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Research Article

A Mixed-Method Study on the Palliative Care Capacity of Social Workers in Flanders (Belgium): A Call to Expand Their Role

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This study explores the palliative care capacity of social workers in Flanders. First, it examines the frequency with which social workers in Flanders are currently performing palliative care tasks. Second, this study assesses their attitudes and competencies regarding the performance of these tasks. Third, as contextual factors also influence this performance, this study explores the level of appreciation experienced by social workers in Flanders. To achieve these objectives, a mixed-methods explanatory sequential design was used. Quantitative data were collected by distributing electronic survey questionnaires on QUALTRICS© to a theoretical sample of social workers in Flemish hospitals, community health clinics, nursing homes, home care, and health insurance services. A total of 499 social workers completed the survey in April and May 2021, of whom 352 met the eligibility criteria and were retained for analysis. Qualitative data were collected based on online focus groups between June and September 2021, in which a total of 24 social workers discussed the main survey results. Transcripts from the focus groups were analysed by using the framework method. The results indicate that the current palliative care capacity of responding social workers in Flanders is limited to tasks related to client assessment and referral, while their potential role extends beyond these tasks. With an expanded role, social workers would be better able to address the social dimensions of care, engage in politicising work, and, in turn, contribute to a holistic and multidimensional approach to palliative care. However, this study illustrates the need to increase the competencies and actual involvement of social workers in tasks associated with this expanded role.

1. Introduction

Social workers are well-positioned to make meaningful contributions to multidimensional palliative care practice. Their contributions can be twofold. First, social workers can play an important role in addressing the nonclinical dimensions of palliative care. They can address psychosocial and spiritual dimensions of care, contributing to a more holistic approach to palliative care practice involving the social networks of persons with serious illnesses and their relatives [1, 2]. Second, since social workers are specifically trained to identify social determinants of health, they can ensure equal access to professional palliative care delivery for their clients [3].

Even though social workers can make meaningful contributions, they are often inadequately involved in daily palliative care practice [4]. Several explanations have been listed in the literature such as unclear role descriptions [5, 6], lack of education related to end-of-life care in social work [7, 8], or the medicalisation of palliative care [9].

The palliative care capacity of social workers, which we define as their "ability to perform general and discipline-specific tasks in palliative care delivery," therefore, remains underused. This capacity is largely defined by social workers' attitudes toward the performance of palliative care tasks as

well as their competencies in performing these tasks. However, contextual factors such as the appreciation of social workers by other care professionals are also important as they influence their ability to perform tasks.

1.1. Study Rationale. To further examine the potential role and actual involvement of social workers in palliative care [10], this study aims to explore the palliative care capacity of social workers in Flanders (Belgium). First, the study examines the frequency with which social workers in Flanders are currently performing palliative care tasks. Second, it assesses their attitudes and competencies regarding the performance of these tasks. Third, as contextual factors also influence the performance of tasks, this study explores how social workers feel about being appreciated by other care professionals.

2. Methods

2.1. Study Design. A mixed-methods explanatory sequential design with quantitative and qualitative methods was used. Based on the guidelines by Creswell and colleagues [11], this design is considered best as the qualitative data support better interpretations of the quantitative data by providing examples or by explaining and contextualising the results. As this design is related to Denzin's triangulation between methods [12], it guarantees an in-depth understanding of the situation while at the same time taking into account the flaws and deficiencies of each single-method. This study consisted of two phases. The quantitative phase consisted of a self-constructed cross-sectional survey questionnaire. Subsequently, focus groups were organised for the qualitative phase. Although both phases were integrated during the focus group discussions, priority was given to the quantitative phase in drawing the main conclusions, while the qualitative findings were used to explain and deepen the findings from the quantitative phase.

2.2. Sample

2.2.1. Eligibility Criteria. Social workers who (A) have a bachelor's (BSW) or master's (MSW) degree in social work or social nursing from an official educational institution and (B) come into contact with palliative care during the exercise of their profession were eligible to participate in the survey round as well as in the focus group sessions. We approached and defined the term 'palliative care" broadly, not as a specialised care service but as a form of care that enhances wellbeing in all situations involving life-threatening illnesses and characterised by death, dying, and bereavement.

2.2.2. Sampling Procedure. Due to the lack of an existing sampling frame, it was not possible to draw a representative sample of social workers in Flanders. We, therefore, had to construct a theoretical sampling frame: the survey questionnaire was distributed to social workers from five types of care organisations in Flanders, which were likely to employ social workers who met the eligibility criteria. These

included the (a) social services of the hospitals ($n = 1268$); (b) health insurance services ($n = 393$); (c) community health clinics ($n = 42$); (d) home care services ($n = 566$); and (e) nursing homes ($n = 116$). Two comments should be made on these numbers. First, for the first four service types, survey questionnaires were sent to the total population of employed social workers. However, as the numbers mentioned above remain estimates of the actual population size, it was not possible to calculate an exact response rate. Second, for the nursing homes, survey questionnaires were sent to a potential number of respondents from a random sample of 80 nursing homes (roughly ten percent of the total number of nursing homes in Flanders). For privacy reasons, all survey questionnaires were distributed by contact persons in the organisations involved.

