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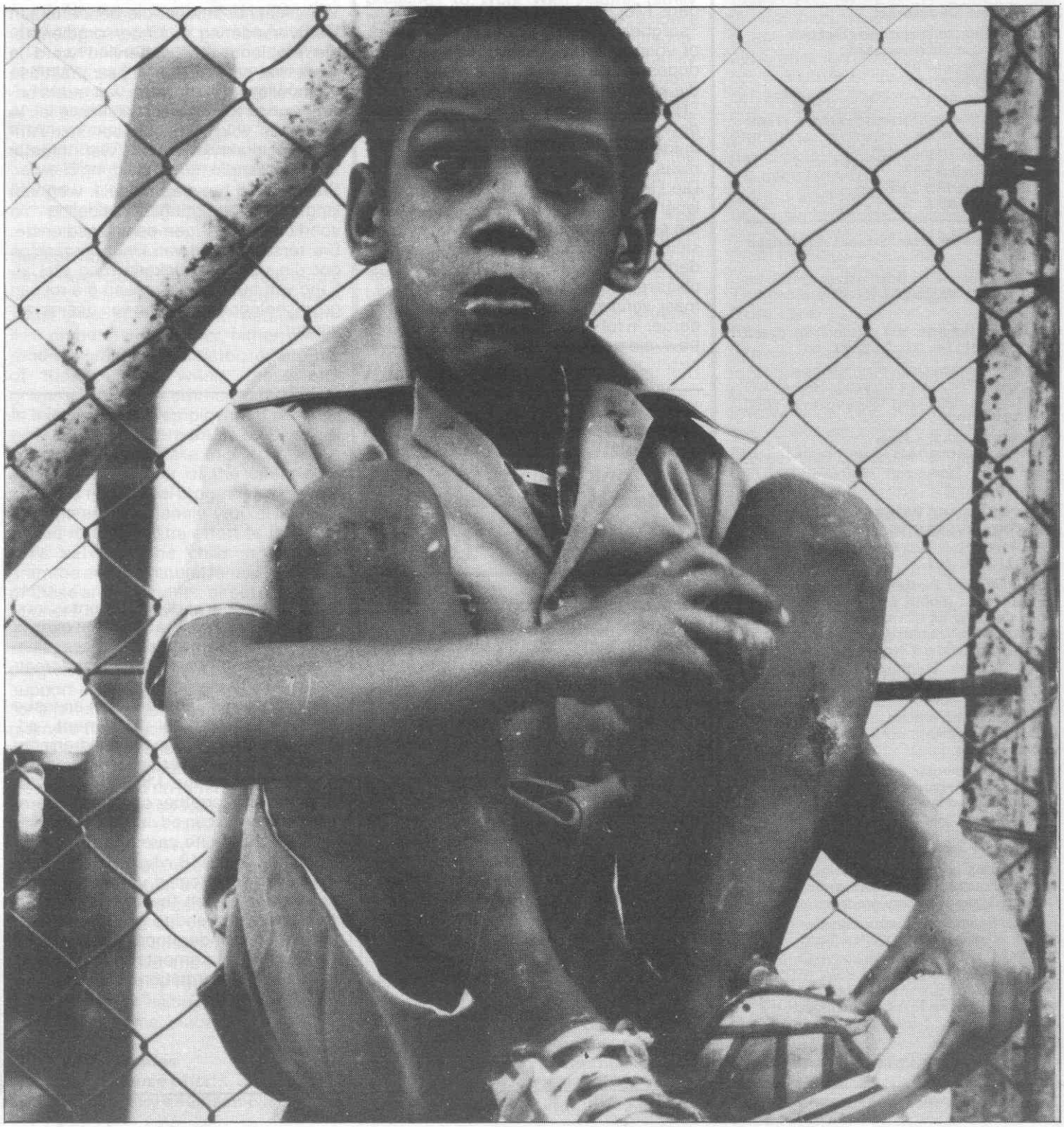
The child care worker



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Redaksie

Kinderhuise en Gesinne: Plaasvervangers of Hulpverleners?

In haar gesprek met *Die Kinderversorger* in ons Februarie uitgawe het Helen Starke die aandag gevestig op Artikel 14(4) van die Wet op Kindersorg (1983) wat Artikel 1(x) van die 1960 Wetgewing vervang. Laasgenoemde het die sorgbehoewende kind gedefinieer, maar volgens Mej Starke word 'n kind nie meer "sorgbehoewend" bevind nie; sy ouers of voogde word nou as nie in staat, of ongeskik beskou om die bewaring van die kind te hê. Sy gaan voort om te sê: "Hierdie is 'n merkwaardige klemverandering, omdat dit die versteurde kind duidelik in die konteks van sy ouerhuis plaas".

Die klem op die gesin reflekteer 'n belangrike internasionale verandering in die opvatting van die taak van residensiële instansies. In die verlede was kinderhuise geneig om as plaasvervangende gesinne op te tree, maar vandag word hulle uitgedaag om eerder 'n rol van ingrypig en rehabilitasie t.o.v. die gesin te speel.

Oor die volgende drie maande is ons van plan om 'n reeks toepaslike artikels oor hierdie onderwerp te publiseer. In hierdie uitgawe verskyn die menings van Frank Ainsworth en Patricia Hansen van Australië, en volgende maand 'n artikel, in Afrikaans, deur Diana Garland van die VSA. Albei bestudeer die behoefte aan klemverandering in kindersorgdienste, die probleme wat ondervind word in werk met gesinne, en 'n paar praktiese voorstelle vir programme wat ouers betrek en wat tot familierehabilitasie lei. In Augustus volg 'n oorsig oor Suid-Afrikaanse praktykmodelle wat hierdie kwessie aanpak.

Staatsbeleid beweeg duidelik weg van langtermyn inrigtingsbehandeling na voorkomende gemeenskapsdienste. Die tersaaklikheid van kinderinstansies oor die volgende dekade mag wel afhang van hul toewyding aan die rol van gesinshelper teenoor dié van gesinsvervanger.

The Association

The NACCW Position Statement on Children in Detention

Reaction to the Position Statement on Children in Detention in last month's issue made it immediately clear that the wording very inadequately conveyed the NACCW's underlying standpoints on the wider issues of detention without trial and the incarceration of children in adult facilities and upon which the Position Statement was based. This led many to interpret the statement as being "soft" on detention. It was not intended to be.

The covering letter under which the Position Statement was submitted to the Minister of Law and Order on 22 May 1987 stated: "At the 1985 Biennial Conference (of the NACCW) a motion was adopted to the effect that children should not be detained in any place other than a recognised place of safety and detention. Our view was that no circumstances should suspend our responsibility for the development and rehabilitation of children and that even in detention children should be accessible to accepted standards of care and treatment".

The specific issue-within-an-issue which the Position Statement addressed was access to the children concerned, and the covering letter went on to propose that the Minister consider "the drawing together of child care professionals who can advise and help plan for the appropriate care and treatment of children under 18 who are detained".

The authors apologise unreservedly to members who felt that they had been misrepresented and to colleagues who may have misunderstood the context of the Position Statement, and trust that the above information clarifies the NACCW's position.

Incorporating Natural Family Members into Residential Programmes for Children and Youth

Frank Ainsworth and Patricia Hansen

Frank Ainsworth is at present doing child care consultancy work in Australia after a period of teaching in Social Work at the Philips Institute of Technology. Author and co-author of several books and articles on child care, he is one of the most experienced people in the field internationally. Patricia Hansen is Chief Social Worker at Austen Hospital in Melbourne.

Background

Most agencies that provide residential services for children and youth make some attempt to work with natural family members; e.g. mother, father, grandmother, grandfather, sister, or brother of those placed within these programmes. Some common approaches to this include the employment of social workers or involvement of other social agencies to undertake this work. Alternatively, a member of the direct care staff in a residential programme may be designated as a family worker and required to make extra effort to maintain links between the child in the programme and the natural family. Under all of these arrangements, direct care practitioners in residential programmes are expected to be responsive to natural family members visiting a child in the programme. They are also expected to support a child planning to return home for a family visit or returning to the programme from such an event.

All of these practices have existed for many years, although increased emphasis is now placed on family work in order to prevent the need for permanent 'out of home' or 'out of family' placements. Studies which have shown children adrift in the system and in danger of permanent isolation from their family of origin have reinforced this emphasis. The importance of work with family members is also underlined by research which shows that the most important predictor of family reunion is the incidence of family visiting to a child whilst in an 'out of home' placement.

Work with families

In spite of all these efforts, disquiet still exists about the effectiveness of approaches to work with natural family members of children placed in residential programmes. Indeed attempts to involve natural family members in family meetings or family sessions, or more formal family therapy ventures, often meet with limited success. When this happens it is not unusual for direct care practitioners to take the view that the problem of engaging natural family members in this way, is the result of their own lack of professional skill. The adoption of this explanation may then lead to attempts to acquire training in specialist forms of family therapy in the belief that these skills will enable them to find more effective ways of working with the natural family members of the children in their care. However, once these skills have been acquired and taken back into a residential programme they are often found not to fit comfortably either into that context, or with the type of client families with whom these practitioners must work. Consequently those approaches are viewed as less effective than was previously considered the case or practitioners may leave the residential programme in order to work in a context where they think *real* family therapy will be possible. In the process residential programmes may be labelled as having nothing to offer the families of children in care.

