Social Work Paves the Way for Change


NASW’s goal during Social Work Month and throughout 2015 will be to educate the public about how social workers and the association have brought about major positive social changes, improved the lives of individuals and families, and will continue to do so in the future.

Social workers have worked to improve the rights of women, African Americans and other ethnic minorities, and the LGBT community. They have also pushed to strengthen the social safety net through programs such as Medicaid, Medicare, and the Affordable Care Act, and advocated for social justice initiatives such as the Voting Rights Act and the Community Mental Health Act.

Social workers also make a difference in the day-to-day lives of millions of Americans by helping to build, support and empower positive family and community relationships. For example, they work in schools helping students overcome obstacles to their education; they work in hospitals helping patients navigate their paths to recovery; and they work in agencies and organizations helping protect vulnerable children and adults from abuse and neglect.

Social workers—more than any other profession—recognize that more must be done to address persistent social problems such as poverty, lack of education and health care access, and discrimination based on gender, race, sexuality, or income. And they know that all people, no matter their circumstance, at some time in their lives may need the expertise of a skilled social worker.

DID YOU KNOW?

Profound changes in family structure have been brought about by the increase in longevity, which has resulted in many four-and five-generation families.

IT’S A FACT

Gaps in social services and economic resources are often the root of homelessness or family violence.
Sometimes informal conversation with friends provides the opportunity to explore not only the future, but also different perspectives on what is happening today. With friends we have the chance not only to disagree, but also to enjoy a bit of gentle sparring over solutions to the challenges of the day. With this in mind, I invited two friends, George Handzo (GH), director of Health Services Research and Quality for Health Care Chaplaincy in New York City, and Gary Gardia (GG), a hospice and palliative care consultant and the course director for the Post-MSW Certificate in Palliative Care, to join me, Helen McNeal (HM), in a roundtable conversation about social work, chaplaincy, and palliative care.

(HM) Today, I see palliative care reaching the tipping point. Increasingly, clinicians, health plans, and—to a small, but growing extent—the public, recognize its importance and value. But much emphasis is on the physician and nurse role. Although some important and notable exceptions exist, social workers and, even more so, chaplains are seen as “ancillary” team members.

(GG) I think more and more reimbursement providers are seeing financial incentives for palliative care. However, quite often, the public views it as pre-hospice or as a temporary holding place until the medical team decides what to do next. Many people, even health care workers, see it as specialized medical care delivered by only physicians and nurses. The Center to Advance Palliative Care (CAPC) definition (click here to view) contributes to this confusion: “specialized medical care for people with serious illnesses... provided by a team of doctors, nurses, and other specialists.” We may be shooting ourselves in the foot with this definition, because it begs the question, “Shouldn’t everyone in health care be receiving specialized care from the medical team, no matter what diagnoses?”

From my perspective, this limited kind of thinking is likely to guide the future of palliative care toward murky waters. Yes, it is truly at a tipping point.

(GH) The financial pressures on the health system—especially for those with chronic illnesses and at end of life—coupled with consumer demands for more respectful and patient-centered care, are not going away. Palliative care is currently the only option that has proved it can address both of these concerns.

I am concerned about the role of chaplaincy, because chaplains have not yet provided robust evidence to demonstrate that we can contribute to achieving the financial goals or “proven” our added value in addressing patient-centered goals. I believe we do contribute, and it will be a loss to patients if we are not included, but we need to produce the evidence.

(HM) I think Gary is right about the definitional challenge. I know that I spend much of my time—even with folks working in palliative care—defining it as more than just upstream of hospice. That said, getting either consumers or health care professionals to agree with the definitions is hard if the reality of their experience doesn’t match the proposed definitions.

We all know that many things contribute to the gap between definition and reality, such as limited reimbursement opportunities for social workers and chaplains or the lack of adequately trained professionals. I do, however, believe that, unless more chaplains and social workers jump on the bandwagon and understand palliative care, we definitely risk a limited view of palliative care as being only about physician and nursing care. How do we reach the medical or community social worker, or chaplain or community religious professional for whom palliative care [might be] just “one more thing” on their already over-flowing plates?