Focus group sessions were organised based on organisational affiliation. Respondents could indicate in the survey questionnaire whether they wanted to be invited to participate in focus group sessions. If yes, they were asked to provide their contact information. Potential participants were then contacted via e-mail to ask whether and when they could participate. Furthermore, additional calls for participation were sent out by contacts in the organisations involved.

2.2.3. Development of the Survey Questionnaire and Focus Group Questions. The main guideline for the development of the survey questionnaire was the "core competencies framework for palliative care in Europe" by Hughes and colleagues [13]. The tasks included in this list were adapted to the Flemish context and presented to field experts in Flanders, including social workers, representatives of care organisations, social work education managers, and policy makers. Based on their feedback, the survey questionnaire was further refined.

The final survey questionnaire was divided into three parts. The first part consisted of items measuring respondents' personal, educational, and professional backgrounds. The second part measured — for a total number of 49 tasks in palliative care divided into ten work packages — on a 5-point Likert scale the following: (a) the frequency with which respondents are currently performing a certain task, (b) the attitude of respondents regarding the performance of this task, and (c) the competency of respondents regarding the performance of this task. The third part measured on a 5-point Likert scale how often (a) respondents feel appreciated by other care professionals when they share their views on end-of-life matters and (b) respondents think that their views on end-of-life matters are considered by other care professionals.

Semistructured focus group questions were formulated after an initial analysis of the quantitative data for each organisational group of social workers. We chose this approach in order to explain the quantitative data while leaving room for spontaneous discussions.

2.2.4. Data Collection Period. Data were collected between April and September 2021. The electronic survey questionnaires were sent by means of an anonymous link on

QUALTRICS© in April and May 2021. Reminders were sent according to the total design method [14]. Subsequently, online focus group sessions, which were audio and video recorded and anonymously transcribed, took place between June and September 2021.

2.2.5. Quantitative and Qualitative Data Analysis. The quantitative data were analysed using the statistical software program SPSS©. Univariate and bivariate descriptive analyses were used to discern and describe the main tendencies in the data. To compare the three dimensions of the tasks list (frequency, attitude, and competency), we used TYPE I and TYPE II disconfirmation scores. TYPE I scores were used to identify which tasks were considered important (scores 4-5 on the 5-point Likert scale) but not frequently performed in daily practice (scores 1-2 on the 5-point Likert scale). Furthermore, TYPE II scores were used to identify which tasks were considered to be unimportant (scores 1-2 on the 5-point Likert scale) but frequently performed in daily practice (scores 4-5 on the 5-point Likert scale). The same strategy was used to identify the tasks for which respondents considered themselves competent to perform (scores 4-5 on the 5-point Likert scale), but which they did not frequently perform in practice (scores 1-2 on the 5-point Likert scale), or vice versa. Missing data were not considered for analysis. Response patterns in which no data were collected for the task list items or which contained missing data for more than 50% of all survey items were not retained for analysis.

Subsequently, the qualitative data were analysed using Nvivo12©. The qualitative data analysis was guided by the framework method set out by Ritchie and colleagues [15]. Coding was done both deductively and inductively. The deductive coding was related to the research questions, while the inductive coding was related to focus group participants' comments on the quantitative results in spontaneous discussions. Codes were grouped into categories and applied to each transcript file until no additional codes emerged. Tendencies and differences in the data were then identified. Both audio and video recordings were destroyed after the identification of the main tendencies and differences.

3. Results

3.1. Characteristics

3.1.1. Quantitative Phase. A total of 499 respondents completed the survey, out of which 111 respondents could not access the full survey questionnaire, either because they did not give informed consent to process their data ($n = 5$) or because they did not meet the eligibility criteria ($n = 106$). These response patterns were not retained for analysis. Furthermore, additional 36 response patterns were not retained for analysis because no data were collected for the task list items ($n = 19$) or because missing data accounted for more than 50% of all survey items ($n = 17$). The response patterns of 352 respondents were retained for data analysis.

Table 1 presents the main characteristics of the survey respondents. Respondents were mostly female (88.6%), with a BSW or MSW degree (81%) and had moderate professional

TABLE 1: Survey respondents' characteristics ($N = 352$).

