

Effective Social Work Practice in Adult Services: A Core Curriculum

Presented by:
The Adult Services Section
NC Division of Aging and Adult Services

In collaboration with:
The Center for Aging Research and Educational Services (CARES)
Jordan Institute for Families at the School of Social Work
UNC-Chapel Hill

The Workshop at a Glance

This curriculum provides new social workers in adult services with the opportunity to review the fundamentals of the Family Assessment and Change Process for working with clients and their families from the screening and intake process to case closing.

Agenda

Day 1

Family Assessment and Change Process
Basic Counseling Skills
Lunch
Screening and Intake
Emergency and Crisis Intervention

Day 2

Introduction to Functional Assessment
Social Assessment
Environmental Assessment
Lunch
Mental Health Assessment

Day 3

Physical Assessment
ADL/IADL Assessment
Economic Assessment
Lunch
Service Planning
Ethnicity
Review

Learning Outcomes for the Curriculum as a Whole

By the end of the training, participants will:

- Explain and demonstrate the steps in the Family Assessment and Change Process
- Explain the major concepts of *A Model for Excellence in Adult Services Supervision and Social Work Practice*.
- Describe how awareness of and sensitivity to cultural differences affect social workers' relationships with adults and their families.
- Demonstrate the use of record-keeping tools for each step of the Family Assessment and Change Process.

Activities that support this objective

- In each module, participants will review the associated step in the Family Assessment and Change Process.
- Participants will identify different family structures and the cultural contexts that support them.

Participants will practice using the record-keeping tools for each phase of their work with clients and families, following the Family Assessment and Change Process.

Overview of the Event

This workshop is sponsored by the Adult Services Section of the North Carolina Division of Aging and Adult Services.

The Core Curriculum was designed by DSS workers (all divisions) and UNC – CARES to provide an overview of social work practice skills presented in *A Model for Excellence in Adult Services Administration and Practice*, developed in association with the Adult Services Section in 1992.

Although this was some time ago, there may still be copies at the DSS

Guiding Principles of the Family Assessment and Change Process

Support: To provide basic resources directly to meet needs, typically in the form of concrete services and emotional aid for clients and families.

Enable: To enhance the client's ability to solve problems and achieve goals by providing information and access to resources, strengthening coping skills, and changing conditions that impede the client's progress.

Empower(ment): Status reached when the client and family believe in their own abilities to manage their lives more effectively and are motivated to do independent problem solving.

Name some behaviors that social workers as professionals exhibit when we support, enable, and empower clients

- Linking clients to services
- Targeting questions to guide activity
- Assessing clients' needs
- Actively listening
- Showing empathy
- Being nonjudgmental (aware of own values)
- Doing research: identifying resources
- Helping clients navigate the system
- Advocating
- Facilitating
- Helping client and family members communicate

The goal of the core curriculum is to provide knowledge tools to be able to do this and that the ultimate goal is to help clients bring about the change they want by assessing, setting goals, making strategies to accomplish them.

Work with clients isn't forever, that like the scaffolding of a building under repair, they help people get what they need to make changes, but after a finite period, but the structure stands on its own. The purpose of Core is to provide a foundation of knowledge for social workers who work with adults and their families to help their clients bring about change in their lives.

Exercise: Creating Your Own Family

Purpose

This activity is designed for participants to think about what constitutes a family. It leads into the discussion of the module's focal point, Family-centered Practice.

Learning Outcomes

Participants will:

- Generate various definitions of family from this group activity and discussion
- Define strengths of their own families
- Understand how changes in the well-being of any family member change the status of other family members.

Think about our own families, but in a different way than you may have done before.

Process of the Activity

Participants may ask whether it's o.k. to include people not related by blood or marriage and pets in their family picture. Assure them that anyone they consider to be family is family.

Write down and draw members of their family on the index card. You might suggest that they remember how they drew their families when they were kids—that's what you're looking for, rather than polished portraits. Alternately, you might begin drawing your own family on a piece of flip chart paper—use stick figures or other simple representations.

- What would happen to your family if that member were no longer a part of it?

- What important role does that family member have within your family unit?
- Would relationships change among the other family members? How?
- How would you feel if that person were no longer part of your family?

Third Step

Why it is important to understand who the client's family is. Possible answers include:

- We understand who is important to the client.
- We find sources of strengths and other possible resources.
- We find a way to demonstrate respect for the client and family by showing willingness to get to know who is in their life.
- Understanding family relationships can help us understand what kinds of interventions will work and what kinds probably will not.

This curriculum is about working with clients and their families within an assessment process and that getting to know the client and their family is an important first step in family-centered practice.

Step 4: What's a Family?

The basic philosophy of this training is that:

- Clients define who belongs to their own families.
- Their *client* is the family as a whole, although one individual may be the point of contact with the agency.
- That service delivery interventions often do not work unless they take into account family and the effect of change on any member.

Principles for Practice: Family-centered, Person-centered, and the NASW Code of Ethics

Purpose

There are three related sets of guidelines for excellent practice in adult services: Family-centered principles developed under the auspices of the Adult Services Section; the NASW Code of Ethics, which provides the foundation for the family-centered principles; and the principles of person-centered practice.

Learning Outcomes

Participants will learn:

- How and why the family-centered principles were developed.
- What they cover.
- How they relate to the NASW Code of Ethics, and what it is
- How they relate to the state's more recent initiative to promote person-centered practice.

Basics of Person-centered Thinking

- Four principal reasons for using a family-centered approach.
- Implications of using a family-centered approach
- Thumbnail sketch of the principles

“So why all these principles? Why are they important? How are they useful to your everyday work with clients?” Some answers might include:

- So we all play by the same rules and understand the same things about our work.
- So we have guidelines for good practice.
- So we have ways to make decisions when we face challenges in practice.
- So people know what our agency stands for.

Process of the Activity

In 1995 the Adult Services Branch of the Division of Social Services convened a group to develop family-centered principles.

Here’s how **Suzanne Merrill**, then head of the Adult Services Section, summarized the principles in a 1997 interview: “The first two principles address how family-centered practice helps individuals and families achieve optimal outcomes, and also how communities benefit. Principles three, four, and five are really the heart and soul of the approach—why it’s important to work in a family-centered way. Those three principles recognize that families define themselves, that families really understand themselves best, and that all families have strengths. Principle four recognizes the individuality of consumers, as well their interdependence with other family members.

Principles six, seven, and eight focus on core beliefs—the rights of families and the importance of recognizing their unique histories, roles, and cultures. These principles also recognize that all families have value and that they’re capable of change and success. Principles nine through twelve recognize differences among families, and how critical it is for social workers to be open to those differences. The last three principles focus on how family-centered practice occurs in an agency, the flexibility required to meet the different needs of families, and acknowledge the NASW code of ethics as a guide for our profession.”

Activity: Family-centered Principles into Practice

Purpose

Learning Outcomes

- Participants will become familiar with the family-centered principles and associate them with their own practice experience.

Process of the Activity

Why it might be important to use a family-centered approach to practice.

What some of the implications for social workers are of being family-centered.

Evaluating the Learning/Transition

Why a code of ethics is important to their work with clients and families. Some answers might be:

- Sets a standard for professional practice
- Protects clients by defining bad behavior
- Enhances practice by defining good behavior

Ethics: Values and Legal Responsibilities of Social Workers

Learning Outcomes

Participants will:

- Identify the six legal duties of Social Workers
- Understand the six core values of the NASW Code of Ethics

Why it is important for social workers to have a Code of Ethics.

- Protection for the worker
- Guide for actions
- Emphasizes importance of human relationships with vulnerable populations
- Sets standards of practice, to protect both workers and clients
- Provides a framework for working with other systems

“Here are the six values the developers of the NASW code thought would be common to everyone who chooses social work as a profession.”

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6 Core Values for Social Workers

- Service
 - Social Justice
 - Dignity and Worth of the Person
 - Importance of Human Relationships
 - Integrity
 - Competency
- (NASW Code of Ethics)

Step 2, Legal Duties of Social Workers

Are you aware of legal duties you have as social workers? Are there things their agencies require of them?

The 6 legal duties.

Here are some notes about each.

