ASSIGNMENT 2

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

* Vulnerability, the susceptibility to harm, results from an interaction between the resources available to individuals and communities and the life challenges they face. Vulnerability results from developmental problems, personal incapacities, disadvantaged social status, inadequacy of interpersonal networks and supports, degraded neighborhoods and environments, and the complex interactions of these factors over the life course.
* Definitions of vulnerability also include being defenseless, exposed, open to attack, sensitive, susceptible, unprotected and weak (McLeod 1985, p. 736), where a position of relative disadvantage is identified (Stevenson 2010).
* One category of population considered vulnerable or at risk are Children; due to their age, children are considered to be at risk for exploitation, abuse, violence and neglect. Vulnerability cannot be defined simply by age. Though age is one component, Vulnerability is also measured by the child's capability for self-protection. The question that arises is, are children capable of protecting themselves. Can children provide for their basic needs, defend against a dangerous situation or even recognize a dangerous situation is developing? These questions call for a redefinition of the concept of self-protection. A child's vulnerability comes from various factors that hinder a child's ability to function and grow normally. Hence self-protection is more about the ability of the child to lead a healthy life within a child protection system; the ability to protect themselves or get help from people who can provide protection. The term vulnerable children refer to an age group that is considered at risk. But vulnerability of children is further compounded by the following factors:
* Age within age: Younger children, especially those below the age of six, are much more dependent on the protection system.
* Provocative behaviors: due to ignorance or misunderstanding of children's mental health or behavioral problems, some people can become irritated or frustrated and hence lash out against children or neglect them completely.
* Powerlessness: comes of the situations and people that surround the children. If a child is given the power by the state, family or community to participate and fulfil their own rights and responsibilities they are less vulnerable.
* Defenselessness: comes from the lack of protection provided by the state or parents or community. If there is no child abuse law than how is a child suppose to defend himself/herself against abuse.
* Passivity: due to situation or treatment of the child. For example a child who is enslaved or oppressed does not have the ability to seek help or protection.
* Invisible: Children who the system does not even recognize are highly vulnerable doesn't have a home or shelter and no means to obtain such an abode

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?

* Professionals who work far from home face some unique challenges when compared to their home/urban counterparts. For some, these challenges may make them more susceptible to workplace violence, or make the impact of workplace violence more serious.
* Rural and remote communities are not homogenous and within these communities, there are different challenges that impact on the safety of once work.

The following are the challenges I might encounter on my new assignment far from home;

* Cultural issues

The types of cultural issues in rural and remote communities can vary considerably. In some communities, cultural issues are complex and multi-faceted. Ignorance of a community’s cultural norms can result in unintended breaches of community protocols, which can lead to people taking offence, tension, and potentially conflict.

* Mandatory reporting requirements.

There can be practical difficulties surrounding mandatory reporting of suspected child abuse in rural and remote communities, where there may be a lack of anonymity and community preference to resolve issues internally.

* Distance management and support.

The managers and co-workers of professionals in rural and remote locations can sometimes be located some distance away from them. This may impact on the capacity of the workplace to be a safe environment and on the support that can be provided following a violent incident.

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

Here is how I can improve “cultural competence.”

1. 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.
2. 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.
3. Determine your cultural effectiveness. A sample breakdown of your patients can help you analyze treatment, compliance, progress, and outcomes among cultural groups.
4. Make your patients feel “at home.” If possible, your staff should reflect your area’s cultural makeup.
5. Conduct culturally sensitive evaluations. Cultural identification often leads to misdiagnosis.
6. 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.
7. Discuss the steps in taking a dietary history for a partner.

The dietary history for a partner is comprised of four distinct steps namely;

1. Nutrition Assessment

2. Nutrition Diagnosis

3. Nutrition Intervention

4. Nutrition Monitoring and Evaluation

Step 1 Nutrition Assessment

Nutrition assessment is the measurement of the extent in which an individual’s

Physiological needs for nutrients are being met. It is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. Nutrition assessment requires making comparisons between the information obtained and reliable standards.

Step 2 Nutrition Diagnosis

Nutrition Diagnosis is the second step of taking a dietary history for a partner. The dependent on the outcome of step 1, Nutrition Assessment. Nutrition diagnosis is the identification and labeling that describes an actual occurrence, risk of, or potential for developing a nutritional problem. Nutrition diagnosis differs from medical diagnosis as it changes as the patient/client/group’s responds to management.

