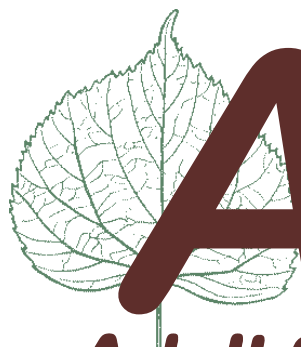




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ASPN

Adult Services Practice Notes

Produced under contract with the Adult Services Branch, Division of Social Services, NC Department of Health and Human Services

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The aspen is perhaps the world's largest organism. Although some aspen forests cover acres and seem to be composed of individuals in all stages of life, they share a common root system.

ASPN: Adult Services Practice Notes is dedicated to providing information on excellent family-centered social work practice with adults and their families.

Ethics Round Table

Our last issue described the National Association of Social Workers' Code of Ethics, which informs the work of social workers in county department of social services because it is the standard adopted in the Principles for Family-Centered Social Work Practice in Adult Services. In that issue, we also provided a set of case examples for you to consider, and in May we convened a round table of five social work supervisors and asked their opinion based on the Code and their experience in practice. Because they found it relevant to use examples from their counties, we agreed to preserve their anonymity and disguise the details of cases they cited. So, let us introduce Alex, Barbara, Carol, David, and Elizabeth, our panelists, and Linda Rahija, Program Coordinator for CARES, who served as moderator. Margaret Morse was there to record their discussion.

The group focused on the first standard in the code, "Responsibilities to Clients" (you can get a copy of the code in MS Word at <http://www.naswdc.org/CODE.HTM>; see pages 4 to 9). Linda summarized the main points of that section by comparing them to the five principal duties of social workers (see the box below). Because their time was limited, the panel addressed two scenarios that focus primarily on the duty to care and how it interacts with professional boundaries. They also discussed privacy and confidentiality, particularly as it relates to the client's public contact with the agency—at the reception desk. Finally, two panelists offered situations that for them had been particularly challenging, both relating to social workers' interactions with other professionals on behalf of their clients. In this issue of *ASPN*, we'll look at their responses to the case examples. As you will see, they are not unanimous in their opinions, which demonstrates the complexity of some of the issues. We hope it also demonstrates the value of discussion in helping social workers come to grips with these difficult decisions. In the next issue of *ASPN*, we'll look at questions they raised about privacy and confidentiality in the agency and interacting with doctors and other human services professionals.

The First Case Example: Attending Mrs. Smith's Funeral

Your client, Mrs. Smith, has died after a long illness. You attend her funeral.

Elizabeth: I don't do it, but I have workers who do.

I see it as a way for the worker to get closure and pay respects to the family, especially if they've been involved with the client for a long time during a period of illness. I don't think it's stepping from the professional to the personal, because you're still there as a professional.

David: I've had a couple of social workers who've gone to funerals, and I think it's great for them to do that, but the question that has bothered me is choosing which funerals to go to. If you're going to go to one person's funeral, you really ought to go to all of them, and they're not doing that. It seems like they're going to their favorite clients', and it's good for them to go to those

Principal Duties of Social Workers

- To Care
- To Inform
- To Support Clients' Right to Self-Determination
- To Maintain Privacy and Confidentiality
- To Warn

funerals, but what about the others?

Alex: I've gone to several funerals, always the ones where there has been little if any family, and that's been closure.

Linda: So it's been a personal choice for you, but it also sounds as if it falls under the rubric of duty to care, which I hear in "paying respects."

Alex: Yes, but we could not possibly go to all of them. My social workers and I could spend a major portion of our days going to funerals. I make my decision on respect and care as a closure to that individual, but also I feel like I'm following through.

Linda: There's an ethical question here, isn't there? One reason to pay attention to ethics is to be aware of these pushes and pulls. Sometimes there's no easy conclusion. Where we get in trouble is when we don't realize there's an issue.

Barbara: I've been to the funeral of a CAP client. Her two relatives wanted to keep her at home, and her condition was really deteriorating to the point where she really needed more care than they could provide. I talked with them about other options. They really didn't want to consider placement for her, but finally they did. After she was placed, the lady lived for maybe a month or so. This was a situation where I felt compelled to go because you don't want to leave the family feeling like you've just come in and offered them a quick fix. You want them to know you were genuinely concerned about their overall situation—the client and the family—and that not only would we be there when they needed us in a difficult situation, but we're here now as well.

