**ASSIGNMENT 2**

1. **Select a population category and discuss why they are referred to as vulnerable or at Risk.**

**Gendered economic risks.**

The differential distribution of resources (financial, social, human and physical capital) between men and women, as well as differential social roles and 5 responsibilities means that the options available to men and women to respond to macro-level shocks and stresses are likely to vary. Economic risks can include declines in national financial resources and/or aid flows, terms of trade shocks or environmental disasters. Stresses might include long-term national budget deficits and debt, lack of a regulatory framework and/or enforcement of health and safety standards at work and lack of an economically enabling environment. Given men’s and women’s differential engagement in the economy, such as the labor market, the impacts of macro-economic shocks are highly gendered. For example, in times of economic crisis, women are often the first to lose jobs in the formal sector

**Gendered social risks.**

Social sources of vulnerability are often as or more important barriers to sustainable livelihoods and general well-being than economic shocks and stresses. At a macro-level, social exclusion and discrimination often inform and/or are perpetuated by formal policies, legislation and institutions (e.g. low representation of women or minority groups in senior positions). In many countries, efforts to ensure that national laws and policies are consistent in terms of providing equal treatment and/or opportunities to citizens irrespective of gender, caste, race, ethnicity, religion, class, sexuality and disability are often weak or uneven. Moreover, although there have been considerable improvements over the last two decades in part due to international movements to address social exclusion, the enforcement of existing anti-discrimination policies and laws is often under-resourced, especially at the subnational level.

**Decision making structures.**

Women’s representation in public works-related decision-making structures is often inadequate to promote their voice; proactive efforts are required.

**Biased in piecemeal rates.**

Piecemeal rates may be gender-biased – they are typically based on male work norms, meaning that even if there are formal provisions for equal wages that women end up being paid less.

**Household heads programmes.**

programmes often target household heads, thereby excluding women in male-headed households from equal participation.

**Discrimination in some kind of work.**

there is often a distinction between ‘heavy’ versus ‘light’ work whereby these definitions are often based on cultural norms of work rather than the actual difficulty and physical exertion required for such work.

**Job consideration or scarcity.**

In contexts of job scarcity women may be pressured by men not to compete for public works jobs.

1. **You have been posted by an NGO to work in a community far from your home.**
   1. **What are some of the problems you might encounter?**

**Impact on organizational culture**

Many workers say the lack of community and disconnect from the overall community culture as one of the biggest downfalls.

There are fewer opportunities to connect and engage with their peers, resulting in a lack of that much-valued sense of ‘camaraderie’ many office workers experience. There’s also a lack of visibility of the overall business direction, mission and values.

Workers don’t build loyalties to the organization; they are more likely to move onto new opportunities.

## Accountability and visibility

Then, there are management and accountability concerns. Workers are actually doing what’s being asked of them? To balance the need for transparency and ‘checking in become difficult, with the threat of becoming a Big Brother-style organization that causes resentment from employees. On the other end of the scale, the need to be visible and show productivity can result in remote employees over-working and doing more hours than their in-house counterparts. They often face difficulties in prioritizing work and gaining insight into bigger picture business priorities or objectives. It’s a process that can result in burn-out, dissatisfaction and ultimately, staff turnover.

## Security

In an age of [global hacks, cyber terrorism](https://www.wired.com/story/2017-biggest-hacks-so-far/) and in fact, physical terror attacks, the question of how employees, keep our data, and our information safe, is at the forefront of everyone’s minds.

In the office, we have protocols, procedures and policies covering everything from virus protection and password policy through to fire evacuation or what to do when working alone in the office. Some of these are still relevant. However, employees encounter an entirely different set of risks when working in shared spaces, home alone, or even accessing business systems on public networks.

## Work-life boundaries

Improved work-life balance is usually cited as one of the major incentives, and benefits of, working from home. However, it’s not a given benefit to workers who are more likely to be subject to home interruptions, and a blurring between work and home life. Without physical boundaries between a work environment and home environment, this can result in longer or unpredictable hours worked increased stress, a strain on personal and professional relationships, and the threat of one, or both, sides taking advantage.

## Time zone and communication concerns

One of the greatest difficulties experienced by working far from one community or dispersed team is the question of communication.

