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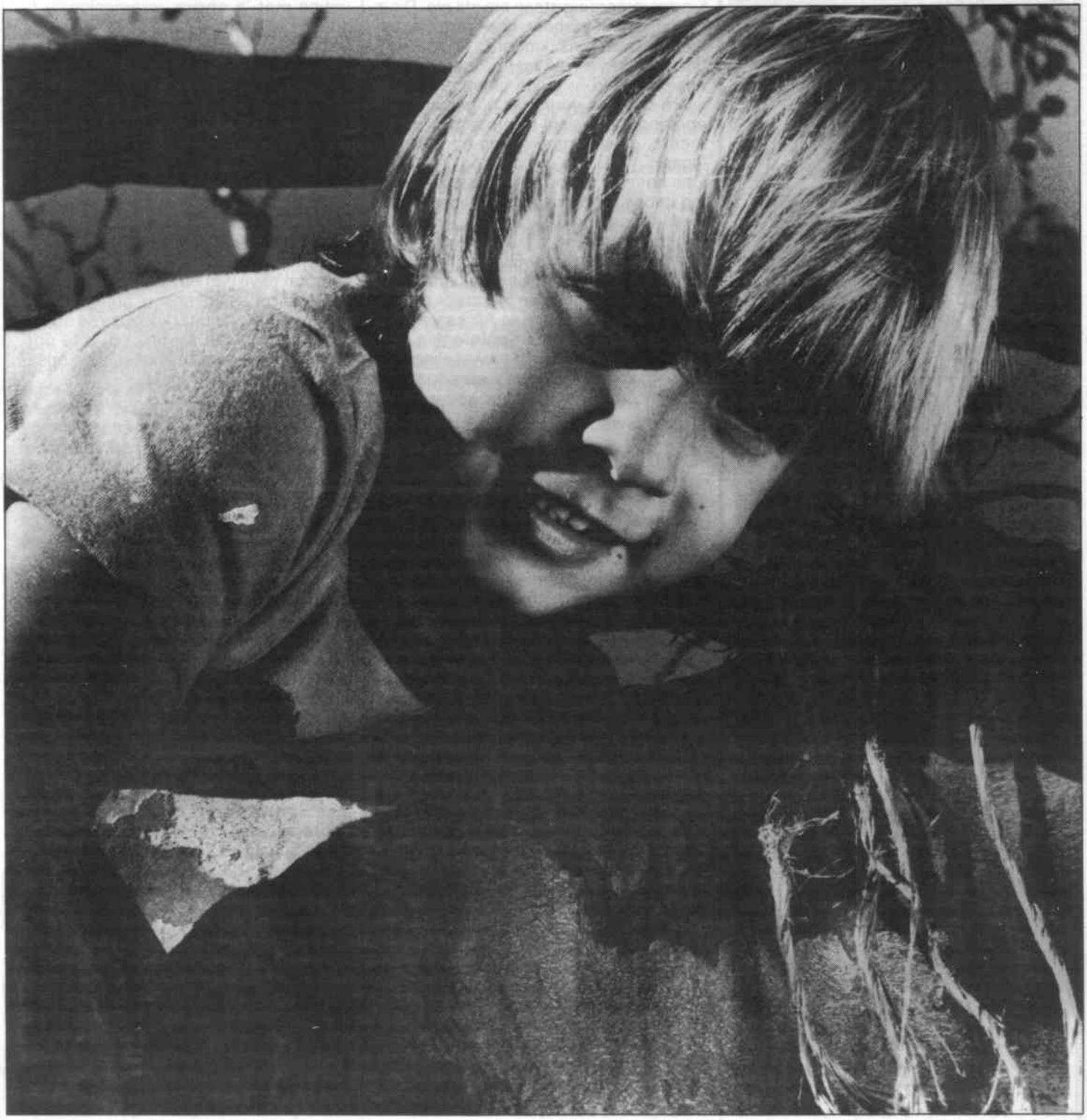
The child care worker



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Konferensie 1987

Elke twee jaar word die geleentheid daargestel vir kinderversorgers — prinsipale, huisouers, bestuurslede, maatskaplike werkers, en dies meer — om vir drie dae bymekaar te kom om te praat oor en te luister na mekaar se ondervindings, om die nuutste gebeure en probeerslae te ontdek, en op sulke seldsame geleenthede weereens bewus gemaak te word dat ons almal deel uitmaak van 'n waardevolle en belangrike beroep.

Kinderversorging staan nie stil nie. Dit is 'n diens wat gehoor gee aan die behoeftes van ons kinders, en daarom baan dit nuwe weë jaar na jaar. Konferensietyd bied 'n gulde geleentheid om saam ons pad vorentoe te beplan deur ervaringe te wissel met staatsdepartemente, gesinsorganisasies en met kollegas.

Ons het min genoeg professionele leiding in ons moeilike werk. Kindersorg literatuur is beide beperk en duur. Byvoorbeeld, een enkele uitgawe van *Child and Youth Care Quarterly* sal u instansie R43.50 kos! Dit is dus uiters belangrik dat ons ons eie literatuur en ons eie praktyksbasis in Suid-Afrika voortbring en ons Nasionale Konferensie bied 'n sinvolle forum vir die wisseling van inligting aan. Ons beoog weereens hierdie jaar om 'n boek uit te gee wat nie slegs die lesings, maar ook die besprekings wat daarop volg sal insluit. U deelname sal dus direk bydra tot Suid-Afrikaanse literatuur.

Die mees belonende aspek van die Konferensie is miskien die geleentheid om na ons oorsese spreker, Thom Garfat, te luister en met hom saam te werk en te gesels. Dit bied die besondere geleentheid om te luister na alternatiewe praktyksmetodes, om probleme en oplossings te vergelyk, en om ons eie rigting met 'n ervare, internasionale figuur na te gaan.

Daar word beweer dat afgevaardigdes net soveel voordeel trek uit geselskap met kollegas as uit die formele referate en aanbiedings van die Konferensie. Dit mag so wees. Kinderversorging bly nog steeds 'n gefragmenteerde beroep in Suid-Afrika, en ons geleentheid om oor departementele, taal, praktyk en kulturele grense saam te span is gering — veral as gevolg van die reuse geografiese afstande in ons land.

Kortom, vanuit u standpunt as kindersorgpraktisyn wat op hoogte met sy beroep wil bly, sien ons u graag by die Konferensie. Vanuit u kollegas se standpunt wat daarvan sal hou om u te ontmoet en gedagtes te wissel, sien ons u graag by die Konferensie.

Conference 1987

Once every two years child care workers — principals, houseparents, committee members, social workers, whatever — have the opportunity to come together for three days to talk and listen, to hear what each other are doing, to discover what is new and what is being tried, and to feel, on these rare occasions, that we are all part of a worthy and important profession.

Child care is not a static task. It is a task which responds to the needs of the children of our world, and therefore it charts new courses decade by decade. Conference is a good place to work out together where our route will take us in the coming years as we compare notes with state departments, with family welfare agencies and with colleagues.

We have little enough professional guidance in our difficult work. Child care literature is both limited and expensive. A single copy of *Child and Youth Care Quarterly* for your institution, for example, costs R43.50! Generating our own literature and our own practice base in South Africa thus becomes extremely important, and our National Conference provides an important forum for the exchange of information: It is intended this year once again to publish a book containing not only the papers presented but also summaries of the discussions following the papers at Conference, so your participation will contribute directly to the South African literature.

Perhaps most important will be our opportunity to listen to and spend time with our overseas speaker, Thom Garfat. This will be an excellent chance to listen to alternatives, to compare problems and solutions, and to check our own bearings
with an experienced international figure.

It has been said that delegates gain as much from meeting with colleagues as they do from the formal presentations at Conference. This may be so. Child care is a very fragmented career in South Africa and our opportunities for meeting across departmental, language, practice and cultural grounds are few, especially in view of the vast geographical distances in South Africa.

In short, from your own point of view as a child care practitioner who wants to keep in touch with his profession, it will be good to see you at Conference. And from the point of view of your colleagues who would like to meet you and exchange ideas with you, it will be good to see you at Conference.

The Treatment Plan — IV

Treatment Plan Formats

Peter Powis, Merle Allsopp and Brian Gannon

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In this article we will present two abbreviated assessment reports and then briefly sketch the treatment plans which might flow from these assessments, demonstrating some alternative treatment plan formats. The writers experienced two problems in deriving the treatment plans. Firstly, all three had practised in different settings which varied in their building designs, staffing patterns and availability of group programmes. Secondly, all three had worked in more sophisticated clinical settings which do not represent the majority of children's homes in South Africa. A conscious effort has been made, therefore, to outline treatment planning procedures which can be followed by all children's homes, even those with more modest staff designs.

CASE STUDY 1

Name: Adél D'Issent, 16 years old, Standard 8.

Background: Adél has just been placed in substitute care because

- She had only attended her previous school on 33 out of a possible 124 days this year. Neither her parents, the school staff nor the social worker have been able to get her to attend school regularly.
- Her intimate relationship with her 22 year old boyfriend was felt to be detrimental to her general development and functioning (she was sexually involved and talking of wanting to fall pregnant and get married).
- She had used her parents' credit card to buy clothes and draw money without her parents' permission.
- She had apparently been easily influenced by peers but her parents had been unable to influence her behaviour.

Additional relevant background information:

- Adél was adopted as a baby by her parents who had also adopted her older brother about two years earlier. She was told about her adoption at an early age.
- Adél's adoptive father suffers from what Adél calls a "nervous problem" for which he has received psychiatric treatment. As a result of this condition he was placed on early pension 2 years ago. He plays a passive but nagging role in the family.
- No major disruptive events are known.

Medical history: Apart from an operation to her foot after a minor accident, nothing of significance is known.

