UNIT 7

SOCIAL CASE WORK IN DIFFERENT SETTINGS

SOCIAL CASE WORK IN DIFFERENT SETTINGS: Casework Practice in different settings: Family, School Settings, Community setting, Case work in Medical & Psychiatric Setting, Team Work.

Casework Practice in different settings:

Family

Family-centered casework practice encompasses the range of activities designed to help families with children strengthen family functioning and address challenges that may threaten family stability. These activities include family-centered assessment and case planning; case management; specific interventions with families including counseling, education, and skill building; advocating for families; and connecting families with the supportive services and resources they need to improve their parenting abilities and achieve a nurturing and stable family environment.

- **Family-centered assessment**
- **Family-centered case planning**
- **Family-centered case management**
- **Working With families and youth**
- **Advocating for families**
- **Working With community resources**

Family-Centered Assessment

Assessment forms the foundation of effective practice with children and families. Family-centered assessment focuses on the whole family, values family participation and experience, and respects the family's culture and ethnicity. Family-centered assessment helps families identify their strengths, needs, and resources and develop a service plan that assists them in achieving and maintaining safety, permanency, and well-being.

There are many phases and types of family-centered assessment, including screening and initial assessment, safety and risk assessment, and comprehensive family assessment. Assessment in child welfare is ongoing.

School Settings:

Professional social workers play a vital role in helping school children of all ages. Traditionally, school social workers serve as liaisons between the home, the school, and the community. Since 1907, school social workers have collaborated with teachers and other school personnel in advancing the purposes of education. School social workers are an important part of the school team, possessing unique interdisciplinary knowledge. School social workers contribute to programs designed for students at-risk due to a variety of factors, including:

- emotional problems,
- poor self-esteem,
- child abuse and domestic violence,
- poverty and unemployment,
- suicidal behavior, drug and alcohol abuse,
- teen pregnancy and parenting,
- discrimination, and
- Attendance related issues.

The School Social Work Program is designed to train school social workers and provide them with the competencies to practice in a variety of traditional and non-traditional primary and secondary education settings. Such competencies include assessing the needs of school children, designing and implementing interventions, and making referrals to other professionals and agencies as needed.

Community setting:

This is another training document in the series of community mobilizing methods for results other than a physical construction such as a communal water supply, clinic or school.

The product or output is a programme of services for vulnerable members of the community, many of whom can help themselves if only they are provided with a relatively small amount of help and encouragement.

What is Social Work?

The profession of Social Work is an odd mixture of many things. It is usually practised by government civil servants in the west (Europe and North America) while

many international NGOs have social workers on their staff.

The clientele of social work are often called the vulnerable, i.e. people whose special conditions or circumstances put them in positions of weakness or vulnerability in comparison with the mainstream of a society. Generally they include members of society who need some help. Typically, these include those with physical or mental disabilities, persons who are not able to work for a living or not able to care for themselves. In special cases, these may include battered women (those who have been physically or emotionally assaulted – e.g. by their spouses – and cannot escape dangerous situations on their own), frail elderly persons, children without parents to support them, or who are being mistreated,

The tasks of a social worker mainly include administration and counseling, along with a little bit of medical (usually psychological) intervention and advocacy. The social worker provides her or his clients with little bits of wisdom, advice, information, counseling, as needed. Every case is different.

The government (or NGO) social worker in a western country (Europe and North America) provides services that are usually provided by elders and family members in other countries. Social work services are too expensive for governments in the least developed countries.

The word "social" is a bit misleading because, in the west, where it is mainly practised, the social worker does not work with a whole society, or even with a community or a group in a social context. The social worker usually handles "cases," and a case is usually about an individual or lately increasingly, a family.

This is even more ironical because where social work is taught, usually in a university in a department or a school of social administration or social work, often (where they are small) they are attached to sociology departments. Such schools or departments, in turn, are then usually also where community development (like much of the material on this web site) is also taught. Community development, in contrast, is an activity aimed at social institutions, such as communities or groups, rather than at individuals. (See Community).