Individuals working across different time zones or even different countries, have logistical challenges. Employees don’t speak the same language, political, cultural or social differences cause difficulties or unforeseen divisions. Workers will also communicate over various digital channels. There’s instant messaging, video calls, Skype, project management tools, forums and of course the fail-safe email. That’s a lot of streams to keep on top of. The result is misunderstandings, a lack of clarity, and an impact on how individuals build and maintain trust with their colleagues. It also adds to that feeling of isolation from the business – of being ‘out the loop’ compared to peers.

* 1. **How can you improve your cross-cultural competence?**

Cross-cultural competence refers to your ability to understand people from different cultures and engage with them effectively. And not just people from the one culture that you’ve studied for years. Having cross-cultural competence means you can be effective in your interactions with people from most any culture. Therefore, the following ways can improve cross-cultural competence;

**Recognize that culture extends beyond skin color.** Although darker-skinned persons are commonly identified as “black” or African-American, some identify themselves as Hispanic, Jamaican, or white. Others may identify with their religion, gender, sexual preference, age, geography, socioeconomic status, or occupation. For example, the “tough-it-out” ethos of firefighters can breed denial of depression or trauma that limits their desire to seek or stay in treatment.

**Find out each patient’s cultural background.** On your intake forms, include questions about race, ethnicity, language(s), religion, and age, or ask the patient to discuss his or her cultural background during the initial interview.

**Determine your cultural effectiveness.** A sample breakdown of your patients can help you analyze treatment, compliance, progress, and outcomes among cultural groups.

**Make your patients feel “at home.”** If possible, your staff should reflect your area’s cultural makeup.

**Conduct culturally sensitive evaluations.** Cultural identification often leads to misdiagnosis.[1](https://www.mdedge.com/psychiatry/article/59732/7-ways-improve-cultural-competence#bib1) For example, African-American men tend to be over-diagnosed with paranoid schizophrenia or antisocial personality disorder.[2](https://www.mdedge.com/psychiatry/article/59732/7-ways-improve-cultural-competence#bib2)

**Elicit patient expectations and preferences.** Some cultures distrust modern drug therapy, while some patients think medication should magically resolve their disorders. Still others think psychotherapy works only for whites.

**Understand your cultural identity.** Do a “cultural self-analysis” and see how your values apply to psychiatry. For example, if your culture values independence and individuality, you may underestimate the effectiveness of family therapy for patients whose cultures value interdependence.

1. **Discuss the steps in taking a dietary history for a partner.**

The dietary history collects retrospective information on the patterns of food use during a longer, less precisely defined time period.  It records a patient’s ***usual*** dietary intake (vs. *actual* food intake)

The original Dietary History data collection method was initially made up of 3 components, 24h recall, Cross check, and the three-day food record.

**The 24hour Recall**  
The Health Professional guides the Patient to recall in detail of all food and drink consumed the previous day as well as any pertinent nutritional/herbal supplements.

**Potential Probes:**

When did you wake up?  What was the first thing you ate and/or drank?

Did you have a morning snack/morning Coffee?

What did you have for lunch?  Anything to drink with that?

Afternoon snack/snack when you came home from school/work?

What did you have for supper?  Did you have dessert?

Snack in the evening/before you went to bed?

Do you take a multivitamin? Any herbal supplements?  Iron pills? etc. at what time of day?

Do you drink water throughout the day?  How many glasses?

These questions provide you with a general account of what the patient consumed yesterday.  Now you’re interested in portion sizes.  
Having visual aids such as food models are helpful here, or having a measuring cup and measuring spoons.  Other visual cues could be remembering that a medium sized fruit is the size of a tennis ball, one serving of meat is about the size of a deck of cards.  Ask them if half of their plate if filled with vegetables/meat/potato etc.

**The Cross Check**  
Now that you have a sense of what the patient ate yesterday, record what day of the week it was.  Was this a typical day for them in turns of eating? Do weekends differ from weekdays?  The cross check is a mini questionnaire on the frequency of consumption of specific food items used to verify and clarify the information gathered from the 24h recall.

**Potential Probes**

Any food allergies/major food dislikes/food groups you avoid (e.g. vegetarian)?

Any health-related diet implications (e.g. gluten free, low sodium)?

Do you normally eat three meals/day? Two-three snacks/day?

Would you call yourself a snacker (i.e. like to graze throughout the day) or do you prefer structured meal times?

Do you find yourself skipping a certain meal more than others (e.g. breakfast, work through lunch)?