- “Reasonable Standard of Care”
- You must be available to clients you serve
- Educate clients on whom to contact & what to do in case of an emergency
- Before going on vacation, notify clients & ensure substitute professional coverage
- Record keeping in a timely manner

Duty to Respect Privacy

- Includes physical space
- Client’s aspects of personal life Symbolic region (person’s alone to share or reveal as he or she sees fit)

Duty to Maintain Confidentiality

- Confidentiality: professional norm that information shared by or pertaining to clients will not be shared with third parties
- Privilege - refers to the disclosure of confidential information in court proceedings (even higher standard of confidentiality)

Duty to Inform

- Informing clients of the nature and extent of the services you and your agency offer.

Duty to Report

- To report to designated governmental authorities indications of certain “outrages against humanity”

Duty to Warn

If a client reveals an intent to harm another person and you determine that the client might act upon that intent in such a way as to endanger another person, then you must;

- Try to arrange for protective supervision of the client
- Warn the intended victim or victims of the threat
- Notify legal authorities of this danger

A Brief Introduction to Person-centered Thinking

Purpose

The state has long supported family-centered practice, and more recently it has added a new set of complementary tools with the adoption of person-centered thinking as a way to interact with clients, particularly during the process of developing service plans. Although endorsed by the state Department of Health and Human Services, reflected in the handout you’ll give participants, it may not be altogether clear how these two approaches fit together. The value of PCT is more immediately apparent in the discussion of service plans, but during the information-gathering phase of assessment, workers have an excellent opportunity to understand more about clients’ and families’ preferences for receiving services.

Learning Outcome

Participants will

- Learn a little about this initiative.

Counseling in Adult Services

Purpose

Adult services social workers use a functional approach to counseling, focusing on problems that will be identified during the assessment as being internal to the client or the client’s family system. The service plan specifies counseling as the appropriate intervention to address identified functional problems related to the client or family’s use of internal resources. For the most part, counseling in county department of social services is not focused on changing a clients’ personality in the way that therapeutic counseling would be. Rather, its purpose is to collaborate with client in the short term to make changes in specific attitudes, emotions, and actions that might interfere with

their use of services, prevent them from obtaining support from others, or block their ability to cope independently.

Learning Outcomes

Participants will

- Understand the scope and limitations of counseling in adult services
- Identify and practice three important counseling skills to use in their practice.

Are you counselors in your work at DSS?

What skills participants use in counseling clients? Some answers may include:

- Get clients to think about things, solve problems (engagement)
- Encouraging clients to communicate
- Listening for things beyond just the words, empathic listening (feeling, content)
- Reflecting what clients say
- Purposeful conversations with clients—always a goal in mind
- Redirection: get conversation onto purposeful direction
- Helping people weigh choices about what to do—information brokering
- Validation and encouragement

Where counseling fits in the Family Assessment and Change Process (just about everywhere).

Skills in counseling:

- Relationship building
- Matching the client's words
- Skilled use of verbal and nonverbal language
- Diffusing anger
- Asking open, nonjudgmental questions
- Empathic listening
- Demonstrating respect for the client.

Why it is important to convey empathy, genuineness, and respect to our clients? What happens if we don't show these behaviors to our clients?

This module will focus on three counseling skills: relationship building, setting limits, and active/empathic listening.

Second Step: Relationship Building

Why relationship building is so important? Some answers might include:

- Build trust for open communication, accurate information
- Build closeness (collaboration)
- Modeling relationships for clients
- Forming boundaries to demonstrate how to do it

Third Step: Confidentiality

Introduce the next exercise.

Exercise: “Never Tell”

Purpose

This activity will help participants understand clients’ possible reaction/emotions when asked to provide/share sensitive personal information.

Learning Outcomes

Participants will identify two emotions that could evolve/occur when clients must divulge personal information.

Materials

- Flip chart and markers

Fourth Step: Setting Boundaries

What differences are there between personal and professional boundaries?”

Personal/Professional

Information Share personal information Sharing one way, subject specific

Share equally Mutual Not mutual

Names First name Respectful of names

Time Unlimited time Always an end

“Case Study of Mrs. Casey.”

Identify the areas in which they think the social worker has crossed the professional boundary she should maintain with the client.

The social worker, Lynn Newcomer, arrives at the home of Mrs. Laura Casey for an initial visit. Mrs. Casey is a frail, 82-year-old woman whose son has referred her for possible in-home aide assistance. The social worker knocks on the screen door and then walks into the foyer calling for Mrs. Casey. Mrs. Casey meets the social worker in the hallway and hesitantly asks what she wants. The social worker begins to relate the son’s concerns and then she suggests that she and Mrs. Casey go sit in the living room so that they can be more comfortable. Fifteen minutes later, a neighbor knocks on the door and then walks in to visit with Mrs. Casey. As the neighbor sits down with an apparent intention to stay, the social worker introduces herself and begins to chat with the neighbor about a mutual church friend. The social worker relates that she has become increasingly disenchanted with this friend’s handling of a recent fund-raiser and the neighbor totally agrees with the social worker that a move to a new church may be the best thing for this “church friend.” The social worker then turns her attention back to Mrs. Casey and says that she is looking forward to working with Mrs. Casey and that her favorite clients are “sweet little old ladies,” such as herself. The social worker asks some basic information for her forms and then makes another appointment to talk with the son and Mrs. Casey.

Among the issues that should be identified are:

- Arriving without notice for a first visit
- Entering home without being invited
- Suggesting they go into the living room, rather than letting Mrs. Casey choose whether and where to talk to her
- Talking about Mrs. Casey's son's concerns without having established any type of rapport with Mrs. Casey
- Failing to maintain confidentiality by explaining her visit to the neighbor
- Rudeness, ageism, and on and on

What might be the impact of these boundary issues?

- Mrs. Casey may never want to see a social worker again, she might get angry with her son, etc.
- Mrs. Casey's neighbor may discuss with the church friend what the SW said.

What are boundaries and how do we know where they are?

Where do the boundaries become confusing? Do they ever stray over boundaries? Is this a problem (or what problems can occur)? How do you define limits with your client or their family member? When do you define limits?

Does anyone has a method which reminds them to ensure appropriate boundaries are set with a client in their environment?

Empathic Listening: What Is It?

Ask participants to think about the "not listening" activity and some of the nonverbal ways they knew their partner was listening. Participants will probably name the body language covered by SOLER.

Empathic listening is hearing both the content and the feelings that an individual communicates and reflecting that perception to the individual so that he/she feels understood.

Empathic listening involves:

- Listening to the client
- Understanding them and their concerns accurately
- Communicating this understanding to them and
- Receiving confirmation that the message was indeed correct

Introduction to Emergency and Crisis

Purpose

An emergency or crisis in the care of an older adult can precipitate the need for a family to seek assistance. This section of the curriculum will define the difference between emergency and crisis for the participants of the workshop.

Why do emergency and crisis appear before screening and intake?

Answers might include:

- Often a client will come to you to initiate services because he/she is in the middle of a crisis or emergency.
- Helping the client and the family to deal with a crisis or an emergency before proceeding may be necessary.

For our purposes, an emergency is a situation where the client or family's life and well-being are in danger from some external circumstance. Clients are in crisis when their usual way of coping has broken down—it is a psychological malfunction internal to the client rather than an external situation that threatens the client's well-being.

What can participants do to help someone who is agitated or angry calm down. Some of the things you or they might mention are:

- Lower your voice in volume and pitch
- Listen to what the person says
- Stay nonjudgmental (client's crisis may not be yours).
- Reassure the person that they will get through the situation.
- Emphasize that you are their partner in dealing with the crisis.
- Use body language, including touch, if it is appropriate/allowed.

Ask the participants to share the feelings they have had when dealing with an emergency (e.g., high anxiety, pressure for immediate decision making, feelings of inadequacy, etc).

- Pray
- Call a halt for a minute to think
- Compartmentalize
- Make a plan
- Help other people stay calm, take control (fear is contagious, so is reassurance)
- Practice scenarios beforehand so that you can do things immediately (For example, Kathy always looks for the fire exit when she checks into the hotel.)

Does participants have the same feelings when they work with someone in crisis? Why or why not?

