Chapter 13
Case Management with Children and Their Families

13.1 Concepts of Case Management

13.1.1 Importance of Case Management

According to Kirst-Ashman and Hull (2006), the following factors are operating to increase the importance of case management for social workers:

- Increased emphasis on maintaining clients in the least restrictive environment;
- The goal of keeping people out of institutions;
- Efforts to reduce or contain costs of providing services;
- Increased attention to rights of clients who often lack awareness of available resources;
- Awareness that some clients cannot follow through on the ordinary referral because of their limited capacities;
- Increased focus on how the environment contributes to client problems; and
- Expansion of human service programmes and increased complexity and fragmentation of services.

13.1.2 Definition of Case Management

According to the Standards of Social Work Case Management developed by the National Association of Social Workers in the United States in 1992:

> Social work case management is a method of providing services whereby a professional social worker assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs. A professional social worker is the primary provider of social work case management. Distinct from other forms of case management, social work case management addresses both the individual client's bio-psychosocial status as well as the state of the social system in which case management operates. Social work case management is both micro and macro in nature: intervention occurs at both the client and system levels. It requires the social worker to develop and maintain a therapeutic relationship with the client, which may include linking the client with systems that provide

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him or her with needed services, resources, and opportunities. Services provided under the rubric of social work case management practice may be located in a single agency or may be spread across numerous agencies or organizations.

13.1.3 Principles of Case Management

Gerhart (1990, cited by Kirst-Ashman and Hull 2006) articulates the following principles of case management:

1. Individualisation of services
2. Comprehensiveness of services
3. Parsimonious services
4. Fostering autonomy
5. Continuity of care

13.1.4 Tasks of Case Managers

Kirst-Ashman and Hull (2006) list the following tasks of case managers:

1. Assessment of the client's needs, social network capabilities and the abilities of social service providers.
2. Development of a comprehensive service plan that includes multidisciplinary professional involvement and maximum client involvement.
3. Intervention directly with the client to strengthen skills and capacities for self-care and/or indirectly with systems impinging on the client.
4. Monitoring of service plan implementation and tracking of client status, service delivery and involvement of social network members.
5. Evaluation of service plan effectiveness and its impact on client functioning, on the social network's capacity to support the client and on the ability of the social service professional to work with the client.

13.1.5 Principles of Teamwork for Case Management

When diverse resources work together in common planning, decision making and consolidated action, they need to work as a team. Timberlake et al. (2008) list the following principles of effective teamwork for case management:

- The client system must sanction the team with the understanding that there will be open communication among members.
- All members of the team must clearly know their own professional identities and the distinctive contribution they and their agencies can make to the team.

- Collaboration necessitates revisions in policy, job descriptions and accountability requirements.
- Members of the team must respect each discipline, understand the service orientation, recognise the competencies, trust the communications and rely on the work of each team member.
- The team must meet on a regular basis for shared communication, planning and evaluation.
- The team must define each person's tasks, roles, goals and methods.
- The team as a whole must systematically review its own process, its accomplishments and failures.
- The team must assume collective responsibility for service outcome.

13.1.6 Techniques of Case Management

The techniques of case management intervention with children and their families may be broadly divided into techniques of direct intervention and techniques of system linkage.

13.2 Techniques of Direct Intervention with Children and Their Families

The main techniques used in direct intervention with children and their families are:

- Giving Information and Advice
- Teaching and Training in Psychosocial Skills
- Counselling.

13.2.1 Giving Information and Advice

The social worker needs to provide information to the client that he or she needs to carry out the tasks identified. The information should be provided in a logical, organised, step-by-step fashion and the client should be invited to ask questions to clarify any uncertainty. Complicated multiple step instructions may need to be written down (Sheafor and Horejsi 2006).

Advice-giving refers to worker statements that recommend what a client should do. It is inappropriate in a counselling-therapy setting but appropriate in a referral, brokering, or advocacy setting. The worker should not offer advice until he/she has determined that the client genuinely wants it and unless he/she has the expertise in that area. The client's receptivity to advice may be tested by asking questions such as "Have you asked others for suggestions?" and "May I tell you what other people do in that situation?". When advice is given, present it in a way that says 'This

is what I would do' or "This is what others have done", explaining the reasons. The responsibility for deciding what to do should be left to the client (Sheafor and Horejsi 2006).

