

# Social Workers in Hospice and Palliative Care

## occupational profile



## Overview

The goal of hospice and palliative care is to improve the physical, psychosocial, and spiritual quality of life for people living with a serious illness and their families. The terms *hospice* and *palliative care* describe two distinct but closely related models of care, both interdisciplinary in nature and available across a wide range of settings.

*Palliative care* seeks to prevent or relieve pain—which can be physical, psychosocial, or spiritual—and other symptoms associated with serious illness. The condition may be either life limiting (terminal) or chronic. Likewise, individuals may access palliative care at any point throughout the illness, from diagnosis to cure or death; they may also pursue curative care simultaneously. *Hospice* is a form of palliative care focusing on support and physical comfort at the end of life—generally defined, in the United States, as a life expectancy of six months or less. Hospice also includes bereavement services for families of hospice patients, and many palliative care programs do as well.

Palliative care is not simply a precursor to hospice. Although some people who use palliative care may subsequently enroll in hospice care, others begin hospice without prior use of palliative care, and still others use palliative care at the end of life but do not choose to participate in hospice. Nonetheless, palliative care social workers play a valuable role in facilitating clients' transition to hospice. A common misconception is that only older adults use hospice or palliative care. On the contrary, palliative care and hospice are available to people across the lifespan. Some hospice and palliative care programs offer both adult and pediatric care; a smaller number of programs specialize in pediatrics.

## Overview of Functions

Hospice and palliative care social workers fulfill a variety of roles and tasks. As in other social work specialty areas, biopsychosocial assessment guides practice and is repeated throughout the episode of care. Assessments focus on the goals, needs, and strengths of both the patient and family caregiver(s). Job functions that a social worker in hospice and palliative care might perform include:

- Counseling and psychotherapy for individuals, couples, and families;
- Providing psychosocial education to patients and family caregivers about coping skills, hospice and palliative care philosophy, and nonpharmacological symptom management strategies;
- Providing in-services to other service providers and organizations;
- Leading community education workshops;
- Planning for discharge, coordinating care, and helping clients navigate systems;
- Facilitating advance care planning and lifespan planning;
- Intervening in crises;
- Mediating conflicts within families, between clients and the interdisciplinary team, and between service organizations;
- Participating in interdisciplinary team meetings, care planning, and ethics consultations;
- Advocating on behalf of the patient and family;
- Identifying and linking clients with resources;
- Facilitating psychoeducational support groups; and
- Documenting social work activities.

Hospice and palliative care social workers spend much of their time directly with clients in home visits, inpatient settings, or office consultations. A great deal of driving to visit clients and some off-hours emergency coverage may be required, particularly in hospice. Social workers also make phone calls to check in with clients and locate resources.

In addition to direct practice, social workers play significant roles—and are greatly needed—in administrative roles, policy, education, research, and macro-level advocacy focusing on hospice and palliative care.

## Benefits and Challenges of Working in Hospice and Palliative Care

Palliative care and hospice offer social workers the privilege of supporting individuals and families during some of the most universal—and vulnerable—life experiences: coping with serious illness, facing one’s mortality, the dying process, and bereavement. Hospice and palliative care social workers witness, on a daily basis, the struggle to find meaning in the face of serious illness and death. They have a unique opportunity to help people identify, try to answer, and live with core existential questions. Social workers may also enjoy the positive regard with which palliative care and hospice are perceived by many individuals, families, and other service providers.

Many hospice and palliative care social workers enjoy the collegiality of working closely with an interdisciplinary team and appreciate working in a medical specialty that prioritizes clients’ psychosocial well-being. Nonetheless, social workers in these settings face challenges similar to social workers in other medical environments: the need to be conversant in medical and pharmacological matters (while maintaining scope of practice), to educate other members of the team about clients’ psychosocial circumstances, and to justify the value of social work interventions. Furthermore, hospice and palliative care social workers may not have access to social work supervision (or, in small organizations or practices, social work colleagues) on the job.

Self-care is vital to professional and personal sustainability in hospice and palliative care. Social workers specializing in these practice areas face loss on a daily basis and may internalize this loss in a variety of ways. On a professional level, hospice and palliative care social workers must maintain strong professional boundaries, continually redefine client “success,” and find ways to honor professional grief when a client dies or experiences a progression in illness. On a personal level, taking time off the job, investing time and energy in enjoyable activities and supportive relationships, and nurturing a sense of abundance can help social workers maintain perspective and energy amid the challenges of hospice and palliative care.

### REFERENCES

National Association of Social Workers. (2004). *NASW standards for palliative & end of life care*. Available at [www.socialworkers.org/practice/bereavement/standards/default.asp](http://www.socialworkers.org/practice/bereavement/standards/default.asp)

National Association of Social Workers. (2008). *NASW code of ethics*. Available at [www.socialworkers.org/pubs/code/default.asp](http://www.socialworkers.org/pubs/code/default.asp)

Data referenced in this profile are based upon results from the *2009 NASW Salary & Compensation Study* (see Notes).

