PART III- FUNDAMENTALS OF HEALTH CARE SOCIAL WORK PRACTICE

Topic One: Different Health Care levels and settings

-***Health care settings*** are practice areas involving the personnel and service delivery facilities

1-Primary health care- the first level of health service, focuses on primary prevention and health maintenance, that is preventing health problems from emerging and providing very early intervention. For example, public health agencies, outpatient clinics health maintenance organizations

2-Secondary health care- this focuses on secondary prevention, or preventing health problems that have already emerged from developing into a worsened state, that is, repair and management. E.g. hospitals

3-Tertiary health care- the last level of health service, focuses on providing supportive assistance to maximize the comfort and function of persons with well-advanced health problems that cannot be cured, being either chronic or terminal in nature. E.g. rehabilitation centers, nursing homes, hospice programs and day care centers

Global focus for Primary Health Care

Concepts of Primary Health Care

-The term **'Primary Health Care' (PHC)** is the name given to the essential healthcare that is universally accessible to individuals and is acceptable to them at a cost that the country and community can afford.

- Often, this level of healthcare is free for people living in rural areas. Primary Health Care gained the world's attention after the 1978 International Conference on PHC held at Alma Ata in the former USSR (now called Almaty in the country that has become Kazakhstan).

-The conference reaffirmed the motto Health For All by 2000. The major points from the conference were

1-Health is a fundamental human right (availability, accessibility, affordability issues have to be addressed)

2-Existing gross health inequalities are unacceptable

3-Promotion of people's health is essential for improved quality of life

4-People have the right and duty to participate in the planning and implementation of health care

5-Government is responsible for achieving Health For All (HFA) 2000

6-PHC is the key to attaining HFA by 2000's target

- Hence we can say that PHC puts emphasis on four areas of strategic importance, dealing with current and future challenges to health. These are: Addressing health inequalities; People-centered care; Better public policies; and Stronger leadership.

-As indicated above the Alma Ata Declaration called for 'Health For All' by the year 2000 and both re-affirmed and significantly developed the principles of the original WHO constitution.

-The central feature of the Declaration was that it called for preliminary healthcare to be at the heart of healthcare systems. Bringing healthcare as close as possible to where people live and work, and constituting the first element of a continuing healthcare process (WHO, 1978: 1)

-Since then many countries have started to follow the approach of PHC to reach rural communities where most of the health problems exist. Primary Health Care (PHC) is 'first contact' essential healthcare based on the following points

1-Practical, scientifically sound and socially accepted practices (e.g. boiling water before drinking)

2- Technology made universally accessible like immunization, contraceptives

3-Affordabel costs to individuals, families, communities enlisting their full participation

- PHC is a gateway to continuum of health care system. It addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. E.g.-maternal and child health child health care, including family.

-PHC focuses on disease prevention and health promotion. It is the type of healthcare delivery sometimes described as 'by the people, of the people and for the people.' It involves the community in the whole process of healthcare delivery and encourages them to maintain their own health.

Principles of Primary Health Care

-The Primary Health Care policy has five principles that have been designed to work together and be implemented simultaneously to bring about a better health outcome for the entire population. The first principle is ***accessibility*** which means universally available healthcare delivery regardless of geographic location. The second principle is ***public participation*** which encourages the community to participate in making decisions about their own health, identifying their own health needs and finding solutions to their health problems. The third principle of ***health promotion*** involves health education on subjects such as maternal and child health, immunization, nutrition, sanitation and control of endemic disease. The fourth principle, ***appropriate technology****,* emphasizes those technologies that are scientifically sound, cost-effective and feasible to be introduced into the community. The fifth principle, ***inter-sectoral collaboration***, emphasizes integrated work with other sectors, such as the Ministry of Agriculture and the Ministries of Education, Housing and Water Resources. Below are also additional points on each of the principles

1. *Accessibility* (equal distribution): this is the first and most important key to PHC. Healthcare services must be equally shared by all the people of the community irrespective of their race, creed or economic status. This concept helps to shift the accessibility of healthcare from the cities to the rural areas where the most needy and vulnerable groups of the population live.
2. *Community participation*: this includes meaningful involvement of the community in planning, implementing and maintaining their health services. Through the involvement of the community, maximum utilization of local resources, such as manpower, money and materials, can be utilized to fulfill the goals of PHC.
3. *Health promotion*: involves all the important issues of health education, nutrition, sanitation, maternal and child health, and prevention and control of endemic diseases. Through health promotion individuals and families build an understanding of the determinants of health and develop skills to improve and maintain their health and wellbeing.
4. *Appropriate technology*: technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and for whom it is used.

5. *Inter-sectoral collaboration*: to be able to improve the health of local people the PHC program needs not only the health sector, but also the involvement of other sectors, like agriculture, education and housing.

Elements of primary Health care services

PHC addresses the following nine issues and problems

1-Health education- This is about education on health problems and how to prevent and control them. In short prevention and control of health problems (E.g. TB prevention)

2-Safe water supply- This is about adequate and safe water supply and basic sanitation (E.g. providing water tabs)

3-Nutrition- this is about the development of effective food supply and proper nutrition. Hence, it is about promotion of food supply and proper nutrition (E.g. use of salt in food preparation)

4-Mother and child health (MCH) care-

5-Family planning

6-Immunization- this is about Immunization against major infectious diseases

7-Prevention and control of endemic diseases - This is about local epidemic diseases control (E.g. malaria)

8-Treatment of common diseases and injuries- This is about appropriate treatment of common diseases and injuries (E.g. flu and car accidents)

9-Provision of essential drugs and medication

In all the above PHC provides promotive, preventive, curative and rehabilitation services. And it has to be sustained by sound referral systems, modern and traditional personnel.