13.2.2 Teaching and Training Psychosocial Skills

Much of case management practice involves teaching clients problem solving and conflict management skills to deal with troublesome life situations, change dysfunctional behaviour and learn effective patterns of social interaction (Sheafor and Horejsi 2006).

13.2.2.1 Psychosocial Skills

Specifically, the clients need to develop the following psychosocial skills:

- Self-awareness
- Thinking skills
- Emotional intelligence
- Interpersonal relationship skills
- Interpersonal communication skills
- Family life education.

The teaching-training methods may be comprised of decision analysis, role play and use of the client–worker relationship as follows.

13.2.2.2 Decision Analysis

Decision analysis is a means by which the worker helps the client consider a range of alternative behaviours in certain situations.

13.2.2.3 Role-Play

Role-playing is often used to assess the nature of the client's interpersonal processes and to practice new social skills (Walsh 2006). Behavioural rehearsal is a technique of role-playing that is drawn from behavioural therapy. It teaches a client how to handle a specific interpersonal exchange for which he or she feels unprepared. It can make use of modelling and coaching. Role reversal is a technique where one person is asked to take on the perspective of another person in an effort to better understand him or her, especially in a conflict situation. It allows the individuals to experience how his or her own behaviour, as dramatised by another, affects others. It can provide insight and maybe even a little humour (Sheafor and Horejsi 2006).

13.2.2.4 Use of the Client–Worker Relationship

Focus on the relationship between the worker and the client works as a model of the client's typical ways of thinking and feeling in other relationships (Walsh 2006).

13.2.3 Counselling Children

Counselling is treating the client's psychosocial problems. The brief practice models of counselling that are discussed in this section are cognitive restructuring, solution-focused treatment and crisis intervention. Across treatment modalities, the focus of these models on immediate or focused concerns, an active stance by the practitioner, and conscious use of time limits were found to be productive (Hepworth et al. 2006).

13.2.3.1 Cognitive Restructuring with Children

Cognitive restructuring is a technique used in cognitive behavioural therapy, solution-focused treatment and emotional management by reframing cognitive distortions.

Cognitive Distortions: Thompson and Henderson (2007) identify the following common cognitive distortions in children:

- It is awful if others do not like me.
- I am bad if I make a mistake.
- Everything should go my way; I should always get what I want.
- Things should come easily to me.
- Adults should be perfect.
- There is only one right answer.
- I cannot help being the way I am; I will always have to be this way.

Reframing Cognitive Distortions: According to Sheafor and Horejsi (2006), the social worker can help a client modify distortions in self-talk, by asking the client to notice that, when you hold to the facts and avoid using inaccurate words, you begin to feel differently and things do not seem as bad as before. Through reframing comments and actions, the social worker gives the client credit for the positive aspects of his or her behaviour relative to the presenting problem. This strategy introduces clients to new ways of looking at some aspect of themselves or the problem (Walsh 2006).

According to Littlejohn and Domenic (2001, cited by West and Turner 2006), reframing can be done from:

- Negative to positive statements
- Past to the future
- Hostile to neutral
- Individual to community interests
- Complaint to request.

Hepworth et al. (2006) recommend the following steps in cognitive restructuring:

1. Accept that self-statements determine emotional reactions to events.
2. Identify dysfunctional beliefs and thought patterns.
3. Identify situations involving dysfunctional cognitions.
4. Replace dysfunctional cognitions with functional self-statements.
5. Identify rewards and incentives for successful coping efforts.

Sheafor and Horejsi (2006) recommend a five-step approach to help a client modify distortions in self-talk, by asking the client to

1. Identify what you are feeling and thinking right now.
2. Get in touch with your self-talk.
3. Examine the objective reality of your situation. Once the facts have been identified, relax, take a deep breath and repeat them out loud three times.
4. Notice that, when you hold to the facts and avoid using inaccurate words, you begin to feel differently and things do not seem as bad as before.

Once the client is able to describe his or her patterns of maladaptive self-talk, the cognitive restructuring techniques of self-instruction, visualisation and journaling may prove helpful:

- Self-instruction comprises of positive self-talk, covert speech and countering negative talk, in the form of a set of statements that are repeated by the client on a regular basis, perhaps three times a day and especially in times of distress.
- Visualisation is a technique in which a client is taught to prepare himself or herself to deal with a worry-causing event by repeatedly imagining this event and mentally rehearsing the steps necessary to handle it successfully.
- Journaling is a technique of keeping a daily log of significant thoughts and feelings (Sheafor and Horejsi 2006).

