Note: This training presentation is continually being evaluated and updated to reflect current needs and best practices. It should be viewed as work in progress.

Any person, organization, or institution making use of these materials must acknowledge that they were developed by the Tanzania Institute of Social Work, Jane Addams College of Social Work, and Midwest AIDS Training and Education Center with support from the US President’s Emergency Plan for AIDS Relief (PEPFAR), USAID/Tanzania, and the HIV/AIDS Twinning Center.

# Learning to Work with Orphans and Vulnerable Children

## A Project of the Social Work HIV/AIDS Partnership for Orphans Vulnerable Children in Tanzania

## Day 5

*Required*

## Social Work Process for Working with Orphans and Vulnerable Children Affected by HIV

1. **Outreach and Identification**

2. **Engagement of Orphans and Families**

3. **Assessing Needs and Strengths**

*Required*

# Social Work Process for Working with Orphans and Vulnerable Children Affected by HIV

4. **Developing a Plan of Care: Networking and Identifying and Referral to Other Resources**

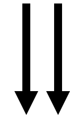
5. **Providing Support and Services within the context of your organization**
   - **Helping HIV Affected Orphans and Vulnerable Children**
   - **Counseling OVC and Their Families**
   - **Developing Support Structures for OVC and their Families**

6. **Ongoing case management, Advocacy and Followup**

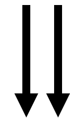
*Required*

# From Assessment to Plan of Care

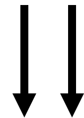
Assessment– Processing the information we have about the clients needs and strengths



Making a Plan



**Implementing the Plan**



Follow-up→ modifying plan as needed

*Required*

# WHAT IS CASE MANAGEMENT

(Definition)

- Case management is one among the approaches that could be used by para social workers when addressing problems of OVCs and their families.

- The objective of case management is to bring about positive and sustainable changes in the lives of people in need.

- OVCs have diverse needs that cannot be met by a single source of services.

- Case management is about managing the delivery of a number of services to improve the condition of children and families.

*Required*

# WHY DO CASE MANAGEMENT?

- **Continuity of care** and services and follow-up.
- Assessment--**comprehensive family centred assessment** of medical, social and psychosocial needs.
- Develop and implement a **service plan**.
- **Co-ordination** of care and referral activities.

*Required*

# WHY DO CASE MANAGEMENT?

- **Minimize duplication** of services
- Periodic **re-assessment and evaluation** of client needs and case management activities
- Developing and maintaining a **service network**

*Required*

# WHAT ARE THE ***FUNCTIONS*** OF CASE MANAGEMENT?

- **Problem solving**
- **Client empowerment** and self directed initiatives to clients.
- Help client **deal with organizational, attitudinal or other service barriers**

*Required*

# WHAT ARE THE ***FUNCTIONS*** OF CASE MANAGEMENT?

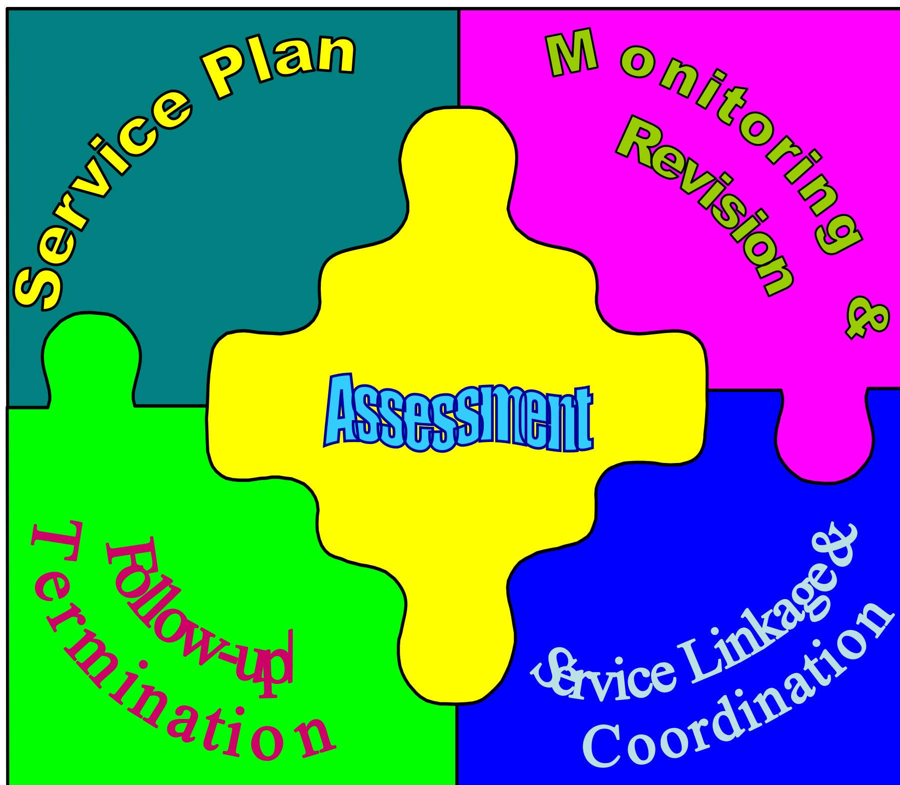
- Support client efforts to **prevent HIV infection** (if negative) and HIV transmission (if positive)

