial languages) and this made it difficult to meet the counseling needs of isiXhosa speakers. It was not ideal that some families were counseled in their second language but repeated efforts to recruit isiXhosa counselors proved to be unsuccessful over the festive period and summer holiday. Strategies need to be put in place to ensure a more comprehensive language offering and a deepening of our understanding of the death and dying rituals of different groups in our city.

Addressing the mental health gap

The COVID-19 pandemic exposed the gap in mental health services, for the health professional, the ill and communities (Nguse & Wassenaar, 2021). The Counseling Collective, through reaching out to the bereaved, were an empathetic ear to the pain and distress they experienced. Health staff were similarly affected, by witnessing the death of so many they cared for, their own or colleagues' illness and deaths, concerns for personal and family safety, yet they needed to continue working (Fernandez et al., 2020). In other settings, the mental health toll on hospital staff has been highlighted (Dawood et al., 2022; Greenberg et al., 2021; Zhang et al., 2020). Spaces for debriefing and more intensive support need to be created in institutions at the coalface of patient care. Many health professionals are not trained to provide basic counseling services, including listening skills. Such skills gaps need to be addressed. Support structures for health care workers and volunteers during crises need to be an integral component of part of health policy and planning.

Mainstreaming palliative care services

The COVID-19 pandemic has highlighted the importance of palliative care skills, both in the management of critically ill patients with life-limiting conditions and in managing bereaved families grappling with a myriad of issues resulting from unexpected loss. Such skillsets are usually not central in typical clinical encounters. Disruptors such as the COVID-19 pandemic demonstrate that "breaking bad news" and listening skills are fundamental to patient engagement. Such cross-disciplinary skills should form part of all undergraduate health professionals' education. This would enable health professionals, working in inter-disciplinary teams to multi-task, addressing the holistic needs of patients.

In addition, the COVID-19 pandemic has highlighted that palliative care services need to be integrated into the ambit of public sector health services, so that health professionals, when reaching the limits of their skillsets, can timeously refer a client to an appropriately trained professional and service. Service design needs to be nimble and be able to adjust to service pressures so that patients and their families experience the support they need. The work of the Counseling Collective demonstrates that a volunteer-based team should be, and was, mustered to support public sector patients in an emergency. From a nursing perspective, mental health nursing crosses the traditional discipline boundaries and the integrated nature of the volunteer response in this paper provides evidence of this. In addition, as for all with life-limiting illnesses, planning for likely contingencies that involve both patients and their families should take place early and be revised as needed.

CONCLUSION

The COVID-19 pandemic exposed gaps in health service delivery and inequities in societies globally. It also provided the opportunity for citizens—in this case, skilled nurses, social workers and psychologists—to step up and provide volunteer services that were sorely needed. Indeed, it demonstrated that volunteerism forms part of a viable health sector response that addresses the implications of a

virulent pathogen such as SARS-Co-2. It provided an opportunity for testing the scope of the meaning of "health is everyone's business" and was a living witness to a 'whole of society' approach to addressing challenges that threaten the wellbeing of society. The experience of the Counseling Collective challenges health systems to factor volunteers into their work, and to develop systems to integrate their contribution into their response to unexpected disruption.

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CONFLICT OF INTEREST

No potential conflict of interest exists.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

CLINICAL RESOURCES

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