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Hospice Bereavement Service Delivery to Family Members and Friends With Bereavement-Related Mental Health Symptoms

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Abstract

Objectives: A sizable minority of those who lose a loved one in hospice will experience symptoms of bereavement-related mental health disorders. Though hospices offer services to bereaved informal caregivers (family members or friends) of patients, little is known about services offered or interest in them. Therefore, we sought to assess services offered by hospice staff and interest expressed by bereaved informal caregivers with symptoms of depression, anxiety, or complicated grief (CG).

Methods: De-identified electronic bereavement care charts of 3561 informal caregivers who lost someone in a large urban metropolitan hospice from October 1, 2015, to June 30, 2016, were reviewed.

Results: Of bereaved informal caregivers in the sample, 9.4% (n = 333) were positive for symptoms of depression, anxiety, or CG. The symptom-positive family members/friends were more likely than other family members/friends to be offered mailings, one-to-one counseling, telephone calls, and reference material. However, interest in most services by symptom-positive caregivers was low, with only 6% interested in one-to-one counseling and 7% interested in outside referral.

Discussion: The findings suggest that hospices offer a range of services to family members or friends with symptoms of anxiety, depression, and CG, but that there can be a gap between what is offered and in the interest levels of the bereaved. Engagement with symptomatic family members and friends could be enhanced in future work.

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Keywords

anxiety; depression; complicated grief; bereavement care; hospice; service utilization

Introduction

Hospice care is utilized by a sizable number of Americans; in 2016, 48% of all deaths of people under Medicare in the United States were in hospice, with as many as 58% of all deaths occurring in hospice in some states.¹ Family members or friends are usually involved in hospice care as informal caregivers and receive support from hospice providers, both before and after the hospice patient passes away.¹

After the hospice patient dies, though most family members or friends will experience grief, the majority will show reductions in their emotional distress over time and then return to their usual pre-loss functioning. However, a minority will develop clinically significant symptoms of depression, anxiety, or complicated grief (CG) after their loss.²⁻⁵ The prevalence of these symptoms in bereaved family members or friends of hospice patients appears to be significantly high, with one study finding that 34% had clinically significant depression symptoms and 24% had CG symptoms 3 months after their loss,² and another finding that 48% had anxiety symptoms 6 months after their loss.⁶ These conditions have, in turn, been associated with negative health and mental health outcomes, including weight loss, increased risk for hypertension,⁷ smoking,⁸ sleep impairment,⁹ and functional impairment.¹⁰⁻¹²

Hospices are required by Medicare to provide bereavement services to family members and friends for at least a year after the hospice patient dies.¹³ About 98% of hospices offer telephone calls, 98% send a letter or card at the time of the death and/or anniversary of the death, 95% send brochures or other educational materials about grief, 88% provide memorials, 72% provide individual therapy, and 51% provide group therapy.^{14,15} The subgroup of bereaved family members or friends with bereavement-related mental health disorders are typically characterized as “at-risk” for negative outcomes by hospice bereavement providers,^{14,16} and receive targeted attention. National survey data indicate that 92% of hospices screen family members/friends for depression or CG at some point after the hospice patient is admitted and 69% screen at the time of the patient’s death, and that 79% provide group or individual therapy.¹⁷

Yet though there are some data on services offered to family members/friends with depression, anxiety, or CG symptoms, more research on how many people in this subgroup are offered services, what types of services are offered, and which services are used is needed. Medicare does not specify which services should be provided by hospice.¹³ Effective individual and group treatments to reduce symptoms of anxiety, CG, and depression post-bereavement have been tested in clinical trials and found effective,¹⁸⁻²³ including cognitive-behavioral treatments and behavioral activation.^{18,20} However, less than half of older adults with bereavement-related mental health disorders receive mental health treatment for their conditions in any setting,⁷ and there are preliminary indications that hospice bereavement services are similarly underutilized. One survey found that only 48%

of family members of hospice patients with depression symptoms used bereavement services,²⁴ and a study of family members considered “at-risk” by hospice providers for negative bereavement outcomes in Colorado found that only 52% used services.²⁵ More data on utilization are needed.

The proposed study sought to add to the limited literature on bereavement services for informal hospice caregivers with symptoms of depression, anxiety, or CG. Although previous studies have separately examined services offered to bereaved informal caregivers^{14,16} and services received,^{16,24} ours appear to be the first large-scale study to be able to compare services offered to service interest in the same at-risk bereaved informal caregiver population. The work can help ensure that informal caregivers of deceased hospice patients with symptoms of depression, anxiety, or CG receive the support that they need.