- Facilitate problem solving and planning

- Work with other organizations to **create networks of care**

*Required*

# WHAT ACTIVITIES ARE INVOLVED IN CASE MANAGEMENT?




*Required*

- Identification of consumer/client
- Engagement to create working relationship
- Assessment to establish working statement
- Service planning
- Linkage with needed services
- Consumer advocacy

# MODELS OF CASE MANAGEMENT

- Generalist
- Specialist
- Case manager (Therapist)
- Family
- Psychosocial rehabilitation – centre module
- Supportive (care model)

*Required*

# ROLES AND RESPONSIBILITIES OF A CASE – MANAGER

- Planner
- Facilitator
- Manager
- Enabler
- Supervisor
- Evaluator
- Resourceful person
- Broker

*Required*

# WHAT DO CASE–MANAGERS DO?—(RESPONSIBILITIES)

- Interviewing clients and their systems.
- Data gathering to establish psychosocial needs of the client.
- Guide discussion and decision making forums among relevant program representatives.
- Monitor to ensure adherence to the plan

*Required*

# WHAT DO CASE–MANAGERS DO?—(RESPONSIBILITIES)

- Conduct counseling with clients and their families during crisis situation.
- Document clients' progress
- Liaison between client and other actors involved in the change process
- Establish and maintain good public relations with resource systems

*Required*

# GUIDES FOR EFFECTIVE CASE MANAGEMENT

- Quick response to the client
- Well developed relationship with client and other systems
- Frequent contacts with client
- Service continuity from intake to follow up

*Required*

# PARA SOCIAL WORKER CASE MANAGEMENT PLAN

| **Needs** | **Goals** | **Planned Interventions** | **Referrals** | **Time Frame** | **Followup and Notes** |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

*Required*

# PARA SOCIAL WORKER CASE MANAGEMENT PLAN

| Needs | Goals | Planned Interventions | Referrals | Time Frame | Followup and Notes |
|---|---|---|---|---|---|
| Child is lonely, depressed | Increase contact with peers | •Help child develop a list of favorite activities and people likes to be with<br>•Involve child in group activities at community center | Refer to director of community center | 2 weeks | |
| School problems | Regular attendance | •Provide school fees and supplies<br>•Meet with school to determine problems and solutions | Case Conference with School | 3 weeks | |
| Health Problems | ▪ Address skin problems<br>▪ Assess HIV risk<br>▪ Provide needed health exam, tests | ▪Initial health center visit<br>▪Counseling regarding health problems and promotion | ▪ Health Center | First visit within 1 week. Followup as needed | |
| Housing | ▪ Assess safety of current housing | ▪Visit home, meet household members, determine needs | ▪ As needed | Within 2 weeks | |

*Required*

# Case management is a process. It can be accomplished through...

- a designated **case manager**
- a **team approach** within an organization
- by **supporting client self management**
- by a **case manager in another community-based setting**

*Optional*

# Case management is a process. It can be accomplished through...

- By **empowering client/caregiver self management**
- Through **networks of workers** in diverse programs
- By **mobilizing volunteers**

*Optional*

# Models of Case Coordination

– **Central coordination mechanism–** an organization coordinates services from various organizations with a **case manager**

– Case managers have standard
  - Procedures
  - Training
  - Evaluation systems
  - Follow-up

