psychological assessment, whereas others look more at environmental factors influencing the client. The best assessment involves an integrative approach that uses a broad lens for assessing clients from both bio-psychosocial and person-in-environment perspectives. Often, a rating scale, such as the one developed by Pomeroy, Holleran, and Franklin (2003), is helpful in providing a comprehensive individual assessment.

Another frequent criticism of assessment is that it often relies on a deficit model. The assessment of a client often involves diagnosis using *DSM-IV*. Applying only a *DSM-IV* diagnosis to a client focuses on a psychiatric problem and pathology and neglects strengths that should be viewed as important aspects of assessment and intervention with clients.

There is much current emphasis on accurate assessment following a traumatic event. The usual belief that having the individual relive the traumatic event has been challenged by recent evidence (Dyregrov & Regel, 2012) that suggests that rapid assessment followed by early intervention is the most effective treatment.

Historical Background

Psychosocial Diagnostic Assessment

From the birth of the social work profession, many different assessment models have been used. Perhaps the most well known is the psychosocial or diagnosis approach first developed by Hollis. This model relies heavily on family and developmental history to reach a psychodiagnostic assessment of the client. An ego-psychology framework (Goldstein, 2002) is fundamental to this approach. Although this approach initially focused to a large extent on a client's developmental history, now the person/client in relationship to the current environment is stressed. According to a psychosocial-ego-psychology perspective, the assessment process has the following steps: (a) assessing the client's interactions with his or her environment in the here and now and how successfully he or she is coping effectively with major life roles and tasks; (b) assessing the client's adaptive, autonomous, and conflict-free areas of ego functioning as well as ego deficits and maladaptive functioning; (c) evaluating the impact of a client's past on current functioning; and (d) examining environmental obstacles that impede a client's functioning (Goldstein, 2002; Hollis & Wood, 1981). According to a psychosocial diagnostic approach, information for client assessment was collected in a variety of ways, including (a) psychiatric interviews to determine a diagnosis, (b) the use of standardized and projective testing to support diagnostic assessment, (c) current psychosocial assessment and study of prior development and adjustment to identify problem areas, (d) use of standardized interviewing to assess problem areas and current functioning, and (e) study of the client-social work relationship to ascertain client's patterns of interactions (Jordan & Franklin, 2003).

The psychosocial assessment model is well suited to today's medical model that involves the study, diagnosis, and treatment format. Many medically based behavioral-health settings use this approach. Furthermore, the focus of many behavioral-health centers on clients' return to more adaptive functioning is also compatible with a psychosocial-diagnostic-ego-psychology model. A *DSM-IV* diagnosis is usually a requirement for beginning treatment, and thus the detailed study using a psychosocial approach is often helpful in arriving at a diagnosis. Structured assessment tools, such as the eco-map (Hartman & Laird, 1983) and the genogram (McGoldrick, Gerson, & Schallenberg, 1999), are also helpful for practitioners in completing assessments. There is a need for more outcome-focused research, however, on the effectiveness of using these instruments. Finally, the development of standardized semistructured interviews using a psychosocial approach is most helpful in promoting current evidence-based assessment.

Problem-Solving Assessment

Another major assessment model was the problem-solving assessment originally developed by Helen Harris Perlman in 1957. This model is based on the psychosocial diagnosis model described earlier and the functional model that focuses on growth and potential as well as agency function. Perlman saw assessment as an eclectic model with four Ps—person, problem, place, and process—as a way to organize information about the client. In terms of person, the social worker should think of the client's personality characteristics and which interactions with the environment are significant. A second area involves a focus on problem: How can the problem be defined? Is it a crisis, a repetitive issue? What other ways has the client sought to resolve the problem? The third category is place or agency. What concerns does the client have about contact within the agency? What is most helpful and what is most harmful about the agency in the process of client assessment? The fourth relates to process. Which intervention will be most successful? What will be the consequences of a particular choice of treatment?

Current assessment still relies a great deal on the problem-solving approach to assessment. First, a very quick assessment tool, such as that outlined by Perlman, is most helpful in the current social-service environment, with its focus on short-term assessment and intervention. Another advantage, especially for culturally diverse clients who may be fearful of interaction with the agency, is the inclusion of Perlman's third P—place—in the assessment process. This approach encourages the social worker to look at how the fears and feelings that clients may have about the agency affect the assessment process. This may be especially true for undocumented clients who are apprehensive that social workers will use their power and authority to report their immigration status.