Scholastic and intellectual functioning: Scholastically Adél is doing very poorly in Standard 8 (Standard Grade). She was promoted although she had failed both Standards 6 and 7.
In 3 years her IQ scores (Verbal, Non-verbal and Full Scale) have dropped from average to well below average. Tests indicate: motivation to try; good perseverence and careful but slow approach to her work; practical mindedness (on the positive side); poor knowledge of language; difficulty comprehending and memorising orally-presented material; poor numerical reasoning and abstract thinking (on the negative side).
In conclusion she is far better at practical than abstract, academic work. She will need specialised assistance with academic work and her school placement needs careful consideration.

Social and interpersonal functioning:
Family —

- Parents have had difficulty adjusting to Adél's adolescence (her need for greater autonomy and increased peer involvement; her challenging of their beliefs and authority).
- As an adopted child she has been treated as "special" and her parents have been reluctant to apply firm limit-setting.
- The father's neurotic condition causes and reflects areas of stress in the family. People do not openly discuss differences or conflicts and the parents avoid their problems by focusing on Adél. She responds by behaving in ways which perpetuate their negative involvement. Adél's brother supports her parents against her and she feels smothered, isolated, angry and somewhat rejected.
- Covertly Adél is very worried about her father and feels a need to support him and distract him from his problems. She also senses her mother's frustrations and feels both supportive and resentful towards her mother.
- Adél is fairly comfortable with her adoptive status, and knows basic details about her biological parents. She does however want to meet them when she is a little older, and sometimes fears that they are dead.

Social skills and peer relationships —
She shows adequate social skills and can relate well to adults and peers. She is neither very demanding nor very aloof. However, she does not easily share her thoughts and feelings with adults. She also appears to be easily influenced by older and more assertive peers, and does not assertively resist sexual exploitation. She still wants to see her boyfriend but no longer wants to marry him.
Recreational activities —
She does not participate in organised sporting or cultural activities (which probably reflects her lack of confidence in her ability to handle structured demands). Nevertheless she shows artistic and creative abilities (e.g. making posters, hairdressing).
In conclusion she shows the potential to form positive relationships with child care staff who are not intrusive yet show support and understanding, and who allow her to dictate the pace at which the relationship develops. She will need to be contained while such a relationship is developing so that she does not allow herself to be negatively influenced. She may be vulnerable to sexual exploitation.

Emotional functioning:

- While she feels confident of relating to adults and peers in informal situations, she feels helpless and inferior in handling structured demands in formal situations (e.g. school). Her self-esteem is therefore rather poor.
- She hides her anxieties (e.g. about her father) and resentment and tends to withdraw into herself when upset. She does however show an ability to process problems and rally her resources without feeling self-pity.

• She shows good (sometimes too good) impulse control and is unlikely to act out aggressively or destructively. She may express her anger by passively resisting or by subtle defiance. As mentioned above, she will have difficulty resisting peer pressure, and will be especially vulnerable to influence by older males.

Identifying Probable Outcomes

The plan will include a number of treatment goals which collectively work towards the successful discharge of the child. However, before the constituent tasks are worked out, it is necessary to establish the *probable* outcome of a case so that ultimate goals are realistic rather than idealistic. For example, in this case it is unlikely that Adél will return in the near future to an adequately coping family setting where "everyone lives happily ever after". She will more likely be discharged as a young adult starting a career whether she returns to her family or to some independent living situation.

An important aspect of the *probable outcome* scenario is that we take into account the existing flow and directions of her life, in a sense joining her in this flow, rather than attempting sudden and dramatic deflections and changes. Treatment plans too often have stereotyped and unitary goals; we expect *all* of our children to succeed according to a single predetermined idealised goal, perhaps squeezing them inappropriately into a mould which frankly doesn't fit. An example of this is expecting all children to matriculate. Such attempts usually generate considerable conflict between staff and children and within the youngsters themselves. The treatment planner "must be open-minded, flexible and imaginative enough to adapt his recommendation to what child, family and community can manage best" (G.A.P. Report 87, 1974, 63). Counter to this principle of "going with the flow", we will nevertheless have to impose some guidelines or restrictions in order to control negative or destructive features of the child's life and environment.

In Adél's case we conclude the following *probable outcomes* in order to set a rough course in her treatment plan:

1. She will more likely be discharged as an independent young adult than back to her family as a dependent child.
2. She will more likely not achieve an academic school-leaving qualification, though we need to leave room in our planning to be certain of this.
3. She is sexually active and this is unlikely to be easily reversed.
4. We probably have her with us for about eighteen months, which establishes an important time-frame within which we have to work.
5. Our task will be focussed more on developing coping strengths within Adél than on work within the family context, but the family remains nonetheless important to her.

Planning Priorities

Most youngsters coming into care require initial procedures which stabilise important unsettled areas of their lives. It should never be forgotten that the removal itself is such an area, and in this regard Beedel's (1970) treatment of the principle of 'holding', referred to earlier, is one of the best texts to consult.

In Adél's case there are four priority plans to be implemented:

1. Attach her to positive peers. Make use of peers to introduce her to the personnel, geography and routine of the institution. Adél is disposed towards peer influence and we need to take this into account from her first day. It is common experience that peer-oriented youngsters, particularly those who are vulnerable or who have specific behaviour or personality problems, gravitate with unerring accuracy to like-minded peers with whom they affiliate or amongst whom they hide, often to the detriment of our ability subsequently to reach them. Early experiences in the institution are significant and by locating Adél intelligently in the social milieu, we establish useful beach-heads.

One hint is to describe the problem not only in conceptual terms but also in behavioural terms.

2. Stabilise her daily routine by contracting quite tightly around daily school attendance. For the past seven months she has attended school for only 33 days and must be out of touch with boundaries and feeling very uncontrolled. This will require support from the child care worker and the setting up of a visible link with the school to monitor her attendance and progress. Educational planning at a more extended level will follow, but regularising her daily routine to this extent is a priority.

3. Involve her family at a social level by inviting them to the unit and opening lines of communication. Adél has ambivalent attitudes to her parents and her positive feelings may be enhanced once the parents are relieved of the conflicts surrounding behaviour management problems. In this case both Adél and her parents may have guilt feelings about the removal from home and the promotion of positive interactions will reduce the effect of these feelings.

4. Place safety and programme controls on her sexual activity. This includes establishing her understanding and use of appropriate contraception and her knowledge of sexual matters. It also includes bringing her boyfriend into the ambit of the living group and making visible to him the new set of adults surrounding Adél and to whom, by implication, he is accountable. Adél's expressed wish to fall pregnant and get married implies a worrying "use" of her sexuality, and this subject will inevitably be an important item on her on-going treatment plan.

These four priorities may be regarded as 'first-aid' or 'casualty' procedures which are necessary to stabilise, contain and make safe potentially destructive features in her life.

Continuing Treatment Plan

For the sake of introducing a simple format for a treatment plan, in this section we will follow the pattern of stating a problem area and then sketching suggested treatment interventions. Normally each intervention would be accompanied by the names of the staff who are to implement it, the criteria (behavioural, attitudinal, etc.) by which we will be able to observe progress or otherwise, and the expected time-frame within which we would hope to see results.

Behavioural criteria: It is very difficult to quantify and describe emotional and behaviour problems objectively, and a major aspect of treatment planning is to construct criteria for measuring successful outcome. One hint is to describe the *problem* not only in conceptual terms but also in *behavioural* terms. For example, instead of stating the problem as "unassertive", state it as "unassertive, as shown by . . .". This gives you the observable ways and the contexts in which a certain child demonstrates his non-assertiveness, and hence a clue as to the signs of improvement we must look for, namely the disappearance of the signs of non-assertiveness and the emergence of behaviours which reflect greater assertiveness.

The reason for such a level of behaviour description in respect of individual children is that treatment plans can be too general to be useful. We could simply plan to "help her with better communication, assist her with schoolwork, harness her stated talents thus building self-esteem". True, but one particular child encounters a problem within his own unique set of interactions with his environment, and for the residential worker it is specifically with these identified problems-in-context that he needs help in order to generalise his better functioning to other areas of his life. This is bootstrapping.

Time-frames: Treatment plans have a limited 'shelf-life' and are constantly updated. A helping procedure or intervention may have to be implemented for one week — or it may have to be maintained for a year. Stating a realistic time-frame at the start does two things. It helps us with our own expectations, for

example, knowing that Rome wasn't built in a day and that building trust in a child may take a long time, so we are not to expect instant results. Also it prevents us from chopping and changing procedures when we get discouraged, thus introducing a confusing inconsistency for the child. A good case manager will keep us to an agreed intervention until we have given it a fair chance to succeed. When we find ourselves saying "We have tried everything" we may not have tried any one thing properly.

A Treatment Plan Format

Let us conclude with six sample items in an on-going treatment plan for Adél, bearing in mind that each of these sections may be updated and/or discontinued after a week, a month or three months.

Problem 1: Poor communication of feelings. Shown by her poor knowledge of language, the poor modelling of her parents who did not openly discuss problems but rather scape-goated Adél, her inability to share thoughts and feelings with adults, her tendency to hide her anxiety about her father, and to express her upset by withdrawal and her anger in passive resistance or subtle defiance.
Interventions:
- "Getting her to talk" will be far harder than simply *showing an interest* in her life. This response from adults will be largely new to her and should be low-key initially. Listening attentively whenever she does speak.
- Good verbal interaction. Basic information-giving and shared planning with eye contact to engage her.
- Frequent reflection of feelings. Initially at non-threatening levels (I see you're not a lover of mealie-meal; I gather you love watching 'Dallas') so that she gets used to having her feelings recognised and accepted.
- Encouraging her to participate in mealtime and other group talking, but sensitive to her own pace.
- Expressing your own feelings unambiguously and non-judgementally (I think this blue goes well with the curtains; I prefer Lionel Ritchie to Rod Stewart).
- Respond with objective and non-critical descriptions for negatively or inappropriately expressed feelings (I can see you've had enough; It is upsetting when that happens).