Aims of the project were

1. To describe the frequency and type (eg, phone calls, home visits, support groups, individual counseling, and referrals) of support offered by hospice staff to family members/friends with symptoms of depression, anxiety, or CG.
2. To describe interest in hospice bereavement support by family members/friends with symptoms of depression, anxiety, or CG.
3. To describe whether hospice family members/friends with symptoms of depression, anxiety, or CG are satisfied with hospice support services received.

Methods

Research Site

The research was conducted in partnership with the MJHS Hospice and Palliative Care, which serves over 5000 bereaved family members per year and has 5 full-time and 4 part-time bereavement counselors. MJHS serves a diverse population, reflective of the population of New York, NY.

Assessment and Outreach Process

After a hospice patient dies, standard practice at the hospice is that their case is immediately assigned to a bereavement counselor, who conducts a bereavement assessment with family members/friends of the deceased within 38 days of the hospice patient’s death. The bereavement support recipient can be any family member or friend of the hospice patient; typically, they have had some involvement in the patient’s hospice care before their death. Based on the level of involvement in hospice care, hospice staff will identify a “primary” informal caregiver before the death. However, multiple people can serve as informal caregivers. After the patient’s death, the bereavement counselor will attempt to contact all (up to 6) identified informal caregivers to conduct bereavement assessments. The counselor attempts to make an initial contact by telephone to discuss possible support needs and offer services that they have determined might be applicable to the client. The counselor typically conducts the bereavement assessment during this initial telephone call. In addition, counselors mail an introductory letter explaining all services available. This material is mailed regardless of whether the family member/ friend is reachable by phone.

Informational mailings (which include grief support group information) continue to be sent at regular intervals at 2, 6, 9, and 12 months after the death. Additional services that can be offered by counselors are mailings, support groups, grief workshops, family counseling, one-to-one counseling, volunteer support, telephone calls, reference material, memorial services, and outside referrals to additional mental health services, as needed.

At any point during the initial 38-day bereavement assessment, during any follow-up contacts, or after receiving the regular mailings, the bereaved family member/friend can express interest in an offered service. The bereaved person is then linked to group or individual service by the counselor.

Chart Review

As part of the 38-day risk assessment, the bereavement counselor completes a structured risk assessment, which is saved in an electronic record. Should the counselor have any follow-up contacts with the family member/friend, in which additional information pertaining to the checklist arises, they also can add it to the checklist then. Data from the checklist were shared with the research team electronically after de-identification. The team accessed de-identified electronic bereavement care charts for family members/friends who had lost someone in the hospice from October 1, 2015, to June 30, 2016, in order to allow for review of bereavement service utilization over a full year. The bereavement counselors also completed assessments and checklists with not only the primary informal caregiver, but up to 6 additional family members or friends. However, as the majority of patients had only 1 caregiver, and in order to have a consistent sample by hospice patient, the current analyses focused only on the designated “primary” caregiver. To ensure that shared data were fully de-identified, detailed notes made by providers during risk assessments were not shared. The data sharing procedures were reviewed and approved by the institutional review board of the City University of New York as well as the MJHS research review committee.

Measures

Bereavement services offered and service interest.—Data on services offered, and services in which family members/friends were interested, are collected in separate categories via the electronic chart, with separate boxes listed for each type of service (eg, support groups, mailings) offered and/or in which there was interest.

Symptoms of anxiety, depression, or CG.—The 38-day risk assessment also includes “present/absent” checklists on the counselor’s impressions of the family member/friend’s mental/ emotional status (eg, symptoms of anxiety, denial, overt anger, extreme depression/sadness) complicated bereavement risk factors (eg, expression of suicidal ideation, inadequate coping skills). As no standardized scales for anxiety, depression, or CG were used by bereavement counselors, we created a composite “any symptoms of anxiety, depression, or CG,” variable based on existing diagnostic criteria for these conditions.^{25,26} The checklist symptoms considered indicative of “symptom positive” status were anxious, fearful, overt anger, clinging, denial, extreme depression/sadness, inadequate coping skills, history of unresolved grief, sleep disturbances, weight changes, hopelessness, depressed mood, concentration, agitation, anhedonia, psychomotor retardation, guilt, low energy, and

suicidal ideation. In addition, separate fields asked providers to identify their impression of the family member/friend's risk for a complicated bereavement, risk level for complicated bereavement outcomes, or impression of risk for a complicated grieving process. All family members/friends rated by counselors as having a "high" or "moderate" likelihood of a complicated bereavement, being at "high risk" for negative bereavement outcomes, or marked as having a "complicated grieving process," were also included in the "mental health symptom positive" group. In exploratory analyses, we examined whether we could identify any specific clusters of mental health symptoms from the checklist, but a low frequency of most of these symptoms prevented us from identifying any clusters.