Prevention services

Prevention activity is very important aspect especially in PHC, and has to be given the due attention. There are primary, secondary and tertiary prevention. *Primary prevention* refers to efforts to prevent occurrence of health problems; very early identification and intervention.

Secondary prevention is aimed at treatment and control of existing health problems; preventing the problem from developing into a more serious state or level (e.g. the spread of cancer or the development of liver damage due to alcoholism). *Tertiary prevention* refers to prevention of secondary disabilities; hence, it is associated with chronic and/or terminal health problems. E.g. diabetes (chronic), HIV (terminal)

Elements of prevention intervention

Prevention endeavors have to be fact-based; integrated; and targeted to need

Principle 1-Fact Based – This means we need to have adequate data management system to identify, stratify, and rank the health risk of the population that we serve

Principle 2-Integrated- This means prevention initiatives have to be aligned with the other goals or initiatives that we have at hand.

Principle 3-Targeted to need- This means prevention initiatives should target the population at risk, based on data. For example identifying and targeting the Most At Risk Population (MARPs) in the case of HIV/AIDS prevention activities. At the same time prevention initiatives should accommodate unique needs of the population in terms of age, gender, language and other preferences.

Different Roles of social workers in Health care Teams

Roles of Social workers in Health Care

-**Client problems**- our first role is about knowing our clients and their problems. We can call it ***Case Finding Process***. This means assessment of the need for social work services. Problems can emanate from ignorance, destructive human behavior, stress, social injustice, aging process, accidents, natural and human made disasters

Some General activities

1-Interventions- for example, explaining the disease and treatment and facilitate communication

2-Collaborations

3-Coordination

4-Advocacy

5-Supervision and administration

6-Assessment

7-Design, implementation of intervention

Some tasks

1-Attain goals of the profession of social work

2-help clients problem solve and cope with life stressors

3-Link individuals with resources, services, and opportunities

4-promoting effective and human service system

5-developing and improving social policy

Functions

-Clinical social work practice – one to one approach

-Community needs assessment

-Outreach to high risk populations

-Health education and promotion

-Policy formulation- in light of globalization and its actions

-Program design and planning

-Gate keeping for an array (range) of health problems (prevention)

-Organization and facilitation of self help groups

-Research in various aspects

-Acting as a therapeutic team member

-Activism- initiate and support movements

Interventions

-Short term psycho therapy

-Crises intervention (in Emergency Room)

-Problem solving, case management (service coordination)

-Behavior modification, anticipatory (preventive) coping

-Cognitive framing

-Community change interventions

-Client and family education

-Developing self, mutual help groups

-Assertiveness, parent effectiveness trainings

-Capacity building and systemic strengthening of health

Role of Social Work in Hospital social Work

1-Adjustment to the health care setting

2-Adjustment to the diagnosis, prognosis (prospect) and/ or treatment plan

3-Pre-admission planning

4-Helping patient and significant others make decisions about treatment related issues

5-Discharge planning

Hospital Social Work- covered earlier. This is one of the most comment setting.

-Hospital social workers assumed tasks that included (Beder, 2006).

- conducting patient assessments regarding their living environment and family situation,

- educating patients regarding the hospital stay and potential impact of the diagnosis,

- assisting patient compliance with physician treatment recommendations, and

- providing a link to community resources to assist the patient post discharge

- Activities and/or roles carried out by hospital social workers as reflected in previous literature included five domains— (Judd & Sheffield, 2010)

1-discharge planning,

2-direct practice activities such as counseling and/or crisis intervention,

3-conducting evidenced-based practice activities,

4-identifying and participating in bioethical issues, and

5-income-producing projects.

- Discharge planning activities were further divided into categories of

(a) assisting patient⁄family in understanding the diagnosis, anticipated level of functioning, prescribed treatment, and planning for follow up;

(b) providing specialized instruction so the patient⁄family can carry out post-hospital care;

(c) coordination of essential community support systems; and

(d) relocation of the patient or transfer to another health care facility.

***The question is how much time social workers in the hospitals spend their time in each one of the activities or tasks mentioned above

Discharge Planning

- In most hospitals in the US a main function of social work is discharge planning.

-From the view point of social work, discharge planning is an aspect of professional activity that helps patients cope with their illness and its effects, move through the hospital system, eventually return to their home with all the necessary supports to sustain their health.

-Provision of concrete services after discharge is very crucial. These include: home health care, medical equipment, transportation, delivery of medical supplies and medications

-There are many patients who are awaiting discharge from hospitals but not sure about where they would go.

Managed care in the US context

-Managed care plans are designed to reduce medical costs

-by discouraging unnecessary services

-by setting limits of duration and types of services

-by providing market inducements for providers to limit the services made available to patients

-Managed Care Companies can place limits on treatment that may well run counter to professional assessment

-This is seen especially in hospitals when patients are discharged before the social workers believe they are ready for and capable of managing outside of hospital.

