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# ASPEN

## *Adult Services Practice Notes*

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by

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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.*

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

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## Do You Know When to Sweat?

Positive outcomes . . . everybody wants them. Particularly in difficult fiscal times, public agencies have increasing responsibility to demonstrate positive outcomes for the time and funds they use. This newsletter focuses on the contribution that individual social workers make when they do excellent planning with clients and families, using the Family Assessment and Change Process to help clients and caregivers identify areas for change, set goals, and make beneficial changes. "That's a really good idea, but it's a lot of hard work, and with my caseload, I just don't have time to do it as well as I'd like," you might say. Our answer is that it's important to choose when to sweat—hard work now, rather than maybe harder work later. We believe you'll find that spending the time on this process at the beginning of your work with clients and families will save all of you time in the long run and get a better result, because the plans you make together will be more likely to succeed and share the work among you. It is also part of the ethical practice that distinguishes excellent professional social workers.

One of the Division's Adult Programs Representatives (APR), who are field based staff and consult with county departments of social services, remarked that "social workers are action-oriented," which is good, but continued, "they sometimes have problems stepping back to look at the need and then the goal" before launching into activities. Although social workers learn the steps of case planning at several different training events, it is supervisors in the DSSs who really make it possible for workers to apply what they've learned. It takes review of the steps and a commitment to family-centered practice to work through the process effectively. In this newsletter, we'll look through those steps with a case example and some notes about what APRs found to be good practice. Then we'll consider how supervisors support excellent case planning.

## Assessment and Checklist for Change

When social workers take a referral, basic information on the client is usually all that is available. Only when the assessment is completed can you get a clearer picture of what is happening with the client and family. All of the information gathered in the assessment should help you, the client, and any caregivers develop a complete and thorough list of needs and areas for change and goals.

It is tempting, though, to write only the areas of change and goals for which you have a ready response—that is, services you manage. This is understandable, particularly when clients have extensive needs. It's easier to go with the "sure thing," the resources you know you can get, than to raise expectations you

## About Mr. Pirelli

Mr. Pirelli came to America from Italy just after World War II, when he was 15. He lived in New Jersey, where he worked as a baker. When he was 62, the man he worked for moved to your county and opened a bakery that made bread and rolls for many of the local restaurants. Mr. Pirelli and his wife also moved to North Carolina to continue working in the bakery. Mr. Pirelli's boss retired and sold the business two years ago, and Mr. Pirelli decided to retire, too. Last year, Mr. Pirelli's wife became ill with cancer and died. Five of their six children still live in New Jersey and have established careers, marriages, and children; the sixth, the youngest daughter Elisa, married a Navy officer and currently lives at the coast. Her husband has just been reassigned to Hawaii, and they expect to move in about two months. When last she visited her father, she was shocked to see him somewhat unkempt, (continued, p. 3)

may not be able to meet. However, you may be underrating the value of the assessment. By making a thorough assessment and reviewing it with your client and family, you help them and other care providers think through the current situation, identify needs, decide what they want to change, and set about finding help in making changes. When you help clients understand how to plan activities and find services to meet goals, you demonstrate how to get resources for change, whether from the DSS or elsewhere in the community.

One APR suggested that the way to be more thorough in identifying problems is to review the sections of the assessment—social, environmental, mental health, physical, ADL/IADL, and economic—separately, to begin with. Focusing on one section at a time can make the process seem less overwhelming. Developing the “Checklist for Change” with the client and family or other caregivers assures that you capture their concerns. In preparing for this step in the process, another APR suggested that social workers go through the assessment tool with a marker and highlight the areas that are clearly of concern to the client.

## Goals

APRs thought that workers were most successful when they

- ♦ were family-centered in their approach throughout the process
- ♦ used the Checklist for Change to help develop goals
- ♦ recorded goals that were individualized for each client, rather than ones that might apply to anybody
- ♦ involved the family and other caregivers in developing goals and documented that involvement
- ♦ made a clear distinction between the goal and the activity to meet the goal (often services)
- ♦ included in the list *all* the client’s goals, not just the ones relevant to the services they personally could arrange.

Setting goals (or at least writing them) seems to be a universal challenge, even though it is one of the most important parts of the process of assessment and case planning. It is routinely taught at the training events offered by the Adult Service Branch: *Guardianship—Planning Services*, *Adult Care Home Case Management*, and *Adult Protective Services Basic Skills*. In CARES’s *Effective Practice in Adult Services: A Core Curriculum*, we devote a full day to the checklist for change and setting goals. Usually, we focus on SMART goals (see the box on the last page), but to look at this task from a different perspective, it might help to think of a goal as an “unproblem,” and this is where the Checklist for Change, backed up by all you’ve learned through the assessment, can help.