What helps and what does not?

Reassure the participants that being able to differentiate between a crisis and an emergency will help them as social workers to respond with a feeling of competence in carrying out the appropriate strategies.

After the participants have had a chance to share some of their experiences, reinforce the differences between an emergency and a crisis, ask them how the social worker's role may differ with each.

Reinforce that in a crisis the social worker is intervening through short term counseling and problem solving to help the client and family find stability and use their coping skills and resources. Crisis intervention is a kind of emotional first aid.

Reiterate that in an emergency, the social worker must work with the client to obtain tangible resources and/or take immediate actions.

Point out that one of the major problems social workers have in dealing with clients in crisis is getting caught up in the client's crisis. We may feel compelled to jump in and "fix" the problem because we know that people usually only turn to professionals for help when their usual methods

of coping (e.g., self-help, support from family and friends, and from other informal systems) are inadequate to meet the challenging situation. Our pressure to perform well for them may be intense. Additional points to make:

There are several problems with trying to fix the crisis for the client. First, it may hinder the client's ability to respond and see options if someone is willing to do this for them. Second, it prevents the client from continuing to respond to the next crisis. This can also make it difficult for clients (and sometimes for the social worker) to see the crisis as an opportunity for change.

Suggest that instead of trying to "fix" the crisis, the social worker may adopt the role of supporting and increasing the client's problem-solving skills to get through the crisis.

Screening and Intake

Purpose

In this module, you will examine the processes of screening and intake and its initial impact in the Family Assessment and Change Process. You will discuss how the environment and the worker's skills during this initial contact with the client and family can affect the services a family receives as well as the relationship that develops between the social worker and the client and family.

The processes of screening and intake set the tone for all future work with the client and family. The first core activity in the Family Assessment and Change Process is "Screening and Intake." Screening can occur either before the intake process begins or during the intake process. Often it happens at both points.

The definition of screening is "a function performed by a worker, with/before referral, and/or at the intake meeting with involves identifying variables and risk factor that indicate the need for referral, help match the family with possible service interventions, and may suggest how quickly action is needed in an emergency or crisis situation." (*A Model for Excellence*, 1992, p. 320)

Show the PowerPoint for screening

Screening is a brief assessment of need and risk. It can serve to match potential resources to the client and family or indicate a need for further assessment and involvement with the agency. The main task of the worker is to gather sufficient information for initial decision making and to begin to create a positive climate for future work with the client and family.

Intake begins with an inquiry by a potential client or family member and ends when an official case record is opened and referred to a social worker for assessment or to some other program. Many clients' problems/needs may be resolved through information provided at intake and no further assistance is needed.

The primary purpose of intake is to match a request for help with the most appropriate sources of that help (*A Model for Excellence*, 1992, p.318).

The intake meeting initiates the relationship-building process and sets the tone for all future work with the client and family throughout the entire Family Assessment and Change Process. For this reason, the circumstances under which this initial contact occurs deserve close attention. Note that the intake meeting can take place in the office or in the home.

The role of the intake worker is to initiate the client and family into the helping process support and empower them from the beginning. Factors such as the physical environment, how the client and family are greeted, what their wait may be like, how knowledgeable and skilled the worker is, affect the success of this initial meeting. Because intake is so challenging, agencies and workers

should prepare themselves as much as possible through training, review of procedures, effective communication between and among workers with different responsibilities, and attention to the environment and paperwork requirements.

List characteristics of a skilled intake worker. You may want to put their responses on the flip chart. Here are some possibilities:

- Good listener
 - Shows genuine concern
 - Asks about clients' concerns
 - Has a nice voice, pleasant personality
 - Normalizes the experience
 - Knowledgeable about services
 - Good at hearing what isn't being said
 - Focused
 - Conveys verbal and nonverbal messages about respect
 - Respects people's time
 - Maintains appropriate eye contact, good facial expression
-
- The intake and screening process can set the tone for all future contacts. Creating a comfortable and supportive environment for the client and family includes paying attention to the physical environment as well as to relationship-building and counseling skills.
 - The physical environment and how the agency moves the client through the intake and screening process can send powerful messages to the client (e.g., "We value your privacy." "We want to make this easy for you." "We respect you." "We are family-centered." "We want to work with you." "We are competent.").
 - The environment is also important for the worker. Does it support the worker in making a good first impression? Are conversations private? Does it enable workers to use their skills optimally by not creating barriers to their relationships with clients? (For example, clients are not frustrated by the time they get to see the social worker.) Do agencies have strategies for maintaining the safety of the workers?

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Day 2

Introduction to Functional Assessment

Social Assessment

Environmental Assessment

Lunch

Mental Health Assessment

Introduction to Functional Assessment

In this session, the facilitator will introduce participants to the concept of what an assessment is, the benefits of doing an assessment, the how-to's of getting the most information, and the components of a functional assessment. It is vital to continually emphasize defining the strengths of the client throughout the assessment process.

Learning Outcomes

Participants will identify the risks and benefits of completing a comprehensive assessment.

Potential responses for workers might include:

- Perceived as being nosy
- Concern about interfering with relationship building with the client
- Discomfort about asking certain questions or discussing some topics
- Fear of opening up a can of worms
- Identifying problems they may not be able to help with.
- Potential risks on the part of clients might include:
 - Being perceived as weak or incapable
 - Revealing much and getting little
 - Embarrassment at sharing certain information
 - Fear of violation of privacy or confidentiality
 - Fear of losing control or autonomy.

Acknowledge to the group that these are formidable risks. Additional answers for benefits might include:

- Understanding of the client's and family's perception of problems and strengths
- A thorough, accurate picture of the client's functioning and the family's involvement
- Impact of functioning on identified problems
- Identification of other problems or potential problems
- Picture of strengths, resources, abilities and potentials
- Baseline from which to measure change and progress

Of particular relevance to teaching participants about assessment is what enables people to take risks. Some examples follow:

- The belief that potential payoffs are sufficient for the risk involved
- Adequate information about what is expected of them so they can make informed decisions about how much to risk
- Confidence in the person who is asking them to take a risk (that he/she is knowledgeable, nonjudgmental, competent, etc.)
- Some degree of comfort with process (setting, pacing).

Step Three: What Is a Functional Assessment?

Rationale for doing an assessment

The purpose of assessment is to assure clients receive high-quality, appropriate care.

- Assessment is a means, not an end. It is to be used as a decision-making tool to help clients identify and be specific about problem areas, strengths, and resources as they envision new possibilities for themselves and identify goals.
- Assessment is collaborative process with client and family. It is also a time to help the client and family organize and make sense of their situation. In so doing, the social worker further develops a constructive relationship with them.
- The client and family's perceptions of functioning are essential to obtain. Sometimes social workers will identify a need for counseling rather than, or in addition to, discrete services and case management.
- Getting the family's perception on functioning can add new dimensions of understanding and clarify information.
- Assessment is used to identify functional capacities, resources, and needs.
- Assessment looks at the interaction between clients' abilities (what's reasonable to expect), their perception and motivation (what do they see as problems and how much energy are they prepared to invest in changing things), and their environments, both physical settings and social networks.
- Assessment of functioning is conducted in six domains: social, economic, mental/emotional, physical, activities of daily living and environmental.

Diagnosis and functional assessment are different. Diagnosis may influence but does not predict functioning. Two people with diagnoses of schizophrenia may have very different functioning—one client may work part-time, attend a clubhouse program, and live in an apartment while the other is unable to tolerate the stress of any work activities and must live in a supervised setting. One person with adult-onset diabetes may have the condition under control, while another may have lost vision or a limb. What each can do may be quite different, regardless of similar diagnoses, as may be their needs for assistance.

Information from interdisciplinary perspectives is sometimes necessary and is usually extremely helpful in completing assessments. Social workers can sometimes use existing multidisciplinary teams in the community or interdisciplinary teams within the DSS to get additional perspectives on clients' functioning. They also may refer to multidisciplinary teams in specialized settings such as Geriatric Evaluation Centers or mental health centers for specialized assessment information.

Another informal way that DSS social workers often obtain information from multidisciplinary viewpoints is by calling, writing, or visiting nurses, doctors, pharmacists, and other social workers that are involved with the client.

