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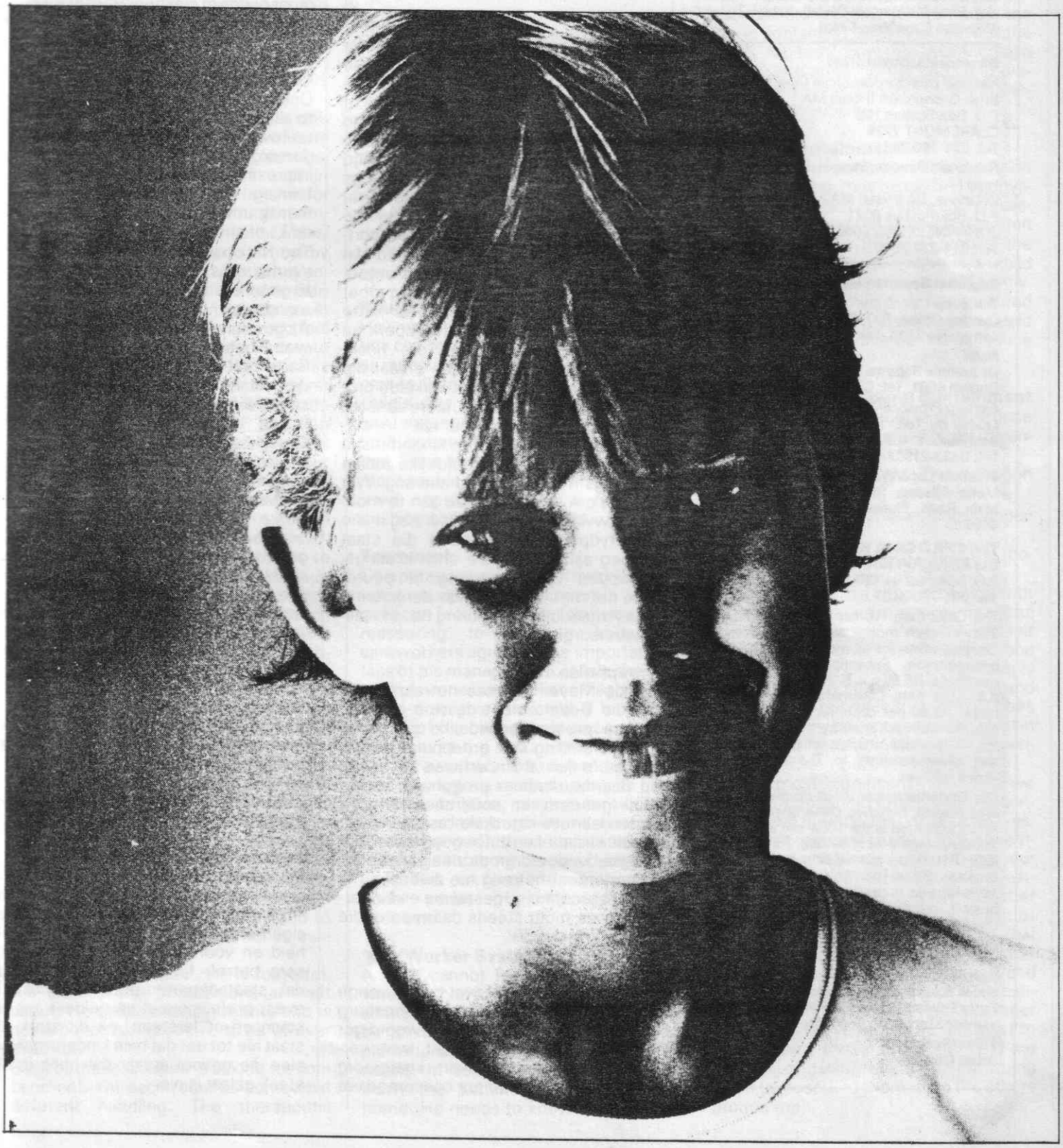
The child care worker



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NASIONALE VERENIGING VAN KINDER-VERSORGERS

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Meer oor Staatsbeleid

Hierdie tydskrif het onlangs gevra of daar wel iets soos 'n staatsbeleid oor kindersorg bestaan. Die mening word uitgespreek dat die verwarrende en uiteenlopende beleide nie alleen tussen nie maar ook binne staatsdepartemente, lei tot swak leierskap aan die kant van die regering en ontmoediging en onsekerheid by kinderinrigtings.
In die afgelope maand het 'n hele paar voorbeelde van hierdie gemors in die daaglikse bedryf van die NVK opgeduik.

Subsidies

Die eerste hou verband met staatstoelae. In sy artikel in hierdie uitgawe sê Ernie Nightingale dat "the present system of state subsidies is perhaps one of the major *demotivators* in regard to fund-raising". Die NVK moes reeds vanjaar 'n paar probleme aanpak in verband met kinderhuise wat met hul begrotings te kort skiet as gevolg van die koste wat hoë kwaliteitsdienste beloop. Oor die afgelope dekade is kinderhuise voortdurend deur die staat gewaarsku dat koshuis-tipe dienste eenvoudig ontoereikend en onaanvaarbaar is – tog moet hulle wat hierdie aanduiding ter harte geneem het nou hul dienste inperk en personeelstrukture aftakel om finansieël deur te druk. Intussen ervaar dié kinderhuise wat swak ontwikkelde programme en personeelstrukture aanbied geen geldelike probleme nie. In dieselfde trant blyk dit dat 'n kinderhuis in die Ciskei nogtans 'n hoofdelike toelae van slegs R73 per maand ontvang. Wat baat dit om kinderhuise so aan te moedig terwyl die subsidiestelsel nog in die steentydperk verkeer? Gee die staat genoeg aandag aan die ontwikkelingsbehoeftes van kindersorg of peuter hulle net met 'n verouderde benadering terwyl hulle lippehulde bring t.o.v. kwaliteitsversorging?

Groephuise

Die de Meyer Komitee het aanbeveel dat die Departement daartoe oorgaan om op proefondervindelike grondslag die daarstelling van groephuise te bevorder. 'n Aantal kinderhuise het reeds op daardie stadium groephuise in gebruik geneem, en sedertdien het nog ander daarmee ingeskakel as gevolg van hul eie inisiatief en hul begrip van hedendaagse kindersorgmetodes. Maar die Departement het nog nie duidelike riglyne vir groephuise gestel nie en kinderinstansies moet steeds daarmee in die duister begin werk.

Opleiding

In 'n formele referaat wat by die vorige Nasionale Konferensie in Johannesburg gelewer is, het die verteenwoordiger van die staatsdepartement wat verantwoordelik is vir swart kindersorg gesê: "As far as staff are concerned we need the right quality of human potential – people with the necessary skills and knowledge for their task. Training courses for staff of children's homes are a very necessary development. The Department would therefore like to be kept informed of registered courses of this nature". By dieselfde konferensie het die staatsverteenwoordiger vir kleurling en Indiër kindersorg gesê: "The staff of any institution is the pivot around which that institution revolves and it is essential that staff appointed have the correct training as well as insight into the inmost needs of children. Recently a more specialised two-year course – the National Higher Certificate in Residential Child Care – was introduced with Senior Certificate as an entrance requirement. Once again it is an opportunity afforded to all population groups". Die staatsverteenwoordiger betrokke by blanke kindersorg het gesê: "One does get the impression that whereas the need for training was originally expressed by management, it now comes from the ranks of child care workers themselves. The National Association of Child Care Workers has, in my opinion, done much to generate this awareness amongst its members."
As gevolg van die NVK se aanmoediging wou 27 studente vir die Nasionale Hoër Sertifikaat kursus in Februarie 1987 by die Natalse Technikon inskryf, *maar 5 swart, 3 Indiër en 3 kleurling applikante is op grond van die sogenaamde "kwotastelsel" toegang geweier. Op dieselfde wyse kan hierdie kursus nie in Johannesburg, waar die hoogste konsentrasie kindersorginstansies in Suid-Afrika geleë is, aangebied word nie omdat die Witwatersrandse Technikon geen van sy kwota aan deeltydse kursusse wil afstaan nie*. Die gevolg hiervan is dat die kindersorgberoep tenspyte van sy pogings om homself te verbeter, deur die einste staat wat hom tot hoër bekwaamhede aanspoor, belemmer word.

Inspeksies

In ander gevalle voel kinderhuise dat Departmentele inspekteure die aard van hulle programme bloot nie verstaan nie, en hulle trek geen ingeligde leiding uit inspeksies nie, afgesien van aanmoediging of waardering.

Bystand en Ondersteuning

Die vraagpunt handel nie eintlik oor die praktiese besonderhede van hierdie sake nie, maar juis oor die gebrek aan algemene waardering, verantwoordelikheid en vooruitbeplanning wat kindersorg betref. Kinderversorgers verwag dat staatsdepartemente hulle akademies, professioneel en geldelik sal bystaan en ondersteun, en dit strek die staat nie tot eer dat baie kinderorganisasies die gevoel ervaar dat hulle in die steek gelaat is nie.

Containment as a Therapeutic Tool

Sharon Bacher

In discussing ways of treating or helping troubled children, the concept of 'containment' is frequently mentioned. We say a child needs to 'be contained'; needs to 'feel contained'. But what is this need, and what can we do to engender in the child the feeling that he is thus contained?

