**The Value of Implementation Science in Bridging the Evidence Gap in Bereavement Care**

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Abstract

There is a gap in the use of evidence in bereavement care. Implementation science is a field focused on moving evidence into practice and therefore may help close the gap. Implementation science advances the design, relevance, and dissemination of research and the adoption, implementation, and maintenance of evidence-based practices. We provide an overview of implementation science, describe five implementation frameworks (Knowledge to Action; Behavior Change Wheel; Exploration Preparation Implementation Sustainment; Interactive Systems Framework; and Reach, Adoption, Implementation, Maintenance), and illustrate their application in bereavement care. These advancements will promote high-quality bereavement care that improves the lives of bereaved people.

Keywords: bereavement care; grief counseling; grief therapy; implementation science; research-practice gap; evidence-based practice

**The Value of Implementation Science in Bridging the Evidence Gap in Bereavement Care**

Bereavement is a normal life experience, yet the unexpected death of a loved one is said to be the most common type of trauma, experienced by 20% of people at any one time and with a lifetime prevalence of 60% (Breslau et al., 1998). Furthermore, while most people are able to accommodate losses into their lives, bereavement outcomes can include suicidality, substance use, social withdrawal, reductions in quality of life and self-neglect (Breen, Hall, & Bryant, 2017). Bereavement results in substantial economic costs to families, health care systems, and society (Stephen et al., 2015; van den Berg, Lundborg, & Vikström, 2017). Despite this significance, the development, availability, and evaluation of effective bereavement care remains embryonic.

Bereavement care is a holistic term comprising three components—grief support, grief counseling, and grief therapy (Neimeyer, 2008). Grief support encompasses the provision of compassion and information from informal networks and formal services (Aoun et al., 2019; Breen et al., 2017). Grief counseling is typically provided by trained professionals and volunteers to normalize the grief experience; foster the integration of the loss into the life story of the bereaved; promote hope, meaning, and posttraumatic growth; and counteract the development of future mental health concerns (Breen & Aoun, 2018). Grief therapy is provided by trained mental health professionals and encompasses psychotherapies designed specifically to reduce symptomatology of grief complications and promote restorative functioning (e.g., Boelen, de Keijser, van den Hout, & van den Bout, 2007; Shear et al., 2016).

There is an evidence-practice gap in bereavement care. In times of loss, family and friends can be extraordinarily helpful, but are not always equipped to provide the support that bereaved people need or would like (Breen & O'Connor, 2010, 2011). As such, many bereaved people receive formalized bereavement care in some capacity (Breen, Aoun, O'Connor, & Rumbold, 2014) or seek the services of a bereavement counselor (Newsom et al., 2017). Unfortunately, however, formalized bereavement care policies and practices are often not evidence-based (Kent, Jessup, Marsh, Barnett, & Ball, 2019). Despite increasing interest in the provision of bereavement care, this misalignment between bereavement care practices and research evidence has been a common theme in bereavement literature for two decades (Breen et al., 2014; Breen & O'Connor, 2007; Bridging Work Group, 2005; Center for the Advancement of Health, 2004; Donovan, Wakefield, Russell, & Cohn, 2015; Hay et

al., 2019; Jordan, 2000; Jordan & Neimeyer, 2003; Neimeyer, Harris, Winokuer, & Thornton, 2011; Silverman, 2000; Wilson et al., 2017).

There is a real need to understand bereavement care systems, determine the barriers of and enablers to bridging the evidence gap, and develop appropriate and targeted strategies to reduce or ameliorate the gap. The relatively new field of implementation science may help provide solutions. Implementation science focusses on investigating how evidence can be adopted, implemented, and maintained in practice. In this paper, we describe the evidence gap in bereavement care, summarize the developing field of implementation science, and discuss a way forward for implementation science to bridge the gap in bereavement care.

## The Evidence Gap in Bereavement Care

Bereavement care came under attack when early studies of bereavement interventions demonstrated little to no effect and that, in some cases, bereaved people may have been better off without intervention. For example, a review of bereavement interventions, published between 1975 and 1998, demonstrated a very small effect size overall and concluded that approximately 38% of participants would have had a better outcome had they been assigned to the control group rather than receiving the intervention (Neimeyer, 2000). Similarly, in 1999, an analysis of 35 bereavement intervention studies reported an overall modest effect size (Allumbaugh & Hoyt, 1999) and a second review the same year, this time focusing on studies with higher methodological quality (e.g., random assignment to condition) and across various modalities (individual, family, or group intervention), concluded that "psychological interventions for bereavement are not effective" (Kato & Mann, 1999, p. 293).