- From watching: ADLS, IADLS, what's important to the client, household hazards, body language, state of clothing
- From smell: alcohol, cigarettes, bug spray, urine, feces, gas, kerosene
- From listening: slurred speech, unusual thought processes
- Focus the interaction
- Redirect

- Revisit topics, elaborate
- Use prompts—verbal or nonverbal
- Eliminate or reduce distractions for worker or client
- Keep outsiders out of interview if necessary
- Put things “in a storage box” and come back to them later
- Conclude
- Say thank you
- Let them ask questions
- Explain what will happen next
- Give them contact information
- “Is there anything I missed?”
- Make next appointment.

An example of an approach to introducing assessment might be:

“Ms. Jones, you’ve told me quite a bit about the problem and what you’d like to see be different. For me to be most helpful, I need to know even more. I’m going to be asking you some questions to help me learn more about you. Understanding as much as we can about your situation will help us explore all the options for changing things—even options we haven’t thought of yet. Sometimes you may wonder why I’m asking you something. If you do, I’ll be glad to tell you how the information might useful. I’d like to hear from your family, too, to get their ideas on this. I believe that learning as much about your situation as possible is very important in making things better. ”

The Adult Services Functional Assessment tool has been developed to use in recording information gathered in conducting an assessment.

Emphasize that just as assessment is not an end in itself, this paper is a tool to be used in recording information; it is not an end in itself. Tell participants that the tool is not designed to be used as an interview guide.

Benefits of using an assessment tool to track information include:

- Organizing the worker’s efforts—checklist
- Helping workers communicate by using the same language
- Assisting supervisors in providing feedback
- Providing a baseline from which to measure change
- Addressing program and system objectives such as measurements of effectiveness and quality

The Social Assessment

- Use the social assessment portion of the Adult Functional Assessment tool to record information strengths in clients’ social functioning
- Identify strengths and problems in clients’ social functioning

“Why is it important to conduct a social assessment of your clients?” Some answers could be:

- To understand clients’ connections with the people (and pets) in their environment
- To understand clients’ preferences about interacting with people

- To understand more or less recent changes in social connection.

Identify methods in which they gather social information from their clients

You can lead a brief discussion on these areas:

- Reminiscence or storytelling
- Direct questions and answers to either the client, family members, others who know the client
- Ecomap and genogram.

What is the importance of the genogram and ecomap?

Tell them how the genogram is used:

- To clearly identify who exists in the family network (who is or might be available to provide social support to a given person)
- To identify the medical history and patterns of behavior that may be relevant to a person's real or believed medical or psychological status
- To formulate hypotheses about family functioning.
- Describe how the ecomap is used:
- To identify members of the household and extended family, the nature of the relationships among them and the resources they exchange with the client;
- To identify other people and systems in the client/family's social environment and the resources exchanged with them.
- To identify the client/family's relationships with community systems.
- To identify present and past contributions of the client to others
- To identify systems from which additional resources might be available.

Environmental Assessment

Purpose

Participants learn about the importance of completing an assessment of the client's environment and identify linkages between environmental information and other areas of assessment, particularly ADLs and IADLs.

Techniques for Environmental Assessment

- Observation
- House tour
- Ask the family how the client functions at home
- Ask other involved agency staff
- Ask clients what they like and dislike about their home and neighborhood
- Ask clients to demonstrate use of equipment
- Use guide as a prompt when interviewing the client



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“What are clues that your client/family is functioning well in the environmental area?”.

Some responses might be:

- Outside of living area is cared for, maintained.
- Food is put away, no bugs or rodents.
- They have taken time to arrange their belongings.
- The house is reasonably clean, free of dust.
- They use the space well.
- They are able to use the whole house.
- There are no unpleasant odors
- The temperature is modulated to be comfortable to the person.
- Client and family can get to where they want or need to go, both in and around the house and in the neighborhood.
- The client/family feels safe in the neighborhood.

What common hazards have they seen when making home visits? Some responses might be:

- No handicap access.
- Drop cords, fire hazards.
- House difficult to get around in.
- Baseboard heating.
- Older homes/apartments that haven't been well maintained.
- No smoke detector, CO detector.
- Drafts, poor insulation.
- Slippery floors, throw rugs.

- Client is wearing unsafe shoes or slippers.
- Poor lighting.
- Unsafe heating devices.
- Flooring is uneven and steps are difficult to navigate.
- Rugs/carpet and linoleum can be slippery or ragged.
- Phone is not available or is difficult to get to.
- Toilet is far away from where the client usually sits or sleeps or height is hard for the client to manage.
- Tub/shower is hard to get into and out of safely.
- Cabinets are too high to reach.
- Client is using towel racks for support in the bathroom.
- The pipes have burst, or the well isn't working.
- Wood is available for a wood stove, but the client cannot chop it.
- The client can't easily or safely reach across stove to knobs.

Assess the environment to look for things that put the client at risk of falling. Why it is so important that they look at this kind of risk in particular.

- Falls are the leading cause of death from injury among people 65 or over.
- Approximately 9,500 deaths in older Americans are associated with falls each year. The elderly account for seventy-five percent of deaths from falls.
- Annually, falls are reported by one-third of all people 65 and older.
- The risk of falling increases with age and is greater for women than men.
- More than half of all fatal falls involve people 75 or over, only 4 percent of the total population.
- Two-thirds of those who fall will fall again within six months.
- Among people 65 to 69, one out of every 200 falls results in a hip fracture, and among those 85 or over, one fall in 10 results in a hip fracture.
- One-fourth of those who fracture a hip die within six months of the injury.

The most profound effect of falling is the loss of independent functioning. Twenty-five percent of those who fracture a hip require life-long nursing care. About 50 percent of the elderly who sustain a fall-related injury will be discharged to a nursing home rather than return home.

Most falls do not result in serious injury. However, there is often a psychological impact. Approximately 25 percent of community dwelling people 75 or over unnecessarily restrict their activities because of fear of falling.

The majority of the lifetime cost of injury for people 65 or over can be attributed to falls.

What's the key reason to conduct environmental assessments?

To prevent falls.



Why is this important?



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Emphasize that it is important to understand how the client and family view the neighborhood. Is it supportive and comfortable, or is the client a virtual prisoner in his home? Does his garden give him physical and spiritual pleasure, as well as food? Is he able to access transportation he needs to get to services or visit other parts of the community?

Note that HOW people are managing in their environment, despite any possible limitations, is as critical as the severity of the problem. As part of strengths-based practice, it is important to identify and acknowledge how people are overcoming challenges. It is also important to recognize that some solutions will involve lifestyle choices with which the worker may not agree, but that it is important to respect and support these choices.

Mental Health Assessment

Purpose

The overview of mental health issues introduces participants to the module on mental illnesses in the older adult population.

Learning Outcomes

- Participants will identify important issues about mental illness and the older adult

Given the changes to the structure and delivery of mental health services in NC, almost all DSS workers see clients who either have mental illness diagnoses, or should have a diagnosis, but, have not had the benefit of assessment. As community first responders, DSS workers are in a unique position to observe red flags for mental illnesses that warrant further investigation. Think about the 5 domains other than mental health and to give an example or two of how mental illness affects their functioning in that area.

Process of the Activity

Discussion of Mental Illness Functioning

It is important to note that more than any other domain, mental and emotional functioning influence the entire functioning of the client and affect the assessment process.

Ask participants why it is important to assess mental and emotional functioning. Possible responses include:

- To determine need for further evaluation, treatment, or intervention for mental/emotional illness
- To determine validity of responses in other assessment domains (social, economic, etc.)
- To use in assessing capacity to consent to services
- To determine ability to cooperate with service plan
- To have a baseline from which to measure improvement or decline
- To help assess safety risks
- To identify strengths and motivation

The primary areas of assessment are cognitive and emotional functioning—thinking and feelings. If a client has serious problems with cognitive functioning, information obtained from the client for the comprehensive assessment must be carefully verified, and in some cases, workers will need to obtain most information from another person.