*Optional*

# Models of Case Coordination

- Developing case management teams
  - Team of workers with an agreement to do case management
  - May be inter-disciplinary
  - Possible members: doctors, nurses, social workers, outreach workers, health educators, peer educators, volunteers
  - Case conferences may provide organization

*Required*

# Models of Case Coordination

- Network model
  - Case management occurs across organizations
  - Need for
    - Communication structures
    - Quality assurance
    - Sharing of information

*Optional*

# Models of Case Coordination

- Volunteer model
  - Buddies or peer case managers
  - Volunteers need:
    - Training
    - Organization
    - Support
    - Follow-up

*Optional– if time*

# Models of Case Coordination

- Client/Caregiver Self Management with Support: Empowerment Model

  - Social Worker assists in
    - Assessing needs
    - Suggesting resources
    - Helping with linkage
    - Monitoring and follow-up

  - Client/Caregiver does the follow-through!

*Required*

# Some guides for working with community groups

- Communication
- Sharing of knowledge and information
- Sharing of decision making (power)
- Networking
- May be:
  - Formal with letter of agreement
  - Informal
- Providing support works both ways!

N

*Required*

# Obstacles to Case Management: Our own reactions

## Fears of contagion

- Fear of death
- Denial of helplessness
- AIDSism
- Gender, Ethnicity, homophobia, sex phobia, addictophobia
- Over-identification
- Anger
- Provider control needs

*Required*

# Obstacles to Case Management

- Stigma of AIDS and HIV risk behavior
- Lack of family or community support
- Impact of HIV Associated Dementia
- Ethical Dilemmas
  - Paternalism versus self determination
  - Confidentiality/Disclosure Issues

