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Implementation and evaluation of a National Bereavement Support line in response to the COVID-19 pandemic in Ireland

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ABSTRACT

Background This study describes the design, implementation and evaluation of a national bereavement helpline developed as proactive tiered response to immediate be reavement care during the COVID pandemic, operated in partnership between a national charity and the National Health Service. The service was based on Psychological First Aid principles adapted to integrate bereavement education. Its aim was to provide asupportive compassionate listening service, education advice resources and sign posting to community services.

Methods Two independent psychologist were commissioned to undertake a retrospective service evaluation of six months of the operation of the line, using a volunteer survey, interviews and line usage data.

Results and Conclusions Results show that the line is meeting a need, PFA + Bereavement is providing a useful framework for service delivery, and there is good adherence to the model. Volunteers are experiencing working on the line as challenging but rewarding. Supervision and debriefing are essential for volunteer well being and confidence. Approximately 10% of callers were referred onto other services. Management report that they good oversight of governance issues and are planning for the future development, and funding of the line for the next two years.

Introduction

The COVID-19 pandemic reached the Republic of Ireland on 29 February 2020. By March 2021, there were 234 541 confirmed cases of COVID-19 and 4666 deaths.[1] Meanwhile, there were non-COVID-19 deaths, which were affected by the strain on hospital services and the social limitations imposed by the management of COVID-19.[2]

To respond to anticipated bereavement needs, a national Bereavement Support phoneLine (BSL) was established in April 2020 through a partnership between the Irish Hospice Foundation (IHF) and the Irish National Health Service Executive (HSE). A scoping document was prepared for the HSE based on a public health approach to bereavement and the Adult Bereavement Care Pyramid[3] (inset Fig. 1). The BSL focused on level 1 support, which is the support of family, friends and peer support and education. It was anticipated that level 1 support, which is the most frequently used level of support following loss,[4,5] would be seriously reduced by the restrictions imposed on funerals, social gatherings and by older people needing to self-isolate. A national telephone helpline would mitigate some of that reduction in support and allow for 'provision of some level two support and signposting to external bereavement support (Level 2), counselling (Level 3) and mental health services (Level 4) as necessary.

A logic model[6] was used to guide the implementation of the service and facilitate communication between the stakeholders (insert Fig. 2). The logic model was reviewed and updated as the project evolved. By June 2020, the BSL was launched as a free listening and support service, open to all nationally. The line was widely advertised through the health service, promoted on national radio and supported by nationally known celebrities. The service operated for 3 hours a day 5 days a week. It was overseen by a governance committee comprising IHF and HSE representatives and managed by the IHF. Volunteers were graduates of the Royal College of Surgeons in Ireland postgraduate bereavement courses run

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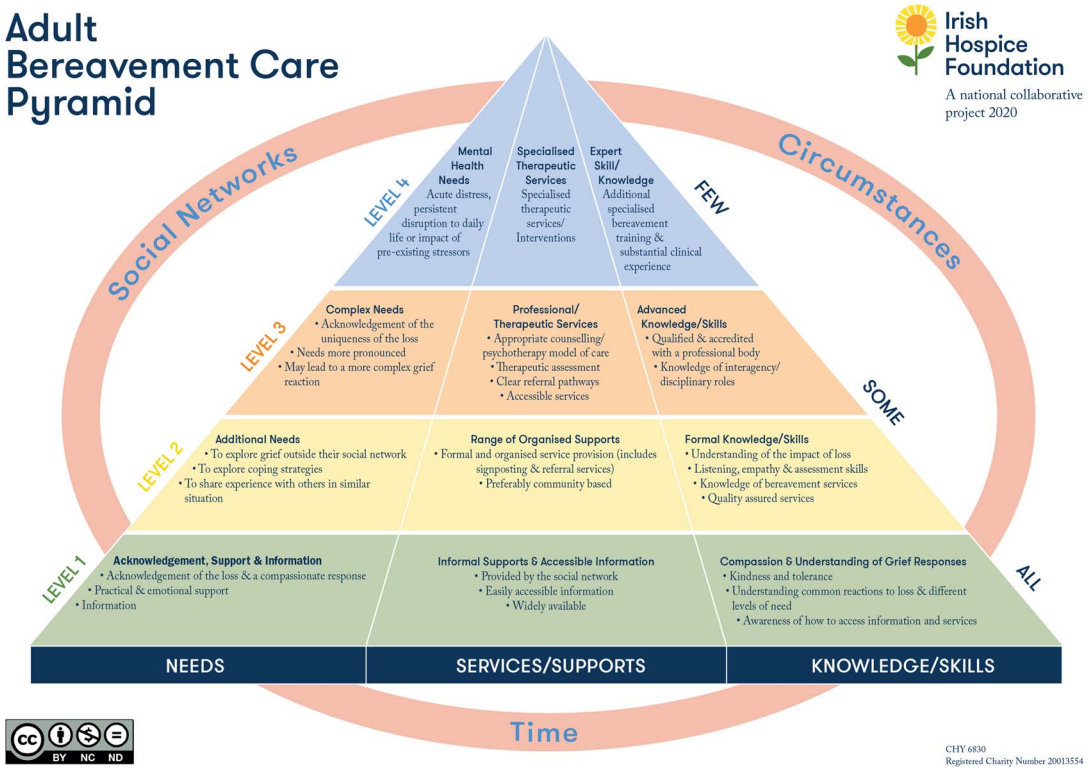