There are two major concerns about the problem-solving approach as used in current assessment practice. First, there is limited attention to the person's strengths and resilience in resolving the problem. Modern

assessment models seek to focus specifically on the strengths a client brings to the situation. The client's definition of the "problem" and what strengths he or she can use and has used in the past to address the problem are considered key. Another major concern about the problem-solving approach is that it is based primarily on practice wisdom, with limited empirical research to support its use. With the emphasis on EBP, research is needed to ascertain the effectiveness of this assessment model as a foundation for treatment interventions with diverse clients.

Cognitive-Behavior Assessment

Cognitive-behavior assessment models have made a major contribution to current practice and research about assessment. Meichenbaum (1993) outlines three metaphors that have guided this complex model—conditioning, information processing, and constructive narrative. Early cognitive behaviorists focused primarily on conditioning as the way certain behaviors were learned. Then the focus shifted to a greater emphasis on cognitions, social learning, and the development of belief systems. Most recently, the focus has been on the use of client narratives and life stories as part of the assessment process.

Jordan and Franklin (2003) identify four attributes of cognitive behavior assessment that are particularly useful in today's practice:

1. Because much of today's practice focuses on short-term intervention, the focus on rapid assessment and treatment is particularly useful. Assessment includes history only as it is related to the client's current functioning, but the main focus is on identifying the faulty learning and cognitive patterns that have contributed to current maladaptive behavior.
2. Much research has been conducted on outcomes of cognitive behavior approaches. This is particularly useful with today's emphasis on evidence-based assessment and treatment.
3. Many assessment and treatment manuals for use with assessing a number of identified client problems, such as depression, substance abuse, personality disorders, and posttraumatic stress disorder, have been developed using the cognitive-behavioral approach.
4. Ongoing assessment has been stressed as essential in evaluating the effectiveness of treatment. The integration of assessment with treatment is very much part of current beliefs about assessment.

Life-Model Assessment

The life-model assessment (Germain & Gitterman, 1996) uses an ecological framework that focuses on the client's interactions with the environment in three main areas—life transitions, environmental pressures, and maladaptive interpersonal processes. Major aims of this theory are to closely link person and environment, stress the client's perspective, and provide linkages among direct service, administration, and policy planning.

There has been some concern that the life-model assessment does not guide current practice interventions very well (Wakefield, 1996). With the need for short-term evidence-based assessment and intervention, the weakness of this link is problematic. The ecological model, however, has served as a foundation for developing multisystematic therapy, an evidence-based therapy that has proven to be useful with youth and families (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). An assessment tool, such as the eco-map (Hartman & Laird, 1983) that is based on the life-model ecological approach, has been useful, although research on this has been limited. Computer software programs may help practitioners use this assessment tool more effectively, standardize its use, and provide more opportunities for research about its effectiveness.

Task-Centered Assessment

The task-centered assessment model developed by Reid (1988) focuses on specific target problems and their desired outcomes. Major steps in this model include task planning, implementation, and review. Task planning builds on initial problem formulation. The client's perception of the problem is considered most important, and the practitioner helps the client in exploring, clarifying, and specifying the problem. Task-centered assessment focuses on a thorough understanding of the client's problems and goals, prioritizing problems and developing a specific contract to achieve the defined goals. This approach is most useful in practice today with a focus on time-limited and evidence-based outcomes.

Solution-Focused Assessment

A major new assessment model is the brief solution-focused therapy assessment developed by De Jong and Berg (2001) for work with mandated clients. With this model, assessment is part of the intervention process. Franklin and Moore (1999) have identified the following methods for conducting a solution-focused assessment:

- Tracking solution behaviors or exceptions to the problem.
- Scaling the problem.
- Using coping and motivation questions.
- Asking the miracle question.

This approach is very client centered and focuses on client's strengths—what clients can do and want to do, not on their deficits and failures. Franklin (2002) identifies positive features of this model with mandated clients:

- Using a nonjudgmental approach in understanding client problems.
- Making the congruence between what the client wants and what services can be provided as close as possible.