-Managed care is also referred to as medical cost containment because it is designed to control access to and the cost of health care

Health Social work in Community Setting

In addition to hospitals, there is Community health care

−Assessment of social and health care needs

-Care and support to promote quality of life, respite & terminal care, information and counseling, organize self determination and action for building community health

-Linking clients to resources or making referrals

-Health promotion work
-Psychosocial support
-Training for family, partners, care givers

Social workers in a Mental Health Setting

Support people with mental health problems in the community, in hospitals on their own or as part of a multi-disciplinary team Tasks typically involve:

-Dealing with the negative societal reaction to the patients

-Assessing levels of risk

-Carrying out needs assessments

-Drawing up and managing a care plan in conjunction with other professionals

-Implementing individual and/or group therapy

-Arranging breaks for caregivers as necessary

-Offering information

-Counseling support to clients and their families

Topic two: Collaborative and Interdisciplinary practice Issues (Cowles, 2003)

Health service settings are multidisciplinary in their nature. There are more than one professional groups or discipline or specialty in a health setting. Multidisciplinary settings are not necessarily interdisciplinary. Interdisciplinary means that various professions or disciplines are working together and collaborating rather than merely (simply) working in the same place. Interdisciplinary in other words means collaboration with consensus. Social professionals such as social workers partner with allied health and mental health providers to build a continuum of care for those individuals, families and communities attempting to cope with the impact of both infectious and non-infectious diseases. We social workers can take interdisciplinary teamwork as a form of group practice that we can engage in.

Development of care plan and establishing roles and responsibilities of the different professionals is very important task. Social workers may work on teams that are:

1-*Multidisciplinary*- where each professional works autonomously with little interaction

2-*Interdisciplinary*- where professionals interact with one another to provide services but maintain clear professional boundaries dictated by distinct terminology and intervention planning.

3-*Transdisciplinary*- where we find close collaboration among professionals, common terminology and goal setting

Rational for interdisciplinary team

Joint working is important for healthcare services. In a hospital or other health setting interdisciplinary approach has to be there for the following rationale. The rational for this is indicated as follows. One, multiple kinds of knowledge and skill need to be involved and applied to best service the patient and the family. Two, the multiple kinds of knowledge and skill need to be involved and coordinated to maximize efficiency and effectiveness. Three, complexity of human problem or health in this case require division of labor.

Members and Characteristics of interdisciplinary team

Interdisciplinary team is distinguished by the following major characteristics. Small group size; Strong sense of group bond; Shared decision making; More frequent, regular, and direct face-to-face communication. The team can include physicians, nurses, social workers, physical therapists, psychiatrists, nutritionists, and others who may be providing care to the patient. People from different professions bring different attitudes, values, skills, and service orientations to the deliberations regarding what may be best for the patient. In some settings social workers could be valued less.

Function of interdisciplinary team

The following are the major functions of the interdisciplinary team

1-Shared assessment of patient problems and needs – this provides holistic view and understanding

2- Exchange of relevant information – this will enhance and bring about effective communication

3-Team teaching of staff/clients- the team can offer a learning opportunity for members of the team as well as outsiders such as students.

4-Development of intervention plans or modifications- plan will be made in collaboration in the team

5-Ethical decision making- in the case of making decisions ethical stand points will evaluated from different perspectives.

6-Deligation of tasks and responsibilities- the teams serves as a media for division of labor.

7-Evaluation of outcome- the evaluation will be made collectively

Common problems in interdisciplinary team functioning

1-turf (domain) protection- every professional tend to protect the profession by putting boundaries so that the other professionals may not involve in a specific part of the case. Co-opting by other professions of tasks that historically have fallen under the rubic of social work

2-different values and perceptions of the problems and needs- there are various views which are challenging to accommodate and manage

3-self promotion- the team could be a platform where the professionals tend to promote themselves instead of solving the problem

4-prestige and status discrepancies that impair open communication- there will be communication problem as a result of prestige and status problems of the team members. As a result of this professional of health care teams may not have equal voices in the care planning process. Even in the western context such as in the UK, hospital social workers may feel marginalized compared to fieldwork colleagues and have a less strong management structure

5-Lack of understanding of one another's language, skills, and knowledge areas- this emanates from the use of different jargons used in the professions. Ambiguity of roles and tasks can happen for the different disciplines may not understand one another's lexicon and procedures.

6-differences in the problem-solving process

The challenges of professional collaboration are not limited to the above points. Professional roles may not be clearly stated. Professional perspectives and ethics may clash. Professionals may change their Workplace. There could be reduction in the resources allocated. There could be increase in cost and decreased hospital stays.

Teamwork Requirements

Cowles (2003, p.21) lists specific objectives that are essential to maximal team collaboration. The following help to address the problems mentioned above:

1-Role clarity with flexibility (Flexible leadership and decision making; and also flexible membership composition based on case needs);

2-Mutual respect and trust;

3-An egalitarian attitude; a sense of equal importance (A sense of group bond and interdependence rather than autonomy);

4-Open communication and sharing;

5-Ability to negotiate and reach consensus; Consensus on group norms, values, commitment and purpose

6-Goal focus and goal clarity;

7-Record keeping of meetings: dates, members present, issues discussed, decisions made etc

8-A stable core membership

9-A sense of both group and professional identity

10-Attention to both the task and maintenance functions of the team

10-A systems perspective

Topic Three: Health Social Worker Knowledge, Functions, Skills, Values

Client Problems

-As health social workers we have to know our clients and their problems. **Problems emanate/ arise from** the following: Ignorance, Destructive human behaviors, Stress, Social injustice, Ageing process, Accidents, Natural & human made disasters. Sometimes arena of social workers and physicians are unclear. The first thing that a social worker should do is 'case finding' where our engagement will involve in. This is an assessment process of the need for social work services.

