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Guidance for Bereavement Support provided by Specialist Palliative Care Social Workers in Ireland

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Authors:

Niamh Finucane Bereavement Co-ordinator, St. Francis Hospice Dublin.

Irene Murphy Principal Social Worker, Retired

Ann D'Arcy Bereavement Co-ordinator, Our Lady's Hospice and Care Services

Estelle McGinley Senior Social Worker, Milford Care Centre.

Aileen Mulvihill Senior Social Worker, Specialist Palliative Care, Longford/Westmeath.

Michelle O'Reilly Senior Social Worker, North West Hospice.

Audrey Roulston Professor of Social Work in Palliative Care, Queen's University Belfast.

Hazel Greene Bereavement Co-ordinator, Galway Hospice

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Glossary of Terms

BRISQ-B	Bereavement Risk Inventory and Screening Questionnaire
BTN	Bereavement Training Network
DHSSPS	Department of Health, Social Services and Public Safety
DOH	Department of Health
DOHC	Department of Health and Children
HPCSW	Hospice and Palliative Care Social Workers Group
HSE	Health Service Executive
ICBN	Irish Childhood Bereavement Network
IHF	Irish Hospice Foundation
MDT	Multi-disciplinary team
NHCP	National Healthcare Communication Programme
NICE	National Institute of Clinical Excellence
RCPI	Royal College of Physicians of Ireland
WHO	World Health Organisation

Guidance for Bereavement Support Provided by Specialist Palliative Care Social Workers in Ireland

1. Introduction

In this document we outline the bereavement support needs of patients and their families as part of a continuum of care from illness into bereavement. We review current understandings of the grief and loss experience in the context of research, guidance and policy. This informs the evidence-based guidance for social workers in their support of patients and their families within specialist palliative care services.

All bereaved people, adults and children, require access to good quality information about grief and most manage their bereavement with the support of friends and family (ICBN, 2014; IHF, 2020; ICBN, 2023). Most people (60%) experience healthy or uncomplicated grief when their loss is accepted, their ability to function in everyday life is regained (Boelen et al., 2007), and they adapt to the death of a loved one without therapeutic intervention (Eisma et al., 2015). A significant minority of bereaved people (approx. 40%) may require extra support to make this adaptation (Aoun et al., 2015). However, evidence suggests that without appropriate support some of these people may develop a range of physical and mental health problems (Stroebe et al., 2007, Thimm et al, 2020), including major depressive disorder (Nielsen et al., 2025), anxiety (Jacobs et al., 1990; Komischke-Konnerup et al 2021), post-traumatic stress disorder (Schut et al., 1991, Onrust & Cuijpers 2006; Smith & Ehlers, 2021) or prolonged grief (Prigerson et al, 2021).

Bereavement care is an integral part of specialist palliative care, and all members of the multi-disciplinary team, including administrative staff, have a valuable contribution to make (NICE, 2004; WHO, 2002; Hall et al., 2012; Ryan et al., 2014; Hudson et al., 2017; HSE & RCPI, 2019). According to the NICE guidance Improving Supportive and Palliative Care for Adults with Cancer (2004), those who experience bereavement should receive, at a minimum, information on loss and support to facilitate grieving, where necessary to prevent the detrimental consequences of bereavement, in line with the findings from public health research (Aoun et al, 2020).

Internationally, it is recommended that all palliative care services have bereavement guidance outlining the range of bereavement services they offer and the pathways for

service delivery (Scottish Government Health Directorates, 2011; Hudson et al., 2017; HSE & RCPI, 2019; National Bereavement Alliance, 2024). Hence, the primary aim of this document is to provide evidence-informed guidance for specialist palliative care social workers who deliver bereavement care services to families of patients with a life limiting illness.

2. Context

Historically, palliative care services in Ireland were established in response to localised need, and were funded from a variety of sources, including statutory, voluntary and charitable organisations. This may explain the significant variance in the availability and delivery of palliative care services throughout Ireland, and the way in which bereavement care can be delivered (IHF, 2006; IHF, 2013). However, there has been considerable investment in the development of palliative care services nationally in Ireland in recent years, supported by a new funding model. This initiative has been guided by two strategic documents, Model of Care (HSE, 2019), and the National Adult Palliative Care Policy (DOH, 2024). The National Adult Palliative Care Policy identifies the development of bereavement services as one of the twenty-five recommendations of the policy. The documents outline the government's commitment to achieving a universal and integrated approach to palliative care for all citizens of the state. Further, the national health policy of Ireland, Sláintecare, recommends that universal palliative care should be a core part of our health system (Houses of the Oireachtas, 2017).

It is now recognised that as well as increasing patient and family satisfaction levels, palliative care involvement has the potential to significantly reduce prolonged grief and post-traumatic stress disorder among bereaved family members (HSE & RCPI, 2019). This is also referenced in the National Adult Palliative care Policy (DOH, 2024). Traditionally 25% of all deaths nationally and 72% of all cancer deaths have been supported by specialist palliative care services (IHF, 2013). Studies have shown that eight out of ten people who die each year would benefit from palliative care (DOH, 2024).

The first iteration of this document by the Hospice and Palliative Care Social Work Group (HPCSW, 2019) commenced with a review of internationally published bereavement guidelines and standards (Aranda and Milne, 2000; DOH, 2008; DHSSPS, 2009; Relf et al, 2010; Agnew et al, 2011; Hall et al, 2012; Bereavement

Services Association/CRUSE, 2014; HSE, 2016; Hudson et al, 2017; ICBN, 2017), taking account of the competency framework for palliative care (Ryan et al, 2014), and the National Model of Care for Adult Palliative Care (HSE & RCPI, 2019). It was originally produced to promote the highest level of standardised practice in the provision of bereavement support for specialist palliative care social work nationally. The group also developed an addendum in 2020 taking account of the COVID context (HPCSW, 2020).

It is timely to update the document in the light of recent service developments and emerging evidence around grief and loss. Consistent with the vision for integrated care under Sláintecare, this guidance acknowledges that specialist palliative care social work services should collaborate with other organisations locally and nationally, to enhance the level and type of service available to bereaved people (Hall et al, 2012; HSE & RCPI, 2019; Jurgens et al, 2025). Further, it demonstrates the commitment to the promotion of a public health approach to bereavement (Aoun et al, 2015; Aoun et al, 2019; HSE & RCPI, 2019). This guidance recognises bereavement as a situated experience for adults, children and their families, which occurs along a continuum. It describes delivery of social work service from pre-death support right through to post-death bereavement care, in line with the competency framework for specialist palliative social work (Ryan et al, 2014) and the best available research evidence.