Children who require this help, are children who seem somewhat out of control. It is as though their feelings, thoughts, and impulses spill over in ways that create anxiety and tension for themselves and in those around them. Often their behaviour is chaotic. Either the child has not developed a healthy inner control system, or else some severe stress has rendered him temporarily out of balance and unable to cope. Thus containment as a therapeutic tool means that we, as adults, need to create structure through which we temporarily relieve the child of his anxieties and prevent him from harming himself or others. The word "temporarily" is worth additional comment. We never grow out of the need for some structure in our lives, but the structure implied by containment in this article is the structure which youngsters should internalise as they mature and become socialised. There is a tendency for institutions to impose a form of permanent containment as a matter of course, perhaps as a means of control. When this happens, containment can become a strait jacket and ceases to be a therapeutic technique.

Examples of children needing containment:

C. aged 10 is in crisis after being separated from her mother. She cries a lot. She runs from adult to adult looking for attention and help, but she is thus unable to develop a relationship with one person. As her distress compounds in this way, so she becomes increasingly clingy, whiney, and silly.

T. aged 14, is impulsive and rebellious. She acts without thinking, and in so doing she is destructive to herself and to others. The careworkers see her as 'asking for punishment'.

D. aged 9 is a 'loskop'. He is forgetful. His clothes and possessions are left about. He misses appointments and is never punctual. He seems to be 'all over the show'.

Each of these children is asking for containment. Yet each requires somewhat different handling. The therapeutic team has a number of resources to provide for this need:

Space Manipulation

One child may feel better contained in a room of his own than when sharing. The insecurities and unpredictabilities of the other children may worsen his own fantasies and fears. A child who is tantrumming or displaying irritating attention-seeking behaviour, may be calmed by a short period of 'time out' in a quiet, non-punitive place. An anxious young child may feel more contained in a small cosy room within easy reach of his careworker, than in a large hard-to-manage room.

Routine Management

Having a structured and predictable routine can be containing and reassuring for an insecure or chaotic child. Routine becomes therapeutic when it organises a child's day, creates dependable behaviour sequences, and helps bridge the time between diferent kinds of activities. Time structures divide the day into manageable portions. Rituals, when used sensibly, provide a means for quelling children's anxieties.

Teamwork

Co-operation between careworkers provides a supportive framework in which a child can feel secure and contained. It is reassuring to him to know his careworkers agree on the important details of his management. While the ability to play one careworker off against the other may give the child a temporary sense of his own power and control, it robs him of the secure knowledge that his careworkers are dependable and that they have a rational approach to his care. In addition, playing careworkers off against each other and causing ill feeling between them can leave a child feeling guilty about his own destructiveness. This can feed into his already irrational sense of omnipotence and badness.

'Key'Worker System

A child cannot feel safe and oriented when he has to relate to a whole lot of adults to get his needs met. He needs to be connected to a small number of people who are there to take care of his needs. In addition the child needs to know the authority hierarchy of the home. He needs to know he cannot be exploited and that he has redress for his complaints. Thus he needs to know his accessibility to his 'caseworker' and to the 'director' of the home.

Rules and Limits

A clear definition of rules and limits enables a child to know where he stands in the community. Vague, unpredictable or arbitrary limits constitute a dangerous environment: there is no way for the child to be 'safe' and to get on with those in authority over him.

The more logical and just the consequences are for his misbehaviours, the more containing they will be for the child. Arbitrary punishments increase anxiety and anger in the child and prevent him from acquiring a sense of personal responsibility.

Physical Containment

A child who is upset, or even a child who is tantrumming, may be calmed by physically holding him. Thus it may be reassuring to a crying child when the adult sits quietly with his arm around the child's shoulders. A frightened child may be comforted by being held tightly. A tantrumming child may be reassured that he is not falling apart by being held in a firm, non-punitive but no-nonsense way.

Verbal and Behavioural Containment

One may calm and 'hold' a child whose feelings and behaviour seem out of control by saying things like:

"It's okay, you're alright. This will soon be over . . ."

"We'll handle this. These things happen . . ."

"You're very angry with me at the moment. Okay, so I also get cross . . ."

Active listening to a child's feelings with empathy and caring is a most powerful containing response. Who has not felt better and renewed in spirit and hope after the experience of being deeply heard and understood? So powerful and rare is this experience that when it does happen, it may become a turning point in a child's attitude to life, and an experience he remembers for years.

Of the most significant resources we have for containing children is the conscious and therapeutic use of ourselves. When we respond to the child with empathy and maturity we lend him our strength, our faith in him, and our greater experience and perspective that after all his world is only temporarily out of balance. When a child perceives that we, his adults, are not overwhelmed as he is by his feelings, his behaviours and his 'badness', he is reassured. He cannot but read in our behaviour the inner message that: 'even if I do feel like I'm falling apart, these adults can hold me together and will prevent me from doing harm to myself, to them, or to the others around me'.

The De Meyer Report — Four Years On

Katy Dempers

Katy Dempers is the Chief Social Worker at the Department of Health Services and Welfare, Administration: House of Assembly

The terms of reference of the Committee of Inquiry into Certain Aspects of Child Care (De Meyer Committee) were to inquire into, and report and make recommendations in respect of the White population group on –

- the nature, range and efficiency of services provided in connection with the residential care of children dealt with in terms of the Children's Act, 1960 (Act 33 of 1960), and the Criminal Procedure Act, 1977 (Act 51 of 1977); and
- the need for new services and the adaptation or modification of existing services in order to ensure that the interests of such children are best served at all times.

The report compiled by the Committee was divided into three sections, namely, places of safety and places of detention, children's homes, and schools of industries. Since the latter institutions are controlled by the Department of Education and Culture, Administration: House of Assembly, this article will not refer to the recommendations made in respect of schools of industries.

The Department of Health Services and Welfare has accepted all the recommendations regarding places of safety and children's homes and has adopted these recommendations to supplement the departmental policy on residential child care.

It should be obvious to the reader that although some of the recommendations are conservative there are a number of recommendations that can be regarded as revolutionary and can only be phased in over an extended period of time.

Places of Safety

The following adjustments took effect imediately at places of safety:

- A more homely atmosphere was created at each place of safety;
- Senior social workers were appointed as heads of the various places of safety;
- Posts were created for clinical psychologists, occupational therapists, professional nurses and additional social workers;
- The number of posts for child care workers was doubled and their salaries were improved;
- A permanent multi-professional team was developed at each place of safety with the result that the quality of assessment and short-term treatment improved greatly;
- Posts were created for security guards and other security measures were initiated;
- Money was made available for pocket-money for children in places of safety and more money is now available for recreation and excursions.

The erection of new places of safety in accordance with modern standards is a long-term project. New standards for buildings have been laid down and existing places of safety are being adapted accordingly, if at all possible. Unfortunately some of the existing buildings are so old that structural modifications cannot be regarded as cost-effective.

Children's Homes

Quite a number of recommendations in connection with children's homes have been attended to and will no doubt receive continuous attention, for instance –

- Appropriate in-service training programmes;
- Security measures and involvement with Civil Defence Programmes;
- Participation in the activities of the liaison committees which were established in the regions;
- The development, expansion and scrutinising of professional and other procedures necessary for an impressible therapeutic atmosphere, such as an individual treatment programme for each child; the necessity for obtaining psychosocial reports on the child and his family before contemplating further steps; the positive involvement of parents; the elimination of measures detrimental to the child's self-esteem, etc.

The Department is pleased to report that all the managements approached in connection with the revision of certificates of registration so far have been co-operative. The certificates of registration are being reviewed to ensure that every children's home is registered for the maximum number of children in accordance with the available facilities at the home. At the same time negotiations are taking place to persuade managements to do away with limited registrations so that children from the same family need not be separated on the basis of sex and/or age.

A short manual has been compiled for the managements of children's homes and should be ready for distribution within the next few months. This manual will supplement the instructions of guide-lines in the Manual for Children's Homes. The aim of the manual is to stress the importance of the management and the skills and knowledge required for the smooth running of a children's home.

In respect of the Committee's recommendations on the location and structural requirements of children's homes it is important to realise that the following aspects, *inter alia*, will be considered when a new home is to be established or when application is being made for alterations to an existing home:

- The erection will only be allowed if the proposed location is near the home's matrix to ensure that children are as near as possible to their parental home;
- Only the cottage system, with no more than 10 children per unit, will be considered;
- All the necessary services and facilities will have to be available in the vicinity;
- The Department will not permit the erection of a children's home for more than 150 children;
- The erection of group homes will be promoted.

These directives will necessarily lead to the improvement of existing children's homes and to an improvement in the planning of residential care facilities on a national basis.

At this stage, all efforts are being made to place committed children in children's homes which are as near as possible to the parental homes of these children. The home language of a child also plays an important role in the selection of a suitable children's home. As a result of this policy one finds that some of the children's homes, which up to now have admitted children from remote places or have accepted children from the other language group without properly providing for treatment and nurturing in the child's mother tongue, are admitting fewer children on average.

Favourable consideration is being given to applications for structural changes which will result in the improvement of

staff facilities at children's homes.
Children's homes are inspected fully every three years. The Department intends changing to an annual inspection service, but the current state of affairs is preventing the implementation of an immediate change. Inspecting officers are expected to observe and evaluate the activities in the children's home and to give guidance to help ensure that the children are given the opportunity to develop to their full potential.