- Emphasizing clients' choices as much as possible.
- Providing education to clients about what treatment will involve.
- Developing specific goals with clients.
- Discussing what is nonnegotiable from the agency's standpoint.

Although research on the use of this model has been positive, more work in this area is necessary to evaluate its effectiveness.

Strengths-Perspective Assessment

A final perspective that has had a major influence on current assessment practice is the strengths perspective developed by Saleeby (1997). This perspective is fundamental to the values-based perspective of social work in that all people are seen as having dignity and worth as individuals as well as the right to self-determination. Using this approach, the practitioner looks for knowledge, competencies, hidden resources, and resilience in each and every client who comes for treatment. The practitioner moves away from identifying only deficits or diagnosing pathology with *DSM-IV* toward a broader understanding of person-in-environment client functioning. The strengths perspective has had a significant impact on mental-health services. Yet the strengths perspective is often seen as only one aspect of a comprehensive assessment, with a diagnostic *DSM-IV* approach having more importance in a behavioral-health service-delivery system. There have been various attempts to develop standardized measures to assess strengths and competencies (Jordan & Franklin, 2003) and also to incorporate a strengths approach into a more traditional psychosocial assessment. Incorporating a strengths-based assessment process has been used in work with battered women (Lee, 2007). With the current emphasis on evidence-based assessment and practice, much more empirical research is needed on outcomes with strengths-based assessment.

Summary of Current Evidence-Based Assessment for Individuals

There are a number of sources of information that a social worker can use in completing assessments on individual clients. These sources include:

- Background information on clients from case records.
- Verbal reports from clients about their feelings, history, and problems.
- Direct observation of nonverbal behavior.
- Observation of interaction with family members and others in clients' environment.
- Collateral information from families, relatives, physicians, teachers, employers, and other professionals.
- Tests or other assessment instruments.

Social workers often begin to work with clients after reading lengthy case records. Although there are advantages to having a preliminary understanding of a client before contact is made, the major disadvantage is that case records may unduly influence the social worker's perception of the client. Case records are often written from a deficit perspective. Frequently, a *DSM-IV* diagnosis is included that may not be current. This may be especially true in mental-health settings when the client has had a long history of mental-health treatment. Research on whether the assessment process is helped or hindered by the social worker's prior perusal of a case record is needed.

The primary source of information for assessment should come directly from the client. The practitioner needs to be a skilled interviewer to elicit information that is particularly relevant to the client's problem. Previously, client assessment was a very lengthy process, often spanning several interviews. The current trend is brief assessment to learn information that is particularly pertinent to the client problem and what will be most helpful in future work. A thorough assessment usually includes the following categories (Cooper & Lesser, 2002):

- Identifying information.
- Referral source.
- Presenting problem.
- History of the problem.
- Previous counseling experiences.
- Family background.
- Developmental history.
- Educational history.
- Employment history.
- History of trauma.
- Medical history.
- Cultural history.
- Spirituality/religion.
- Mental status and current functioning.
- Mental status exam.
- Multiaxial *DSM-IV* diagnosis.
- Recommendations and goals for treatment.
- Plans to evaluate.

Including an evaluation plan provides an empirical foundation for the assessment process.

A major source of information for assessment comes from the social worker's observation of nonverbal behavior. What demographic

information do we learn nonverbally—sex, age, race? How is the client dressed? How does the client answer questions? How does the client relate to the worker?

Often, the social worker has an opportunity to observe the individual client in interaction with others—family members, friends, group members, or other professionals. This can be an important source of information about the client's challenges in personal relationships with others.

The social worker can learn important information about the client from collateral contact with others, including family and other professionals. It is important, however, that the social worker not rely too much on negative reports of family members. Family members may present distorted views of clients based on their own interests. Reports from others should only be a *secondary* method for receiving information to use in a client assessment.

The final method of gathering information for assessment is through tests or assessment instruments. Because many of these instruments have been standardized, assessment through these measures is considered important in promoting EBP.

Assessment Scales and Tools

The next section explores some of the scales and assessment tools that have been used in assessment of individual clients.