It is suggested that practitioners in residential programmes already have a range of relevant skills which need to be adapted and utilised more fully in direct work with the natural family members.

The difficulties of working with family members, as outlined above, suggests that direct care practitioners need to develop ways of working which more easily fit their particular context of practice. Moreover, it is suggested that practitioners in residential programmes already have a range of relevant skills which need to be adapted and utilised more fully in direct work with the natural family members. This offers a more appropriate way to proceed than attempts to apply approaches that have been developed in other contexts, especially clinical settings. Such settings are vastly different in form from residential programmes. Before elaborating on the more constructive use of existing skills it is necessary to examine ways in which current approaches to residential practice may, however unwittingly, exclude family members from active involvement in the care process.

The exclusion of family members from care

All too often when a child is admitted into a residential programme, the agency and its practitioner workforce unwittingly exclude family from continued involvement with their own child. The too ready assumption is that because the child has to be admitted into care the natural family has failed and is no longer capable of offering any care to that child. This is especially liable to happen if the agency views residential programmes as providing substitute family care and uses the family as a model for the design of group homes. This model reinforces the exclusion of family members from the care process because of the way in which it encourages practitioners to view themselves as substitute parents.

Indeed such conceptualisations imply that direct care practitioners are now acting 'in place of' the natural family members rather than as partners with family members in the caring process. Under these conditions it is hardly surprising if the natural family members feel excluded and consequently show a limited willingness to be involved in family sessions or to maintain contact with their own child. It can be argued that the process when enacted in this matter, leaves them with few other choices. When the above occurs the family model, when applied to residential programmes, is "anti" rather than "pro" the natural family.

The inclusion of family members as partners in care

It can be argued that all family members,

irrespective of their limitations or personal difficulties, are capable of offering some care for their child. Whatever they have to offer should be given a prestigious place in any residential care plan, no matter how limited this may be. This requires that we recognise not only the difficulties family members may have, but most importantly those areas of skill or competence that they possess.

In order to incorporate the skills of family members into the care process it is necessary to review how we think about residential programmes, the function that they need to perform and the role of direct care practitioners. This demands a significant re-conceptualisation of residential practice.

The first step is to recognise that residential programmes, including group homes, are *open membership groups*, rather than family groups. In open membership groups there is regularly changing membership and involvement is invariably on a time limited basis. Such membership groups can offer important sources of personal security, identity formation, nurturing care, and socialisation opportunities. This group model more accurately reflects the true characteristics of residential programmes. Moreover, it reduces the temptation to try to artificially replicate the family unit which has, in fact, an entirely different set of features. When residential programmes are viewed from this perspective it is possible to dispense with the notion of group homes or other residential programmes as constituting substitute family care. Rather, such programmes can be seen as an alternative to various forms of family living or as a supplement to such arrangements. Indeed direct care practitioners can then begin to pursue actively the growth-enhancing dimensions of group living unencumbered by historically outmoded conceptualisations of the task of residental care services.

Under the membership group model the task of the direct care practitioner moves to one of *shared care* with family members. The practitioner becomes a partner with family members in ensuring that the natural family's child is cared for appropriately. In this senario, direct care practitioners become family support workers rather than substitute parents. In partnership with family members their task is to ensure that as much care as is feasible remains with the natural family. This is a position which is at the forefront of respite programmes for intellectually or physically disabled children, and which warrants wider adoption by the child welfare sector. This proposal implies that the natural family must be involved increasingly in the actual residential programme, undertaking child caring tasks alongside direct care practitioners. This involvement obviously requires agreement between natural family members and direct care practitioners, and must be the subject of clear negotiation at the point of admission of a child into care, and as a condition of that admission wherever possible. Only in this way will natural family members be sure of a continuing place in the care process and be able to engage comfortably with a residential programme.

Practical ways of working with family members

There are a range of practical activities in all residential programmes in which natural family members might be asked to be involved as their contribution to the continuing care of the child. These activities also cluster around some of the traditional areas of skill of direct care practitioners such as organisation of the care environment, use of everyday life events, and activity programming.

It is entirely practical to think in terms of a natural family member working with a practitioner around the admission of a child to care. The natural family member might assist the practitioner in ensuring that the bedroom to be occupied by the child is clean and tidy and that the child's personal belongings are carefully stored in accordance with the child's wishes. Indeed a family member might agree to help decorate a bedroom for the child, or to build a new bookshelf or toy cupboard for use in the child's bedroom. Such activities would not only help to *organise the care environment* for the child, but would give the natural family member an ongoing stake in that child's comfort. *Everyday life events* provide the arena for promoting a child's growth in terms of competence in a range of social and life skills. In this area a family member might engage with a practitioner around meal preparation, or the purchase of clothing for the child. A family member might be involved in discussions with the nearby school which the child attends whilst in the programme. The possible range of shared tasks is never-ending. Importantly, when these tasks are shared by practitioner and family member, they confirm the family member's ongoing responsibility for the care of their own child.

Finally, as an example in the area of *activity programming*, it is possible to conceive of a family member's involvement with practitioners in a range of recreational, or similar, pursuits. Camping weekends, seaside excursions, sports events, picnics and the proverbial barbeque, are all group activities to which family members can make a useful contribution. Such events often provide excellent opportunities for relaxed exchanges between practitioners, family members and children, that are educational in value and an immense boost to personal morale. Family members' involvement in such activities well and truly incorporates them into a residential programme and helps to maintain their links with their child.

This involvement of family members in the way suggested would help to resolve the often problematic issue of visiting. Family members would have a concrete reason for being in the programme and be able to demonstrate their value to the programme. The process would facilitate their acceptance of a continuing responsibility for their child. It would also help to reduce the sense of failure which is always felt by family members when a child is placed in 'out of home' care.

It can be argued that all family members, irrespective of their limitations or personal difficulties, are capable of offering some care for their child.

Practitioners as teachers

The incorporation of family members into residential programmes provides an occasion for practitioners to obtain information about how family members engage with their child. It allows direct care practitioners to monitor these exchanges, and if appropriate, to intervene and teach parenting skills to the actual family members. The exploitation of available opportunities for direct care practitioners to undertake these teaching tasks is grossly underdeveloped. If practitioners pursue these avenues and take on the teaching role it is possible that the current impasse in relation to attempts at family work may be overcome. By selecting the involvement of families in programmes as the mode for working with families, the format is one which suits the context of residential practice. This then uses the unique features of residential programmes in a positive way.

Dilemmas in implementation

Clearly any proposals for incorporating family members into residential programmes in the manner suggested have resource implications. Whilst the new mode of practice will utilise family members as resource persons, it will also make additional demands on practitioners. In this regard agency administrators will need to review and upgrade staffing allocations to programmes in order to support this type of service development.

It will, of course, be tempting to simply increase expectation of existing staff and not add new resources. If this occurs, failure to implement those new ways of working with natural family members is likely to occur. Because of

resource constraints it will also be tempting to argue that new modes of practice cannot be developed since no new resources are available. In this respect it is worth noting how, in regard to respite programmes in the field of physical and intellectual disability, this has not proved to be the case. In fact, a commitment to a service model which encourages natural family members to continue to be involved with the care of their children, rather than to totally abandon them to the care of others, and a firm 'value' position which supports this, has resulted in the argument for increased resources being fought and won. The message is that strong commitment to this new mode of practice by the child welfare sector is a precursor to effective resource acquisition.

It is possible to dispense with the notion of group homes or other residential programmes as constituting substitute family care.

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Movement Therapy

Michelle Lingér

Michelle Lingér is a child care worker at Friederich Schweizer Kinderheim in Cape Town

When it was discovered that one-on-one therapy was not having the desired effect with a certain group of our children who exhibited communication problems and tended to act out non-verbally, we decided to enlist the help of Annie Fiske, a well-known movement therapist.

Over the course of the next ten weeks, her little group awoke from their emotional hibernation and tentatively reached out. It was quite apparent from the start that the common denominator amongst these children was a poor self-image, underlying anger, weak boundaries and inappropriate behaviour, e.g. overly anxious to please, displacement activities, minor self-destructive behaviour.

I was invited to attend these sessions so that I would be able to monitor and contain any problematic behavioural aftermath that might occur after a session, as a result of the therapy causing a child to become quietly introspective but then to act out later against these feelings.

They could rock, cry, laugh, roll up in a blanket or just sit and stare.

Our first session was a mixture of vibrant excitement, anxiety and a good deal of curiosity. As we progressed, we developed our own comfort zone; a place where the children found it permissible to be themselves, without repression and without labels. They could rock, cry, laugh, roll up in a blanket or just sit and stare in this ever-protective cocoon where there was unconditional acceptance.

Annie arrived every Monday afternoon armed with a variety of tapes, tape recorder, books, a very large blanket, paints and plaster of paris. The children stamped and shrieked to the rhythmic beat of African music, sat wide-eyed listening o wonderful stories of bunyips (little animals that crept into your imagination) or in moments of sadness just sat and pondered as to why they were here in a children's home. The lilting, melodic strains of Debussy and Vivaldi accompanied the hugging exercise — each child hugged or was hugged in turn by another. I was particularly moved by the warmth and intimacy that accompanied this particular movement. As the music wafted soothingly, eyes closed and thumbs crept mouthward and a ubiquitous sense of peace enfolded us all.