Research
On the recommendation of the De Meyer Committee, the Department has decided to undertake research in respect of children who are being released on licence.
The co-operation of children's homes and social workers rendering aftercare services have been obtained and a study, over a 12-month period, is being made of each child released during 1986. The results will be processed as soon as possible after December 31, 1987.
Most of the recommendations with financial implications could not readily be implemented.
A departmental study group is reviewing the existing subsidy scheme. It is envisaged that more emphasis will be placed on apposite qualifications and that a national posts and salary structure will be made available and be subsidised accordingly.
There are at present nine children's homes accommodating 332 children, which function without the services of an internal social worker. The largest of these homes accommodates 95 children whilst an average number of 30 children is being catered for in the other eight homes. In spite of the progress being made one is disturbed about these few managements who are still so far removed from adopting the principle that each children's home should be a therapy centre.
The research section of the Department's Directorate of Social Welfare has been requested to investigate the matter of a realistic ratio of staff to the number of children. The study will include all types of posts e.g. child care workers, social workers, clinical psychologists, etc.
The De Meyer Committee exposed a number of weaknesses which indicated not so much ignorance as an arrogant sense of complacency which left little room for introspection.
All of us concerned with children in residential care will have to remain sensitive to the needs of children and will frequently have to be reminded of this.
It will be our responsibility to keep pace with ever-changing procedures and requirements in the field of child care, and it is quite clear that there will always be room for improvement.

AIDS: Policy and Decisions in Children's Homes

Dina Hatchuel

Introduction
What are we to do if we discover that a child in our care has been infected with AIDS? Do we keep him in our care and in our schools and at what risk to him, the other children and staff? Or do we discharge him and to whom? What will we do if we discover a staff member in our employ has AIDS? Will we end his/her employment with us and if so why?
AIDS is a serious medical issue confronting child caring agencies, schools, and foster care agencies. Originally AIDS was associated with specific medical and social groups such as blood recipients, male homosexuals and intravenous drug abusers but the epidemic has grown to include hetrosexual men and women, children, and infants

In the USA 250 children under the age of 13 years have developed AIDS symptoms.

across the board. In the USA 250 children under the age of 13 years have developed AIDS symptoms. Providing services to these children has become a volatile issue amongst parents, educators, child care workers and local communities. Not only is AIDS a new and relatively unknown disease but, as a disease which ends in death, it has caused a wave of panic and fear in all communities. Statements, decisions and policies have been made rashly and without sound reasoning and many AIDS victims have faced unnecessary ostracism, exclusion, and harm.
In the USA today there is an all-out effort to provide management committees and boards of education with knowledge and a clear understanding of AIDS so that if agencies or schools are ever faced with an AIDS victim in their midst, through limited and specific means

Statements, decisions and policies have been made rashly and without sound reasoning and many AIDS victims have faced unnecessary ostracism, exclusion, and harm.

their management of the situation can be rational and based on sound information.

What is AIDS?
AIDS stands for Acquired Immune Deficiency Syndrome. It is a recently recognised disease which occurs in some people months and others years after infection. It is caused by a virus HTLV-III/LAV (Human T-Lympho-tropic Virus Type III/Lympha denopathy-Associated Virus) that attacks and breaks down a particular type of cell in the immune system leaving the body vulnerable to a variety of illnesses. It is these illnesses, which normally pose no threat to a healthy person, that can cause death in an AIDS victim. The most common illnesses found in people suffering from AIDS are Pneumocystis Carini Pneumonia (PCP) and Koposis Sarcoma (KS) a rare form of skin cancer.
It is important to note that the AIDS virus does not necessarily result in AIDS. Only a minority of AIDS virus carriers become sick with AIDS. Co-factors such as alcohol and drug abuse, poor nutrition, stress and other illnesses are said to play some role in the development of the disease.

How is AIDS Transmitted?
The AIDS virus is not airborne and it is not easily transmitted. It is spread only through semen, body liquids and blood-to-blood contact. Children who have contracted the AIDS virus have done so

namely –
- from an AIDS carrying mother during pregnancy or at birth or later through breast milk;
- from blood transfusions or blood products contaminated with the AIDS virus. (Current screening programmes have reduced this possibility to zero in USA);
- from sharing hypodermic needles in drug abuse;
- from sexual activities with AIDS carriers (incest and amongst teenagers).

There are no cases of children contracting AIDS or the AIDS virus from other children. It is unlikely that if a child with AIDS gets cut or injured at school that other children are at risk of infection. Skin is an excellent barrier to infection and for transmission to occur infected blood has to enter the blood stream directly. Daily activities such as working in a group setting, shaking hands, attending public events, eating in restaurants, and swimming in public pools can occur without any risk of contracting AIDS. No AIDS infections are known to have been transmitted through tears, saliva, coughing, sneezing, casual kissing, sitting on toilet seats or changing nappies of an AIDS infected infant. The practice of becoming "blood brothers" amongst children presents a small risk and this practice should be discouraged. However, none of the 100-plus medical practitioners having accidental pricks from needles recently in contact with blood of AIDS patients have developed infection with the AIDS virus.

What Happens When a Person Becomes Infected With AIDS?

One of three things happens when a person becomes infected with AIDS:

1. Most infected people develop antibodies to the virus and remain healthy displaying no symptoms though they can transmit the virus to others through blood-to-blood contact.
2. A smaller group develop AIDS Related Conditions (ARC) characterised by mild to severe illnesses.
3. An even smaller percentage develop AIDS indicated by specific life-threatening diseases such as KS and PCP.

The symptoms of AIDS are listed below:
- Recurrent and persistent colds, bronchitis and stomach flu.
- Unexplained persistent fatigue.
- Unexplained fever, shaking, chills, drenching night sweats lasting longer than several weeks.
- Unexplained weight loss.
- Swollen glands usually in the neck, groin, and armpits which are unexplained and last longer than 2 months.
- Pink to purple flat or raised blotches or bumps occuring on or under the skin inside the mouth, nose, eyelids or rectum. These resemble bruises but don't disappear and are usually harder than the skin around them.
- Persistent white spots or unusual blemishes in the mouth.
- Persistent diarrhoea.

Most children infected with AIDS become ill very early in life (under 1 year) and symptoms include failure to thrive, chronic diarrhoea, pneumonia and upper respiratory tract infection, and candidiasis. These conditions in an AIDS victim most often result in death.

Can AIDS Be Managed?

AIDS should be treated like any other infectious diseases. Many people infected with AIDS are asymptomatic carriers and therefore most often undiagnosed. Children's homes and schools should not wait until they encounter an identified child or staff member infected with AIDS before updating their infectious diseases precautions. The goal should be to protect the entire population without stigma or discrimination. Precautions should include the following:
- Basic hygiene: encourage handwashing with liquid soap, drying hands with disposable towels, and washing clothes in hot water.
- Use non-sterile disposable gloves when handling blood (open sores, cuts, cracked skin, wounds, nosebleeds) and when handling secretions (faeces, urine, vomit). Double bag all soiled items.
- Clean spills with chlorox bleach disinfectant immediately.
- Refrain from sharing personal toiletry items like scissors, nail files, razors, towels, toothbrushes and other implements that could become contaminated with blood.

Treatment of AIDS victims takes place according to the illnesses contracted. If one is aware of an AIDS victim in our midst the following precautions should be taken:
- Keep the child with AIDS away from other children when bleeding exists, when open sores cannot be covered and when biting or scratching behaviour could result in potential transmission.
- Keep the child with AIDS away from other children when acutely ill or special medical procedures might induce bleeding (colostomy care, suctioning, tube feeding, catheterisation).
- Keep the child with AIDS away from other children when measles or chickenpox is occurring in the environment and inform the child's physician immediately.
- Never give a child with AIDS a live vaccine.
- Toys for the preschooler with AIDS virus who is still mouthing items should not be shared with others and should be washed daily with disinfectant.
- A child with AIDS should not share his food or drink with others.
- Do not share thermometers of AIDS victims with others.

For most infected school-aged children the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent non-existent risk of transmission of AIDS. A restrictive environment is required only for preschool children, severely handicapped children, and children who lack control over their body fluids, display biting behaviour, have uncoverable sores or have a need for medical procedures which induce bleeding.

Decisions and Policies

Adoption and foster care agencies should add AIDS virus screening to their routine medical evaluations of children before placement. Adoptive and foster parents with AIDS infected children need to prepare for the medical care of the child and consider the social and psychological effects on their families.

Decisions about the type of care setting and education of a child diagnosed as having AIDS should be made on a case-by-case basis depending on the age, behaviour, neurological development and physical condition of the child.

Decisions should be made by a team consisting of the child's doctor, public health personnel, children's home/school principal, management committee representative, social worker and agency worker. In each case, the rights and benefits of the infected child must be weighed against those of the others in the children's home/school.

It is *not* advisable to have a blanket policy as
- new information is found continually and would influence policy which could then become outmoded;
- factors surrounding each case vary and differ and so a blanket policy may be unappropriate to some cases and
- physicians may be reluctant to reveal the diagnoses of AIDS if they know the consequences will not be in the best interests of the child.

Unwarranted panic and hysteria result when confidentiality is lost, always to the detriment of the victim and his family.

It is essential that confidentiality be maintained as it becomes extremely difficult to handle the situation appropriately when confidentiality is lost. Furthermore, unwarranted panic and hysteria result when confidentiality is lost always to the detriment of the victim and his family, children's home and/or school.

The same applies to a staff member who has AIDS – there is a need for team decisions on a case-by-case basis and confidentiality.

Kindermishandeling: Implikasies en Voorkoming

L. Rech, G.K. Minnaar

Dr L. Rech is 'n psigiater en G.K. Minnaar is 'n kliniese sielkundige. Albei is werksaam in die kinder- en gesinseenheid by Weskoppies-hospitaal, Pretoria

Die voorkoms van kindermishandeling in al sy verskillende vorms kan beskou word as 'n dramatiese teenstelling teenoor die gewone versorging, vertroeteling en liefde wat ouers aan hul kinders gee. Daar is hedendaags 'n baie duidelike toename in die bewustheid en erkenning van kindermishandeling, soos beskryf deur Kempe *et al.* Die verskynsel van kindermishandeling is egter nie iets nuuts nie en toon 'n lang geskiedenis, wat reeds oor die eeue heen beskryf is.