These relatively pessimistic findings underscore the principle that the absence of evidence is not evidence of absence. A look at the designs of the intervention studies shows limited use of adequate control groups, small sample sizes that reduced statistical power to detect effects, presence of confounding variables that masked intervention effects, use of measures without adequate reliability and validity, and high drop-out rates (Allumbaugh & Hoyt, 1999; Kato & Mann, 1999). Additionally, the inconsistent results are likely to have been influenced by the wide variability in target population, intervention provider, duration, type, timing, and scope of included interventions, evaluation methodology (outcomes, measures, timing of data collection), and overall study designs (Jordan & Neimeyer, 2003; Rolls & Penny, 2011; Waller et al., 2016; Wilson et al., 2017).

There is encouraging evidence for bereavement care from more recent studies, due to improvements to interventions and the study of them. Meta-analyses and reviews of

bereavement studies show that interventions offered to bereaved people with higher levels of grief symptoms and distress have outcomes similar to those found for psychotherapies targeting other issues (Currier, Neimeyer, & Berman, 2008; Hoyt & Larson, 2010; Neimeyer & Currier, 2009; Waller et al., 2016). Furthermore, a meta-analysis of 14 interventions designed to lessen complicated forms of grief showed that the interventions were effective and that the reductions in symptomatology were maintained over time (Wittouck, Van Autreve, De Jaegere, Portzky, & Van Heeringen, 2011). Analyses have demonstrated larger effect sizes for interventions delivered by practitioners with more training, to clients who were seeking help compared to clients recruited to 'pad out' the sample, and to clients with more grief-related distress (Allumbaugh & Hoyt, 1999; Schut, Stroebe, van den Bout, & Terheggen, 2001).

Despite the positive evidence in recent analyses, the initial, negative conclusions about the effectiveness of bereavement care interventions have contributed to the evidence-practice gap. The findings have been used in some sectors to derail the provision of bereavement care. For instance, there are suggestions that bereavement care should be offered only by informal community networks (Kellehear, 1999), yet the presence of bereavement care in these networks is less than optimal (Aoun, Breen, White, Rumbold, & Kellehear, 2018). One of the potential dangers of viewing bereavement care solely as a community matter is that it would be no longer offered in settings such as hospitals or hospices or as a core part of palliative care. This state of affairs is especially concerning as bereavement care practices are already less developed than other components of palliative care practice (Guldin et al., 2015).

There are multiple other factors contributing to the poor use of evidence in bereavement care. The workforce is diverse and often disparate due to the broad range of practices encompassed within bereavement care. Bereavement counselors come from a wide array of disciplines (e.g., psychology, sociology, social work, nursing, psychiatry, education); range from having extensive formal training and/or experience in bereavement care to having very little of either; may be paid or work in a volunteer capacity; and may work within the public, private, or not-for-profit sectors (Breen, 2011). Bereavement care is often under-funded (Breen et al., 2014), provided in a piecemeal fashion (Wilson & Playfair, 2016), and bereavement care providers report a wide range of knowledge, training, and experience in relation to providing bereavement care (Breen, 2011). Analysis of university textbooks (Corr, 2019), courses (Breen, Fernandez, O'Connor, & Pember, 2013), and surveys of graduates (Barclay, Wyatt, Shore, Finlay, Grande, & Todd, 2003; Dickinson, 2012; Dickinson & Field,

2002; O'Connor & Breen, 2014) highlight the limited grief education available to health professionals across disciplines. Given that most bereavement care is provided by people without specific qualifications or credentials in thanatology, it is not surprising that some professionals who provide bereavement care may draw upon outdated and potentially harmful understandings of grief (Dodd, Guerin, Delaney, & Dodd, 2017; O'Connor & Breen, 2014; Ober, Granello, & Wheaton, 2012). It is this complex state of affairs that led to Wilson et al. (2017) to assert that "bereavement service outcomes need to be carefully researched so that evidence can drive service refinement and expansion" (p. 242). The end result of the evidence gap is that bereavement care is not as effective as it could be and could be detrimental to bereaved people at their most vulnerable time.