General characteristics	
Gender	
Male	11.4% ($N = 40$)
Female	88.6% ($N = 312$)
Years of professional experience	
>5 years (few experience)	19.7% ($N = 69$)
5–20 years (moderate experience)	48.4% ($N = 170$)
<20 years (much experience)	31.9% ($N = 112$)
Age	
>25	9.9% ($N = 35$)
26–40	47.7% ($N = 168$)
41–67	42.3% ($N = 149$)
Organisational affiliation	
Hospital social service	42.3% ($N = 149$)
Health insurance service	33.2% ($N = 117$)
Home care service	13.4% ($N = 47$)
Nursing home	9.7% ($N = 34$)
Community health clinic	1.9% ($N = 5$)
Grade	
Social work (BSW/MSW)	81% ($N = 285$)
Social nursing	19% ($N = 67$)
Contact with palliative care in education and professional life	
Palliative care content in education curricula	
Present	45.8% ($N = 189$)
Not present	54.2% ($N = 160$)
Continuing education on palliative care	
Yes	29.9% ($N = 105$)
No	70.1% ($N = 246$)
Contact with palliative care in professional life	
Full sample ($N = 352$)	
Frequent (daily-weekly)	59.1% ($N = 208$)
Less frequent (monthly)	22.4% ($N = 79$)
Not frequent (yearly-never)	18.4% ($N = 65$)
Hospital social service ($N = 149$)	
Frequent (daily-weekly)	65.1% ($N = 97$)
Less frequent (monthly)	13.4% ($N = 20$)
Not frequent (yearly-never)	21.5% ($N = 32$)
Health insurance service ($N = 117$)	
Frequent (daily-weekly)	61.5% ($N = 72$)
Less frequent (monthly)	32.5% ($N = 38$)
Not frequent (yearly-never)	6% ($N = 7$)
Home care service ($N = 47$)	
Frequent (daily-weekly)	42.5% ($N = 20$)
Less frequent (monthly)	21.3% ($N = 10$)
Not frequent (yearly-never)	36.2% ($N = 17$)
Nursing home ($N = 34$)	
Frequent (daily-weekly)	52.9% ($N = 18$)
Less frequent (monthly)	26.5% ($N = 9$)
Not frequent (yearly-never)	20.6% ($N = 7$)

experience (48.4%). Furthermore, most respondents worked in hospitals (42.3%) and health insurance services (33.2%), followed by home care services (13.3%) and nursing homes (9.7%). The majority of respondents (54.2%) did not receive information on palliative care during their education, and a minority of respondents (29.9%) followed continuing education courses on palliative care. Despite the lack of specific education, 81.5% of respondents indicated coming into contact with palliative care at least monthly in their professional lives. These percentages differ, however, between organisations: respondents from hospitals and health

insurance services indicated coming into contact with palliative care on a more frequent basis than respondents from nursing homes and home care services (65.1% and 61.5% against 52.9% and 42.5%, respectively).

3.1.2. Qualitative Phase.

Twenty-four social workers participated in a total of five focus groups, out of which nine participants worked in a hospital social service, eight worked in a nursing home, four worked in a health insurance service, and three worked in home care services. No focus group session was organised for the community health clinics since no willing participants could be found, while two focus group sessions were organised for the hospital social workers. Twenty-three participants were female and one participant was male.

3.2. Palliative Care Tasks.

Table 2 presents survey respondents' performance of palliative care tasks, i.e., the frequency with which they perform tasks, their attitudes regarding the performance of these tasks, and their competencies in performing these tasks.

3.2.1. The Frequency with which Social Workers Perform Palliative Care Tasks.

Respondents reported frequently talking with clients (64.3%) about the social consequences of a serious illness and with relatives about the social (64.3%) and financial (64.7%) consequences of a serious illness. Furthermore, they reported frequently assessing clients' needs (81.6%), especially the applicability of financial reimbursements (78.9%). Based on this assessment, they frequently guided clients to nonprofessional (67.3%) as well as professional (78.9%) forms of support. Consequently, they frequently cooperated with other care professionals (76%) and referred clients to them (78.3%).

Respondents stated that they did not frequently perform tasks related to dealing with clients and relatives from different cultural backgrounds. Respondents did not frequently assess the needs of these clients and their relatives (43.7% and 44.6%, respectively), while a majority of respondents did not frequently start a conversation about end-of-life with these clients and their relatives (66.5% and 65.3%, respectively). Furthermore, respondents do not frequently talk about religion or spirituality with clients and relatives (65.6% and 63.9%, respectively) or perform politicising tasks such as recognising and addressing (40.4% and 45%, respectively) structural problems in the guidance and support of clients. Two other separate tasks that respondents indicated they did not frequently perform are advocating for relatives' needs after the death of a client (41.5%) and mediating conflicts between clients and relatives (40.9%).

3.2.2. Social Workers' Attitudes regarding the Performance of Palliative Care Tasks.

The results show that respondents generally have a positive attitude regarding the performance of palliative care tasks since more than 50% of respondents considered 46 out of 49 tasks to be important for their social work practices. Three tasks were considered important by less than 50% of respondents: talking with clients or relatives about religion/spirituality (38.4% and 31.7%, respectively) and assessing clients' needs using instruments (49%).

To compare respondents' attitudes regarding the performance of palliative care tasks and the frequency with which they perform them, TYPE I and TYPE II disconfirmation scores were calculated. TYPE II disconfirmation scores equalled 0%. Thus, there are almost no respondents who indicated frequently performing palliative care tasks while having a negative attitude towards them. TYPE I disconfirmation, or tasks that respondents did not frequently perform while having a positive attitude to perform them, was found in 18% to 29% of respondents as shown in Table 3.