# Salary Analysis of Social Workers in Hospice and Palliative Care [n = 940]

## ANNUAL SALARY BY AGE<sup>1</sup>



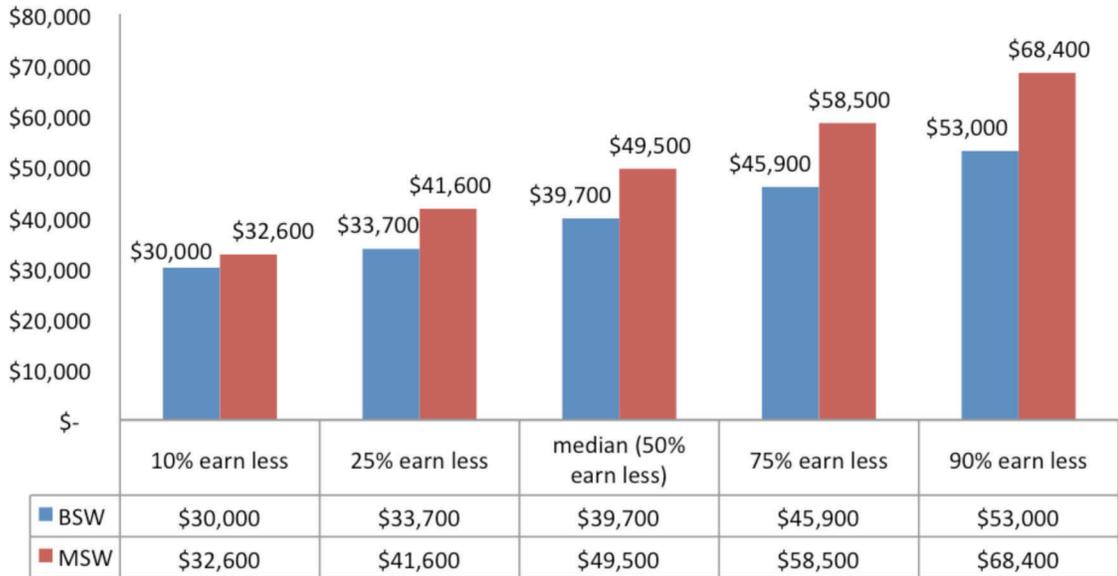
## ANNUAL SALARY BY YEARS OF EXPERIENCE<sup>2</sup>



<sup>1</sup> Your age? (under 25; 25-29 20-24; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65 and older)

<sup>2</sup> In what year did you first begin working in the social work field?

## ANNUAL SALARY BY DEGREE<sup>3</sup>



## ANNUAL SALARY BY CERTIFICATION<sup>4</sup>



<sup>3</sup> Which of the following academic degrees do you hold (if any?)

<sup>4</sup> In which of these areas (if any) do you hold current certifications? Please check all that apply.

## ANNUAL SALARY BY CERTIFICATION (CONTINUED)



## ANNUAL SALARY BY SECTOR<sup>5</sup>



<sup>5</sup> On October 1, 2009, what was the sector of your primary social work position?

## ANNUAL SALARY BY PRACTICE AREA<sup>6</sup>



## ANNUAL SALARY BY REGION<sup>7</sup>



<sup>6</sup> Which one option best matches the primary practice area of your primary position? (Please check the one best option.)

<sup>7</sup> On October 1, 2009, what was the city, state, and ZIP code of your primary work location?

## ANNUAL SALARY BY CENSUS REGION



## ANNUAL SALARY BY CENSUS REGION (CONTINUED)



## Survey Methodology

This survey was sponsored and developed by NASW. Data were collected and tabulated by Readex Research, an independent research company. To broaden representation of the profession, NASW partnered with a number of other social work membership organizations to create an expanded list of U.S. professional social workers for sampling purposes. These partner organizations were:

- Association for Oncology Social Workers (AOSW)
- National Hospice & Palliative Care Organization (NHPCO)
- National Network for Social Worker Managers (NNSWM)
- The Rural Social Work Caucus
- Society for Social Work Leadership in Health Care (SSWLHC)

The total number of unduplicated individuals among these five lists and the NASW domestic membership was 101,995. The overall sample size of 78,777 consisted of the 73,777 with a valid email address on file and a systematic sample of 5,000 (from the 28,218 who could not be reached via email).

Data collection utilized a mixed mode approach. For those with a valid email address, invitations were sent via email to access a Web-based survey. Those without an email address were sent invitations via regular mail, with the option to fill out a provided paper survey or to access the survey online via a provided Web site address.

Data were collected between October 1 and November 24, 2009. 23,889 unduplicated usable responses were received, for a 30% response rate. Among these, 22,000 responses were randomly chosen for inclusion in the final tabulation. The data have been weighted to account for disproportional response between the email and regular mail samples. Percentages based on all 22,000 responses are subject to a margin of error of  $\pm 0.6\%$ .

### RESPONDENT STATUS

The compensation analysis focuses on the subset of “valid answering practitioners”—that is, U.S.-based respondents confirming paid employment or self-employment on October 1, 2009 in a social work-related position (defined as any position that requires or makes use of one’s education, training, or experience in social work), and reporting regular salary or wages. Percentages based on these 17,851 “valid answering practitioners” are subject to a margin of error of  $\pm 0.6\%$ . *Results are not shown in this profile if there were fewer than 30 valid values in a category.*

Removed are those who did not answer at all, those who provided a report considered to be an outlier (top 1% and bottom 1% of all responses), and those who did not answer in a coherent manner. The tabulated base of the “answering practitioners” is 17,911.



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