3. Fundamental Principles

Several fundamental principles underpin this guidance, which aims to promote best practice by specialist palliative care social workers when working as an integral part of a multi-disciplinary team and when delivering bereavement care. These principles were identified following a review of relevant national standards, frameworks and policy and are aligned with the national competency framework for palliative care (Ryan et al, 2014). See Table 1 for more details.

Table 1. National Standards, Frameworks and Policies reviewed

Authors	Year	Title of document
National Bereavement Alliance, UK	2024	Bereavement Support Service Standards
Department of Health, Ireland	2024	National Adult Palliative Care Policy
Irish Childhood Bereavement Network	2023	Standards for Supporting Bereaved Children and Young People
Irish Hospice Foundation	2020	Adult Bereavement Care Pyramid. A National Framework
CORU (Regulating Health and Social Care Professionals)	2019a	Social Workers Code of Professional Conduct and Ethics
Health Service Executive & Royal College of Physicians of Ireland	2019	Adult Palliative Care Services Model of Care for Ireland
Health Service Executive	2018	Second National Intercultural Health Strategy 2018-2023
Health Service Executive	2016	National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death
Irish Childhood Bereavement Network	2014	Irish Childhood Bereavement Care Pyramid
Ryan et al.	2014	Palliative Care Competence Framework - Social Work chapter
Department of Health and Children	2010	Palliative Care for Children with Life-limiting conditions
Department of Health and Children	2001	Report of the National Advisory Committee on Palliative Care

The fundamental principles for bereavement care are as follows: access, values and diversity, partnerships, quality assurance and governance.

3.1 Access

All people have a right to information to facilitate access to support, according to need, both pre and post death

- Palliative care services should have defined pathways to facilitate seamless access to additional services, if required.
- Family or carer need for bereavement support should be identified via the multi-disciplinary team (MDT) as part of the overall needs assessment process.
- People can self-refer or be referred to services as individuals, a family or as a group for an assessment of need. Referrers must obtain consent from individuals to make a referral for bereavement support.
- After the death of a family member, bereaved relatives should have access to information which should:
    - normalise grief and explain how to access support, if required
    - be made available in different languages and formats
- If the service has a waiting list, clarification is required regarding how the person can be supported in the interim.

3.2 Equality, Diversity and Inclusion

Support must be accessible in line with organisational Equality, Diversity and Inclusion policies which aim to dismantle barriers based on poverty, race, ethnicity, language, sexual orientation, gender, age, culture, disability, socio-economic status or religious beliefs.

Services provided should promote:

- confidentiality.
- consent.
- a safe and accessible environment.
- respect for the individual and their unique experience and expression of grief.
- a family systems perspective.
- recognition and acknowledgement of loss over time including the social, financial and practical implications.

- equity of provision and access regardless of race, ethnicity, sexual orientation, gender, age, culture, language, socio-economic status or religious beliefs.
- an intercultural approach to planning and delivery of care.
- a prompt response to any concerns regarding a patient or family member's immediate mental health needs, with onward referral to appropriate professionals or agencies as necessary.
- co-produced care planning in line with experiences, expectations and wishes using relevant assessment frameworks.

Children and vulnerable populations merit particular attention in the needs assessment process and require a proactive approach to the provision of bereavement support.

3.3 Partnership

People live within communities and social networks. Collaborations and partnerships with a range of agencies and institutions can broaden access to a range of bereavement support and improve overall service quality. Specialist palliative care social workers should work in partnership with others as appropriate to:

- develop links with external bereavement support agencies and local communities, to ensure a full range of up to date, appropriate bereavement service information is available.
- engage with local bereavement networks where they exist.
- contribute to the development of compassionate communities in relation to illness, grief, dying and bereavement.
- promote self-assessment and empower individuals to explore and engage in the most appropriate service in terms of location, identified need and level of service.
- adopt a systematic approach to the assessment of bereavement needs, taking account of family resilience, coping and vulnerability .
- develop clear processes for making onward referrals, which avoid duplication of services and manage delays when requesting specialist services.

3.4 Quality Assurance

People have a right to high quality, evidence-based support appropriate to their level of need.

- All paid and voluntary staff in a palliative care service, who have contact with family members during the illness trajectory, and with bereaved individuals, will require bereavement awareness training, to ensure they meet the competency requirement for specialist palliative care staff (Ryan et al., 2014). This training should be provided by members of the Social Work team, and the content should raise awareness of risk or vulnerability factors and factors that may enhance resilience (See Appendices 1 and 2).
- Agencies should acknowledge the impact of working in a context of loss, grief and bereavement for staff and volunteers, and provide support.
- Where services have volunteers engaged in bereavement support, clearly defined roles outlining their responsibilities and commensurate training must be provided by the agency. The social work team are responsible for the clinical management of these bereavement volunteers and assessing the level of need of individuals or groups prior to them attending a bereavement volunteer.
- Systems should be in place to facilitate user feedback in relation to bereavement support services (See Appendix 3 for suggested evaluation form).
- Bereavement services should be audited and reviewed regularly. Findings from audits, service evaluations, new research evidence or policy developments should underpin changes to service provision. See Appendix 4 for sample audit tool. The Irish Childhood Bereavement Network (ICBN) has national standards for supporting bereaved children and young people, which includes a Self-Assessment Tool for Bereavement Services (ICBN, 2023). See Appendix 5.

3.5 Governance

Services must have a clearly defined, transparent structure and model of care with appropriate safeguards to ensure good governance at all times. We recommend that services consider the following points:

- To ensure ethical, safe and appropriate service delivery, all social work staff should have the appropriate skills and competence for the roles they undertake (CORU, 2019a), which will reflect the social work competencies in the Palliative Care Competence Framework (Ryan et al., 2014).