13.2.3.2 Solution-Focused Counselling with Children

Solution-focused treatment emphasises the construction of solutions and deemphasises the problems. The client begins with a problem statement but quickly moves to solutions. In this model, the cause of the problem and the solution are not necessarily connected. It assumes that change can occur when clients are motivated and empowered to construct solutions. Clients and families are considered experts because they have the knowledge, resources and strengths needed to formulate solutions. It is strongly influenced by the views of Milton Erikson that people are constrained by the social construction of their problems. According to this view, people have untapped unconscious resources which can be released by shifting their perspectives (Hepworth et al. 2006). It is similar to cognitive restructuring because the professional has an active role in first helping clients to question self-defeating constructions and then assisting them to construct new and more productive

perspectives (Nichols and Schwartz 2004, cited by Hepworth et al. 2006). It assumes that people respond better to a present and future counselling orientation than they do to a past orientation focused on why they have a problem they cannot solve (Thompson and Henderson 2007).

According to Walsh (2006), the solution-focused practice is influenced by the following theories:

- The systems thinking as developed at the Mental Research Institute (MRI) in Palo Alto views clinical problems as developing because people establish patterns of interaction in relation to a life problem such as underreacting, overreacting, avoiding, denying and even taking actions that worsen the situation. In a sense, the problem becomes the sum of the failed solutions. MRI interventions represent efforts to identify and explore a client's vicious cycle and find new ways of interrupting the problem cycle.
- The communications theory about words having an impact on people's attitude towards self and the world influenced the shift from problem-talk to solution-talk.
- The crisis theory providing focused, effective and short-term intervention for people in need of immediate relief.

The following types of questions are employed to enable clients to arrive at specific goals and to think of exceptions to problems:

- Miracle Questions: For example, "If a miracle happened overnight and your problem was solved what would you be doing differently?"
- Scaling Questions: For example, "On a scale of 0–10, where 0 is the worst that things could be and 10 is the day after the miracle, where are you right now?
- Exception Questions: Ask about instances of exceptions to the problem situation (Thompson and Henderson 2007).

Kilpatrick and Holland (2006) list the following assumptions of solution-focused family interventions:

- The unsolvable problems presented by the client are reframed to be solvable.
- The problem is defined as a part of the change process.
- Only a small change is needed that will snowball into dramatic changes.

Campbell et al. (1999, adapted by Thompson and Henderson 2007) present the following five types of statements that assist clients in moving away from the problem impasse towards solutions:

1. Normalising statements let clients know that they are not alone in experiencing their problem.
2. Restructuring statements are used to rephrase the impasse as directions for the future.

3. Affirmation statements reinforce positive steps the client has already taken.
4. Bridging statements connect clients' attributes to with the next steps for achieving goals.
5. Between-session homework statements serve to connect the sessions and move clients towards their goals.

13.2.3.3 Crisis Intervention

A crisis is defined by James and Gilliland (cited by Hepworth et al. 2006) as a perception of an event or situation that creates an intolerable difficulty that exceeds the resources or coping mechanism of the person. A crisis can be developmental, which is predictable, or situational, which is unexpected (Walsh 2006). Examples of developmental crisis situations for children are starting or changing schools. Situational crisis situations that children and adolescents may experience are loss, bereavement, grief, family violence, parental separation/divorce, potential suicide, abuse (Rose and Fatout 2003), commercial exploitation and disasters.

People's reactions to crises typically go through several stages:

1. The initial rise in tension is accompanied by shock and perhaps even denial of the crisis-provoking event.
2. To reduce the tension, the individual resorts to his or her usual emergency problem-solving skills. When they fail to alleviate the tension, heightened tension ensues.
3. The individual experiences tension so severe that the person feels confused, overwhelmed, helpless, angry or perhaps acutely depressed. The length of this phase varies according to the nature of the hazardous event, the strengths and coping capacities of the person and the degree of responsiveness from social support systems. The person may suffer a mental breakdown, or in extreme situations, attempt suicide. Prolonged crisis-related stress without relief has the potential to severely affect cognitive, behavioural and physical functioning (Hepworth et al. 2006).