Do you tend to have the same breakfast every day?

What’s your favorite breakfast cereal?

Do you drink fluid milk (or milk alternative)?

Do you normally bring a lunch from home or do you more often eat at the (cafeteria/local café/fast food restaurant)?

How often do you eat red meat? Fish?

Are there any vegetables you dislike/avoid?

How often do you have dessert?

What’s the most common method of food preparation in your house (e.g. frying, baking, steaming vegetables vs. boiling, etc.)?

How often do you fill your water bottle?

Do you remember to take your (vitamin/supplement) every day?

Pick two of your most favorite foods from each of the four food groups (Vegetables & Fruit; Grain Products; Milk & Alternatives; Meat & Alternatives)

**Three Day Food Record**

A three-day food record is designed to get an accurate description of the partner typical daily diet. Since this food record will be used to help make appropriate dietary changes it is important that one should try not to change the usual eating patterns for these three days. Please try to be as accurate as possible by recording all of the foods and beverages one eat and drink. If the food is prepared at home or in a restaurant, please include a description of the preparation techniques (ex. grilled vs. fried). In order to get an accurate representation of the partner diet, record food intake for 2 weekdays and 1 weekend day (ex. Monday, Thursday, & Saturday).

1. **Why is it important to formulate objectives in the counseling Process?**

To observe and differentiate the roles and functions of clinical mental health counselors in various settings and the importance of relationships between counselors and other professionals, including interdisciplinary treatment teams.

To help identify and implement concepts of management of mental health services and programs, including areas such as administration, finance and accountability.

To discuss and evaluate professional issues that affect clinical mental health counseling (e.g., core provider status, expert witness status, and access to practice privileges within managed care systems).

To provide diagnoses, diagnostic criteria, and diagnostic tools for mental and emotional disorders.

Help interview, evaluate, produce a treatment plan, and manage a caseload with assigned clients.

It assists to observe and discern the potential for substance abuse disorders to mimic and co-occur with a variety of medical and psychological disorders as well as distinguish basic psychopharmacological classifications and medications.

It evaluates the impact of crisis, disasters, and other trauma- causing events on people.

Help in research and identify the operation of an emergency management system within clinical mental health agencies and in the community.

1. **Explain circumstances that may require prescription of nutrition supplements.**

Patients who are discharged from hospital on Nutrition Supplement will not automatically require Nutrition Supplement on prescription once they go home. They may have required Nutrition Supplements whilst acutely unwell or recovering from surgery, but once home and eating normally the need is often negated. Therefore, it is recommended that Nutrition Supplements are not prescribed following hospital discharge without first assessing the need for them. If ONS is required, a switch to one of the first line should be considered, unless the patient is under dietetic care or second line prescribed Nutrition Supplement is deemed necessary.

Review of treatment. To assess the benefit of the prescribed nutritional supplements, individuals should be reviewed within 3-6 months of commencement by the clinician who initiated them. When the aim of starting prescribed supplements is achieved, the supplements should be discontinued. Patients in the final weeks of life are unlikely to benefit from prescription supplements. OTC supplements may be a better option due to palatability

1. **Explain why the elderly are considered to be vulnerable to malnutrition.**

## ****Digestive System Changes****

A healthy digestive system is necessary for proper nourishment. With age, the digestive system’s ability to function optimally declines. This decline can be seen throughout the [digestive tract,](http://www.merckmanuals.com/home/digestive_disorders/biology_of_the_digestive_system/effects_of_aging_on_the_digestive_system.html) from the mouth all the way through to the anus. A decline in upper digestive tract function can cause decreased saliva production, cause trouble swallowing (as mentioned earlier) and create an increase in gastroesophageal reflux disease (GERD) due to a dwindling strength of the muscle connecting the stomach and esophagus. Age related changes to the stomach lining put the elderly at higher risk for gastric ulcers and [B12 deficiency](http://www.health.harvard.edu/press_releases/vitamin_b12_deficiency), as well as a decreased capacity to hold food. With time, our body also loses its ability to digest [lactose](http://www.merckmanuals.com/home/digestive_disorders/biology_of_the_digestive_system/effects_of_aging_on_the_digestive_system.html), the sugar in milk, which may cause certain individuals to experience pain, bloating and possibly bacterial overgrowth within the small intestine. As well, overall movement of food through a senior’s digestive tract tends to be slower contributing, in part, to constipation.

