

Planning Activities and Services

In one sense, planning for services is the part of the Family Assessment and Change Process that everyone understands—figuring out with the client and family what assistance they need and want (including your own services as counselor and facilitator for change), finding a way to help the client and family get this assistance, and in some cases, actually providing it for the client and family. While everyone understands what service planning is, it still takes all of your social work skills to do it well.

The Social Work behind the Record

“Service plans and interventions are designed to achieve the optimal fit between the clients’ need to improve, regain, or sustain functioning and the amount of assistance or services they need to achieve the outcomes specified in the goal statements” (*A Model for Excellence*, p. 41). How do you, as a social worker, help the client and family achieve this optimal fit? *A Model* suggests that the plan you develop with the client and family should:

- flow directly from the goals which, in turn flow directly from the Checklist for Change identified in summarizing the assessment

- address the clients’ instrumental (material) and affectional (emotional/spiritual) needs
- take into consideration all of the resources available through formal and informal channels
- emphasize those resources that may meet multiple needs of the client and family simultaneously
- model problem solving for the client and family (adapted from *A Model for Excellence*, p. 86).

These points make a very useful checklist against which you can mentally assess each plan you write. In writing plans that measure up to this list, you use your knowledge of the resources in your community, conduct and synthesize the most thorough assessment possible, write relevant functional goals that reflect the real concerns of the client and family, and, most importantly, think creatively.

Workers are usually more effective when they avoid thinking of DSS services as the only way to help clients and families meet their goals. Drawing support from a variety of sources may provide a better “safety net” for the client and should reduce the demand on your time for each client. It should also help make DSS services available to those who most need them.

Social workers not only think about what clients want, but also think about the capabilities and state of mind of these clients and their families. Is the client in a crisis state and needing strong support, including an array of DSS and non-DSS services, or is the client in a stable situation requiring some services but mostly information, direction, modeling, or inspiration to enable him to act in his own behalf? Is his informal support network strong or weak? Deep or shallow?

When DSS services are the most appropriate way to meet the client’s needs, you know from experience the importance of thinking creatively about how to apply them. Even the most experienced workers have to guard against the bad

habit of applying a set of standard recipes. (To detect a possible recipe habit, ask yourself, “Do a lot of my service plans look almost exactly alike even though the clients and their families are fairly different?”) Instead, social workers challenge themselves to think about how best to serve the unique needs of the client while working within the constraints of eligibility requirements, waiting lists, and the other facts of DSS life.

Why Is the Service Plan Important?

This may seem like a silly question. It is at the center of your job as a social worker. You are more likely to be asking, “Why does it matter how I write up the service plan?” There are several reasons why it matters. First, a well-defined service plan, made with the participation and agreement of the client and family, spells out the mutual responsibilities of the client, social worker, and often the family. This helps to prevent future disappointments and squabbles over false expectations or shifting responsibility. Everyone involved knows what to expect. Second, the service plan acts as a reminder to all parties about the responsibilities they have accepted. Third, it helps you budget your own time by laying out the activities you will need to undertake for this client. Fourth, it helps your supervisor assess at a glance the thoroughness and appropriateness of your approach to the case. Fifth, it helps you and any workers who might have the case after you to review what has been tried in the case. When added to the quarterly reviews and reassessments, the service plan helps show what has worked well with this client and what has not.

Using the Adult and Family Service Plan

In the preceding chapter you were introduced to the tool we recommend for recording the service plan. You began the Adult and Family Service Plan by recording an abbreviated form of the client’s highest priority problems in a Checklist

for Change (first column), followed by the goals that you and the client and family set together (second column), and the date by which all involved hope to meet each goal or check on progress (third column). In this chapter our focus is on recording what is going to be done, by whom, to achieve the goals. This can be recorded in the fourth and fifth columns of the Adult and Family Service Plan. These two columns are titled “Activities/Services” and “Person/Agency Responsible.”

The length of this tool (i.e., the number of sheets actually used) will vary considerably from client to client, depending on the number of goals set and the number of activities needed to achieve them. Use as many pages as you need. You probably will want to add the client’s name and case or ID number to each page, because we can always count on pages becoming separated.

How to write on the service plan is relatively straightforward, while what to write is more difficult. Let’s begin with the easy part, using the sample beginning on page 78. Stop and look at the example for a moment before you read any further.

Although the sample is typed so that you can read it more easily, you may want or find it necessary to handwrite your plans. Some social workers may use a computer to enter information. The important thing is that the information is legible and understandable for use by all involved.

At this point you have already filled in the identifying information, the Checklist for Change (problems/needs), the corresponding goals, and target date for their achievement. As the example shows, all activities and services in the plan will be linked to one or more of the functional goals.