Step 3 Nutrition Intervention

An intervention is a specific set of activities and associated materials used to address the problem. Nutrition interventions are purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for an individual, target group, or the community at large. This step involves selecting, planning, and implementing appropriate actions to meet patient/client/groups’ nutrition needs.

Nutrition counselling sets the stage for optimum dietary adherence and therefore becomes the most important intervention yielding long tern positive results. It is

Step 4 Nutrition Monitoring and Evaluation

In the Nutrition Care Process, Monitoring refers to the review and measurement of the patient/client/group’s status at a scheduled (preplanned) follow-up point with regard to the nutrition diagnosis, intervention plans/goals, and outcomes, whereas Evaluation is the systematic comparison of current findings with previous status, intervention goals, or a reference standard. Monitoring and evaluation use selected outcome indicators (markers) that are relevant to the patient/client/group’s defined needs, nutrition diagnosis, nutrition goals, and disease state. Monitoring and Evaluation are based on the outcome of nutrition

assessment which gives valuable indicators, nutrition diagnosis and the

intervention chosen. The purpose of monitoring and evaluation is to determine the degree to which progress is being made and goals or desired outcomes of nutrition care are being met. It is more than just “watching” what is happening; it requires an active commitment to measuring and recording the appropriate outcome indicators (markers) relevant to the nutrition diagnosis and intervention strategies.

1. Why is it important to formulate objectives in the counseling Process?
2. Explain circumstances that may require prescription of nutrition supplements.

* There are several reasons one may be prescribed nutritional supplements.
* If one is finding it hard to eat normal foods due to illness;
* Have difficulty swallowing normal foods due to illness;
* Have lost weight through illness, medical treatment or surgery;
* Have lost weight without intending to.
* Pregnant Women: Women also need nutritional supplements during pregnancy, and breastfed infants need vitamin D. Folic acid—400 micrograms daily, if a woman is unable to get all the dietary requirements that, she requires from her daily intake of food, prescription of nutritional/dietary supplements is required. However, pills and tablets cannot replace a healthy balanced diet. The stress, therefore, must be on maintaining a diet high in vegetables and fruits.
* The following groups of people may require dietary supplements:
* People consuming fewer than 1600 calories per day
* Pregnant and breast-feeding women
* Postmenopausal women and those with heavy menstruation
* Chronic diarrhea
* Food allergies and food intolerances
* Vegans (who do not include even dairy products in their diet), and anyone eliminating an entire food group from their diet

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

* Older adults (aged ≥65 y) tend to be more prone to nutritional deficiencies because aging may come with an accumulation of diseases and impairments. These include cognitive and physical decline, depressive symptoms, emotional variations and poor oral health, along with socioeconomic changes. All of these factors may directly influence the balance between nutritional needs and intake. Even in cases of adequate nutrient and energy intake, the nutritional status of older adults can be challenged by a compromised nutrient metabolism (such as absorption, distribution, storage, utilization, and excretion), drug–nutrient interactions, or altered nutrient needs
* When it comes to nutrition, the elderly are an especially vulnerable population. Malnutrition in the elderly does not discriminate between race, gender or socioeconomic [status](http://link.springer.com/article/10.1007%2Fs12603-012-0374-8). All elderly can be at risk of declining nutrition.
* **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.

* **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 Dental Health**

Dental health is often overlooked when sousing 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.

* **Trouble Swallowing**

Trouble swallowing, otherwise known as dysphagia, is a serious problem and is fairly common among the elderly population. 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 the 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.

* **Decreased Thirst and Hunger Sensations**

As the body ages our it 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.

* **Money Worries**

Large number of elderly, have poor nutrition because of their financial worries. Many elders depend on an ever-dwindling savings or a small pension to survive.  Sometimes that money just does not seem to be quite enough. As a result, the quality or quantity of food they buy is sacrificed leaving them nutritionally at risk.

* **Chronic Illness & Medication**

As the body age, it will develop some of chronic disease. 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.

* **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 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 well as a decreased capacity to hold food.

Reference:

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