C.A.R.E.: A Model for Improving the Process of Assessment

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Abstract

Assumptions, perceptions, and expectations (APEs) determine how individuals view the social world and the people who live within, especially if persons do not share the same cultural experiences or beliefs of other individuals. Health care workers serve a variety of individuals from a multitude of cultural and ethnic backgrounds. Although workers are charged with developing individualized plans of care to address the multiple disadvantages and unique needs experienced by persons who admit for healthcare service, APEs held by the worker moderate the clustering of disadvantage experienced by clients within the social environment, further separating them from those who make determinations of, and decisions about, care. Although factors connected to vulnerability or disadvantage may affect the well-being and outcomes of clients, the process of othering, either implicit or explicit, creates and maintains a state of inequity, documented through assessments, care plans, and other formal artifacts of service. This paper uses a critical lens to review how APEs intersect with the existing processes and procedures of assessment, affirming and enhancing clusterings of disadvantage and social injustices experienced by clients, creating corrosive and reified states of chronic disadvantage that lead to poor and pervasive patterns of outcomes for vulnerable persons relegated to the category of the other and proposes a model of C.A.R.E. to improve outcomes during the assessment process.

Keywords: Admission process, APEs, assumptions, disadvantage, expectations, othering, perceptions, stigma, long-term care

Key Practitioners Message:

➢ *Attitudes, perceptions, and expectations of human service professionals influence the process of assessment, which influences documents of care.*

➢ *The bias of human service workers can be explicit or implicit, malevolent or benevolent. Regardless of intent, all bias skews the accuracy of assessments for older persons admitting for services, including Long Term Care.*

➢ *Inaccurate assessments can influence plans of care for long periods of time, within and across systems.*

➢ *Personalizing the process of assessment improves the accuracy of assessment for older persons admitting for services.*

➢ *Incorporating clients into initial and on-going assessment by Connecting through Active engagement, Relationship building, and Empathetic response creates better, and more accurate, assessments.*

Othering may be defined as an intentional and structured process, which separates persons into groups of *them and us*. Hatzenbueler, Phelan, and Link (2013) examined such intentional acts as functions of social control that create a stigma to *keep people down*, *keep people out*, and *keep people away*. The division is apparent in commonly alienating subjects such as politics, religion, and migration; yet, *othering* is also present in ways persons assess, evaluate, and document the needs of human beings.

Othering can take place on a large group basis; however, it also occurs in smaller and more intimate ways that separate and marginalize individuals. Though the intent of this process may not be nefarious, it creates and maintains separations between people. *Benevolent othering* was defined by Grey (2016) as a tendency of offering concern and equality that preserves barriers of individuality and equity, maintaining "subordination of (mental health) care users" (p. 241). This *benevolent othering* is seen in helping professions, such as social work, where workers are charged with evaluating and triaging multiple needs, separating and categorizing individuals, often through a superficially benevolent process of *doing to* (Grey, 2016).

To examine the role of social work and conceptualize procedures and practices of *benevolent othering,* this paper will identify factors that contribute to *benevolent othering* within social work assessment procedures.

Background

Human service professionals, such as social workers, provide services to vulnerable persons by identifying the needs of individuals seeking services, optimally working with these individuals to identify and develop strengths, linking individuals to appropriate and available services, and advocating for issues of social justice, improving and sustaining the lives of persons within the social environment (IFSW [International Federation of Social Workers], 2016).

Multiple factors create and maintain marginal-

ization, contributing to what Wolff and de-Shalit (2007) described as clustering of disadvantage, impacting one's ability to thrive within the social environment, with clients seeking assistance, or coming into care, experiencing risk, vulnerabilities, and situational stressors. Because these factors are bounded by time, space, and place, human service workers use assessment tools to triage specific needs, target interventions, and develop plans of care; yet, the assessment process is influenced by the attitudes, perceptions, and experiences (APEs) of social workers and other helping individuals (Werner & Araten-Bergman, 2017). Though such bias may be implicit, it explicitly affects decisions and delivery of care for those who seek assistance from professionals ethically obligated to respect "the inherent dignity and worth of the person" (NASW [National Association of Social Workers], 2017, para 9).

Assessments

Persons seeking assistance from human service organizations are initially assessed to evaluate current and anticipated needs for services related to the identified problem, including identification of the underlying diagnosis or other factors supporting the identified problem(s) (SAMHSA [Substance Abuse and Mental Health Services Administration], 2009). The intake process is usually the first formal contact between the client and an organization, providing opportunities to create shared knowledge between the individual and the organization. These assessments inform decisions for plans of care that attempt to match services with needs, driving the delivery of services (SAMHSA, 2009).