In the example on the next pages, the connection between goals and activities is made clearer by blocking off the activities associated with one set of goals (i.e., one or more goals growing out of the same area for change). Notice that items on the Checklist for Change can have more than one goal, and that the goals, in turn, can have more

than one activity or service to meet them. Conversely, some activities and services can be used to meet more than one goal. As you use these tools, you will develop for yourself clear ways of marking how items for change, goals, and activities relate to one another. However you choose to key the activities to the goals (the example shows one possibility), you will probably find it helpful to number the items for change and the goals in a way similar to the example, because when you come to monitor progress on the Interim or Quarterly Review, you will have a quick way of referring to them (see the example in Chapter 7).

In the first two items for change, the example shows a situation that you will likely encounter frequently: whether to lump goals together when planning activities or to split them up. For the first item, Mrs. J.'s safety, there seem to be two areas of concern: the stove being turned off consistently and other safety hazards in her home. The activities that address goal 1A don't have any relevance to goal 1B, so the social worker separated them with a line and labeled them independently with their own letters.

Identifying a new physician meets goals 2A and 2B, short-term and long-term health care, so they are lumped together. Goal 2C has two activities directly associated with it to line up an eye exam, and the last activity, helping arrange transportation, covers all three goals, although there isn't an easy typographic way to show this.

The activities and services you list can be as detailed and specific as you need them to be. In the example, the social worker does not break down each activity into every possible discrete step, but she finds it worthwhile to detail procedures enough to help guide the client and family through the process. It may be useful to break down activities into smaller steps when different people are responsible for carrying out different pieces or if the client or family find a series of small victories helpful in achieving the more major victory of accomplishing the goal.

The "person/agency responsible" entry is

made adjacent to the activity in the next column. In the example, there is a dotted line leading from the activity to the responsible party, but you could key numbers to these entries as well.

Planning the Activities

Now let's talk about the specifics of the sample plan. Goal 1A is that the stove will be turned off consistently when it is not being used, and that this would be demonstrated for a month. There are many possible approaches to this goal, depending, in part, on the social worker's judgment about the possible sources of the problem, as well as on what the client and family think and on what is acceptable to them. In this case, the social worker concludes with Mrs. Johnson and her son that the main reason she leaves the stove on is that she cannot see clearly whether the knob is in the "off" position and that because one knob is missing and the other difficult to turn, her arthritis makes it hard to turn it all the way off. Accordingly, the three of them plan three activities:

- a. Mrs. Johnson thinks she can confirm the "off" position by touch. The social worker and her son mark the stove knob with a piece of tape that she can feel when it is at the "off" position. This is done before the end of the visit and is so noted on the Plan.
- b. Second, Mrs. Johnson agrees to turn off the stove after every use. This reflects Mrs. Johnson's agreement to be careful with the stove and affirms her responsibility as an independent adult to make this change.
- c. The son agrees to make random checks on the stove. This serves three purposes. If there is a different reason for the problem, he will likely find this out quickly and indicate the need for a different approach. Second, if they were right about the cause, Mr. Johnson will see quick improvement in one of the things that was most worrying him. Third, if eyesight and

Client: Mary Foster Johnson

Adult and Family Service Plan

Case # 95-10019

ID # 18937485368

Initial Update Quarterly Reassessment

(Use additional sheets as necessary.)

Date initiated 2/6/95

Checklist for Change (Problem/Need)	Goal	Target Date	Activities/Services	Person/Agency Responsible	Activity Done	Goal Met
<p>1. Mrs. J. is not safe at home: stove is not turned off; problems with heating pad, stove knob missing, dark stairs, slippery rugs</p>	<p>1A. The stove will be consistently off when not in use for 1 month</p>	<p>3/6/95</p>	<p>a. Mark stove's off position with tape..... b. Mrs. J. will turn off stove... c. Mr. J. will monitor stove to reassure himself.....</p>	<p>SW, Mr. J. Mrs. J Mr. J</p>	<p>2/6</p>	
	<p>1B. Identified hazards in Mrs. J.'s home will be fixed or removed within 6 weeks.</p>	<p>3/22</p>	<p>a. Rugs tacked down securely, new heating pad purchased, stove knob replaced, temporary lighting for stairs b. Find source of help for permanent lighting on stairs (COA, church, Boy Scouts?).....</p>	<p>J. Family J. Family & SW</p>		
<p>2. Mrs. J. lacks current medical care: her arthritis, her cloudy vision, her forgetfulness have not been evaluated recently</p>	<p>2A. Mrs. J. will have a physical exam within 6 weeks.</p>	<p>3/22/95</p>	<p>a. Identify new physician, make appointment, and have physical.....</p>	<p>Mrs. J</p>		
	<p>2B. Mrs. J. will have a plan for routine preventive medical care</p>		<p>a. Get voucher for eye exam from Services for Blind b. Make appt. w/eye doctor, have eyes checked.....</p>	<p>SW Mrs. J</p>		
	<p>2C. Mrs. J. and family will know causes of cloudy vision within the quarter and whether/what treatment is possible</p>		<p>c. Arrange transportation to both types of appointments.</p>	<p>SW or J. Family</p>		

memory were both parts of the problem, the monitoring will help to reinforce and remind Mrs. Johnson how important it is to check that the stove is off.