We expect to follow this level for one month before we evaluate and consider reflection of more significant feelings which may be more difficult for her to 'own'.
Task: Observe her communication patterns with peers and with adults so as to confirm or review the information we have in our assessment.
Note: We have written out the interventions very fully here, but once your staff team is familiar with the process these may be abbreviated and perhaps recorded as key phrases on your filed or written treatment plan (See Fig.1). The fuller form as above makes for very useful experience for new child care workers.

Problem 2: School problems. Shown by non-attendance, continued failures, reducing IQ test scores, poor scholastic results in language, comprehension, memory, numerical and abstract thinking areas.
Comment: School will not easily turn into a 'success' area in her life. Our task is to make it a more positive experience in which her efforts are acknowldeged and she makes some gains, and which gives us time to confirm or review the prognosis that she has no academic future. We have four months before we have to make a decision about her educational/vocational future.
Interventions:
- Recognise and acknowledge *attendance* more than scholastic performance at this stage.
- Refer to school matters as objectively as possible and with little or no value comment. Expectations will only increase anxiety which she deals with characteristically by withdrawing.
- Provide individual support during homework period to ensure that all homework tasks are completed so that she doesn't have the additional anxiety of going to school with uncompleted work.
- Identify the subject(s) which will reflect her practical mindedness, her motivation and perseverance, and concentrate on these with a view to gains.

Problem 3: Abuse of others' property. Shown by using her parents' credit card to buy clothes and draw money.
Comment: This may or may not be a real problem and the above incidents may have been situational in that provision for her own needs was not adequately made in the family's budgetting.
Interventions:
- Ensure that she has enough money at her disposal for her personal needs.
- Discuss and plan with her budgetting for her personal wardrobe.

Task: Observation in the unit will establish the extent to which this area needs any further attention.

Problem 4: Psychosexual inadequacies. Shown by her wish to fall pregnant and get married, the fact that she is easily influenced and vulnerable to sexual exploitation.
Comment: It is unclear to what extent her mother has been an adequate sex-role model. It also appears clear that Adél has been socially isolated, not participating in sporting or other social activities. She needs some exposure to the principle of "Be a woman before being a mother".
Interventions:
- A younger female child care worker should be assigned the role of key worker attached to Adél as a sex-role model with whom she might identify. This would be a good person to impart sexual information to her.
- For us to have access to Adél's feelings and thinking, it is essential that issues surrounding sexuality be 'open for discussion' in an accepting way in the unit. This could be demonstrated by literature being seen to be available. "Not only must the unit recognise the child's past history: it must also accept (her) history and the people represented in it. To devalue or ignore this is to devalue or ignore a part of the child as a whole person and to limit the material (she) and the unit have available to work on" (Beedel, 1970).
- Her responsiveness to peers suggests that Adél would benefit from social groupwork around the issues of relationships and sexuality if such a programme is available in the children's home.
- Emphasise *her* tastes in dress and fashion to balance the single issue of attractiveness which implies *others'* tastes. This would include some activities like window-shopping. Bear in mind her interest and abilities in hairdressing.
- Supplement her relationship with her

PROBLEM	TREATMENT
Poor communication of feelings (language, models, inability to share with adults, hiding feelings about father, indirect expression of feeling)	Showing interest and listening rather than "getting her to talk" Engage in verbal communication; eye contact Reflect neutral feelings to show acceptance Draw her into group conversation e.g. mealtimes Express own feelings unambiguously — modelling Reinterpret negative expressions positively/neutrally
School (attendance, failures, declining IQ and scholastic problems)	Emphasise gains in attendance rather than achievement At this stage few expectations (scholastic) Get homework tasks done Check out need for subject tutors/extra lessons later
Abuse of others' property (credit card incidents)	Serious? Observe in group and report later Ensure enough money for personal needs Help with budgetting for clothing

FIG. 1: Extract from filed copy of Treatment Plan for Adél D'Issent

boyfriend by expanding her contact with peers in different settings. This will be difficult, but perhaps structured groups within the institution may be a start.
- Find opportunities to 'debrief' her after evenings out, getting her to talk about about what kind of other people were there.

Problem 5: Non-assertiveness. Shown by her being easily influenced, her limited experience of working at limits which her adoptive parents were reluctant to apply, her parents and brother having 'ganged up' on her to which she reacted obliquely and passively, her feeling of helplessness in the face of demands in structured situations, and her inability to assertively resist sexual exploitation.
Interventions:
- Present her with choices and options (Do you want to go along? Do you want to share in this? Your turn to choose).
- Engage her in group discussion and planning, asking her views and preferences.
- Reinforce assertive behaviour, not taking sides but supporting her right to her own views and preferences. Tell her when you think she has handled a situation well.
- Direct counselling on how to handle herself when she has been victimised.
- Again, a social groupwork or drama group, if available, will be an advantage.

Other problem areas which need to be included are poor use of her creative and artistic talents, her uninvolvement in sporting or social activities and her need to develop independent living skills.

By-products of Treatment Plans
There are some treatment goals we may set which are difficult to implement directly, and we should distinguish between specific interventions on the one hand, and desired by-products of these on the other hand.
For example, child care staff often decide to 'build a relationship' with a child. This is hard to do in vacuo. Rather, a relationship tends to grow when people *do* things together, when they accumulate a set of shared experiences and come to have value and meaning in each other's lives. The treatment plan should thus specify concrete activities aimed at relationship-building instead of vague and poorly operationalised outcomes.
Similarly, improved self-image is often a by-product of *experiences* of acceptance and achievement. There are many things we could do to enhance self-image and we could have stated this as Problem 6 with the following interventions:
- Reflecting on things well done.
- Labelling things as positive.
- Pointing out growth.
- Noticing improved ways of handling social situations — and many more.

But we should take care not to build a fragile self-image for a child based on *our* valueing or praise, for this could become an end in itself which leaves her subtly dependent, seeking praise and approval. The important words here are that Adéle personally *experiences* her growing value. Finding an activity in which she achieves will do more for her self-esteem than verbal praise.

Evaluation
These are, of course, the tasks which are discussed in supervision. It needs to be established that child care staff are finding opportunities to implement the plans or that they are creating opportunities where necessary, and that they are

A good case manager will keep us to an agreed intervention until we have given it a fair chance to succeed.

using them effectively. It is in supervision that the care worker's understanding of the treatment goals is ascertained, as well as the extent to which he or she has the practice skills to carry out the tasks. Aspects of the treatment plan are reviewed in supervision, and the plan as a whole is reviewed by the wider team on a regular *and scheduled* basis.

CASE STUDY 2

The following case illustrates a difficult situation in that the child is clearly disturbed, but the children's home has limited access to specialist helping professionals. Naturally, where possible, such a child would be assessed by specialists such as a child psychologist, psychiatrist, psychiatric social worker or occupational therapist. However, some children's homes do not have access to such people, or have to wait for a long time before such assessments can be arranged. What follows illustrates what can be achieved when a basic team of social worker, principal, teacher and child care workers use the little information available in a systematic way, and plan accordingly.

Name: Mark Multiprob, 8 years old, Sub B (Grade 2).
Background: Mark, the fifth of six children, was placed in the children's home at two-and-a-half years after being exposed to neglect, alcoholism and family violence. His four older brothers live in another children's home and his younger sister lives with his grandmother.
Despite a history of disruptive behaviour in the children's home, he was placed with foster parents at about five-and-a-half years. After two years, the placement failed and Mark was returned to the children's home. The reasons for the failed placement can be summarised as follows:
- Aggressive behaviour towards his foster brother who was the same age but a high achiever (unlike Mark).
- Soiling and wetting himself (and smearing faeces on his foster brother's bed).
- Wilful disobedience towards his foster parents.
- At school he was disruptive and showed specific learning problems.

There were times when Mark was affectionate and obedient, but these times were short-lived.
On returning to the home he showed the following behaviour:
- Enthusiasm for outdoor activities and an ability to hold his own in relation to other children in physical activities.
- The ability to show involvement, perseverence, co-operation and warmth when receiving quality attention.
- Disobedience and disruption of group activities.
- Very active behaviour and difficulty sticking to structure/rules/routines.
- Bedwetting two to four times a week.
- At school he tested the teachers' authority and easily became discouraged; he was however showing some progress.

Other behaviour observed was that he seemed to seek out male child care staff and older boys, and that whenever he started getting close to a staff member he would start creating distance between himself and that person (e.g. by withdrawing, behaving disruptively).
Apart from the services of a part-time social worker, the availability of a General Practitioner and contact with Mark's teacher (who is a remedial teacher), the home does not have the services of other professionals. Therefore, the only other information available is the following:
- He is of slightly above-average intelligence but has learning problems (specifically perceptual problems and poor fine motor control which affect his writing).
- He very seldom has contact with his biological parents, but attaches great importance to his weekly contact with his older brothers.
- He appears to have escaped situations which he found difficult to handle by behaving badly (e.g. he had already been to three schools, had moved from the children's home to foster parents, and back).
- There is no physiological/medical problem to explain his bedwetting.
- His ex-foster parents well-meaningly spent many hours helping Mark with his schoolwork. They seemed to be trying to get him to achieve on the same level as their high-achieving son.