One of the many motivating facts pushing the development of this web site is that the empowerment of communities is important and highly needed in low

income countries. Limiting the training of community workers to those who are studying in universities, limits the available number of potentially capable community workers; this should be taught to middle school level students (after they have been working out in the real world and have some life experience).

Where is CBSW Appropriate?

Rich countries can usually provide social work services (on an individual or family basis, not community based), and poor countries rely on the advice, experience and knowledge of elders and family members. So where would it be appropriate to place a community based social work programme? Community based social work services are needed where they cannot be provided by elders and families, but where there is not enough finance available to provide it on an individual basis.

The situation which comes to mind most readily is where there are large displaced or refugee populations, in camps, in poor countries. Further to that, after the emergency is over, those same refugees may return home. Their lives will have been interrupted, losing many family members, including elders and family members, thus the need for social work services remains. So long as there is enough funding available for a professional social worker to supervise the community based work, keeping it up to required standards, the community itself can supply the energy, time and interest in making it work.

Apart from refugee situations, wherever there is a large disaster that results in the removal of elders and family members, and/or which disrupts the normal and traditional social organization, are included among situations where it would be appropriate to set up a community based social work programme. Post disaster situations would be included in these.

Where there are large refugee populations, the basic services, food, water, shelter, elementary medical, are usually provided, often by UN agencies and international NGOs. Finance is not unlimited, however, so there may only be a token attempt at providing social work services, if any at all. This is a good situation in which to consider organizing a community based social work programme.

Community Perceptions:

When a child is a witness to atrocities that destroy her world, she is affected. To watch your family members and/or neighbours being shot or bombed produces immense trauma if you are a child. In many cases, the experience results in the child withdrawing into herself, refusing to talk, and/or refusing to respond to daily interactions. The child who is traumatized by the same events which lead to refugee or displaced communities, may display behaviour that is often misinterpreted by her remaining family or care givers. Sometimes she is deemed as mentally retarded, and beyond recovery. Sometimes she is seen as affected by evil spirits. Sometimes her condition is seen as a punishment for previous misdeeds by her family members. In all these cases, there is much shame and secrecy associated with her behaviour. All too often her care givers do not understand that she is reacting to the terrible events of the disaster or civil war, and they do not know that the condition can be reversed by a few simple interventions.

Many times such children are hidden (even tied up) in darkened rooms away from public view. They cannot dress or clean themselves, and often are found in their own filth and in poor health, hungry, dirty, sick, weak and helpless. Public announcements do not get the message across. Hands on intervention is needed to assess each child.

If they are traumatized by atrocious events, and not retarded or otherwise disabled by other factors, they can show remarkable changes, learning to dress themselves, clean themselves and feed themselves. This requires patience, love and care, extended over several weeks and months. A stimulus or two in the form of a doll, and perhaps later a ball, are effective and useful tools for the job.

Here is a situation, repeated hundreds of thousand times around the world, where a community based social work programme is appropriate. This is a typical or classic situation for CBSW.

A single, university educated, professional social worker can appraise the situation, prescribe appropriate interventions, and monitor. Community mobilizers can work with the community members to identify hidden and suffering children, recruit community level social workers, arrange for their training and supervision,

organize CBOs to manage and operate the CBSW programme at community level, and ensure an effective flow of information. Local residents, on a volunteer basis or with some incentives, can provide the care and stimulation to the children in need, and keep the mobilizers informed about changing conditions and further needed training. This is only one of many kinds of situations involving vulnerable refugees or displaced persons in communities disrupted by (but surviving) disasters caused by natural or human made events.

The PHC Principles:

The "Primary Health Care" (PHC) policy promoted by WHO (UN World Health Organization), has several basic principles, perhaps the best known one being that prevention is better than cure.