Standardized forms have long been employed during the assessment process to create an accurate evaluation of need. In 1917, Mary Richmond published assessment forms, establishing a standard of practice for social workers who develop interventions and plans of care to address the needs of vulnerable individuals. Indeed, Tomberlin, Eggart, and Callister (1984) described the importance of standardized forms for "consistent and efficient patient evaluations in a short period

of time" (p. 348). Assessment forms are employed as tools to help individualize care; however, the standardized nature of these tools, limits the identification and individualization of the presenting client.

The accuracy of assessments is dependent upon the questions asked and answered, the purpose of the organization, and the engagement between the worker and client. Although classic literature finds that professional assessments judge clients with accuracy (Schrauger & Osberg, 1981), multiple factors can influence the assessment process, including time allotted for the assessment, the skill, and experience of the worker, and the APEs of workers. This process is prevalent in the way older persons are assessed upon entering residential or long-term care (LTC).

Othering as a Product of Assessment in Long-Term Care

Multiple disciplinary assessments are conducted upon, or shortly after, admission to residential or LTC. Initial assessments are completed to create a holistic assessment of the resident's unique needs. Additionally, many assessments are standardized and involve the process of checking boxes and determining categories of care, based upon the current evaluation of persons who have recently experienced trauma and/or continued states of delirium, brought on by changes of condition, acute injury or illness, or side-effects of drugs. Kosar and his colleagues (2017) noted the problem of misdiagnosis due to delirium contributing to poorer short-term and long-term outcomes.

Additionally, the social history of the new resident may be unknown or unshared. As a result, data informing these assessments are often not an accurate reflection of the resident's normal state. Though assessments are updated, they may merely add to the initial assessment.

Once initial assessments are entered into electronic medical records, ticked boxes from inaccurate assessments may continue to identify goals and objectives of care, regarding these baseline assessments. Although social workers and other providers are charged with accurately assessing and individualizing plans of care, standardized forms and electronic medical records promote what Grey (2016) described as the continued separation and categorization of individuals, often based upon an inaccurate assessment of the initial presentation of the resident.

Additionally, rapid assessments of newly admitted residents are mandated by regulation, contributing to what Schnelle et al. (2004) called "the culture of inaccurate documentation" (p. 1378), with deadlines for assessments having greater magnitude, than accuracy.

APEs

Health care workers' attitudes, perceptions, and expectations may further contribute to inaccuracies, which align with Goffman's concept of stigma as a perception of "blemishes of character" (Goffman, 1963, p.4), echoing historical views of deservingness, dating to the Old Poor Laws of 1601. Historical views of deservingness separated clients into two arbitrary categories the "worthy" and "unworthy."

Though the helping professions, including social work, advocate for value-free practice, which maintains the dignity and worth of individuals (National Association of Social Workers, 2017), the beliefs, values, and experiences of workers, coupled with increased scarcity of available resources, influence decision making regarding care (Banaji & Greenwald, 2013). These discrediting influences contribute to inaccurate and unfair assessment practices for vulnerable persons. Additionally, Banaji and Greenwald (2013) declared that APEs provide a default of decision, especially when judging persons belonging to other social groups, creating and maintaining barriers to understanding and empathy for persons seen as *other*.

Assumptions

Assumptions are what persons believe to be true (VIU [Vancouver Island University], 2018). One's assumptions reify, over time, and create meaning.

Although assumptions are made by everyone, they create "a flawed foundation for our understanding" (VIU, 2018, para. 4).

For persons seeking assistance, assumptions held by the health care worker result in inaccurate and skewed assessments, which drive plans of care and delivery of services. Inaccurate assessments prove even more problematic when considering how written information and electronic medical records remain accessible for years, cementing perceptions of clients across, and within, agencies and organizations.

Perceptions

Perceptions are how person regard, understand, and interpret one another (VCI, 2018).

Perceptions are unique to the person holding them, arising from personal values and beliefs, informing positions of explicit and implicit bias (Banaji & Greenwald, 2013; VCI, 2018).

For persons seeking assistance, perceptions of health care workers create and maintain stereotypes and discrimination, limiting the individualization of care.

Expectations

Expectations are assertions that something will happen and is inevitable. Expectations are based on personal experience(s) and generalize future events (VCI, 2018).

For persons seeking care, expectations of staff influence plans of care, creating barriers to meaningful relationships and limiting positive outcomes.

Othering

Persons who seek assistance are often confronted with bureaucratic and compulsory procedures that categorize individuals into groups defined by the presence and intensity of need, formalizing positions of power (Johnson et al., 2004). This differentiation was described by Lister (2004) as othering - the division people make between persons defined as persons, and us defined as them.

Powell and Menendian (2017) defined othering as "a set of dynamics, processes, and structures that engender marginality and persistent inequality…" (para. 12). Standardized forms are an alternative to long-hand assessments, and though they serve as an important information-gathering tool, they fail to capture the unique needs of the whole person, and often support labeling practices that continue to oppress vulnerable persons.