If a client has serious emotional problems—for example, depression—the illness can negatively bias the client’s perception of problems and potential solutions and sap motivation. Thus, it is important to assess mental functioning for its own sake (in the sense of raising the question of need for treatment) and for its impact on the client’s functioning in other areas.

Strengths in Mental and Emotional Functioning

Participants are assessing mental/emotional functioning not only for problems that clients might have, but also to identify strengths in this domain.

What are characteristics that indicate strengths in mental and emotional functioning? Among the responses you might expect to see are:

- Good coping skills
- Resilience
- Intact memory
- Ability to manage stress
- Ability to learn
- Ability to develop and maintain positive relationships with others
- Positive attitude
- Healthy self-esteem.

Mental illness has been treated differently than other illnesses. One of the reasons people are often uncomfortable talking about mental illness is because of the stigma associated with it. Where does the stigma come from? To some degree, it comes from the historical treatment of mental illness.

Early on, mental illness was perceived to be possession of evil spirits, and people were chained and beaten. Later it was associated with moral shortcomings—if people just tried hard enough, they could pull themselves out of their problems. More recently, families, especially mothers, got the brunt of blame for causing mental illness. Only in the past 15 years or so have we begun to understand the biological and genetic aspects of mental

illness. This understanding has taken away some of the blame and made it easier to see some of the more severe mental illnesses as brain diseases. Stigma has begun to decrease as a result of several factors, including attribution of causation to biological causes outside of the patient or family's control; new treatments that have been demonstrated to be effective—new medications such as

Prozac for depression and Clozapine for schizophrenia; \new forms of psychotherapy such as cognitive behavioral therapy; and a consumer movement in which people with mental illness and their families have stepped forward to tell their stories and advocate for appropriate services. Stigma gets at some of the reluctance in discussing mental functioning, but not all. Another barrier is the discomfort of communicating with someone who is behaving very differently from our sense of what is normal. Carrying on an interview with someone who is hearing voices, stringing unrelated phrases together, or behaving peculiarly can be unnerving—particularly if you have little knowledge about mental illness. Knowledge, skills, and practice can go a long way toward alleviating difficulties in talking about mental illness. When social workers feel competent and confident about assessing mental and emotional health and know they will do something useful with the information they obtain, they are more comfortable with this assessment.

Cognitive Disabilities

Because older adults are at higher risk for cognitive disabilities, this module focuses on warning signs of conditions that cause memory impairment.

Participants will be able to:

- Differentiate between Age Associated Memory Loss and Alzheimer's Disease
- Identify symptoms of delirium, depression, and dementia

What other cues might give insight into the client's mental status? Ask participants to consider:

- *Thought content.* Assesses what the client is saying for indications of hallucinations, delusions, obsessions, symptoms of dissociation, or thoughts of suicide. Dissociation refers to the splitting-off of certain memories or mental processes from conscious awareness. Dissociative symptoms include feelings of unreality, depersonalization, and confusion about one's identity.
- *Thought process.* Thought process refers to the logical connections between thoughts and their relevance to the main thread of conversation. Irrelevant detail, repeated words and phrases, interrupted thinking (thought blocking), and loose, illogical connections between thoughts, may be signs of a thought disorder.
- *Cognition.* Cognition refers to the act or condition of knowing. The evaluation assesses the person's orientation (ability to locate himself or herself) with regard to time, place, and personal identity; long- and short-term memory; ability to perform simple arithmetic (counting backward by threes or sevens); general intellectual level or fund of knowledge (identifying the last five Presidents, or similar questions); ability to think abstractly (explaining a proverb); ability to name specified objects and read or write complete sentences; ability to understand and perform a task (showing the examiner how to comb one's hair or throw a ball); ability to draw a simple map or copy a design or geometrical figure; ability to distinguish between right and left.
- *Judgment.* Asks the person what he or she would do about a common sense problem, such as running out of a prescription medication.

- *Insight.* Insight refers to a person's ability to recognize a problem and understand its nature and severity.

What sorts of interactions with clients would give them information about this. Here are some possibilities.

- Did the client remember the appointment and know who you are?
- Could the client supply his/her address, phone number, date?

If the client shows any indications of not being oriented or if family or referral sources have expressed doubt in this area, you may choose to assess formally by asking the client where he/she is, what the date is, who you or other people present are, and (if they do not know the other three) who they are.

Emphasize that the point of doing an assessment of mental functioning is not to diagnose clients. The purpose of the mental/emotional assessment is to observe symptoms that:

- Could signal the need for further assessment and treatment
- Could affect the client's ability to participate in assessment and planning
- Cause impairments in functioning.

Observation of significant or persistent symptoms of mental or emotional problems should cause the social worker to encourage the client and family to seek further assessment and possible treatment by a medical or mental health professional.

About 75 percent of the clients who come to DSS Adult Services are older adults. Most of these people do not have mental illness. Of those who do, however, there are four illnesses that most warrant our attention. Two mental illnesses, anxiety and depression, are significant because of the prevalence rate of symptoms among older adults. Two mental illnesses delirium and dementia, are less common, but have very serious implications.

Depression has long been identified as the most common mental illness among older people, but depression among the old is now recognized as being somewhat less intense and pervasive than with younger people.

Recently, some studies have shown symptoms of anxiety to be more pervasive among older people than any other age group. Symptoms of anxiety include fear and excessive anxiety or worry along with other symptoms such as rapid heartbeat, muscle tension, trembling or feeling shaky, difficulty concentrating, dry mouth, irritability, dizziness or lightheadedness.

For older clients, (and others where indicated) the social worker might ask, "Do you have any concerns about your memory?" Tell participants that they should be aware that most older people do not have significant memory problems, but they do have some changes in their memories. And many older people are afraid that these memory changes signal Alzheimer's disease.

If you have concerns that a client's memory needs further assessment, they might say that they "need to ask some questions involving your memory." People with memory problems often continue to have very good social skills and cover their memory deficits by distracting or confabulating (making up stories).

If impaired memory is a concern, it needs to be assessed directly. One relatively simple way of doing a preliminary screen is the SLUMS. Pass it out as a handout and give website address (http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf).

Give background of how this test is different than the MMSE and the Short Blessed.

Tell participants that the SLUMS will not identify some people who may be impaired, but people who are identified by this screening tool as being impaired are very likely to have cognitive problems that warrant further evaluation.

(Optional.) If there is time (about 20 minutes), have participants practice with SLUMS. Have them get into pairs, one playing the worker, one the client. Have the worker introduce the SLUMS exam and ask the questions, and then change roles. Discuss the experience.

Step Two: Delirium, Depression, and Dementia

Delirium, which usually comes on quickly and causes confusion and difficulties with attention, is a medical emergency that requires prompt attention. Treatment for the underlying physical condition that causes delirium usually corrects the illness.

Clinical depression is more than the blues. It is not a natural part of aging—it is an illness and a treatable illness. Depression in older people can look like dementia in that it often causes difficulties in concentration and memory. Depression is treatable with medications and psychotherapy and treatment should be actively pursued.

Dementia has different causes—a few that are reversible—but the most common is Alzheimer’s disease. Dementia is impairment in short- and long-term memory as well as in other areas of brain functioning that causes significant problems in work, social activities, or relationships with others. Either of the two conditions mentioned earlier, delirium or depression could occur with dementia and cause excess disability. Treatment should be sought for these conditions to improve overall functioning. Dementia is not curable, but it, too, is treatable, and assistance can greatly enhance the quality of life for the client and the family.

Review the 10 warning signs of mental illness.

Hallucinations and Delusions

Let’s assume that a family member has told you that they think their mother is hearing things but won’t let you refer to them in discussing it. This is a symptom that needs further assessment. If the suspicion of hallucinations is fairly strong, you may choose to work with the family and client to press for further assessment by a medical professional.

On the other hand, you may choose to do further assessment yourself before determining whether additional evaluation is warranted. You might simply and directly ask the client “Do you sometimes see (or hear) things that the people around you don’t see (or hear)?” They could respond “What do you mean?” to which you might say, “Do you ever hear voices telling you things that other people don’t hear?” or “Do you see things that people who are with you don’t see?” If the person admits to seeing or hearing things others don’t, you might ask the client if what they see (or hear) frightens or worries them. Ask if they have ever talked with a doctor about this or taken medication. If so, find out if it helped.