Crisis assessment emphasises emotional reactions, coping capacity, the conditions that prompted the occurrence of the crisis, and clients' perception of the situation, social supports and strengths. The temporal focus is on the here and now and the goals are limited to alleviating distress and enabling clients to regain equilibrium. It delineates tasks that the client can perform to achieve a new state of equilibrium. Although crisis professionals are active and directive in defining tasks, clients are encouraged to participate to the extent that they are capable of doing so. After completion of the essential tasks, the worker moves into the final major activity of anticipatory guidance that assists clients to anticipate future crisis situations and to plan coping strategies that will prepare them to face future stresses (Hepworth et al. 2006). The skills required for crisis intervention are poise, creativity, flexibility, quick mental reflexes, tenacity, courage, a clear sense of reality, strong resilience and energy (Rose and Fatout 2003, p. 129).

James and Gilliland (2001, cited by Hepworth et al. 2006) recommend six-step problem-solving model for crisis intervention:

1. Define the problem.
2. Ensure client safety.
3. Provide support.
4. Examine alternatives. The social worker should think of alternatives and the extent to which they promote:
   (1) situational supports, involving people who care about what happens to the client,
   (2) coping mechanisms, represented by actions, behaviours or environmental resources that clients may use to get past the crisis situation and
   (3) positive and constructive thinking patterns that effectively alter how the client views the problem, lessening his or her level of stress and anxiety.
5. Make plans.
6. Obtain commitment.

13.2.3.4 Play Therapy

Advantages of Play Therapy: Incorporating play into counselling with children has several advantages:

1. The child is given freedom to make choices.
2. Play evokes fantasies and unconscious feelings.
3. Play offers familiar tools for children to use.
4. The only limits required are to keep the child and others safe from harm.
5. Play therapy allows the child a safe place to act out feelings, to gain understanding, and to change (Bradley and Gould 1993, cited by Thompson and Henderson 2007).

Schaefer (1993, cited by Thompson and Henderson 2007) identified the following therapeutic powers of play:

1. Overcoming resistance
2. Communication of self-expression
3. Competence and self-esteem
4. Creative thinking for problem solving
5. Catharsis to release strong emotions
6. Abreaction or adjustment to difficulties by symbolically reliving them
7. Role-play of new behaviours
8. Fantasy to make sense of painful reality
9. Metaphoric teaching through stories, playing and artwork
10. Attachment formation
11. Relationship enhancement
12. Positive emotion

13. Mastering developmental fears through repeated play activities
14. Game play help develop ego strength and interaction skills.

Qualities of a Play Therapist: According to Kottman (2001, cited by Thompson and Henderson 2007), the effective play therapist will most likely be a person who has the following qualities:

- Playful and fun-loving attitude
- Willingness to use play and metaphors as communication tools
- Flexibility and ability to deal with ambiguity
- Comfort with children and experience interacting with them
- Ability to set limits and maintain personal boundaries.

Play Toys and Media: The following categories of play media appropriate for different age groups could be arranged in the room after making sure that they are safe:

1. Real-life toys: Doll house with dolls, furniture and household items, cars, buildings, animals, medical kit, school kit, money and so on.
2. Creative expression and emotional release toys: Chalks and blackboards, crayons, paints, brushes, white and coloured paper, scissors, puppets, clay, sand tray and so on.
3. Acting-out and aggressive-release media: punching toy, pounding bench and so on.
4. Story books and games (Geldard and Geldard 2002).

Play Stages: Orton (1997, cited by Thompson and Henderson 2007) suggests an integrated approach to the therapeutic play process that moves through five stages:

1. Relationship: If a strong relationship is built, the child feels accepted and understood.
2. Release: The child uses play to express feelings and to ease tension through cathartic release.
3. Re-creation: The child begins to explore significant events or relationships that trigger uncomfortable thoughts and feelings.
4. Re-experiencing: Children begin to understand the links between past events and to connect that knowledge with current thoughts, feelings and behaviours.
5. Resolving: Resolving is reached when children are able to act on their understanding and to experiment with various solutions.

Play Therapy Skills: Kottman (2001, 2004, cited by Thompson and Henderson 2007) identified the following basic skills for play therapy:

- Tracking: Describe what the child is doing
- Restating content: Paraphrasing

- Reflecting feelings
- Returning responsibility to the child to build self-reliance, self-confidence and self-responsibility
- Using the child's metaphor without imposing the counsellor's interpretation of the meaning
- Setting limits in the play area to keep the child safe, increase self-control and enhance self-responsibility by:

  - Protecting the child from hurting self or others
  - Keeping the child from damaging the play setting
  - Maintaining the toys and play media
  - Staying in the session for the scheduled amount of time.