- Each agency has responsibility to ensure that there is sufficient staffing to respond to the needs of individuals and families who may experience high levels of difficulty before and following the death of a patient.
- Specialist palliative care services should have a designated bereavement co-ordinator (DOHC, 2001) within the social work team (HSE & RCPI, 2019).
- Clinical supervision should be made available to Social Work staff involved in the delivery of bereavement services. This supervision should be offered regularly and can be individual and/or group supervision.
- Bereavement Support Volunteers actively engaged in providing bereavement support must receive regular training and supervision. Support should be delivered in line with level 2 competencies and can be supported by the associated e-Learning programme (IHF & BTN, 2025).
- All Social Workers should regularly attend education and training events for their continuous professional development in line with the CORU *Guidance on CPD Framework*, (2019b) requirements (e.g. 30 CPD credits in every 12-month period).
- Social workers must adhere to their organisational policies on confidentiality, safeguarding, risk assessment, complaints and GDPR, with clear response times.

4. Guidance for Bereavement Care

Acknowledging that loss, grief and bereavement occur along a continuum, this guidance outlines the role of the specialist palliative care social workers when providing care from the initial point of contact with the specialist palliative care service, around the time of death and into post-death bereavement care (HSE & RCPI, 2019). We acknowledge the role of other members of the multi-disciplinary team, particularly during the patient's illness. However, this guidance is for specialist palliative care social workers.

4.1 Pre-death: Balancing and exploring risk and resilience

End-of-life care and the death of a family member create multiple transitions for individuals within a family, as well as for the family as a whole. The context within which families live, including previous experiences of loss and illness, influence how they cope with this illness, any impending and actual losses after the death and their response to grief. Preparedness for death has also been found to be a key factor for individuals, helping to ameliorate post loss psychological morbidity (Hebert et al, 2009;

Neilsen et al., 2017), and contributing to lower levels of somatization (Schmidt et al., 2025).

Assessment should be multidisciplinary and interdisciplinary in nature (Hall et al, 2012) and where possible, should involve direct input from the patient, their relatives or family carers and professionals involved in their care. Consequently, a family's bereavement needs should be continuously assessed from the point of referral to the service and into bereavement, with their consent (DOHC, 2001; HSE & RCPI, 2019; Coelho et al., 2025). It should consider both the needs of individuals and of families, adopting a family systems perspective, acknowledging the family is broader than kinship ties. It should consider the individual and family's needs from both a resilience and risk perspective (Relf et al., 2010; HSE & RCPI, 2019; Archer and Machin, 2024). (See Appendices 1 and 2 for more details.) The social work service can be offered to a family on referral from a member of the multi-disciplinary team, or directly by the social worker. Individuals and families may also self- refer.

The social worker's role in the pre-death phase is to work within the context of the family system to explore and support the patient and family's preparedness for death by:

- facilitating and supporting transition and adjustment to a relative's life-limiting illness and their impending or actual death.
- advocating for a patient's prognosis to be communicated in an appropriate and timely manner.
- facilitating communication between the patient, their family and members of the wider multi-disciplinary team, on key issues such as:
    - exploring a patient's will and preference around their care plan and exploring if any documentation has been completed to date around their advance care planning wishes or any shared decision-making agreements in line with the Assisted Decision-Making (Capacity) Act 2015.
    - realising aspects of their advanced care planning wishes.
    - advocating for consideration of the physical environment in which care takes place, where and when bad news is communicated or sensitive conversations take place.

- addressing practical and financial stresses associated with illness and death.
- engaging with the patient and family members to assess perceived risks and anticipated coping mechanisms, underpinned by knowledge of bereavement risk factors and resilience (Appendices 1 and 2).
- providing advice and guidance to families living with a life limiting condition, in supporting them to consider the needs of children and young adults.
- supporting individuals and families to recognise and navigate different coping mechanisms and communication styles, particularly where conflict arises.
- providing information and advice to families on communicating with those who are perceived or assessed as vulnerable, that promotes their inclusion and understanding of their relative's condition.
- maximising input from existing support services utilised by any children or vulnerable adults in the family.
- acting as a key resource to the wider multidisciplinary team around the issues raised above.

The ability of the surviving parent to support and nurture a healthy emotional expression of grief for the children is the most significant protective factor in limiting negative outcomes from the experience (Worden, 2001; Haine et al, 2008; Howell et al, 2015; Wardecker et al, 2017; Sandler et al, 2018). Parents frequently look to healthcare professionals for guidance with this, and there is also evidence to suggest that children may benefit from opportunities to engage directly with these healthcare professionals (Fearnley & Boland, 2019; Marshall et al, 2022). With their systemic training, knowledge, experience and skill level, social workers are ideally placed to guide parents and other family members to support children before and after the death of someone significant in their lives. When indicated, social workers can engage in therapeutic work with children and their families before and after the death. Social workers can also help families to facilitate opportunities for legacy work and memory making.

Social workers are a key resource to multi-disciplinary colleagues in understanding and supporting the needs of children and families at this time. Specialist palliative care social workers significantly contributed to the development of a module for healthcare professionals around preparing children when someone close to them is dying (NHCP, publication pending).

4.2 Around the time of death

In palliative care settings where a social worker is available around the time of death, their role may be to assist families in preparing for change and managing intense emotion.

As death approaches, the multi-disciplinary team (MDT) is conscious of the need to be as inclusive as possible regarding all family members. However, strained relationships may be intensified around the time of death, and some individual family members may benefit from the support of the social worker to acknowledge their distress and to help them to implement strategies to diffuse the situation (Tzvetanova, 2024).

Discussions may need to take place regarding who wishes to be present when the patient dies, which should acknowledge any particular preferences stated by the patient and should be communicated to the MDT.

For many individuals, anticipating and being present at a death is unfamiliar and they may welcome guidance on their presence and interaction towards the end of life. Similarly, the decision of some individuals who do not wish to be there at the time of death may require negotiation with other family members, as this can create discord.

Maintaining an environment that is restful and dignified for the patient is paramount. Where family tension or conflict impinges on this, particularly as the patient is actively dying, the social work role is to facilitate open communication or assist them in managing their distress.

Parents frequently look to healthcare professionals for guidance when parenting at the end of life (Fearnley & Boland, 2019). Social workers can offer guidance and support

on communicating with children when a patient has entered the dying phase. They can support families to facilitate visits by children to their dying family member. When relevant, social workers can support families to communicate the news of a death to children and young people, or to other family members who are perceived to be vulnerable, such as those with additional needs or health issues.

