A DESCRIPTIVE STUDY OF THE ROLE OF THE CHILDREN'S HOME IN THE TREATMENT AND MANAGEMENT OF THE ABUSED CHILD.

By

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ABSTRACT

The researcher believes that childhood should be a time of joy and discovery in which children are nurtured and loved so that they may grow up into responsible and caring adults.

For some children, this does not occur and they are subsequently admitted to residential care settings because of child assault, traumatic experiences and severe neglect.

This descriptive study explores the management and treatment of abused children in residential care. The researcher based the investigation on the assumptions that carefully constructed treatment programmes exist, which involve the abuser, the Child Care Worker and the Social Worker in order to help the abuser and attempt to break the vicious future cycle of abuse.

The researcher approached 17 Children's Homes in the Western Cape to participate in the study and seven of these Children's Homes constituted the sample used in the research. Permission was obtained from the principals of the Children's Homes to interview the Social Worker and a Child Care Worker individually. A questionnaire was constructed which would be used in a structured interview. Two of the selected Children's Homes were chosen randomly for a pilot study in order to test the questionnaire.

The findings of this study reflected that individualized treatment programmes are available for all children in residential care. The treatment and management of abused children do not differ since most children in residential care are regarded as having suffered some form of abuse prior to admission. The study further highlights that the Child Care Worker and the Social Worker assume significant roles in the treatment and management of all children in care. While their tasks and roles differ, a degree of complementarity exists between the Social Worker and the Child Care Worker.

The investigation also identifies that the abuser is not really involved in the treatment process, despite some minimal efforts which may be made to engage their participation in the residential care programme.

The researcher concludes the study by quantitatively and qualitatively evaluating the findings of the research and by proposing some recommendations for future research and practice in residential child care programmes.

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CHAPTER 1

1. INTRODUCTION:

Throughout history children have been subjected to the type of treatment which we now term abuse and neglect. From the beginning of the nineteenth century concern for children has focused primarily on the protection of society from children and the control of delinquent youth. The primary concern with children was in terms of the prevention of crime and anti-Social behaviour. Towards the end of the nineteenth century and immediately after the Second World War, an explicit concern with protection of children from cruel, neglectful or abusing parents emerged.

A growing concern has been expressed by members of the legal, medical and Social work professions, both locally and abroad about the increasing numbers of victims of child abuse and neglect.

This enormous increase in concern over the plight of abused and neglected children has been accompanied by sophisticated, expanded coercive interventions and early detection strategies. The rationale that it was the sole responsibility of a specific profession or discipline, no longer applies. It meant that all individuals, disciplines or organizations involved in child and family care, had to involve themselves in the identification, prevention or treatment of child abuse and neglect.

In South Africa, the Southern African Society for the Prevention of Child Abuse and Neglect (SASPCAN) was established on 11 May 1985 in an effort to co-ordinate and plan effec /e ways of dealing with child abuse and neglect.

It is now widely recognized that child abuse also brings with it specific dynamics and problems which need to be addressed and which necessitates adjustments in the existing services offered to children in need of care, protection or treatment.

The demands placed on the public to participate in the prevention of child abuse, has increased reporting and early detection. This has further contributed to the removal of children to alternative safe residences.

Hence, increasing numbers of children with child abuse histories are being admitted to residential care. The admission of the abused child warrants the need for purposeful therapeutic planning, programming and evaluation. As one acknowledges the changing population entering residential child care, there is also the need to recognize that the Children's Home should provide more treatment oriented services to its residents. Children coming into care are more difficult, disturbed and differ from the dependent child in need of care, more often admitted previously, which further highlights the need for a change in the outdated custodial model of residential child care.

The erroneous notion that placing the abused child in residential care, necessarily represents 'treatment' must be overcome. Placement in residential care can be therapeutic, regrettably, it frequently is not.

This preliminary investigation is based on the assumption that Children's Homes have carefully constructed, individualized treatment programmes for the abused child, which involves the participation of both the Child Care Worker and the child's parents or primary caregiver.

2. BACKGROUND OF THE PROBLEM:

As times change, the children coming into care have changed. Values and childrens' institutions have also changed. Ongoing management of the child's day, more sophisticated academic programmes and experiential learning are all attempts which have been made to nullify the effects of traumatic, negative experiences of early life and to reintegrate the child into the community with more adequate coping skills.

As the pendulum swings to helping the child, institutional 'fences' are given up in favour of relationship, and goal-oriented treatment. Children are no longer incarcerated in institutions, instead they are guided in a more free, warm and accepting environment.

Dinnage and Pringle in their classic text on facts and fallacies about residential care, emphasize that the quality of residential care is inevitably and inextricably bound up with the quality of residential staff. Since the Child Care Worker's role is so demanding and responsible, some training must be regarded as essential. We are also cautioned about the unrealistic and misleading over simplication that affection and commonsense are sufficient by themselves for efficient child care. (Dinnage and Pringle 1969: 32).

Herbert Baines (1985) concurred that 'there is a need for the Child Care Worker in South Africa to see his role as something which has an authentic place within the residential treatment repertoire and that this is something which needs to be worked on ...'. It is further emphasized that the Child Care Worker has a very important role and that this role is central to the work of residential treatment. The need for a knowledge base and ongoing training which would lead the Child Care Worker to become a more skilled sophisticated practitioner, rather than a mere caretaker or custodian is emphasised.

Yet Block, Petersen, Scheepers & Elk (1985) confirmed in their study of Child Care Workers in Cape Town, that Child Care Staff frequently worked long hours; lacked privacy; had exposure over long periods to emotionally hungry children and were also involved in a diversity of other tasks.

It is recognised that fewer 'normal' children enter residential care and childrens' institutions have subsequently to change their role or provide an inadequate and inferior service.

Child Care Workers are invariably linked with parenthood, by nature of the role which they occupy in residential care. However, demands are being made on them to provide the child with opportunities and skills which could help him/her to overcome personal problems and difficulties.

Baines (1975), also emphasises that the Child Care Worker should be able to evaluate a social history of the child, which had been prepared by the Social Worker, be capable of formulating remedial programmes or design interventions based on these, and also from psychiatric assessments, educational testing and family systems analysis. Current literature on residential child care highlights the need forongoing training and supervision.

Literature concerning residential treatment for children demonstrates an almost universally shared, strong belief in the value of parental involvement. (Maluccio & Marlow, 1975). This involvement is seen as a vital component of treatment for several reasons: it reduces parental pathology and its negative effects on the child's adjustment. Although extensive research on parental involvement in the residential treatment of the abused child is not available, the findings of current studies are persuasive.

Nancy Avery (1975) commented that 'The treatment goal in protective service is to strengthen the family unit by helping the parents deal with unresolved conflicts, feelings of inadequacy, loneliness, and/or lack of confidence thereby enhancing their capacity and ability to provide good child care' (Ebeling & Hill, 1975). The literature also emphasise that the care staff and treatment agents, should deal with their own feelings about the abusing parent (Ebeling & Hill, 1975). In order for the Children's Home to be effective, a neutralised position should be attempted at least, in order to assist both the abused and the abuser. Frequently, the abusing parent's greatest barrier to developing a trusting relationship is a fear of abandonment or rejection, which is further compounded by feelings of failure and inadequacy.

Although limited research is available about the exact role which the child plays in the abuse, sufficient findings concur that some children are more at risk than others. It has also been found that temperamental differences may make some children more apt to be abused, particularly if they are irritable, negativistic, demanding, unresponsive, overly dependent or hyperactive.

In a survey done (David Gil, 1970) in 1967-68 on child abuse, the children included in the study presented with 'persistent behavioural atypicality in 24,5% of the cases'.

Specific behavioural syndromes were observed which were presented by abused and neglected children in a therapeutic centre. They identified the three syndromes as depressive, negativistic and aggressive.

The abused child entering residential care does tend to display behavioural patterns which could be seen in terms of the syndromes identified by Flanzraich and Steiner. Hence, the Child Care Worker must have the support and guidance of an interdisciplinary team in order to render an effective service to the often difficult, abused child.