Knowledge requirements

-Social workers have to have extensive knowledge on several issues such as knowledge of: Medical and emotional problems, Psychopathology, Epidemiology, Organizational theory, Health and illness behaviors, Social determinants of health and illness and their impacts, Individual and environmental risk factors, Models of healthcare/ generalist social work practice, Sociology of medicine, Research Methodology.

-In professions there is **"autonomy of knowledge"** that leads to **"autonomy of practice"**. Social work is not different from this reality (Cowles, 2003, p., 41). For someone to join the profession he/she has to pass through the educational process. Somebody has to first understand what social work is all about (Better to refer to the most recent definition by IFSW and IASSW, 2014).

-Scientific knowledge is produced through "unbiased observation (objectivity) and theory building" (Cowles, 2003, p. 42). **Knowledge** is beyond data gathering and includes providing explanations on the gathered facts (p.42). Knowledge is a process of data gathering, hypothesis making and developing explanation or what we call t**heory**. It also includes modifications with new evidences. We usually develop research questions from our simple observations and hunches or practice hunches (or wisdom) and that is the first step in the scientific process.

-Social workers need to develop their knowledge in the following **generic areas**: Human Behavior and the Social Environment; Social Welfare Policy and Programs; Social Work Practice; and Research Methods. In addition to the above points health social workers need special skills and levels of knowledge. This means consistent with and within the context of the person-in-environment and bio-psychosocial orientations health social workers need to understand the following five points: **the patient population and their health problems**; the **organizational setting**; **the community**; **intervention modalities**; and **methods of research and program evaluation** (Cowles, 2003).

The following is a discussion about the understanding social workers should have in health field or specific knowledge area in practicing at hospital setting (Cowles, 2003, pp. 44-45)

1-Understanding the patient population and health problems-

-We see two things here. This is first about understanding the **characteristic of the client population**- their health, illness and sick-role behaviors. The understanding includes characteristics such as age and other socio-demographic factors and other related issues. This

knowledge facilitates the engagement, assessment, planning, cooperation, and overall communication with the patient and family members.

- This is also about understanding **the problem area**. This includes the following points: being familiar with the usual path, treatment, and management of a particular illness. Knowledge on the nature of the health problem (s) dealt with in the setting. For example, let us take kidney failure. What it is? How it is manifested? What are the causes effects and treatments? This understanding allows the social worker to knowledgeably interact with the other health care professionals with whom it is necessary to communicate on behalf of the patient.

-The social workers need to see how a certain disorder can be explained through a biopsychosocial perspective. Seeing the disorder in relation to the human diversity is important at this point. This is because the diversity affects health behavior, illness behavior and sick-role behavior. Social workers need to acquire **terms and vocabulary** from the **medical and psychiatric fields as well as from public health**.

2-An understanding of the organizational setting

-The characteristics of the organizational setting have impact on the implications of social work. For example, whether it is a profit-making or non-profit making or whether it is a hospital or health center or NGO or FBO etc. This includes understanding all **issues regarding the organization** such as the missions, functions, health service interventions, authority, structure, types of health professions and occupations in the setting, and their roles, role expectations of social work. **Organizational policies**, rules, regulations and interdisciplinary teamwork principles and practice problems have to be understood. This facilitates interdisciplinary teamwork and informal advocacy on behalf of the patient.

3-Knowledge of the community

-This is about acquiring **holistic knowledge about the surrounding community**. This includes the characteristics of the surrounding community such as rural, urban or suburban, population demographics, political attitudes, major business and industry (economic activity). This allows the social worker ease in linking patients to resources and facilitating referrals to other health-related programs that will aid the patient. We need to scan and use the resources of that community in general sense and resources specific to the needs of the client population and problem area served by the practice setting.

4- Understanding of specific treatment modalities and intervention approaches

-There are several **intervention approaches** that social workers use to deal with the problems of their clients. These include crisis management/ intervention, grief counseling, behavioral modification, case management and so on. And social workers need to have the understanding about these modalities. Social workers need to use **approaches tailored to the needs** of the particular client population, problem area, and organizational characteristics. This allows the social worker to meaningfully interact with patients and family members in the role of counselor and confidante (entrusted person). This skill enables the social worker to connect with the patient or family member to address emotional concerns and help the patient resolve problems as they relate to medical condition.

5-Knowledge of research and evaluation and documentation

-The social worker's ability to design and conduct research keeps social work vital and responsive to patient needs. At the same time it helps for documenting new areas of knowledge and understanding. Research on existing programs, especially those that reinforce interdisciplinary cooperation, is vital to serving patients' and family members' needs. Social workers need to do documentations that are appropriate to and/or required by the practice setting.

Skills requirement

-Preventive work,

-Health care decision making

-Counseling, even for resisting patients

-Participation in differential diagnosis

-Clinical or psychosocial interview

-Ability to help patients 'see' causes

-Training clients and family members (e.g. life-skills training)

-Referring and linking clients to appropriate programs

-Using resources efficiently and effectively

-Health promotion- knowing what and how to promote

-Research and evaluation

Skills and competencies in health care social work

3.3.1-Collaborative and interdisciplinary/multidisciplinary practice issues

3.3.2-Skill requirements and interventions: assessment, engagement, communication, case management with different client groups

3.3.3-Roles and functions of health care social workers

Skill Requirements

1-Preventive work

2-Health care decision making

3-Participation in diagnosis

4-Clinical or psychosocial interview

5-Ability to help patients 'see' causes

6-Training clients and family members (e.g. life skills)

7-Referring and linking clients to appropriate programs

8-Using resources efficiently and effectively

9-Health promotion (what and how)

10-Research and Evaluation

Skill can be defined as the ability to do something. We may have different types of skills. Professional skill is different from other types of everyday life skills such as driving or bike riding. The knowledge requirements and the fact that it is bounded by professional values and ethics are among the differentiating points of a professional skill from other skills. Cowles (2003) stated that "Professional skill involves the ability to act appropriately by drawing upon a body of knowledge and a set of values and ethics while interacting with a complex set of often-changing conditions" (p. 61)

Professional skills are characterized as follows (Cowles, 2003, p. 61)

1-Conscious- performed with awareness of what is being done

2-Purposeful- performed with an objective

3-Disciplined- performed not impulsively but with control

4-Responsible- performed with mindfulness of obligations to the values and ethics of the profession

There are different techniques in a skill category. For example, active listening is a communication skills technique. Techniques are specific behaviors.