Although it is not mentioned specifically here, if Mrs. Johnson gets help reducing the pain of her arthritis (see activities for item 2), this, too, may help the problem.

The first activity for goal 1B involves agreed-upon plans for members of Mrs. Johnson's family to fix specific safety hazards identified during the assessment. Notice that the nature of temporary lighting is not spelled out. The social worker judges that this client and family are able to explore these alternatives themselves. The second activity has the client/family/social worker team committed to getting permanent lighting on the stairway.

The activity to meet goals 2A and 2B shows Mrs. Johnson, with help from the social worker, accepting responsibility for identifying a new physician and making an appointment. The social worker knows how easy it is to get into the habit of thinking only of what people and agencies can do for the client, so she helps identify which elements in the plan the client can realistically do for herself.

For goal 2C, there are two activities to help Mrs. J. get her eyes examined. The last activity (c) in this space responds to the client's obvious need for assistance in getting to and from her medical and eye appointments. The social worker and Mrs. Johnson's family decide to collaborate in arranging this transportation.

Goals 3A and 3B reflect a long-term change Mrs. J. would like to see in her life—that she can perform her own self-care adequately. The first activity, however, acknowledges that she would like some short-term assistance until she is able to explore the possibilities for rehabilitation with her new physician. To begin with, though, the in-home aide will assist Mrs. Johnson in bathing and in washing and grooming her hair twice a week. Depending on what Mrs. J. learns

from the physician, she and the social worker may develop new strategies to meet these goals that involve Mrs. J. taking on more self-care and discontinuing the aide's services.

Goals 4A, B, and C are designed to help Mrs. J. improve her outlook on life, which may also help her meet her other goals. The first two activities are aimed at helping Mrs. J. through the grieving process. In this case, the social worker had training and experience in counseling skills, and she felt that she and Mrs. J. had established a rapport that would enable them to work together, so she provided counseling as a DSS service. Notice that the second activity, Mrs. J. finding out about the bereavement group sponsored by the local Hospice, may later help her meet goal 4B, if she decides to join. Mrs. Johnson initially seemed ambivalent about joining, so the social worker did not push her to go but suggested that learning about and thinking about such a group be one of her activities. The social worker offered to get her the literature about the group.

The activities for Goal 4B are designed to broaden Mrs. Johnson's social contacts, and, in part, to reduce the burden on her son and family. The social worker, client, and family take a three-pronged approach here. Mr. Johnson will talk with the minister about getting the church more involved. Even though in most cases Mrs. Johnson is encouraged to handle activities that can be done over the phone, she feels hesitant to ask for more attention, fearing that the minister may take it as criticism of his current involvement. The social worker also knows that it is hard for a person who is depressed to reach out to others.

For the second activity, although it is difficult for her, Mrs. Johnson takes responsibility for reaching out twice a week to make a social phone call to someone other than her son and his family. This will not only give her the contact of that phone call, but it will probably increase the chances she will receive phone calls and visits.

For the third activity, the social worker gets

another agency involved. Mrs. Johnson agrees to go to the local senior center, which offers meals at lunchtime and other activities, to see whether she enjoys it. The social worker arranges for the county Council on Aging to pick Mrs. Johnson up in their van. If she enjoys the trip, senior center activities may become a regular part of her service plan.

Finally, Goal 4C measures how well meeting the other two goals is helping Mrs. J. feel better about her life. Because the social worker used the Geriatric Depression Scale at the assessment to understand more about Mrs. J.'s mental and emotional state, they agree to use it again at the first monitoring visit to see how the scores change. However, to give Mrs. J. another concrete way of measuring changes in how she feels, the social worker suggests that she mark on her calendar how each day had gone, so that she can see herself how her feelings are changing and relate positive change to her actions.

The Signatures

There are three spaces for signatures at the bottom of the page—one for the social worker, one for the client, and one for others. It may work best to sign and date the plan when you first use it, and then initial and date revisions and changes as you add them (see the example in Chapter 7).