Mouzakitis & Goldstein, (1985) note that interdisciplinary teams in the treatment of abused children are either under utilised or non existent. They also postulate that if social workers, nurses, lawyers, psychiatrists and other caring professions were to work together, the cycle of abuse could be broken. No one discipline can handle or understand the complex problem of child abuse on its own.

Staff in Children's Homes tend to render services in a somewhat lonely and isolated environment. In order to be effective with the abused and neglected children in care, efforts must be made to tap the resources of various disciplines.

Further research and investigation in this aspect of service delivery could be undertaken in order to upgrade current programmes.

3. PURPOSE OF THE STUDY:

Increasing numbers of children presenting with a history of child abuse and neglect, are being admitted to residential care. Previously, children mostly came into care with dependency needs and as victims of unforeseen social circumstances.

The changing population of children entering residential care also highlights the need for changes in the policy, philosophy and management of these children. It further translates into a need for purposeful planning, programming and evaluation.

A transition from the custodial model to updated facilities, adaption of Child Care practice and philosophy is essential. More abused children are also coming into care, because of the ineffectiveness of foster care to address the problems and chaos which comes with the abused child. In a study done in Cape Town, Brian Gannon (1987) found that 13% of the sample involved in the study on foster care, had been admitted to childrens' institutions from foster care. This implied that nearly one out of seven children in Children's Homes and places of detention had been admitted as a result of foster care breakdown. It was also established that a significant portion of children in institutions have been admitted after one or more foster care placements. This emphasizes the need for the Children's Homes to review its effectiveness, programmes and staffing structure as it moves into providing a therapeutic programme for children.

This transition also has the implicit goal of involvement of the systems which affect and impinge on the child and his situation. The family or primary caregivers involved in the child's life prior to admission to care, must be included somehow in the treatment of the abused child. However, the involvement of the family has to be negotiated carefully and cannot be undertaken in a haphazard fashion. It is highlighted in current residential child care literature that effective, nurturant ways must be developed to reach out to the families of children in care. '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'. (Child Care Worker, June, 1987: 3).

Children coming into care are more difficult, disturbed and differ from the dependent child previously admitted into care. The demands placed on the general public to report alleged or suspected child abuse, has contributed to more sophisticated identifications and detection strategies. This also meant that more children were being removed from abusive, violent environments and placed in substitute care.

Previously, people were reluctant to 'become involved'. However, organizations like SASPCAN and the SAP Child Abuse Unit (South African Police Child Abuse Unit) has made it easier for early reporting.

The assumption is held that Children's Homes have changed along with the population coming into care and that specifically designed programmes, goals and strategies are available for the abused child admitted to the Children's Home.

The lack of adequate knowledge of precisely how abused children are handled in Children's Homes has contributed to the current enquiry. When children are admitted to care, the Child Care Worker becomes the 'front line' person. However, specific skills, training and knowledge are needed in order to serve these 'troubled children' effectively. Brian Gannon (1988) emphasized that the South African Child Care Worker deserved appreciation for the range of work which is done by him/her with the children who experience various problems.

The need for support and ongoing training of Child Care Workers is essential. Much potential is reflected in the child care field locally and more effective use could be made of the Child Care Worker's resources and skills. The Child Care Worker is the most significant caregiver in the Children's Home and does have a valuable role to fulfil. Similarly, supervisors have the responsibility to engage the Child Care Worker in such a fashion as to stimulate optimal growth and development.

Clearly, the children entering residential Child Care are different and subsequently require new skills and knowledge. It is also evident that there are resources within the child care field and service which are not being fully utilized or developed. Hopefully, this study will highlight the need for ongoing training and supervision of Child Care Workers in order to upgrade the current service delivery to the children in care.

4. OBJECTIVES OF THE STUDY:

This preliminary investigation will examine the following assumptions:

1. A treatment programme is constructed by the Social Worker at the Children's Home.

2. The Child Care Worker is involved in the planning and implementation of the treatment programme.

3. Some attempt is made by the Children's Home to include the parents or significant caregivers in the treatment of the abused child.

4. Child care Workers receive supervision and training for their tasks and role in the Children's Home.

5. SPECIFIC RESEARCH QUESTIONS:

This preliminary investigation would address the following aspects:

1. What is the nature of the Treatment Programme for the abused child in a Children's Home?

2. Are the Child Care Workers involved with the Social Worker in implementing and devising the Treatment Programme?

3. Does the Treatment Programme at the Children's Home involve the abused child's parents/significant caregiver?

4. Does the Child Care Worker receive supervision and training?

6. OUTLINE OF THE STUDY:

The following aspects are covered in the Chapters that follow:

Chapter 2 — Provides the definition of terminology and identifies the focus of the study.

Chapter 3 — Examines theoretical perspectives on child abuse and reviews literature and research on the subject.

Chapter 4 — Provides the relevant literature review of residential care, with some focus on the South African perspective.

Chapter 5 Reviews the major tenets in treatment and treatment methods for children in care.

Chapter 6 Presents the Research Design and Methodology which was applied in the Study.

Chapter 7 Presents the findings and an analysis of the Study.

Chapter 8 Contains the Evaluation of the Findings.

Chapter 9 Contains Conclusions and Recommendations of the Study

CHAPTER 2

DEFINITION OF TERMINOLOGY AND CONCEPTS

CHAPTER 2 DEFINITION OF TERMINOLOGY AND CONCEPTS:

For the purpose of this study, the following concepts will refer to:

1. CHILD ABUSE AND NEGLECT:

Child abuse is any act or omission that endangers or impairs a child's physical or emotional health or development.

The term 'Child Abuse' includes:

a) Physical abuse or non accidental physical injury
b) Emotional abuse
c) Neglect
d) Sexual abuse and exploitation

2. PHYSICAL ABUSE:

Any non accidental injury or pattern of injuries to a child as a result of acts of omission or commission by a parent or caregiver - these could include: severe beatings; shaking; burns; human bite or grab marks; strangulation which results in unexplained bruises; welts; lacerations or abrasion; fractures; dislocations; severe head or internal injuries.

3. EMOTIONAL ABUSE:

Involves excessive or unreasonable parental demands, which place expectations on the child beyond his/her capabilities. These include:

Constant criticism; belittling; persistent teasing. Failure to provide the psychological nurturing necessary for a child's physical and emotional growth and development is also considered a form of emotional harm. This also includes both behaviour towards the child and withdrawal of interaction with the child.

4. **SEXUAL ABUSE:**

Refers to the exploitation of a child by an older person or an adult for the sexual stimulation and/or gratification of that person as in fondling, voyeurism, exhibitionism and involvement with sexual intercourse, incest, pornography and child prostitution.

5. **NEGLECT:**

Neglect is the failure to provide a child with the basic necessities of life - food, clothing, shelter, emotional security, medical and dental care, and adequate supervision which is necessary for the child's optimal growth and development.

6. **PARENT:**

Throughout this paper, 'parent' will refer to either the most recent caregiver, or the natural parent. This would further imply that the significant carer i.e. the person to whom the child will be discharged to, will be regarded as 'parent'. Hence, 'parent' would refer to the most significant support systems in the community during and after residential care treatment.

7. **FAMILY:**

Throughout this paper, family will refer to the parents and siblings or potential caregivers who are involved with the treatment programme while the child is still in residential child care.

8. **CHILD CARE WORKER:**

This would refer to the primary caregiver whilst the child is in residential care. In cases where relief house parents are used to provide care, the assumption is held that the same training and supervision is afforded as is available to the primary caregiver.

The terms house parent and Child Care Worker will be used interchangeably in this study.

9. CHILDREN'S HOME:

Any residence or home in terms of the Child Care Act of 1983, maintained for the reception, protection, care and bringing up of more than six children or pupils apart from their parents, but not including any school of industries or any reform school.