Skilled activities in helping Stages of helping process

1-Engagment ……………………………………….Engagement

2-Observation……………………………………….Data collection

3-Assessment……………………………………….Assessment

4-Cooperative planning……………………………Intervention Planning (contracted)

5-Intervention modality……………………………Plan intervention

6-Research/evaluation……………………………..Evaluation of progress/effect

7-Termination/closure …………………………….....Termination

8-Communication…………………………………. (Throughout the helping process)

9-Empathy…………………………………………. (Throughout the helping process)

Case Management Model

Effective co-ordination of the required services is case or care management services; among other professionals social workers work as case managers. Historically case management evolved in the USA in 1970s where health care and social welfare services were provided by numerous agencies.

Definition: Case Management Model

A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

Purpose-why is it needed?

Health care systems can be complicated. Patients may not know all the questions to ask the physician. Medical language is often unfamiliar and physicians cannot spend enough time with them to help them understand all the complexities of their illness. Case manager bridges that gap to assure that they have all the information they need to make well informed health care decision. Case manager helps the patient understand and cope with the medical, insurance, and emotional issues confronting him/her.

In the case management, a comprehensive assessment is performed and recommendations to enhance the client's health care and living situation provided. A clear plan for coordinating the client's health care and maintaining or improving the client's health is provided.

How does it work?

A case manager will work with the client, his/her family, physicians, dietician and other health care providers to ensure the client or the client's family members receive all the necessary services to promote the client's health. In addition, case manager provides linkages to other resources and services important for family well being.

Steps in case management

The following are the major steps for case management

1-Needs assessment involving all parties

2-Drawing up a care plan, its objectives, strategies, resources are agreed by all

3-Negotiation of agreements or contracts with service providing organizations

4-Regular case review and monitoring

5-Incorporate necessary changes

Case Managers Roles

-Counselor/ therapist

-Problem solver

-Broker, coordinator

-Advocate

-Expediter

-Planner

-Record keeper

-Service manager

-System modifier

HEALTH SOCIAL WORK ASSESSMENT

Social Workers evaluate the strengths and needs of individuals and members of their social support network as part of a social work assessment to identify assets and potential barriers to care. Social workers help health-care teams assess psychological and social issues such as domestic violence, and socioeconomic barriers to the attainment of quality health care, among other issues.

Assessment

One of the major services that social workers need to provide on ongoing bases is assessment. Assessment is mainly about gathering comprehensive information that would be used in developing interventions and health care strategies. The Code of Ethics of NASW (2008, p.20) stated the following regarding assessment. It is "a fundamental process of social work practice. Treatment and intervention strategies/plans require that social workers both assess and reassess client needs client needs and modify plan accordingly". Regarding the scope of social work assessment in health care setting the Code of NASW (2008, p.20) stated areas including "considering relevant biomedical, psychosocial, and spiritual factors and the needs of the individual client and the family (as defined by the client)"

Social work assessment has to be comprehensive and culturally competent. To achieve this essence the following points has to be included (NASW, 2008, pp. 20-21)

1-Past and current health status including genetic history of family health

2-The impact of the health conditions or treatments on cognitive, emotional, social, sexual, psychological, or physical functioning

3-The impact on body image, intimacy, and sexuality

4-social history, including current living arrangement and household environment

5-Work, school, or vocational history

6-Stage in the life cycle and related and relevant developmental issues

7-Cultural values and beliefs, including views on illness, disability, and death

8-Family structure and the client's role within the family

9-Social supports, including formal and informal support systems

10-Behavioral and mental health status and current level of functioning, including history, suicide risks, and coping styles

11-Financial resources, including access to and type of health insurance

The client populations on which health social workers can make comprehensive assessment include children, people with severe and persistent mental illness, immigrants and refugees, people with substance use disorders, victims of violence or trauma, homeless people, and people with physical or psychiatric disabilities.

Culturally competent assessment with interdisciplinary input is the bases for planning and intervention from which health social workers start implementing to ensure client well-being and through a continuum of care.