The social worker can also be an important resource in supporting families in their response to the death and the rituals following the death, including providing practical information on organising a funeral or accessing financial supports. There is evidence that financial distress can be associated with adverse outcomes in bereavement (Newsom et al, 2017; Nielsen et al, 2017) and it is recommended that priority should be given to assessing the financial needs of individuals and families from lower socio-economic backgrounds (Roulston et al, 2016). The social worker can assist families in accessing appropriate resources, where possible, to ensure a dignified funeral arrangement for the patient.

Some patients and families will wish to explore the possibility of repatriation before death or repatriation of the body for burial abroad. It is important that they receive appropriate information in a timely way about the medical, legal, national, and international procedures and protocols and associated costs. They may also require support around exploration of cultural priorities/values to assist them in decision making.

4.3 Bereavement support after the death of a patient

Each service should provide good quality information about grief and bereavement, and develop their own bereavement care policy, outlining service provision which may include onward referral pathways within the local community (HSE & RCPI, 2019; IHF, 2020; ICBN, 2023). Following the death of the patient, it is the responsibility of the MDT to review the circumstances of each patient's death, their understanding of the family's perception of the death and their perceived capacity to cope with the loss, in order to highlight people who may need an additional level of bereavement support or counselling (Ryan et al, 2014). Some individuals and families will request no further contact, and some may self-refer to services in the post death period (HSE & RCPI, 2019).

5. Referrals to the service

Where individuals self-refer to the bereavement service or are referred by a member of the MDT, with the consent of the individual, there should be contact within 10 working days of the referral. This includes a first post death screening or assessment. See Appendix 6 for a sample assessment screening template. Contact may be by telephone or face to face, where contact is not established a letter should be sent.

6. Assessment

An assessment of bereavement support for family or carers should be conducted as part of the palliative care needs assessment process (HSE & RCPI, 2019). The purpose of the first contact with a bereaved individual, regardless of the source of referral, is to jointly explore with the individual their grief experience (Guldin & Leget, 2024), how they are coping, their level of perceived support and their capacity to access and utilise that support. This should include assessment of vulnerability, risk and resilience factors as outlined in Appendices 1 and 2, drawing on the social work code of ethics (CORU, 2019a) and competencies (National Head Medical Social Workers Forum, 2013; Ryan et al, 2014). The Confidential Working Agreement (Appendix 7) may be used to capture relevant information and illustrate the proposed action/care plan. It also addresses the extent and limitations of confidentiality. This can be completed verbally in cases of telephone support.

In line with the Public Health Approach to bereavement care (Aoun et al, 2012) different levels of bereavement support and counselling may be provided to meet the range of support needs of bereaved individuals and families (HSE & RCPI, 2019, IHF, 2020). The first post death assessment must uphold the ethical responsibility of specialist palliative care providers to only offer support where it is indicated (Relf et al., 2010). Practitioners can support an individual's resilience and capacity to cope with loss (Machin, 2014) through their understanding of the mourning process and by creating a supportive environment (Zalli, 2024). Awareness of the important role extended family, rituals and social support play in fostering family resilience in bereavement facilitates a wider assessment of the needs of the individual in their social and cultural context (Yıldırım & Çelikkol, 2025).

Identification of those who may be vulnerable in bereavement or at risk of prolonged grief disorder, can enable Specialist Palliative Care Social Workers to target intervention where it is needed most. This can be explored using assessment tools such as the Adult Attitude to Grief Scale (Machin, 2014), or the Bereavement Risk Inventory and Screening Questionnaire (BRISQ-B) (Roberts et al, 2017).

The outcome of an assessment may suggest that no formal intervention is offered or required but may allow for an individual to self-refer in the future should their need change. Similarly, the assessment process should respect the individual's capacity to make decisions about the level of support or counselling they require at that time. If an individual declines services, and if they are not deemed to be a risk to themselves or others, this should be respected. However, if an individual expresses suicidal ideation, or is deemed to be at risk of self-harm, their General Practitioner should be notified (CORU, 2019a, Archer & Machin, 2024).

Different families and individuals will need differing levels of support after a loss (NICE, 2004; Aoun et al., 2015). Given the dynamic nature of grief, needs can also change and evolve over time. It is not expected that all Specialist Palliative Care Services will provide each of the levels of support outlined below (DOH, 2024). However, each service should be able to support family members 'universal grief needs' "…by acknowledging current or anticipated losses, supporting the expression of emotions and providing information about the grieving process." (HSE & RCPI, 2019: 87).

Professionals working within the service should all have an awareness of the levels of need and of support (Ryan et al, 2014). Each palliative care service should develop links with other agencies to facilitate referrals to a range of supports and services and develop clearly defined pathways for onward referral to more appropriate services in the bereaved person's local community (HSE & RCPI, 2019, DOH, 2024). Where a specialist palliative care service provides bereavement support services, a social work assessment will determine the appropriate response provided based on the level of need identified. Needs will be continually assessed recognising the dynamic nature of grief and the fact that individual or family need can change over time. The different levels or tiers of need are outlined below.

7. Levels of Need

The Loss, Grief and Bereavement pathway in the Adult Model of Care recommends an integration of post death support with pre-death service provision, with a tiered approach to need using a family systems perspective (HSE & RCPI, 2019), acknowledging that family is broader than kinship ties. This aligns with the Adult Bereavement Care Pyramid (IHF, 2020) and the Irish Childhood Bereavement Pyramid (ICBN, 2014), two national models for the provision of bereavement care. The National Adult Palliative Care Policy (DOH, 2024) supports this approach. Acknowledging the variance of experience and support needs in bereavement, the Pyramid models (IHF, 2020 & ICBN, 2014) depict 4 levels, as described below.

7.1 Level 1: Universal need to have the death acknowledged and the provision of information about grief and bereavement.

It is recommended that as a minimum, specialist palliative care services should provide information about grief and bereavement to those affected by the death of a patient (NICE, 2004; Scottish Government Health Directorates, 2011; Bereavement Services Association/CRUSE, 2014; HSE & RCPI, 2019). This information should be made available in a variety of forms:

- Information leaflets or booklets, based on research evidence, made available at the time of death in all settings, supporting individual choice and contributing to higher levels of grief literacy (Selman, 2026).
- Signposting towards other resources about bereavement, including the availability of appropriate and quality digital resources.
- Unless no further contact has been requested, a letter should be sent to the patient's main contact person/relative, subject to GDPR 2016 legislation, within 3 months of the death (Hudson et al, 2017). This should offer written information on bereavement and how to access support, including bereavement events.
- Where resources allow, other events such as a psycho-education information event on bereavement, coordinated by members of the social work team should be provided within 3-6 months of the patient's death. At this event people will be informed about grief, what to reasonably expect for themselves and their families and have their experience of grief normalised where appropriate.
- Opportunity for remembrance may be provided to the bereaved as a form of communal support.