10. TREATMENT:

For the purposes of this study, treatment will refer to all those processes and actions or decisions which are necessary to address the problems presented overtly or experienced by the resident in the Children's Home.

11. MANAGEMENT:

Management will refer to the attitudes, behaviour or policy which may be needed to accomodate or contain a child's maladaptive behaviour. Management differs from the term 'treatment' in the sense that it refers to the overall, broader functioning of the Child Care staff and the efforts to provide a service for the child in care. Although management of children is relevant to the policy, beliefs and assumptions propagated by the actual management or 'managers' of the Children's Home, it does not refer to parties or people such as the management committees, per se.

CHAPTER 3

LITERATURE REVIEW

CHILD ABUSE

CHAPTER 3 CHILD ABUSE - LITERATURE REVIEW:

1. INTRODUCTION:

Child abuse is certainly not a phenomena which is unique to the 20th century, despite the fact that it was essentially discovered in the early 1960's. The problem of child abuse has really only emerged in the last twenty years, as a social phenomena which necessitated the involvement and taking responsibility by various professions and disciplines.

This phenomena was also different from most of the social problems which were dealt with previously and it meant that new skills, forms of interventions and organizational arrangements needed to be developed.

Children have been ill-treated by adults throughout history, but it is only occasionally that concern about the issue has gathered any momentum. It is only at certain times in history, especially towards the end of the 19th century and immediately after the Second World War, that there has been any explicit concern with protecting children from cruel, neglectful or abusing parents.

The abuse of children is an old problem and society's current reaction to it merely reflects the cultural and philosophical attitudes and changing values. These attitudes and values, however, ultimately become embodied in legal structures in an effort to manage and combat the problem of child abuse.

In South Africa, child abuse has become recognized as one of society's most complex and devastating problems. This recognition and deepening professional concern has caused more pressure to be applied on various professional groups and persons in society. Pressure has been applied on the State, policymakers and professions to intervene and become involved in addressing the problem.

The question 'what is to be done'? remains important and has many implications, particularly when it asserts that some person or office is responsible for controlling, preventing, or eradicating the problem. Nigel Parton, (1985) says that it is often seen as primarily the responsibility of social workers to do something about child abuse, so that when things go wrong, they are held to blame. Child abuse cannot be eliminated without the support and participation by the State, policy makers, educators and most other caring disciplines.

Since the subject does provoke emotive responses, some difficulty is experienced in approaching the problem objectively. Parton (1985) argues that time should not be wasted arguing about problem ownership and causality. He emphasizes that the State must assume responsibility in funding and management of prevention and treatment of child abuse.

Practitioners can play a crucial role in the prevention of further abuse by consolidating and evaluating past research about when and why parents abuse their children, and also highlighting the kind of programmes that research has shown to be effective in curbing the problem.

Even social work, as a profession, needs very much to acquaint itself with the knowledge base relating to all facets of child abuse, in order to contribute to the development of knowledge. Susan Smith (1984) noted that social workers have been accused of merely reading descriptive material about child abuse instead of research related material. While Cain and Kierman (1979) concluded that social workers did not possess a solid knowledge base about child abuse.

It is also important to acknowledge the influence of the term 'the battered child syndrome' (Kempe & Kempe, 1978) on the management and development of child abuse. The medical model emerged from this term and it focused primarily on the pathology of abusers. This also implied that by curing parents of their abusive tendencies, the problem would dissipate. For the first few years after the 'discovery' the media focused on the most extreme cases of battery in which children were beaten, burned and tortured by their caretakers. This sensationalism drew the public's attention to the increasing problem.

However, this approach ignored less extreme cases of abuse, assault and neglect. The recognition of the limitation of this 'disease model' caused practitioners and policymakers to reconceptualize abuse and to consider a variety of abusive and neglectful parental behaviours that could hinder the child's optimal development.

1.1 THE NATURE OF CHILD ABUSE:

Child abuse was largely invisible in the nineteenth century. Historically, society has not been troubled by the maltreatment of children and where children were not wanted, mortality ran high. In the nineteenth century in London, 80% of the illegitimate children who were put out to nurse died; unscrupulous nurses collected their fees and promptly did away with the babies. When a profit could be made, adults sometimes sold children into slavery or used them as a source of cheap labour (Kempe and Kempe 1978).

Infanticide, in some cultures had acceptance as a means of controlling population size and eliminating children with birth defects.

Ignorance and carelessness about the physical and emotional needs of children was the norm for a long time, and maltreatment of children continued until the late twentieth century, virtually unchallenged.

Two beliefs were prevalent in maintaining the status quo - children were seen as their parents' property and it was assumed that parents had every right to treat their children as they wanted to and they were seen as their parents responsibility. Secondly, for many centuries, harsh treatment was justified by the belief that severe physical punishment was necessary to maintain discipline, transmit educational decisions and to expel evil spirits.

However, there were occasional periods of protest and history reveals influential individuals who spoke out against the maltreatment of children. Plato, in 400 BC advised teachers to train their children not by compulsion, but as if they were playing. But respites were shortlived for the highly vulnerable children.

The change in cultural views can be traced to early days of the child welfare movement in America. In New York in 1825, the New York Society for the Reformation of Juvenile Delinquents established a house of refuge, primarily for wayward children and only secondarily for the neglected and abused.

The Society for the Prevention of Cruelty to Children was founded in New York in 1871. Following this, many other similar societies were formed in different parts of the United States and Great Britain which stirred the public conscience about destitute children.

Still, old values have not been eradicated completely and as recently as 1975 the United States Supreme Court ruled that States were permitted to decide if teachers could physically punish children in school. Values are however, clearly changing and the same act that might have met with applause from clergymen a hundred years ago, might be referred to the authorities of criminal justice today.

The history of the emergence of child abuse as a social issue, involves a growing recognition of maltreatment as an unnecessary evil, the technical capability to trace clues that tell a story of inflicted injury and the community's readiness to address the problem constructively.

1.2 HISTORICAL DEVELOPMENT OF CHILD ABUSE:

John Caffey, father of paediatric radiology, spent nearly twenty years trying to fit bony abnormalities, seen on x-rays into known syndromes.

In 1946, he published his first article suggesting that non-accidental injury was prevalent in society. The response by the public was one of horror and disbelief. He persisted and from 1946 numerous articles were published.

However, the credit for first stating confidently and publicly that some of the injuries were not due to accidents, belongs to the radiologist Silverman (1974) when he told the American Roëntgen Ray Society in Washington in 1951:

> 'It is not often appreciated that many individuals responsible for the care of infants and children (who cannot give their own history) may permit trauma and be unaware of it, may recognize trauma but forget or be reluctant to admit it, or may deliberately injure the child and deny it'.

In spite of the growing uneasiness, particularly among radiologists, cases continued to be noted in literature as a syndrome of unknown etiology, usually as a chronic subdural haemotoma or as a condition of increased metaphysical fragility of infancy.

In 1955, a paediatrician from Michigan, followed a ten-year retrospective study of injured children attending his hospital and concluded that the syndromes described by Caffey, Silverman and others were different manifestations of the same basic process of repeated inflicted injury. Wooley (1955) was also the first to note the social and psychiatric aspects of battering parents and to observe the scapegoating element present in some cases.

Deepening professional concern on the subject in America dates from 1961, following a symposium organized by Kempe at the American Academy of Paediatrics. This was followed by the coining of the term 'The Battered Child Syndrome'. Articles were also subsequently published in 1963 by British paediatricians.

Since this time, most disciplines involved in child and family care programmes have acknowledged and investigated the phenomena.

Child abuse is certainly not new to this century, particularly if we look at the life stories of many famous and rich historical figures. Many famous personalities like John Wesley, Frederick the Great, and Lady Jane Grey complained bitterly of their treatment in childhood. It seems that Henry VI appealed to his Council for protection from his tutor, while Charles I substituted Mungo Murray when he was to be punished. These same authors have drawn attention to the considerable evidence of child abuse and infanticide in English literature. The relationship between illegitimacy and infanticide was the theme of the ballad 'The Cruel Mother', while Shakespeare as shown by Lady Macbeth, was also aware of the infanticide impulse. It was also written that 'infanticide is practised as extensively and legally in England as it is on the banks of the Ganges' (Nigel Parton, 1985).