Values and Ethics

-Respect for client's culture, diversity

- Spirit of service – this is promoting client's well being as a prime responsibility,

-Importance of human relationships

- Client's right to self determination

-Client's right to participation

-Treating each person as a whole

-Identifying and developing strengths (strengths perspective)

Value bases for health social work practice

3.1.1-Core social work values

3.1.2-Code of conduct and protocols

3.1.3-Ethical considerations

Value and Ethics

Value is something regarded as important and worthwhile; whereas ethics is behavioral norms that reflect our underlying values. As a profession, social work holds the following core values

1-Service

2-Social justice

3-Dignity and Worth of the person

4-Importance of human relationships

5-Integrity

6-Competence

1-Value- Services

Ethical Principle- Social workers' primary goal is to help people in need and to address social problems

2-Value- Social justice

Ethical principle- Social workers challenge social injustice

3-Value- Dignity and Worth of the Person

Ethical Principle- Social Workers respect the inherent dignity and worth of the person

4-Value- Importance of Human Relationship

Ethical Principle- Social workers recognize the central importance of human relationships

5-Value-Intergity

Ethical Principle- Social behave in a trustworthy manner

6- Value- Competence

Ethical principle- Social workers practice within their areas of competence and develop and enhance their professional expertise

Hence, we can say social work is among the most value-based profession. In relation to this the NASW Code of ethics charges social workers:

1-To treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity

2-To promote client's socially responsible self-determination

3-To enhance client's capacity and opportunity to change and to address their own needs

4-To resolve conflicts between clients' interest and the broader society's interests in a socially responsible manner

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NASW, 1996

1-Respect for clients' culture and diversity

2-Promote client's well-being as a prime responsibility, spirit of service

3-Importance of human relationships

4-Client's right to self determination

5-Client's right to participation

6-Treating each person as a whole

7-Identifying and developing strengths

Ethical Standards of Professional Social work Practice

(Social workers' ethical responsibilities to clients)

1-Commitment to clients

2-Self-detemination

The basic social work values i.e. respecting the uniqueness of each individual, alongside a commitment to social justice, have to be also applied in health and well-being through social health model.

3-Informed consent

4-Competence

5-Cultural competence and Social Diversity

6-Conflicts of Interest

7-Privacy and Confidentiality

8-Access to records

9-Sexual relationship

10-Physical contact

11-Sexual harassment

12-Deregatory language

13-Payment for services

14-Clients who Lack decision making capacity

15-Interruption of Services

16-Termination of Services

Topic Four: Some of the theories in healthcare social work

I-Health Belief Model

(The following discussion is excerpted from the book chapter of Nancy K. Janz; Victoria L. Champion & Victor J. Strecher in Glanz et al)

Introduction

This is one of the most widely used conceptual frameworks in health behavior. The Health Belief Model (HBM) explains change and maintenance of health-related behaviors. It also serves as a guiding framework for health behavior interventions. HBM was developed in the 1950s in the US by a group of social psychologists in public health service. The HBM was developed to see the responses of people in the US to the Free program that tried to screen tuberculosis among eligible adults in the 1950s and 1960s. The program was interested to look at the factors that facilitated or inhibited positive responses. The point is that the people have to do X-rays- and their readiness for the test has to be understood. In short the Health Belief Model was originally developed to explain why people failed to participate in health screening for tuberculosis despite accommodations such as mobile vans that came into the neighborhoods.

The theory underlines that human behavior stems from rational, logical thought processes. People make health choices largely based on consideration of the costs and benefits of various actions. The HBM is a value-expectancy theory which falls under cognitive theory. Under cognitive theory, behavior is a function of the subjective value of an outcome and the subjective probability, or expectation, that a particular action will achieve that outcome.

Value-expectancy in health related behaviors is as follows. The desire to avoid illness or to get well (this is an example of value). The belief that a specific health action available to a person would prevent (or ameliorate) illness (this is an example of expectation). In this expectation issue; we can further see the following. First, individual's estimate of personal susceptibility to and severity of an illness; the second is, the likelihood of being able to reduce that threat through personal action.

In general, it now is believed that people will take action to prevent, to screen for, or to control ill-health conditions.

1-If they regard themselves as susceptible to the condition

2-If they believe it would have potentially serious consequences

3-If they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or severity of the condition and

4-If they believe that the anticipated barriers to (or costs of) taking the action are out weighted by its benefits

The model posits two major components of health behavior: threat and outcome expectations.

Components of the HBM

Empirical evidences support that the Health Belief Model (HBM) predicts health outcomes. This means each component predicts health outcomes. The HBM has the following six components: 1) Perceived Susceptibility 2) Perceived Severity 3) Perceived Benefits 4) Perceived Barriers 5) Cues to Action 6) Self-Efficacy

1-Percieved Susceptibility- This refers to one's subjective perception of the risk of contracting problem of a health condition. In medically established illness, it includes acceptance of the diagnosis, personal estimates of re-susceptibility, and susceptibility to illness in general.

2-Perceived Severity- This refers to feelings concerning the seriousness of contracting an illness and its consequences. It also includes feelings concerning the seriousness of leaving it (the illness) untreated. These feelings include the following: evaluation of both medical and clinical consequences (for example, death, disability, and pain), and also evaluation of possible social consequences (such as effects of the conditions on work, family life, and social relations). The combination of susceptibility and severity has been labeled the perceived threat.

3-Perecevied Benefits- This refers to the beliefs regarding the effectiveness of the various available actions for reducing the disease threat. Hence, there would be perceived benefits of taking the health actions. Other factors include non health-related benefits (for example, quitting smoking to save money; getting a mammogram to please family members). Thus, an individual exhibiting an optimal level of beliefs in susceptibility and severity would not be expected to

accept any recommended health action unless that action also was perceived as potentially efficacious. This means action has to be perceived as efficacious.

4-Percieved Barriers- It is obvious that the recommended behavior may not be acted because of perceived barriers. Among others, perceived barriers can also be the potential negative aspects of a particular health action. This refers to various things. The first is analyzing and weighing the action's expected effectiveness against perception that it may be expensive. There should be an acceptable cost, as cost is one of the barriers.Second, it may be dangerous (having negative side effects or iatrogenic outcomes). Third, it may be unpleasant (painful, difficult, upsetting). Or it may be inconvenient. Furthermore, it may be time-consuming etc. Perceived benefits and perceived barriers/cost collectively are named outcome expectations.