The making of masks was a highlight for most. Classical guitar music (Requiem for a Dead Child) lamented softly in the background while the children lay perfectly still and Annie and I applied the wet plaster of paris and moulded it to their faces. Once the moulds had hardened, the children had their own masks which they could then paint as they saw themselves.

I have no doubt that Annie, with her gregarious, outgoing, uninhibited, laughing personality has somehow, through the deep perceptual and conceptual empathy that she has shared with our children, brought home to them the fact that life is so often filled with pain, but that it need not be forever. Using the movement therapy technique has had far-reaching results for our children, the most important being, I feel, the experience of unconditional acceptance and tolerance for all.

Books

Stress Management

Peggy Roggenbruck Gillespie and Lynn Bechtel

LESS STRESS IN 30 DAYS

An integrated program for relaxation

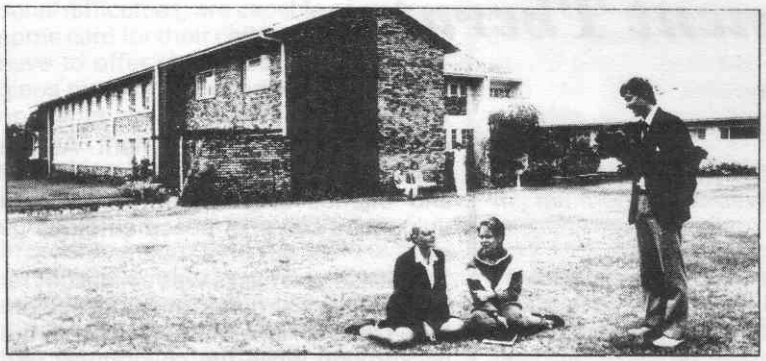
A Plume Book from the New American Library

Less Stress in 30 Days is a stress management programme which includes excercises that can be integrated into any daily programme.

There are checklists and charts to help identify the causes of stress and how it affects people. It assists one in identifying one's own stress buttons and in how to work through tension. The daily programme can be completed in 15 minutes, and includes muscle relaxation, breathing and visualisation techniques.

The programme is very simple to follow, direct and of immediate benefit. All the techniques can be used individually or in a group situation. This programme could be used with a group of children who are very tense and angry and could assist in the improvement of self-control.

RvdM



HS VAN DER WALT HIGH SCHOOL, PAARL

In response to our recent request for "home visit" articles the following was kindly submitted by the Principal, Mr J.H. Wessels.

Inception and Purpose

H.S. van der Walt High School resorts under the Department of Education and Culture, Administration: House of Assembly. It was founded in 1915 to protect and educate girls who had been declared in need of care and is the oldest child care school in the country built for girls.

The school provides for the re-education of a maximum of 180 girls between the ages of approximately 12 to 21 years who, according to the Child Care Act (Act 74 of 1983) have been found to be in need of care and, either committed to the school by a Commissioner of Child Welfare, or transferred there by the Minister of the Department of Education and Culture or the Minister of Health and Welfare.

Surroundings — Grounds

The institution is situated in Paarl on 12ha of ground lying between the Berg River and the hospital. Apart from the 13 well-equipped classrooms the school has a library and a hall which doubles as a gymnasium. Plans for extending the present facilities have been approved. The girls are acommodated in 5 hostels of 36 girls each. Each hostel is controlled and administered by a senior housemother, assisted by a housemother and prefects. The latter sleep in single rooms, while the other girls share 3-bed and 5-bed rooms, spacious enough to give each a reasonable amount of privacy. Each girl has her own built-in cupboard. Independence as well as a sense of self-pride and achievement is encouraged by making the girls responsible for their personal appearance, clothes, cupboards and rooms and by giving them specific duties. The girls gladly take part in making their hostels more homely. Each hostel has recreational facilities such as a television set, piano, hi-fi, tabletennis set, etc. Newspapers and magazines are delivered daily while each hostel also has its own flowerbeds and lawn.

The hostels are provided with fruit from the school orchard. The grounds, enhanced by lawns, evergreen shrubs, flowerbeds, shade trees and benches are well cared for and have often been admired by visitors to the school.

On the grounds there are three netball courts, three tennis courts, a practice wall, an athletics field, a hockey field as well as a swimming pool and change rooms. The principal, deputy-principal, a head of department and a psychologist live in houses on the grounds.

Philosophy

By encouraging each pupil to take part in the variety of activities offered, the school aims at developing her as a whole person, always bearing in mind her personal needs and individual potential. By giving her a career-orientated education, a healthy religious, moral and social awareness, and by improving her health by means of guidance, correct eating habits, exercise and games we make it possible for each and every girl to become an honest and useful member of society.

Courses Offered

The standard 6 and 7 pupils receive tuition in the basic subjects: English, Afrikaans, Mathematics, General Science, History and Geography. During these years they are also introduced to Accountancy, Typing, Needlework and Clothing and Home Economics, optional subjects for the Senior Certificate from which they will have to choose for standards 8-10. The school psychologists assist them in making their final choice using aptitude and interest tests where necessary.

Pupil receiving remedial tuition.

External Activities
Sport — Sports such as athletics, cross-country, swimming, tennis, netball and hockey are organised on an inter-hostel and inter-school level. Matches are regularly played at home and away. These provide the necessary opportunities for making and maintaining social contact with the outside world. Participation in sport is compulsory for all those who are medically fit.

Cultural — Orators' contests are held and the winners go forward to take part in inter-school competitions as well as in the annual Paarl Eisteddfod. Some of our girls have done very well in this field. Inter-hostel debates are held once a term in the school hall. Our school choir takes part in the annual song festival organised for all the schools in and around Paarl. They also perform at church services as well as school and local functions. Modern Dancing and Drama may also be taken extramurally.

Deserving pupils may take Textile Design, Fine Art, Jewellery Design or Pottery at the local art centre. Educational and cultural excursions are arranged to the Nico Malan Theatre, Oude Libertas Amphitheatre, etc. to see plays, operas and ballets. Hobbies are encouraged and the girls must practise one from a variety of courses and activities offered once a week. An exhibition of their handwork is held once a year.

Religious Practice
Religious instruction and practice forms an integral part of the school life. This is done not only for the sake of religion but to foster and develop a moral awareness in the girls. On Sunday mornings the girls attend the services and confirmation of the churches to which they belong. One period a week is set aside for religious instruction while the ACSV and the Assembly of God church have weekly bible study groups. Should a pupil need spiritual guidance or help her minister is approached to counsel her.

Supportive Services
There are three full-time psychologists on the staff. They are responsible for the orientation of new pupils, psychological testing and the placing of pupils in the most suitable courses and standards. They have interviews with the pupils, deal with any personal problems and provide career, marriage, and family guidance. If necessary they help pupils find work once they have left school. Two remedial teachers provide professional help for pupils with learning disabilities. The nursing sister deals with all medical problems and advises the girls on family planning. She also renders first-aid when necessary while a district surgeon has a clinic at the school regularly.

Individualisation
The school and its activities are all geared to give each pupil as much individual attention as possible. The importance of the peer group and the fact that a person cannot develop fully while isolated from the community are well understood and always kept in mind.

H.S. VAN DER WALT

Staff Members
The staff consists of the principal, 1 senior deputy principal, 3 heads of departments, 17 teachers, 1 teacher librarian, 2 remedial teachers, 1 school psychologist, 2 assistant school psychologists, 1 nursing sister, 1 senior provisional administration clerk, 1 provisional administration clerk, 1 typist, 1 part-time provisional administration clerk, 5 senior housemothers, 5 housemothers and 2 driver/factotums.

Accommodation, clothing
The girls are allowed to arrange their single, 3-bed or 5-bed bedrooms according to their tastes. They may wear casual dress during their free time and in the hostels. When a pupil is admitted she is provided, if necessary, with a basic wardrobe of her own choice. She is issued with a complete school uniform and church outfit which becomes her property, while her sports clothes remain the property of the school.

Privilege System
A privilege system is in operation. According to this system pupils are evaluated each month and placed in one of five groups, according to their behaviour and achievements. Pupils in group one have the most privileges. They are allowed to go shopping whenever they wish (as long as this does not clash with school activities or duties) and are allowed to go home, or to approved friends, for every weekend. Each subsequent group has fewer privileges.
Group 4 girls do not leave the school grounds during the term while group 5 girls forfeit all holidays. As this grouping is revised regularly the pupils feel the consequences of their misdemeanours and are encouraged to improve their behaviour in order to be promoted. Thus the discipline of the school eventually leads to self-discipline.

Contact with Family and Friends
The pupils are all allowed to write to their parents and guardians. Approved visitors are allowed to visit the girls at school on the first and fourth Sundays of every month. Pupils in groups 1-3 may go home or to approved friends for certain weekends. If the money is available and a social worker recommends it, the school provides pupils with a return ticket home once a year, thus enabling them to spend at least one holiday, usually a long one, at home. Pupils may go out for every holiday if their behaviour and the circumstances at home allow it.