1.3 WHAT IS CHILD ABUSE? - A DEFINITION:

Kempe and Kempe (1978) say that child abuse involves a hurt child, but the web of cause and effect is imperfectly understood. One approach is to look at the symptoms that the child presents. Another is to look at the actions of the caretaking adults. Four categories are usually used to classify their behaviour: physical violence, physical and emotional neglect, emotional abuse and sexual exploitation.

Newberger and Bourne (1979) says that child abuse and child neglect are catchall euphemisms for a variety of childhood injuries that are believed to be derived from parental acts of omission or commission.

The literature on child abuse shows that dilemmas are evident in pinpointing a standardized definition of child abuse. Susan Smith (1984) concurs that nearly every article or volume written on child abuse begins with a discussion of problems inherent in defining it.

Gerbner, Ross and Zigler (1980) commented that this lack of a definition also reveals the primitive theoretical level of child abuse research. Without a standardized definition, research findings and data could be misleading because identical labels could be used to describe different phenomena.

The inclusion of neglect as a form of violence toward children, marked a critical conceptual change in the evolution of a definition of abuse. The inclusion of neglect in the definition, highlighted the wide range of behaviours that are potentially harmful to children. This broader definition also implied that it was not only aimed at parents who maim or kill their children, but it now became applicable to all parents who use any form of physical discipline, as well as to a host of socially sanctioned practices that could hinder the child's development. This broader definition also forced society to look differently at corporal punishment in schools and institutions as well as at other forms of violent disciplinary treatment outside of their homes.

This definition also holds implications for the way children are treated whilst in detention, albeit in prisons, reformatories or places of detention. At a conference on child abuse, in July 1987 at the University of the Witwatersrand, papers were presented which highlighted the alleged abuse of children in detention. The Argus, 16 May 1988, reported that three policemen were fined R50 for forcing a small group of strollers to swim naked in a dam after midnight. The magistrate ruled that these children were not 'like normal children of 10 years' and were used to 'street life' (Argus, 16 May, 1988).

No standardized definition has been conceptualized by any one discipline, thus the definitional dilemma remains unsolved.

Some authors argue that the definition should be broad enough to take into account less obvious forms of abuse such as cigarette burns and torture, but not so broad as to make it impossible to distinguish abusive behaviour from normal adult behaviour.

Another perplexing problem in the definitional drama is determining the point as the punishment continues at which discipline becomes abusive. There is a need for a cut off point, or most parents who do not know better could face charges of child abuse when their children are disciplined.

1.4 INDICATORS OF CHILD ABUSE AND NEGLECT:

There are a number of indicators to suggest whether a child may have been abused. However, the presence of one or more indicators does not necessarily mean that a child will or is being maltreated. Generally, the higher the proportion of indicators present, the greater the likelihood that child abuse is occurring or will occur. Indicators include:

i) Physical Abuse:

- Bruises, welts, cuts lacerations, burns, human bite or grab marks or any other type of injury which is unexplained or could not have been self inflicted.
- Repeated injuries or accidents that are bizarre or vaguely described.
- Bruising on a young baby who is not mobile.
- Parental discipline inappropriate for a child's age and development.
- Parent or careprovider seemingly unconcerned about child's condition.
- Parental delay in seeking medical attention for child.

ii) Emotional Abuse:

- Child extremely withdrawn, anxious or depressed.
- Child overly compliant or excessively aggressive.
- Child excessively critized by parent.

- o Child rejected or over protected by parent.
- o Child failing to thrive for no medical reason.
- o The child is prone to making constant negative comments about own behaviour: 'I'm good, no good'.

iii) Neglect:

- o Child constantly seeking adult attention.
- o Child developmentally delayed.
- o Child consistently listless, fatigued and lethargic.
- o Child underweight or constantly hungry.
- o Child's medical or dental problems unattended - poor physical hygiene.
- o Left alone at home or unsupervized under circumstances in which injuries may occur or when the child's health or person may be endangered.

iv) Sexual Abuse:

- o Injury to, or itching of child's genital area.
- o Child reporting sexual activity with others.
- o Child exhibiting bizarre or sophisticated sexual knowledge or behaviour.
- o Child showing either a fearful avoidance of, or secretive interest in, adults of a particular sex.
- o Sudden marked decline in child's academic performance.
- o Mother frequently absent from home.
- o Father or male provider misusing alcohol or drugs.

Other general indicators of abuse are when a child:

- o Demonstrates a reluctance to be with a parent.
- o States that he or she or a sibling has been maltreated.
- o Is overly rigid in complying with adult instructions.
- o Is very wary or constantly anxious.
- o Goes to school early and is reluctant to return home after school is dismissed.

1.5 EFFECTS OF CHILD ABUSE:

Children may sustain a number of emotional, psychological and developmental problems and trauma as a result of being abused. Physical abuse can result in neurological damage or death.

Lack of parental affection, non-acceptance, and emotional abuse, can be catastrophic for a child. Seriously neglected children may become distrustful of adults and suffer life-long emotional damage. Very often they have a low self esteem and low self image; they may eventually come into conflict with the juvenile justice system.

All child sexual abuse experiences could be regarded as potentially harmful to the child. Frequently, the child believes he or she is responsible for the abuse, for causing the family crisis following disclosure and that he or she did something wrong.

Paul Rosman (1985) concluded that many female adolescents who present with disturbances of conduct, including sexual promiscuity; runaway attempts; suicide attempts; aggressive and provocative behaviour toward others come from broken homes and may have been exposed to previously undisclosed sexual and physical abuse. Rosman also argued that ego development could be affected adversely as a result of the abuse.

Barton Schmit (1979) states that abused children are withdrawn, listless or immobile. Speech delays and gross motor delays leading to a false diagnosis of mental retardation are common.

Martin (1976) described the abused child as presenting with negativistic, hostile and difficult behaviour.

1.6 THE CYCLE OF ABUSE:

Kempe & Kempe (1978) claim that the most consistent feature of the histories of abusive families is the repetition from one generation to the next. There appers to be a pattern of neglect, abuse, parental loss and deprivation.

In each generation, we seem to find in one way or another, a distortion of the relationship between parents and children that deprives the children of the consistent nurturing needed to develop their potential fully.

The parenting may be inadequate because of physical and emotional absence, which early in life, results in the failure to thrive syndrome.

When the parent is consistently absent, emotionally the child may suffer from a deprivation that may go unrecognized.

Little is known about how the parenting abilities are passed down from one generation to another.

Although it is not conclusive proof, some fairly convincing evidence exists that young children do repeat behaviour or experiences from their first two years, which indicates that they were aware, on a non-verbal level, of what was occurring. It is precisely these early traces of pre-verbal experiences which are so difficult to recapture consciously, that may be tormenting the subconscious of the abusive parent and making it difficult for him to change.

The mechanisms by which abusive parents repeat the parenting patterns to which they were exposed are common to us all, it is only the nature of the patterns which differ.

There is no question that we are exposed to many constant models of parenting as we observe the treatment of young children in our own families and in the families around us. But our ability to choose among models may well be limited by the nature of our own experience. In a time of crisis for the parent, when the relationship with a child has reached the point of unbearable stress, it is seldom logical thought that governs the parents' behaviour, it is the underlying tone of the relationship.

This is probably why many 'good, adequate' parents, who have emphatically rejected their own parents' child rearing methods, may revert in moments of crisis, when their own carefully thought-out methods are not working well, to the methods they have rejected.

Then they may discover that they have slipped into patterns they experienced as children. Only if they are aware of what has happened, are they able to bring some reasoning to bear on the situation.