Fig. 1 Adult bereavement care pyramid.

Objective	Input	Activity /Output	Short-term Output	Long-term Output
1.Set up Technical Infrastructure	HSE expertize IHF source equipment	Acquire Freephone number Commission telephone software to answer and route calls, and record metrics on call activity Acquire mobile phone to record out of hours calls	Freephone number 1800 807077 set up AWS Connect software working for all call operators Call operators equipped with headsets, and laptops where required	Weekly & monthly reports on line activity No technical issues since line went live Callers out of hours using facility to leave messages
2.Identify BSL resource requirements	Staff Time	Capacity Planning Determine internal IHF resources Identify Volunteer source Track costs	Capacity Model prepared Staff assigned Volunteers interviewed/trained and assigned Costs recorded	Level of caller volume recorded and reviewed Low level of call waiting Cost analysis March 2021
3. Set out governance structure	Time HSE/IHF meetings Legal review	Prepare draft MOU IHF and HSE	File copy of signed MOU Minutes of steering group meetings	Clarity of responsibility Successful partnership Management oversight
4. Identify appropriate model of support	Staff Time External consultant	Overview of Literature Design intervention based on Psychological First Aid and Bereavement Theory	100% attendance at training Use of each dimension recorded	Fidelity to model
5. Establish metrics framework	Staff Time	Define the metrics to record call activity levels/nature of calls	Metrics reports designed Evaluation framework agreed	Evaluation Jan 2021
6. Promotion of BSL	Staff Time Cost	Prepare branding Prepare materials (fliers, radio ad, briefing packs) Secure radio and TV slots HSE dissemination/Nursing homes GP surgeries	Number of ads Number of emails Number of posts	Call peaks matched to campaigns audience metrics social media penetration
7.Continuous audit to monitor quality improvement	Staff Time External consultant	Monitor metrics Daily debrief with volunteers Weekly supervision	Callers impacted by Covid Callers equality of access regardless of geography Caller satisfaction	Meeting Level 1 needs education on bereavement Identification of needs and signposting to services

Fig. 2 Bereavement support line project logic model.

in association with IHF. A service review and evaluation was scheduled when the line was six months in operation.

Literature review

COVID-19

Review articles[7,8] identified that COVID-19 with its increased death toll and severe impact on social structures would impact on the normal experience of loss and mourning. The main themes noted were as follows: survivors faced multiple losses; they had to live with considerable uncertainty; autonomy was reduced and there was little choice about the place of death or nature of care; community support was disrupted and, in some cases, devastated. Barriers existed to being present at death due to contagion, and burial rituals were curtailed. COVID-19 'has dramatically altered how older adults live, die, and mourn'.[9]

There is agreement that there is an increase in the risk factors associated with the development of prolonged grief disorder (PGD) and that it requires professional intervention.[10] In general, PGD is present for up to 10% of bereaved people, however it may be as high as 30% for those who experience exceptional losses such as the loss of a child. In a pandemic, it is estimated that this could go as high as 43%.[10,11] A recent 2022 study[12] of 1600 people in the Netherlands found that people bereaved during COVID had more acute grief reactions. Since acute grief is a predictor of prolonged grief, these data would suggest that the pandemic will lead to a greater demand for bereavement services at all levels.