## What is Implementation Science?

Implementation science is an emerging, rapidly growing, and multidisciplinary field that fosters the development of implementable innovations and investigates their adoption, implementation, and sustainment in practice. Implementation science is the study of methods to promote the introduction and integration of research findings and evidence into healthcare policy and practice to improve the quality and effectiveness of health services (Eccles & Mittman, 2006). Implementation science aims to provide evidence-based solutions to bridging research and practice and thereby improving patient outcomes. So, while the goal of both health services and implementation research is to increase the impact of health services, this is addressed in health services research by trying to improve the effectiveness of clinical interventions through understanding the determinants of client/patient behavior; while in implementation science it is by improving the effectiveness of implementation strategies through understanding the determinants of behavior change at the system, organizational, and implementer levels (e.g., service providers, organizational leaders and policy makers; see Table 1).

Early illustrations of the research trajectory placed implementation research at the end of a research "pipeline" after efficacy and effectiveness studies. Furthermore, implementation was often assumed to occur as a consequence a unidirectional dissemination process, such as publishing journal articles or presenting at conferences. These linear depictions often considered implementation to be a single event when an organization or individual decides to adopt an innovation. However, a decision to take-up an innovation does not necessarily lead to the innovation being put into practice, and certainly does not signify it will be maintained in practice over time. It is now acknowledged that implementation is a complex, multistage,

and multilevel process warranting investigation. Furthermore, the implementation and sustainment of innovations should be considered from the beginning of the research process, during needs assessment and innovation development (i.e., during health services or clinical research), and should involve stakeholders in participatory research methods to increase the probability the innovation will be feasible, acceptable, and appropriate. A popular implementation saying is that "people cannot benefit from services they do not receive." Without implementation, the costly and timely academic studies to build evidence of innovation effectiveness are wasted.

The implementation of evidence-based practices requires a deep understanding of context. Implementation usually requires change at multiple levels, including policy change, organizational change, and individual behavioral change. As such, single strategies (e.g., training, incentives, feedback, and social marketing) to bridge the gap show little effect (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012; Grol & Grimshaw, 2003; Grol & Wensing, 2004; Michie, van Stralen, & West, 2011). Furthermore, bereavement care providers do not necessarily have the access, time, or skill to search, critically evaluate, and implement the research literature, and few are active researchers (Breen, 2011; Breen & O'Connor, 2013). Instead, the adoption, implementation, and sustainment of innovation requires supportive organizational cultures that are committed to change, recognize the need for the change, and have the appropriate leadership, staff, structure, policies, practices, and skills necessary to bring about change (Michie et al., 2011). Given these issues, the provision of information alone, even in the form of standards and guidelines, is unlikely to have any effect on bereavement care interventions.

## Implementation Science Frameworks

There are numerous implementation frameworks to guide the study and practice of implementation. In 2015, a systematic review identified 49 implementation frameworks relevant to healthcare published within the previous 10-year period (Moullin, Sabater-Hernàndez, Fernandez-Llimos, & Benrimoj, 2015). The result of this review was the Generic Implementation Framework (GIF), which illustrates that the core components of implementation as the process of implementation (often divided into phases), multilevel factors or determinants that influence implementation (both positively as enablers and negatively as barriers), strategies to assist the implementation process, and the evaluation of indicators of implementation success (Moullin et al., 2015).

Recommendations for how to use implementation frameworks (Moullin et al., in press) indicate that multiple frameworks may be required to address all of the core components of implementation. For example, one framework may be used to guide the process of implementation, another for the selection of implementation determinants, and another for evaluation. Alternatively, there are comprehensive implementation frameworks that serve multiple purposes. A study conducted a network analysis of implementation frameworks to provide a list of the most cited implementation frameworks (Skolarus et al., 2017). We briefly describe below some of the most popular frameworks that may be used for the implementation of evidence in bereavement care—the Knowledge to Action framework (Graham et al., 2006), the Behavior Change Wheel (Michie et al., 2011), the Exploration, Preparation, Implementation, Sustainment framework (Aarons, Hurlburt, & Horwitz, 2011), the Interactive Systems Framework (Wandersman et al., 2008) and Reach, Adoption, Implementation, Maintenance framework (Glasgow, Vogt, & Boles, 1999).

**The Knowledge to Action Framework**

The Knowledge to Action (KTA) framework is a process framework depicting the steps in knowledge creation and action (i.e., implementation; Graham et al., 2006). Knowledge creation involves the tailoring of evidence to address a need through synthesizing the literature and creating tools for implementation (e.g., a guideline for complicated grief intervention). The Action Cycle is a series of overlapping and iterative steps involved in putting the developed tool(s) into practice. The framework was the informed by the review of 31 planned action theories about the process of change (Field, Booth, Ilott, & Gerrish, 2014).