Carol: I faced an ethical dilemma attending the wake of a coworker's relative. I had just started the position I'm in now, and one of the employee's parents died. I went to the wake, though I wasn't sure if I should go, because I didn't know the person, and I really did not know the employee very well. I wanted to be there for support, to let the employee know that I cared, but I didn't want to be seen as an intruder. My employee later called and thanked me.

Linda: I think you've actually hit one of the nails on the head about this particular issue, and that is, "What's your intention?" I think the worker who is going to the funeral for personal closure presents a greater ethical dilemma than a worker who is going to pay respects after an involvement with a very difficult family problem-solving situation.

Elizabeth: Why?

Linda: Because I think it moves from the professional to the personal, and the code tries to keep us in the professional. When we train social workers about using self-disclosure, for example, we tell them that sometimes it can be an effective way to develop rapport with the client. However, if workers don't really understand their intentions about self-disclosure, they can get into murky water. Workers may be bringing up their own issues, and they may not have thought through how this self-disclosure is going to be received by the client. If the worker is saying it for his or her own benefit, the ethical line has been crossed. When workers use self-disclosure, it has to be about the relationship with the client—building rapport or helping the client see something from a different perspective—always directed to the purpose of the professional relationship.

Elizabeth: At the same time, though, we don't allow workers good avenues for releasing the personal feelings they develop as a result of working with people. If it is a long-standing relationship or a long illness and you've been there to help the client and family deal with it, you do have personal feelings, even though you've stayed on the professional side in offering help. To me, attending the funeral may be both personal and professional.

Linda: I agree that we are not good at helping social workers take care of themselves. I encourage DSSs and other organizations I work with to have a way in house to help workers come to closure. Some places have memorials—a memory tree or a

meeting when they get together to talk about clients they've lost. They may bring in someone from hospice and do some grief work. We forget that closure is not just about deaths—sometimes it's about clients moving away, being taken off of our rolls, or moving from one functional state to another and becoming someone else's client because their needs change. I think it's very important to pay attention to personal feelings, and support from their supervisors can help them stay professional in the relations with clients.

David: I agree that going to pay respects would be o.k., but going for your own personal interests doesn't sound ethical. Another problem, though, is that if you're going to pay your respects to Mr. Adams and a month later Mr. Jones dies, you ought to go for Mr. Jones, too. Alex said that you can't go to all of them. If you can't do it, don't do it, don't go to funerals at all. We make the presumption that what the other clients don't know won't hurt them, but it's amazing how clients talk to each other. I think that we may be hurting people and not realizing it.

Barbara: I think it's really important to look at the particular situations. For me, it's as if you are saying that if you do something for one client then you have to do it for all. I don't think that's really applicable. This situation may require something that another one doesn't. I think that was a part of my decision to go. That family was so torn about having to make that decision about placing their relative. Even though the decision was theirs, we assisted them with the process. At the end I didn't want them to feel as if we'd taken them there and then left them. It wasn't about bringing me closure, it was about bringing it full circle professionally. To me that made a major statement for DSS and our reputation, and I felt it was important for those reasons.

Linda: In training we say that everything you do is an intervention as a social worker. The way you answer the phone, the way you show up or not show up at

a funeral, the way you sigh when the client sits down, even though you might be sighing about something else. It is all fraught with meaning. Our clients are constantly making interpretations about what we do. Decisions have to be made every day based on the best knowledge that you have, the best awareness that you have in the framework of ethics.

The Second Case Example: Sally White and Mr. Jones

Sally White, the daughter-in-law of your client Mr. Jones, says that she can no longer care for him in her home. She wants you to persuade him to go to an adult care home. He is often abusive when he talks to her, and you wonder how she has put up with him this long.

David: Issues around placement come up a lot, whether the department should try to talk someone into going into a nursing home.

Linda: What's the ethical dilemma here?

Alex: Who is your client?

Linda: So who is your client? The individual? The family?

Alex: It's got to be the individual.

Linda: Tell me more about that.