Bereavement care

Three papers[13,14,15] address the best approach to bereavement care at times of mass bereavement. One study[14] recommended a tiered approach, which offers 'the right level of care

at the right time' and notes that low intensity interventions such as a helpline may be sufficient for people with transient grief. A systematic review of services[16] identified the key elements of effective bereavement support in times of mass bereavement. The common features of services identified as effective were: a proactive outreach; event-specific competencies as well as bereavement skills, an emphasis on educational content and centrally organized but locally tailored and delivered interventions.

Evidence gathered following disasters[17] suggests that survivors do not get the psychological support that they need. In response to the need the American Red Cross and the World Health Organization provide Psychological First Aid (PFA) training programs, to emergency workers and volunteers. The National Child Traumatic Stress Network has published a PFA field operations manual, which has a bereavement assessment and triage section.[18,19] PFA is endorsed by expert consensus and integrated into guidance for psychosocial support in disasters.[20,21] It is underpinned by five 'essential elements': safety, calming, connectedness, self-efficacy and hope. PFA provides a broad focus including immediate practical needs, physical care and safety and emotional support. The model promotes an understanding that distress is normative in disaster situations, that social contact and listening ameliorate acute distress.

BSL volunteers were trained in the key steps in offering support in a time of crisis: Care, Protect (Urgent Protocol), Comfort, Practical, Education on Loss, Coping with loss and Connect to Support. The basic grief assessment[18] included time since loss, severity of loss symptoms, interference with normal functioning and other concurrent mental health stressors; callers with poor adaptation, high range of severe symptoms and concurrent mental health treatment indicated need for professional support.[12,14] Bereavement education was based on two models Worden's Task Approach[22] and Stroebe and Schut's Dual Process Model.[23] Worden's work provided an understandable map of grief and allowed for both a validation of tasks achieved and a focus on coping difficulties. Dual Processing brought a focus on not just the content of loss but the necessary psychological flexibility of moving between states of grief and coping, which promotes adjustment. Callers at risk for PGD or who may need more specialized intervention were signposted to local bereavement and mental health services. This was resourced by the IHF Bereavement Hub's national database of community bereavement supports, mental health services and counselors.

Helplines

Telemedicine advances[24] were implemented rapidly in many countries as a response to COVID-19, to maintain healthcare services. Helplines and web-based resources were used by mental health and bereavement services. The evaluation of such services is limited. Generally, the most commonly reported data for helplines are line usage and caller satisfaction data.[25] An online review survey of 1396 users of the Samaritans in 2012 found that perceived helpfulness was high with 64.7% being moderately or very satisfied.[25] Case histories of disasters demonstrate that basic support can be delivered by well-trained volunteers.[17] However, helpline volunteers experience high levels of emotional impact and burnout leading to a high level of dropout in these services.[26]

Aims and objectives

The aim was to respond to a perceived gap in bereavement support that arose as a result of the severe restrictions in social contact, resulting from COVID-19 regulations. Based on PFA and bereavement public health principles, the rationale was that timely accessible support, by telephone, would lead to education about grief, normalization of responses, listening and support to express grief and signposting if necessary to other resources.

Four objectives guided the evaluation.

BSL evaluation objectives

1. Determine if an adequate system to recruit, train and supervise volunteers to run the line was achieved. (Implementation)
2. Determine if support was provided in line with PFA principles and Bereavement Theory.(Intervention)
3. Describe line usage and the main features of calls and outcomes.(Intervention)
4. Explore the experiences of the helpline volunteers (Implementation).

Methodology

In order to capture the diversity of the line experience, a mixed methods approach was used; data were obtained from a range of sources: an electronic survey of volunteers, in-depth interviews of volunteers and senior management, analysis of line activity data using Amazon Connect and a review of daily volunteer log call database, and of supervision records. An invitation and information sheet were sent to all volunteers in November 2020. Those who consented were sent an electronic survey or invited to interview. An independent psychologist designed the survey and conducted the in-depth interviews. The qualitative data were thematically analyzed. At the time of the survey, there were 17 volunteers; 86% were female, 14% male averaging 60 years ranging from 41 to 73 years. Most (93%) had a postgraduate qualification in