Holiday Entertainment
During the holidays the teachers on duty take the girls who cannot go home on various outings and arrange other forms of entertainment for them. They visit places such as Table Mountain, Cape Point, the ice-skating rink, Paarl Rock, Bain's Kloof, Goudini Spa and the beach, to mention but a few.

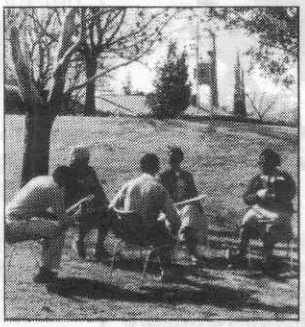
Finance
This is a state school. As such the state provides the pupils with most of their requirements. The costs involved were approximately R5 500 per pupil in 1983. The school, together with the Board of Control, is responsible for the administration of the School Fund which is raised by the staff and used solely for the benefit of the pupils. The School Fund is used among other things to finance educational excursions and holiday tours; to acquire facilities not provided by the state; to hire films; to provide refreshments on outings, at sports meetings, the matric farewell and prize-giving. Contributions to the School Fund, no matter how small, are always much appreciated.

Period of Detention and School Leaving
Although the law makes provision for the detention of pupils until the age of 21 they are usually released subject to certain conditions on achieving the highest scholastic qualifications of which they are capable. In deciding whether or not to release a pupil her behaviour and home circumstances are taken into account by the Board of Control with whom the final decision rests. Pupils without parents or homes to go to are assisted in finding jobs and accommodation. After leaving school the girls usually remain under the supervision of the social worker for a period of two years during which six-monthly reports on their orientation and progress are made to the school.

Nuusbrokkies Newsbriefs

Transvaal

SOS Mamelodi Three-quarters Empty
In December 1986 the SOS Mamelodi Children's Village was opened. The social worker and child care staff had been employed some three months previously and given a three-month training course. They also spent time with the staff at the Ennerdale Village and were taught on-the-job skills by their experienced staff members. In addition the NACCW was pleased to have a large contingent of these staff members join us in Pretoria for the first weekend of the BQCC course last year. This careful preparation of staff members prior to employment is unique in South Africa and SOS is to be commended on this approach. The opening of this excellent new home offering a high standard of physical care and a good staff/child ratio was therefore a significant event in black child care work. The staff looked forward to the opening with great excitement and were anxiously awaiting the arrival of the first children. Seven months later they are still waiting. Only 27 children have been admitted to the home — a home with a capacity of 100 children and with trained staff to receive them. This fact is indeed disturbing when seen against the background of research done by the NACCW on the shortage of places for black children. 17 500 places are needed for black children in South Africa. Equally disturbing is the fact that the SOS organisation has built a home for 150 children in Botswana. There are at present five children in that home.



SOS Mamelodi students at NACCW course in Pretoria

Pretoria Course
On Friday 26 June a two-day course for child care personnel began at the Louis Botha Children's Home in Queenswood, Pretoria. Course leaders included Di Levine, Jacqui Michael and Brian

Jacqui Michael

Gannon. Module I of the BQCC course was completed and senior staff attended a parallel course of practice seminars.

Meeting of Provincial Welfare Staff
The Regional Director, Di Levine, addressed a meeting of approximately 40 social workers of the Community Services Division of the Transvaal Provincial Administration. These social workers are responsible for rendering a wide range of

Di Levine

services to blacks in the Vaal-Triangle and West Rand. The subject of the talk was "Helping the Child at the Time of Placement".

Natal

Natal Technikon Hope
Following on an unsuccessful outcome of the NACCW's representations to the Minister of Education and Culture regarding the refusal earlier this year by the Natal Technikon to admit black, coloured and Indian students to the child care course, the Association sought an assurance from the Natal Technikon that all eligible students would be admitted in 1988, failing which the NACCW would not be able to support the course at that institution after the end of 1987. Professor A.C. du Preez, Rector of the Technikon has replied stating that his council is negotiating an improved basis upon which students are admitted, and expressing the belief that a new dispensation will be finalised before the end of this year.

Follow-up Workshop
The Regional meeting took place on 26th June at William Clark Gardens where Jill Challenor of Child Welfare's Hilltops Children's Home in

Jill Challenor

Pietermaritzburg conducted a follow-up workshop to that run by Brian Gannon earlier in the year on practical approaches to discipline.

Bouwerk by NG Kinderhuis in Malvern
Sewe nuwe wooneenhede word tans opgerig, elk waarvan tien kinders in enkel of dubbel kamers sal huisves. Elke eenheid sluit 'n sit/eetkamer met kombuis asook 'n woonstel vir die personeel in. Die bestaande geboue word ook verbou in vier wooneenhede vir twaalf kinders elk. Die administrasiegebou word uitgebrei om meer kantore te verskaf vir die sielkundige, maatskaplike werkster en administratiewe personeel, en maak voorsiening vir 'n waarnemings- en speelkamer. Daar word verwag dat hierdie ontwikkeling teen Augustus 1988 voltooi sal wees.

Ethelbert Home's 80th Anniversary
On 27th June Ethelbert Children's Home in Malvern celebrated its 80th Anniversary with a Bumper Fete. Principal Ernie Nightingale reports that the anniversary has been marked by the drawing up of an

Ernie Nightingale

extensive renovation and maintenance programme for the existing cottages. Ethelbert Home pioneered the cottage system approach in South Africa, and their present cottages were built in 1957.

Open Day
William Clark Gardens in Sherwood held their Annual Open Day on Saturday 16th May. The highlight was the presentation of the Midmar Mile Swim Certificates to children who had completed the event.

Eastern Province

Malcomess Principal Appointed
Selma Wastell, until recently Vice-Principal of St Michael's Children's Home in Cape Town, has been appointed Director of the East London Children's Home, Malcomess House, with effect from 1st August 1987. A trained artist and subsequently a successful businesswoman, Selma entered the child care field in the late 1970's and soon qualified with her National Higher Certificate in Residential Child Care. She worked as a child care worker for five years before being appointed Vice-Principal, acting as Principal during Vivien Lewis' overseas visit in 1984. Since then she added the role of Unit Manager to her portfolio. Selma has taken part in a number of NACCW conferences and seminars and last month lectured at the Eastern Cape course. In June she spent ten days at Malcomess House on an orientation and "hand-over" assignment. Barrie Lodge, the present Director, takes up his appointment as Headmaster of St George's Home in Johannesburg in late July 1987.

Hankey School Hostel
The National Director was asked to consult with a local interest group in Hankey (some 50km from Port Elizabeth) concerning the declining enrolment in their local school hostel. Fred Wells, Principal of the Eastern Province Children's Home, accompanied him at a morning workshop in Hankey on June 13th. Brian Gannon outlined the combination of declining population growth rate among whites, the effect on population in the Port Elizabeth area of economic decline in that region, and the Education Department's budgetary constraints on new project development. Coupled with these was the inadvisability of drawing so-called welfare clientele to rural hostels which could not compete financially with the programme and staffing costs of a proper children's home. The workshop concluded by establishing some guidelines for the necessary improvement of the present hostel, and by planning some research areas as to future development possibilities.

Willie van der Merwe

Ugie Kinders Verhuis
Ds Willie van der Merwe berig dat hy op die oomblik van bakboord na stuurboord beweeg om die tydelike huisvesting in Port Elizabeth vir 90 kinders van die MTR Smit-Kinderoord te reël. Ongeveer 60 kinders is reeds na ander kinderhuise oorgeplaas. Daar word uiteindelik beoog om 100 kinders in Port Elizabeth te huisves. Ds van der Merwe berig meer hieroor in ons Julie uitgawe.

Western Cape

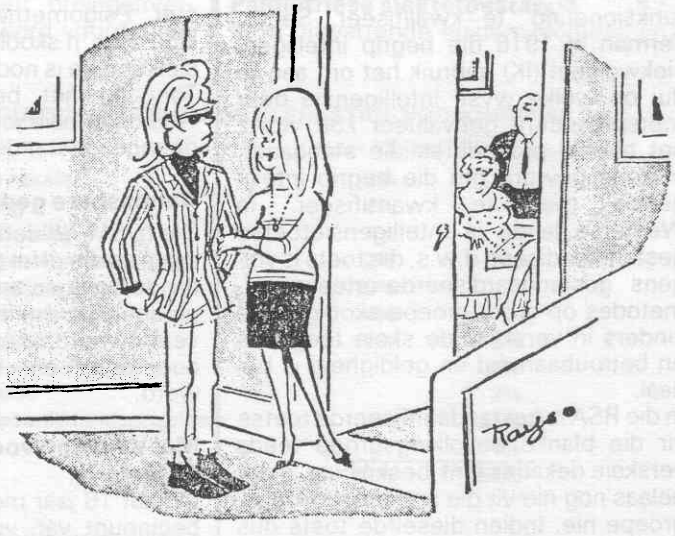
Workshop on Institutional Abuse
Chris Giles, clinical psychologist with Cape Town Child Welfare Society, who makes a valuable contribution to child care in this region, ran a workshop for the Western Cape NACCW members on institutional abuse. Three areas which were discussed in groups were: (1) Seeing institutional abuse both as direct abuse and as neglect; (2) Abuse by bureaucracy whereby children are mismanaged by and get lost in the welfare system; (3) State and legislative abuse, for example, detention of children, where legislation fails to accommodate the needs of children.