(GG) I think the real challenge is motivating social workers and chaplains to take on—more advocacy/leadership roles. In health care, it is not uncommon for us to focus heavily on pain and symptom management and then take a “when and if there is time” approach to addressing suffering. It
time for social workers and chaplains to get out in front of the medical model and help to forge the path for true holistic and interdisciplinary care.

(GH) For community religious professionals, what is required of them in a palliative care context is not “one more thing,” it is an accepted part of their ministry, and I think most recognize that. However, the vast majority have no training in pastoral care, especially end-of-life care. Also, for the most part, the health system not only has failed to include them as real members of the health care team, but also has often made it clear that their presence is, at best, tolerated and, at worst, actively blocked. But I believe that both of these barriers can be overcome.

(HM) Knowing both of you have strong opinions on this, my question is how do we motivate social workers, chaplains and community clergy to take on this additional role given all of these challenges?

(GG) Much information is on the Internet about exploring ways to get young people to vote in local elections. The belief is that the youth of today are interested in politics, but they have a growing sense of learned helplessness, believing “my efforts do not matter.” The effect of this thinking is that it places people in a victim role; the future will be determined by someone else. One of the questions I hear most often from social workers is, “How do we get people to value us?” My response is always the same: “As in all areas of life, the way to get someone to value you is to show up with value.”

How do you motivate social workers and chaplains to become leaders? Create leadership opportunities, and ask people to join in.

(GH) As the palliative care course for spiritual care providers at the Institute for Palliative Care, California State University San Marcos has demonstrated, a substantial segment of this community will jump at it once accessible and affordable training is available. They also need structures that provide them with ongoing support and mentoring. I would encourage the denominational leaders and seminary leaders to see how vital this work is—but more than that—how important training is. Some people who lead organized religious communities do not know how to care for people in their times of greatest need, and, in some cases, do not think that care is part of their job. We wonder why people are leaving these communities in droves. We need to continue to explore that further and highlight the issues that lead to individuals prematurely leaving the field.

(HM) Some people—especially with so many Americans now declaring themselves to be “spiritual, but not religious”—perceive that the role of the social worker and that of the chaplain are or could be complementary.

(GG) This is true. In light of the current focus on finding ways to reduce health care costs, we need to ensure people see the dollar value of addressing suffering (the psychosocial and spiritual components of illness). What is the cost/benefit ratio of having skilled social worker or chaplain intervention? This question takes us back to the mission and vision of the hospice pioneers: “There must be a better way to address illness than simply focusing on the body.” We are still having the same problem and the same conversation.

(GH) The goal should be for social workers and chaplains to present a united front on the importance of psychosocial and spiritual care and to demonstrate why both disciplines are required, rather than allowing us to be split by the system.

(HM) Speaking of challenges, we all know that hospice and palliative care have been successful in serving largely the Caucasian community, but the need is no less great among Americans of other cultures. Reaching these communities makes social work and chaplaincy all that much more critical. Are there innovations you see that are breaching these barriers?

(GG) Because most palliative care in this country is hospital based, who receives it is dependent on how well the hospital reaches the underserved in its community. There needs to be a desire to; understand various cultural, religious, and lifestyle obstacles; and a willingness to help people overcome those obstacles and in order to better understand the benefits of palliative care—leading to the referral. Once again, that means skilled social workers and chaplains who have the availability to engage in some level of community engagement, doing more than just crisis management on a day-to-day basis. Because we are most often talking about serious illness (at least as palliative care exists today), the solution is rarely as straightforward as simply making a referral. It also is imperative that we step back and ask the difficult questions (difficult from so many different perspectives): “Who are the underserved in the world of palliative care and in our communities?” Part of the solution is to continue to work toward an earlier integration of palliative care.