Assessment of Progress: Barnes (cited by Thompson and Henderson 2007) has suggested the following criteria for assessing progress in play therapy:

1. The child comes to the sessions looking more hopeful and relaxed.
2. The child appears to have increased confidence.
3. The child can summarise what has happened and what has been learned.
4. The child's interactions with parents appear more relaxed.
5. Play patterns, interactions and/or body language have changed.
6. The child openly raises a problem or concern.

13.2.4 Working with Parents/Families

13.2.4.1 Positive Beliefs About Families

Collins, Jordan, and Coleman (2007, pp. 23–26) note that negative attitudes to families, make the social worker blame the parents, fail to respect or embrace diversity, impose singular or restrictive views and erect barriers that prevent an open understanding and acceptance of the struggles of family life and its members. By comparison, positive attitudes to families form a necessary base for constructive family social work. They recommend the following beliefs to guide family social work:

1. A child's emotional and behavioural difficulties should be viewed within the context of the family and the larger social environment.
2. Most family difficulties do not appear overnight but have developed gradually over the years.
3. All people need a family.
4. Families want to be healthy.
5. Families want to stay together and overcome their differences.
6. Parents need understanding and support for the challenges involved in keeping relationships satisfying and for raising children.

7. Parents can learn positive, effective ways of responding to their children if they have opportunities for support, knowledge and skills.
8. Parents' basic needs must be met before they can respond effectively and positively to the needs of their children.
9. Every family member needs nurturing.
10. Family members regardless of gender or age deserve respect from each other.
11. A difference exists between thoughts and actions in parenting.
12. A difference exists between being a "perfect" parent and a "good enough" parent.
13. Families require fair and equal treatment from environmental systems.

13.2.4.2 Intervention with Families

In the early stages of family intervention, the social worker may ask family members to talk directly to him or her about sensitive issues, rather than to one another, to minimise interpersonal tensions. If tensions are so high that productive interactions cannot proceed, the worker can use displacement stories as a means of taking the family's focus off itself and giving it some distance from its own concerns. The story selected has to be of a hypothetical family with similar problems and the worker asks the family to share observations and suggest interventions (Kilpatrick and Holland 2006).

According to Hepworth et al. (2006), on-the-spot interventions are a potent way of modifying patterns of interaction by intervening immediately based on communication that takes place in the sessions. They provide the following guidelines for making such interventions:

1. Focus on process rather than content.
2. Give feedback that is descriptive and neutral rather than general or evaluative.
3. Balance interventions among the family members to divide responsibility.

Hepworth et al. (2006) suggest that the social worker can facilitate positive interactions in following ways:

- Coach family members to own their feelings.
- Translate complaints into requests for change.
- Clarify positive intentions.

The social worker may carry out the role of a mediator in resolving family conflicts. The mediator facilitates separating people from the problem by asking each participant to describe the problem and to state his or her feelings about the problem. The mediator's skills are to help clarify perceptions, to reframe the problem presented in the interests of the participants present and to validate each participant by using reflective listening techniques. Each party needs to feel heard by the

mediator. Each party is encouraged to use "I" statements than "you" statements (Parsons et al. 1994).

According to Compton and Galaway (1989, cited by Parsons et al. 1994, pp. 274–275), the techniques used in mediation include the following:

- Bring about convergence of the perceived values of both parties to the conflict.
- Assist the parties in identifying common interest in a successful outcome.
- Help the parties identify that they have more at stake in a continuing relationship than the issue of the specific conflict.
- Facilitate communication by encouraging them to talk to one another.
- Help each party recognise the legitimacy of the other's interests.
- Avoid a situation in which issues of winning and losing are paramount.
- Break the conflict down to separate issues.

Parsons et al. (1994, p. 275) recommend the following skills for mediation among others:

- Reframing partisan, persuasive and emotionally laden statements into less toxic, more interests-based language.
- Promoting each participant's listening by reflecting and asking each participant to reflect back what he or she heard.
- Moderating so that one person does not dominate the conversation or does not dominate the other party.