At the case discussion, the following conclusions were reached:

- Much of Mark's behaviour reflects a basic lack of trust and sense of belonging. While he clearly wants to be loved and to belong, his experience tells him that to become attached to others ultimately leads to disruption, rejection, and hurt.
- Mark's self-esteem is clearly very poor. Much of his disruptive behaviour seems to reflect a feeling of total inadequacy to deal with the demands which he faces (e.g. in the classroom, during structured activities). It is therefore not surprising that in such situations his behaviour is disruptive.
- The fact that nobody has stuck with Mark probably not only makes him feel that he is "bad", but also that he is very powerful. So powerful in fact that no adults can contain him.
- Related to the above, there is absolutely no sense of order and consistency in Mark's life, and these factors may explain his uncontrolled behaviour including his bedwetting.
- It is reasonable to hypothesise that Mark feels angry and depressed about his life. His disobedience and hostility towards other children appear to be his only means of expressing these feelings.
- The value of Mark's contact with his brothers should not be underestimated. He probably derives at least some measure of stability and sense of belonging from this contact.

Note: The format of a treatment plan for Mark is arranged under goals and interventions.

Goal 1: Provide an environment where Mark can slowly develop a sense of trust and belonging.
Intervention:

- The provision of a key worker who plays a significant role in Mark's daily life seems very important. Emotionally he is at a developmental stage where most of his activity would have been confined to a small family group and still dominated by his parents. All staff should remember that emotionally Mark is functioning a lot like a *toddler*. They should not therefore expect him to act like an 8 year old. Realistically, although he could cope physically, we should bear in mind his "toddler" stage when dealing with tasks like bed-making, dish-washing, etc. for which we may have to use humour, distracting techniques, reminders and assistance. In the early stage of treatment we should expect Mark to be building *inner* perceptions and experiences of trust, so rapid improvement in behaviour is not expected. A theme for *all* interventions is to aim for *small* changes and *gradual* change.
- Houseparents should provide some quality attention every day, without forcing closeness. They will respond warmly when he reaches out. This quality attention should be provided *unconditionally*, regardless of his behaviour.
- If he starts testing out when the relationship starts developing, houseparents should label or reflect on his fear of being hurt/disappointed/let down. They may also humorously tell him they are "too tough" and they like him too much to be pushed away (if this is appropriate to the situation).
- Give him a sense of belonging physically by emphasising his *own* personal space, e.g. *his* bed, bedspread, *his* cupboard (put his name on it); pictures on the wall above *his* space which are meaningful to *him*; put his photo and photos of other children in the hallway or entrance of the house. Ensure respect of *his* space and his possessions.

A relationship tends to grow when people do things together, when they accumulate a set of shared experiences and come to have value and meaning in each other's lives.

- Until Mark is properly integrated into the home, the only "outside" involvement should be with his brother and family if they make contact (i.e. no host parents at this stage).

Goal 2: Provide effective containment (including a sense of order, predictability and stability); support staff in coping with inevitable non-compliant behaviour.
Intervention:

- Ensure that daily and weekly routine governs his life, from waking up to bedtime. Consistency is of great importance.
- As far as possible ignore negative behaviour. When this cannot be ignored, have a plan which *all* staff can carry out automatically, e.g. time out. Time out may involve removal from a group if he is disruptive, but (a) he should be accompanied by a staff member so as to minimise the sequence of disruption/rejection, and (b) time out should not include any enjoyment or games which would reinforce the disruptive behaviour.

Goal 3: Build self-image and self-esteem, and thereby help improve peer relationships.
Intervention:

- Look for and recognise positives, e.g. drawings which can be put up on walls.
- A male child care worker to whom Mark already relates well, should take him for physical activities three times a week (alone and/or with other children). Informally focus on body image and physical strengths/abilities. Child care workers will also sew seeds of change by saying for example: "Guys who learn to run/jump/ride so well also learn to improve their writing/reading, etc. Next time you're writing, you'll remember that."
- Houseparents should label/reflect/model expression of feelings when the opportunity arises.
- He might later be assigned to an activity group but at this stage the main focus of our work is on one-on-one interaction.

Goal 4: Schoolwork and scholastic problems.
Intervention:

- Accept that he may fail Sub B this year and that in long-term this may be a good thing.
- His teacher should continue working on and monitoring his disabilities.
- His teacher should follow a theme of working for small improvements and reinforcing these; she should focus on positives.
- His teacher will inform his houseparents of progress and positive incidents.
- In order to take pressure off Mark, houseparents will help him with his homework, but only where essential. The teacher will handle all other aspects of his work. Otherwise houseparents or child care workers will only focus on *improvement* reported by his teacher.

Note: Obtain information on the parents' situation and their present attitude towards Mark. The social worker should contact the external social worker and meet with the parents if possible. At this stage no specific intervention will be aimed at Mark's bedwetting. The above interventions may well affect bedwetting (the star chart has already been tried without success). Progress will be monitored by the social worker and houseparents and one specific male child care worker during weekly supervision. The case should be reviewed in two months' time with all present. Copies of the plan should be sent to the social worker, principal, houseparents, child care worker and teacher.

Conclusion

To make this series more practically useful — and to anticipate some of the "yes, buts . . . " of readers, the authors have decided to follow these two cases up in next month's issue. That is, difficulties and progress in the treatment will be considered as we update these plans.

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Situations Vacant

Khayalethemba

A project of Mfesane

Requires the services of a suitably experienced and qualified person to fulfil the position of Principal of a children's home for 180 children in Mdantsane, (near East London) Ciskei.
Duties will include —
- Overall responsibility for the total administration of the institution.
- Guidance of the psychosocial development and the spiritual and social care of the children.
- Recruitment, development and training of staff and the growth of a strong team that will function for the healing of troubled children.
- Planning with management the eventual movement of the institution into new premises.

Salary is negotiable. Should a social worker be appointed, salary will be based on senior supervisor scale. Please apply in writing to Mrs G.H. Lorentz, Regional Manager (Ciskei), Mfesane, P.O. Box 550, King Williams Town 5600, or for further information call 0433-21595.

Louis Botha

Home for Children, Pretoria

Invites applications for the post of
FULL-TIME SECOND SOCIAL WORKER (Non-resident).
Applicants must be registered and fully bilingual. Experience in child care a recommendation. Salary on social work scales according to qualifications and experience. Benefits include Pension and Medical Aid schemes. For further information contact the Principal on 012-73-6184.

PRINCIPAL/HOUSEMOTHER
Required for small children's home in Kenilworth. Wife to be employed in the home and husband to work out. Successful applicants must be willing to undergo child care training. Driver's licence essential.
Written applications in own handwriting including a CV and copies of testimonials and contactable references to be sent before 15th September 1987 to Management Committee, 52 Waterloo Road, Wynberg 7800.

Situations Wanted

Young man 27 seeks child care position in Cape Town area. Willing to undergo necessary training. Contact Anthony Doherty on 021-45-1651.

Child Care Work on a Cold Floor

Next time you are tempted to feel discouraged about your work or disgruntled at your working conditions, spare a thought for the child care workers at the Special Care Centre run by Oasis in Elsies River.
The Oasis Association for the Mentally Handicapped does most of its work with mentally handicapped people who are trainable and who thus may be productively employed, albeit in protected employment situations. Through its training centres and workshops, Oasis provides training and employment in four centres in the Cape Peninsula. The organisation has also made use of a group home for accommodation for working adults who might otherwise have had to be institutionalised.
But their most difficult task is the care of profoundly and severely retarded children in their Special Care Centre. These are children with an IQ of less than 30. Because most of these children cannot walk, talk, sit or feed themselves they require intensive, minute-by-minute care by truly committed child care workers. Such children merit only a R3.00 per school day subsidy, and the service incurs a large financial deficit for Oasis each year who struggle for staff salaries, and suitable equipment and facilities. Worst of all, the only venue they have for this work at the moment is the floor of a side-aisle of an Elsies River Church. Every time there is a service or funeral, all equipment and furniture must be taken up and stored away. In this situation, on the floor, amongst stacks of temporarily moved chairs and in what looks like a refugee station, care workers daily carry out the most moving, caring and loving tasks for children who can do little for themselves.
Oasis has plans for a better centre to be built in Ravensmead where there will be proper rooms for ten children each, space for exercise and free movement, and eventually (in Phase II of their planned development) a hydrotherapy pool. But even Phase I is R475 000 away. In the meanwhile, for these child care workers, it is business as usual each day under the leaky roof and on the cold floor.
If you are moved to help in any way, perhaps even to visit and encourage the staff with some "morning tea", the organisation's Public Relations Officer and fund-raiser is June Hutchinson who can be contacted on 021-61-2419.

Nuusbrokkies Newsbriefs

National

Conference 1987
The NACCW's 1987 Biennial Conference offers a feast of stimulating material for hungry child care personnel. Apart from the papers to be presented by our visiting speaker, Thom Garfat, to the plenary sessions of Conference, there are no fewer than 36 presentations for delegates to choose from according to their own fields of interest. These presentations will be in the form of papers, workshops and seminars, and will represent a good platform of current South African practice.
In addition to this, the Conference itself is preceded by a One-Day National Seminar on Child Care Worker Training. This day will be of interest to those who are involved in the field of training and education for child care staff. This day will deal not only with the formal training courses presently offered but also with various aspects of in-service training. The One-Day Seminar will begin with a review by Thom Garfat of Child Care Worker Training in North America.
For most of the Conference sessions delegates will be able to choose from four alternative presentations, so all needs and interests will be catered for. An encouraging number of South African practitioners have prepared papers, panels and workshops, and this year's Conference will indeed be a forum of current South African practice and ideas.
The theme of the Conference is *Today's Child, Tomorrow's Adult*, highlighted in the Keynote Address of our visiting overseas speaker, Thom Garfat of Canada. On Wednesday 7th October specific presentations of interest to management committees have been included, and agency social workers will find presentations relevant to their field on Thursday 8th October.
There will be a number of panels devoted specifically to child care policy, and representatives of the Departments of Health Services and Welfare have accepted invitations to be present. A number of presentations deal specifically with programmes developed around education, family work, child abuse, after care, drug dependency, adolescent counselling and street children.
A number of child care worker issues are addressed including the question of staff members who have their own families ad children on campus, child care workers who leave the profession and residential social work approaches.
A number of social occasions have been planned and out-of-town delegates will have an opportunity to visit Gold Reef City on the last night of Conference.
An important occasion at Conference time is the holding of the NACCW's official Biennial General Meeting which will take place on the afternoon of Friday 9th October. The out-going National Chairman's Report and the election of a new National Chairman will be important features of this meeting which all delegates are invited to attend.
At this Conference there will be something for everybody. Many of the sessions take the form of panels and workshops so that all delegates will be able, if they desire, to participate and contribute.