5) Cues to Action - This concept is about cues that trigger action. Cues instigate actions. We see cues as trigger mechanism. These cues could be bodily events or environmental events, such as media publicity. The cues are strategies to activate one's "readiness". These cues are potential factors to make people ready for perceived susceptibility and perceived benefits.

6) Self-efficacy- Self-efficacy is defined as "the conviction that one can successfully execute the behavior required to produce the outcomes". It requires a good deal of confidence that one can, in fact, alter for example lifestyles, life-long habits, etc. before successful change is possible. For behavior change to succeed the following must be fulfilled. As indicated earlier people must be threatened by their current behavioral patterns (perceived susceptibility and severity). In addition, people must believe that change of a specific kind will result in a valued outcome at acceptable cost. Furthermore, they also must feel themselves competent (self-efficacious) to overcome perceived barriers to taking actions. Self-efficacy in short means one's confidence in one's ability to take action.

Other variables- In addition to the above components, there are other variables that have contributions in affecting the health behaviors. Diverse demographic, socio-psychological, and structural variables may affect the individual's perceptions and thus indirectly influence health-related behavior. Specifically, socio-demographic factors, particularly educational attainment, are believed to have an indirect effect on behavior by influencing the perception of susceptibility, severity, benefits, and barriers.

Using the HBM to Address Public Health Concerns

The HBM continued to be a major organizing framework for explaining and predicting acceptance of health and medical care recommendations. The HBM has been used extensively to determine relationships between constructs and behaviors of public concerns as well as to inform interventions. For instance, tailoring messages for breast cancer screening using the HBM constructs of susceptibility, benefits, and barriers has been found to increase mammography adherence (regular check-up for breast cancer).

Empirical evidence supports the Health Belief Model's ability to predict health outcomes. Becker and colleagues (1977; Maiman, Becker, Kirscht, Haefner, & Drachman, 1977) were able to explain 39% of the variance in dietary adherence using the Health Belief Model's components in multiple regression analysis. Components of the Health Belief Model, such as perceived susceptibility, were measured in the group's dietary adherence, the model's components were important to understanding the dietary adherence.

The HBM suggests that for individuals who exhibit high-risk behaviors, perceived susceptibility is necessary before commitment to changing these risky behaviors can occur. For example, perceived susceptibility to HIV/AIDS was associated with behavior changes, including increased condom use, fewer sex partners, and a decreased number of sexual encounters. If perceived HIV/AIDS threat is high, and perceived benefits outweigh perceived barriers, the HBM predicts that a cue to action could prompt an individual to adopt AIDS preventive behaviors. The cue is thought to stimulate the belief-action link.

The HBM constructs/models can be used as measurements in research. Prior to engaging in instrumental development, researchers should search for instruments (e.g. survey tools) that have previously been developed and have established validity and reliability. Only when these cannot be found should scale development be undertaken. This means development of new assessment tool.

In conclusion, the Health Belief Model should be taken as a model or a combination of constructs. It is not a collection of equally weighted variables operating simultaneously. In order to influence health-related behaviors, one has to use the health belief variables including self

efficacy. It has to be noted that the beliefs and behaviors of each of the individuals is a crucial point to bring improved health.

It is reasonable to assume that a theory such as the HBM is applicable to different cultures. It also is important to realize that constructs may have to be adopted to make them more relevant to the target culture. The dimensions of the HBM can be useful in understanding health behaviors in multicultural settings. The cultural beliefs of the target population have to be considered as the same time.

II- Stages of Change

The "stage" construct provides a temporal (time) dimension of change. The Transtheoretical Model (TTM) construes (interprets) change as a process-involving progress through a series of six stages discussed briefly below. The stages model can be applied in a range of health and mental health behaviors.

1-Precontemplation: This is the stage in which people do not intend to take action in the foreseeable future. At this stage people may be uninformed or under-informed about the consequences of their behavior. On the other hand, they may have tried a number of times and become demoralized about their abilities to change. At this stage people tend to avoid reading, talking, or thinking, about their high-risk behaviors. Generally, there is no motivation or readiness to think about change.

2-Contemplation: This is a stage where people intend to change. This is a period of ambivalence (feeling two conflicting emotions at the same time). This is because there is awareness of the pros and the cons of changing. As a result of this, the process here can take long period of time. There is less immediate action and there is a tendency of behavioral procrastination.

3-Preparation: This is the stage in which people intend to take action in the immediate future. People at this stage develop a plan of action, such as joining a health education class, consulting a counselor, talking to their physician, buying a self-help book etc.

4-Action: This is a stage where people made clear and overt modifications in their life styles within the past six months. In short the action is observable. Of course, there should be criteria to consider the actions as sufficient.

5-Maintenance: This is a stage in which people strive to prevent relapse (or staying sober). This is a time where the actions are maintained for long. At this stage people develop the confidence not to be tempted by relapse.

6- Termination: This is a stage where the individuals develop the total self-efficacy and do not succumb (fail) to temptation. In whatever condition they are in, those who reached at stage will not turn back to their old unhealthy habit. This is an ideal stage where there will be zero temptation and total self-efficacy. For example, physical exercise, consistent use of condom, weight control etc.

III- Processes of Change

Processes of change are the covert and overt activities that people use to progress through the stages. We use these processes of change for intervention programs. The following ten processes are crucial.