One of the earliest and most well-known scales is the Wechsler Adult Intelligence Scale (WAIS), first published in 1955 and now in its fourth edition (2007). The current version, which is used to measure adult intelligence of people between 16 and 90 years of age, consists of 10 core subtests and 5 supplemental subtests. The 10 core subtests include under the area of verbal comprehension, similarities, vocabulary, information; under the area of perceptual reasoning, block design, matrix reasoning, and visual puzzles; under the area of working memory, digit span and arithmetic; and under the area of processing speed, symbol search and coding. The median full-scale IQ is 100, and 68% of adults fall within one standard deviation, or within 85 to 115. It has been suggested that there may be age differences that are not sufficiently taken into account in WAIS IV (Benson, Hulac, & Kranzler, 2010).

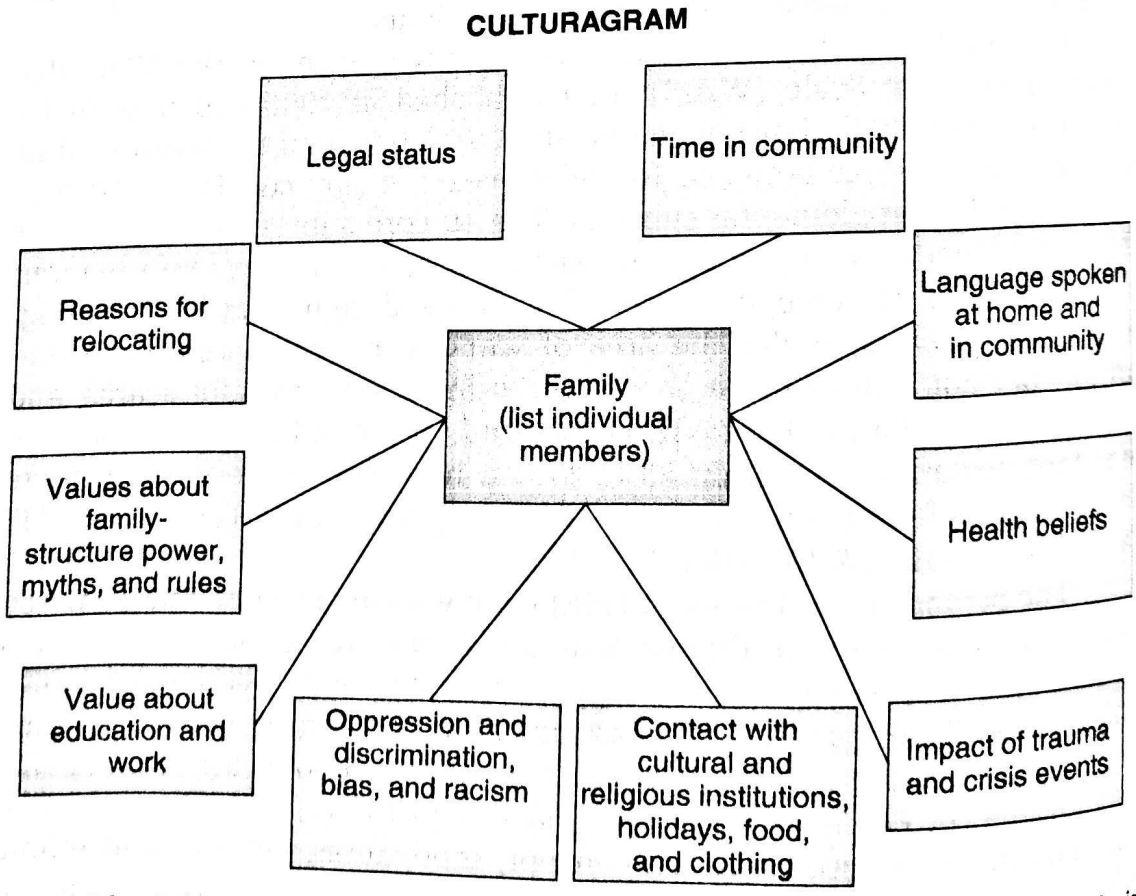
The person-in-environment (PIE) testing scale developed by Pomeroy et al. (2003) is helpful in that each area is considered either as a problem or strength. The categories are appearance, biomedical/organic, use of substances, developmental issues/transitions, coping abilities, stressors, capacity for relationships, social functioning, behavioral function, sexual functioning, problem-solving/coping skills, creativity, cognitive functioning, emotional functioning, self-concept, motivation, cultural and ethnic identification, role functioning, spirituality/religion, and other strengths. Not only is the individual client assessed on these different areas, but

each area is also studied in relationship to family, friends, school/work, community, and social work intervention. The value of the PIE rating scale is that it provides an organized, systematic way to acquire important information about the client.