Lynette Rossouw

ILEX Ruilstudent in VSA
Op Donderdag 20 Augustus, het Lynette Rossouw, die 1987/88 ILEX ruilstudent, op JFK lughawe in New York aangekom om by twintig ander ruilstudente uit Europese lande aan te sluit. Lynette was by Tygerberg Hospitaal in die Wes-Kaap werksaam in 'n program met seksueel-mishandelde kinders. Sy is van plan om gereeld gedurende haar verblyf in die VSA vir *Die Kinderversorger* te skryf en ons sien uit daarna om in haar ervarings te deel. Dit is haar eerste besoek aan Noord-Amerika.

Eastern Province

Busy Day
Thursday 27th August is a busy day for the Border Region. In the morning there is a meeting of the Residential Social Workers' Group at the King Williams Town Children's Home and this is to be followed by a Principals' Group meeting. Later that day the Annual General Meeting of Malcomess House takes place in East London, at which the guest speaker will be the Mayor of East London, Mrs Elsabe Kemp.

Training Course
The next residential weekend for the BQCC and Senior Staff Seminars takes place from Friday 28th August to Sunday 30th August. Visiting lecturers will include newly-appointed Regional Director Lesley du Toit, and Marcelle Biderman-Pam from Cape Town. The BQCC students are completing Module III which deals with Public Welfare Policy and with Daily Routines. This weekend will be devoted to the concept of the therapeutic milieu and the coursework will be built around Trieschman, Brentro and Whittaker's book *The Other 23 Hours*. The BQCC students will join the senior staff group for a number of workshops.

National Director Addresses Two Medical Forums
On Wednesday 12th August, the National Director addressed the SA Academy of Family Practice and Primary Care on the subject of *The Child Without a Family*. He referred to the challenge to the child care service to move towards a preventive role and away from institutional care. There would always be a need for institutions, but the nature of the work was constantly changing to reflect current needs. Child care workers were having to deal with older children, and there was a shift in practice towards building competence for independent living skills on a short-term basis rather than on providing long-term substitute care. More child care workers than ever before were engaged in professional training for their work, with over 600 child care workers enrolled in formal training courses today as against a few dozen ten years ago. On the following evening Brian Gannon addressed the UCT Medical School Congress on aspects of the United Nations Declaration of the Rights of the Child. A major problem facing child care in South Africa was related to the racial differentiation of services whereby the experience and expertise of white, coloured and Indian practitioners was administratively separated from the overwhelming needs which existed amongst black children, and for whom several agencies were doing pioneering work but largely having to reinvent the wheel. Solutions attempted so far were using large-scale institutional models which presented the danger that when we reach the 21st Century, "black child care" would be one hundred years behind the service for other races which was making good progress towards non-institutionalising models. The child care service was also waiting with bated breath to study the practice implications of the new state policy of privatisation in welfare.

Natal

Ethelbert Children's Home Plans Differentiated Service
Ethelbert Children's Home, which pioneered the cottage system in South Africa over thirty years ago, is planning programme and structural changes which will incorporate short-term, intensive family and child services, with only a limited provision being made for long-term care which will probably be off-campus in community houses.
Mr Nightingale said, "I think children's homes must respond to the clear intentions of the new Child Care Act by attempting to fulfil permanent placements for children within the maximum two-year period of a court order". He feels that children's homes have a constructive role to play *earlier* in family welfare agency treatment plans — and not at the end of those plans when all else has failed.
The home intends to involve parents actively in continued responsibility and commitment to the care of their children. Wherever possible a five-day residential programme will operate with parents maintaining specified responsibility areas for their children. Where family prognosis is poor, the emphasis will be on preparing children for successful foster placement. "Too many youngsters are placed with foster families who are well-intentioned but who cannot cope with the demands of deprived and abused children. When these placements break down the child arrives in a children's home with two failed family experiences and two experiences of rejection or separation. Children's homes have the experience and expertise to turn that cycle around by working with children for a short period *prior* to foster placement".
"Ethelbert expects to devote no more than 14 beds to long stay children. For the rest, two years will be our maximum turn-around target".

Regional Executive Meeting
The Regional Executive of the Natal Region held a working session with the new Regional Director, Lesley du Toit, on August 11th. Immediate priorities discussed were training courses including the BQCC which has been running in Natal for the first time this year. Syllybus planning for the meetings of the Principals' Group and the Residential Social Workers' Group was also on the agenda. Lesley is wanting to compile a schedule of need areas in the Natal and Eastern Province areas, and child care staff at all levels are welcome to discuss specific needs with her. Her address is NACCW, P.O. Box 28323, Malvern 4055, and her telephone number 031-44-1071.

Transvaal

New Course for Soweto Children's Homes
Although the black homes in Soweto send representatives to the Basic Qualification in Child Care course, the NACCW Transvaal Executive has long been concerned about the fact that our training programmes have not reached those child care workers who care for infants and pre-schoolers. The reasons for this are firstly, that staff members have been unable to leave their babies in the mornings, and secondly, they felt that most of the material on the BQCC course did not address specific preschool concerns. This situation is about to be rectified. Jean Wright, principal of Guild Cottage, has agreed to chair a new training sub-committee and she, together with the Regional Director, have had two meetings with the staff of Othandweni (Child Welfare Society) Children's Home and the Orlando Children's Home to ascertain the specific training needs of such staff. In summary, the staff expressed the desire to know more about baby care, physical and emotional aspects, stimulation of preschoolers, child development, and principles of handling children of this age. It was agreed that the NACCW would arrange training sessions every two weeks, to be presented at the Soweto homes, so that relief staff could be brought in for brief periods of time.
At the same time Professor Lucy Wagstaff, professor of Community Peadiatrics at Witwatersrand University and based at Baragwanath Hospital, has offered to extend the facilities of the toy library at Baragwanath to these homes, and has also kindly agreed to assist us in the development of this training programme. This is an interesting and exciting extension of our work in the Transvaal.

Training
The counselling module of the BQCC starts on 9th September. Please note the change of venue: this part of the course will be held at St Mary's Children's Home, Zinnia Street, Rosettenville. However, the home will not be available on the 30th September, and on that day we move back to our usual venue at RAU, Block D, Les 202.

The Child Care Act
At the last meeting of the Principals' Group, Mrs Koen, Chief Social Welfare Officer of the Department of Health Services and Welfare (House of Assembly), asked the NACCW to convene a working group urgently to submit recommendations on the Child Care Act. It does appear that there will possibly be changes to the Act introduced in the current session of parliament. This group meets on 24th August.

Pretoria Course
The next Pretoria course, which will include lectures on the BQCC and also practice seminars for more senior staff, takes place at the Louis Botha Home for Children on 28th and 29th August. The lecturers will include Di Levine, Jacqui Michael and Lee Nell. Among the subjects to be dealt with include the orientation of new staff and the development of effective host-parent programmes.

People
We were very pleased to welcome Barrie Lodge, the newly appointed headmaster of St George's Home in Bedfordview, to his first meeting of the Regional Executive Committee of the NACCW on 6th August. We wish him every success in his new post and look forward to his continued close association with the NACCW in the Transvaal.

Toekennings
By 'n kort plegtigheid by die toekomstige Nasionale Konferensie sal die toekenning vir Erelidmaatskap van die Instituut vir Kinderversorging aan twee persone wat


Ken McHolm

merkwaardige en onafgebroke bydrae tot kindersorg gelewer het, oorhandig word: Ds Martin van Rooyen, wat onlangs as prinsipaal van Ons Kinderhuis in Bloemfontein afgetree het na 'n tydperk van 31 jaar in die diens van kindersorg, en Ken McHolm wat as hoof van St George's Home in Johannesburg afgetree het nadat hy meer as 30 jaar by hierdie instansie betrokke was.

Western Cape

Annie Starck Birthday Celebrations
Annie Starck Village in Athlone celebrates its birthday on Saturday 29th August and child care colleagues are warmly invited to attend. Proceedings start at 3 p.m. and the guest speaker will be educationist Randall van der Heever, principal of Spes Bona School. The children will also present an entertainment programme. Enquiries: 021-638-3127.

Official Opening of Group Home
NACCW National Director, Brian Gannon, was guest speaker at the recent opening of the Fish Hoek group home of St Michael's Home in Plumstead. He observed that one of the disturbing lessons learned during the six months since the children moved in was how much these youngsters had had to *unlearn* from their previous institutional experience. He congratulated St Michael's on extending the range of services they provided to include this style of care which was so much better than keeping children unnecessarily in large and unnatural living groups. Colleagues from other children's homes, welfare organisations and the Department of Health Services and Welfare attended and had the opportunity to see the home.