Soorte Kindermishandeling

Kindermishandeling kan onderverdeel word in vier algemene kategorieë (Tabel I) wat die ouderdom en ontwikkelingsfase waartydens die kind mishandel is weerspieël.

Gebrekkige emosionele en fisieke groei by die kind sonder organiese redes – 'non-organic failure to thrive'

Hierdie aspek kan gesien word as 'n vroeë vorm van disfunksie tussen die ouers en die kind. Die omvang daarvan kan van so 'n belangrike aard wees dat die kind se groeipotensiaal so ingeperk kan word dat dit kan lei tot verstandelike gestremdheid by die kind.

TABEL I
Soorte Kindermishandeling

Gebrekkige emosionele en fisieke groei by die kind sonder organiese redes
Kinderverwaarlosing
Fisieke mishandeling
Seksuele mishandeling

Kinderverwaarlosing

Kinderverwaarlosing het 'n nog groter omvang. Spesifieke vorme sluit in mediese, emosionele, opvoedkundige en fisieke verwaarlosing.

Fisieke mishandeling

Fisieke mishandeling verwys na fisieke geweld teenoor die kind.

Seksuele mishandeling

Seksuele mishandeling verwys na die uitbuiting van kinders vir die seksuele bevrediging van volwassenes. Hierdie seksuele uitbuiting mag voorkom in enige stadium van die kind se ontwikkeling.

Fisieke en Emosionele Gevolge

Die gevolge van al die verskillende soorte kindermishandeling is heterogeen en afhanklik van faktore soos die intensiteit, duur en tipe van ouerlike disfunksie, konstitusionele faktore by die kind, en omgewings-veranderlikes. Fisieke gevolge sluit in:

Die dood

Volgens die Newcastle-navorsingsprojek het meer as een uit elke 10 gevalle van kindermishandeling tot die dood gelei.

Ernstige en dikwels permanente fisieke beserings

- Kneus- en brandmerke wat veroorsaak kan word deur sigarette, warm metaalvoorwerpe, erge loesings met 'n verskeidenheid voorwerpe, en brandwonde veroorsaak deur kookwater.
- Okulêre beskadiging.

TABEL II
Voorkoming van Kindermishandeling

Risikofaktore by die ouers
by die kind
Doeltreffende professionele opleiding
Onderrig en verbetering van ouerlike vaardighede
Voorsiening van die nodige dienste

- Organiese skade wat verstandelike gestremdheid, serebrale gestremdheid en epilepsie tot gevolg mag hê.
- Intra-abdominale beserings. Hierdie beserings is 'n algemene oorsaak vir die dood by die mishandelde kind. Die mees algemene bevindings is 'n geruptuurde lewer of milt, hoewel skade aan die kind se dikdermkanaal ook algemeen voorkom. Beserings aan die buik word egter dikwels deur die ouers ontken. Daarom is dit belangrik om enige besering aan die buik waarvan die etiologie nie duidelik is nie, deeglik na te gaan vir moontlike fisieke mishandeling.
- Normale ontwikkeling kan benadeel word deur verwaarlosing en swak fisieke versorging.

Emosionele gevolge

Die gevolge is nie bekend nie. Enkele van die kenmerke wat waargeneem is, word hier genoem:

- Onvermoë of probleme om genot te put uit die lewe.
- Onvermoë om te speel.
- Gedragsprobleme en 'n lae frustrasietoleransie.
- Opposisionele gedrag.
- Swak selfbeeld.
- Sosiale isolasie.
- Swak sosiale interaksie en meer fisiek aggressiewe gedrag.
- Wantroue in mense.
- Oorversigtigheid.
- 'n Pseudovolwasse houding.
- Kompulsiewe gedrag wat 'n verdedigingsmeganisme is teen onbewuste angstigheid.
- Versteurde eetgewoontes soos gulsigheid en 'n oormatige groot aptyt.
- Onoordeelkundige binding met ander.
- Aandagsoekende gedrag.
- Omgekeerde versorging waar die kind gewoonlik omsien na die ouers se behoeftes, bv. om ouers te voorsien van sigarette.

Een uit elke drie mishandelde kinders toon akademiese onderprestasies ten spyte van die feit dat die potensiaal wel aanwesig is.

- Leerprobleme – een uit elke drie mishandelde kinders toon akademiese onderprestasies ten spyte van die feit dat die potensiaal wel aanwesig is; probleme kom voor t.o.v. spraak, taal, persepsie en ander kognitiewe aspekte.
- Langtermyneffekte in die vorm van versteurde persoonlikheidsontwikkeling en gebrekkige ouervaardighede wat daartoe lei dat die mishandelde kind die mishandelaar word.
- Waar seksuele mishandeling plaasvind, is die algemeenste probleem in die kinder- en adolessente jare seksuele aanpassingsprobleme; probleme wat voorkom is bv. preokkupasie met seksuele aangeleenthede, oormatige masturbasie, vroeë belangstelling in seksuele verhoudings, onvermoë om seksuele impulse te kontroleer, swangerskap, geslagsrolidentifikasieprobleme, promiskuiteit, homoseksualiteit en seksuele molestering van kinders. Tydens die volwasse jare kom probleme soos aversie teenoor seksuele aktiwiteite, onbevredigende seksuele verhoudings, homoseksualiteit, promiskuiteit, prostitusie, betrokkenheid by bloedskandeverhoudings, onvermoë om eie kinders teen bloedskandeverhoudings te beskerm, seksuele molestering van kinders, en selfs impulse om 'n kind ernstige seksuele skade aan te doen

Voorkoming van mishandeling
'n Belangrike faktor is die vroeë identifisering van gesinne wat 'n risiko is vir kindermishandeling. Die opsporing van sulke gevalle moet bv. by die voorgeboorteklinieke nagegaan word. Die algemene praktisyn, kraamhospitale, asook die rol van die gemeenskapsuster is hier belangrik. (Tabel II)

Risikofaktore
Die ouers –
- Mishandeling van een of albei ouers self tydens die kinderjare.
- Pleegsorgplasing en sorgbehoewendheid as kenmerke van die ouers se kinderjare.
- Onvolwasse ouerskap bv. 'n tienerhuwelik.
- Enkelouergesinne.
- Huweliks- en finansiële probleme.
- Sosiale isolasie.
- Psigiatriese probleme bv. depressie, skisofrenie, dwelmmiddelmisbruik, psigopatiese persoonlikheid.
- Verlaagde intellektuele funksionering.
- Enige ander faktore wat mag lei tot 'n versteuring in die bindingsproses tussen ouer en kind.

Die kind –
- Premature babas.
- Geestelike gestremdheid of neurologiese onvolwassenheid.
- Fisieke gestremdheid.
- Die kind voldoen nie aan die hoë ouerlike verwagtings nie.
- Temperamentele verskille.
- Pleegsorg en/of aanneming.
- Stiefkinders.
- Onbeplande of onwelkome kinders.

Doeltreffende professionele opleiding
Doeltreffende opleiding van professionele persone om bewus te word van die mishandelde kind en hoe om so 'n kind te behandel word benodig. Daar word gevoel dat die opleiding van professionele mense soos dokters, maatskaplike werkers, onderwysers, en verpleegkundiges om kindermishandeling te hanteer

Weinig of geen opleiding word tydens voor- of nagraadse studies aan genoemde professies gebied nie.

tans nie voldoende is nie. Weinig of geen opleiding word tydens voor- of nagraadse studies aan genoemde professies gebied nie. Alle professies wat met kinders werk, bv. ook die regsprofessie, predikante, en sielkundiges, behoort opleiding in die hantering van kindermishandeling te ontvang. Ideaal gesproke, sou 'n gekombineerde kursus vir al die genoemde beroepe van waarde wees, sodat elkeen die ander se rol beter sal kan verstaan met die oog op identifikasie en behandeling van mishandelde kinders.

Onderrig en verbetering van ouerlike vaardighede
Die potensiaal vir kindermishandeling bestaan reeds tydens die kinderjare en daarom moet die kerk, skool en jeugbewegings betrek word om kinders voor te berei vir ouerskap d.m.v. lesings, praatjies, ens. Op hierdie manier kan daar dus ook voorkomend gewerk word.

Voorsiening van die nodige dienste
Menige van die vroeër bestaande ondersteuningsbronne, soos die uitgebreide familie en godsdiens, wat die gelukkige saamwoon van mense bevorder het, het verval. Die oorbeklemtoning van die he-

Die gemeenskap moet kennis dra van die aard van kindermishandeling en hiervoor moet al die bestaande media betrek word.

dendaagse materialisme en die gebrek aan ondersteuningsbronne moet vervang word deur bv. gespesialiseerde eenhede wat, met die hulp van 'n welsynsorganisasie, 'n 24 uur-diens kan bied aan gesinne waar mishandeling mag plaasvind.
Gerehabiliteerde mishandelaars kan ook in ondersteuningsgroepe georganiseer word om potensiële mishandelaars by te staan met raad en hantering.
Nasorgsentrums is van groot waarde. Die identifisering van ouers wat vir pleegsorg of aanneming gekeur moet word, is van groot belang.

Die gemeenskap moet kennis dra van die aard van kindermishandeling en hiervoor moet al die bestaande media betrek word. 'n Nasionale register waar alle gevalle van kindermishandeling of potensiële mishandelaars aangeteken word, is van belang, aangesien dit ook kan bydra om die probleem van 'verlore' gevalle uit te skakel en meer effektiewe behandeling in die hand te werk.
Die instelling van 'n komitee word bepleit, waar al die professies betrokke by kindermishandeling op 'n gereelde grondslag gevalle kan bespreek, asook oor behandeling en voorkoming in die algemeen menings kan wissel.