2. INCIDENCE OF CHILD ABUSE:

According to audio visual material presented by the Leeds University, England (1988) one out of six children are victims of incest and sexual abuse.

S. Freedberg, a psychiatric social worker at the Red Cross Childrens' Hospital, Cape Town, stated at a conference on child abuse (1977), that more cases of abuse were previously overlooked, due to lack of professional awareness. She also recorded that 164 child abuse cases were referred to the hospital between January 1973 and December 1976.

D. Heeger from the Addington Hospital, Durban stated that 544 white children were admitted because of child abuse between 1 January 1980 and 29 February 1984. During the period, 836 types of abuse were identified. (Winship 1984).

At King Edward Hospital, Durban, the following statistics reveal the increased admissions to hospital due to child abuse:

1979	-	8 children
1980	-	16 children
1981	-	36 children
1982	-	87 children
1984	-	144 children

Freedberg (1977) states that according to other studies, the expected incidence for a city the size of Cape Town (population 1 million), would be 200 - 300 new cases a year.

In the 'child watch' campaign which was established to aid children at risk in London, the following facts were revealed on 30 October 1987.

1. 4 million adults have suffered cruelty as children. In every age group, one child in 10 suffered some form of cruelty, emotional, physical or sexual abuse.

2. It is estimated that one and a half million children were suffering then.

3. Nine out of ten cases of sexual abuse occur within the family circle.

An early attempt to establish both the number of cases per year, and the proportion of the population affected in Great Britain was made by Mrazek, Lynch and Bentovin (1981). However, a limited number of professionals were approached and the response rate was not high - 39%.

The United States Government made an attempt to provide a national prevalence rate by collating the statistics produced by the designated authorities to which mandatory reports are made. Subsequent research has shown that reports are not always made and there is good reason to believe that basing a prevalence rate on reported cases will always underestimate the extent of the problem. This is particularly the case in Britain, where reporting is not mandatory and professionals give priority to the obligation to maintain the client's right to confidentiality.

There is evidence that the methods of obtaining information influence the reporting rate. Nash and West, (1986) circulated questionnaires and then interviewed a number of respondents. Of the abuse that was reported only 6% was disclosed at the interview for the first time; had all the respondents to the questionnaire been interviewed, the figure might well have been higher.

Thus, a number of factors make it difficult to assess the incidence of abuse accurately. Incidence rates are largely based on the number of cases which are reported, while many child abuse cases are never reported.

Though it is difficult to determine the overall magnitude of the problem, sufficient evidence exists that this type of violence does occur.

Many writers acknowledge that published figures are nearly always underestimates of the true scope of the problem. An annual report published by the British NSPCC (National Society for the Prevention of Cruelty to Children) in 1987 reflected the following:

Referrals and Cases:

Referrals	23 175
Children involved	45 713
Children in Open Cases	4 916
Children in Open Cases	5 217
Children helped in 1986/7	50 629

(Referrals include reports of suspected incidents of child abuse and other concern received by the NSPCC which may require investigation or other assistance).

The Children:

Under 5 years	17 492
5 - 9 years	13 204
10 - 14 years	8 417
15 - 17 years	2 363
Not recorded	4 237

What was the concern?

Physical abuse	4 670
Sexual abuse	2 327
Neglect	5 964
Left alone	4 113
Failure to thrive	223
Emotional abuse	2 051
Risk of abuse	2 805

Rates of incidence are also based upon the definitions used and if broader definitions are used, the numerical numbers are much higher. The dilemma surrounding a standardized definition contribute to available statistics, which reflect phenomena ranging from the number of deaths from abuse to the number of children who get spanked every year.

In different countries, current statistics are released by specific interested parties and organizations. These could include hospitals, child and family treatment units, or family care welfare agencies.

Gerbner, Ross & Zigler (1980) caution against quibbling over numerical niceties in order to disguise inaction.

Arguments also exist about whether child abuse has increased or whether reporting and detection thereof has become more efficient and effective.

The video 'Through the eyes of a child', produced by the Leeds University, England (1988) challenges one to overcome the 'don't want to get involved' and the 'it is their business' syndrome. Once society has overcome these syndromes, then one could talk in terms of breaking the cycle of abuse and a more realistic reflection of the scope of the problem could be obtained.

3. ETIOLOGY OF CHILD ABUSE:

The forces that drive parents or child minders to abuse the children in their care are numerous and complex. Practitioners, professionals and people dealing with abused and neglected children must attempt to understand the etiological factors of this phenomenon in order to render effective services to both the abused and the abuser.

Newberger and Bourne (1979) concur with the notion that several causal agents are involved in child abuse. They claim that child abuse has been viewed as a symptom of childhood mental illness in the parent; as the culmination of a lifelong experience of violence toward the caregiver; of environmental and social stresses on the family, and of society's acceptance and promotion of physical violence.

A single theory cannot be promoted, which would sufficiently explain the phenomenon of child abuse and neglect. It is necessary to acknowledge that several factors contribute to the causes of child abuse. Much research has been done to investigate the significance of these factors in the occurrence of child abuse. Critiques have been levelled at research studies which addressed single factors only in order to highlight the significance of these factors in the individual studies.

It is also clear that most factors addressed in various research projects are valid but the focus ought to be placed on the combination of factors and its relevance with particular families at a given time.

Smith (1984) in her critical analysis of research findings about the etiology of child abuse, has concluded that the following areas are significant:

1. Sociological/Environmental factors in abuse.
2. The role of the child in the abuse.
3. The psychological/personal factors of the abusive parent.

3.1 SOCIOLOGICAL AND ENVIRONMENTAL FACTORS IN CHILD ABUSE:

The importance of environmental factors in contributing to child abuse was emphasized by Gil (1970) who conducted the first large scale study in 1967 - 1968 on child abuse. He stated that poverty, its associated difficulties, the overall cultural sanctioning of physical force in child discipline and specific child rearing traditions of different social classes or ethnic groups were major causative factors. Many stereotypes about child abuse and its etiology is still prevalent. Smith (1984) argues that the assumption that child abuse is broadly distributed throughout society, and that it is unrelated to socio economic class, is a myth.

Pelton (1978) concluded in his research that abuse and neglect are related to degrees of poverty, even within the lower class. He found that injuries were more likely to be severe or fatal when income was at the lowest level.

Cultural values and child rearing patterns have also emerged as significant factors in the causes of child abuse in specific families. Newberger and Bourne (1979) agree that there is increasing consensus on the association between the 'acceptable' though violent means of 'disciplining' children and the occurrence of child abuse. We only have to refer to some of our more traditional child rearing practices which includes 'whipping' disobedient children, depriving them of food or shelter and similar activities.

Corporal punishment, which frequently more than hints at blatant assault, is practised in some South African schools and is widely accepted and sanctioned by society. Increasingly reports are published about so-called 'disciplinary measures' taken in respect of minor children at specific schools. The depiction of violence on television and in movies can also affect how adults or older siblings approach issues of conflict (Milner, 1979).

In our own communities, older children are frequently involved in caring for young, infant children, because of the lack of finances for alternative child minding. This practice could also be conducive to child abuse in specific families.

Several other precipitating factors, including marital conflict, desertion by spouse, unemployment, financial difficulties and child misbehaviour have been related to child abuse.

Social isolation has also been found to be a significant concomitant of child abuse. Research has highlighted that adequate parents have more support from friends and family and are generally better at seeking out support, than are abuse parents. (Lynch and Roberts; 1982).

It is evident that when current stressors exceed the available resources and strengths of the family, parents tend to lash out aggressively. It is important to acknowledge that some families and individuals have different thresholds of stress tolerance and abuse can be provoked more easily in some families, then others.

Milner (1979) developed a Child Abuse Potential Inventory and the factor analysis of 160 items identified seven major stressors in order of significance; distress; unhappiness; rigidity; problems from family and others, loneliness, child with problems and negative concept of the child and self.