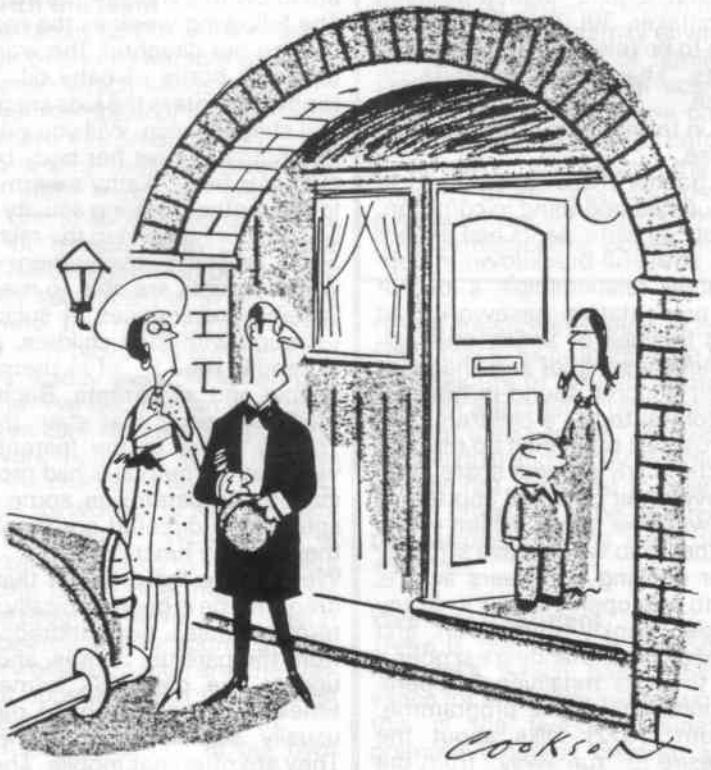
Work with Families:
A South African Practice Model

Gillian Quintrell and Margaret Crowley talk to The Child Care Worker about their family liaison programme in the social work department at St Michael's Children's Home in Cape Town.

There is the story of the father who arrives at the children's home in an inebriated state to see his son. He is intercepted by a child care worker who points out that he is an embarrassment to the institution and to his son in that condition, and asks him to visit when he is sober. Two weeks later an identical situation occurs, and the father is again sent away. Six weeks later the father visits a third time, now even more the worse for wear than previously. The child care worker tells him she is sick and tired of his coming in this condition, and that he may never come again after he has been drinking. But today the father responds: "I feel so ashamed and so guilty at having let my family and my son down, that I didn't think I could face him without some Dutch courage. My first two visits made me feel even more inadequate, and I haven't been able to come near for six weeks. Today I had to get really 'tanked up' to be able to face *you* to say all this, let alone to face my son."

As long as we cling to the "we can care for your children better than you can" attitude, there will be mutual suspicion between child care workers and the parents. "Perhaps the most damaging consequence of this predisposition to 'blame the parents' is that it causes us to under-utilise our most valuable 'natural resource' in child treatment: the parents themselves" (Whittaker, 1979, 30). Staff often find it difficult to understand deeply the lives of the families from which children are referred. There is a social distance which can be closed only by first-hand knowledge, and our team at St Michael's had become acutely aware of the discrepancies in their knowledge of the children between the children's home setting and their own homes. Thumbadoo and Veeran (1986) report that while parents had always been invited to events on the annual programme, "we had not organised an occasion where parents were invited to a get-together where the focus was on parents themselves, their importance and role at Lakehaven". It was decided to add two posts to the social work department at St Michael's to study the problems and issues surrounding family work, and to develop an appropriate programme.

Staff often find it difficult to understand deeply the lives of the families from which children are referred.



Have a great time. Come back as late as you like. Just remember – we're telling the social worker *everything!*

Some problems

We began by visiting every one of the parents of the St Michael's children who were traceable, and the few who lived far afield were contacted by telephone. The way we were received in those early days, told us much about the problems we were going to face in our work with parents. The door would open just a crack. When we introduced ourselves, somebody would shout down the passage, "It's the welfare!" We were greeted by apology or with exaggerated politeness, and the early meetings were conducted with an awkward and stiff formality. It became clear that our style of operating would have to be as informal and relaxed as possible. Parents were to mention past experiences of "being talked down to" by professionals who visited them, being intimidated by big words and by quotations from the Children's Act. "When they walk in here with a file, I feel just like a case". By deformalising our approach, for example by introducing ourselves using our first names, we soon succeeded in the initial goals of the programme, which were to introduce ourselves and familiarise ourselves with the parents, and most commonly today we are welcomed and invited to share a cup of tea as we talk.

Catch-22 situations

What impressed us most as we got to know parents was the greyness and hopelessness of many of their lives. Many parents, often single or divorced, with very low educational qualifications, had been expected by agency pro-

grammes to find work. The present employment climate made it virtually impossible for many of them to do so. They were unable to compete in an open labour market. They often found themselves in vicious cycles: a mother would take in an "uncle" in order to support herself; this would be contrary to her agreement in renting a Council house and she would be threatened with eviction. We succeeded in some cases in having parents with extremely low educational qualifications being considered for disability grants. This in turn succeeded in breaking up log-jams, and we were able to report to the family reconstruction agencies that the case had got moving again, and was presenting new possibilities. Many agencies seemed to have closed their files on these parents; some parents reported not having seen a reconstruction worker for eighteen months. Hatchuel (1986) confirms that when "the prognosis of the family for reconstruction seems poor the social worker tends to make the case dormant or even close the case rather than work on what she may view as a losing battle. The fact that a relationship between the child and his family still exists and requires attention is neglected". It is at this point that the children's home has a gap to fill and where it has some skills to offer. More than this, one *constant* in the family's life is the child who is represented more consistently by the children's home team than by the agency social worker who tends to change or be replaced often. "These changes anger families who see themselves as having to repeat their life histories and problems and relate intimately to every new social worker." (Hatchuel, 1986,16)

Liaison with reconstruction workers

By reporting progress to the reconstruction agency, and suggesting renewed visits, several children have been enabled to return to their families. For example, when the previous report had stressed the financial strictures of the parent, this problem had now been resolved and other plans could be considered. Initially some of the reconstruction agencies were resentful at our "interference" in their cases, but this, as a result of good liaison work, is no longer the case and our work is generally acknowledged and appreciated. It had become discouraging when further retention reports tended to be repeats of earlier further retention reports with little more being updated than age and school standard.

Range of services

The work which we have done with the families has varied considerably, from basic practical help to assistance with parenting skills.

Basic support: Frequently we assist families during weekends and holiday periods with food parcels. In one case we supplied beds which the parents later insisted on paying something for. We helped in the furnishing of a bedroom for two boys who were to be returned home.

Maintaining treatment programmes: It has been possible for us to include parents in making specific plans for their children. For example, when a treatment plan calls for a certain adult response, parents have been involved in participating while the child is at home. If a child is being penalised for breaking a window, for example, the parents assist in holding the child to his obligation.

Parenting skills: Not surprisingly, parents often experience the same management problem that child care workers experience with certain children. We have been able to share our approaches with the parents and to help them to apply these approaches — as well as learning from the parents how they manage the children. "Parents are often the best 'expert' on their troubled child" (Whittaker, 30). It is not uncommon for us to be telephoned by a parent who reports, "I have tried such and such an approach . . . " and then for this to be discussed in terms of its effectiveness, or otherwise.

These parents are usually socially isolated themselves. They are often not mobile. They are the kind of parents who, for example, do not attend Parent-Teacher Association meetings at schools.

Listening: Bacher (1985) wrote that her parent group had one thing in common, namely that "all participants had experienced the stressful breakdown in coping and family relationships, a loss of hope as preventative casework had failed, and feelings of anger, unhappiness, helplessness, grief and shame at having their children found in need of care and committed to a children's home". As trust has been built up through our contacts, many parents share at an intimate level their personal and family problems with the family liaison workers. A mother who would have strongly denied her drinking two years ago, is now able to talk openly about it. Many parents feel frankly unforgiven and judged, and an understanding ear goes a long way towards regaining co-operation and interest in our programme. Mandelbaum (1972) talks about the family's desire to "run away" from the fact that their child has had to be removed because the removal raises all sorts of ghosts in their own lives. The family has in a sense to be fetched back after thus running away, they "must undo their act by returning to claim the child", and often they need help with this initiative.

Involving the parents at the children's home: As recently as 1979, Whittaker wrote: "Success in treatment depends substantially on our ability to involve parents . . . as full and equal partners in the helping process. What, then, accounts for the failure of group child care settings to develop dynamic and effective methods of working with parents . . .? That such a gap in services exists is evidenced by the lack of literature on family participation in residential care." In the few years since then, we haven't had a great deal more literature to base our work on, and we are aware that we are in an experimental phase. We have found that it is mostly with the younger children that we can involve parents in parenting tasks within the unit, for example, bathing, being at meals, and putting to bed. With older children this is usually not appropriate.

A child care worker in Pretoria became aware that 6-year-old Kathy in her unit experienced her own mother as cold and non-nurturing. She had involved the mother in mealtimes at the children's home and was now getting her to put her daughter to bed at night. However, this remained a stiff and self-conscious exercise for the mother — and thus not satisfactory for Kathy. The child care worker longed to take the mother's hands and *make* her caress her child, but knew this was not the solution.

The following week as the mother was bathing her daughter, the worker handed her a bottle of baby oil. "In these Highveld winters the kids are getting dry and chapped skin. Will you rub this well into Kathy all over her body before you put her to bed?" Kathy's warm response to her mother's caring activity proved to be the turning point in the relationship.

Such *practical* involvement in tasks which parents are able to manage give valuable experiences of successful interaction with their children, and begin to rebuild their belief in themselves as people and as parents. Bacher (1985) made the point that even though the "*raison d'etre* of the (parents') group was that its members had proved to be inadequate parents in some gross respects, we directed our input towards their healthy functioning".