13.3 Techniques of System Linkage for Children and Their Families

13.3.1 Need for and Problems in System Linkages

13.3.1.1 Need for System Linkages

Intervention with children for secondary and tertiary prevention requires coordination of services by systems such as supplementary and substitute child welfare systems, juvenile justice system, legal advocacy, education, vocational guidance, psychiatric and physical health services, and so on.

13.3.1.2 Problems in System Linkages

Each of these systems operates within a value, practice and policy context. Accordingly, these systems differently perceive the child's/family's needs for resources and can support or have conflict with them (Thomlison 2007). Shulman (1984, cited by Yanca and Johnson 2008) has identified three blocks in the interactions of clients with environmental systems:

The Complexity of Systems: The very institutions set up to solve problems have become so large, complex and impersonal that it has become difficult for people to understand how to approach these systems and use the resources they provide.

Self-Interest: The self-interest of the systems often is in conflict with the interest of others.

Communication Problems: Often there is a lack of adequate communication or there is inaccurate communication among the systems. As a result, the systems cannot work together.

Social disadvantages often make accessibility to, utilisation and satisfaction with services difficult for marginalised groups. Distance, inconvenience of timings, cost, administrative formality, legal barriers, discrimination and emergency situations are found to be barriers to access to social services, as mentioned below:

Distance: Kabeer (2004) notes that services of various kinds tend to be concentrated in locations, which privilege the wealthy and in urban and easily accessible rural areas. The poor generally have to travel longer distance to access services.

Administrative Formality: The use of social services often requires a certain amount of administrative formality. For instance, users may need some form of identification, insurance numbers, identity cards or registration with a specific facility. This inevitably entails paperwork and can disadvantage some groups of people, especially illiterate persons, some very old people or those with mental or psychological problems who do not live with caring relatives (UNESCAP 2002).

Legal Barriers: Non-availability of legal documents often becomes a barrier to access to services. Governments can review the regulations on service provision to identify those elements – whether laws, regulations, standards or procedures – that tend to exclude the poor (UNESCAP, UNDP and ADB 2005).

Discrimination: Users are discriminated against due to their race, religion or caste (Kabeer 2004).

Affordability: People may simply not be able to afford the services, especially the poor in developing countries. Even when ostensibly free at the point of use (like many health and welfare services), there is a hidden cost, for example, of transport to the service, time lost from work, costs of childcare and costs of prescribed medicines (UNESCAP 2002). Besides reducing the direct costs, Governments can also try to reduce opportunity costs. The most direct way of doing this is by extending the network of services to bring them closer to communities. But it is also possible to consider mobile services, such as satellite clinics, that might reach distant villages once a month (UNESCAP, UNDP and ADB 2005).

Emergency Situations: During wars or civil conflicts and natural disasters, social service delivery systems are often disrupted or even abandoned in the case of some war zones, or the civil aid functions usurp the wider welfare aspects following natural disasters (UNESCAP 2002).

13.3.1.3 Implications of the Problems with System Linkages

When organisations provide only the primary service for which they are established and do not provide related services or coordinate with other organisations that provide related services, they only partly meet the needs of the people. As a result, people either do not get all their needs met, or face a fragmented social service delivery system, in which they have to deal with problems such as discontinuity and inaccessibility of services.

Sometimes with intervention of more than one system, things get worse rather than better because people's lives continue to be controlled by others, and they experience system-induced traumas. These may be repeated, insensitive and humiliating interviews; a frightening medical examination; a confrontation involving the perpetrator or the victim's family; an unpleasant placement experience; treatment that the child finds unhelpful or traumatic and court testimony. Often the most problematic aspects of intervention are, not knowing what is going to happen and having no say in decisions. It is important that the intervention not exacerbate the child's sense of powerlessness (Faller 1993).

13.3.1.4 Techniques of System Linkage

The main techniques of system linkage are:

- Information and Referral
- Inter-Organisational Collaborations
- Utilising and Enhancing Natural Support Systems
- Forming Self-Help Groups
- Conflict Mediation.

13.3.2 Information and Referral

To perform the role of information about and referral to the formal systems, social workers must have thorough knowledge of the available formal systems and their benefits, eligibility criteria and application procedures, so that they can make appropriate referrals. Working relationships with key contact persons are essential to making successful referrals (Hepworth et al. 2006). According to Sheafor and Horejsi (2006), the social worker should:

1. Understand the client situation,
2. Assess the various resources available to meet client needs and
3. Connect the client with the resource.

In some instances, it will help to accompany family members to the resource on their first visit.