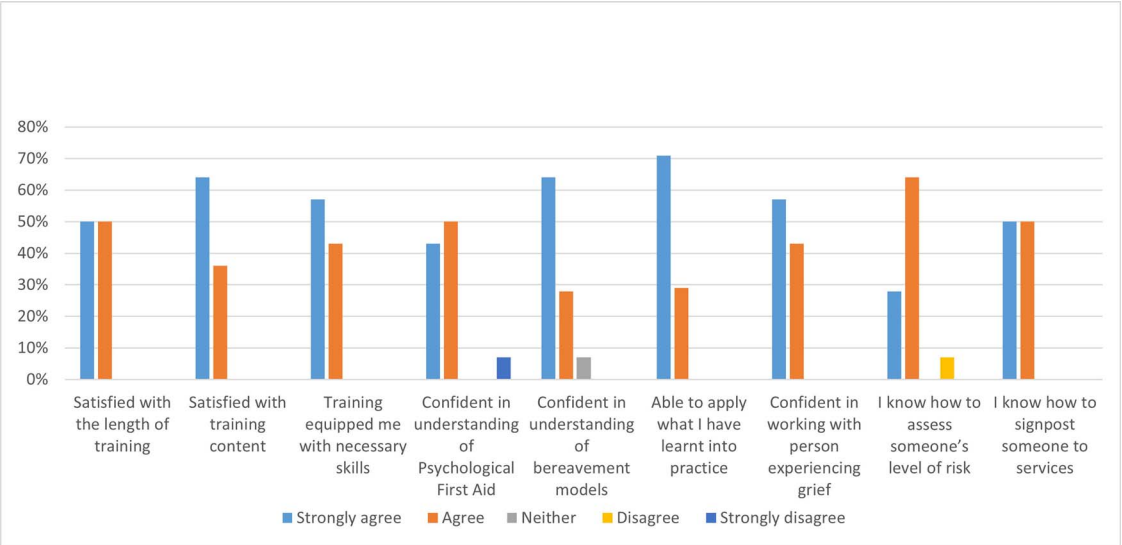

Fig. 3 Satisfaction and self-reported outcome of BSL training ($n = 14$).

bereavement care. The survey response rate was 82% (15 responded, one participant competed only section one of the survey so valid responses are reported out of 14). There were 691 calls recorded on Amazon Connect. Volunteers' data collection logs were modified at the end of August 2022; hence completed call data for 374 calls were available on the database covering the period September 2020 to January 2021. There were 66 records of supervision sessions from June 2020 to January 2021. Each supervision session was documented and analyzed using a thematic analysis to extract themes.

Results

Objective 1: determine if an adequate system to recruit, train and supervise volunteers to run the line was achieved

Volunteers were graduates of a postgraduate training in Bereavement. Eighteen hours of additional training were provided. The training consisted of an update on the psychosocial response to COVID-19: PFA training, review of two models of bereavement care, training on the use of the line equipment and reflective practice and self-care (Fig. 3).

Following the daily line hours, a debrief session was facilitated by the line manager. Two supervision sessions were offered each week with the clinical psychologist. Volunteers were required to attend the daily debrief if they were rostered on and they were required to attend one supervision session per week.

Volunteers expressed a high level of satisfaction with the management of the line, and the training provided. Most were very satisfied with content and timing of training, the majority (93%) either agreed or strongly agreed that they were confident in their knowledge of bereavement theories and PFA.

Training was self-assessed by volunteers as fit for purpose—most strongly agree or agree that they were confident in their ability to apply their training, to work with callers experiencing grief and loss, and signpost callers to appropriate services if necessary. See figure 3.

Some (43%) reported that they feel they need more training. The areas that they identified for future training were update on COVID-19, dealing with callers with mental health issues and repeat callers. All volunteers (100%) reported that they found the daily debriefs with management and weekly supervision helpful in a variety of ways:

"I was left with an 'unsettled' feeling after one call I received but in the debrief session afterwards my mind was put at rest after discussing this and listening to feedback from the line coordinator as well as the other volunteer on the line that day." (V2)

The main themes were as follows: anxiety about competence; adherence to the model; dealing with boundaries; emotional impact; reflecting on connection to self, feedback from management and group process. Processing the in supervision calls facilitated the volunteers reflecting on the emotional impact of the call 'He was so shook, I just listened to him and said "how is it for you" . . . he was silent I said "so sad and so sudden" . . . he just cried. For myself it brought me back to my own mothers' death . . . just a well of sadness'. (V9) Volunteers were emotionally taxed at times 'As she started to talk I felt quite overwhelmed, so much, then I thought just let