The client's signature appears on the tool as an affirmation that the client is an active participant in making this plan and agrees to all parts of it. Some experienced social workers emphasize the value of having the service plan signed by the client. There are, however, exceptions when it is not appropriate to get a signature. For example, if the client is not capable of participating in the service plan in any way (e.g., unconscious or severely demented), or if he is suspicious about signing things, no attempt should be made to collect a signature.

Even if the client does not sign the plan, it is recommended that he be given or sent a copy. Other copies should be given or sent to any family members involved in the plan.

The social worker does not need to make a

special visit to the client's house for the sole purpose of getting his signature or giving him a copy; however, the signature could be obtained or a copy given in a visit planned for another purpose. For instance, in our sample case the social worker got Mrs. Johnson's signature on the previously agreed-upon service plan when she visited to introduce Mrs. Johnson to her new in-home aide. All would agree that the client's participation in and agreement to the service plan is more important than the signature. The signature should be merely a reflection of that process.

The space for an "other" signature is for any informal caregiver, friend, or family member who has agreed to take a significant role in the service plan. Though not legally binding, this plan represents an understanding between the client and the social worker that this person will perform the agreed-upon activities, and it should be signed to signify agreement to the relevant parts of the plan. In the case example, the son definitely should be encouraged to sign, and it might be helpful to get his wife's signature as well, since she is implicitly a part of many of the things her husband or family will do. Other formal service providers such as other agencies or independent professionals will not sign this tool. Their agreement/participation will be secured through contracts, service plans, or other agreements either with the client, the family, or with the DSS.

Frequently Asked Questions

Question: When I used dictation, I would explain why I chose the services I did. How can I do that in this format?

Answer: The main reasons most people want to explain is to convince their supervisor they have made the right choice or to make notes to themselves and colleagues about possible next steps.

If your reason is the first one, your supervisor will want to see whether the activities in your plan follow logically from the Checklist for Change and goals

identified with the client and family. If they do, you will seldom need to explain your choices.

It is up to you to weigh the decisions and make an informed professional judgment about what course to recommend to the client and family for any given goal. If you are a new worker, you will probably want to talk about some of your ideas with your supervisor or a more experienced colleague. Even if you are not a new worker, some cases will raise serious doubts about the best way to proceed. In these cases you should talk to your supervisor or ask to have the case “staffed.” Sometimes your supervisor may want to know whether you considered some specific options, and he or she will ask you.

If, on the other hand, you want to keep track of additional ideas or notes to yourself for follow-up, you can record them in your Contact/Activity log for reference (see next chapter). For example, the social worker in the sample case might write “If the eye exam shows cataracts and Mrs. J. chooses surgery, we may need more in-home aide services during the recovery period.”

Question: You don't seem to have very many examples of services provided by anyone other than the client, the social worker, and the family in your service plan, even though you said we should involve other people, agencies, and groups. Why is that?

Answer: You are absolutely right. In this case the client had been isolating herself from others in her potential informal network such as her neighbors and her church, so her immediately available social resources were relatively limited. At the same time, further knowledge about Mrs. Johnson's eyesight, physical health, and possible depression will be

needed before it can be determined whether other services should be considered.

This service plan explores use of the Council on Aging's senior center services. It lays the groundwork for involving other formal and informal supports by asking the client to consider a bereavement group as well as getting the church involved in providing social stimulation. Mrs. Johnson's agreement to phone someone twice a week may also broaden her informal support network and give her additional information about other resources. Thus, the next plan may show a wider range of service/activity providers. As other agencies get more involved in the future, details about their services will be identified in contracts, service plans, or other agreements between them and the client, family, or DSS.

Key Points

- Columns four and five of the Adult and Family Service Plan (“Activities/Services” and “Person/Agency Responsible”) are the blueprint for how the goals of the client and family will be met.
- The client's and family's participation and agreement are essential to a workable plan.
- Sometimes it is necessary to plan a set of actions and services that will not completely reach the client's goal but will lay the groundwork for future actions to meet the goal.
- Knowledge of resources, a good assessment and summary, and creative thinking are the most important tools you can bring to this step of the Family Assessment and Change Process.
- A well-defined service plan assures that all parties have the same expectations.
- A thorough plan helps social workers

- budget their time and anticipate their clients' future needs.
- The client is usually the best person to be responsible for any of the service plan activities he is capable of doing.
 - The client's signature on the service plan is an affirmation of his central role in the planning process.
 - Effective service plans make use of all appropriate resources.
 - When DSS services are the best resource for the job, creative thinking assures the best fit to the client's needs.
 - By reviewing the activities and services, the supervisor can assess the appropriateness of the social worker's efforts to address the Checklist for Change and goals reached with the client and family.
 - Often the same actions and services can meet more than one of the client's goals.
 - The service plan provides future workers and supervisors who may interact with the client and family with a history of approaches tried.