Cultural Assessment

One area of much importance in today's practice is that of cultural and ethnic identification. An increasing number of urban, suburban, and rural clients are either first- or second-generation Americans (U.S. Census, 2000). Understanding a client's cultural background is very important in completing an assessment. The culturagram (Congress, 1994, 2002; Congress & Kung, 2005) has been useful in assessing people of color (Lum, 2004), victims of domestic violence (Congress & Brownell, 2007), older people (Brownell, 1997), children (Webb, 1996), and clients with health problems (Congress, 2004). Making use of a paper-and-pen diagram, the culturagram (see Figure 5.1) looks at reasons for immigration, length of time in the United States, legal status, language spoken at home and in the community, health beliefs, crisis events, holidays, contact with religious and cultural institutions, beliefs about education and work, and beliefs about family structure and roles. As the United States becomes increasingly

Figure 5.1
Culturagram—2007



From "The Culturagram," by E. Congress (Figure 144.1, p. 971; Figure 144.2, p. 974), in A. R. Roberts (Ed.), *Social Workers' Desk Reference*, 2008, New York, NY: Oxford University Press. Reprinted with permission.

diverse, it will be even more important to develop and use assessment tools to better understand clients from different cultural backgrounds.

Suicide Assessment

Suicide assessment and prevention is an important part of any comprehensive assessment process. The number of suicide attempts is on the rise, especially among adolescents. The following factors have been cited as associated with high risk of suicide (Hepworth, Rooney, Rooney, Larsen, & Strom-Gottfried, 2005):

- Feelings of despair and hopelessness.
- History of previous suicide attempts.
- Concrete, available, and lethal plans to commit suicide.
- Family history of suicide.
- Ruminations about suicide.
- Lack of support systems.
- Feelings of worthlessness.
- Belief that others would be better off if one were dead.
- Age—very old or adolescent.
- Substance.

In completing a comprehensive assessment in which the client speaks of feelings of hopelessness, the social worker should not avoid introducing the discussion of suicide, because it is a misconception that talking about suicide will give a client the idea.

There have been a number of scales developed to ascertain suicide risk for adults, such as the Hopelessness Scale (Beck, Resnik, & Lettieri, 1974); the Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979), and the Suicide Probability Scale (Cull & Gill, 1991). The Children's Depression Scale (Kovacs, 1992) and the John Hopkins Depression Scale (Joshi, Capozzoli, & Coyle, 1990) are helpful instruments in assessing children's and adolescents' risk of suicide.

DSM-IV Assessment

In behavioral-health settings, social workers are frequently expected to understand and make a *DSM-IV-TR* diagnosis. The following categories are included in *DSM-IV* (American Psychiatric Association, 1994):

- Disorders usually first diagnosed in infancy, childhood, or adolescence.
- Delirium, dementia, and amnestic and other cognitive disorders.
- Mental disorders due to a general medical condition.

- Substance-related disorders.
- Schizophrenia and other psychotic disorders.
- Mood disorders.
- Anxiety disorders.
- Somatoform disorders.
- Factitious disorders.
- Dissociative disorders.
- Sexual and gender-identity disorders.
- Eating disorders.
- Sleep disorders.
- Impulse-control disorders not otherwise classified.
- Adjustment disorders.
- Personality disorders.

These diagnoses are descriptive in nature and not tied to any theoretical framework. A *DSM-IV* diagnosis has five axes:

Axis I: Primary clinical disorder.

Axis II: Personality disorder or mental retardation.

Axis III: Medical problems.

Axis IV: Psychosocial issues.

Axis V: Global Assessment of Functioning.