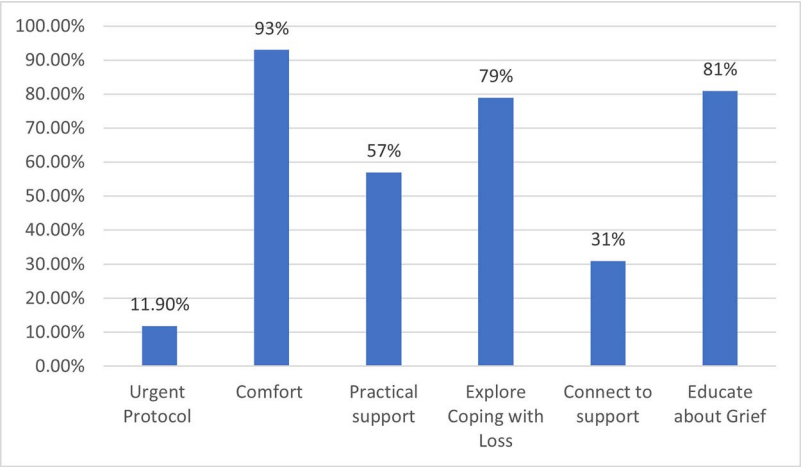

Fig. 4 Elements of PFA used during calls as recorded by volunteers ($n = 267$).

the story unfold, she was calmer at the end' (V3). Sharing how they managed to hold their own distress and be present on the line was inspiring and supportive of all the volunteers. 'It is good to hear other people talk about X, I thought I had make a mess of that call.' (V5). They reported high levels of job satisfaction (100%) and most (86%) expressed an intention to continue volunteering.

Objective 2: determine if support was provided in line with PFA principles and Bereavement Theory

Fidelity to the intervention was tracked by volunteers recording their interventions into the volunteer log following each call. Adherence to the model was discussed at debriefing and in supervision (insert Fig. 4).

The completed logs indicated that the volunteers adhered to the first principle of PFA, the need to check on the current safety of the caller and to determine if the caller need to be advised to seek further help from a GP or a mental health service, 10% of callers' required urgent follow-up. Providing comfort, educating about grief and exploring ways of coping with loss (93%, 81% and 79%, of calls respectively) were the most frequent interventions used; practical support was noted in over half of the calls (57%).

Objective 3: describe line usage and the main features of calls and outcomes

The average length of a call was 20 minutes but there was a wide range from 3 minutes to 90 minutes. The volunteers maintained a database. Most (74.2%) callers were female and 25.8% male. The majority had lost a parent followed by loss of a spouse and smaller number had lost a sibling, relative, child or a friend.

Theme	Sample Quote
The impact of COVID -19	*Caller's dad died in April of COVID-19, acquired in hospital. She had not seen him for 2 months - feels "robbed" as a result. Good family, GP and work support. Less angry than she was and feeling better since calling"* *Caller's husband died in November 2020 after a long illness. Caller had looked after her husband at home all through illness which was difficult especially in last 12 months, he was demanding, verbally abusive and aggressive. He was moved to local hospital on Fri November 2020 due to very high warfarin levels, and deteriorating condition. Caller tearful at times, related experience of the care given in local hospital which, by her account, wasn't very satisfactory. Husband was alone when he died. Nurse's comment upset her "you were better off not being here as it wasn't nice".* *"I couldn't attend the funeral (of father) I was sick at the time, no removal, no cuppa tea afterwards sure it was disrespectful after all he did. I feel we all failed him in the end"*
Emotional pain and distress	*Caller's partner died last week, buried day previous to call…. she was completely overwhelmed with grief, during the call she went through sobbing, rage, complete denial of his death. By end of call she was calmer and appointment with GP was made for 2.30pm that day.* *Female caller, very sad and distressed, partner died suddenly in July, they were 33 yrs together. Their only son aged 16 died suddenly 16 yrs ago. Never lived alone before, only dog for company. Partners sister and own sister good to her. They were due to be married in June, rescheduled to Oct. Partner was buried in his wedding suit.*
Healthcare services restricted	*Callers lost her boyfriend in March 2020, though a sudden death from Covid -19.She was not able to attend funeral and did not see him for some time just before he died. They had been in relationship, they met through attendance at a mental health support day care centre, which is now closed due to COVID restrictions. This was her social world. She had no way of contacting the service manager. She is suffering from depression compounded by her grief experience.*
Healthcare professionals	*Junior doctor called to debrief after COVID death on ward.* *GP called looking for resources for patients.* *Nurse rang on behalf of a resident in a hospital/nursing home… having difficulty comprehending and coping with death of her sister.*

Fig. 5 Themes extracted from line data recorded by volunteers ($n = 337$).