Based on the focus group discussions of these results, five tendencies can be described. First, dealing with clients and relatives from different cultural backgrounds was considered important by respondents for their social work practices but was not frequently performed. Focus group participants referred to the lack of diversity in client populations despite the fact that the current Flemish society is characterised by superdiversity: "I think it is more difficult to reach those people who do not speak our language (Dutch). Working with interpreters creates gaps in understanding and the different culture creates barriers as well since talking about grief differs between cultures."

Second, high disconfirmation scores were found for tasks relating to politicising work such as addressing (24.6%) and advocating (22.9%) structural problems in the guidance and support of clients. In the focus groups, nursing home social workers often referred to the fact that care managers did not expect social workers to perform a politicising role. As one participant commented, "Sometimes I have the feeling that they have difficulties with our critical point of view and the questions we ask."

Third, 20.7% of respondents think it is important to advocate for relatives' needs after the death of clients even though they do not frequently perform this task in practice. In the focus groups, hospital social workers pointed to time constraints in organising aftercare for clients' relatives. According to these participants, home care social workers should be responsible for tasks related to bereavement support and other forms of aftercare for relatives. However, home care social workers pointed to organisational and financial constraints to perform these tasks: "It is strange when you can make just one phone call to relatives after the death of a client or that you have to take a day off to go to a client's funeral. Especially when you have been guiding and supporting those people for a long period of time, sometimes even for years."

Fourth, 21.3% of respondents consider mediating conflicts between clients and relatives to be important although they do not frequently perform this task in practice. Focus group participants confirmed that social workers should perform this task on a more regular basis. As one nursing home social worker argued: "Colleagues (doctors or nurses) often avoid relatives who want to enter into a conflict with clients or care professionals, while these are the people who

TABLE 2: Survey respondents' (N = 352) performance of palliative care tasks.

Palliative care tasks	Frequency score*			Attitude score**			Competency score***		
	1-2	3	4-5	1-2	3	4-5	1-2	3	4-5
Work package 1: talking with clients and their relatives about living with a serious illness									
(1) Practical consequences (clients)	19.9%	21.5%	58.6%	2.6%	7.1%	90.3%	8%	24.7%	67.3%
(2) Practical consequences (relatives)	23.9%	18.8%	57.3%	2.3%	6%	91.7%	15.1%	21.7%	63.2%
(3) Financial consequences (clients)	23.9%	42.7%	33.4%	6.5%	9.9%	83.6%	15.1%	36.9%	48%
(4) Financial consequences (relatives)	15.1%	20.2%	64.7%	6%	11.9%	82.1%	7.1%	23.3%	69.6%
(5) Social consequences (clients)	11.7%	24%	64.3%	2.8%	9.7%	87.5%	8.2%	24.4%	67.4%
(6) Social consequences (relatives)	11.7%	24%	64.3%	2.8%	10.8%	86.4%	7.4%	20.2%	72.4%
(7) Psychological consequences (clients)	18.2%	31.8%	50%	6%	12.2%	81.8%	15.1%	36.1%	48.8%
(8) Psychological consequences (relatives)	18.9%	31.7%	49.4%	6.8%	13.9%	79.3%	10.8%	33.3%	55.9%
(9) Religion/spirituality (clients)	65.6%	24.1%	10.3%	29.5%	32.1%	38.4%	52.8%	31%	16.2%
(10) Religion/spirituality (relatives)	63.9%	26.9%	9.2%	40%	28.3%	31.7%	54.2%	29.8%	16%
Work package 2: assessing clients' and their relatives' needs and organising appropriate support and guidance									
(11) Assessing clients' needs	6.6%	11.8%	81.6%	0.9%	2.6%	96.5%	4%	11.2%	84.8%
(12) Assessing clients' needs by using instruments	38.7%	30.1%	31.2%	17%	34%	49%	31.8%	35.2%	33%
(13) Assessing the needs of clients from a different cultural background	43.7%	26%	30.3%	10%	15.1%	74.9%	37%	38.7%	24.3%
(14) Assessing whether financial reimbursements are applicable to the situation of clients	10.3%	15.8%	73.9%	2%	8.5%	89.5%	10.8%	14%	75.2%
(15) Assessing relatives' needs	16.5%	22.2%	61.3%	4.8%	11.9%	83.3%	6.3%	22.2%	71.5%
(16) Assessing the needs of relatives from a different cultural background	44.6%	29%	26.4%	13.1%	23.4%	63.5%	32.4%	42.3%	25.3%
(17) Assessing whether financial reimbursements are applicable to the situation of relatives	25.3%	21%	53.7%	11.1%	15.1%	73.8%	17.7%	22.8%	59.5%
(18) Guiding clients to professional forms of support	11.1%	10%	78.9%	3.1%	4.6%	92.3%	5.4%	11.7%	82.9%
(19) Guiding clients to nonprofessional forms of support	15.2%	17.5%	67.3%	4.6%	8.3%	87.1%	10.3%	18%	71.7%
(20) Supporting relatives after the death of a client	31.6%	28.8%	39.6%	8.5%	16.8%	74.7%	16.8%	31.8%	51.4%
Work package 3: contributing to clients' care planning									
(21) Talking with clients about advance care planning	28%	33.4%	38.6%	4.6%	12.9%	82.5%	14.8%	33.9%	51.3%
(22) Mediating conflicts between clients and their relatives	40.9%	32.7%	26.4%	9.1%	19%	71.9%	24.5%	37.3%	38.2%
(23) Checking whether clients and relatives understand the situation	18.8%	23.9%	57.9%	4.5%	11.6%	83.9%	11.9%	25.9%	62.2%
(24) Checking whether clients are able to make decisions themselves	21.7%	25.1%	53.2%	4.5%	12.2%	83.3%	17%	28.4%	54.6%
(25) Involving a legal or nonlegal representative when clients are unable to decide themselves	25.6%	23%	51.4%	3.4%	11.4%	85.2%	13.9%	25.9%	60.2%
Work package 4: advocating for clients' and their relatives' needs									
(26) Advocating for clients' needs	13.7%	19.4%	66.9%	2.6%	5.1%	92.3%	5.4%	17.6%	77%
(27) Advocating for relatives' needs	19%	26.4%	54.6%	5.7%	9.9%	84.4%	8.5%	23.9%	67.6%
(28) Advocating for relatives' needs after the death of a client	41.5%	28.4%	30.1%	10.8%	18.8%	70.4%	23.6%	32.2%	44.2%