Many settings only made use of Axis I. Although reliability and validity are seen as important in the use of any scale, there is a question about whether *DSM-IV* has satisfied this criterion. Kutchins and Kirk (1997) are particularly concerned about the lack of reliability, whereas Neimeyer and Raskin (2002) see *DSM-IV* as based on social-political processes rather than evidence-based research. Social workers, however, are most concerned that *DSM-IV* is based on a deficit model with no focus on the context or environment in diagnostic assessment. To increase understanding of diagnosis as related to person and environment, the National Association of Social Workers (NASW) has published the PIE system developed by Karls and Wandrei (1994), which looks at roles and conflicts in roles as crucial in assessment.

Use of the multiaxis approach in *DSM-IV* is most compatible with social work's focus on PIE. Whereas Axes I, II, and III are psychiatric or medical classifications, Axis IV and Axis V consider context and social environment. There is some concern, however, that Axis I receives the most attention. Another positive factor about *DSM-IV* is the inclusion of the Appendix I Outline for Cultural Formulation and Glossary of Culture Bound Syndromes. This demonstrates recognition that there are psychiatric disorders other than the ones most frequently known in American culture.

A very useful diagnostic tool in evaluating mental functioning is the mental-status exam. The Mini-Mental State Examination (MMSE) that has been published by Paveza, Cohen, and Blaser (1990) addresses the following issues:

- Orientation to time and place.
- Registration (how much repetition is needed to understand a concept).
- Attention and calculation.
- Recall and memory.
- Language.

The practitioner asks the client certain structured questions with a cut-off score of 23 that is considered acceptable for both cognitive and mental-health functioning, although those tested with less education, who are older, or who are from different ethnicities may show different results (Fillenbaum, Heyman, Williams, Prosnitz, & Burchett, 1990).

Depression and Anxiety Tests

There have been a number of tests developed to measure mental-health disorders in adults. In practice, social workers frequently encounter clients with depressive disorders, including Major Depressive Disorder and Dysthmic Disorder. The most widely used measurement for assessing depressive symptoms in adults is the Beck Depression Inventory (Beck, Steer, & Brown, 1996). This test consists of 21 items rated on a 4-point scale ranging from 0 to 3 that measures the intensity of depressive symptoms. A score of 0 to 13 indicates normal level of depression; 14 to 19, mild to moderate level; 20 to 28, moderate to severe level; and 29 to 63, extremely severe level of depression. The client fills out this depression inventory in a short period of time. Since the Beck Depression Inventory was first developed in 1951, numerous research studies have shown it to have excellent reliability, with a test-retest coefficient of 0.90 as well as concurrent and criterion validity.

Clients self-administer the Beck Depression Inventory, but the Hamilton Rating Scale for Depression (Hamilton, 1967) is completed by the interviewer. It consists of 18 items measured on a 5-point Likert scale and contains items on depressed mood, suicide, anxiety, general somatic symptoms, and loss of interest in work and social activities. The Hamilton Rating Scale has been widely used with the elderly, people with HIV/AIDS, and adults with minor depressive disorders.

A number of instruments have been developed to measure anxiety disorders, especially trauma and phobia. The State Trait Anxiety Inventory (STAI) is a standardized self-report instrument with 20 questions in the state section and 20 questions in the trait section. The scale has been

validated and reported to have alpha reliability coefficients ranging from 0.86 to 0.95 (Spielberger, 1983).

A challenge with self-report anxiety and depression scales is that often there is not good differentiation among them. Stulz (2010) has developed versions of the Beck Anxiety Inventory and Beck Depression Inventory-II that strive to differentiate these two psychological symptoms. The result of purified scales, however, has been limited, as these two sets of symptoms seem to be linked and difficult to differentiate. The use of purified scales, however, may help clarify the effects of interventions on anxiety and depressive symptoms.

To evaluate posttraumatic stress disorder (PTSD), the Trauma Symptom Checklist (TSC-33) is useful. A client rates 33 items, such as insomnia and feeling isolated from others from 0 (never) to 3 (very often). The scale has been shown to have internal consistency, with an alpha of 0.89 (Briere & Ruentz, 1989).