1-**Conciousness raising**: This involves increased awareness about the causes, consequences, and cures for a particular problem behavior. This change process involves several interventions. The following interventions are common: increase awareness; providing/ receiving feedback, confrontations, interpretation, bibliotheraphy (collection of therapy) and media campaigns.

2-Dramatic relief: This move people emotionally to make change because they have seen others' experiences. There is noticeable thing for the change. This initially produces increased emotional experiences followed by reduced affect if appropriate action is taken. Interventions include psychodrama, role playing, grieving, personal testimonies, and media campaigns. These are examples of techniques that can move people emotionally.

3-Self-reevalation: Combines both cognitive and affective assessment of one's self-image with and without a particular unhealthy habit. Interventions include value clarification, healthy role models, and imagery. These are techniques that can move people evaluatively.

4-Environmemtal reevaluation: This combines both affective and cognitive assessments of how the presence or absence of a personal habit effects one's social environment, such as the effect on others of smoking. It is obvious that one can serve as positive or negative role model for others; and understanding this is part of environmental reevaluation. Empathy training, documentaries, and family interventions can lead to such reassessments.

5-Self-liberation: This is a belief that one can change. It also includes the commitment and recommitment to act on that belief. This also includes enhancing the willpower (the ability to control one's thoughts and actions in order to achieve what one wants to do). Some of the measures to enhance willpower include: New Year's resolutions, public testimonies and multiple choices.

6-Helping relationships: This is about building social supports. This combines caring, trust, openness, and acceptance as well as support for healthy behavior change. Measures such as rapport building, a therapeutic alliance, counselor calls, and buddy systems (making new friendship) can be sources of social support.

7-Counterconditioning: This requires the learning of healthier behaviors that can substitute for problem behaviors. Relaxation, assertion, desensitization, nicotine replacement, and positive self-statements are strategies and measures for safer substitutes.

8-Contingency management: This is about knowing the consequences of taking steps in a particular direction. This involves both punishments and rewards. Reinforcement measures will be taken increasingly to increase the probability of repeating healthier responses.

9-Stimulus control: This is about removing the cues (triggers or signals) for unhealthy habits and adding prompts for healthier alternatives. Avoidance, environmental reengineering, and self-help groups can provide stimuli that support change and reduce risks for relapse.

10-Social liberation: This comes through an increase in social opportunities or alternatives, especially for people who are relatively deprived or oppressed. To increase these opportunities especially related to health promotion, we do advocacy, empowerment procedures and take appropriate policy measures. These can help people to make change.

IV-The biopsychosocial approach in health care delivery system

The biopsychosocial approach considers three overlapping aspects of the patient's functioning. The biopsychosocial approach enables social workers to assess each of these domains to gain a full understanding of the patient. The "bio" refers to the biological and medical aspects of the patient's health and well-being. This model states the importance of recognizing the physical state of human beings in (bio), among others. These include possible genetic predisposition and neurotransmitter imbalance. Genetic factors can be causes of death or can determine life span. There are diseases like diabetes, schizophrenia run in families.The "psycho" refers to the patient's self-worth, self-esteem, and emotional resources as they relate to the medical condition. The emotional or psychological aspects are in the psycho. These include one's psychological make-up, irrational beliefs, frustration, chemical imbalance-mood (affective) disorder.

The "social" refers to the social environment that surrounds and influences the patient. The social involves the socio-cultural, socio-political, socio-economic conditions. The socio-cultural includes social and cultural norms, cultural differences, cultural change and cultural ritual. The socio-political includes political fraternity or conflict of society. It also includes policies and laws governing life aspects e.g. taxation, labour issues, environmental issues etc. Socio-economic includes income, education and occupation.

There is another dimension called the spiritual in the model. Hence the bio-psychosocial and spiritual model is one of the strength based perspectives in social work practice. It includes bio, psycho, social and spiritual components. The spiritual is about finding the meaning of lives. For example, feeling empty inside or missing something or search for more-high meaning (such as extreme happiness). As indicated earlier this approach provides a holistic view because it seeks to encompass the whole picture of the individual and places the individual in a context that informs social work intervention.

The following indicates the Health Related Consequences on the dimensions:

1-Physical effects- these include chronic headaches, chest pains, heart trouble, blood pressures, stomach ulcer, appetite loss, disturbed sleep patterns, skin irritation

2-*Psychological consequences*- ways of thinking, feeling and behaving downs, inability to think clearly and denial of reality, agitated (arguable) state, can't handle feelings, mood swings

3-Social consequences- relationships damaged, isolation (secrecy), self (obsessed), communication difficulties

4-Spiritual consequences- feels helpless and hopeless, despair, dishonesty with self and others, self-worth diminished, dominated by fear-trapped not free

Cyclic Relationships of the Factors

The above four components are interdependent to one another. A life change event (more of social) can produce emotional distress. For example, we can take divorce or separation or loss of jobs. Emotional distress causes physiological changes which make a person vulnerable to disease. The physical health problem can erode self confidence, limits physical activity and can affect social/family roles, in turn cause emotional distress, impaired immune system function. Hence, when an individual is sick all dimensions of the person will be affected. It is in short the whole person.

This model implies that the "whole person" should be assessed for effective diagnosis and treatment. Mental and physical health are related due to cyclic association. Various forms of mental illnesses have rates of physical illness far in excess of expected frequency in the general population. We can ask the following questions in practicing in the health care setting

1-Did patients have people in their immediate environment that could care for them?

2-What supports existed and what needed to be enhanced?

3-Were there community resources that could be brought to patients to help them recover?