## ****Chronic Illness & Medication****

As we age, we are more likely to be dealing with some sort of chronic disease. One [estimate](http://www.parl.gc.ca/content/hoc/Committee/411/HESA/Reports/RP5600467/hesarp08/hesarp08-e.pdf) finds that 74-90% of seniors have at least one chronic illness with almost three quarters of seniors taking at least one medication. The most common chronic diseases within the elderly community are cardiovascular disease, diabetes and respiratory diseases. Each of these can influence the nutritional status of those suffering with them in a number of ways. Medications can affect one’s appetite, bowel movements, taste perception, saliva production, and alertness level among other things. All of these side effects can have a negative impact on nutrition, especially that of a frail elder.

## ****Money Worries****

For a large number of elderly, poor nutrition in their golden years stems from their financial worries. Many seniors depend on an ever dwindling savings or a small pension to survive.  Sometimes that money just doesn’t seem to be quite enough. As a result, the quality or quantity of food they buy is sacrificed leaving them nutritionally at risk.

## ****Incontinence****

What does bowel or urinary incontinence have to do with poor nutrition, you ask? Many individuals, whether old or young, limit their intake of food or drink when they suffer from incontinence to avoid having embarrassing ‘accidents’. While at home incontinent individuals may feel more comfortable eating and drinking but if social events or errands are planned intake may be purposefully limited. For nutritionally vulnerable seniors, skipping meals can be quite damaging.

## ****Decreased Thirst and Hunger Sensations****

As we age our body goes through a number of physiological changes including a decreased sensitivity to hunger and [thirst](http://www.medscape.com/viewarticle/567678). Many elders do not receive strong signals from their body telling them that they need to nourish or hydrate themselves. When this happens, especially in combination with other factors on this list, malnutrition and dehydration can result.

## ****Trouble Swallowing****

Trouble swallowing, otherwise known as dysphagia, is a serious problem and is fairly common among the elderly population. Some [estimate](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3426263/) that at least 15% of elderly exhibit some form of swallowing difficulties. Dysphagia can be a result of an age-related decline in swallowing function, stroke, dementia, radiation to the head or neck or a neurodegenerative disease. [Signs](http://www.mayoclinic.org/diseases-conditions/dysphagia/basics/symptoms/con-20033444) that your elder is having swallowing difficulties could be gagging or coughing while eating, pain with swallowing, the sensation of food being stuck in the throat, or hoarseness of voice. The dangers of dysphagia are not only that it impacts ability to obtain proper nutrition but those with dysphagia are at high risk for the very serious aspiration pneumonia.

## ****Poor Dental Health****

Dental health is often overlooked when sussing out for the root cause of an elderly person’s poor nutritional status but it can cause significant dietary problems. Whether this is because of missing teeth, dental pain, or poor fitting dentures, dental problems can seriously impact nutrition. Food choices and, therefore, nutrition are limited when dental issues exist.

## ****Poor Mental Health****

Just as physical health can play a role in the nutritional status of older seniors, so can mental health. Failing memory and cognition as well as depression can significantly impact dietary intake. Poor memory and cognition often can lead to forgetting to eat or drink putting them at risk for weight loss, malnutrition and dehydration. Depression can limit motivation to eat, cook and shop for food.

## ****Poor Mobility****

Whether poor mobility is due to decreasing physical ability or simply poor energy levels, it can seriously impact a senior’s nutrition. Younger adults may not fully appreciate how much energy it takes for the elderly to do the things they do so readily. A trip to the grocery store may be only thing an elder suffering from poor mobility can do in a day. There may be days when seniors decide it isn’t even worth going to the store to pick up groceries. This could mean they go to the nearest convenience store or fast food restaurant to pick up their next meal or they simply do without. The problem with acquiring food at local convenience stores or fast food joints is that the foods available at these locations are quite limited and often times devoid of much nutrition.

***Reference;***

*Dr. Moffic is professor of psychiatry, Medical College of Wisconsin, Milwaukee.*

*Moffic HS, Kinzie JD. The history and future of cross-cultural psychiatric services. Comm Mental Health, 1996.*

*Whaley A. Cultural mistrust of white mental health clinicians among African Americans with severe mental illness. Am J Orthopsychiatry 2001.*