Behandeling van Kindermishandeling
Die behandeling behels verskillende vorms van terapie, asook 'n kombinasie van die volgende:

Gesinsterapie
Hier word gekyk na die verskillende patrone van interaksie in die gesin en gepoog om dié interaksie so te wysig dat 'n herhaling van mishandeling nie weer voorkom nie en om gesonder verhoudings aan die gang te sit.

Individuele psigoterapie
Hierdie tipe terapie, soos spelterapie, kan aan die kind gebied word om hom te help om negatiewe gevoelens 'uit te speel'. Beide die ouers kan ook baat by psigoterapie om gevoelens van bv. aggressie deur te werk.
Ander terapieë soos huweliksterapie en groepsterapie kan beide vir die kind en volwassene van belang wees.
Daar is egter geen spesifieke modaliteit wat gebruik word nie en elke gesin is uniek. Elke gesin se behoeftes moet bepaal word en die terapie moet daarby aangepas word.

Verwysings
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Summary
Child maltreatment in its various forms can be regarded as contrasting dramatically with the usual care, nurturing and love that is given to children by their parents. Four types of child maltreatment are recognised and can be divided into organic failure to thrive, child neglect, and physical and sexual abuse.
The effects on the child are heterogeneous and depend on factors such as the intensity, duration and type of parental dysfunction, constitutional factors present in the child, and stress resulting from environmental influences. Emotional and physical sequelae are the usual presenting symptoms.
Risk factors present in the parents and in the child are important. All professionals working with children should be on the alert for these factors if the often catastrophic consequences are to be prevented. Further aspects in prevention that should be looked at are: firstly, adequate training of professionals in the early identification and management of these families should be undertaken; secondly, parental skills must be improved; and thirdly, provision of the necessary services to deal with the problem must be instituted.
The management of maltreated children is best conducted on a multi-professional basis and may take various forms, such as individual, group and/or family therapy.

Nuusbrokkies Newsbriefs

Canadian Guest Speaker for Johannesburg Conference

Thom Garfat, Director of Treatment at Youth Horizons, a multi-service children's agency in Montreal, Quebec, will be the Keynote Speaker and will give three other papers at the National Conference in Johannesburg in October. He is speaking on The Empowerment of Youth in Care at the *Whole Days, Whole Lives* Conference in Boston, Massachusetts in March this year, and participating in a panel on Future Directions for the Child Care Profession. A man widely experienced in all aspects of child care, Mr Garfat hopes to spend some time in South Africa visiting other centres.

The dates of the Conference whose theme will be *Today's Child, Tomorrow's Adult*, have been slightly shifted to October 7-9, with the One-Day National Seminar on Child Care Worker Education and Training taking place on Tuesday 6th October. Advance programmes of the Conference will be sent out by June 1987, and delegates from other centres will be able to benefit from special group air fares.

Khayalethemba Struggles

Khayalethemba is a children's home in the sprawling residential area of Mdantsane north of East London. The home, administered by

Principal Mzanywa Mketo

Mfesane, accommodates 176 children. In recent weeks the social worker and two child care workers of the home have been attending case conferences and in-service training courses and observing staff supervision at the nearby King Williamstown Children's Home. However, Khayalethemba has a major problem in that it is situated within the Ciskei which has not increased capitation grants to keep pace with others in South Africa. Accordingly the home receives a *per capita* subsidy of only R73 per month – a figure which would not cover even the food costs of the average children's home in this country. Inevitably the buildings are falling into disrepair, proper facilities for child development, play and education are totally beyond their reach, and for the laundry for 176 children, the home depends on one domestic washing machine! The NACCW has communicated this problem to the South African Ministry of Constitutional Development and Planning, pointing out that Khayalethemba serves not only the Ciskei, but the entire Cape Province, many of its children coming from as far afield as Cape Town.

Natal

The Basic Qualification in Child Care course began at the beginning of February at St Philomena's Home with an enrolment of 48 students. Module I is being co-ordinated by Kathy Mitchell and Norma McCormack. The National Higher Certificate in Residential Child Care course got off to a highly controversial start at the Natal Technikon when Black, Coloured and Indian students were refused admission due to the so-called "quota system". Of the 27 would-be students, only 16 were accepted. The NACCW made immediate representations to the Minister of Education and Culture in Cape Town through Durban MP Roger Burroughs, but at the time of writing this problem has not been settled.

80th Anniversary

Ethelbert Children's Home in Malvern celebrates its 80th Anniversary this year with a Bumper Fete on 27th June at the time of its Annual General Meeting. This children's home has the distinction of having opened its present cottage system buildings as long ago as 1957. In 1986, its new building, Khulula, which provides transitional care in an independent-living unit, was opened. "Khulula" is a Zulu word which means to untie or set free.

Vondsinsameling

Aan die einde van Maart 1987 sal die NVK 'n vondsinsamelingveldtog in Natal van stapel stuur om die aanstelling van 'n streeksdirekteur in hierdie gebied te ondersteun. Aksie Sorg-Trust, die vondsinsamelingliggaam van die NVK, sal 'n promosie organiseer waar beide die Nasionale Voorsitter en die Nasionale Direkteur toesprake sal lewer. Dit sal ongeveer R25 000 per jaar kos om so 'n aanstelling te ondersteun, en die Natalstreek wil graag 'n rol speel in so 'n projek.

Ontwikkeling by Pietermaritzburg

Die Mary Cook-Kinderhuis is tans besig om 'n R175 000 ontwikkelingsprogram te voltooi wat hulle in staat sal stel om 30 in plaas van die huidige 20 kinders te versorg. Hulle is van plan om seuns op te neem om die skeiding van gesinne te vermy. Volgens die prinsipaal, John Webster, word die ou

John Webster

slaapsale in enkel-, twee- en driebed kamers onderverdeel. Die kombuis word opgeknap en 'n studiesentrum en speelkamer word aangeskaf. Die kinderhuis, wat beide Engelse en Afrikaanse studente huisves, sal drie huismoeders, 'n voltydse maatskaplike werker en 'n deeltydse kliniese sielkundige aanstel.

People

Sue Bishop, who has been associated with the Home for some years, has been appointed Principal of Wylie House in Ridge Road, Durban, and we welcome her to her new post.

Major I Howard Sercombe, who contributed our September, October and November cover photographs in 1986, has retired as principal of Baynes Memorial (Salvation Army) Home in Pietermaritzburg, having been sent "back to the pulpit" in Port Elizabeth. His place has been taken by Captain Sedgewick whom we welcome to his new post in child care.

Eastern Province

Child Welfare Opens Safety Home

East London Child Welfare Society has opened a third short-term place of safety house which can accommodate up to six children in need of emergency care. The new house in Southernwood, called Sunshine Place, was opened on 15th January, and within three days had 5 children admitted. Tilana Werth, an experienced child care worker who formerly ran one of the group homes of the King Williamstown Children's Home, is the Housemother. The Society has for some time run similar

homes in East London, in Pefferville and Duncan Village for coloured and black children respectively. The Pefferville house has been closed as a result of population moves and a new house is being sought in Buffalo Flats. These homes which accommodate not more than six children each are not registered and receive only a place of safety grant.

Third Group Home for Malcomess House
Barrie Lodge, principal of East London Children's Home, reports that the generosity of a service club has enabled the home to start its third group home in the town. This means that a total of 25 children will now be accommodated in this type of community-living home. The reduced number of children in the old Malcomess building now allows for the development of programmes for harder-to-serve youngsters together with a number of improved services for all of the children in the wider programme. Malcomess has been successfully developing a range of residential services as

Barrie Lodge

part of a comprehensive child care system for East London.

Western Cape

Keeping Staff Meetings Going
Willie Bock, until recently principal of Leliebloem House, has returned to full-time teaching, and during the interregnum before the new principal assumes office, the National Director of the NACCW is meeting regularly with the staff to maintain the momentum of their programme. First task for 1987 has been the undertaking of a re-evaluation of all of the 72 children in the home in order to restate development and treatment objectives. Such an evaluation always produces daunting lists of individual and group tasks.

Pretoria Welfare Conference
Doug Pearce, principal of Tenterden Place of Safety, together with representatives of the Cape Town and Regional offices attended recently a Departmental Conference in Pretoria. The new Child Care Act was a topic for discussion, as was the development of Places of Safety as assessment centres. Doug Pearce was also able to visit the Tutela, Jubileum and Norman House places of safety, and has brought home a number of ideas to discuss with his staff team in Cape Town.

Transvaal

Training
27 new child care workers enrolled for the Orientation Course prior to the start of BQCC Modular Course lectures again on March 4th. The course will continue at RAU but the venue is changed to Block D, Les 202. The first module runs until 24th June. Last year a Facilitators' Group was formed to assist children's homes to develop an in-service training programme which would ensure integration of the knowledge gained on the BQCC course into the day-to-day practice of the child care worker. This group will meet again on 17th March at 09h00 at Nazareth House in Yeoville.

Vergaderings
Die Maatskaplike Werkergroep het onlangs by Strathyre vergader. 15 maatskaplike werkers het saam met twee studente, die behoefte om die rol van die werker in die kinderhuis te verduidelik, bespreek. Hierdie groep vergader weer by Arcadia om 09h00 op 26 Februarie, en die daaropvolgende vergadering vind op 26 Maart plaas. Die Uitvoerende Komitee vergader om 08h30 op 19 Maart by Nazareth House, en die Prinsipaalgroep kom om 10h00 op dieselfde dag byeen.