Another, that is particularly applicable here to community based social work, is the idea that resources should not be spent on expensive cures for a few people. Underlying this is a public health policy in support of the greatest good for the greatest number. With a limited budget available, that means to concentrate on a few common diseases, to provide elementary training to persons educated at low levels, and reaching the most rural and remote patients. This gave rise to the popular (but slightly inaccurate) concept of "The Barefoot Doctor." (Also see Water and PHC). If the PHC policy is transferred to the need for social services, then the idea is to give elementary training to persons without university level education, concentrating on the most common and easily treated conditions, and relying on a referral system for more complicated diseases or conditions.

The goal in community based social work, then, is to organize a cadre of community members who can be given low level training (ie not requiring university education) to treat a limited number of social conditions of vulnerable community members. Their interventions will not be as flexible or a sophisticated as those of social workers with university level education and extensive social work training, but they will be able to reach a wider proportion of the population than if only highly skilled and relatively costly professionals are employed. "The greater good for the greater number."

Structure:

What is a possible structure for a CBSW programme?

Where you have a population of refugees or others who have had severe disruptions in their community lives, where they are able to access support for their immediate needs (food, shelter, water, housing) but no social welfare. Where you may have a professional social worker or two for a population too large for them to reach everybody. Where you have a situation conducive to organizing voluntary community groups.

There you have the basis for CBSW.

The professional social workers need to make a needs analysis to determine the limited number of conditions that can be addressed by community workers with low level training. They then need to train and to supervise the training of a cadre of community workers who have access to the client community or communities. Both the needs assessments and the training would not be once-off, but ongoing. They and the community workers (mobilizers) need to identify, recruit, and train community members, as community leaders of the programme, as practitioners of social work interventions in their communities, and as monitors of the changing situations in their respective communities.

Members of the community groups conduct the social work interventions. They need to be supported with training and guidance by the mobilizers and (more indirectly by) the professional social workers.

What results in effect is like a social work pyramid, with the professional social worker(s) at the apex, possible social work trainers (temporary or long term) supervised by the social workers, mobilizers, community leaders and managers of the community groups (CBOs) and community and CBO members who conduct most of the interventions.

Training and Support:

In general, community mobilizers should never be trained once-and-for-all, but need regular support, encouragement, and a forum in which to ask questions that arise in the field (See Training Methods). In CBSW this is even more a requirement. First, mobilizers without formal training (the main audience for this web

site) need continued support and professional inputs.

Second, the tragedies witnessed in CBSW require field workers to meet with their colleagues to share experiences and to be re-energised and re-infused with enthusiasm and positive attitudes. A CBSW programme as described above needs a routine and predictable forum for getting mobilizers together to share experiences, to ask questions arising from the field, and to obtain inputs from more highly trained and educated social workers. A training unit could be an answer to this need. How it is to be set up depends upon available finances and circumstances.

An initial training programme for the mobilizers could use the first six training modules from this web site. They can be printed and handed out in the training programme. They can be easily adapted to developing a CBSW programme. The training for social work, in contrast, needs to be defined and generated by the professional social workers, after they make their initial appraisal of the situations, and will be modified as new information comes in.

Case work in Medical & Psychiatric Setting:

Medical and Psychiatric Social Work is a branch or specialisation in professional social work. The medical and psychiatric social workers are employed in health settings like hospitals, community health care projects, medical and psychiatric rehabilitation agencies, psychiatric treatment centres and counselling centres. The role of the medical and psychiatric social worker is to help individuals with social, economic and psychiatric problems that arise because of ill health, disability and economic problems. They help to enable the person to lead a productive and satisfied life to the best of his abilities. The social worker uses his skill in relationship with the client system, and understands the problems faced by the client. It could be economic problems, attitude towards the problem faced by the client, the nature of the relationship he has with other support systems like the family, employers and referral agencies. The social worker gets the cooperation of the family treatment of the client and uses community resources that are available.