7.2 Level 2: Need for support from someone outside of the family or natural support network to review the loss and explore coping strategies. Services at this level may include:

- Offering individual support to review their unique experience of the loss and where appropriate, to normalise their grief reactions or escalate to a higher level of support, if warranted after assessment
- Offering the opportunity to meet with medical or nursing staff previously involved in the patient's care, if this will help overcome barriers to grieving. The support of the social worker can be important if the person is receiving or is likely to need further bereavement support.
- Peer support which provides an opportunity for bereaved people to meet others who are experiencing a similar loss and to support each other through mutual understanding and sharing of what they are going through.
- Support by trained bereavement volunteers with level 2 skills and knowledge who receive regular supervision.

Services offering support at this level should be familiar with the newly developed competencies for Level 2 bereavement support and ensure their service aligns with these competencies (IHF & BTN, 2025).

7.3 Level 3: More pronounced or intense bereavement support needs than at level 2, requiring a professional response to meet this need. Social workers and others may provide this level of service with appropriate training. The purpose of this therapeutic, evidence-based intervention is to provide an opportunity for the bereaved person to talk through their experience of loss and to review how they are coping and adjusting to their changed circumstances (IHF, 2020; Worden, 2003). This may be:

- individual, family and group professional support and counselling.
- an invitation to attend a bereavement support group facilitated by members of the social work team. Professionally led groups may also be supported by trained bereavement volunteers. Group support is recognised as a format for providing tailored approaches for specific cohorts, such as those parenting children after the death of a partner and co-parent (Anderson et al, 2023; Finucane and Concannon, 2020; Yopp and Rosenstein, 2013). The peer support dimension is recognised as an enhancing coping and adjustment (Holmgren, 2023; Richardson, 2016).

- An invitation to engage in up to six sessions of bereavement counselling, prior to a review, and any additional sessions being agreed, which mirrors Cruse Bereavement Care guidelines (Newsom et al., 2017). The number of sessions allocated to each bereaved person will be based on assessed need and resources available within the service, which will be communicated to the bereaved individual during their bereavement assessment. Appendices 6 and 7 provide templates that services can adapt to contract with clients and record contact with bereaved individuals and the agreed outcome/action plan.
- Ensuring the individual is made aware that they can avail of bereavement support and counselling at any time in the future should they wish to do so, thus acknowledging that grief is an ongoing process and a person's need for support may change over time.

7.4 Level 4: At any point in the grief trajectory, following assessment, a minority of people may present with complex bereavement needs, such as the risk of suicide/extreme emotional and psychological distress, to prolonged or persistent and intrusive grief symptoms (Maciejewski et al, 2016). All bereavement service personnel, including specialist palliative care social workers, must be aware of the ICD-11 diagnostic criteria (WHO, 2018) and the DSM-5-TR criteria (American Psychiatric Association, 2022) so that they recognise prolonged grief and serious risk to health and well-being arising from the death. This is important as there is emerging evidence, that support in the early months after loss for some individuals, may reduce the risk of complications in their grief in the longer term (Scottish Government Health Directorates, 2011; Fenger-Gron et al, 2018; Duffy and Wild, 2023). Such individuals may access support from staff with specialist training within the agency if available or may require an onward referral to external agencies offering specialist bereavement counselling or specialist teams (e.g. mental health services via the General Practitioner). Systems should be in place to formally capture onward referrals and to manage delays in accessing the relevant specialist services (see Appendix 6).

8. Conclusion

This document provides evidence informed guidance to all specialist palliative care social workers who are involved in the delivery of bereavement support to patients and families. While acknowledging that the majority of bereaved individuals manage their grief with good quality information and their informal support networks, a significant minority of bereaved people may require additional supports. The guidance recognises the differing levels of need which may emerge after a significant loss and advocates an appropriately matched response.

While recognising the variation in service structure and resourcing nationally, this guidance strives to ensure a minimum level of standardised practice for specialist palliative care social workers and how bereavement services could be structured, irrespective of geographical location. The guidance emphasises the social and cultural context of the illness and loss and highlights the importance of continuous bereavement support from the first point of contact with a specialist palliative care service, right up to, and following, the patient's death (DOHC, 2001; HSE & RCPI, 2019; DOH, 2024). It also takes account of the competencies required by social workers working with bereaved people (National Head Medical Social Workers Forum, 2013; Ryan et al, 2014).

The guidance is underpinned by a number of key principles: Access; Equality, diversity and inclusion; Partnership; Quality Assurance and Governance. It acknowledges the wide range of grief experiences and needs encountered by individuals and families and suggests how palliative care social work services can be structured and delivered using a tiered system of bereavement support (Aoun et al, 2012; Aoun et at, 2015; Aoun and Rumbold, 2022).

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10. Appendices

Appendix 1: Factors influencing risk in bereavement:

Definition:

Risk factors in bereavement are the qualities of individuals and aspects of their situation that may increase the likelihood of vulnerability in coping with a significant loss (Relf et al, 2010:6). A review of the factors that influence grief conclude that those most vulnerable to poor outcome in terms of complicated grief (Lobb et al, 2010) and post-loss depressive symptoms (Nielsen et al, 2017) are as follows:

- Loss a child (Lobb et al, 2010)
- Spousal loss at a young age (Nielsen et al, 2017)
- History of previous multiple losses and life struggles (Lobb et al, 2010; Nielsen et al, 2017)
- Lack of preparedness for the loss (Lobb et al, 2010, Nielsen et al, 2017)
- High levels of care-giver burden pre-death (Nielsen et al, 2017)
- High levels of pre-death distress and depressive symptoms (Nielsen et al, 2017)
- High levels of family conflict (Kissane et al, 2016)
- Financial distress and poverty (Newsom et al, 2017; Nielsen et al, 2017; Roulston et al, 2016)
- Lower levels of educational attainment (Nielsen et al, 2017).