Table 2: Continued.

Palliative care tasks	Frequency score*			Attitude score**			Competency score***		
	1-2	3	4-5	1-2	3	4-5	1-2	3	4-5
Work package 5: sharing information on the care trajectory with clients and their relatives									
(29) Starting a conversation about the end-of-life with clients	30.6%	31.4%	38%	14.5%	27.9%	57.6%	27.1%	38%	34.9%
(30) Answering clients' questions on the end-of-life	39.3%	31.2%	29.5%	9.4%	18.9%	71.7%	28.4%	35.8%	35.8%
(31) Starting a conversation about the end-of-life with clients from a different cultural background	66.5%	23.8%	9.8%	19.9%	23.9%	56.2%	57.8%	30.8%	11.4%
(32) Starting a conversation about the end-of-life with clients' relatives	41.5%	29.8%	28.7%	15.1%	23%	61.9%	24.1%	35.8%	40.1%
(33) Answering relatives' questions on the end-of-life	36.8%	29.1%	34.1%	10.8%	17.9%	71.3%	22.9%	39.3%	37.8%
(34) Starting a conversation about the end-of-life with clients' relatives from a different cultural background	65.3%	23.9%	10.8%	21.9%	23.3%	54.8%	54.3%	33.8%	11.9%
Work package 6: evaluating the care planning									
(35) Adjusting clients' care plans	37%	27.9%	35.1%	12.5%	17%	70.5%	23.6%	29.1%	47.3%
(36) Recognising gaps in clients' care plans	36.9%	27%	36.9%	12.3%	14.2%	73.5%	25.9%	29.9%	44.2%
(37) Reporting gaps in clients' care plans	39.3%	28.8%	31.9%	13.7%	15.7%	70.6%	27.9%	28.5%	43.6%
Work package 7: cooperating with other care professionals									
(38) Cooperating with other care professionals to guide and support clients	8.3%	15.7%	76%	0.9%	4%	95.1%	3.7%	14.9%	81.4%
(39) Referring clients to other care professionals	6.6%	15.1%	78.3%	0.9%	2.3%	96.8%	4%	13.2%	82.8%
(40) Referring clients to specialised palliative care	23.4%	18.6%	58%	4.9%	7.7%	87.4%	10%	26.4%	63.6%
(41) Defending the social work perspective in discussions with other care professionals	27.7%	29.1%	43.2%	4.9%	17.7%	77.4%	14.6%	30.6%	54.8%
Work package 8: sharing knowledge and skills with other care professionals									
(42) Clarifying the importance of addressing the practical consequences of a serious illness	34.1%	27.2%	38.7%	7.8%	17.5%	74.7%	14.5%	29.5%	56%
(43) Clarifying the importance of addressing the financial consequences of a serious illness	28.9%	30.9%	40.2%	7.5%	16.4%	76.1%	10.9%	28.7%	60.4%
(44) Clarifying the importance of addressing the social consequences of a serious illness	30.4%	31.2%	38.4%	6.9%	16.6%	76.5%	11.5%	31%	57.5%
(45) Clarifying the importance of addressing the psychological consequences of a serious illness	32.8%	31.9%	35.2%	8.9%	20.1%	71%	17.2%	35.2%	47.5%
Work package 9: reflecting on own social work practices									
(46) Thinking about own limits in guiding and supporting clients	17%	32.2%	50.8%	2%	8.9%	89.1%	8.9%	37.4%	53.7%
(47) Finding balance between letting a case go and sticking to it	11.8%	31.3%	56.9%	1.4%	8%	90.6%	8.6%	38.4%	53%
Work package 10: politicising social work									
(48) Recognising structural problems in the guidance and support of clients	40.4%	36.4%	23.2%	7.7%	19.2%	73.1%	24.7%	40.8%	34.5%
(49) Addressing structural problems in the guidance and support of clients	45%	33.7%	21.3%	8.9%	19.8%	71.3%	29.2%	41.5%	29.3%

*Frequency scores-how frequently do you perform this task?: 1-2 (infrequent)/3 (not infrequent)/4-5 (frequent). **Attitude scores-how important do you consider this task for your social work practices?: 1-2 (unimportant)/3 (not unimportant)/4-5 (important). ***Competency scores-how competent are you to perform this task?: 1-2 (not competent/3 (not competent, not incompetent)/4-5 (competent).