Namaqualand Visitor
At its meeting on Thursday 25th June the Residential Social Workers' group of the Western Cape Region was host to Louise Angless, recently appointed social worker at the Roman Catholic Mission Children's Home in Kamieskroon. This is one of three children's homes in Namaqualand and Louise was able to talk about the isolation experienced by the staff at these homes. The Western Cape Region of the NACCW has been asked to promote some training opportunities for staff at these homes, but so far distance and manpower problems have delayed the implementation of such plans.

Research Planned
On Thursday 11th June the principals of the white children's homes met in Cape Town to discuss the decreasing enrolment in their institutions. The National Director provided background statistics which showed that the number of children's homes for whites had declined from 111 to 74 (33 percent) over the past twenty years. The fact that there were 23 000 vacancies in white boarding schools in South Africa, coupled with the fact that some 1 750 children who should be receiving statutory care were enrolled in rural Western Cape boarding hostels, highlighted the fact that children's homes' numbers will probably decline even more. Against this, Peter Powis, clinical psychologist at Tenterden Place of Safety, outlined the dual problem of some children's homes' reluctance to admit "difficult" children, and his own reluctance to refer certain children to children's homes

Chris Steenkamp of Durbanville Kinderhuis, who attended the meeting

where he was unsure of the suitability of their programme to manage them. There was clear indication of new demands being made on children's homes and it was decided to ask the NACCW to undertake research into needs and the development of responsive programmes in the Region.



"Stop worrying—of course they won't like you."

Psigiatriese Perspektiewe in Kinders en Adolessente met Verstandelik Gestremde Ontwikkeling

H. Faul

Dr Faul is 'n psigiater en lektor by Ga-Rankuwa-hospitaal en MEDUNSA, Pretoria.

Gestremde verstandelike ontwikkeling verwys na ondergemiddelde algemene intellektuele funksionering wat ontstaan in die tydperk van ontwikkeling en geassosieerd is met belemmering van aanpasbare gedrag.

Omtrent 1 persent van die bevolking van 'n land voldoen aan die kriteria vir die diagnose van verstandelike gestremdheid. Die algemeenheid van ernstige verstandelike gestremdheid (IK< 50) is 3-4/1 000 kinders en die meeste van hulle het 'n organiese siektetoestand. Die belangrikste kenmerke van die toestand word beskryf as: 'beduidende ondergemiddelde algemene intellektuele funksionering wat tot gevolg het, of geassosieer word met tekorte of defekte in aanpasbare gedrag met 'n aanvang voor die ouderdom van 18 jaar'.

Beduidende ondergemiddelde algemene intellektuele funksionering

Dit is dadelik nodig om 'beduidende ondergemiddelde algemene intellektuele funksionering' te kwalifiseer. Sedert Terman in 1916 die begrip intelligensiekwosiënt (IK) gebruik het om aan te dui op welke wyse intelligensie deur toetsprosedure geëvalueer kon word, het hierdie prosedures die standaardmetode geword om die begrip intelligensie mee te kwantifiseer. In Westerse lande is intelligensietoetse gestandaardiseer, d.w.s. die toets is volgens gestandaardiseerde steekproefmetodes op groot groepe skoolgaande kinders in verskillende skole toegepas en betroubaarheid en geldigheid is bepaal.

In die RSA is gestandaardiseerde toetse vir die blanke bevolkingsgroep reeds verskeie dekades lank beskikbaar, maar helaas nog nie vir die ander bevolkingsgroepe nie. Indien dieselfde toets dus noodgedwonge op die ander bevolkingsgroepe toegepas moet word, lei dit tot onbetroubare resultate en niemand is heeltemal seker of die werklike intelligensie van die betrokke kind gemeet word nie. Die groot taak om gestandaardiseerde toetse vir die res van ons bevolking te produseer geniet die aandag van die Raad vir Geesteswetenskaplike Navorsing.

Waarskynlik is verstandelike gestremdheid die gestremdheid wat die moeilikste deur ouers aanvaar word.

Volgens *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* word persone met 'n IK van 70 of minder as intellektueel gestremd beskou. Aangesien die norm vir 'n gemiddelde IK 100 op die skaal is, kan begryp word dat die toetse uiters noukeurig deur ervare opgeleide toetsafnemers toegepas behoort te word. 'n Geneesheer kan met kliniese evaluering 'n beoordeling van die verstandvermoë by benadering vasstel. Psigometriese toetsing van die kind deur 'n skoolsielkundige of kliniese sielkundige is nodig om die IK te bepaal. Toetsing het beperkte prognostiese waarde in baie jong kinders en in slegs geringe verstandelike gestremdheid.

Aanpasbare gedrag

Die *(DSM-III)* definieer 'aanpasbare gedrag' as die effektiwiteit waarmee 'n individu voldoen aan die standaarde van persoonlike onafhanklikheid en sosiale verantwoordelikheid wat van sy/haar ouderdom en kultuurgroep verwag word.

Met aanvang voor die ouderdom van 18 jaar

Omdat 18 jaar meestal as die arbitrêre beginpunt van volwassenheid beskou word, word intellektuele gestremdheid wat eers ná 18 jaar begin, gediagnoseer as dementia, d.w.s. die verlies van voorheen bestaande intellektuele vermoëns. Wanneer 'n persoon onder die ouderdom van 18 jaar eers vir 'n tydperk verstandelik normaal ontwikkel het en nog voor 18 jaar deur siekte, ongeluk of andersins gestremd geword het, word beide verstandelike gestremdheid en dementia gediagnoseer.

Subgroepe van verstandelike gestremdheid

- Ligte verstandelike gestremdheid (IK = 50-70) — 80 persent van gestremdes;
- Matige verstandelike gestremdheid (IK = 35-49) — 12 persent van gestremdes;
- Erge verstandelike gestremdheid (IK = 20-34) — 7 persent van gestremdes;
- Uiterste verstandelike gestremdheid (IK = onder 20) — 1 persent van gestremdes.

Uiterste en erge verstandelik gestremde kinders is nie in staat om hulself teen algemene fisieke gevare te beskerm nie. Hulle toon dikwels anatomiese of fisiologiese abnormaliteite. Spraak ontwikkel meestal nie. Hulle vereis konstante versorging en toesig.

Matig verstandelik gestremde kinders hoef nie beskerm te word teen algemene gevare nie, maar hulle is nie in staat om hul eie sake te beheer of te leer beheer nie. Hul mylpale is matig vertraag. Hulle leer praat, bly emosioneel kinderlik en ongeinhibeerd, toon min dryfkrag, maar leer mettertyd selfversorging aan. In 'n eenvoudige omgewing kan hulle selfversorging en basiese sosialisering geleer word. Beide groepe ontwikkel dikwels epilepsie.

Kinders met ligte verstandelike gestremdheid se persoonlikhede varieer saam met dié van die algemene bevolking. Hul denke is konkreet en hul vermoë tot abstraksie is swak. Hul woordeskat bly beperk. Hulle is opvoedbaar in spesiale skole. Hulle kan later in die gemeenskap aanpas. Werkgeleenthede vir hulle is afhanklik van die

ekonomie en die betrokke gemeenskap se houding daarteenoor.
Die afsnypunt van 70 op die IK-skaal is egter gekies om intellektuele gestremdheid te definieer juis omdat die meerderheid van persone met 'n IK van laer as 70 so beperk is in hul aanpasbare gedrag dat hulle besondere beskerming en spesiale onderrigmetodes vereis.
Omdat die afsnypunt vir verstandelike gestremdheid as 70 beskou word, plaas dit individue wat 'n IK van tussen 70 en 84 het, in 'n grensvlak, aangesien die laagste syfer vir ondergemiddelde IK as 85 geneem word. Vanselfsprekend sal hierdie individue in die skoolsituasie sukkel om te vorder. Wanneer skool mislukkings of gedragsafwykings die aandag op hulle vestig en hul IK dan bepaal word, kan hulle na aanpassingsklasse met meer intensiewe onderwyshulp oorgeplaas word.

Probleemgedrag van die verstandelik gestremde kind
Daar is 'n groot variasie in die gedrag van verstandelik gestremde kinders. In een ondersoek wat deur 'n bekende psigiater gedoen is, was simptome wat die meeste by sulke kinders voorgekom het die volgende:
- Rusteloosheid
- Herhaalde, doellose bewegings
- Obsessionele gedrag
- 'n Ongewone soeke na sensoriese stimulasie
- Stereotipe spel
- Woede-uitbarstings.

Oorsake van probleemgedrag
Dit is baie belangrik dat ouers en ander gesinslede gehelp moet word om te verstaan waarom die verstandelik gestremde kind probleemgedrag mag openbaar. Dit kan gewoonlik deur een van die volgende redes verklaar word:
- Dit is die kind se manier om homself te beskerm teen te hoë eise waaraan hy nie kan voldoen nie, weens sy beperkte vermoëns;
- Dit is die disfunksie van sy brein wat veroorsaak dat abnormale gedrag verskyn;
- As die kind weens sy beperkte vermoëns nie aanvaar of begryp word nie, is hy in der waarheid verveeld en benodig meer sinvolle stimulasie uit sy omgewing;
- Die kind mag benewens sy verstandelike gestremdheid ook nog aan 'n erkende psigiatriese siektetoestand ly, wat vir sy gedrag verantwoordelik mag wees;
- Die kind mag ook nog aan epilepsie ly, waardeur sy gedrag verder versteur word.