The Fear Questionnaire (FQ) developed by Fisher and Corcoran (1994) is a 24-item instrument designed to assess target phobias as well as general fears. The instrument has an alpha of 0.82 for the three subscales and 0.92 for target phobias.

Personality disorders (Axis II on *DSM-IV*) have long been difficult to assess in only one interview. Often the client with a personality disorder does not have any other mental disorder and may be of above-average intelligence. In contrast to other psychiatric disorders, those people with personality disorders may not experience much discomfort and often do not seek mental-health treatment except in crisis. When a client has repeated difficulties in work and personal relationships, the possibility of a personality disorder should be considered. Personality disorders include Borderline Personality Disorder, Antisocial Personality Disorder, Paranoid Personality Disorder, Narcissistic Personality Disorder, and Obsessive-Compulsive Personality Disorder. Because personality disorders may be difficult to recognize in clients, social workers can help ensure the accuracy of the diagnosis by the use of standardized, structured interviews, such as the Structured Clinical Interview for Diagnosis (SCID-II; Garb, 1998). Because clinicians tend to overdiagnose or underdiagnose clients, the use of a structured interview often yields more reliable results (Wood, Garb, Lilienfeld, & Nezworski, 2002).

The Minnesota Multiphasic Personality Inventories (MMPI and MMPI-II) developed by psychologists in the 1940s are well-established standardized tests for assessing personality disorders (Jordan & Franklin, 2003). Other standardized personality-assessment tests, including the Millon Clinical Multiaxial Inventory-III (Millon, 1997) and the California Psychological Inventory (McAllister, 1996), are also useful standardized personality-assessment measures. It is important for social workers who want to make the assessment process more evidence based to learn more about these standardized psychological tests that measure personality disorders.

Substance-Abuse Assessment

A social worker who is asked to assess adults often misses a diagnosis of alcohol abuse and dependence. Part of the challenge is that alcohol is a legal substance and also a very accepted part of social interactions. *DSM-IV* has very specific diagnoses for alcoholism, but often social workers think primarily of another diagnosis. Frequent alcohol use may result in the development of symptoms (anxiety, depression, medical conditions, cognitive difficulties) that may suggest diagnoses other than alcohol abuse. Furthermore, many adults with other psychiatric disorders attempt to self-medicate with drugs or alcohol, with the result of a dual diagnosis of alcohol abuse and another psychiatric disorder. A contributing factor is that few clients directly state that they have a problem with alcohol, as denial is frequently used in an attempt to cover up a substance-abuse problem. The social worker must often act as a detective in looking for signs that may indicate an alcohol problem. During the assessment process, often a client who indicates work difficulties because of frequent absences or encounters with the law because of domestic violence or driving violations may be signaling a problem with substance abuse.

There are a number of assessment instruments that have been developed to measure the presence, extent, and severity of substance-abuse problems. Two widely used assessment tools are CAGEii, developed by Ewing (Mayfield, McLeod, & Hall, 1994), and the Michigan Alcohol Screening Test (MAST; Selzer, 1971). CAGEii makes use of four questions related to desire to cut down on drinking, response of others to drinking, guilty feelings about drinking, and time of drinking. A positive response to two or more questions signifies a possible substance-abuse problem and need for further investigation. The MAST makes use of 25 items to ascertain alcohol use or abuse. More comprehensive than the CAGEii, the MAST is often used to find out more information about the extent or severity of a client's substance abuse. A version of this test, Drug Abuse Screening Test (DAST), has also been used to detect drug abuse.

Assessment of Older People

Because social workers often encounter older people in their practice, assessment issues for older people need special attention. Depression is frequently an emotional disorder experienced by older people, yet it is commonly underdiagnosed. The Geriatric Depression Scale (GDS) is most helpful in assessing depression in older people (Brink et al., 1982). There are a number of versions of this test ranging from 1 to 30 items. This test is very helpful as an initial screening tool to assess depressive symptoms among the elderly.

Another frequently used assessment tool with older adults is one that assesses functional status. There are numerous assessment tools that evaluate functional status. Some of the issues covered in

functional-assessment instruments include the following areas: ability to use the telephone, shopping, food preparation, housekeeping, laundry, medication responsibility, and financial management.