13.3.3 Inter-organisational Collaboration

Inter-organisational collaboration involves creating a shared vision and developing new goals. Ownership and control of the project are balanced and risks and benefits are shared (Hepworth et al. 2006). Miley et al. (2007) list the following benefits of inter-agency collaboration:

- Broad base of ownership and a diverse pool of expertise
- Distribution of costs and responsibilities of new ventures among the coalition members.
- More power to influence decision-makers, legislators, the media and the general public.

13.3.4 Linkages with Natural Support Systems

Relatives, friends and neighbours are natural support systems that can be activated in times of adversity. Members of these systems can often be available immediately when a crisis occurs and can provide ongoing support (Hepworth et al. 2006). Natural helpers, colleagues and informal networks are also useful support systems. Support occurs when relationships are based on reciprocity, mutuality and shared power in an atmosphere where people can offer what they have to offer and receive the resources they seek. Social workers can encourage the clients' social support systems to develop purposefully, by enhancing their interactional skills and activating natural helpers (Miley et al. 2007).

Nonetheless, informal resources should not be strained, be exhausted or cause a hardship to the providers. They cannot provide long-term solutions to social problems. Instead, the preferred approach should focus on coordination between formal and informal resources (Hepworth et al. 2006).

13.3.5 Linkages with Self-Help Groups

Self-help groups (SHGs) are non-hierarchical groups of persons with similar concerns or problems joining together to be a helpful resource for one another. The caring that occurs in SHGs creates an empathic environment for exchanging ideas and providing relevant information, offers strategies for coping and problem resolution and empowers group members to confront troubling issues (Miley et al. 2007). Social workers need to form SHGs or link clients with SHGs.

13.3.6 Conflict Mediation

According to Parsons, Jorgensen and Hernandez (1994), the social worker takes up the role of a conflict mediator when the need is to reconcile opposite or disparate

Chart 13.1 Summary of Techniques of Case Management with Children and their Families

Giving Information and Advice
- Give information in a logical, organised, step-by-step fashion.
- Give advice only when the client genuinely wants it and if the worker has the expertise in that area.
- Let client take the final decision.

Teaching and Training in Psychosocial Skills

Use:
- Decision analysis
- Role-play, behavioural rehearsal, role reversal
- Client–worker relationship

DIRECT INTERVENTION WITH CHILDREN AND THEIR FAMILIES TO STRENGTHEN SKILLS AND CAPACITIES FOR SELF-CARE

Counselling Children

Use brief practice models of counselling:
- Cognitive restructuring
- Solution-focused treatment
- Crisis intervention
- Play therapy

Working with Parents/Families

Make on-the-spot interventions to facilitate positive interactions:
- Focus on process rather than content.
- Give descriptive and neutral feedback rather than general or evaluative.
- Balance interventions among the family members to divide responsibility.
- Coach family members to own their feelings.
- Translate complaints into requests for change.
- Clarify positive intentions.
- Mediate in resolving family conflicts.

Information and Referral
- Understand the client situation.
- Assess the various resources available to meet client needs.
- Connect the client with the resource.
- If necessary, accompany the client to the resource on their first visit.

Inter-Organisational Collaborations

Use inter-organisational collaboration for:
- Broad base of ownership and a diverse pool of expertise
- Distribution of costs and responsibilities among the collaborators
- More power to influence legislators, the media and the public.

SYSTEM LINKAGE FOR CHILDREN AND THEIR FAMILIES

Linkages with Natural Support Systems

Activate linkages with:
- Relatives
- Friends
- Neighbours
- Natural helpers
- Colleagues
- Informal networks

Linkages with Self-Help Groups
- Form SHGs or
- Link clients with SHGs

Conflict Mediation

Mediate in conflict between:
- The clients and the service providers
- Between systems on behalf of clients

points of view and engage the disputants in a unified action. Such mediation may be needed not only between the clients and the service providers but also between systems on behalf of clients. Occasionally, breakdowns occur between clients and service providers so that clients do not receive the needed services to which they are entitled. Clients may not have adequately represented their case, may have withdrawn application or the service provider may have withheld services (Hepworth et al. 2006). A set of antecedents exist for evolution of a conflict among systems, such as competition of scarce resources, lack of role clarity, or other situations that create a "we/they" mindset, for example, between two childcare agencies or between management and staff of one agency (Parsons et al. 1994).

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