For example, let’s say that you are a placement worker, and you have gotten the referral to see Mr. Pirelli, because that’s what his daughter seems to think he needs. You visit him at home, and the case example shows part of your summary. One of the issues raised by his daughter is that he

seems to have been losing weight without wanting to. You would ask him whether he sees this as a problem, too, and if he says yes, you would write on the Checklist for Change, “Mr. Pirelli is losing weight.” After you’ve gotten all the assessment information, and it’s time to work with Mr. Pirelli about his goals, you could just write down the “unproblem”: “In a month (when you check again on this problem), Mr. Pirelli will have maintained his current weight or gained weight.” (Does this fulfill all the conditions of a SMART goal?) Notice that this goal statement really belongs to Mr. Pirelli because it answers a problem he and his daughter have identified. It’s the test that you, the client, and family will use to see if the activities and services you plan together are working: More weight loss in one month, not working; weight stable or up, working.

## Planning

Now for the “action.” Why is the problem happening? What do you see in the information Mr. Pirelli and his daughter provided that could be the cause of weight loss? Where would you suggest that they start to find out? Developing a useful case plan depends on finding out why a problem is happening and addressing the causes.

Once again, APRs noted that social workers who use the service plan as a working document—as a way to list all the strategies the client, family, caregivers, and worker will use to get to the goal—have better results. In Mr. Pirelli’s case, probably one of the first things you would suggest as part of the assessment process is that he consult his physician, to make sure he doesn’t have a physical condition that is causing the weight loss problem. You would also help him find a way to get his dentures repaired. Are you concerned about his mental health, both now and when his daughter moves away? How will you help him with that? These, then, might be the top of the list on the service plan.

It takes time, though, to get appointments with physicians. It may be hard to find a dentist he can afford. It takes time to adjust to losses, past and prospective. In the meanwhile, are there other things Mr. Pirelli and his daughter can do to prevent further weight loss? These would go on the list, too, and you would probably ask them to let you know when they have done them.

But wait a minute, you work in the Placement unit. Does any of this have to do with placement? In Mr. Pirelli’s current condition, probably not, though he became your client because that was the only solution his daughter could see at the beginning. But even if we imagine him much more vulnerable and unable to continue safely at home, the problem and goal remain the same (losing weight: prevent further weight loss), though the strategies you develop with him, his daughter, and the providers in an adult care home might differ. You would track the things you all do to identify the cause of the problem and resolve it, and together you would test these actions against the goal. And this is good social work, and a good service to the client.

## More about Mr. Pirelli

and he had lost a lot of weight. She asked him whether he would move back up north to be with one of her brothers and sisters, and he said he couldn't stand the weather there any longer. She believes that he needs "looking after," but she can't do it herself. She has called your DSS to talk about placement, even though Mr. P. says he'll die before he goes to one of those old folks' places. He has, however, agreed to meet with you and Elisa for an assessment.

Here's some of what you find:

**Social:** Mr. P. sees Elisa about twice a month, on weekends. He calls one or two of his other children about once a month, but he can't afford to call more often. Although he was raised Catholic, he rarely goes to church, and the nearest one is about 20 miles away. One of his favorite activities when he was younger was bocce, but he doesn't have friends to play with here. His wife of 50 years has died recently.

**Environmental:** Mr. P. lives in a small house alone. He manages the exterior upkeep on his own and has small, neat flowerbeds. He says he's having some difficulty bending to weed them because of arthritis in his knees and wrists. The house is tidy but very dusty. He remarks that his wife always kept a very clean house, and she would be embarrassed by the way it looks now. There is very little evidence of cooking in the kitchen, but there are boxes from some prepared foods in the trash. On

your way to his house, you noticed that there's a congregate meal site about half a mile away. There is also a senior housing project under construction nearby.

**Mental:** Mr. P. greets you politely when you arrive. You notice, though, that when you and Elisa are talking, he looks away and seems sad. He says that he hasn't been sleeping very well, but "You gotta expect things to be bad when you get old—it ain't no picnic."