Sociodemographics.—Family member/friend sociodemographics were collected on a separate self-report measure, which was mailed to family members/friends by an external evaluation agency contracted by MJHS Hospice and Palliative Care and collected by return mail. We obtained de-identified versions of these self-report surveys completed by family members/ friends who lost someone in the hospice during the same interval as the chart review (from October 1, 2015, to June 30, 2016). However, because our access was limited to de-identified data, we were not able to match self-report data with electronic chart-review data. Informal caregiver sociodemographic variables collected in the self-report survey were gender, education level, Hispanic ethnicity, race, and relationship to the deceased.

Satisfaction.—An item on satisfaction with hospice services was also collected on the same self-report measure as the sociodemographics and could also not be matched with service use data or mental health symptoms data. The item was "how much emotional support did the hospice team provide to you (the family member/friend) after the patient's death?" Response categories were "less than was wanted," "right amount," and "more attention than was wanted."

Data Analysis—As the electronic checklist coded response as text fields, all were translated into dichotomized numeric values for analysis. Descriptive statistics were used to describe the sample characteristics and provision of bereavement services. χ^2 tests were used to compare the type of support offered by hospice staff to all bereaved informal caregivers and then to the subgroup with symptoms of anxiety, depression, or CG. We also examined how many of the bereaved informal caregivers in the mental health symptom-positive group were interested in the services offered to them using χ^2 tests.

Results

A total 3561 bereaved primary informal caregivers who lost a loved one in the hospice from October 1, 2015, to June 30, 2016, were connected with MJHS bereavement support and had electronic bereavement risk assessment data available. A total of 490 of these family members or friends (13.8%) also completed the self-report survey, with some incomplete responses within the survey. The difference in sample size between the risk assessment checklist and self-report survey was due to the self-report survey being administered and returned by mail.

Sample Characteristics

Of the 490 family members/friends with self-reported sociodemographic data available, 74% were female (Table 1). The majority of the sample was 55 and above. Family members/friends were fairly diverse, with 76% white, 17% black, 7% Asian, and 13% Hispanic. Most (91%) of them spoke English at home.

In terms of relationship to the deceased, among those family members/friends who completed the self-report survey, the majority ($n = 272$, 55.7%) were children of the hospice patients, and 23.3% ($n = 112$) were partners/spouses. Most of the remainder were other relatives (siblings [$n = 26$; 5.3%], nieces or nephews [$n = 25$, 5.1%], daughters- or sons-in-law [$n = 12$, 2.5%], grandchildren [$n = 6$, 1.2%], or parents [$n = 9$, 1.8%]). A total of 15 (3.1%) were friends of the deceased and 11 (2.3%) had other relationships. Most of those who completed the self-report survey experienced the death of their family member or friend either at home ($n = 251$, 44.1%) or in a hospice facility ($n = 139$, 24.4%), whereas 96 (16.9%) experienced the death in a hospital, 61 (10.7%) in a nursing home, 16 (2.8%) in an assisted living facility, and 5 (0.8%) in another location (results not shown).

Mental Health Status

Of the bereaved primary informal caregivers with risk assessment data available ($N = 3561$), 9.4% ($n = 333$) were mental health symptom-positive. The most common mental health symptoms identified by bereavement counselors were anxiety ($n = 76$, 2.0%), overt guilt ($n = 14$, 0.4%), and extreme depression/sadness ($n = 11$, 0.3%). Only 1 person expressed suicidal ideation (results not shown). Bereavement counselors rated 87 family members/friends ($n = 2.3$) as at “high” risk for a complicated bereavement and 68 ($n = 1.8\%$) as at “moderate risk” (results not shown).

Services Offered

Of the bereaved primary informal caregivers with risk assessment data available, memorial services, telephone calls, and reference materials were the most frequently offered hospice services (Table 2). Caregivers with symptoms of anxiety, depression, and CG were more frequently offered additional mailings, one-to-one counseling, telephone calls, reference material, support groups, and memorial services than those without these symptoms, and were less likely to be offered volunteer support, family counseling, and workshops. Among the symptom-positive group, 87% were offered memorial services, 63% were offered telephone calls, 60% were offered reference materials, and 60% were offered one-to-one counseling (Table 2).