Explain that people who are having hallucinations don’t “think” they are seeing or hearing things, they are. Brain imaging techniques have shown that the brain activity of a person having a hallucination of seeing, for example, an animal approaching is the same as actually seeing the animal coming. This helps explain why you can’t talk a person out of a hallucination. Hallucinations are symptoms in much the same way as fever or diarrhea or pain. Medical treatment for underlying illnesses sometimes cures hallucinations. Medication is also often helpful in alleviating or minimizing hallucinations if there is no cure for the underlying illness.

Responding to the feeling that the hallucination or delusion arouses (fear, anger, etc.) is appropriate. You are not, however advised to agree with the content or to try to talk people out of their beliefs. Something like, “I don’t see the strangers, Mrs. Jackson, but I can see how frightened you are” can be helpful in conveying empathy.

If there is suspicion of impaired judgment—something you’ve observed or the family has raised—you will need to ask questions to assess judgment. You need to find out whether the person can recognize and respond to risks. Some sample questions might be “If you are about to run out of the medicine you take every day for your blood pressure, and you don’t have a doctor’s appointment for two weeks, what will you do?” Or “If you were to wake up at night and realize that your power was out and your house was very cold, what would you do?”

Ask participants for examples of other questions people ask to assess judgment. Record on the flip chart.

How to introduce mental health assessment, including creating a climate with these expectations:

- That everyone has feelings of depression and anxiety at times—and many people have more serious problems
- That problems will be shared and discussed
- That clients will not be judged
- That problems will be normalized
- That assessment takes place with recognition of the influences of the client’s culture
- That help is available to those who want it

Social workers will approach mental health assessment with the presumption that the client is mentally healthy but with a high degree of sensitivity to indicators of possible distress. The most important symptoms for DSS social workers to be alert for are those listed on the ASFA tool.

Using the ASFA as an interview guide is not recommended, but routinely probing certain areas with every client is a good idea. These are:

- Activity level
- Mood
- Appetite
- Sleep
- Substance use

You can use the acronym: AMASS.

Symptoms such as suspiciousness, hallucinations, bizarre behaviors, etc., are more likely to be identified by others than through questioning the client. The social worker who is alert to possible signs of mental health problems will identify which areas indicate further specific questioning.

The first four areas (mood, activity level, sleep, and appetite) are likely to be affected if the client is experiencing mental or emotional problems.

These are areas that are relatively easy to probe—that is the client will usually have no problems talking about them with the social worker.

Questions that get at the client’s perception of mental and emotional functioning and their mood include: “How do you think you’re coping with things these days?” “Do you get upset often?” “What is your mood like?” or “Do you often worry about things or feel sad much?” Another way to normalize discussion in this area is to say something like: “The problems you’ve been telling me about are enough to cause anyone to worry some” or “Many people in your situation would get down in the dumps at times. . . . What’s it like for you?” Developing a “formula” that you use

to get at this information can help you feel comfortable introducing this topic. Find words that you are comfortable with, and use them. Ask for examples from the audience.

Tell participants that whatever questions they ask to get clients talking about mood, they will need to allow time for clients to respond fully. Sometimes just waiting or using a minimal encourager such as “oh” or “um” will encourage them to say more. Follow up with more specific questions about what they’ve said. Using the same words clients use can be helpful. Examples might be “What is it like when you’re as nervous as you say?” or “You say you manage o.k., but you look very sad. Do you feel that way often?” You might also ask if there have been times in the past when they have had really difficult times coping with problems.

Ask clients general questions about their activity level, appetite, and sleep, and about recent changes in these areas. Significant increases or decreases often signal mental or emotional problems. When asking about sleep problems, it is helpful to know if they have trouble getting to sleep, staying asleep, or waking early and being unable to return to sleep. Early morning waking are often associated with depression. Markedly increased or decreased appetite can signal depression. And increased activity can be an indicator of mania in someone with bipolar disorder. The other area to be assessed routinely is abuse of substances. This area has a very high a probability of being problematic and a very low probability of being identified without direct questioning. For this reason, asking about it routinely is a good idea. People are unlikely to mention their use of alcohol or other drugs without being asked specifically what they use and how much. Ask if they drink beer, wine, or other alcohol. If yes, ask how much, how often, and if they’ve ever had any problems as a result of their drinking. Street drugs used to be an issue mostly with younger adults, but times have changed. It’s a good idea to ask adults of any age about use of these drugs, and about prescription and over-the-counter medicines, if you haven’t already done so.

Effective Social Work Practice in Adult Services: A Core Curriculum

Presented by:

The Adult Services Section

NC Division of Aging and Adult Services

In collaboration with:

The Center for Aging Research and Educational Services (CARES)

Jordan Institute for Families at the School of Social Work

UNC-Chapel Hill

The Workshop at a Glance

This curriculum provides new social workers in adult services with the opportunity to review the fundamentals of the Family Assessment and Change Process for working with clients and their families from the screening and intake process to case closing.

Day 3

Review of Assessment Process

Physical Assessment

Activities of Daily Living, Instrumental Activities of Daily Living

Lunch

Economic Assessment

Introduction to Service Planning

Ethnicity

Review

Overview of the Physical Assessment

Purpose

In the first half of the morning session, participants will focus on the assessment of a client's physical health. It is important for social workers to understand the terminology associated with a client's physical health, even though it is not their role to diagnose illnesses.

Learning Outcomes

- Participants will identify the difference between clients' diagnosis and functioning.
- Participants will identify three ways that social workers can assess clients' physical health.

Diagnosis (noun) The art or act of identifying a disease from its signs and symptoms

Function (noun) The acts or operations expected of a person or thing. Function implies a definite end or purpose that the one in question serves or a particular kind of work it is intended to perform

Give examples from people on your caseload who have similar diagnoses (diabetes, for example) but whose abilities to manage their own affairs are very different. As an example, you might contrast someone who manages her insulin, diet, and exercise very well with someone else who is not able to manage these things and has had legs amputated as a result. Emphasize that what clients can do for themselves, with or without assistance, is what the *functional* assessment is designed to find out. Although many diagnoses suggest areas where the client's good functioning is at risk, they don't tell you how the client is managing.

Why DSS social workers need to assess clients' physical health—after all they are not doctors or nurses.

Possible responses include:

- Diagnoses can suggest current or future situations that may limit functioning
- Social workers may spot symptoms that require immediate treatment.
- Social workers may identify symptoms that, while not emergencies, signal a need for medical evaluation. For example many cases of urinary incontinence are the result of infections, medications, or other reversible or remediable conditions. Hearing loss that may result from wax buildup or be improved with hearing aids. Poor vision may be restored or partially restored with surgery or new glasses. New medications may provide better relief of symptoms from chronic illnesses.
- Social workers may spot cases of “polypharmacy”—where clients are taking many medications that can interact adversely with one another or that produce other risks to functioning.

Second Step

What are some of the difficulties DSS social workers encounter in assisting clients with physical health issues? Some responses might be:

- Lack of knowledge about symptoms and illness
- Lack of understanding of the impact of social issues on health by some health professionals
- Difficulties in getting through to clients' physicians—lack of respect from some doctors
- Inadequate availability or quality of health care professionals
- Barriers to access.
- HIPAA regulations that prevent disclosure of information

Ask participants how they can deal with these difficulties. Some responses might be:

- Learning more about symptoms and illness
- Using resources to get needed information (e.g., books on illness, medications, and contacts with medical providers—physicians, nurses, OTs, PTs, pharmacists, and others—to get or share specific information)
- Being good observers and reporters. You don't have to know what a configuration of symptoms means to be able to describe behaviors or symptoms to a medical professional.
- Coaching clients and families or teaching them what to say to medical professionals. Helping them prepare for questions that are likely to be asked. Doctors will often want to know about history, onset, duration, severity, and pervasiveness of symptoms.
- Developing agreements about sharing medical information and/or getting appropriate releases from clients.