3.2 ROLE OF THE CHILD IN ABUSE:

It is difficult to assess the role which the child plays in the abuse because of the retrospective element of most studies and research. One cannot easily ascertain whether the abused children were difficult hence the abuse, or whether they are difficult because of the abuse.

Martin (1976) identified six factors which affected the parent-child interaction:

1. Characteristics of the child which makes him/her more difficult to care for and the mother is incapable of providing good mothering.
2. Chance events affecting the mother-child relationship (i.e. difficult pregnancy or desertion of father whom the child resembles).
3. Disruptions in attachment.
4. Mismatch of the child and parent's expectations.
5. Developmental level of the child - parents unable to deal with behaviour of a particular stage.
6. Child's provocative or attention-seeking behaviours.

Questions are also raised about 'differences' between the abused and non-abused child which could be identified in early childhood. Lynch (1976) argues that some children are more at risk than others or than their siblings, for instance. In her study of twenty five children and their siblings, she discovered that abnormal pregnancy, labour or delivery, neonatal or other separations in the first year of life, were all factors which were strongly represented in the abuse sample. Although the sample was drawn from a hospital population, where more health related abnormalities would emerge, the findings showed the differences of characteristics of abused children and their non-abused siblings.

Research findings and studies are insufficient to claim that abused children are difficult or different at birth, although many writers claim that the abused child is perceived as a more demanding infant than non-abused children. (Martin, 1976; Lynch & Roberts, 1982).

The role of the child in abuse is significant and should be explored in order to improve our understanding and management of abused children and abusive parents.

Martin (1976) mentions that the abused child is often different from normal, serene and calm children. He also emphasizes that there is definitely no masochistic tendency to be discerned in the abused child.

It is evident that the child plays much more than a passive role in the abuse, although it is uncomfortable to accept that an innocent child can and does play a role in his own abuse. Friedrich and Boriskin (1980) have identified the following factors in producing parental stress reactions which could stimulate abuse:

1. prematurity
2. mental retardation
3. physically handicapped and sickly children
4. genetic contributions
5. parent's conception of the abused child as being different.

Previously, child abuse was described mainly in terms of the defectiveness of the parent, but several studies reflect that the child and/or specific traits are also significant in stimulating abuse.

Difficulties are presented in attempting to reflect on the personality of the abused child, prior to the abuse incident. Frequently, personality traits and characteristics have been noted afterwards and have no doubt, been affected by the abuse incident.

Factors such as temperamental differences have been noted and over represented in the abused sample included in the studies by Gil (1970) and Kadushin and Martin (1981). These differences were: irritability; negativism; demanding or unresponsive behaviour.

3.3 PSYCHOLOGICAL AND PERSONALITY FACTORS OF THE ABUSIVE PARENT:

One cannot readily assume that all abusive parents are confined to a specific personality type, intelligence level or social class since insufficient research is available in this area. Simultaneously, it is also difficult to say that child abuse is psychodynamically related and has nothing to do with race, colour, creed, sex or income. Although a study by Smith, Hanson and Noble (1973) showed that abusive parents were young and predominantly of a lower social class.

Literature studies during 1962 - 1972 mainly reflected child abusers as having defective characters and personality structures. Even Polanski (1981) stated that 'the abusive parents were depicted as a group of people with a modal personality; less able to love; less capable of working productively; less open about feelings; more prone to living planlessly and impulsively, but also susceptible to psychological symptoms and to phases of passive inactivity and numb fatalism. The overall image is one of persons who do not cope well.

Previously, it was assumed that all abusive parents had suffered abuse and deprivation in their own childhood (Spinetta and Rigler, 1972; Lynch and Roberts, 1982). Overall research findings do not concur with this, although the social histories of abusers frequently reflect adverse, traumatic experiences to a greater degree than the non-abusing parent.

Problems commonly reflected by the abusive parent relate to self-esteem; dependance; emotional deprivation; low frustration tolerance/impulsivity; feelings of isolation and loneliness. A rigidity in relation to expectations of the child seem to occur commonly with the abusive parent, who perceives the child as being 'different'.

4. THE TREATMENT AND MANAGEMENT OF CHILD ABUSE:

4.1 THE ABUSER:

Child abuse and neglect has generated much attention and many services have subsequently been developed or introduced in order to manage, prevent or combat the phenomenon.

Much of the focus in the literature is on the treatment of the victim while the offender is often dealt with through the criminal justice system.

As professionals and others realized that the abuser also needed treatment, several philosophies, treatment techniques and perspectives were developed which could be utilized in therapy with the abusing parent.

Although current treatment modalities differ in philosophy, major theoretical tenets and treatment procedures, many similarities exist.

The following encapsulates the available treatment models which are used to work with the abusing parent:

4.1.1 Psychotherapeutic Perspective:

From this perspective, parents are viewed as requiring treatment and supportive services to help them overcome their emotional disturbances. The children of these abusing parents are usually transferred out of the home situation, while the treatment improves the psychological health of the parent.

This 'medical model' perspective also implies that the abuser suffers from an underlying personality disorder. The emotional problems which the parent experiences are evident in their inability to tolerate frustration in interaction with the child; hostility; aggression; rigidity; depression; self depreciation and anxiety.

Shorkey (1979) states that this psychoanalytic model also specifies that the major sources of underlying disorders of abusing parents are inadequate mothering or nurturance in the early developmental stage and the lack of adaptive development of ego and superego functions, because of inadequate resolution of phases of psycho-sexual development.

Treatment is usually long term i.e. one or two years involvement between the abusing parent and the therapist. Changes in ego functions, such as impulse control, object relations and problem solving or appropriate use of defense mechanisms are major signs of client improvements.

The efficacy of treatment also largely depends on willing and ongoing participation by the abusing parent. The abusing parent, according to Shorkey (1979), is seen as resisting awareness of their condition and avoiding painful aspects of therapeutic resolution of their problems, if they refuse to co-operate.

The treatment process also includes engaging the clients in the process, reviewing the client's developmental history and current functioning, identifying and working through repressed conflicts; and improving aspects of the client's ego functions.

Major techniques include support, catharsis; ventilation; anxiety reduction; uncovering; insight facilitation; interpretation; clarification, use of transference relationship and assurance. It has also been emphasized that confrontation as a technique in psychotherapy is important, after an adequate treatment relationship has been established. Martin (1976) argues that the abusing parent requires much support and one should not use confrontation. Some differences of opinion exist in this area.

While acknowledging the effectiveness of this type of individual treatment for the abusing parent, an effort must be made to use family and/or marital therapy later once sufficient improvement has been noted.

4.1.2 Group Therapy:

McNeil and McBride (1979) highlighted the value of using group therapy with abusive parents. Twelve couples who were identified as abusive and high risk parents, were treated in group therapy sessions over a two-year period. The programme focused on the marital relationship, parenting skills and the mutual development of support systems. During this period, encouraging signs of growth were noted, despite the initial resistance and testing out behaviour of the members.

Another group therapy programme organized by Paulson, Chaley and Paulson et al (1973, 1974), attempted to provide a positive 'reparenting' experience for abusing parents who suffered severe emotional deprivation during infancy and childhood. This programme produced a positive outcome after three years.

The traditional psychotherapeutic techniques which are usually tapped in this regard include reassurance, abreaction; catharsis; confrontation and ongoing stimulation of the group process.

4.1.3 Transactional Analysis:

The use of transactional analysis in groupwork with abusing parents, also seems popular with a measure of efficacy. The three ego states (parent, child and adult) which are reflected in the overt behavioural patterns of individuals, provide the behavioural referrent for assessment and treatment in transactional analysis. Drawing heavily on the psychoanalytic concept of symbiosis related to the disturbed parent-child relationships, the major focus of treatment is to break up destructive symbiotic relationships and to realign the relationship in a more constructive way.

In terms of this approach, symbiosis occurs in at least two ways in abusive families: symbiosis between parent and child result in abuse when the parent's demands for caring and nurturing from the child are frustrated causing anger and resentment which leads to the pathological acting out.