Service Interest

Of the bereaved primary informal caregivers with risk assessment data available, interest was highest in mailings (43%), telephone calls (25%), reference materials (16%), or memorial services (11%; Table 2). Those with symptoms of anxiety, depression, and CG were significantly more interested in mailings, support groups, one-to-one counseling, telephone calls, reference materials, outside referrals, and memorial services than those without these symptoms. They were also less likely to decline services or to not have their interest in services evaluated (Table 2). Among the mental health symptompositive group,

66% were interested in mailings, 47% in reference materials, 47% in telephone calls, 18% in memorial services, 7% in one-to-one counseling, 7% in outside referral, and 3% in support groups.

Examining interest within the mental health symptompositive group by services offered to them, we found that interest was highest in telephone calls (45%, $n = 150$) and reference materials (44.4%, $n = 148$; Table 3). Interest was lower in one-to-one counseling, mailings, workshops, family counseling, and memorial services.

Satisfaction With Services

When asked if they had received the right amount of support after the death from the hospice, 14.4% of the 459 family members/friends who answered this item on the self-report survey said they had received too little support ($n = 66$), 1.3% too much support ($n = 6$), and 84.3% ($n = 387$) the right amount of support (results not shown).

Discussion

This study provides preliminary findings about services offered by the hospice staff to bereaved primary informal caregivers with possible symptoms of anxiety, depression, and CG, and caregiver interest in these services. The prevalence of 9.4% of mental health symptoms in this sample is slightly lower than in other bereaved samples and roughly consistent with the rates of depression and CG found in bereaved informal caregivers in other hospice samples using evidence-based screening tools (13%-20%).²⁻⁵ The difference between our sample and other hospice samples is likely due to the lack of use of standardized measures for CG, depression, or anxiety disorders.

Hospice bereavement counselors appear to offer more intensive services to those with symptoms of anxiety, depression, or CE, implying that providers are both recognizing these symptoms and considering the level of need when offering hospice bereavement services. This finding is consistent with previous studies of hospice service provision.^{14,16} The partner hospice, like most hospices,^{15,16} generally takes a stepped-care approach; general information and support (eg, condolence cards, mailings) are provided to all bereaved family members, while counseling and referrals are offered to those most at risk. Future work could explore the general efficacy of this approach and alternative models of targeting services, so that hospices can most efficiently utilize their bereavement services.

Bereaved informal caregivers with mental health symptoms also expressed higher interest in services than the other bereaved caregivers. This is consistent with previous research, as depression, anxiety, and/or grief severity have been frequently associated with greater bereavement service use.^{24,27-31} In addition, family members and friends seem to be mostly satisfied with bereavement support received, a finding also consistent with previous studies in hospice.³² At the same time, within the mental health symptom-positive group, interest in most types of hospice bereavement supports was low. These findings are consistent with previous hospice-based studies, which found that about one-third of all bereaved family members or friends utilize hospice bereavement services^{24,33} and that less than half of those with symptoms of CG or depression do so.^{17,24} These findings are also consistent with

broader trends in mental health care, which indicate that the majority of Americans with any type of mental health symptoms do not utilize support from mental health professionals.^{34,35}

Although reasons for low interest in bereavement services remain unknown and could not be explored in the current analyses, some factors that have been identified in previous research include not thinking participation would be helpful, and not wanting to seek support outside family members or friends.^{24,33} It is also likely that many bereaved family members are overwhelmed after the death and do not have the time or energy to engage in bereavement services. In addition, perceptions and labels of bereavement services could affect their use. The term “bereavement counselor” could potentially imply a narrower focus than support services actually entail and may limit caregiver understanding the scope and potential benefits of services. This concern has been raised in overlapping fields; relabeling palliative care as “supportive care” has been posited to facilitate enrollment,³⁶ for example, and fear of being labeled as depressed has been found to impact engagement in depression care.³⁷ In response, some hospices have adopted more generic titles such as “family support worker” for bereavement counselors. Future work could explore the impact of this approach. In addition, there is a trend within hospice toward beginning engagement with bereavement counselors pre-loss, in order to both prevent negative outcomes and allow for greater continuity of care from pre- to post-loss.^{14,38} The effectiveness of these attempts at increasing engagement in bereavement services could be studied in future work.