The database had an open field in which the volunteers could record a brief summary of the phone call. Thematic analysis identified four themes, the impact of COVID-19; emotional pain; reduction in access to healthcare services and enquiries from other professionals (insert Fig. 5).

Overall 30% of callers were sent information and signposted to community and bereavement services. At the end of the call, callers were asked, if appropriate, how the call was for them; data were available on 110 callers. Of that group, 75.2% were satisfied, 20.7% were neutral and 4.1% were dissatisfied.

Objective 4: explore the experience of volunteers

Volunteers were asked to rate to what extent they were emotionally impacted by the calls they have received. All volunteers reported that they were in some way impacted—43% a little, 14% somewhat and 36% moderately. Overall their role satisfaction was high (100%) and retention was good, with two volunteers retiring for personal reasons. Burnout was not measured directly but by asking about intention to continue on the line. Some 86% of volunteers reported that

they intended to continue to work on the helpline. They reported that helpful factors in managing the impact of the calls were timely consistent feedback from management about distressed callers, feedback that follow-up calls and signposting people to GP and mental health service were completed.

Discussion

Main findings of this study

This study describes a proactive Level 1 national response to bereavement care during the initial COVID-19 pandemic. It was designed to be accessible and timely, providing the core elements of PFA coupled with support to express grief, education on loss and signposting if necessary to other services. The study reports a retrospective evaluation of 6 months of the telephone helpline.

Volunteers reported that they were satisfied with the timing, content and duration of the training. They found debriefing and supervision supportive and containing, the majority stayed with the service and did not experience undue personal distress as a result of listening to bereaved callers.

The main themes of the calls were as follows: impact of COVID-19; emotional pain; reduction in access to healthcare services and enquiries from other professionals.

COVID-19 restrictions on social contact and social support prevented visits to hospitals and family presence at the time of death; the limitations on funeral rites resulted in reduced communal space to grieve and for some callers, the closure or reduction of mental health services created additional stressors. Callers were more emotionally distressed with high affect at the time of the call. This is in line with data from the Netherlands where people reported that they were acutely emotionally distressed following COVID deaths.[12] Some 10% of callers had urgent care needs and were advised to contact their general practitioner or mental health service. This is lower than would be expected from the literature, which suggests that up to 43% of a population could be at risk for prolonged grief disorder. However, the line data were early in the onset of COVID 19 and PGD is usually not diagnosed until 6 months post loss so high rates of PGD may yet emerge.

What is already known on this topic?

There is little research on formalized bereavement support (and the degree of bereavement need) during pandemics. A systematic review conducted early in the pandemic confirmed this[7] and a further review[15] emphasized the importance to designing a healthcare system response to bereavement care. PFA is an effective first-line intervention in catastrophes/natural disasters and so was adapted to shape the BSL. As a national service, the BSL set out to both support and to signpost, hence building on the recommendations of the review papers.

What this study adds

This study traces the set-up and initial operation of a national bereavement intervention; it demonstrates the use and acceptability of a Bereavement PFA model during the first 6 months of a service's operation in the context of a pandemic which necessitated major restrictions. The intervention was designed relative to the public health approach and incorporated signposting to more specialized services.[4,5,15]

Limitations of this study

Data reported here are objective service use data and the self-reported experiences of volunteers. Evaluation of the efficacy of helplines[25] is difficult due to the confidential nature of the service, once off contact with callers and the distressed nature of the calls. The BSL attempted to record caller satisfaction but the field was used in only 1 in 6 callers mainly due to the high level of emotional distress during the call and volunteer reluctance to ask. Ensuring a systems-led approach, future evaluations of the BSL should identify targeted outcomes not just at the individual caller level but also at organizational, cross-organizational and community levels and, finally, national level.[27]

Conflict of interest

UB and JB were commissioned as independent researchers to conduct this evaluation. OK is manager of the service.

Data availability statement

Data available on request.

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