Behandeling van probleemgedrag
Wat kan gedoen word om die kind met bg. probleme te help? Waarskynlik is verstandelike gestremdheid die gestremdheid wat die moeilikste deur ouers aanvaar word. Indien hulle dit nie kan doen nie, volg óf oorbeskerming, verwerping, bedekte verwerping óf ontkenning van die gebrek. Al hierdie houdings vind dan aanklank by die ander kinders en dra by tot die gestremde kind se probleme.
'n Realiteitsoriëntering met die praktiese deurwerk van probleme is herhaaldelik nodig t.o.v. versorging, sosialisering, opleiding, seksvoorligting, mediese sorg, en langtermynversorgingsprobleme.
Dit is nodig dat 'n gestremde kind se ontwikkelingsmoontlikhede aan die ouers verduidelik moet word sodat die kind se potensiaal in elke ontwikkelingstadium maksimaal kan ontplooi. Dit sal voorkom dat onrealistiese eise aan die kind gestel word of dat so min van hom

Werkgeleenthede vir hulle is afhanklik van die ekonomie en die betrokke gemeenskap se houding daarteenoor.

verwag word dat hy verveeld en moeilik raak. Die SA Nasionale Raad vir Geestesgesondheid, Posbus 2587, Johannesburg 2000, het 'n brosjure met adresse van beskikbare fasiliteite in die RSA vir verstandelik gestremde persone. Evalueringsklinieke, voorskoolse sentra, opleidingsentra, beskermde werksentra en tehuise word daarin aangedui. 'n Kind wat verveeld by die huis gesit het, mag 'n hele persoonlikheidsverandering ondergaan as hy gedurende die dag in 'n geskikte sentrum geplaas word.
Aggressiewe en rustelose gedrag en veral woede-uitbarstings lei dikwels tot verwerping van die kind en bemoeilik sy opvoeding. Omdat epilepsie dikwels by verstandelik gestremde kinders ontwikkel en die voorkoms toeneem met die ernstiger grade van gestremdheid, mag abnormale gedrag deur breingolfversteurings veroorsaak word voordat die tipiese *grand mal*-aanvalle ontwikkel. Elektroënsefalogramstudies in hierdie pasiënte mag 'n aanduiding van die probleem gee. Goedgekontroleerde anti-epileptiese behandeling bring dikwels groot verbetering in die gedragsprobleme van sulke kinders. Kinders met epilepsie toon 'n groter risiko om psigiatriese afwykings te ontwikkel as kinders daarsonder.
Bednatmaak mag regstreeks verband hou met epilepsie, of met die ernstigheid van die verstandelike gestremdheid. As 'n kind wat voorheen droog was, weer begin natmaak, mag dit 'n aanduiding van emosionele of psigiatriese versteuring wees.
Ander gedragsprobleme wat soms voorkom, veral by die ernstiger gestremde kinders, is herhalende selfbesering en die eet van vreemde voorwerpe (pika). Hierdie en ander probleme kan soms suksesvol deur gedragsterapie verminder word. Die ouer kan geleer word hoe om onaanvaarbare gedrag uit te wis en aanvaarbare gedrag te beloon. Klein dosisse orale fenotiasien help om rustelose en aggressiewe gedrag te beheer en die kind meer ontvanklik vir gedragsterapie te maak. Daar is ook navorsing gedoen oor die gunstige effek van klein dosisse langwerkende fenotiasien wat gewoonlik een keer per maand ingespuit kan word en sodoende die daaglikse inname van tablette uitskakel. Elke individuele kind se medikasiebehoeftes moet geëvalueer en dienooreenkomstig behandel word.
By ernstige breinskade kan die verstandelike gestremdheid gekompliseer wees deur fisieke afwykings, bv. serebrale verlamming met spastisiteit, ander fisieke gestremdhede, hidrosefalus, ens. Hierdie toestande mag bydra tot die kind se abnormale gedrag en mag ook medikasie bemoeilik. Uiteraard moet sulke ernstig gestremde kinders deur 'n spesialistespan geëvalueer en behandel word.

Psigiatriese siektetoestande
In 'n omvattende epidemiologiese stu-

TABEL I. PSIGIATRIESE STEURINGS IN ERNSTIGE VGO-KINDERS[1]

	Onder 15 jaar	Bo 15 jaar
Aanpassingsreaksie	**6%**	
Gedragsteuring	**4%**	
Emosionele steuring	**4%**	
Geïsoleerde gewoontesteuring	**2%**	**5%**
Ernstige stereotipie en pika	**10%**	
Hiperkinetiese steuring	**4%**	
Kindertydpsigose	**17%**	**8%**
Skisofrenie (volwasse tipe)		**6%**
Affektiewe siekte		**3%**
Gedrags/persoonlikheidsprobleme		**25%**
Ander		**4%**
Totaal	**47%**	**51%**

VGO = verstandelik gestremde ontwikkeling.

die toon 30 persent (volgens ouervraelys) tot 42 persent (volgens onderwysersvraelys) kinders met verstandelike gestremdheid gedragsprobleme. In die ernstiger verstandelik gestremde groep toon 50 persent 'n psigiatriese steuring, soos geëvalueer deur 'n psigiatriese ondersoek van die pasiënt en onderhoud met die ouers. Daar is nie 'n kenmerkende tipe steuring nie (Tabel I).

Daar word gereken dat ongeveer 50 persent van die inwoners van 'n inrigting vir verstandelik gestremdes gedragsprobleme as gevolg van psigiatriese aandoenings sal hê. Die herkenning van psigiatriese afwykings is belangrik omdat hulle deur behandeling verbeter mag word en sodoende die kind se beheer en opvoeding mag vergemaklik. Die graad van psigiatriese of gedragsafwykings mag selfs meer belangrik wees as die graad van vertraging wanneer 'n besluit geneem moet word of die kind binne die gemeenskap of in 'n inrigting tuis hoort.

Sekere psigiatriese afwykings kom meer dikwels by verstandelik gestremdes as onder die normale bevolking voor, nl. die defektiewe aandagsindroom met hiperkinese, kinderoutisme en atipiese stereotipe bewegingsafwyking. Hier volg 'n kort bespreking van genoemde sowel as ander psigiatriese afwykings wat by verstandelik gestremde kinders mag voorkom.

Die defektiewe aandagsindroom met hiperkinese

Hierdie steuring kom voor onder die ligte en matige subgroepe van verstandelik gestremde kinders, veral dié met ernstige taalsteurings. Onvermoë om te konsentreer, impulsiwiteit en oormatige motoriese aktiwiteit is die hoofkenmerke van die sindroom.

Die kinders met ernstige en uiterste gestremdheid het nie voldoende intellektuele kontrole om hul aandag sinvol te konsentreer nie; dus reageer hul hiperkinese nie op metielfenidaat nie.

Daar is spesifieke medikasie wat die simptome mag verbeter, al kan dit nie die toestand genees nie, bv. metielfenidaat of imipramien. Dit moet onder toesig van die psigiater toegedien word, aanvanklik verkieslik in die hospitaal om die dosering in te stel. Die middels is by kinders met epilepsie teenaangedui.

Kinderoutisme

Outisme kom dikwels saam met verstandelike gestremdheid voor wanneer die basiese ontwikkeling van die kind versteur word, en nie slegs gestrem word nie, en daar ernstige kwalitatiewe ontwikkelingsafwykings verskyn wat nie vir enige stadium van menslike ontwikkeling normaal is nie. Die hoofkenmerke wat reeds vóór 30 maande teenwoordig is, is 'n onvermoë om te respondeer teenoor ander mense (outisme), uiters gestremde taalontwikkeling en bisarre reaksies op die omgewing. Indien spraak teenwoordig is, kom vreemde spraakpatrone voor soos onmiddellike en vertraagde egolalie, metaforiese taal en voornaamwoordomkering. Omtrent 70 persent is verstandelik gestrem, 40 persent met 'n IK laer as 50. Epilepsie ontwikkel in ongeveer 25 persent van outistiese kinders. Gelukkig is hierdie toestand baie seldsaam (2-4 gevalle per 10 000 van die bevolking).

Outistiese simptome is beskryf in verskeie sindrome soos fenielketonurie, tubereuse sklerose, mukopolisakkaridose, rubella, lues en hidrosefalus, asook in neurodegeneratiewe steurings soos sub-akute sklerose-rende panensefalitis, lipiedsteuringsiekte en Schilder se siekte.

'n Differensiële diagnose van outisme is: verstandelike gestremdheid met outistiese trekke, maar nie die volle sindroom nie; uitgebreide ontwikkelingsafwyking van jong kinders, ('Childhood Onset Pervasive Developmental Disorder'); doofheid en ontwikkelingsafwyking van taalvermoë, reseptiewe tipe.

Vandag word erken dat verstandelik gestremdes wel aan manie of depressie kan ly.