(GH) I agree on all counts. Again, the economics of our current delivery of healthcare are on our side, as it is becoming increasingly clear that underserved populations are costing systems a lot of money. It is increasingly clear that many of the barriers to good access to healthcare and appropriate use of services are social and religious. Social workers and chaplains can be the bridge builders here. One big problem is educating our colleagues about why this is important and how to do it more effectively.

(HM) If you had the opportunity to guide today’s social work and chaplaincy leaders in preparing for palliative care, as well as the increasing importance of both culture and spirituality in the role of the social worker, what would you recommend?

(GG) This is a good question. My solution is developing palliative care social work leaders. This is what I had in mind as we developed the CSU Institute’s Post-MSW Certificate in Palliative Care. As social workers, we pride ourselves on our effectiveness and our ability to get things done for those we serve, yet I am not sure we are as comfortable with the idea that good leadership requires the daily application of social work values: openness, communication, fairness, inclusiveness, collaboration, and trustworthiness. Yet consider how each of these values might be translated into skills for an effective leader. In short, whether we think about it on a regular basis or not, when we commit to social work as a profession, we were also are committing to taking on a leadership role, regardless of our job description.

However, today, with all the emphasis on medicine and nursing, I think often
social workers in palliative care are waiting for someone to “invite” us to the leadership table. It does not work that way. The way to become a great leader is to show up each and every day as a leader. Leadership takes skill building, vision, and planning, but isn’t this the true spirit of social work? Leadership means getting out of the crisis management mindset and becoming proactive at the mezzo and macro levels of practice. Do you see something that needs to be changed? Go change it.

(GH) To make a contribution, one has to play on the team and establish one’s value to the team. Chaplains and community religious professionals often have no idea how to be team players, and many actually think of this as selling out to the medical model. We are now in a team game.

(HM) Although it is not a surprise to any of us, it seems we agree that the bottom line is that, if palliative care is to address the many challenges it faces—including the full potential of its definition and serving all those who could benefit from it—today’s social workers and chaplains need to set aside their conditioning and experience so far and step up as leaders. If social workers and chaplains can recognize the importance of this challenge, and embrace the skill building and leadership development needed to achieve their full potential, not only will they and their organizations and patients benefit, but so will the field of palliative care.

The Rev. George F. Handzo, BCC, is widely regarded as one of the foremost authorities on the deployment and practice of professional healthcare chaplaincy. With over 25 years in directing Chaplaincy programs, he is leading his field in the creation of practices and services which combine spiritual care with proven business benefits for healthcare institutions, their staff and their patients.

Gary Gardia, MEd, MSW, LCSW, holds a Master's Degree in Education and another in Social Work and is a Licensed Clinical Social Worker. He received the National Hospice and Palliative Care Organization's (NHPCO) Heart of Hospice Award for developing innovative programs to meet the needs of caregivers and the bereaved. He is also the recipient of the 2015 Social Work Hospice and Palliative Network (SWHPN) national Award of Excellence in Professional Education.

Helen Briggs McNeal is the Executive Director of the California State University Institute for Palliative Care located at Cal State University San Marcos. Helen has consulted with both U.S. and Canadian government agencies on palliative care strategies. She is also the co-author of Module IV: Palliative Care of A Comprehensive Guide to the Care of Persons Living with HIV/AIDS. In addition to a degree in Business Administration from the University of Michigan, she has done post-graduate study in business, psychology and organizational development.

RESOURCES
NASW Hospice and Palliative Care Credentials:
• http://socialworkers.org/credentials/credentials/chpsw.asp
• http://socialworkers.org/credentials/credentials/achp.asp

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For more information, visit SocialWorkers.org/Sections

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NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

- Administration/Supervision
- Aging
- Alcohol, Tobacco, and Other Drugs
- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
- Social Work and the Courts

For submission details and author guidelines, go to SocialWorkers.org/Sections. If you need more information, email sections@naswdc.org.