TABLE 3: Highest type I* disconfirmation scores between respondents' attitudes regarding the performance of palliative care tasks and the frequency with which these are performed ($N = 352$).

Palliative care tasks	Type I disconfirmation score
(1) Starting a conversation about the end-of-life with clients from a different cultural background	29%
(2) Starting a conversation about the end-of-life with clients' relatives from a different cultural background	28.9%
(3) Assessing the needs of clients from a different cultural background	26%
(4) Addressing structural problems in the guidance and support of clients	24.6%
(5) Recognising structural problems in the guidance and support of clients	22.9%
(6) Mediating conflicts between clients and their relatives	21.3%
(7) Advocating for relatives' needs after the death of a client	20.7%
(8) Assessing the needs of relatives from a different cultural background	20.6%
(9) Reporting gaps in clients' care plans	18.6%
(10) Recognising gaps in clients' care plans	17.9%

*Type I disconfirmation score: tasks that are considered important for social work practices (score 4-5 Likert scale) but not frequently performed in practice (score 1-2 Likert scale).

you should talk to and get to know better to understand their situation!"

Fifth, tasks related to evaluating care plans are considered important but not frequently performed. High disconfirmation scores were found for the tasks of recognising (17.9%) and reporting (18.6%) gaps in clients' care plans. Focus group participants explained this by stating that social workers are not structurally involved in the development or evaluation of care plans, which was especially emphasised by the nursing home social workers. As one participant put it, "I never considered social work as being a purely administrative job. We have to be able to coordinate the care planning and adjust it when necessary. We need to be the spokespersons of clients and relatives and continue to point out their wishes to other care professionals."

3.2.3. Social Workers' Competencies regarding the Performance of Palliative Care Tasks. More than 50% of respondents felt competent to perform the majority of palliative care tasks listed in this study (28 out of 49 tasks). Respondents felt competent to assess (84.8%) and advocate for (77%) clients' needs, especially the applicability of financial reimbursements (75.2%). Respondents also felt competent to guide clients to professional forms of support (82.9%), to cooperate with other care professionals (81.4%), and to refer clients to them (82.8%).

Respondents felt that they were not competent to perform tasks in two areas. First, more than a quarter of respondents felt that they were not competent to start a conversation with clients about end-of-life (27.1%) or answer questions on end-of-life matters (28.4%). This was especially the case with clients or relatives from different cultural backgrounds. A majority of respondents felt that they were not competent to start a conversation about end-of-life issues with clients (57.8%) or relatives (54.3%) from different cultural backgrounds. A majority of respondents also felt they were not competent to talk about religion or spirituality with clients (52.8%) or relatives (54.2%), which could be important in this group. Second, more than a quarter of respondents felt that they were not competent to

recognise (25.9%) or report (27.9%) gaps in care plans for individual clients, as well as to address structural problems observed in care plans (29.2%).

To compare respondents' competencies regarding the performance of palliative care tasks and the frequency with which they perform them, TYPE I and TYPE II disconfirmation scores were calculated. All scores were between 0% and 10%, which implies that respondents gave similar scores on the variables measuring their competency regarding the performance of tasks and the variables measuring the frequency with which they perform these tasks. Consequently, there are no tasks for which a substantial number of respondents indicated that they do not feel competent to perform them, while frequently performing them, or vice versa.

Focus group participants explained the low disconfirmation scores as follows: when social workers frequently perform certain palliative care tasks, they will also feel more competent to perform these tasks and vice versa. According to the participants, this is a direct consequence of the lack of content on end-of-life themes in educational curricula and the necessity to gain work experience to develop competencies. As one hospital social worker explained, "I am less competent to evaluate care plans just because I just do it less." A colleague responded that "We don't learn how to do this during our education time so it all depends on the specific service you are working in. [. . .] You gradually learn to perform these tasks as you perform them."

3.3. Appreciation of Social Workers by Other Care Professionals in Palliative Care. Figure 1 illustrates the level of appreciation respondents indicated they had experienced from other professionals in palliative care. The first graph shows how often respondents feel appreciated for their views by other care professionals, while the second graph shows how often respondents experience that these views are considered.