Situations Wanted

CHILD CARE WORKERS/ HOUSEPARENTS
Needed to care for the daily needs of deprived children. We are looking for resident child care workers to join our multi-disciplinary team. Preference will be given to Jewish applicants who are matriculated. Full board and lodging, pension fund, medical aid. Salary negotiable. In-service training is provided. Please telephone 011-728-6124 for further details.

WYLIE HOUSE CHILDREN'S HOME
Live-in child care worker required for small European children's home. Previous experience preferable. Age between 25-55 years. Please telephone the Principal on 031-21-0837.

Situations Vacant

Child Care Worker seeks position, residential or non-residential, in Cape Town area. Contact Rossina Wisniewski on 021-24-4624 during office hours.

Experienced Child Care Worker, 26-year-old male presently studying at Unisa, seeks child care position in Cape Town area. Write to G. C. Voller, 2 Jonro Court, Nicol Street, Tamboerskloof 8001.

Handling Sexual Abuse in Residential Care

Jean Wright, Cecile Frankel, Susan Crafford

Jean Wright is Director of Guild Cottage, Johannesburg. Cecile Frankel and Susan Crafford are Social Workers at Child Welfare Society, Johannesburg.

Introduction

Jane walked home from school. It was a nippy winter's day and she shivered in her thin school jersey. As she walked down the drive her tummy seemed to turn over. She couldn't quite remember what had happened to make her feel so ill. She walked through the hall on the way to the kitchen. There was Peter's shadow across the floor.

Jane remembered.

She ran to Nana's room and the tears and words poured out together. Peter had been to her bed the night before. He wanted to crawl in and hold her. He was sixteen and a large strong fellow. Jane was terrified. Would Nana please help?

Kelly was on his way from the shops, kicking the dust on the pavement, when Andrew the neighbourhood thug caught up with him. "I'm coming with you Kelly" he called. "I've got something special to show you!" Kelly's mind was on fire balls and he called "Come on then!"

When they reached the cottage Andrew pushed him into the toilet. It wasn't fire balls he took from his pants but his penis and forced himself on Kelly.

Pandora's box was opened. Sex abuse was part of the life-style of some of the children in our care. It was unthinkable that this could exist in our cottage home.

There was an explosion of feelings among child care workers and social workers alike. What kind of care were we giving? Most important of all how could we protect our children?

We were aware that thirty percent of children had come into our care having been sexually abused, usually within the family setting.

Thus another of our immediate concerns was that these children were acting out sexually in the home environment and tended to abuse other children. Few of the children in our care were thus untouched by sex abuse. The problem had been exacerbated and indeed required immediate attention. We needed to educate and strengthen the children in order that they could take responsibility for their own bodies and learn to recognise appropriate behaviour.

Our first step was to explore relevant literature on the subject (see bibliography at the end) and to consult with other professionals in the field.

In exploring the literature we realised that it was of prime importance that the team come to terms with their own feelings surrounding sex abuse. Our own value system had to be considered. Issues such as masturbation, sexual play with animals, sexual play with each other as well as sexual activity within the family or with a stranger, needed discussion.

The literature was helpful in providing a guide to a child protecting himself from sex play with adults not within the family setting. Incest is clearly a far more complex problem involving the *status quo* of an entire family. Can a child say "No" to an otherwise caring father?

The literature to which we had access did not plan any programmes for children already severely abused nor contain suggestions for children indulging in inappropriate sex play in a residential setting.

The team of social workers spent a great deal of time examining the above issues prior to working with the children to ensure that subjective feelings did not intrude.

It was with no small anxiety and trepidation that the problem was addressed. Ultimately it was agreed that in order to help, certain risk-taking was necessary and that possibly "forewarned would be fore-armed."

It was decided that the best way of strengthening the children to protect themselves was to give them the necessary information in a group setting.

It was also decided that handling the already abused child should also be attempted in a group.

The message we wished to convey was that bad touching and sex abuse were problems which could be discussed in a trusting environment. As with other problems such as alcoholism, stealing, etc. there was hope of a solution.

Our ultimate goal for the abused children was to enhance their self-esteem sufficiently in order that they could in fact live with their past experiences.

It was decided that a start be made with latency aged children as this was where the main problem lay.

Two group programmes were therefore developed. Similar areas were covered in each programme, one for prevention and one for known abused children.

The emphasis differed in that the prevention group was informative and instructive. The four sessions covered body parts, conception of babies, right and wrong touching, rights which belong to every person and the right to say "No".

The group for abused children was intended to be experiental and therapeutic. It included several stories told in the third person which were in fact based on their own experiences.

Characteristics of Sex Abuse Prevention Group

This consisted of seven children, who had not to our knowledge, been sexually abused. There were four boys and three girls. Their ages ranged from nine to thirteen years. They were regarded as emo-

Moenie Stilbly Nie!

Oralee Wachter
Afrikaans: Elsabe Steenberg – Tafelberg R7.50

'n Hardebandboekie wat bestaan uit vier kortverhale, gerig op kindermolestasie. Dit is in eenvoudige Afrikaans geskryf en groot gedruk. Maklik leesbaar vir kinders vanaf ses jaar oud. Die boekie is mees geskik vir jonger kinders in relatief aangepaste huishoudings.

Moenie Stilbly Nie is besonder geskik om gebruik te word as voorkomingsmaatreël en kan voorgelees word vir 'n kind, of selfs 'n groepie, van vier jaar en ouer. Die oogmerk sou dan inisiasie van bespreking wees. Alhoewel die verhale kort en redelik omsigtig is, kom die punt tog duidelik oor.

Hierdie boekie is waarskynlik te naïef om gebruik te word in situasies of gemeenskappe waar seksueel afwykende gedrag soms reeds aanvaar word.

Renée van der Merwe

tionally of latency age development although chronologically four were approaching puberty.
All these children were of normal intelligence except one was dull and receiving special education.
Five of these children were in regular contact with their families, two were being hosted.
Of the seven children, four were considered to have a positive prognosis in terms of future coping skills while three were considered negative in prospect.
This group was led by a team of three social workers. There were four 45-minute sessions held twice a week for two weeks, in the social workers' office, a venue known well to the children. All four sessions were videotaped.

Characteristics of Sexually Abused Group
This consisted of six children, two girls and four boys ranging in age from eight to thirteen years.
Four of the children were resident in Johannesburg Child Welfare Society's Cottage Homes.
Two children, siblings, were in the care of step-parents. They had been released on licence seven months prior to the group.
Three children were tested at normal intelligence while the other three were dull and all were classified for special education.
As mentioned above two of the children lived with their families, one had limited contact and three had no contact with families of origin and no regular hosts.
Five of these children were markedly disturbed and only one child, a boy, was thought to have a positive prognosis for his future.
This group was led by the same team of social workers. There were six sessions held over a two-week period, once again in the social workers' office. Four sessions were videotaped.

Assessment and Emerging Trends
Sex abuse prevention group
- The children were very involved. They came punctually and enthusiastically throughout the four sessions.
- They sat up and listened and maintained eye contact.
- The body parts were quickly memorised.
- Some of the more abstract information was handled well.
- All the children, except for Jane (quoted at the beginning of the article), participated in the discussion.
- They verbalised easily and their comments were spontaneous and appropriate.
- At certain stages they were embarrassed but the giggling soon subsided as their interest mounted.
- Trust between them and the leaders appeared to be easily established.
- The group was enjoyed by children and leaders alike.
- The social workers left the group with a sense of achievement.

The children were asked several weeks after the groups were held if they would like to continue and their spontaneous approach was in the affirmative.

Sex Abuse Group
- The children were initially involved. The siblings were fetched from their home for each session and returned thereafter.
- The group was seldom punctual and arrived in the room with hyped-up feelings. Often they had to be called from their rooms.
- They had difficulty in verbalising and could not maintain eye contact.
- Their comments were often irrelevant and even bizarre.
- They had great difficulty in learning and retaining any information other than parts of the stories read to them.
- Looking at the pictures of a naked body and unborn babies proved uncomfortable.
- As the group sessions proceeded a lethargy developed in the children which was reflected in the leaders.
- The leaders found the process onerous.
- Body language appeared to be the only method of real communication. They indicated a need to touch and hold, to move around with their hands or actually stand up and turn away.
- One child acted out masturbation while another assumed the foetal position.
- There was no spontaneous emotion, and lack of trust both between the children and between the leaders and children was very evident.
- The "unsaid" clearly governed and inhibited the group process.

Evaluation
It remains to be noted that the first group, which had a primarily intellectual focus and was largely educational appeared to achieve the goal of assisting children to become aware of the right to care for themselves physically. This programme will be used again or included in other group sessions.
A similar sense of achievement was not experienced with the second group.
In the first group the children, except for possibly Jane, were, to our knowledge, not normally abused, nor were they being abused.
In the second group, as far as we knew, all the children had suffered sexual abuse and most of them were indulging in abnormal sex play within the residential setting.
The following deductions regarding the abused group are subjective and cannot in any way be regarded as a definite guideline in working with children who have been and are being sexually abused:
- The group was composed of children who were damaged and their reactions were therefore more primitive, leaning heavily on body movement for communication.
- The sense of loss intrinsic to sexually abused children exacerbated the feeling of low self-esteem and inability to trust.
- There was resentment of the two children brought in from the community and a resistance to them in the group.
- The real issues were never handled due to unresolved attitudes of the leaders and the notion that following a set programme would encourage feelings of security in all concerned.