**The Behavior Change Wheel**

The Behavior Change Wheel (BCW) is a framework for developing implementation strategies to embed innovations through behavioral change (Michie et al., 2011). The wheel allows researchers to identify barriers and enablers of changing a behavior and map them to three domains that underpin behaviors—capabilities (physical and psychological), motivations (automatic and reflective), and opportunities (physical and social). In addition, they may be mapped using the related Theoretical Domains Framework (Atkins et al., 2017). These barriers and enablers may be ascertained via a range of methods including surveys, interviews, and focus groups. Once identified, each barrier may be connected to one or more of nine interventions functions. As an example, if physical capabilities (e.g., knowledge and skills) are barriers to bridging research and practice, the most appropriate interventions would target training and enablement. On the other hand, limited social opportunity (e.g., competing

workplace demands, cultural norms about bereavement) require interventions that would provide environmental restructuring and modelling opportunities.

**The Exploration, Preparation, Implementation, Sustainment Framework**

The Exploration, Preparation, Implementation, Sustainment (EPIS) framework (Aarons et al., 2011; Moullin et al., 2019) is a multiphase, multilevel framework comprising factors influencing implementation within the outer context of a service system and inner context of an organization, the factors that bridge the inner and outer contexts, and the influences related to the innovation itself. The factors that influence the process are likely to vary for every context and across each phase of implementation. The EPIS framework may be used to develop a program theory of the change. Subsequently, measures may be selected to quantitatively measure the moderators of change and implementation outcomes. In addition, qualitative exploratory work or process evaluations may be guided by definitions provided in the framework through the development of interview or focus group guides, and in the analysis of the collected data. Detailed, up-to-date information, including measures, and definitions are available from www.episframework.com. For bereavement care, the EPIS framework could be used to investigate the implementation of evidence across the sector from the perspectives of employers and managers who hire and supervise bereavement counselors.

**The Interactive Systems Framework**

The Interactive Systems Framework (ISF; Wandersman et al., 2008) describes the interaction between three systems: (a) prevention synthesis and translation system, (b) prevention support system, and (c) prevention delivery system. As the names of the systems imply, the framework was originally developed in the field of prevention, specifically the prevention of youth violence and child maltreatment; however, the framework is widely applicable including to bereavement care. Similar to EPIS, the ISF may be described as a process and determinant framework. It shows that evidence must be collated and tailored, and then must be supported to be put into practice in the delivery system (i.e., by the providers of bereavement care).

**The Reach, Adoption, Implementation, Maintenance Framework**

The Reach, Adoption, Implementation, Maintenance (RE-AIM) framework is generally described as an evaluation framework (Glasgow et al., 1999). It provides a structure to quantify the degree of Reach (number of participants/clients/patients that receive the innovation and the representativeness of those participants), Effectiveness of the intervention and/or implementation strategy, Adoption (number of individuals or organizations who take

up an innovation and their representativeness), Implementation (measures of determinants, fidelity and implementation costs), and Maintenance (continuation of the intervention over time). This framework could be used to document the success of innovation implementation in bereavement care (e.g., the implementation of a bereavement risk assessment measure and intervention strategy). Calculations, tools, and worksheets to assist in applying the framework are available from: www.re-aim.org.

**Future Directions for Applying Implementation Science to Bereavement Care**

The rationale for applying implementation science to bereavement care is the same as in other areas of concern; namely, to address the evidence-practice gap in order to improve health services and peoples' quality of life. Bridging the evidence-practice gap in bereavement care will require a systematic approach that clearly describes current practice, identifies the factors that facilitate and impede the adoption of innovation, and determines or adapts an appropriate framework to guide implementation. To our knowledge, no such process has been employed in bereavement care, but there are opportunities to learn from other fields where implementation frameworks that have been applied (Moullin et al., 2015; Moullin et al., 2019).

Evidence-based guidelines (e.g., Hudson, Hall, Boughey, & Roulston, 2018), practice standards (e.g., National Institute for Health and Clinical Excellence, 2004; Palliative Care Australia, 2018), a Delphi study of practitioners' research priorities (Hay et al., 2019), explorations of bereavement care practice (Breen, 2011, Wilson & Playfair, 2016), and systematic reviews and meta-analyses of bereavement care interventions (e.g., Currier et al., 2008; Waller et al., 2016; Wittouck et al., 2011) provide direction concerning the evidence to be translated. What is missing is the comprehensive, systematic, and context-specific investigation of the *specific* evidence that needs to be translated and the identification of factors that act as enablers of, and barriers to, the application of these in practice, particularly from the points of view of people who provide bereavement care. Such investigations would result in the development and testing of implementation strategies that will be most effective in promoting occupational innovation in bereavement care.