Source: Roberts, Severinsen, Kuehn, Straker & Fritz, 1992

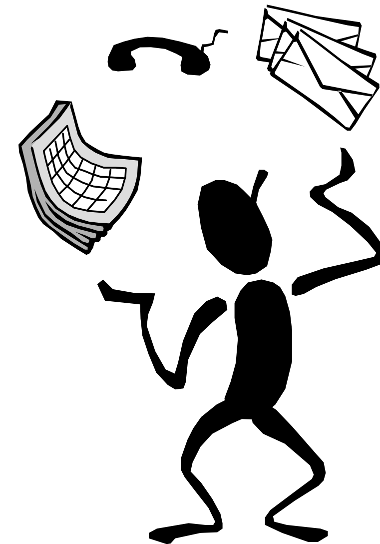
*Optional*

# Accessing Case Management Resources

Source: Project HOPE HELP Project, 2006

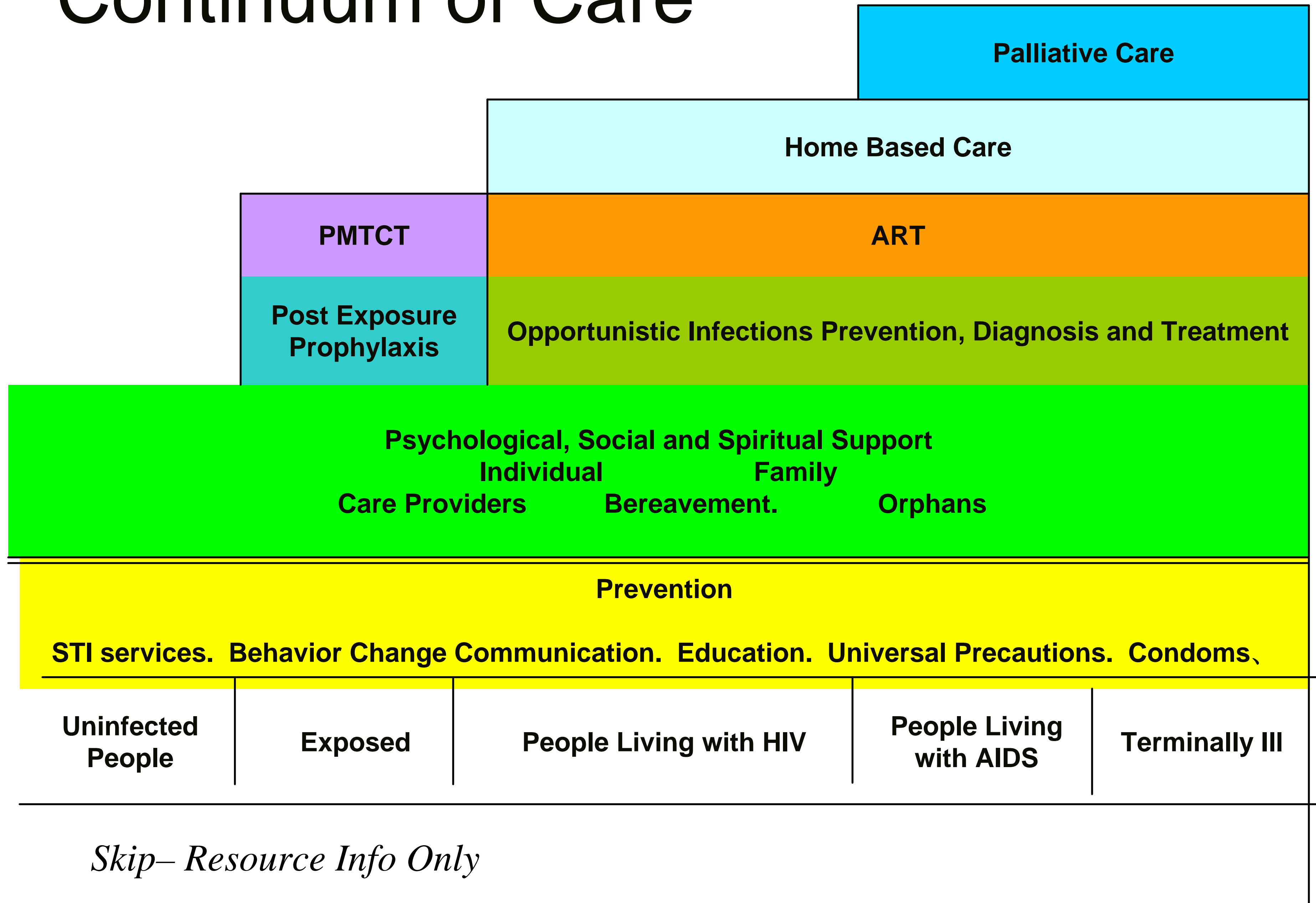
# What are Some of our Roles in Systems of Service?

- Network developer
- Network resource
- Use network as a resource
- Service Coordination
- Building resources
- Community Building
- Service Delivery
- Mobilizing family, friends, community groups



*Required-- Brainstorm*

# Continuum of Care




*Skip– Resource Info Only*

# What are Possible Sources for Help for OVCs?

Schools

Clinics

Hospitals

Dept of Social Welfare

Churches

Most Vulnerable Children Committees

AIDS Service Organizations

Support/self help groups

Faith based organizations

Associations, burial societies, etc.?

Food programs

HIV Implementing Committees

*Required-- Brainstorm*

# What are Possible Sources for Help for OVCs?

Community developers

Businesses

Outreach workers

Health educators

Volunteers

Home based care workers

*Required*

NGOs

Police

Other child service programs

Adoption programs

Foster parents

Others????

# *Don’t re-invent the wheel! Resources and Referrals:*

- CM agencies must have current resources and referrals at all times.
- Resources and referral sources frequently change.
- This information needs to be shared.
- It is pointless for a new case manager to start off “hunting” for commonly used referrals and resources.

*Required*

- The CM must learn how to access referral sources expeditiously.

- There are certain eligibility criteria for most referral sources and it is the CM's job to know these requirements.

*Optional.*

# Do You Know Your Resources?

## Types of Resources (Brainstorm)

*Required– Brainstorm examples of resources*

# Resource Tips

- Create a resource guide for the region that lists services for their topic

- Specific agencies or programs that offer assistance for their need

- Any programs or agencies not  traditionally used that you have accessed for your clients.

*Required*

# Do You Know Your Resources?

- Housing
- Financial Assistance
- Transportation
- Alcohol and Substance Use Treatment

*Optional*

# Do You Know Your Resources?

- Legal

- Supportive Services

- Others??????

*Optional*

# Mapping Exercise--work in groups of about 8 from same area if possible. Appoint a recorder to present summary

- What are possible sources of help for orphans and vulnerable children in the community? See previous list for help!
- Using large paper and marker pens make a map or picture of your community
- Put the possible resources on the map
- How do these relate to each other? Draw arrows (→)
- Put your map up.
- Go back into large group. Each group to put up map and present
- Discuss findings.