Third Step

There are three principal ways that social workers can assess clients' physical health:

- Clients' self-assessment
- Checklists of symptoms and illnesses
- Reviews of clients' use of medications

One of the best indicators of clients' health is their own assessment of it. A good way to obtain a client's perception of their health is to ask them to say whether they think their health is excellent, good, fair, or poor. Often, if the worker pauses, clients will offer additional specific information after giving their rating. For example, the client might say, "I have diabetes, but what bothers me most is my arthritis." Social workers can get important insights into clients' acceptance of their illness and compliance with treatment by listening carefully to what they say: "The doctor says I have high blood pressure, but I feel worse when I take the medicine." Clients may rate their health as good or excellent even when they have chronic illnesses, and this provides the social worker with a measure of how well clients are coping with any challenges. According to the research on the use of this measure, however, people age 65+ who rate their health as poor have a risk of dying within the next 1 to 6 years that is almost 3 times that of people who rate their health as excellent, regardless of any other factors. (J M Mossey and E Shapiro, Self-rated health: a predictor of mortality among the elderly. *American Journal of Public Health*, Vol. 72, Issue 8 800-808. This is the first study, but later studies have confirmed the finding.)

Asking family members for their perceptions of client's health can also be informative, corroborating the client's assessment, identifying discrepancies in what the client says and what health professionals may have said, or offering new or additional information on symptoms and compliance with treatment recommendations.

Sometimes, it is so easy to focus on clients' illnesses that workers fail to recognize strengths they have in this domain.

Identify strengths in physical health and list on flip chart. Responses may include:

- Lack of illness
- Not having complications that often result from illness
- Knowledgeable about their illnesses
- Compliant with medical recommendations
- Follow health promotion and preventive practices.

Health Risk and Age: The risk for disease varies according to the age of the individual. It can be helpful to be aware of these differences in conducting a physical assessment with clients. Have participants look at the page in their notebooks, Risk of Disease by Age Group.

Symptoms Indicating a Need for Immediate Attention: It is also helpful to know when to encourage or seek emergency care for clients.

Here are some common indicators of the need for emergency medical care.

Fever: Fever over 103° (less for older people) or fever accompanied by such symptoms as headache, photophobia, stiff neck, reduced consciousness, productive cough persisting over 3 days or associated with shortness of breath, abdominal pain and tenderness, bloody or persistent diarrhea, expanding redness of skin, or infected laceration or skin ulcer indicate a need to seek immediate medical attention.

Fainting: Fainting is not a benign symptom in adults. A client who faints should be taken promptly to an emergency room.

Chest pain: Any unexplained, steady, or recurring chest pain, especially in a consumer over 35, should prompt a visit to the emergency room.

Abdominal pain: Most abdominal pain is caused by normal gas in the intestines and peristalsis. Deep, steady pain, especially when associated with fever, requires a medical attention without delay.

Shortness of breath: Acute shortness of breath that is unexplained by an existing diagnosis is a medical emergency.

Bleeding: Bleeding that is bright red, spurting, or cannot be controlled with external pressure requires prompt attention.

Major Illnesses: Some major illnesses that clients have are especially important to monitor with medical professionals. These include:

- Epilepsy
- Asthma
- Heart disease
- Gastric ulcers
- Hypertension
- Diabetes
- Thyroid disease
- Arthritis

Remember that social workers can go to other sources for additional information (e.g., *PDR*, pharmacist, other drug reference books, doctors, etc.) Discrepancies in how medications are prescribed and taken and concerns about multiple prescriptions or clients' understanding of medications should be noted on the form for follow-up later.

The Adult Services Functional Assessment tool also provides a place to record information about assistance with treatment, past medical history, and durable medical equipment and supplies.

Overview of ADL and IADL Assessment

Purpose

In this section, participants will learn about the assessment of activities of daily living and instrumental activities of daily living. Participants will be familiarized to the ADL/IADL section of the ASFA and practice the skills they need to conduct an ADL/IADL assessment.

- Participants will define the activities of daily living and instrumental activities of daily living and understand how the ability to carry them out, with or without assistance, affects their quality of life and ability to remain independent.

The Activities of Daily Living (ADLs) include ambulation, bathing, dressing, eating, grooming, toileting, and transfer (to and from bed, chair, and car).

The Instrumental Activities of Daily Living (IADLs) include home maintenance, housework, laundry, meal preparation, money management, shopping/errands, telephone use, and transportation use.

More recently, people have identified EADLs (Enhanced ADLs): learning to use new technology, communicating with family and friends, engaging and leisure and hobby activities.

Why it is important to assess ADLs and IADLs. Possible answers include:

- Identifying strengths
- Identifying problems in functioning that could be eliminated through treatment
- Identifying problems that may be permanent but whose impact can be reduced
- Identifying potential dangers caused by limitations
- Identifying what care or assistance the client is receiving from others and the effect on the care provider

Emphasize that accurately assessing clients' ability to carry out the ADLs and IADLs that support self-care is essential in obtaining a clear picture of the client's situation.

Determining the causes of problems in functioning and whether treatment for underlying causes has been sought is important to accurate assessment.

For example, if a client has urinary incontinence, it may be a function of an underlying medical condition, a medication, or difficulty getting to the bathroom in time. Simply identifying the difficulty in functioning is usually not enough.

Direct observation of functioning (when possible) and verification with family or others help confirm (or dispute) clients' evaluations of their own abilities. Older people often underrepresent the difficulties they have in performing activities. Asking family and others about client's functional abilities provides an additional degree of reliability in assessment.

Resources for Clients

Review some of the strategies participants identified in the first exercise for overcoming barriers to performing the task. Which ones relied on the individual learning new ways to do things? Were there others that relied on assistance from other people? Were there ones that relied on assistive technologies, remembering that "technology" in this case can be fairly low tech?

Occupational therapists (OTs)

. . . Occupational therapy is about understanding the importance of an activity to an individual, being able to analyze the physical, mental and social components of the activity and then adapting the activity, the environment and/or the person to enable them to resume the activity. Occupational therapists would ask, "Why does this person have difficulties managing his or her daily activities (or occupations), and what can we adapt to make it possible for him or her to manage better and how will this then impact his or her health and well-being?"

http://en.wikipedia.org/wiki/Occupational_therapy

Home health agencies often have occupational therapists on staff or under contract. Hospitals also have OTs, and some OTs are in private practice.

North Carolina has a state-sponsored Assistive Technology Program that offers some free and some paid services through centers across the state. See their website for more details:

<http://www.ncatp.org/Overview.html>

Review the ADL/IADL decision tree.

Has cure/correction been actively sought for underlying illness or condition that causes or contributes to problems in functioning?

-
-

If No, seek medical or other evaluation.

If Yes, has rehabilitation been actively sought to correct or restore as much functioning as possible?

-
-

If No, seek rehabilitation evaluation. If Yes, have client and family been made aware of all assistive devices that might improve functioning?

-
-

If No, seek further evaluation or provide client with information

If Yes, is client coping well emotionally with impaired functioning?

-
-

If No, evaluate for need for DSS counseling or further mental health evaluation.

If Yes, support and commend him/her.

Very often social workers become involved with clients because they have some problem in ADL/IADL functioning, so a thorough assessment in this domain is essential. Use the decision tree approach that:

- focuses on cure or correction of the underlying cause of the problem in functioning
- looks at remedying as much of the underlying problem as is possible, if total correction is not possible
- offers assistance in compensating with the limitations of functioning when correction or further remediation are not possible
- provides assistance in coping with the emotional aspects of living with functional limitations when needed.

Economic Assessment

Learning Outcomes

Participants will

- Identify items that can affect clients' budgets
- Understand the importance of doing a thorough economic assessment
- Identify and practice strategies for asking questions about this sensitive topic
- Identify ways to gather information about this domain without asking questions.

Step Two: The Economic Assessment

“Why is it important to conduct the economic portion of the assessment, especially when finances are often a difficult area for you, as well as the client/family, to talk about?” Possible answers are:

- Social worker and client/family need to be aware of how well they are functioning, largely because this can affect resolution of problems in other areas
- To help family become aware of possible resources, if there are needs
- To gauge their capacity to manage their affairs
- To help with better management
- BUT NOT to determine if client/family is eligible for social services.