Atipiese stereotipe bewegings-afwyking en self-beserende gedrag

Stereotipe of doellose motoriese aktiwiteit (liggaamswiegbeweging of flapbeweging van die hande) word in tot 40 persent van vertraagde kinders vermeld. Dit moet onderskei word van bewegingsafwykings op 'n neurologiese basis (chorea of atetose), tics of middelgeinduseerde diskinese. Stereotipe soos liggaamswiegbewegings is primitiewe self-stimulerende aktiwiteite wat voorkom wanneer persone nie effektief op hul omgewing kan respondeer nie, weens eie onvermoë of omgewingsarmoede of hiperstimulasie. Dit mag verband hou met verveling, blindheid, sensoriese defekte, Lesch-Nyhan- en De Lange-sindroom, maar meestal met uitgesproke taalsteurings.

Maniese of depressiewe reaksies

Vandag word erken dat verstandelik gestremdes wel aan manie of depressie kan ly. Omdat hulle dikwels nie oor genoegsame vermoëns beskik nie, kan hulle nie altyd hul gevoelens uitdruk nie en word depressie indirek in nie-verbale gedrag uitgedruk, bv. aggressiewe uitbarstings, teruggetrokkenheid of liggaamlike klagtes.

Maniese episodes toon nie dieselfde mate van kenmerkende aansteeklike opgewektheid en slim woordspelings nie, maar kom dikwels tot uiting in slaaploosheid of oormatige prikkelbaarheid.

Skisofrene afwykings

Dit is baie moeilik om die diagnose van skisofrenie of skisofreniforme afwyking in sommige verstandelik gestremde kinders te maak. 'n Uitsluitingskriterium vir die diagnose van hierdie toestande is die teenwoordighied van 'n organiese breinafwyking. Dit is nie altyd moontlik om organiese skade uit te sluit nie. Aangesien taalvermoë dikwels ontoereikend of afwesig is by verstandelik gestremdes, kan nie so maklik vasgestel word wat hulle dink of voel nie. Derhalwe word dit duidelik in die DSM-III gestel dat skisofrenie en skisofrene afwyking alleenlik in verstandelik gestremdes diagnoseer kan word wanneer die simptome van skisofrenie definitief teenwoordig is en nie moontlik bestaan a.g.v. probleme in kommunikasie nie. Reid meen dat dit onmoontlik is om skisofrenie te diagnoseer in 'n persoon met 'n IK onder 40.

Nogtans kom psigotiese simptome wat na hierdie toestande lyk by sommige verstandelik gestremdes voor. Die ouers merk miskien op dat die kind alleen praat en lag, hom gedra asof hy gesigshallusinasies of vervolgingswaan het en miskien selfs kla dat hy stemme hoor. Medikasie sal dan nodig wees om die psigose onder beheer te bring.

Ander psigiatriese toestande

Delirium ontwikkel makliker in die verstandelik gestremde kind wat aan ernstige infeksie ly as in die normale kind. Ander organiese breinsindrome wat mag voorkom is dementia (veral in Down-sindroom na 35 jaar) en dié wat ontstaan a.g.v. alkohol- of daggamisbruik, vitamientekorte of sifilitiese infeksie. Angstoestande, konversieafwykings, aanpassingsreaksies en antisosiale gedragsafwykings kan ook by die verstandelik gestremde gediagnoseer word, alhoewel dit dikwels nie as sulks herken word nie.

Aangesien dit meestal die algemene praktisyn is wat eerste opgesoek word as die verstandelik gestremde kind met gedrags- en ander probleme presenteer, moet hy wel deeglik kennis dra van die voorkoms van hierdie afwykings, dit vroegtydig herken en verwys vir volledige diagnose en behandeling.

Dit is ook die algemene praktisyn('t bepaalde genetiese, metaboliese of endokriene afwykings by pasgeborenes moet vermoed en verwys vir uitkenning om latere verstandelike gestremdheid te voorkom. Veral fenielketonurie en kretinisme is hier belangrik.

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Summary
Approximately 1 percent of the population of a country fit the criteria for mental retardation. The DSM-III criteria are: significantly subaverage general intellectual functioning (IQ 70 or below on an individual intelligence test administered by a psychologist); concurrent deficts or impairments in adaptive behaviour (age taken into consideration); onset before the age of 18 years. Four subtypes are recognised: Mild — (IQ 50-70); moderate — (IQ 35-49); severe — (IQ 20-34) and profound — (IQ below 20).
The group of individuals with an IQ between 70 and 84 suffer from 'borderline intellectual functioning' and this group is not classified under mental retardation but under 'conditions not attributable to a mental disorder (but) that are a focus of attention or treatment'. Mentally retarded children may exhibit problem behaviour caused by a variety of factors. It is important to rule out latent epilepsy and psychiatric illnesses aggravating behaviour disorders in mental retardates. Attention deficit disorder with hyperactivity, childhood autism and atypical stereotyped movement disorder are more common in retarded children than in the normal population. Manic or depressive reactions, schizophrenia, organic mental disorders, substance abuse, conduct disorders, etc. should be recognised by the general practitioner and referred to a psychiatrist for treatment.

Regulation 33(2)(f) under the new Child Care Act (No.74 of 1983) for the first time requires children's homes to have on file a "treatment programme" in respect of each child. In this series of four articles the authors explore the purpose and nature of such a document.

The Treatment Plan — II

Assessment as the Foundation of the Treatment Plan

Peter Powis, Merle Allsopp and Brian Gannon

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This article will deal with the assessment conducted prior to the child's admission to the residential setting, or early during the child's stay. However, assessment is an on-going process throughout the placement period and the principles discussed will continue to apply to later assessments. As the assessment aims to assess the functioning of the child and his system in a number of areas (see below), it usually requires the input of a number of professionals.
In general terms, the assessment takes into account the ultimate goals of the programme — for example, moving a child as soon as possible back to his family, to foster care or other permanent placement such as a group home — and sets out to establish the things which must be put right to reach those goals. More specifically, the purpose of an assessment is to identify strengths and deficits in the child and family's functioning, so that those working with the child and his significant others may act systematically and therapeutically towards those goals. Whoever requests the assessment should be explicit about what they want from the assessment, how they hope to use it, and who will be using the assessment report in compiling and implementing a treatment plan. The more specific the brief, the more helpful the assessment will be. Unless this is made clear, the language and ideas presented in the assessment report may be incomprehensible and useless to those who requested it. A complex assessment report may lead to a treatment plan which is too complex to be monitored and implemented effectively.

A framework for assessment

What follows is one possible framework for the assessment of children in substitute care.

Chronological chart of significant events
A chronological chart of significant events in the child and family's history is essential. Such events include all descriptions such as divorce or separation, births and deaths in the family, removals from family and other changes in caretakers, hospitalisations, and incidents such as violence, physical or sexual abuse, destitution, changes of school and place of residence. In addition the attempted solutions to the problems should be ascertained (especially attempted solutions by helping professionals, e.g. confrontation of parents, play therapy).
By highlighting the family's experiences over time and the child's experiences at various ages, hypotheses may be generated about (a) family functioning; (b) effects on the child's physical, intellectual and psycho-social development and (c) the child's way of seeing himself, others and his world. These hypotheses can then be explored during further stages of the assessment. The chronological chart also suggests provisional goals of treatment (of both child and family) as well as what kinds of approach are most likely to be effective. By studying the

interplay between the characters in this chronological history one can gain some idea of *who* has *what* problem, and this has some implications for deciding *who* will work with which client.

Intellectual and scholastic functioning
The child's adaptation to the school environment plays a central role in the success or failure of the placement. The importance of this part of the assessment is therefore self-evident. In the pre-school child assessments of intellectual and motor development may indicate interventions aimed at preventing later scholastic problems (e.g. an occupation therapy home stimulation programme).
There are many cases where the child's history and the professional judgement of qualified people are sufficient criteria for deciding whether or not systematic stimulation or remediation is required. In other cases intelligence and other formal tests are required. IQ scores on their own are insufficient, and a description of the child's strengths and weaknesses in different areas of intellectual functioning (e.g. memory, comprehension, attention span, perception, numerical reasoning, etc.) should be provided. The possible involvement of physiological, emotional and family factors should also be discussed. Naturally, recommendations will be made regarding additional assessments required as well as possible interventions. Depending on the case, teachers, school clinic staff, occupational therapists, psychologists and medical professionals may be involved.