*Required– Move to next section*

# CASE CONFERENCES

- Meeting conducted by a worker in human services to discuss client's problem and service plan

- Composition
  - Workers within or between agencies.
  - Services providers
  - Involving families, caregivers, clients?

*Required*

s

# CASE CONFERENCES: Purposes

- Help to clarify the client's situation and his/her behavior
- Help to determine the best service plan
- Help to set new service plans
- Helps to set new service plans.

*Required*

# STEPS FOR CONDUCTING CASE – REFERENCE

- Presentation of summary: relevant information about case
- Discussion of the case
- Developing and selecting options: the service/case-management plan
- Summing up
- Ending of the conference.

*Required*

# Self Care, Support and Avoiding Burnout

Source: Linsk, Steinitz, et al., Caring for Yourself So You Can Care for Others, Catholic AIDS Action, Namibia, 2001

*Required– title of section*

# Developing Your Support Plan

– Helping is like building a fire–

- If you don't tend the fire it will go out can't burn and provide energy

- What fuels the fire?
  – Support
  – Knowledge
  – Self care
  – Other???

*Required*

# Do Helpers Need Support?

- The “super” helper
  - Everyone comes to him or her for help
  - Very good at listening, problem solving, making others feel better
  - Their role is the helper

*Required*

# How Long Can the Super Helper Help?

It depends.

- If they have their own supports can help for a very long time

- If DON'T have support
  - May feel exhausted or burdened
  - May not be dealing with own life
  - May feel annoyed, irritable, stressed or angry

*Required*

# Who Is Our Support?

- Exercise:  Who is in our life?
  - Who provides basic support?-- Food, home, and other necessary things
  - Who helps if you need to borrow something?
  - Who helps if you are sick and need care?
  - Who do we tell personal information to?
  - Who do we tell how we feel with?
  - Who can help us relax or play?

*Required*

# Where Do We Find Support?

- Do you have a support place?
  - Church
  - Family gatherings
  - Community events
  - Home
  - Social place – often where food or drink are served
  - Work place

*Required*

# Burnout

- No fuel for the fire
- Caregiver exhaustion leads to reduced ability to provide care
- Emotional and behavior responses include:
  - withdrawal from care
  - feeling overwhelmed by the care needs

*Required*

# Signs of Burnout

- Multiple losses-- family or work or both
- No time to use coping strategies
- Increased stress may lead to physical,emotional symptoms
- Decreases the joy in life

*Required*

# Preventing and Addressing Burnout

- Identify the loss and its meaning
- Take time to talk with colleagues and/or friends and family

*Required*

# Preventing and Addressing Burnout

- Recognize the process of grieving
- Utilize successful coping and grieving strategies

*Optional*

# Developing a Burnout Prevention Plan

- Regular Burnout Debriefing
- New Learning leads to less burnout
- Take a break– allow the coping to work!
- Recognize your successes

*Required*

# Developing a Burnout Prevention Plan

- Problem solving
- Deep breathing, yoga, exercise
- Journaling to increase understanding and acceptance

*Required*

# Creating Boundaries

- What are the limits of caring?
  - Program boundaries
  - Our own personal boundaries
  - Avoiding harm to ourselves or others

*Required*

# Setting Boundaries

- Clear about how much time can spend
- Clear about what can and cannot do
- Clear about the kinds of relationships are acceptable

*Required*

# Setting Boundaries

- Being able to say no, while still valuing the person
- Helping find another source of help (refer)
- Avoiding places that may be dangerous
- Limiting topics of conversation

*Required*

## **Within** the Boundaries or **Outside** Boundaries?

- Client asks volunteer to come over at 2 in the morning because of a family crisis
- Client asks staff member to provide food for the family
- Client asks volunteer to go out socially
- Client asks staff member to help solve a family conflict