“What would indicate to you that a person/family is functioning well in the economic area?” Some possible responses are:

- Bills are paid
- Person owns own home
- Enough food in the house
- Prescriptions are filled
- Has car or can pay for transportation
- Has discretionary money (for gifts, entertainment)
- Is managing money or has someone to do it
- Is satisfied with financial situation.

If you find positive information in these areas, you can acknowledge that the client is functioning well, note this on record-keeping tool, and move on.

Review the responses they have given for indicators of good economic functioning and acknowledge that the opposite condition would likely be indicators of poor economic functioning. Ask “What other things might you see that suggest that the client is not functioning well or is at risk in this area?” Among them might be:

- There are no lights, heat, or cooling when you visit.
- The client isn’t using resources for which he/she is probably eligible:
- Food Stamps, Medicaid, Social Security.
- The client can’t afford durable medical equipment that might make it more possible to function in other areas (e.g., tub seat, walker, glasses).
- You see stacks of unopened bills.
- You see lots of catalogs, sweepstakes entries, or other types of junk mail used in scams, or perhaps magazines that seem out of keeping with the person’s interests or unopened boxes from sweepstakes companies.
- There are new, expensive acquisitions that might be considered “discretionary spending” while other bills are unpaid.
- The client and/or family is worried about finances and talks about being overwhelmed.

What clues do you have you gotten from information about other domains? In the ones just listed, durable medical equipment and problems paying for medication probably would have come up in connection with physical health and ADLs, while bill paying is one of the IADLs. Similarly, problems with bill paying or involvement with scammers can be early signs of cognitive decline. Discuss the greater risk that older adults will encounter scammers, that consequences of being scammed can be devastating both psychologically and financially, that people who are victimized

once are often victimized again, and that North Carolina has several programs in place to prevent this sort of crime. The Attorney General's office circulates regular scam alerts, participates in local SCAM JAMs to educate people, and cosponsors a Victim's Assistance Program to keep people from being repeatedly victimized. Also, among the things adult protective services investigates is the financial exploitation of a disabled adult.

Have you ever had or anticipate having difficulties or feeling uncomfortable about gathering information requested in the tool about a client's financial affairs? List some of the "Challenges in Gathering Economic Information" in the areas noted on the record-keeping tool.

Some responses may be:

- Worker feels uneasy inquiring about money
- Client feels this area is private information
- Client/family does not have accurate information
- Client/family does not have all the needed information.

Step Three: Asking Sensitive Questions about Finances

What are some techniques for getting information? The questions are interventions and the client/family is listening to what they say and how they say it. Here, more than in many other areas, it may be important to explain exactly why workers are asking the questions they ask

Note a strength that you see in this area, for example: "You seem to manage well on a limited income," or "You are very careful about paying bills on time," or "You keep important papers/good records, and that makes it so much easier to see what's going on with your money," or "You are making very good use of the money and other support you have available." This empowers clients by recognizing their abilities and may support them as they share information. Acknowledge with the client/family that taking a close look at their finances may be uncomfortable (even more than other areas), but that a close look at the economic picture may help you together discover ways to improve it. (For example, "The more you can tell me, the more we will be able to focus on your needs and to identify possible resources.")

Begin with some more comfortable questions. For example, you could start with the cost of prescriptions: "How are you managing to pay for them?" Often this will allow them to share other problems in expenditures. Then you can move to more specific questions about income and other expenses.

After a relationship has been established with the client/family, or in doing reassessments, it may be appropriate to explore other issues in economic functioning:

If finances are managed by someone else, workers might ask, "How did that come about?" or "How do you feel about it?" Asked of clients and family members individually, this may bring out different priorities for use of the money.

Although end-of-life planning issues can also be sensitive to discuss, assessment in this area opens the door to talking about long-range plans such as burial insurance, financial powers of attorney, long-term care (insurance, preferences), wills, and whether the client's family is aware of these plans.

Moving Toward Change: Summarizing the Assessment

Purpose

Participants now learn the steps in the process between completing the comprehensive functional assessment and developing with clients and families a Checklist for Change. There are three principal stages in this process: summarizing and making sense of the assessment information, identifying strengths, and then identifying with clients and families areas for change. To begin with, participants learn about summarizing assessment information from three different activities—critiquing summaries others have written, drawing a client in his/her situation, and describing what they have drawn (summarizing aloud) to another participant. After these exercises, they will play the role of the client whose situation they have summarized while a partner helps them develop a checklist for change.

Purpose

The activities in this section get participants to use various ways of thinking about and describing their client's situation. It also allows them to understand enough about their client that they can play the client's role in the checklist for change exercise at the end of the day.

Learning Objective

Participants will

- Review the assessment data they remember about one of their clients using and be able to summarize aloud the situation of the client.

Things to watch out for:

- All the domains accounted for
- Relevant information that will justify any plans that are developed later
- No judgments about the clients, just the facts
- No extraneous information.

Summarizing with the client is an extended example of reflective listening—they will be restating what they thought they heard and confirming it, and refining their understanding about the client's situation.

What are the benefits to the client and family of having the social worker summarize the assessment information? Some of the things you may hear include

- They'll feel as if someone has been listening to them
- They have the chance to add information or correct things
- Hearing someone else summarize the situation can help them have insight or a different perspective.

Summarizing the assessment

- Can be a bullet list or a written narrative
- Starting place for mentioning areas for change
 - Identifies some focus areas, but not specific services



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Why summarize in writing?

- Place for you to record your perceptions and to note themes and connections (this is a place of insight) based on behavioral data
- Gives you and future workers a snapshot of how things are with the client at the beginning of the relationship and along the way.
- Place to note strengths and areas of concern
- Transitional piece between functional assessment, the checklist for change, and goal setting with the client and family



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Summary

- **Should be inclusive but not redundant**
 - You make cross references to other pages in the assessment tool, rather than writing something you've written elsewhere
- **Describes the client's behavior or functioning, and only then your interpretation**
- **Does not include items that you are not willing to share with the client**



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What a Summary Does

- **Helps the client and family begin to focus: from a lot of information and concerns to some specific areas where change is most needed, desired, and likely**
- **Helps the client and family to clarify, and the social worker to check out, the accuracy of the information and everyone's perceptions**



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What a Summary Does

- Brings scattered elements together and allows patterns or relationships between domains, issues, and concerns to be seen
- Prepares the the client and family for the hard work of making changes, as the social worker supports seeing things from different perspectives and helps them to focus on areas where they and others will take action.



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What a Summary Does

- Supports the social worker's interpretations and understanding of the client and family system, and uses the worker's professional skills of processing, synthesizing, and negotiating
- Validates the client and family's work with the social worker: **You have heard them!**



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Third Step: Writing the Summary

Remember the importance of telling the client and family the strengths you see. This demonstrates to clients that you value them and it reminds them of their skills and resources. It also helps to put the change process in a positive light

Agenda for Change

Remember that even though the summary process is for sharing information with the client and family, it is also a prime place for using empathic listening skills to validate the client's and family's feelings and perceptions about their situation.

Adult Services Functional Assessment

Tool

Purpose

This activity will assist participants to the ADL/IADL portion of the ASFA tool.

Learning Outcomes

- Participants will identify key aspects of the ADL/IADL section of the ASFA tool

It is important to find out the client and family's perception of the client's functional abilities.

See the following points:

- Minimizing difficulties or denying problems have major implications for setting goals and using services.
- On the other hand, a client who is totally focused on what he/she cannot do may be missing some very important functional competencies and suffering emotionally as a result.
- Client and family's perceptions of the causes of functional difficulties are important in their willingness to participate in further evaluations and treatment. Are they aware that treatment could help?
- Have participants look at section B. Point out that they can use a check to identify the activities that the client needs help with, the amount of help needed, and whether the needs are being met. Additional comments are to be added, as the social worker deems necessary.
- The worker is also to assess whether the client can read and write. Discuss the implications for the assessment of the client being unable to read and write.

Step 2

Very often social workers become involved with clients because they have some problem in functioning, so a thorough assessment in this domain is essential.

Remind them to use a decision tree approach that focuses on cure or correction of the underlying cause of the problem in functioning as well as looks at remedying as much of the underlying problem as is possible.