Neimeyer and Burke (2013) reviewed the clinical literature and summarised categories of factors that may give rise to concerns about an individual's capacity or ability to cope with loss and change and may lead to the development of complicated grief. The categories are as follows:

Background factors

• Close kinship to the dying person (especially spouse or child loss)

• Female gender (especially mothers)
• Minority ethnic status (in the United States)
• Insecure attachment style
• High pre-loss marital dependence
• Religion and spiritual beliefs and practices (for some, religious/spiritual belief results in lower levels of grief and, for others, a stronger faith can lead to more severe experiences of grief)

Treatment-related factors

• Aggressive medical intervention (for example, intensive care, ventilation, resuscitation)
• Ambivalence regarding treatment
• Family conflict regarding treatment
• Economic hardship created by treatment
• Caregiver burden

Death-related factors

• Bereavement overload (multiple losses in quick succession)
• Low acceptance of impending death
• Violent death (suicide, homicide, accident)
• Finding or viewing the loved one's body after a violent death
• Death in the hospital (rather than home)
• Dissatisfaction with death notification

Appendix 2:

Characteristics that indicate a resilient or vulnerable response in bereavement

Specific indicators of a vulnerable response; • Avoids facing the issues of impending loss resulting from the illness • Does not demonstrate coping strategies that make use of inner resources and external sources of support • Cannot acknowledge the current emotional and social impact of the illness • Does not feel hopeful that strength or meaning may come from the experience (Relf et al, 2010:16).
Specific indicators of a resilient response: • Can face the issues of impending loss resulting from the illness • Demonstrates coping strategies that make use of inner resources and external sources of support • While acknowledging the current emotional and social impact of the illness, there is hope that strength and meaning may come from the experience (Relf et al, 2010:16).
The elements which characterise **resilience** are: • Personal resourcefulness: where there are qualities of flexibility, courage and perseverance. • A positive life perspective: where there is optimism, hope, a capacity to make sense of experience and motivation in setting personal goals. • Social embeddedness: where support is available and there is the personal capacity to access it (Machin, 2014:32).

Appendix 3

Bereavement Service Evaluation Form

We would be delighted if you could take a few minutes to provide feedback on the bereavement service that you received. Feedback, both positive and negative, informs how we deliver services in the future.

1. Please rate your overall satisfaction with the bereavement service (tick or circle one).

1	2	3	4	5
Very dissatisfied	Somewhat dissatisfied	Unsure	Somewhat satisfied	Very satisfied

Comments:

2. Please rate your satisfaction with the number of appointments provided (tick or circle one).

1	2	3	4	5
Very dissatisfied	Somewhat dissatisfied	Unsure	Somewhat satisfied	Very satisfied

Comments:

3. Please rate your satisfaction with the duration of appointments (tick or circle one).

1	2	3	4	5
Very dissatisfied	Somewhat dissatisfied	Unsure	Somewhat satisfied	Very satisfied

Comments:

4. Please rate your satisfaction with the frequency of appointments (tick or circle one).

1	2	3	4	5
Very dissatisfied	Somewhat dissatisfied	Unsure	Somewhat satisfied	Very satisfied

Comments:

5. Please rate your satisfaction with topics discussed during the sessions (tick or circle one).

1	2	3	4	5
Very dissatisfied	Somewhat dissatisfied	Unsure	Somewhat satisfied	Very satisfied

Comments:

6. Were there any other topics that you would have liked to have discussed during the sessions?
   Yes / No
   Comments:

7. Has accessing the bereavement service helped you to cope better with your bereavement? Yes / No
   Comments:

8. Please rate how likely you are to recommend this bereavement service to a relative or friend.

0	1	2	3	4	5	6	7	8	9	10

Not at all likely.....Extremely likely
   Comments:

9. How could we improve the bereavement service?
   Comments:

10. Any other comments:

Appendix 4

Guidelines for Bereavement Care: Audit Tool

Audit the following components by finding evidence in the organisation to support the statements or by using a selection of staff, volunteers or records (as indicated). Grey areas do not need to be completed as they apply to statements that have only compliance or variation as an option. For other areas a random selection of 10 files or staff should be used.

Compliance should be recorded by a √ . Variation should be indicated with X or N/A as appropriate. Please note, it is unlikely that a recording of N/A will be used because the audit will only measure standards that should be implemented and adhered to across agencies. The scores should be calculated at the end of each column, and a summary of findings should be written highlighting relevant points and/or a description to explain findings. An action plan should be agreed and used to inform issues or identify areas of concern.

Bereavement Standard	1	2	3	4	5	6	7	8	9	10	Total Ticks	Total N/A
1: A booklet or information leaflet available after the death of a patient.												
2: All Social Work staff are in receipt of clinical supervision.												
3: All volunteers actively engaged in providing bereavement support receive regular supervision.												
4: Systems are in place to screen individuals being referred to the service, prior to being allocated to a SW, volunteer or group.												
5: Systems are in place to formally capture onward referrals to specialist agencies or teams for complex grief.												
6: Systems are in place to offer psycho-education information events on bereavement, within 3-6 months of the patient's death.												
7: Systems are in place to obtain service user feedback when individuals exit the bereavement support service.												

8: All staff who have contact with family members during the illness trajectory and with bereaved individuals received bereavement awareness training from the Social Work team. *Ask 10 staff confirm this.*												
9: Following the death of a patient, the MDT reviewed the circumstances of the death and the family's perceived capacity to cope. *Ask 10 staff for evidence to support this OR Examine 10 sets of records for evidence to support this.*												
10: Contact was made within 10 working days of a referral or the patient's death where an individual was deemed to be vulnerable (e.g. mental health history, multiple losses, multiple stressors, limited social support, addiction or financial issues). *10 sets of patient records for evidence to support this.*												
11: An initial assessment of bereavement support was conducted. *Examine 10 sets of records for evidence to support this.*												
12: There is evidence that consent was obtained prior to onward referral to another agency/professional. *Examine 10 sets of records for evidence to support this.*												
13: There is a written action plan completed for each patient/client who accesses the service. *Examine 10 sets of patient records for evidence to support this.*												