Future Plans
1. As stated above Group No.1 will be used again in its entirety or included in other group settings.
2. Group No.2 will be repeated with other children with a change of format.
(a) The focus will be more therapeutic and less educational.
(b) The pace will be slower and geared directly to the needs of the children.
The leaders, from knowledge gained in one-to-one counselling with the child and from consultation with child care workers, will discuss every possible issue which can arise in the children's sexual activities. In this way confidence will be gained in handling the problems with the group. Children should be more thoroughly prepared for the group prior to the start of the programme. To this end all children should have individual counselling reoßsding their abuse before and after the programmes. The groups should be more actively orientated – puppets, family dolls, and drawings should be freely used. The current abuse being experienced within the residential setting must be handled in order to establish any form of trust.

Conclusion
There is undoubtedly a value in developing specific programmes to help children in care to protect themselves. However, this should be undertaken in a milieu therapy approach where everyone involved with the children concerned plays a role and is informed of the process.

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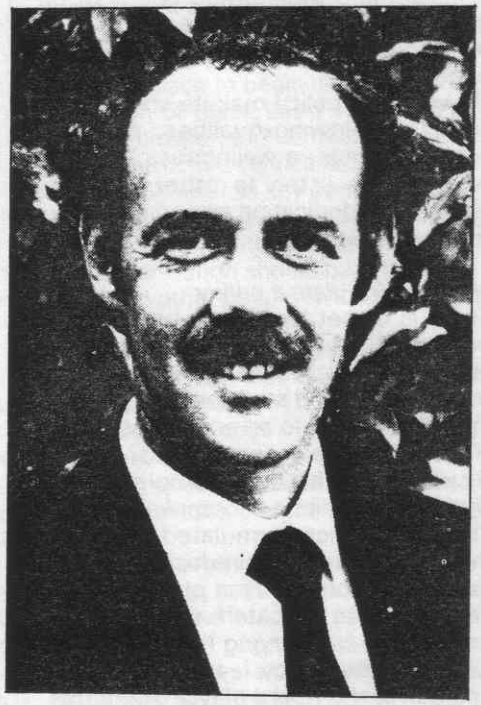
Management Principles in Children's Homes

Ernie Nightingale



Ernie Nightingale

The first of two articles by Ernie Nightingale, National Chairman of the NACCW and Principal of Ethelbert Children's Home in Durban

The not-for-profit organisation has a different "bottom line" from the profit-making organisation. The ability of the non-profit organisation to survive is not immediately based upon how well it performs its service, but rather on its ability to convince its constituents that it is doing what it claims to be doing. If the management of a health club is not careful about the amount of money spent on services and maintenance, the club could go out of business. On the other hand, a children's home can perform in the same negligent manner and continue to survive.

The public has a much more difficult time assessing the value of the product of a children's home. Who can place a value on a human life, or measure the effectiveness of caring? Children's homes deal in intangibles, which, though they may have a far-reaching impact, are difficult to immediately evaluate.

This raises the question: "Are Boards of Management of children's homes any less responsible to the general public than a Board of Directors to its shareholders?"

The Children's Act defines a Board of Management as consisting of "not less than seven persons". No attempt is made to define any criteria or qualifications for these persons who are legally entrusted with the well-being, care, protection and bringing up of children. In reality this means that members of a Board of Management are volunteers – people who are (1) not paid for their work, (2) who know that *they don't have to* do the job for a living, and (3) can therefore quit at any time they like.

The functions of a Board of Management can best be summarised under three main headings: Policy Making; Overall Control; and Fund-raising.

Policy Making

The basic causes of many of the problems experienced in children's homes can be traced back to this important function of the Management Committee. Children's homes which have no policy to work to, or an outdated and irrelevant policy, or one which continually changes without any previous evaluation or forward planning, doomed to experience hardship and trouble.

General trends in child care in South Africa seem to suggest that Boards of Management pay scant attention to the *formulation* and *review* of their policy. The effects of this are particularly noticable in the following areas:

- children's homes still being regarded as the "local charity down the road";
- the "cap-in-hand" public approach and attitude of the institution;
- the general impression in the minds of the public that anything is good enough for the "poor kids" in the home;
- the failure of Management Committee members to transfer those principles and practices they would consider essential in their professional or commercial activities to the functioning of their voluntary activities;
- a failure to render adequate services in the face of limited resources; and
- the inability to render services appropriate to the needs of the clients.

These can be best summed up in what may be referred to as *bad marketing policy*. Children's homes are guilty of feeding the public with soppy, emotional tales of deprived children and totally fail to make known the range of services rendered by them. This bad marketing allows the public to see the child as the object of its sympathy instead of seeing the institution as the vehicle to his recovery.

Children's homes are guilty of feeding the public with soppy, emotional tales of deprived children.

The policy of a children's home should be a mutually agreed upon statement of the *course of action*, or a statement of intent, which the institution will follow in order to achieve the desired results.

The effectiveness, or otherwise, of the services rendered by the children's home in meeting the needs of the *current* population of children should be the criteria used to determine the validity of the policy. Constant review and assessment is therefore an important function of the Board.

Policy makers should possess at least *one* of the following qualifications:

- a working knowledge of the law and related legal requirements;
- a knowledge of relevant child care literature;

- an understanding of the needs of children and their families;
- insight into the staffing needs of organisations and institutions;
- financial and administrative knowledge.

However, *all* policy makers should possess the following qualities: an openness to change; a willingness to learn; an ability to listen to other points of view; and a dedication and commitment to the institution.

How to formulate a policy
There is no set formula to be followed, but the following questions should be answered in satisfying the requirements of a sound statement of policy:
What is the task to be accomplished?
How will this be accomplished?
By whom will this be accomplished?
By when must it be accomplished?
The policy, once formulated, becomes the instrument against which the *task* is measured. This policy is presented and interpreted to the staff who are then responsible for carrying it out. The execution of the policy leads to the next function of the Board of Management.

Overall Control
Overall control implies the *delegation* of certain powers and duties to paid employees. All too often Boards see delegation as being the end of their responsibilities and delegation of authority and responsibility becomes an abdication of committed involvement. However, delegation in fact implies continuing responsibility and accountability.

Boards of Management are accountable to the general public in the same way as a Board of Directors is accountable to its shareholders.

Boards of Management are accountable to the general public in the same way as a Board of Directors is accountable to its shareholders. Members of the public support a non-profit organisation for altruistic or religious reasons. They *expect* the institution to do what it says it does. Accountability to the public means *informing* them of the work being done. This is an on-going process during which reports are given on the state of child care, the range of services rendered, the results of these services, the expectations and plans of the institution.
Fiscal accountability is thus presented against service delivery and not as an expression of an emotional response to the plight of troubled children.
Boards of Management are also responsible to their clients, i.e. the children and their families. Welfare authorities place children in good faith, believing that the institution is able to deal professionally with the demands of each case and that what is "in the best interests of the child" is the criterion against which all work is done. Overall control means *knowing* what is "in the best interests"; ensuring that professional standards of care and treatment are maintained and that evaluation of the effectiveness of the services is undertaken; holding employees accountable for effective service delivery.
Overall control also means being responsible to one's employees. It is a sad fact that most individuals who work in residential institutions for any length of time come away from the experience debilitated rather than inspired. The amount of job satisfaction they receive seems to be inversely proportional to the size of the institution. Key people in small well-run institutions may have most feelings of self-esteem and feel they are making a real contribution to child care, while workers in large institutions often feel used and unappreciated. Responsibility to employees ensures having clear, attainable goals and expectations for them; a "people policy" which cares for the individual; staff training and supervision programmes; clear lines of delegation and a system to maintain the self-esteem and respect of each employee.

Fund-raising
It has almost become the rule, rather than the exception, that ineffective service delivery and poor management practice are explained away under the disguise of "limited resources". The use of "resources" as an excuse has become a popular way of evading the real issues and such limitations become excuses rather than areas needing special attention and extra work. Funds are available, but they have to be obtained through careful planning and lots of hard work. The attitude of members of Committees towards welfare clients needs to change from one of sympathy to that of "clients deserving real effort" in order for fund-raising to become a stimulating and challenging function of Management. The preparation of budgets and provision of adequate funds for the task remain vitally important tasks of every Board of Management. The present system of State subsidy is perhaps one of the major *demotivators* in regard to fund-raising. The subsidy system which provides 100 per cent reward for poor service delivery totally fails to provide incentives or motivation for any improvement. A subsidy system based on a *per capita* amount as opposed to one linked to staff design and service delivery tends to encourage the "limited resources" excuse referred to above.
Boards of Management who are committed to good child care have to work that much harder at raising the extra funds needed.

The present system of State subsidy is perhaps one of the major demotivators in regard to fund-raising.

Excuses, Excuses
There are many excuses. The most common excuse used by children's homes is "what can you expect from a non-profit (charitable) organisation?" or "we just can't afford the best people. What can you expect for the salaries *we* pay!"
Yet, non-profit organisations can be competent, but if they are, it is because the people within the organisation are *competent*. Organisations can develop right ways of doing things, ways which can be handed down from person to person. But even knowing how to do something the right way is not adequate if the individual to whom the task is given cannot carry out the task. Management is all about people. Management has been defined as the act or science of getting work done through people. But management is not just *getting* people to do things. It is *helping* people to do things, to grow more proficient and so to feel better about themselves and what they contribute. Inherent skills, talents and gifts need to be nurtured, developed and matched to the task at hand.
The competent organisation needs to build itself up. This means that the individuals, volunteers and employees should be working for the good of the whole. People grow. Organisations grow. People change. Organisations change. Growth and change require constant review and adjustment. Competent organisations cannot be static organisations.

How to Get Competent People
The following guide, slightly amended to suit children's homes, was offered by World Vision for the recruitment of volunteers in a religious organisation. In its amended form it makes sound sense for the selection of Committee members as well as for the appointment of staff.
Purpose: You can't decide what kind of people you need until you have clearly defined what it is your organisation is about. What is its fundamental purpose? (Refer to Policy Making).
Objectives: There are some long-range things that your organisation must do if it is to fulfil its purpose. What are they? This is the major weakness of most not-for-profit organisations. Child care workers are future-oriented people – working towards goals that will be realised in years to come. But we have to decide specifically what it is we are to *accomplish*.