In summary, the social worker should probably best begin with a general psychosocial-assessment report, including the diagnosis that was outlined previously. As part of the assessment report, the social worker can use or consult with other professionals about standardized assessment instruments for depression, anxiety, substance abuse, and functional ability.

Evidence-Based Assessment

There have been some attempts to provide evidence about the use and effectiveness of different evidence-based assessments. For example Moon (2002) looks at the diagnosis of separation-anxiety disorder and reviews evidence-based methods of assessment, including clinical interviews, self-report scales, parent-teacher reports, behavioral observations, and self-monitoring, whereas O'Hare (2002) looks at three major functions of evidence-based social work practice, including assessment. The assessment protocol is based on the use of valid scales to complement the qualitative interview. Key factors are seen as domain-specific research on relevant psychosocial risk factors, especially those that are amenable to change.

Much of the evidence on the effectiveness of various assessment tools are specific to various assessment tools, such as Shek and Ma's 2010 article that examines a specific family-assessment instrument (namely, the Chinese Family Assessment Instrument [C-FAI]: Hierarchical confirmatory factor analyses and factorial invariance).

Efforts to gather general assessment information through specific computer-software programs or semistructured interviews, however, represent an attempt to standardize information taken for assessment. Although standardized general-assessment tools are in their infancy, in contrast, there are a number of well-researched inventories for specific disorders, such as depression and anxiety. Reliability and validity have been well established for many of these diagnostic instruments. One challenge, however, is that these diagnoses must be identified before a client can be given a specific test. Another challenge is that these tests focus on a specific disorder, and there is no provision for strengths that a client may have in coping with the psychiatric disorder or for social-support systems that can help mitigate the negative effects of the mental disorder.

Implications for Social Work on Micro-, Mezzo-, and Macrolevels

The importance of a comprehensive assessment for individual clients is evident. No treatment intervention can begin before there is assessment

about the nature of the problem and what strengths the client brings to resolving the problem. The nature of the problem is not only psychological but often familial and social. The social worker must also look to the family and community for strengths and resources in addressing the problem. Accurate assessment is probably more challenging than ever for microlevel practice, because with short-term treatment social workers are very limited in the amount of time that can be spent in the assessment process. Although assessment tools to examine the severity of mental disorders have been well documented, a continual challenge has been the limited number of well-researched, general-assessment instruments. Because cultural background is such an important component in the assessment process, more attention needs to be given to research on quickly administered assessment tools that address this factor.

Mezzolevel practice is designed to change the systems that most directly affect the client—namely, the family, peer group, and classroom (Hepworth et al., 2005). A social worker completing a comprehensive assessment considers not only the individual but also the environment surrounding the client. In order to understand the psychological functioning of the client, it is important to understand the impact of the family, school, or work environment. The multiple focus of the PIE rating scale (Karls & Wandrei, 1994) can be helpful in assessment on a mezzolevel.

How is assessment related to the macrolevel of practice? First, most agencies require a structured proscribed assessment form that may vary in length. Sometimes a *DSM-IV* diagnosis receives much more attention than the assessment of the client's strengths. At other times, the required assessment may be so lengthy and irrelevant that clients do not connect with their social workers during the assessment process, thus impeding future treatment interventions.

A faulty assessment process is problematic for several reasons. First, an important problem to include in treatment planning may not be recognized. This may happen when the social worker has to make speedy assessments with very limited time. Second, if too much time is spent on unnecessary assessments, then the client may leave before treatment has begun. In today's practice, assessment and intervention are frequently interwoven. This speaks to the importance of a focused relevant assessment if the treatment intervention is to be helpful.

Conclusion

Individual assessment of adults continues to be as important for social workers as in the early days of psychosocial diagnostic assessment. Much has changed though. The assessment process is much shorter and focused on the problem at hand. Often, assessment is not separate from intervention. Although we have developed well-documented specific tests to assess the presence of specific mental disorders, general-assessment instruments have not been subject to such empirical investigation. With the current

focus on EBP, it is crucial that we apply the same standards to the assessment process. Because assessment continues to be an essential first step in engaging and understanding clients, empirical evidence to support decisions about assessment models and methods is much needed.