**Physical:** Mr. P. is about 5 ft. 7, and he says he weighs about 100 lbs. He said that he was "grande" when he was younger, because his wife used to cook him such good things. Apart from arthritis, he doesn't complain of any other problems, but he says the bottom plate of his dentures broke, and he hasn't had the money to replace it. He saw a physician about two years ago.

**ADL/IADL:** Mr. P. does ADLs independently. He says he buys food to microwave, but he doesn't like it much. He would like the house to be cleaner than it is. He manages his money but doesn't always have enough.

**Economic:** Mr. P.'s employer never sponsored a pension plan, so Mr. P.'s income is from social security, and he receives his wife's survivor benefit. He has a small savings account left from the sale of his home in New Jersey, but his wife's illness took quite a bit of it. His children have offered to send him money and have even sent checks, but he has always returned them. Mr. P. doesn't use any community services.

Client: Mr. Pirelli Case # 22222

**Adult and Family Service Plan**

X Initial  Update  Quarterly  Reassessment ID # 2222222222

(Use additional sheets as necessary) Date initiated 03-30-03

Checklist for Change (Problem/Need)	Goal	Target Date	Activities/Services	Person/ Agency Responsible	Activity Done	Goal Met
1. Mr. Pirelli has lost a lot of weight. He is 5'7" and 100 lbs. His wife used to do all the cooking.	Mr. Pirelli will maintain his current weight or gain weight.	4-30-03	1. Schedule Dr.'s appt., screen for depression 2. Refer to congregate meal site. 3. Refer to in-home services for someone to cook & prepare nutritious meals. 4. Monitor weight monthly. 5. Have a nutrition specialist from the health department make a home visit to teach nutrition & cooking skills.	Client, SW, Dr., congregate meal site, in-home services, health department		
2. Mr. Pirelli does not have friends to play bocce with here.	Mr. Pirelli will participate in bocce or another activity that he enjoys with others 1x a week.	4-30-03	1. Contact area senior center, churches, and community groups to get a list of monthly activities. 2. Mr. Pirelli will review list and pick an activity. 3. Have Mr. Pirelli offer to teach a class on bocce in the area. 4. Have daughter, Elisa, visit regularly while she still lives close by.	Client, SW, community organizations, daughter		
3. Family members all live far away from Mr. Pirelli.	Mr. Pirelli will be able to be in contact with	4-30-03	1. Assist with developing a budget. 2. Family will purchase phone cards to send to Mr. Pirelli so he can call whenever he wants. 3. A... least 1x a we	Client, SW, family, Life line, library		

Why the library?  
To see the whole service plan, visit the CARES website, <http://ssw.unc.edu/cares/aspn/Pirplan.pdf>

## You're Not in This Alone: The Role of Supervision

According to the APRs, supervisors who were very good at supporting case planning seem to use similar strategies. They make time to meet with all new workers and review new cases until the workers understand the task. They provide feedback and guidance about correct documentation for service planning. One supervisor gives new workers copies of service plans from past cases (with identifying information deleted) as a model of the content, style, and correct way to complete them. For veteran workers, these supervisors review at least two cases a month, chosen at random. All had an open-door policy for workers to discuss cases. They encourage their workers to use the service plan to track completed tasks and help

them manage time effectively. Some supervisors have "staffings" of all new cases. Others have peer reviews of records, because this helps workers become more focused on their own work and style.

The Core training and the training the Adult Services Branch offers are a good start for learning how to use the Family Assessment and Change Process, but APRs reported that supervisors also felt that "refresher" workshops would help reinforce the learning. One supervisor felt that workers who attend trainings more often for service planning and goal setting are more motivated.

Making and sustaining change is difficult, not only for clients but for workers. Knowing when to sweat is one

thing, but doing it consistently when you begin with clients and families is hard. Just as you provide support for making changes for your clients and families, though, support can help you maintain and improve your professional practice. Next issue, we'll look at your own resources for change.

### How SMART Are the Goals?

- S:** Is the goal *specific*?  
**M:** Can clients *measure* whether they've met the goal?  
**A:** Is the goal *attainable*?  
**R:** Is the goal *realistic*?  
**T:** Is there a *time* by which the client will see results?

*Thanks to Allison Shavitz for interviewing the APRs and writing an initial draft of this newsletter.*

*Thanks to Kelly Blankenship for the plan.*

Visit the CARES web site at <http://ssw.unc.edu/cares/cares.htm>  
for on-line copies of this newsletter, updated calendar of workshops,  
links to background materials for events, and much more.

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Next time:  
Resources  
for Change

## CARES

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