Organise: Our organisational structure should reflect our objectives. It will indicate to us the natural formations and work groupings. When is the last time you sat down with your organisation chart in front of you and asked, "Does this organisation make sense in light of what we are trying to accomplish?"

Position Description: The trouble with most job descriptions is that they only describe things like "responsibilities" and "accountability". That's fine. We need those things defined. But the primary purpose of a job description should be to describe the objectives of the individual working in this area. The higher up we move in the organisation, the more important this becomes. What does this job description tell you about the skills and gifts the position needs?

Selection: Much has been written on all of these topics. The biggest failure in selecting people is not taking the time to get that *fit* which is part of the definition of competence. There is an interesting psychological factor at work here. Often we find someone who at first glance looks just right. We spend time and effort learning more, talking to the person, perhaps even doing some convincing about why this person should work with us. About the time we are ready to make a formal invitation, some clouds appear on the horizon. We see some areas of weakness. But we have made such a high emotional and time investment that we go ahead anyway, hoping for the best. It takes a great deal of energy, and often a lot of courage, to keep working until we find the competent person.

Standards: Most people will respond to the expectations of their leaders. If the leader has high expectations of the person, so will that person. If the leader doesn't expect much, chances are neither will the person. Expectations are communicated through standards, descriptions of what is to be done and how it is to be done. This is one of the most difficult of management tasks. Good performance needs to be reinforced. Less-than-adequate performance needs to be noted and plans to correct it carried through. It takes time.

Delegation: This is really the other side of the standards coin. If delegation is assigning work to people and management is accomplishing results through others, they are not much different. Delegation assumes that part of the work can be done more effectively by someone other than the delegator. It assumes that the one receiving the delegation is competent to do the task delegated. Delegation takes a lot of time. It often seems easier to do it ourselves, rather than ask someome else to do it. But when we fail to delegate, we are in effect working at a level *less* than our own competency, while depriving someone who is competent of the opportunity to do what he does well.

Training: Talked about a lot, isn't it? But somehow it seems that it either costs too much, or we don't have the time. Gifts need to be sharpened into skills. As the nature of the work expands, the people must also expand.

Summary

The best place to begin is *to begin*. The execution of these basic steps will set the organisation on the road to creative and constructive service delivery.

- Bring together all key people who can lead others. Ask them to start thinking and dreaming with you about where your organisation should be going.
- Bring in other people who can contribute to the planning.
- Set goals and priorities.
- Analyse what steps are needed to accomplish the goals.
- Estimate the cost – in people, money and time.
- Assign specific people to the tasks.
- Communicate the goals in every possible way.
- Remember you are in a process.

Generally, but not always, the Board of Management should not legislate or direct the "how" of professional practice. This aspect of management is left to those who have the knowledge, training and expertise in child care, social work and similar professions and I shall be dealing with this in the next article. However, the methods which are used by the professionals must conform to the overall policies of the institution. This must be managed by the Board.

INTERVIEW

The New Child Care Act

The new Child Care Act came into operation on 1st February 1987. The Child Care Worker interviewed Helen Starke, Director of the Cape Town Child and Family Welfare Society, on points of interest to child care institutions and staff. Numbers in brackets refer to the relevant sections of the Act

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CCW: The Draft Child Care Bill was published in 1981 – and now only in 1987 has it been enacted. Why, do you think, the delay?

HS: There are two major issues faced in the new Act which have probably drawn a lot of comment. The first concerns certain provisions for the adoption of children without the consent of their parents (19), and the second is the mandatory notification by dentists, medical practitioners or nurses of suspicion of child abuse (42). Also, if one compares the Act and Regulations with previous Drafts, one can see many alterations, omissions and refinements which have no doubt taken time to effect.

CCW: Adoption without consent of parents is one section to have undergone several changes from the Draft Bill.

HS: The Draft Bill did away with the necessity for parental consent if a child was not returned to the parents within one year of the court order or if the parents failed "to maintain regular contact with that child". In the Act (19), parental consent is unnecessary if the court order (which has a maximum duration of two years) has been extended by the Minister beyond the initial period. The effect of Section 19 then becomes dependent on the period of the order. What is important is that the Act places the best interests of the *child* first, and makes the distinction possible between biological parenthood and psychological parenthood. This has probably been a significant philosophical bridge to cross.

Helen Starke

CCW: The period of an order thus can be shorter than two years?
HS: The Act (16) makes provision only for a *maximum* period of two years, and I think that some of our thinking about permanency planning has found a place here. Social workers should, in my view, not allow a two-year order to be made by default. For example, for a baby they could recommend a shorter period and thus introduce some urgency into the planning for a child. Not that, on the other hand, there should be any undue pressure to have a child adopted – either for idealistic reasons or to save the state money! We will all have to explore the workings of the new Act, but these are new flexibilities for us to be aware of.

CCW: The emphasis has moved away from "the child in need of care" to the inability or unfitness of parents.
HS: This is indeed a change. The old Section 1(x) "list" has been replaced by a Section 14(4) "list", but this time focussing on the parents. A child is no longer "found in need of care"; his parents or guardians are now found "unable or unfit to have the custody of the child". It is an important change of emphasis, since it clearly places troubled children within the context of their parental homes. The implications for child care work are that whereas your clientele was formerly tidily defined in terms of Section 1(x) of the 1960 Act, now you will have a far less static and more process-oriented definition – and in line with the whole idea of contextual or ecological treatment. The Draft Bill, interestingly, used the term "foster child" to include children sent to children's homes, but this is not retained in the Act. Other changes of nomenclature are of interest. Children may be sent, admitted or transferred to, received or placed in, but no longer *committed* to children's homes. The old term "CCE" for Children's Court Enquiry will have to be modified since the new Act refers to an Inquiry!

CCW: How else is child care work directly affected?
HS: One important aspect is that the treatment role of children's homes is confirmed. Regulation 31 makes it clear that proper arrangements must be made "for the treatment of the children in the children's home by a social worker, medical practitioner, psychiatrist or psychologist when such treatment is necessary", and that a separate file should be kept for each pupil to contain, amongst other things, "the treatment plan for the pupil and any evaluation reports in regard thereto". So the Act expects active consideration to be given to more than custodial functions of the institution.

CCW: The Act begins by establishing a Child Welfare Advisory Council.
HS: In fact the Act has been promulgated without this chapter being put into effect. It's hard to see why further structures are necessary to advise on Child Welfare. In one respect, since half of the maximum twelve members of this Advisory Council (2) will be representatives of the different state departments, this could be little more than an interdepartmental committee with limited room for wider representation of the child welfare field. This is also only an *advisory* council, and I am not sure that it will be able to bring much order out of the chaos of different policies in different departments. On the other hand, though there is already an interdepartmental committee on welfare, perhaps one which gives full attention to child welfare would have advantages. One positive aspect related to this is that so far there is only one set of Regulations, and these have been issued in the name of the General Affairs Minister, and hopefully we will continue to have only one set of Regulations.

CCW: Do children's rights find any expression in the Act?
HS: To some extent, yes. In the case of adoptions the court will not grant the application unless it is satisfied (18) "that the child, if over the age of ten years, consents to the adoption and understands the nature and import of such consent". Further, a children's court cannot grant an adoption unless the proposed adoption will serve the interests and conduce to the welfare of the child. Corporal punishment of girls is not permitted, and may also not be inflicted on a boy in respect of whom a social worker, psychologist or medical practitioner has forbidden such punishment. In any event, corporal punishment may only be inflicted in the presence of a person designated by the management. It is interesting that isolation, confinement, and refusal of leave are prohibited as forms of punishment by the Regulations. Further retention of a child who has attained the age of 18 requires his consent with that of his parents. A person of 18 can give consent for an operation or any medical treatment on himself. By the way, it is important to note that a social worker as referred to in the Act is one working for a state welfare department or a family welfare society and not a children's home social worker.

CCW: Regulation 32(1) is an innovation in respect of children's homes.
HS: It is unusual since it seems to list, in a very legalistic way, the offences for which children may be punished, and it raises the humorous image of a naughty ten-year-old being told to miss his pudding because "without the consent of the owner thereof you appropriated, used or intentionally or through gross neglect damaged or destroyed" Johnnie's balloon! But seriously, it appears to make a legal requirement of good, middle class behaviour from children who in many cases are in the institution to be helped with their behaviour disorders.

CCW: It seems a much slimmer document than the 1960 Act.
HS: It is shorter. The section on adoption is streamlined. The sections relating to the appointment of probation officers and to schools of industries and reforms schools in the 1960 Act are not repealed by this Act and would thus form part of a consolidated Act. The old Section 83 providing for temporary custody is not included, so the children involved in divorce proceedings are not covered in this Act, which is a failing since such custody now has to be decided in the Supreme Court, which is expensive.

CCW:Do you foresee any problems with the implementation of the Act?
HS: I think that as with any legislation, we must work with it and test it. Probably there will be a number of amendments in the early years as it becomes fine-tuned, but it is refreshing to have new legislation and I think our task will be to use it creatively and according to its intentions. The danger is that social workers and children's homes could just continue as before. For example, the Draft Bill provided for the lapse of a court order after a maximum of two years, and a new court order was necessary if further retention was sought. However, the insertion of Section 16(2) in the Act allows the Minister to extend the period of a court order as with Section 46 of the 1960 Act, and it would be a pity if such "loopholes" resulted in the intentions of the new Act being ignored.