Benevolent Othering

Grey (2016) explained that persons receiving services commonly experience a benevolent type of *othering* where they are treated kindly, but held at a distance, seen as less able to control life circumstances, dependent upon assistance from others. The process of assessment may be impersonal, but it is not necessarily intentional; regardless, documents of assessments often reduce persons to checked boxes and filled blanks, supporting disparity and disadvantage (Wolff and de-Shalit, 2007), and supporting what Freire (1968/1970) described as a process that "dehumanizes the oppressed" (p. 44).

The assessment process frames the interaction, informed by the attitudes, perceptions, and experiences of social workers and others, who view vulnerable persons as unable to make good decisions and life choices. Though *benevolent othering* is employed, ostensibly, to help others, it patronizes and infantilizes those seeking care, creating and maintaining dependency through the imbalance of power between those who help provide access to care and those who receive it (Sakamoto & Pitner, 2005). Whether the act of *othering* is motivated by exclusion or inclusion – intentional or not - it dilutes and depersonalizes individuals, limiting opportunities for success (Johnson et al., 2004).

Assessment as Process

The assessment has long been defined as a top-down systematic process, designed to identify the needs of the presenting individual as accurately as possible (Wright, Williamson, & Wilkin-

son, 1998). Despite efforts to personalize plans of care, the process of assessment is frequently a time-limited experience that fails to holistically evaluate individuals, reducing persons to demographic statistics and quantitative measurement, limiting outcomes for those dependent upon the decisions of others (Freire, 1968/1970; Schnelle et al., 2004).

Persons seeking assistance from social service organizations live and operate within social contexts. So too, do health care workers. The likelihood of *othering* practices increases according to organizational culture, with a greater number of institutional characteristics associated with a greater prevalence of *othering*, creating higher degrees of vulnerability for persons seeking formal assistance through organizations and institutions of care (Goffman, 1961) and influencing significant consequences to health and well-being (Johnson et al., 2004).

Though assessments are intended to personalize the response to individualized need, the process of assessment is often a route taking of name, address, age, gender, and status, with demographics serving as determinants of response, often collected by persons holding clipboards or staring at screens, which differentiates persons sitting on opposite sides of desks.

Johnson et al. (2004) determined othering as organizational discrimination, which "can reinforce and reproduce positions of domination and subordination" (p. 253). When formulating answers to formulated questions are used to create documents of assessment, processes of care and caring become mere responses to objective data, influenced by workers whose conceptions and perceptions influence drivers of care (Johnson et al., 1998).

Conceptual Model

The conceptual model depicted in *Figure 1* assumes that disparities exist in the process of assessment and illustrates the mediating influence of workers' APEs upon the creation of documents of care. These disparities create threats to well-being for persons seeking assistance, limiting opportunities and outcomes for persons who have less power (Prasad, 2018).
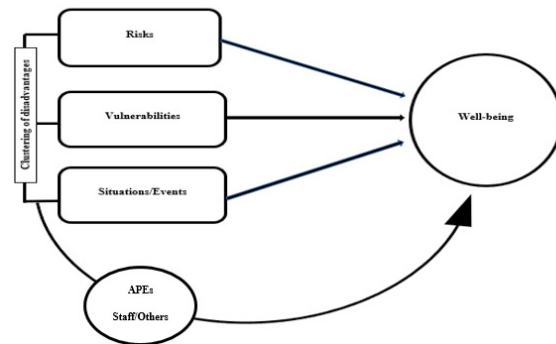
Figure 1. Authors' conceptual model of the relationship of clustered disadvantage; attitudes, perceptions, and expectations of staff/others; and well-being for persons seeking assistance through social service organizations.

It may be hypothesized that multiple disadvantages faced by persons entering care are further complicated by the APEs of workers. Although any factor of vulnerability or disadvantage may affect well-being, Wolff and de-Shalit (2007) argued that multiple factors often intersect with multiple vulnerabilities, clustering together and creating corrosive disadvantage that leads to persistent patterns and poor outcomes.

Although the definition of well-being is subjective, the Centers for Disease Control and Prevention (CDC, 2016) noted the role of relationships and social ties in the promotion of well-being. Health care professionals should interpersonally engage with clients to develop plans of care, adopting qualitative measures to assessment procedures and intentionally engaging with clients, establishing a personalized partnership of care. Engaging clients in the assessment process is not a substitute for documentation of standardized needs; rather, it provides an enhancement for evaluation, and an invitation for clients to engage in the reflection of the current situation(s) and action to address them, with the praxis of engagement serving as a catalyst for better outcomes.