Alex: We do not go out and persuade anybody to go into placement. It's a real question, an extremely painful question. We may feel clients would be safer in placement, but it is still their self-determination of where they want to be. Until they are unable to make those decisions, we do not tell people they have to go into placement. We can provide them with information initially, but if they say "I'm not going to move out of my home," then there's nothing you can do about it. I can say, "Yes, you're right, but you need to have this information. There may be other ways to allow you to remain in your home and not have these issues." But we do not help by pushing for placement.

Carol: Our services are by request, with the exception of APS, unless we have a situation where we have to have the court make a decision.

Elizabeth: When I was a hospital social worker, this was a common request. There was real dilemma a lot of times, because we really didn't know much about the situation that they left. Hospital stays are notoriously short, so we had something to fall back on—what was the real medical need for this client. And if the medical need could not be met based on what both the client and the family were saying, then we had a duty to make sure that people were placed in a facility that would meet their needs.

Linda: What would you do if that person refused?

Elizabeth: If the person absolutely refused to go, we had to discharge the patient home with whatever services we could put in there.

David: I notice the code says under self-determination, "Social workers may limit clients' right to self-determination when in the social worker's professional judgment clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others." That could relate to someone who is not willing to go into a nursing home whose health is suffering as a result. A thing that comes into play for me is that I don't feel the state standards for facilities guarantee acceptable care, so it's hard to think clients will receive better care in a facility than they would at home. Also, many people who don't want to go to a facility and end up there lose their will to live and don't last very long. In those cases, I think you've precipitated a client's dying.

Alex: There's a legal issue here. As long as adults have the ability to make decisions and understand the consequences, they have the right to make those decisions. That can really get us into a conflict. Several years ago we had a client who went back and forth from home to hospital. She could pass any and every mental status exam to show she understood the consequences her actions. She was determined to die

at home, to stay at home. She refused services, so she had nothing coming in, except the rescue squad who came regularly to pick her up off the floor. She was not getting any personal care, although she desperately needed it. We had a huge ethical question, yet we could not impose our desires on her as long as she could make a decision.

David: You may substantiate self-neglect, but if the person has capacity to consent and doesn't want you there, you have to leave.

Barbara: I think it might be helpful to involve the physician.

Alex: We had the physician involved, we had the psychiatrist, the home health. We had a plan. If the EMTs went in and found her unable to make a decision, that's where the threshold was. We would have reason to go to the judge and get an order. And it never happened. She did die at home.

Linda: When the North Carolina General Assembly addressed the issue of elder abuse, they faced the ethical dilemma of self-determination: At which point does the state intervene? What is the threshold? They decided to err on the side of self-determination. DSS and mental health can make a determination of disability for adults over 18, but no one can make them accept services unless they've been adjudicated incompetent.

Alex: And you know, I don't have any problem with it. On a case-by-case basis it can drive you wacky, but the bottom line is that this is to assure that everybody has the right of self-determination.

Margaret: We've been talking as if individuals stand alone. What about Mr. Jones's rights compared to the rights of Sally White, who is taking care of him?

Alex: You've got to make some decisions. Are you going to take on the concerns of one family member to the detriment of the other?

Carol: If you don't accept Mr. Jones as your primary client in this situation, you get into a cobweb of problems. How far do you go into the family's personal lives?

Barbara: I think you have to look at who's responsible. Are we saying that she's his primary caregiver? I think additional information would really be needed. He's abusive—and just exactly what's happening as a result of that. We may have a situation for adult protective services or possibly one where we would talk with her about services for him in the home. If she's *not* his caregiver, then this is really a situation she would need to address.

Linda: What I heard in your comment is that we do have a duty to do a full assessment, not just for him, but for her, the family, the dynamics. We can choose how far to go into all those dynamics, but we have to understand the whole picture.

Thanks to Alex, Barbara, Carol, David, and Elizabeth (you know who you are) for sharing their wisdom.

The duties of a social worker are based on Barry Cournoyer, The Social Work Skills Workbook, 2nd ed. (Boston: Brooks/Cole: 1996), pp. 54–61.

CARES Training Events in 2000–2001

Adult Services Supervisors' Curriculum (4 events: modules 1, 3, 4, and 6)

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Effective Counseling in Adult Services (4 events)

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Geriatric Mental Health (2 events)

An Introduction to Aging (3 events)

Working with Clients with Severe Mental Illness: The DSS Perspective (3 events)

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and registration materials.

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Registration materials from the North Carolina Institute on Aging

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