14: Patient's main contact person/relative was contacted within 3 months, unless they requested no follow up. *Examine 10 sets of records for evidence to support this.*												
15: The need for ongoing support is reviewed after 4 – 6 sessions of bereavement support. *Examine 10 sets of patient records for evidence to support this.*												

Additional Comments from Auditors

Auditor's details:

Name / Job Title

……/ ……..…….……

Signature (Date)

……(_ _ / _ _ / _ _ _ _)

Action Plan:

Appendix 5

Irish Childhood Bereavement Network (ICBN) 'Standards for Supporting Bereaved Children & Young People – A Framework for Development' 2023. Appendix E: Self-Assessment Checklist for Bereavement Services

Appendix E

Self-Assessment Checklist for Bereavement Services

	Criteria met	Criteria outstanding	Action required. By whom?
Checklist for registered charity organisations:			
All necessary governance procedures are in place to guarantee a transparent service which is run to the highest standards (as set out in the Charities Act 2009 and any future amendments or updates to charity regulation legislation).			
Policies and procedures to ensure that records are maintained in a confidential manner in accordance with the Data Protection Act (2018) and the Freedom of Information Act 2014.			
Adherence to the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016.			
Adherence to Children First Act 2015 and National Child Protection Guidelines.			
Adherence to relevant national regulatory requirements, including those outlined above and all other requirements relevant to your organisation.			
Checklist for all organisations (including registered charity organisations):			
Clear, accurate and up to date written information outlining the range of services and identifies the level(s) of specific need it can meet.			
Document clearly the model of care within your service.			
Knowledge of contemporary understanding of children's grief and appropriate interventions.			
Provision of information on children's bereavement through leaflets, useful links, websites, information on further reading materials.			

	Criteria met	Criteria ouutoruling	Action required. By whom?
Cleart_,, identmed ref=l pathways. to all levels of bereavement □port offered bya sef!Ace provider and 5tructul1:! of referral if the p-avider-finck that d-iikfrs needs do n.otaliSJI'Witt'l the services they prO'lide.			
Written consent of parent5 or guardians. for children to aoces:s servic_es, and ,.,erbal assent from the dhild who is availing of 5!..IflPOit..			
Transpa□ c15:5e5.51Tlent of the child's bereavement in.tervention needsm e;ngjf'i:!•1ihatthe serYice be- g offe1ed isthe most appropriate at that time and can be met by the service [P«lVidier..			
Eva ation and feedbaick p;ilities andprocedures.			
All aw.arenes.s. of *the* limiratioos of rnnlidentialit)' when working with rnilruen.			
A safe process of recruitment, se eaion, and probationaiy period for serwice personn.el and VCI eers..			
Train· g an.di support of all :staff and volunteers to underpin the sefVic.e level provided.			
Regular p1t:1fessional si..tpe'Vis.i.on, Con• ucus Professional Development, and seff-care• □ • ies, for a l individuals involved• supporting bereaved dhildreri.			
ProYiding in an ethical maMer, in ao:::ordarKe with the Code of E1thics pertaining ta 1iheu partic.ula.r profession..			
Agencies shall seek and ere.ate opportunities to work co labaratively with other organisations proYiding support m ohildren **and families 'MKI** experience bereavement			
Mherence•to relevant **na·on.ar1** egula.tol)' requiranent:s, in.duding those outlined above and all other req..irement:5 relevant to your organisation.			

Appendix 6

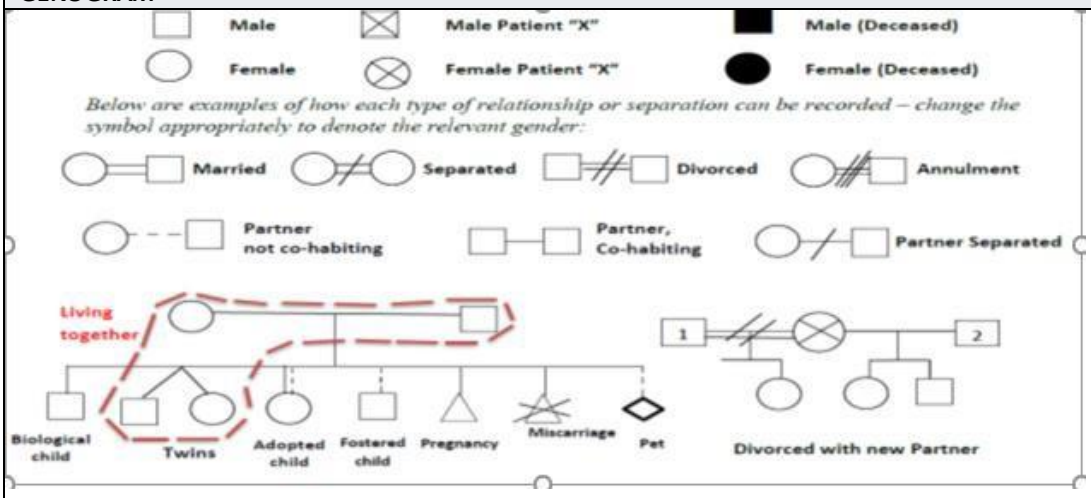
This Sample First Post Death Screening Assessment form is based on the information that will be in the Community Care Record template (the national Electronic Health Care Record in development). However, the information will visually be presented differently in the final version of the template, but the content will be what is outlined below.

Specialist Palliative Care Bereavement Support and Counselling Adult and Child Assessment

CLIENT INFORMATION
Adult Assessment ☐
Name of Bereaved Person: **MRN:** **Date of Birth:** **Address:** **Contact Number:** **Email:**
Main Contact person: **Relationship:** **Address:** **Contact Number:**
Name of the Deceased: **MRN:** **Date of Birth of the Deceased:** **Date of Death:** **Place of Death:**
Known to another Counselling Service previously or present? Yes ☐ No ☐ **When:** **Main reason:**
GP Name and Contact Number:
Have you had contact with GP since death? Yes ☐ No ☐ **What did the GP recommend, including medication prescribed?**
Have you ever had contact with the Mental Health Service, Psychiatry or Day Hospitals? Yes ☐ No ☐ **Contact Details:** **Consent to contact: Yes ☐ No ☐**
Child Assessment ☐
Name of Bereaved Child: **MRN:** **Date of Birth:** **Address:**
Parent/Guardian: **Relationship:** **Address:** **Contact Number:** **Email:**
Parents or Guardians aware of referral to Bereavement Support and Counselling: Yes ☐ No ☐ **If no, please specify reason:**
Name of the Deceased: **MRN:** **Date of Birth of the Deceased:** **Date of Death:**

Place of Death:
School class or year child is in: Receiving supports from school: Yes ☐ No ☐ Consent to contact: Yes ☐ No ☐ If yes, Contact Details:
Known to another Counselling Service previously or present? Yes ☐ No ☐ When: Main reason:
GP Name and Contact Number:
Have you had contact with GP since death? Yes ☐ No ☐ What did the GP recommend, including medication prescribed?