We do have the problem that our children's home is geographically distant (in terms of *miles*, not hundreds of miles) from the parents' homes, and that getting to the children's home at such times is not easy. These parents are usually socially isolated themselves. They are often not mobile. They are the kind of parents who, for example, do not attend Parent-Teacher Association meetings at schools. We were particu-

larly pleased, however, at our Christmas pageant last year, to see that one hundred percent of the local parents attended — often in the company of their separated husbands or wives.

Effect on children

An important consequence of our programme has been that children no longer need to be anxious about the skeletons in their cupboards. They have come to trust us with the deeper knowledge and experience that we now have about their families. There is less need for them to split off their home situation from the children's home situation. A child who would have been excrutiatingly embarrassed to mention this one year ago, was able to remind us that her mother would appreciate a food parcel for the weekend. Several of the children have actually asked us to visit their families to discuss a particular problem that they are having. The fact that the children no longer need to mediate between two entirely separate systems, has relieved them of considerable stress. Sometimes the prognosis for the parents is hopeless and there is little chance of ever reuniting the family. Nevertheless this programme often contains for the child the problems and uncertainties surrounding his family, allowing him to get on with his own life without the continuing anxiety and doubt. By stabilising the family questions, we can get on with growing the child.

Linking with the team

Clearly, the family liaison workers are in possession of a considerable quantum of information which needs to find its way to other members of the child care team. To make this programme work, a proportion of time must be devoted to attending staff meetings and case meetings, and to consultations with supervisors or directly with child care workers. There is another important role that we play specifically at St Michael's Home where the child care workers work on a shift basis and are therefore not always readily available when parents 'phone. We become an important link between care workers and parents. We also work, naturally, at the request of staff in the children's home at all levels. A child care worker, or the unit manager, or the clinical psychologist, or social worker may ask us to visit parents with specific tasks. One important result of this programme for staff, therefore, has been that they appreciate the consistency of information and the consistency of approach with the children and families they are working with.

We in turn are conscious of our own limitations. Bacher (1985) noted the fact that "these parents were, as a group, vulnerable, and all suffered from some degree of disturbance". Whittaker (1979) questions the view of English and Finch that it "is probably safe to say that the majority of emotional problems in children are created by emotional problems of their parents". However, there *is* individual and family pathology which we are not equipped to deal with and which often has to be referred to other professionals on the team or to other agencies.

Five-day treatment

There is one method of working at St Michael's which has particular relevance for the family liaison workers, and this is the five-day residential programme whereby children are at the children's home only from Monday to Friday, and by design, spend their weekends at home. This is not simply a system of "weekends off". These weekends are systematically used to involve parents in the continued responsibility for their children. The five-day programme is most valuable when release to parents is seriously contemplated. It may begin with a Saturday and Sunday leave period. This may later be allowed to start on a Friday afternoon, which means that the parents have to handle Friday nights, perhaps with adolescent children. The period may be even further extended, whereby the child has to leave for school from his parents' home on a Monday morning, and once a parent is able to handle children successfully from Friday night to Monday morning, it is a short jump to where she has to handle them on a full-time basis. Contact with parents is intensive. Coming weekends are planned carefully — from ensuring that there is

Brief Report

Johannesburg Children's Home

Joan Rubenstein, Director of the Johannesburg Children's Home, and Michelle Gordon, social worker, report briefly on aspects of their family programme.

No matter how caring and pleasant an institutional environment may be, it cannot meet each child's need to have his or her own family. It has always been our goal at Johannesburg Children's Home to return as many children as possible to the community. We have introduced two important programmes to facilitate the successful implementation of this goal. Our after-care facility helps families cope when children are returned to their care. The children are transported to Johannesburg Children's Home after school, where they are fed and given the opportunity to participate in our daily programmes. They return to their parents in the evenings and over weekends. This greatly reduces the stress on the family and increases the children's chances of integration back into their families successfully.

Often, our children's parents' inability to cope with the normal demands of life is the prime cause of these children being institutionalised. With this in mind, we have introduced a volunteer programme whereby trained "lay therapists" help these parents with issues such as budgetting, discipline, and nutrition, thereby enabling certain children to return to a much improved family environment.

The breaking down of family relationships leaves emotional scars on children. If we can intervene positively in parent-child relationships before institutionalisation is necessary, the children's chances of successful adjustment are greatly enhanced. With this in mind we have introduced a potentially exciting new concept at Johannesburg Children's Home, a "Drop-in Centre" for families experiencing problems in parent-child relationships. The centre will provide a counselling and an educational facility for these families.

An additional service offered to our parents has been the STEP programme (Systematic Training for Effective Parenting). This programme deals with the teaching of basic parenting skills. The programme aims to teach alternatives in terms of discipline, developing positive relationships with children and effectively communicating and listening to children. We had to adapt the programme to meet the specific needs of the biological parents. One of the biggest problems was the fact that the children only spend weekends with their parents, and the parents do not have adequate opportunities to practise the skills they are learning. We felt that some sort of follow-up was necessary and therefore incorporated sessions after the group had terminated in order to continue practising the implementation of the skills.

Many of the parents are very autocratic in their parenting, and democratic parenting is something unfamiliar to them. It was therefore important to move at the parents' pace and to allow for gradual integration and learning.

The group was very successful and the parents proved to be open to learning and change, and we feel they benefitted from their exposure to alternative ways of parenting. We will continue to offer these groups to parents of our children.

Our work at Johannesburg Children's Home has many facets, but there is clearly only one objective: to maximise the life opportunities of all the children entrusted into the home's care.

sufficient food to planning some family activities and preparing parents for some child management or discipline problems. The children are then delivered personally by the family workers at the weekend and collected by them on Sunday evening. There may be one or two further contacts in the week. Every parent is thus seen by staff at least once or twice every week.

The other side of the story

There is a great danger in assuming that it is only the *parents* who must be helped and taught with the aim of reuniting the family. While we are dealing with emotional and developmental problems with the children in the children's home, we have consciously to match our behavioural goals *not* to the children's home but to the family. By perhaps providing too much domestic help and tolerating too much noise in the institution, we add subtle burdens to the parents and jeopardise plans for returning children. The children need to learn just as much about "doing for themselves" and contributing to the work, to the needs and the comfort of the family. Being willing to help with tidying, cooking and washing up, and being able to iron, sew on buttons or fix appliances, the children contribute to the success of the reunited family and are also making their commitment and investment. The children's home's task is to neutralise whatever negative contributions *the children* made to the original failure of the family, and to give them some portable problem-solving skills to use back home. One adolescent girl who lived through three weeks of arguments between mother and stepfather on return home, was able to recognise the destructive dynamics and she called a family meeting which forced the adults to face issues objectively. We might mention at this stage that it is here that we sometimes hit some of the snags of long-term institutional care. Sometimes we come across a child who has been too comfortable in a children's home. For example, he might have had his own room for some time, and is therefore unwilling to make the step back towards his less well-endowed home. We feel that had there been a level of contracting at the start of the child's stay, which outlined the purposes of his placement and our hopes for his return home, this situation could have been avoided. Similarly, at admissions meetings with parents it is always stressed that "we are not here to take your place or to take over your responsibilities. We are here *for a time* to help you with your family, and we will all have to work actively at getting the family back together again."

The static diagnosis

Perhaps the single greatest benefit from the family liaison programme has been the disappearance of what one might have called 'the static diagnosis', so common in children in care. Through our regular visits and engagements with parents, we have had a completely dynamic, up-to-date image of the parents, once or twice a week. This has been true also for the children, who have been very much more in touch with the reality of their families. We would estimate that about half of the present child population in our children's homes would be able to return home as a result of this sort of programme. The other half would be made up of very much more difficult children, or of adolescents who would not go home in this context anyway, but who might nevertheless go home once they have completed their schooling.

By perhaps providing too much domestic help and tolerating too much noise in the institution, we add subtle burdens to the parents and jeopardise plans for returning children.

Alternative placements

The depth of contact with families also makes it possible for us to decide *sooner* whether a child is likely to return home or whether alternative plans should be considered. As a result, many of our children who would otherwise have remained "in limbo" in our institution, probably for many years, have been placed with former "host families" or have been placed in our group home in Fish Hoek where they can lead a completely non-institutional life.

Perhaps the selection of staff members for this programme has contributed to its success. Gillian Quintrell is a senior child care worker with eighteen years' experience and who knows her field thoroughly. Margaret Crowley is an experienced District Nurse, and a grandmother. This experience in community nursing has been invaluable, and the fact that the two work as a team allows for some "mummy-daddy" strategies. An unco-operative mother who was allowing her twelve-year-old son to watch pornographic videos once brought Margaret's imperious District Nurse authority to the fore, and Gillian could maintain the supportive role. One father said, "I find it difficult being confronted about my private life by a 23-year-old social worker."

Expensive programme

The family programme adds considerable costs to our overall budget. It entails two staff members over and above the normal care and treatment staff complement. It entails considerable travelling and many telephone calls. But worse than this, the state subsidy in no way takes into account the *increased* work necessary once the children are actually released to parents. At this point the real load is placed on both parents and children and all of our preparation is put to the test. The six months following return home are in many respects more intensive than when the children's home staff were carrying the children during the week. From a legal point of view we can maintain our authority and ultimate responsibility during the allowed six-month leave period — but the grant stops after fourteen days!

There is a positive side to the costing too. One of the family workers also acts as an assistant to the children's home's social worker, attending to all of the statutory paperwork, thus freeing the social worker to do social work.

Conclusion

We believe that this programme makes it possible for us to pay more than lip-service to the principles of prevention, permanency planning and family reconstruction. Hatchuel reports the findings of Simmons, Gumpert and Rothman (1973) that "the more involved the parents are in the child's placement, the more positive the growth was on the part of both the parents and the children" (1986,16). We have achieved the beginnings of a "through-flow" of children which avoids long-term institutional care. There is no doubt in our minds that the children needed to come into the children's home in the first place and to go through our residential programme. But equally there is no doubt in our minds that most of these children are not candidates for long-term care in a so-called "last resort" institutional placement. The programme may cost us an extra R30 or R40 per month per child, but better that than R600 per month per child for ever.