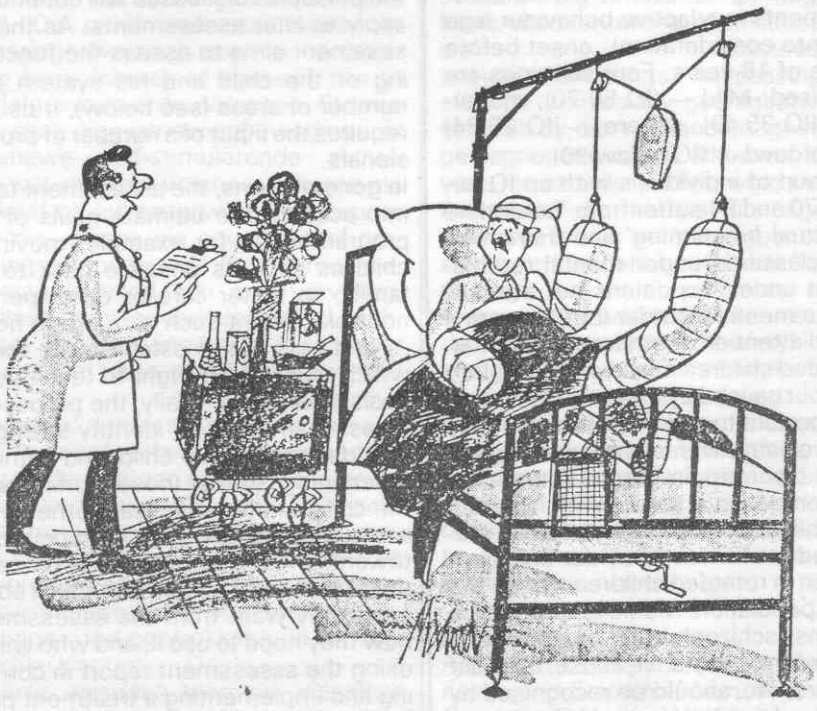
Social or interpersonal functioning
Here the assessment agent(s) rely on (a) reports and observations by family members, teachers, social workers, substitute caretakers, etc. and (b) interviews with the child and (where applicable) the family.
Where applicable, the family network should be assessed. How do the family members' behaviour fit together? What role does the child's problem and/or the child's institutionalisation play in the maintemance of the family's organisation? Why is it that the child's institutionalisation should have occurred now and not earlier, or later? What is the child's role in the family and what are the relationships like between the child and other family members? The child will often try to replay his family role in the residential setting, and staff need to understand this role. What are the attitudes of family members towards the placement and their future involvement in the treatment plan? What, tentatively, is the prognosis for family treatment and involvement and how may family resistance best be handled?
The family assessment and an assessment of the child's general interpersonal strategies suggest what kind of behaviour child care staff might expect and how they might deal with it. For example, the child may distance himself from adult males (who should devise ways of establishing a non-threatening relationship) while becoming overdependent on adult females (who should not allow this problem to become entrenched).
Another essential aspect of the interpersonal assessment deals with the child's strengths and deficits in handling everyday social situations, especially peer relationships. The child's participation in recreational/social/cultural/sporting activities should also be described. The child's ability to init»afe ideas and relationships, to sustain relationships, to act autonomously or dependently and his susceptibility to being influenced are important issues. Naturally the age of the child must be considered when assessing these areas.

Emotional functioning
Here the assessment agent(s) rely on (a) reports and observations from family members and other significant people; (b) clinical interviews and (c) projective techniques such as play, drawings, etc. Useful behavioural indicators include: malingering and psychosomatic complaints; avoidance of certain situations (e.g. peer group activities, school), eating and sleep disturbances, bedwetting, withdrawal, tantrums and aggressive outbursts. The absence of these indicators (e.g. social involvement, enthusiasm about school) is positive and should be briefly discussed.
The general aim of this aspect of the assessment is to provide an understanding of the child's view of himself, his world and significant others, as well as his attitude towards the past, present and future. Does he, for example, blame himself or others for his situation? Does he feel inferior and disliked or confident and well liked? What are his fears, anxieties, regrets and aspirations? What is the quality of his impulse control? Does he feel relieved and hopeful, hostile and resentful, or depressed and hopeless about his placement?

The so-called emotional aspects of functioning should always be seen within their interactional context.

The so-called emotional aspects of functioning should always be seen within their interactional context (e.g. to whom and in what situations does the child feel most angry, anxious or inferior? How do others respond to these responses to them?)

Conclusion
As can be seen, it is possible to collect a mass of potentially useful information about any child. The practical usefulness of this information however depends on the ability of the assessment agent(s) to condense the *relevant* information into a form which has meaning to all those entrusted with the treatment plan. The vital process of transforming assessment information into an active treatment plan will be discussed in a future article.



"Excellent news, Mr. Harvey — it's all psychosomatic."

The Treatment Plan

The Leliebloem Assessment Exercise

The Child Care Worker is currently running a four-part series on The Treatment Plan and on page this month the subject of assessment as the foundation of a treatment plan is discussed. However, to some children's institutions comprehensive assessment is not always readily accessible; it can also be expensive if it must be bought out; it can also result in unintelligible information for less-sophisticated staff teams.

Leliebloem House is a children's home for 72 children in Belgravia, Athlone. During the recent interreguum before the new principal was appointed, the NACCW was asked to provide an interim staff programme over the months February to May 1987. It was decided to use this time for the staff to redefine their goals in respect of the present group of children, and out of this developed a set of workshops on preliminary assessment or screening of children. Child care staff are probably in a better position than anyone for observation and first-hand experience of the children, and as such they are in touch with a considerable amount of information. With regard to establishing treatment objectives, getting the right answers is largely a matter of asking the right questions, and to this end the staff worked at developing a simple screening instrument.

Child care staff are probably in a better position than anyone for observation and first-hand experience of the children.

The Categories

No attempt was made to arrive at an empirically-based set of assessment criteria. The idea was to create a model which would hold various aspects of a child's behaviour up for scrutiny by the child care workers themselves, and which, in terms of specific areas of child development, would try to cover all the bases. It was agreed that when someone asked "How is Jill getting on?" it was utterly inadequate to answer "Okay". At the first workshop the staff grouped developmental areas into a small number of easily-understood headings. The following five headings were agreed upon: Physical, Educational, Social, Psychological and Cultural. In addition to these, basic information needed to be included about the child's family, and about adjustment within the residential environment.

Screening

Screening implies an enquiry which can be carried out by non-technical staff and which can separate children into such categories as:-

(1) Those with normal developmental problems or problems which we understand and can manage without highly qualified assistance.

(2) Those whom we are unsure about and who might fall into the "at risk" category.

(3) Those whose behaviour and development frankly disturbs us and whom we feel the need to refer for more qualified help.

The children who fall into category (3) will no doubt have to be referred for thorough evaluation. The children in category (2) are those we would be better advised to have seen by someone, after which they may well be reslotted into category (1) or (3) depending on the findings of further evaluation.

Commonly used screening instruments include Rutter's *Children's Behaviour Questionnaire* and Stott's *Bristol Social Adjustment Guides*. Both are very much more sophisticated instruments constructed as simple behaviour checklists to be completed by teachers, parents or child cared workers, but which are empirically related to very large samples of children which make them accurate discriminators of children at risk. Their advantage is that those who complete the questionnaires have to make no clinical judgements; they answer direct checklist questions on children's behaviour on the "Never-Sometimes-Often" model and these answers are statistically processed.

At Leliebloem we did not attempt such an empirical model, but simply a method by which all relevant developmental and problem areas could be held up for consideration in our evaluation.

Asking the Right Questions

The staff workshops were then devoted to our five developmental categories and those regarding family and children's home environment. In each case the staff attempted to arrive at a minimum number of questions to cover the important information. These are purposely *not* reproduced here, since the Leliebloem evaluation form has no pretensions to being a model for all. Indeed, its singular value to Leliebloem is that it was developed with and by the staff who would use it, and who thus understood it and would be committed to using it.

What was of interest was that staff realised that some categories were easier to evaluate (or at least have evaluated) than others. For example, both physical and educational evaluation fell within the ambit of highly specialised professions. Child care workers were less anxious about physical development

The fund-raising saga continues...

"Quick, please—I'm double-parked."

because they knew that the local clinics and pediatric hospital were skilled and reachable resources, and the instructions they received from doctors or dieticians were informed and unambiguous. Similarly educational evaluation could make use of immediately accessible data like school standards, median ages for the different classes, test marks and IQ scores.
Where the staff struggled more was on areas such a social, psychological and cultural development, and here the workshops produced some conceptual criteria only after many hours of teaching and discussion.

Application of Information Gained
The idea behind this project was that staff having completed a form for each child in consultation with the social worker, and in many cases with the child him/herself, would come away with itemised task lists, treatment plans if you like, in respect of each of the children in their care. Each category on the form included space for future goals to be recorded. As was to be expected, no child came away without new goals having been established. What was unexpected was that some children, whose behaviour staff had somehow "got used to", presented very disturbing pictures indeed, and they became the focus of

Getting the right answers is largely a matter of asking the right questions.

immediate and urgent action. Many children were seen in a new light after the evaluation. For example, one aspect of the social development section was the drawing, together with the children, of their "social maps" which portrayed the significant people in their lives including their distance and their value. Many had tragically empty social maps, others had only sketchy information about significant family members, while yet others were preoccupied with parents they never saw.

Planning Value
The project was reported on by the staff at a meeting of the Management Committee, and this resulted in an advisory group being set up to consider needs in staffing and facilities which should be met to deal adequately with the tasks generated by the evaluation.

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A child care worker is....

Conscientious but not a perfectionist
Discerning but not critical
Disciplined but not demanding
Energetic but not self-seeking
Friendly but not familiar
Generous but not gullible
Gentle but not hyper-sensitive
Holy but not holier-than-thou
Humorous but not hilarious

Loyal but not sectarian
Meek but not weak
Progressive but not pretentious
Self-reliant but not self-sufficient
Serious but not sullen
Steadfast but not stubborn
Tactful but not timid
Tenderhearted but not touchy
Unmovable but not stationary.

Cover picture courtesy The Homestead

"The kiss of life? To a goldfish?"