In the medical setting, the worker acts as the link between the doctor and the patient. She acts as the source of knowledge for the client. In the community health care organizations, the worker understands the social-cultural patterns of the

community, the health practices of the community, the needs of the community and interprets these to the team of other professionals with whom she works. Her main role in the community is to elicit participation of the community in planning their health care, provide health education and help them to use preventive services effectively. In the psychiatric setting, she does the mental status examination of the client, understands the psychosocial problems of the client and interprets the same to the psychiatric team. Her main role is one of counseling and education of the family to understand and accept the client. In the drug addiction centers, she is the link between the psychiatric and medical team, the family and the client. Apart from counseling the client, she works towards the rehabilitation of the client in the community and helps him to become a productive member of the community,

History

Medical Social Work had its beginning in England and the United States of America. In 1880, a group of volunteers working for an asylum in England paid friendly visits to the discharged patients to find how they were adjusting to their home conditions. In 1885 Sir Charles Loch recommended that the lady almoners should visit the patients at home to prevent the abuse of drugs given freely in the charity hospitals. The almoner, while investigating the financial problems of the clients, found other sets of social and psychological problems that needed handling. Hence, apart from the medical help given, she also tapped other community resources in order to help them overcome social problems.

In the "United States of America, around 1900, nurses visited the discharged patients in their homes and showed the importance of understanding the patient in his social situation. In 1902, Dr. Emerson of John Hopkins University, Baltimore, made the medical students visit the patients in their homes. This helped the students become aware of the impact of the social and cultural factors in health. In 1905, a – medical social worker was appointed at the Massachusetts General Hospital, with the establishment of the Social Service Department. In the first thirty years, more social

Psychiatric Setting

Apart from individual patient care, the social workers were also involved in other activities like administrative planning, joint teaching and research. They were

involved in the planning Bond implementation of community health care activities. In the west, the medical social workers have firmly established themselves and work as members of the health team. Their main role revolves around the treatment of the psychosocial dimensions of the patient's personality.

The Envisaged Tasks of the Medical Social Worker

The medical social worker is involved in the following areas: direct service to the client system, teamwork, administration, teaching, supervision and self-development, and community health.

Direct Service to the Client System

Social evaluation of the individual patients in terms of their ability to participate in the treatment process. Interpretation of the nature of the illness to the patient and his family an individual basis. Visits to patient's home for assessment of the psychosocial situation. Counseling and helping the patient and family to deal with the psychological and social problems arising out of the illness and giving information on the prognosis, treatment process and rehabilitation. Environmental modification through work **with** employers, family and others to enable the patient to benefit maximum from the treatment process. Organizing with patients, volunteers and other agencies, therapeutic, educational and recreational activities for group of patients and their relatives. Placement and institutionalization of destitute and other patients, if and when found necessary. Follow up of the client system to ensure fullest utilization of the services given. Referring patients and their families to other social welfare agencies.

Team Work

Interpreting the role of the social worker to the other team members. Interpreting the patient's psychosocial needs to the other team members. Participating in formulating a diagnosis and planning **the** treatment. Consultation to and from other members of the team.

Work with various members of the team.

Community Health Work

Involving the community in carrying out a community survey and use of media to identify needs.

Correctional Social Work

With 1.6 million Americans behind bars and the cost of their care rising, NASW believes preventative services, alternatives to incarceration, and an emphasis on prisoner rehabilitation must be undertaken. Adequate services both inside and outside of the prison could reduce rates of incarceration and recidivism for the betterment of individuals and society as a whole.

A number of facts about the prison population, although disturbing, point toward solutions for stemming the growth in numbers of incarcerated individuals:

- People of color are disproportionately represented in the prison population.
- Substance abuse and mental illness underlie many offenses committed.
- An estimated 200,000 prisoners have severe mental disorders, while others have mental health problems that are undiagnosed and untreated.