Passive abuse, when one parent allows abuse of the child by the other parent, also reflects the symbiotic relationship between the parents as they compete for the child ego state.

Shorkey (1979) says that an important aspect of treatment using transactional analysis is strengthening the separateness of ego states by confronting discounts - the thought process that underlies symbiotic behaviour, consisting of devaluing:

1. the existence of the problem
2. its significance
3. its solvability, or
4. the person's ability to handle it.

Other elements of the treatment process include contracting with clients to achieve desired change, using script questionnaires and correcting information for effective parenting.

4.1.4 Behaviour Therapy:

Behaviour therapy with the abusing parent focuses on increasing the knowledge and skill needed for positive and effective parenting, correcting misinformation and reducing the frequency of undesirable behaviour.

The treatment is based upon the assumption that the abusing parent is often deficient in knowledge of the social, psychological and environmental needs of their infants and children, as well as in knowledge and skill related to effective and humane methods of child management.

This perspective also acknowledges the presence of irrational beliefs, ideas and expectations about their children and their behaviour, as well as inappropriate methods of discipline, which contribute to the occurrence of abuse. Contrary to the psychoanalytic view, the behavioural perspective sees identified behavioural deficits as the core problem, rather than as symptomatic of underlying personality disorders.

Assessment and treatment focus on the identifiable and observable behaviour of parents in their current interactions with their children. Treatment time varies from one month to one year.

Shorkey (1979) argues that according to the social learning theory, there are several possible historical antecedents for inappropriate behaviour or deficits in current behavioural repertoires, including lack of exposure to required knowledge, inappropriate modelling, lack of corrective feedback related to adaptive behaviour patterns insufficient and inconsistent social reinforcement and deficits in discrimination training.

Techniques are selected according to the individual assessment of treatment goals. These techniques may include social reinforcement; extinction; discrimination training; relaxation training; desensitization; corrective feedback; cognitive restructuring; homework assignments and instructions. Supportive services are used in conjunction with therapy to reduce environmental and social stresses that make adequate family performance difficult for the client.

4.1.5 Family Therapy:

The rationale for using a family therapy approach is based on the assumption that the components of isolation, anomie, mobility and loss of the extended family are etiological agents in child abuse. Also that child abuse by one family member is indicative of some family pathology.

McKamy (1977), described a programme using multiple family therapy with three or four families. These families met for a group therapy session for approximately two hours in a large treatment group, where a mutual support system was developed and provided.

Therapeutic techniques used included listening skills, support, interpretation and facilitation of problem solving efforts. Group processes include problem specification, bargaining, conflict resolution and contracting between family members.

No specific outcome data of the use of multiple family therapy is available but the researchers concluded that the method seemed effective in dealing with abusing parents.

Residential care is frequently combined with family therapy in order to assist the whole family.

In 1974, a residential treatment programme was initiated by Kempe (Martin, 1976) which attempted to improve the parent-child interaction, as well as provide for specific treatment needs of the abused, the abuser and the siblings. Many residential family programmes currently exist in England (Park Lane Hospital, Oxford); Denver, St. Louis; New York and Los Angeles.

Although residential family programmes are used frequently abroad, few facilities exist locally, where treatment is rendered in the home or after the child has been removed to substitute care.

Ebeling and Hill (1975), emphasize the importance of multiple family treatment bearing in mind all the persons within the family, not only the abused and the abuser.

The various models of treatment recognize the importance of historical elements and their relevance for current pathological behaviour. Behavioural referents of the client are also used in assessment, treatment planning and evaluation.

It is also vital that we acknowledge the difficulty embodied in providing treatment for the abusive parent. Martin (1976) argues that the following components are essential for therapy with the abusing parent:

1. It is essential to involve more than one person in the treatment process. The developmental conflicts of the abusive parent, causes the tendency to split objects into good and bad. Multiple therapists must be involved in the treatment and these could include the health worker, voluntary aides and lay therapists.

2. Treatment of the abusive families require much more outreach than is normally done in traditional psychotherapy. Abusive parents are suspicious, distrustful and extremely needy with minimal ability to delay gratification. The parent may also require concrete evidence of giving in order to accept that the therapist cares about him.

3. Treatment cannot be short term or time limited as with other clients.

4. Court ordered therapy or involvement with representatives of courts, provides some special problems in therapy just as it does with other patients, where the legal system is either requiring the therapy or requesting periodic feedback from the therapist.

5. The reactions and counter tranferences of the therapist are especially common and important when working with the abusive parent. The neediness for acceptance, warmth and nurturance of the abusive parent may lead to the therapist 'adopting' the client, with inappropriate counter transference implications.

The relationship between the parent-abuser and the abused child is ultimately the primary symptom in the child abuse situation. While all members of the family may need a variety of types of treatment, it is essential that this primary symptom of family dysfunction be addressed. The parent's expectations, fantasies and conflicts around the child must be dealt with in therapy in order to improve the child care practice of the parent.

All too frequently, inappropriate measures of parenting ability are used. When the parents take the social worker's advice to obtain a job, keep therapy appointments, obtain better housing and show psychological growth, this is often used as a rationale for returning the child to the parental home.

Criteria which are directly related to the positive changes in the parent-child interaction must be used to evaluate the possibility of reinstating the child in his parental home.

4.2 THE CHILD:

Several treatment approaches are available for the abused child and the problems which he is experiencing. Treatment is generally geared to developmental delays and deficits or it can involve crisis care, psychotherapy, preschool or day care and substitute care.

What is certain though, is that some type of direct help for these children is needed in order to work through the trauma of his experience. Individual psychotherapy or play therapy are alternatives, while for some children, especially sexually abused children, group therapy can be used effectively.

Mrazek (1981) presented documentation on the use of group therapy with sexually abused children with some success. However, she emphasized that the group therapy must be interrelated with the overall treatment for the family and with the legal action which had been taken.

The goals of the group could include:

1. The provision of a safe setting where the children can talk or play through their feelings about the problem and their experiences.

2. Assistance to improve social skills.

3. Provision of male and female adult roles which are different to those which the children had experienced in their parental homes.

Frequently, the abused child has to be removed from the violent environment and placed in substitute care. Much controversy exists about the decision to remove the child from home or to provide in-home treatment. Franklin (1975) says the mistaken notion that separating a child from his family is always a last resort and harmful is widely believed by social workers. In fact, he argues that the contrary is true. The Queensland Centre for Prevention of Child Abuse in their brochure state 'while the safety of the child is given first consideration, efforts are made to keep families together wherever possible. Removal of the child from the family is the last resort'.

When the abused child is removed and placed in foster care or a childrens' home, they are supposed to receive the treatment services that they may need to remedy the effects of the past maltreatment.

Often insufficient attention is paid to the psychotherapeutic needs of abused children after removal from the abusive environment. Physical and emotional suffering which could impede the abused child's development in several ways are experienced. Treatment of the abused child should therefore, include comprehensive developmental assessment and regular reviews by medical, psychological and social work personnel in order to monitor the abused child's improvement.

4.2.1 Multidisciplinary Approach:

Norman (1982) argues that since there are varying expressions of the maltreatment syndrome in children, in their parents, and in total family dynamics, the family assessments treatment programmes and evolving prevention models, must encompass a multidisciplinary approach.

No one person or discipline has the expertise needed to deal with this multifaceted problem nor with the prevention entirely on its own.

Professionals, according to the literature, must communicate and learn to work together and this involves the establishment of trust, of mutual sharing of ideas and professional roles. Kovitz, Dougan, Riese and Brummit (1984) described a programme that was initiated using the multidisciplinary team at Alberta Childrens' Hospital with much effectiveness

This programme emphasizes that there is a need to move beyond an interdisciplinary team composition, towards the establishment of a multidisiciplinary team approach where a broader availability of resources, skill and expertize can be tapped.

The literature seems to suggest that there are many factors which contribute to the occurrence of child abuse. It is clear too, that professional groups working with abusive families should be cognizant of the myriad causes of child abuse, albeit environmental or psychological.