Confidentiality Limitation Explained: Yes ☐ No ☐

GENOGRAM


How does the client feel they are coping?
Physical Health
Current: Past:
Well-Being and Mental Health
Current: Past:

Support Systems
Child Assessment -How is the child coping at school?
Coping Mechanisms
Other Losses
Concurrent Stressors
Person's Own Concerns
Alcohol Consumption
In Adult Assessment- Is this a way of coping with your loss?
Drug Use
In adult Assessment -Is this a way of coping with your loss?
Self-Harm
Suicidal Ideation
Risk Taking Behaviour

Changes in Eating Habits
Changes in Sleeping Habits
Other Issues

Outcome of Assessment

SIGNATURE	
Print Name:	**Signature:**
Registration Number:	**Date and Time:**

Appendix 7

BEREAVEMENT SUPPORT
CONFIDENTIAL WORKING AGREEMENT

(*Refer to National Data Set Requirements on last 2 pages)

Name: _____

Address: _____ **Postcode:** _____

Telephone: (H) _____ **(W)** _____ **(M)** _____

Age*(DOB): _____ **Gender*: Male / Female /Other** _____

Preferred Pronoun: _____

Ethnicity: _____

Emergency Contact Person: _____

Telephone: _____

Address: _____

Name of deceased: _____

Relationship*:_____

Place of death: _____ **Date:** _____

Diagnosis*:_____

Confidentiality explained Yes ☐ No ☐

GP details:

_____

Permission to Contact GP if necessary Yes ☐ No ☐

Other Professional Support Received. Please Specify:

_____

_____

Initial Assessment:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Key Issues:

Action Plan:

Contact Arrangements:

Any other issues:

Signature: (Service user) _____

Signature: (Staff member) _____(Designation) _____

Date: _____

Summary of contact

Session 1: Date: _____ Duration: _____

Mode of Contact: Telephone contact ϒ Online ϒ

Face to Face: Individual ϒ Family ϒ Group ϒ Office ϒ Hospice ϒ Home visit ϒ

Session 2: Date: _____ Duration: _____

Mode of Contact: Telephone contact ϒ

Face to Face: Individual ϒ Family ϒ Group ϒ Office ϒ Hospice ϒ Home visit ϒ

Session 3: Date: _____ Duration: _____

Mode of Contact: Telephone contact ϒ

Face to Face: Individual ϒ Family ϒ Group ϒ Office ϒ Hospice ϒ Home visit ϒ

Session 4: Date: _____ Duration: _____

Mode of Contact: Telephone contact ϒ

Face to Face: Individual ϒ Family ϒ Group ϒ Office ϒ Hospice ϒ Home visit ϒ

Review: Date: _____ Duration: _____

Mode of Contact: Telephone contact ϒ Face to Face: Individual ϒ

Family ϒ Group ϒ Office ϒ Hospice ϒ Home visit ϒ

Further Sessions Agreed:

Referral to other agency:

Signature: (Service user)_____

Signature: (Staff member)_____
Designation*:_____

Date:

Date of final session: _____

Length of support*: _____

Evaluation form issued: **Yes / No**

Date: _____

Evaluation form returned: **Yes / No / Not Known**

Additional contacts
Session: Date: _____ Duration: _____

Mode of Contact: Telephone contact ϒ

Face to Face: Individual ϒ Family ϒ Group ϒ Office ϒ Hospice ϒ Home visit ϒ

Session: Date: _____ Duration: _____

Mode of Contact: Telephone contact ϒ

Face to Face: Individual ϒ Family ϒ Group ϒ Office ϒ Hospice ϒ Home visit ϒ

Minimum Data Set Requirements

Gender
- Male
- Female
- Other *use standard HSE descriptor*

Service user analysis – Age

0-17 From birth up to and including 17 years and 364 days old (Child)*

18+ From day of 18th birthday onwards (Adult)

*indicates a person under the age of 18 years. A 'child' is defined under the Child Care Act 1991 as anyone under the age of 18 years who is not married. In rare situations, a person aged 16 or 17 who is married may present, but for the purposed of this metric, they are counted by their age.

Number of contacts
No. of individual (new):
No. of individual (ongoing):
Family group contacts

Contact Type
Post Death Visit Post death Phone call Therapeutic telephone call
Trained bereavement volunteer support
Professional Support (face to face)
Psycho educational group Therapeutic Group

Designation of staff member (Record the professional group of the member of staff or volunteer providing the bereavement support)
Contact Person
Staff member
Volunteer

1. **Wait times:**
   a) Time from **point of referral** (day 1) to **point of assessment** of bereavement need by a professional. The initial assessment may be face to face or by therapeutic phone call.
      i) No. of referrals who received an assessment by a bereavement professional **within 10 working days**
      ii) No. of referrals who waited for an assessment by a bereavement professional **over 10 working days**

   b) Time from **point of assessment** (i.e.: identified need) to **service delivery** – which could be volunteer appointment; professional appointment; discharge from service or formal referral to GP/a mental health service or to another service.

i) No. of referrals with assessed bereavement need who received a bereavement service by a bereavement professional **within 10 working days**
ii) No. of referrals with assessed bereavement need who waited for a bereavement service **over 10 working days**

2) Discharges:

1. **Planned:** Where there is an agreed plan for the service to finish. Often a collaborative decision between the service and the client. Can include, for example appropriate ending of sessions; recommendation or advice about another service etc.
2. **Unplanned:** Abrupt ending, for example client DNA's appointments, doesn't respond to messages/contact
3. **Formal referral to GP/a mental health service:** Where a professional in the service makes formal contact and referral to GP and/or a mental health service.