Although 76% of respondents indicated that they frequently cooperate with other care professionals, they do not always feel appreciated for their views on end-of-life matters.
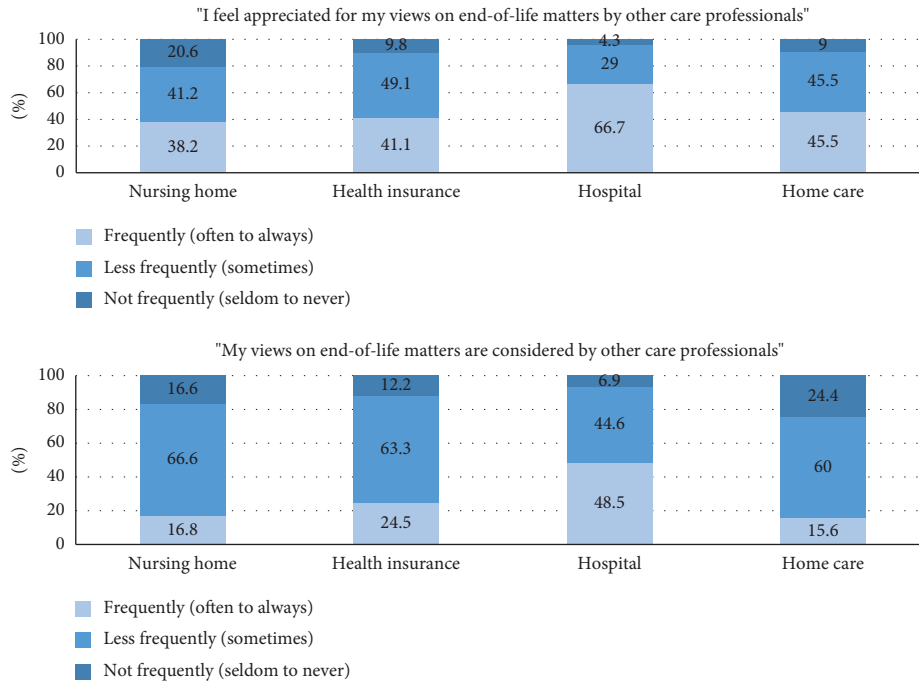
FIGURE 1: Appreciation of social workers by other professionals in palliative care ($N = 352^*$). *Nursing homes ($N = 34$), health insurance services ($N = 117$), hospitals ($N = 149$), and home care services ($N = 47$).

Two findings deserve further explanation. First, hospital social workers are the only group in which a majority of respondents (66.7%) frequently feel appreciated (compared to 38.2%, 41.1%, and 45.5% in nursing homes, health insurance, and home care services, respectively). Focus group participants, however, nuanced this result by pointing out the difference between acute and chronic hospital services. As one participant put it, "Appreciation depends on colleagues and multidisciplinary cooperation. In the geriatric service, I am just as important a member as the occupational therapist or the physiotherapist. In acute services, however, this is not the case. The role of social workers is really limited there." Second, nursing home social workers feel least appreciated for their views, as a fifth of the respondents in this group (20.6%) indicated that they seldom or never feel appreciated by other care professionals (compared to 9.8%, 4.3%, and 9% in the health insurance services, hospitals, and home care services, respectively). One participant in the focus group explained this result by pointing to the limitation of the social worker's role to administrative tasks, while another participant described the general underappreciation of nursing home staff.

Furthermore, a majority of respondents in each organisational group indicated that their views on end-of-life matters are not always considered by other professionals. However, there was a substantial difference between hospital respondents and the other organisational groups. In the former group, 48.5% of respondents indicated that their views are frequently considered, compared to 16.8%, 24.5%, and 15.6% in nursing homes, health insurance, and home care services, respectively. In the focus groups, hospital social workers explained this result by pointing to their responsibilities in the hospital discharge

process. As one participant commented, "They (other care professionals) need us to discharge patients from the hospital. [...] Our views are frequently considered because we have a practical function in the hospital. The sooner we act, the faster patients can leave. [...] Because of this we can exert pressure but there are of course also many discussions." However, participants from all groups did not describe such discussions as disturbing, but rather as a precondition to critically examine the care provided. As one nursing home social worker commented, "I feel that other professionals do not always take my view into account. I do not have a monopoly on the truth so it is not even necessary. Yet, I always try to expand the views of others. You just have to be critical as a social worker. So, even if they do not agree, we should at least be able to have a discussion!"

4. Discussion

This mixed-method study explores the palliative care capacity of social workers in Flanders, defined as their "ability to perform generic and discipline-specific tasks in palliative care." The results show that respondents have a positive attitude regarding the performance of palliative care tasks and the competencies to perform the majority of them. Nevertheless, the results also illustrate that respondents in various care settings in Flanders do not always feel appreciated by other care professionals for their views on end-of-life matters and that these views are not always considered.