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The Child Care Act at a Glance

Di Levine

It is important for child care workers to be familiar with major aspects of this legislation, mainly because it has a critical influence upon our work. It states what we can or cannot do, and indeed gives us the very authority to exist at all. Because this Act has only recently been implemented, there is still confusion about how it should be interpreted.

The Children's Home

A children's home is defined as a place of residence for more than six children living apart from their parents. Every children's home has to apply to be registered as a children's home and has to have a WO number and a fund-raising number. The board of management must consist of not fewer than seven members. A children's home may be inspected at any time by a state official and the state departments usually conduct regular inspections. If the Minister is dissatisfied with the standard of care provided by the children's home he can withdraw the registration certificate and the children's home will be obliged to close. However, this is a most unusual event, and on the whole, the state inspections do not place rigorous controls over the day-to-day functions of the children's homes.

Child Welfare Advisory Council

The Act makes provision for a multi-racial council whose function will be to make recommendations to the Minister to ensure adequate welfare services for children and to investigate any complaints. This section of the Act has in fact not been put into effect.

Children's Courts

The children's courts operate differently from any other court of law. Firstly, no one is on trial. The whole purpose of the inquiry is to determine what would be best for the child. So the hearing is normally not held in a courtroom, and the atmosphere is informal. No one can attend the hearing except those people directly concerned, so that everything that is said is confidential — the press are not allowed to report on proceedings or reveal the identity of the child. However, the magistrate (called the Commissioner of Child Welfare) can call wtnesses. The main evidence is the social worker's report. The parents, foster parents or adoptive parents are allowed to bring their own lawyer to represent their interests, but at the moment there is confusion about whether the child can bring his own lawyer. Social workers have repeatedly called on the law makers to allow the child separate legal representation. We await clarification on this point.

There is no right of appeal to the Supreme Court (except in the case of adoption). This has meant that the Commissioners of Child Welfare have been able to interpret the Act in vastly different ways and on occasion in ways that social workers felt did not serve the best interest of the child.

At the children's court inquiry the court must establish either that the child has no parent or guardian, or, that the parent is unfit or unable to have custody of the child. The exact words used in Section 14(b) of the Act are:

"the child has a parent or a guardian or is in the custody of a person who is unable or unfit to have the custody of the child, in that he —

(i) is mentally ill to such a degree that he is unable to provide for the physical, mental or social well-being of the child;

(ii) has assaulted or ill-treated the child or allowed him to be assaulted or ill-treated;

(iii) has caused or conduced to the seduction, abduction or prostitution of the child or the commission by the child of immoral acts;

(iv) displays habits and behaviour which may seriously injure the physical, mental or social well-being of the child;

(v) fails to maintain the child adequately;

(vi) maintains the child in contravention of section 10;

(vii) neglects the child or allows him to be neglected;

(viii) cannot control the child properly so as to ensure proper behaviour such as regular school attendance;

(ix) has abandoned the child; or

(x) has no visible means of support.

In other words, the court has to establish that the parent is unfit or unable to care for the child. This provision ensures that only the most needy children come within the ambit of the welfare system, and in effect also means that children in care have been deprived, usually physically, emotionally and socially.

At the conclusion of the children's court inquiry the Commissioner can decide —

- To send the child back to his parents under the supervision of a social worker.
- To order that the child is placed in foster care.
- To order that the child is placed in a children's home.
- To order that the child is placed in a child care school.

In the case of any placement away from the parents the effect of the court order is that the parent loses custody of the child, and that the right to discipline the child is given to the new custodians (either foster parent, children's home, or child care school). However, the parent retains the right to consent to medical treatment for the child, to consent to the child's marriage and to deal with any property the child has. If a child needs medical treatment urgently, and the parent cannot be traced, the head of the institution or the superintendent at the hospital may sign consent.

The court order giving the children's home the authority to keep the child expires or lapses after two years. This order can be renewed if a report is written to explain why it is necessary to keep the child for a further two years. The reason for this is to make sure that we do not keep children in care for unnecessarily long periods. The thinking behind this is to encourage children's homes to make rapid plans to return the child to the community. When this is not done the state is in fact asking why not, and what efforts have been made to rehabilitate the family.

A children's home can keep a child until the age of 18. At that point the order automatically expires and the child may leave the home. There is no provision for after-care of the child or his family once the order expires.

Adoption

There is one section of the adoption law that is of particular importance to those dealing with neglected children. This section deals with the circumstances under which a child can be adopted without the consent of the parent. We have had many situations where children have been more or less abandoned by their parents, but these children were not able to be adopted. This new law will have the effect of making it easier for the children to be adopted. The law says that a child can be adopted without parental consent if —

- the parent is mentally ill;
- the parent has deserted the child and his whereabouts are unknown;
- the parent has assaulted or ill-treated the child;
- the parent has encouraged the seduc-

tion or prostitution of the child;
- a child who has been in a children's home for over two years — in other words, the order placing the child in the home has expired, and the parents have not been rehabilitated;
- A parent is withholding his consent unreasonably.

This gives the impression that it will be very easy to have children adopted. This is not the case in that it will have to be proved that the adoption is in the best interest of the child, and thus these cases will be very carefully examined before any adoption order is made.

Leave of Absence
A child may be granted leave of absence for a period of six months from a children's home. This is commonly being used when a child is released from the children's home as a period in which the children's home can exercise some supervision of the family in case a breakdown of the placement occurs.

Compulsory Notification of Abused Children
In terms of this section of the Act, every dentist, doctor or nurse who suspects that a child has been ill-treated, or that the child suffers from any injury that has been deliberately inflicted on the child, must inform the Regional Director of Health and Welfare of his suspicions regarding that child.

Contribution Orders
The Commissioner may order that the parent of the child in care should contribute towards the costs of maintaining that child.

Regulations Applying to Discipline of Children
The regulations of the Act have laid out careful guidelines with regard to discipline of children. The head of the children's home must be the person who decides what punishment the child should receive, taking into account the nature of the transgression, the age of the child, and any instruction given by the management committee on discipline. Isolation, confinement (locking up the child) or refusal to allow the child the usual contact with the community, is forbidden. Also forbidden is corporal punishment (hitting) of girls, and a state or family welfare agency social worker, psychologist or doctor can forbid corporal punishment to be used on a boy. The head of the home must be satisfied that the child will not be "physically or mentally" badly affected by corporal punishment. Only an instrument approved by the management committee may be used to hit a child. A punishment register must be maintained by the children's home which details the name of the child, why he was punished, and the nature of the punishment.

Martin Wolins: An Appreciation

Brian Gannon

At a time when residential child care was very much the whipping boy of more respectable professions, it was refreshing to come across the writings of a man who sought the *positives* in child care. Such a man was Martin Wolins. Many of us worked with children who had to be in group care situations whether or not the "experts" agreed that it was good or bad for them. We were made very aware of the clever clichés derived from disapproving academics' pronouncements, for example that "any home is better than even the best institution", and this was discouraging to those of us who worked in institutions anyway.

New criteria
Wolins helped us to identify more clearly the criteria of what we would call "success" in group care. If we were locked into the western nuclear family model where everyone lived happily ever after, then we had failed before we started, since for most of the children we worked with this option for them — at least in terms of their family of origin — had already run out. Wolins looked rather at a number of developmental potentials in the children themselves when discussing successful outcome, and he did this across a wide range of European and Israeli cultures and ideologies, frankly challenging many of the presuppositions of the Western psychology of the day. When he studied such factors as intellectual development, psychosocial maturity and the development of values, group care for children was cast in a far more positive light, and this pointed up the child care worker's role as a builder of mature, independent adults with good chances of becoming good parents in the next generation.

When he studied such factors as intellectual development, psychosocial maturity and the development of values, group care for children was cast in a far more positive light.

Martin Wolins taught in the School of Social Welfare at the University of California (Berkeley) for nearly thirty years. He worked for four years with the Child Welfare League of America, and was Professor at the Tel Aviv University School of Social Work until his death in 1985. His colleague, Yochanan Wosner (1987), writes of him: "A large part of Martin's scholastic energy was devoted to a sometimes lonely, often unpopular, but always vigorous and data-based advocacy for responsible and accountable social work in general, and child and youth care in particular. His main thrust was directed toward the understanding of residential settings and their intelligent, controlled and planned use."

Ingredients for success
What were the ingredients for success in group care which Wolins distilled from his studies? Some, quoted from a publication of almost twenty years ago, sowed the seeds for much of our contemporary thinking.
- *The nature of our expectations*. A refusal to accept the pessimistic, determinist view that separation and deprivation inevitably cause irreparable damage, and a belief in the capacity of residential environments to promote growth and change in children.
- *A predictable future for the child*, unencumbered by continuing doubts about the possible rehabilitation of his family. This indicates the urgency of our decision as to whether work with the family or the formulation of an alternative permanent plan for the child is more feasible.
- *Social integration* within the living unit, the institution campus and the wider community, emphasising the need for opportunity to establish working social networks which have portability into adult life.
- *Peer impact*. A healthy children's community "endowed with rights and responsibilities" exerts positive socialising influences.
- *Competence-building activity*. Socially constructive tasks give children a sense of achievement and pride of ownership.
- *A unifying ideology*, conveying a secure world view or life philosophy, offers a "moral anchorage" not possible in an ideologically confused or impoverished setting.

Thank you
Thank you, Martin Wolins, for helping child and youth care work to break free of some of its negative stereotypes, and for giving us some new categories for thinking from which we derive belief in our work, and the children, hope.

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