Potentially contributing further to low bereavement service interest, MJHS Hospice and Palliative Care attempts to provide services informal caregivers living out of state, many of whom may prefer to receive services locally. Their use of bereavement support outside the partner hospice was not captured in our data. Moreover, there is great cultural and religious variation in mourning practices, particularly around informal and formal sources of support,³⁹ and some of the bereaved may have preferred to seek services within their own communities. The limited fields collected in the existing data did not allow us to explore cultural preferences or patterns in our sample. Finally, many hospice patients are only enrolled in hospice services for a brief time before the death,⁴⁰⁻⁴² which can limit hospice staff’s ability to build relationships with family members or friends and may impact engagement post-death. Future work could explore how some of these factors would apply to bereaved family members or friends with anxiety, depression, and CG services, and why there is variability in interest across different types of services being offered.

More generally, bereavement care, both that initiated before the hospice patient’s death and post-bereavement, could be more directly guided by theoretical models. Among the most applicable would be resilience-focused models,⁴³ which consider strengths and risks both at the individual level (eg, attachment style, past history of depression, previous loss experiences, and level of social support)⁴⁴ and family level (eg, level of family conflict or cohesion, family norms around coping with loss).⁴⁵ Moreover, the bereaved person’s attachment style has been identified as a risk factor for developing CG (with those with insecure attachment more at risk for the condition),^{46,47} but can also impact treatment-seeking.^{48,49} Attachment style could either facilitate or make engagement in bereavement services more challenging. Both attachment theory and risk and resilience models could

explicitly guide hospice care, from the first meeting/assessment through the post-bereavement period and could both assist in targeting care and enhance continuity of care.⁵⁰

Future work could also focus on variability in bereaved primary caregivers' preferences and need by age; the current caregiver sample, such as most groups of hospice caregivers,³⁸ varied by age. Both available services and service interest can vary by age.³⁵ For example, caregivers with children or adolescents might benefit from a family-centered orientation to bereavement services; family-focused grief therapy has been found effective at preventing CG, for example.⁵¹ Our inability to match family member/friend demographics with service use prevented us from exploring differences in interest or use by age, but future work could explore these differences in more depth in hospice settings. Alliance between providers and clients have been found to be one of the most effective aspects mental health treatment.⁵² Although time limits on hospice bereavement services might limit building of these relationships, future work could both explore the quality of bereavement counselor-caregiver relationships and explore methods to enhance these relationships.

Results suggest that hospices could seek to better engage bereaved family members/friends with mental health symptoms. Interventions could be designed to enhance engagement. One or 2 sessions by bereavement services focused on anticipatory grief might be initiated before the death, for example, and help to build these relationships. Researchers have recommended that engagement efforts could focus on enhancing perceived need and decreasing stigma around bereavement service use.^{24,33} Similar interventions have been developed to enhance engagement among older adults with depression in the general population (eg,⁵³⁻⁵⁵), which could potentially be adapted for hospice settings. More research also could explore new approaches to managing grief, which simultaneously can enhance engagement, such as "walking groups," in which volunteers meet in a predesignated place and walk and talk about grief with any bereaved who attend; the goal is to provide a space to both share grief and build connections with both volunteers and other walkers.⁵⁶

There are several limitations in this study. First, the electronic records used in the analysis were not developed for the specific purpose of this study, and, due to differences in how data were collected, we could not match data on services with sociodemographic or satisfaction data. This prevented the researchers from exploring some questions of interest, such as whether interest varied by race, ethnicity, age, or relationship to the deceased. Nevertheless, the project provides data on the associations between services offered and service interest that has not been previously explored. Second, data were based entirely either on provider impressions or self-report; there was no way of verifying ratings against other reports. The identification of risk factors only based on clinician judgment is subjective and can potentially vary across bereavement counselors, by caregiver, and by the relationship between counselors and caregivers. A range of brief screening tools for poor bereavement outcomes have been validated and utilized in real world practice, including the nine-item Patient Health Questionnaire (PHQ-9) for depression,⁵⁷ the Brief Grief Scale for CG,⁵⁸ the Generalized Anxiety Disorder seven-item (GAD-7) scale for anxiety symptoms,⁵⁹ and multicomponent tools such as the K6 and K10 scales,⁶⁰ and the Distress Thermometer.⁶¹ Future work could attempt to integrate these standardized measures into hospice care and compare positive screens to clinician ratings.