Although the palliative care capacity of social workers in Flanders is limited to tasks related to the assessment and referral of clients, their potential role extends beyond these tasks. There are, for example, tasks for which respondents in this study have a positive attitude but which they do not

frequently perform. However, these are tasks that we may expect to be performed by social workers for two reasons. First, social workers are well-positioned to address the social dimension of palliative care, for example, by involving clients' social contexts [2] and by acting as a bridge between clients, relatives, and professionals in care institutions [16]. Although respondents in this study do not frequently mediate conflicts between clients and relatives or advocate for relatives' needs after the death of clients, they have a positive attitude regarding these tasks. This also applies to tasks related to evaluating care plans, through which they could ensure that the wishes of clients and relatives are respected by all professionals involved. Second, tasks related to politicising work are discipline-specific tasks through which social workers can put typical social work values, such as social justice, into practice. For example, by performing a politicising function, social workers can address unequal access to professional palliative care for vulnerable and underserved populations [17, 18] at the organisational or policy level. Although they do not frequently perform policitising tasks in palliative care, respondents in this study have a positive attitude regarding the performance of these tasks.

Future research should examine the most acceptable and feasible strategies to expand the role of social workers in Flanders so they can fully address the social dimension of palliative care and engage in politicising work. However, this study points to two important preconditions for implementing this role. First, although respondents indicated having a positive attitude toward the tasks associated with this role, they also indicated feeling less competent or less capable of performing them. The competencies of social workers to perform these tasks must therefore be increased. Second, in line with previous research [16, 19], this study illustrates that competencies in palliative care are a product of education and work experience. For social workers to gain further experience, it is important to increase their actual involvement in palliative care by addressing contextual factors that prevent them from performing tasks related to an expanded role. All Flemish care organisations should therefore improve the appreciation of social work in palliative care among other care professionals, which can, in turn, increase the job satisfaction of social workers [20]. Furthermore, as focus group discussions also pointed to a lack of time and resources or the nonstructural involvement of social workers in multidisciplinary cooperation, these factors must also be considered.

The contribution of this study is twofold. First, the study contributes to contemporary social work research by addressing the need to further examine the role and involvement of social workers in the broader field of palliative care (i.e., the field of death, dying, and bereavement). Additionally, it may inspire other researchers to consider our approach to palliative care capacity, namely the idea that social workers' ability to perform tasks not only depends on competencies. It is equally important to consider their attitudes toward palliative care tasks [21, 22] and contextual factors that facilitate or hinder the performance of tasks [10]. Second, this study contributes to overall palliative care practice in Flanders. As medical professionals cannot address all realms of death, dying and bereavement, holistic, and multidimensional palliative care practice requires the actual involvement of other professionals such as social workers. This study shows that social workers in Flanders can contribute to a holistic and multidimensional approach to palliative care by specifically addressing the social dimension of care. Therefore, palliative care practice can be improved overall if there is more actual social work involvement and more opportunity for social workers to gain experience in this field.

This study has three limitations. First, the results of this study are not representative of the whole population of social workers in Flanders due to the lack of an existing sampling frame. To account for this limitation, we constructed a theoretical sampling frame aiming to reach as many social workers as possible in relevant care settings. Moreover, by adopting the principles of triangulation between methods in the sequential explanatory design, we ensured that we got as clear a picture of the situation as possible. Second, for the sake of clarity, the differences between the various groups based on organisational affiliation were not fully addressed in this article. However, our data remain available for future research or practice development that aims to examine and address the differences between the various groups. Third, the opinions of other professionals on the social work role and the involvement of social workers in palliative care were not covered in this study. This could also be addressed in further research.

5. Conclusion

The palliative care capacity of responding social workers in Flanders, defined as their "ability to perform generic and discipline-specific tasks in palliative care," is limited to tasks related to client assessment and referral. However, as their potential role extends beyond these tasks, future research should examine the most feasible and acceptable strategies to expand the role of social workers so they can fully address the social dimension of palliative care and engage in politicising work. An expanded social work role and increased involvement of social workers would contribute to a holistic and multidimensional approach to palliative care practice. Nevertheless, this study points to a need to increase the competencies of social workers for tasks associated with this role and to address relevant contextual factors that prevent social workers from performing these tasks.

Data Availability

The quantitative data are currently available upon request from the corresponding author and they will be made available in a depository. Access to the qualitative data is restricted for privacy reasons as focus group participants could potentially be recognised and traced.

Additional Points

What is known about this topic? (i) Social workers are well-positioned to make meaningful contributions in palliative care. (ii) Social workers are inadequately involved in daily palliative care practice. What this paper adds? (i) This study contributes to the literature on the potential role and actual involvement of social workers in palliative care. (ii) This study shows that responding social workers in Flanders primarily perform tasks related to client assessment and referral, while their potential role extends beyond these tasks. (iii) We suggest that expanding the role of social workers would contribute to a more holistic and multidimensional approach to palliative care.

Disclosure

Conflicts of Interest

The authors declare that there are no conflicts of interest with respect to the research, authorship, and/or publication of this article.

Authors' Contributions

All authors participated in the discussion on the design of this study, data collection, and data analysis procedures. BT was primarily responsible for implementing data collection and data analysis procedures and conducted the main writing process of this article. All authors provided feedback on the interim results of the data analysis, critically revised the different versions of the manuscript, and read and approved the final manuscript.

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