*Optional*

## **Within** the Boundaries or **Outside** Boundaries?

- Client asks volunteer to help them go to clinic

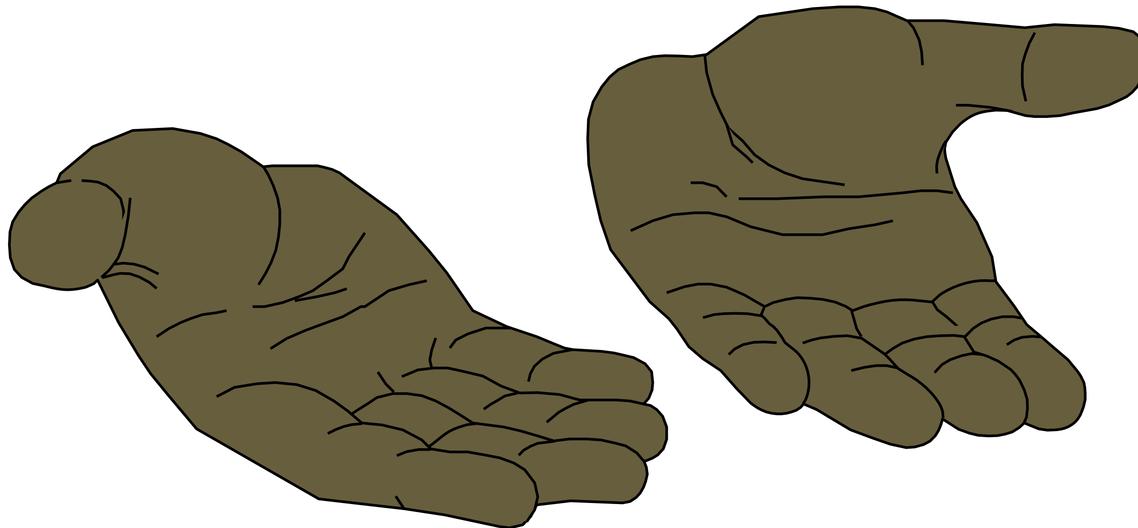
- Client follows staff person everywhere they go

- Organization asks staff to work all night and day for 3 days

*Optional*

# The caregiver has two hands

- One to care for the care receiver
- One to care for him or her self



*Required*

# A Personal Support Plan

- Who helps
  - Task help
  - Feeling/Talking help
- Where to get help
  - Support places
- Checking in
  - Stress
  - Success
  - Problems
- What helps?
  - Talk
  - Actions
  - Sharing the task
  - Pacing and breaks
- Getting credit
  - Self credit
  - Credit from others

*Required—Show only if time is short*

# Caregiver Support Plan--

- Understanding
  - – Do we have the knowledge to do the job?
  - – Lack of understanding leads to more stress
  - – Improving Understanding
    - Training
    - Reading
    - Getting advice

*Required*

# Developing a Support Plan

- Feelings—
  - Sensing how we feel
  - Expressing how we feel
    - To self
    - To others
  - Transforming feelings to positive action

*Required*

# Caregiver Support Plan

- Sharing the tasks
  - Can we help each other?– Make a trade--I'll do this part if you can do that
  - Be clear about what you CANNOT do
  - What NEEDS to happen when?

*Required*

# Caregiver Support Plan

- What is the coping plan?– Taking care of ourselves
  - The idea of respite– take a break
  - Sharing the stress– letting someone know
  - Accepting the losses
  - Use of stress reducers: exercise, meditation, self reflection, diet

*Required*

# Caregiver Support Plan

- *Self Care* --Caring for yourself so you can care for others
  - Time
  - Social support– find someone who can hear you
  - Back-ups– who can “fill in” when need another helper
  - Helping Networks

*Required*

# Celebrating Success

- We can be successful helpers even when there is sadness and loss
- Need to see how we are helping
- Need for
  - Hope
  - Meaning of the work

*Required*

# Supporting the Caregiver

- Ceremonies

- Sharing

- Gifts

*Required*

# Group Exercise: Case Conference to Develop a Service Plan

- Appoint a recorder to present at recap
- Discuss the group's case for this week (25 minutes)
  - What is your reaction
  - What do you see as strengths and needs
- Work in mini-groups of 4-5 people (45 minutes)
- Take roles of client, family members, parasocial worker/case manager, community people, schools, NGOs, etc.
- Conduct a case conference.
  - Present relevant background and assessment information
  - Develop a plan of care for the case using community resources (case management service plan)

*Required*

# Case Discussion Debrief

- In large group, each group to present (25 minutes)
  - A brief description of the client system presenting problem
  - At least 2 parts of the case management plan

- Discuss main points we've learned about using assessment to develop service plan (15-20 minutes)

*Required*