Assessment as Praxis

Critical consciousness compels social workers and other helping professionals to see beyond answers obtained from standardized forms. Intentional engagement of those seeking services creates a space for holistic assessments, which engage clients in the assessment process, providing a path for workers to *do with*, rather than *do to*, minimizing oppression created by imbalances of power (Sakamoto & Pitner, 2005). Tylee and his colleagues (2012) described the importance of collaboration, between providers and patients, on positive outcomes for health and wellness.

C.A.R.E.

We propose the integration of a model of C.A.R.E. into the process of assessment, especially initial assessments. This model augments existing processes of assessment and utilizes relationships to enhance client well-being by "*C*onnecting through", "*A*ctive engagement", "*R*elationship building", and "*E*mpathetic response". C.A.R.E. incorporates the process of *working with* clients to develop plans of care that best meet identified needs. C.A.R.E. establishes clients as their experts, and affirms the right to make the decisions that they determine are best. Establishing clients as their own best experts helps workers develop more accurate assessments through engagement practices, involving removing desks and other physical barriers during assessment. Additionally, the active incorporation of interpersonal skills, such as, addressing the client by name throughout the process of assessment; gathering information through open-ended questions and active listening (defined as summaries and reflections); appropriate use of affirmations, including maintaining a non-judgmental disposition, including the use of person-first language and avoiding pejoratives such as *habits*. Further, including the client in the development of goal setting, including the asking of *the miracle question*, incorporates a person-centered vision of the client's best self, in the best situation, at the best time.

Actively and authentically engaging clients takes time. Collaborative processes are more time in-

tensive than standardized assessments; however, while the C.A.R.E. process would add time to initial assessments, the investment may provide a more accurate measure of where the client is, and where the client would like to be going. Such accuracy will help practitioners to be collaborative create interventions and responses that better address the needs of the clients and, more importantly, invite clients into a process that focuses on active engagement with the assessment process, creating a praxis of care, which builds on the capacity of all engaged stakeholders. The mediating influence of care upon well-being is depicted in *Figure 2*.
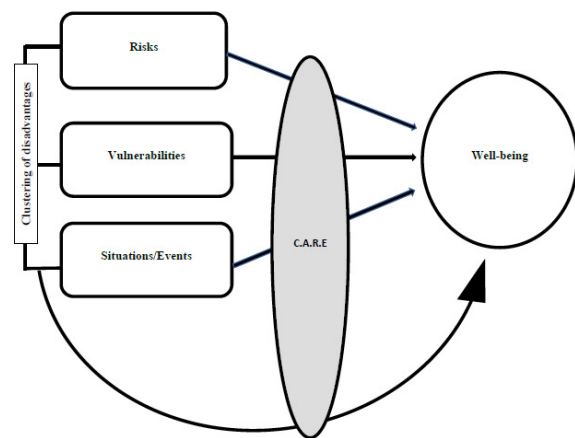
Figure 2. Authors' conceptual model of the relationship of clustered disadvantage; attitudes, perceptions, and expectations of staff/others; and well-being for persons seeking assistance through social service organizations, with C.A.R.E. as a moderating factor.

Conclusion

Evaluating the needs of new clients and residents is not intended to be a one-size-fits-all model of practice. Needs vary from person to person and place to place, as does the perception of well-being, defined as satisfaction regarding access and opportunities for mental, physical, and social health (Centers for Disease Control and Prevention, 2016). The C.A.R.E. model respects this variance and conforms to current recommendations of resident assessment as a personalized, evolving, and on-going process (Toney-Butler & Unison-Pace, 2019).

Care matters. It affects how we relate to others and how others relate to us. "Unequal" treatment is the manifestation of a lack of empathy, created through the process of *othering* those who are different. Incorporating C.A.R.E. will allow social workers and other health care workers to "approach questions of social reality and knowledge production from a more problematized vantage point, emphasizing the constructed nature of social reality" (Prasad, 2018, P.7) to assess: How is the client affected by the social environment? How can the client be supported? How can client well-being be enhanced? How can we recognize well-being for the client? How can we recognize what works for the client? How can we come to know how to do better? How can we move beyond the forms and make meaningful connections that not only identify the individual needs but the individual, as well? This study hopes to personalize care, by **C**onnecting through **A**ctive engagement, **R**elationship building, and **E**mpathetic response, with the ethical tenet of respecting the dignity and worth of the person as the core of C.A.R.E.

As Perlman (1979) reminded us:

> …our lifetime relationship experiences, especially those that drove deep into us at times of our helplessness, need, dependency upon the caring of others, condition us to want not only whatever material or psychological aid we need but also another human being to resonate to our distress. (p. 53)

Meeting people *where they are*, looking people in the eye, calling them by name, actively listening to their troubles and triumphs show people that they are not just cared *for*, but cared *about*, as well.

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