Although the effectiveness of some practices to promote rehabilitation—such as helping prisoners maintain family ties and responsibilities—are known, the social work profession should identify others through research (for example, other options for dispute resolution, alternatives to prison, and effective treatments within correctional settings). In addition, social workers in correctional settings need specialized training, including the ability to communicate with prisoners from other cultures. Finally, social workers should participate in national policy debates, collaborate with other organizations that deal with prisoners, and advocate preventative efforts, including community-based services to treat addiction and mental illness before these become criminal justice issues.

Aged Care

Medical (skilled care) versus Non-Medical (social care)

A distinction is generally made between medical and non-medical care, and the latter is much less likely to be covered by insurance or public funds. In the US, 86% of the one million or so residents in assisted living facilities pay for care out of their own funds. The rest get help from family and friends and from state agencies. Medicare does not pay unless skilled-nursing care is needed and given in certified skilled nursing facilities or by a skilled nursing agency in the home. Assisted living facilities usually do not meet Medicare's requirements. However, Medicare does pay

for some skilled care if the elderly person meets the requirements for the Medicare home health benefit.

Thirty-two U.S. states pay for care in assisted living facilities through their Medicaid waiver programs. Similarly, in the United Kingdom the National Health Service provides medical care for the elderly, as for all, free at the point of use, but social care is only paid for by the state in Scotland, England, Wales and Northern Ireland are yet to introduce any legislation on the matter so currently social care is only funded by public authorities when a person has exhausted their private resources, for example by selling their home.

Elderly care emphasizes the social and personal requirements of senior citizens who need some assistance with daily activities and health care, but who desire to age with dignity. It is an important distinction, in that the design of housing, services, activities, employee training and such should be truly customer-centered. However, elderly care is focused on satisfying the expectations of two tiers of customers: the resident customer and the purchasing customer, who are often not identical, since relatives or public authorities rather than the resident may be providing the cost of care. Where residents are confused or have communication difficulties, it may be very difficult for relatives or other concerned parties to be sure of the standard of care being given, and the possibility of elder abuse is a continuing source of concern. The Adult Protective Services Agency -a component of the human service agency in most states -is typically responsible for investigating reports of domestic elder abuse and providing families with help and guidance. Other professionals who may be able to help include doctors or nurses, police officers, lawyers, and social workers.

Improving mobility in the elderly

Impaired mobility is a major health concern for older adults, affecting fifty percent of people over 85 and at least a quarter of those over 75. As adults lose the ability to walk, to climb stairs, and to rise from a chair, they become completely disabled. The problem cannot be ignored because people over 65 constitute the fastest growing segment of the U.S. population.

Therapy designed to improve mobility in elderly patients is usually built around diagnosing and treating specific impairments, such as reduced strength or poor balance. It is appropriate to compare older adults seeking to improve their mobility to athletes seeking to improve their split times. People in both groups perform best when they measure their progress and work toward specific goals related to strength, aerobic capacity, and other physical qualities. Someone attempting to improve an older adult's mobility must decide what impairments to focus on, and in many cases, there is little scientific evidence to justify any of the options. Today, many caregivers choose to focus on leg strength and balance. New research suggests that limb velocity and core strength may also be important factors in mobility.

The family is one of the most important providers for the elderly. In fact, the majority of caregivers for the elderly are often members of their own family, most often a daughter or a granddaughter. Family and friends can provide a home (i.e. have elderly relatives live with them), help with money and meet social needs by visiting, taking them out on trips, etc.

One of the major causes of elderly falls is hyponatremia, an electrolyte disturbance when the level of sodium in a person's serum drops below 135 mEq/L. Hyponatremia is the most common electrolyte disorder encountered in the elderly patient population. Studies have shown that older patients are more prone to hyponatremia as a result of multiple factors including physiologic changes associated with aging such as decreases in glomerular filtration rate, a tendency for defective sodium conservation, and increased vasopressin activity. Mild hyponatremia ups the risk of fracture in elderly patients because hyponatremia has been shown to cause subtle neurologic impairment that affects gait and attention, similar to that of moderate alcohol intake.