Conducting a behavioral diagnosis through a barrier and enabler assessment provides a structure that may be used to inform the development, implementation, and evaluation of strategies designed specifically to bridge research and practice in bereavement care. The use of multiple methods is particularly desirable in both bereavement care and implementation research because, when combined, results are triangulated, the advantages of each are

optimized and the limitations are diminished (Neimeyer, Hogan, & Laurie, 2008). Undertaking such a process would substantially contribute to our knowledge of embedding innovation into bereavement care practice and would bridge the research-practice gap that remains a central concern in the grief literature. These objective may be achieved by applying frameworks from implementation science.

An important point to note is the evidence-practice gap is not a unidirectional problem where blame is assigned to practitioners for not implementing the latest research findings, but equally a result of researchers not involving stakeholders, focusing on internal rather than external validity, and not disseminating their results. Implementation science aims to address both issues. Researchers often do not include practitioners in the research process, which results in interventions that may not be feasible, applicable, or needed in practice (Hay et al., 2019). The different priorities and limited partnerships between practitioners and researchers also explains why the systematic study of bereavement care interventions remains limited. A mapping exercise of childhood bereavement services in the UK showed that:

> Child bereavement services were struggling with a considerable burden of
> demand for [evaluation] information from a range of users… The most
> common forms of evaluation were post-intervention user satisfaction surveys
> of core interventions, using self-completion questionnaires. However,
> collection of basic data was limited and patchy, and evaluation of outcomes
> of organizational processes and reporting on the findings were less common.
> (Rolls & Penny, 2011, p. 43)

Implementation science provides a way forward because it focusses heavily on context and participatory research methods.

Surveys of public health researchers have indicated the low priority assigned to disseminating their findings (Brownson et al., 2013). Although approximately three-quarters recognize the importance of dissemination, dissemination to end-users remains passive (e.g., academic journals and academic conferences) rather than actively considering the needs of practitioners and policymakers (Brownson et al., 2018). Scientific journals are the most popular avenue for researchers to disseminate their findings, despite bereavement care providers rating these articles as the least helpful in their practice and preferring to gather information from books, colleagues, and workshops (Bridging Work Group, 2005). Interviews with 19 bereavement counselors in Australia showed that only three of the counselors reported accessing information from journal articles (Breen, 2011). A more recent Delphi survey of 176 experienced bereavement care professionals with membership to a

bereavement care organization (The Australian Centre for Grief and Bereavement) showed that 76.7% reported journal articles as a common method of keeping up-to-date with bereavement care information (Hay et al., 2019). Although the latter study suggests an increasing uptake of research findings, the sample is not likely to be representative of bereavement care providers generally. Therefore, although having a dissemination plan is a positive step, it still positions practitioners as receivers of research rather than collaborators. Fundamental changes to how research is conducted is needed.

**Conclusion**

Many bereaved people receive sub-standard bereavement care, in part due to an evidence-practice gap. This state of affairs is neither the fault of bereavement care providers nor researchers alone, but requires change for from both parties. There is evidence for bereavement care in particular populations and situations which could be more widely implemented, but equally improved study designs to develop interventions that are better targeted to clients' needs is required. Implementation science is a rapidly evolving field that may assist and is yet to be applied to bereavement care. Improving the development and implementation of evidence in bereavement care is a vital step towards providing efficacious and cost-effective support to bereaved people. Implementation frameworks facilitate systematic, comprehensive, and context-specific identification of the specific evidence that needs to be translated; the identification of factors that act as enablers of, and barriers to, the application of the evidence into practice; and the subsequent development and evaluation of evidence-based strategies to implement the evidence into practice. Ultimately, the hope is that the application of implementation science to bereavement care will improve the wellbeing of the large number of bereaved people in our communities.

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Table 1

*A Comparison of Health Services or Clinical Research and Implementation Research*

|  | **Health services or clinical research** | **Implementation research** |
|---|---|---|
| **Aim** | Understand processes and factors associated with health | Understand processes and factors associated with implementation |
| **Intervention** | Clinical intervention or innovation | Implementation strategy |
| **Determinants** | Health behavior determinants | Determinants of practice/influencing factors |
| **End-user** | Patient or client | Implementer |