Moreover, measures of satisfaction with services were based on a much smaller subsample that completed a mail-in survey. Response rate on the survey was very low (14%) because it was mailed; mailed surveys have been found to have a lower response rate than phone surveys.⁶² It is also likely that those in the subgroup who were willing and able to return a mailed survey experienced higher functioning than the other bereaved informal caregivers in the sample. Finally, although information was collected from a large, diverse, metropolitan hospice, the result cannot be generalized to other hospices or to other regions of the country. All of these considerations limit the generalizability of our findings.

Conclusion

Our findings suggest that hospices offer a range of services to family members or friends with symptoms of anxiety, depression, and CG, but that there is a gap between what is offered and in the interest of the bereaved. Results suggest that engagement could be improved if reasons for low interest were better identified and addressed.

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Table 1.Sociodemographics of Bereaved Family or Friends, From Self-Report Survey.^a

	N	%
Age		
18-34	5	1.0
35-54	116	23.6
55-74	305	62.3
75 or older	64	13.1
Female gender	366	74.4
Race/ethnicity		
White	353	76.2
Black/African American	78	16.8
Asian	31	6.6
Indian/Alaska Native	1	0.2
Hispanic	64	13.1
Education level		
Less than high school	14	2.8
High school graduate	88	18.1
Some college	98	20.2
Four-year college graduate	127	26.1
More than 4-year college	159	32.7
Language spoken at home		
English	426	90.6
Spanish	15	3.2
Chinese	12	2.6
Other	11	2.3

^aN = 490.

Table 2.

Bereavement Services Offered to and Interest Expressed by Bereaved Family or Friends, Comparing Those With and without Symptoms of Anxiety, Depression, and Complicated Grief.^a

	Services Offered			Service Interest		
	Total N (%)	Symptoms + n (%)	Symptoms – n (%)	Total N (%)	Symptoms + n (%)	Symptoms – n (%)
Mailings	86 (2.4)	26 (7.8)	60 (1.9)	1529 (42.9)	220 (66.1)	1309 (40.6)
Support groups	39 (1.1)	12 (3.6)	27 (0.8)	34 (1.0)	10 (3.0)	24 (0.7)
Workshops	854 (24.0)	41 (12.3)	813 (25.2)	28 (0.8)	3 (0.9)	25 (0.8)
Family counseling	903 (25.4)	41 (12.3)	862 (26.7)	6 (0.2)	1 (0.3)	5 (0.2)
One-to-one counseling	1413 (39.7)	200 (60.1)	1213 (37.6)	48 (1.3)	24 (7.2)	24 (0.7)
Volunteer support	538 (15.1)	20 (6.0)	518 (16.0)	5 (0.1)	0 (0.0)	5 (0.2)
Telephone calls	1641 (46.1)	211 (63.4)	1430 (44.3)	904 (25.4)	155 (46.5)	749 (23.2)
Reference material	1403 (39.4)	201 (60.4)	1202 (37.2)	574 (16.1)	157 (47.1)	417 (12.9)
Outside referral	891 (23.8)	87 (26.1)	808 (25.0)	45 (1.3)	24 (7.2)	21 (0.7)
Memorial services	2504 (70.3)	289 (86.6)	2215 (68.6)	402 (11.3)	60 (18.0)	342 (10.6)
Other	65 (1.8)	22 (6.6)	43 (1.3)	–	–	–
Not evaluated	422 (11.9)	23 (6.9)	399 (12.4)	–	–	–
Not yet decided	–	–	–	132 (3.7)	20 (6.0)	112 (3.5)
Declines all follow-up services	–	–	–	263 (7.4)	8 (2.4)	255 (7.9)

^aN = 3561.

^bP < .05.

Table 3.Among Family Members or Friends Positive for Mental Health Symptoms, Service Interest When Services Offered^a

	Services Offered		χ^2	P Value
	Interested, n (%)	Not interested, n (%)		
Mailings	10 (3.0)	16 (4.8)	9.58	.002
Support groups	0 (0.0)	12 (3.6)	0.39	.535
Workshops	3 (0.9)	38 (11.4)	21.56	<.0001
Family counseling	1 (0.3)	40 (12.0)	7.14	.008
One-to-one counseling	20 (6.0)	180 (54.1)	5.84	.016
Volunteer support	0 (0.0)	20 (6.0)		
Telephone call	150 (45.0)	61 (18.3)	139.40	<.0001
Reference material	148 (44.4)	53 (15.9)	142.73	<.0001
Outside referral	22 (6.6)	65 (19.5)		
Memorial services	59 (17.7)	230 (69.1)	8.50	.004
Other	2 (0.6)	20 (6.0)	0.95	.331

^aN = 333.