There are difficulties inherent in defining child abuse, but this should not act as deterrent in dealing with the problems of abuse.

Although the abuse of vulnerable children is bewildering and upsetting to even supposedly objective professional persons, treatment must be offered to both the abuser and abused. The increasing incidence of child abuse may very well be regarded as a reliable indicator that the current management of the abuser is ineffectual.

As professionals in the family and child care field, we are responsible for developing mechanisms to improve existing service delivery programmes. We should also be exploring the various resources which are currently available and developing potential avenues which could be utilized in providing treatment to both the perpetrator and the victim.

This study hopes to highlight that the Children's Home can fulfil a valuable role in the treatment of both the abused and the abuser. The non-threatening atmosphere and supportive relationship which could be provided by care staff at the children's Home, may not represent comprehensive treatment for the abusive parent, but it certainly could be used as a stepping stone in addressing some of the difficulties which contributed to the abuse. The acceptance and assistance to the abusive parent can be provided by staff who are trained, equipped with the necessary skill or expertise and who would receive ongoing supervision.

CHAPTER 4

RESIDENTIAL CARE

CHAPTER 4 RESIDENTIAL CARE:

1. INTRODUCTION:

Whatever the priorities in child welfare policies as a whole and the arguments in favour of community-based programmes, residential institutions for children are still common and are required to care for specific groups of children.

McPherson (1987), argues that the reasons for a need to provide residential care to children are very simple - it is because of the conditions which the poor and vulnerable children find themselves in. He also argues that the situation in the mid-1980's is not very different except in degree from that of twenty five years ago and judged to be such 'as to make necessary some kind of fulltime care for children outside their families, as a last resort when all other measures have failed' (World Health Organization, 1962).

This is evident all over the world and it appears particularly in the cities of poor countries. In Bombay, for instance, it has been estimated that 1 500 children are abandoned each year. For a host of reasons, increasing numbers of babies and young children are without care; parents die; illegitimate babies are abandoned by their mothers because of social hostility and prejudice; but total destitution seems to be the major cause.

Many of these children must be cared for by organized services substituting for family and community care and support.

The provision of substitute care for these children in the form of residential homes represents a profound dilemma for social policy in poor countries. This dilemma is frequently evident in the inadequate funding and lack of subsidized programmes for all children.

The problem is further aggravated by legislation, which means that different services and funds are available to children with the same disadvantaged situation. Arguments about responsibility for the service delivery programmes and funding result which cause further delays in addressing the needs of these children or their families.

With continuing urbanization, far reaching social change and deteriorating economic conditions, there is a profound need for provision to assist these needy children. In addition to these considerations, there are particular special needs for children who are the victims of abuse, neglect and exploitation.

Most Children's Homes throughout the ages, have been founded with the best, often most noble motives. Yet literature usually portray the Children's Home as a harsh, unimaginative and sterile place called 'the home'. Although the founder members always believed that the children's needs and interests were being catered for, the general opinion still reflected much ambivalence and scepticism.

Residential care of children is an important and valuable part of any comprehensive system of child care provision since it does offer many needy children protection, parenting and care.

Our society is not structured through its informal facilities to support and contain all people. Changing trends have dictated and decreed that society adapts to a style of living where the maladjusted, the malfunctioning or different person can be cared for in an alternative structure, which we commonly refer to as substitute care. Broadly speaking then, residential care could also be described as the provision of supplementary resources to enable a society to cope with the essential needs of living. In terms of this, we can say that residential care evolved as a necessary development in our society.

The concept of residential care has been used in many ways and although there are inherent differences, we can distinguish the types of residential care which:

1. provide treatment or rehabilitation
2. contain or restrict people
3. is concerned only with the provision of a supportive, safe living environment.

Much controversy surrounds the decision to place or not place a child in substitute care. The placement of children, with its dilemmas, is a practice probably as old as society but when King Solomon was handed the baby, this type of decision was needed. Similarly, Moses' fate was decided after being found in the bulrushes!

Frequently, the Children's Home is viewed as the last resort or a shelter until a suitable foster placement can be arranged. Loffel, (1988) stated that while foster care held enormous potential for healing and growth for the child in care, it also held the potential for intense pain and disruption in the lives of foster families and a recurrence of rejection and separation trauma for the children. Many children are sent to Children's Homes after the foster care placement had failed because of a variety of reasons. Children's Homes should be regarded as a venue where each child admitted to its care, is provided with the opportunity to grow, develop and be regarded as an individual with the need for a warm, caring relationship.

Mellet (1988) emphasized that the bonding with a caring person is a crucial factor in the healthy physical and mental development of the child. Hence, both Children's Homes and foster care placements have their place in the service provision to children in need of care.

Some children cannot tolerate the 'closeness' in a foster care situation, because of their personality and temperamental makeup, but can adapt very well in the Children's Home (Mellet 1988). When good, suitable foster homes are unavailable, it becomes unrealistic to think in terms of ideal placements, and the question which should be addressed, is more often what is possible, rather than what is the ideal way of handling the situation.

The ideal is that the right place for the child to be is with his family, but if this is impossible or unsafe, alternatives must be sought.

The family is generally perceived as the fundamental unit responsible for and capable of providing a child on a continuing basis with an environment which serves his numerous physical and mental needs during maturation. The child's body needs to be tended, nourished and protected while his intellect needs to be stimulated and alerted to happenings in the environment. The child also needs help in understanding and organizing his sensations and perceptions. All these functions and many others are carried out by parents within the boundaries of a family setting. This picture of the family is an ideal one and is often not matched by reality.

The decision to place a child in the Children's Home also implies that a situation will be created in which the needs, rights, power or opinion of a member or members of the child's family will be disregarded in order to act in the interest of the child in question.

There are however, a large number of children who still need to be accommodated in what has been the main form of provision for them over the past 100 years - Children's Homes.

Stroud, (1973) commented that one of the challenges of the coming decade would be the rethinking of the whole concept and replanning of the residential service, to make it more efficacious with more clearly defined objectives.

However, before we can attempt to upgrade and develop this service provision to children in need of care, we need to have clarity on what we think residential care or treatment is all about.

1.1 WHAT IS RESIDENTIAL CARE AND TREATMENT:

Maier, (1972) states that residential treatment involves 'a therapeutically designed round-the-clock living-in experience, the purpose of which is care and treatment. Its clinical components are an integration of functions, structure, physical setting and immediate social environment'.

He argues that there are three vitally important components which should be evident in the 'experience'.

Firstly, a preventive programme designed to create a physical, social and ideological environment which will minimize experiences that are beyond the child's threshold of successful mastery while simultaneously protecting the community from the child's deviant behaviour and guarding against undue pressure from family, peers and the community association.

Secondly, a programme that could provide the child with the potential belief that he will be able to cope with the routine of daily life in the home.

Thirdly, a programme offering a manifold treatment effort combining a multitude of functions so that the totality of the residential group living experience can serve as a corrective life experience.

The community home then which provides the type of care described above by Maier (1972), can be seen as an integral part of child care service delivery and not as an isolated facility.

The tasks of residential care is dependent upon:

1. Reasons for admission
2. Personality of and type of child
3. Philosophy and policy of the residential child care unit
4. Staffing structure
5. Progress of family rehabilitation

These tasks of residential care are not only the concern of the care staff or the Social Worker. Every team member, whether they are part of the domestic, laundry or gardening teams, have a role to fulfil in the accomplishment and practice of residential care tasks.

Hatchuel, (1985: 12 - 15) concluded that the following tasks of residential care seemed to be prevalent and have also been identified and recognized as such by management committees and principals of Children's Homes:

1. To meet the full needs of the child - the child's basic material needs, security and nurturing needs, acceptance and self worth needs, self actualizing and growth needs.

2. To ensure the fullest educational development of the child.

3. To protect and ensure the physical growth of the child.

4. To provide an environment which will prepare the child for the wider world.

5. To expose the child to a spiritual dimension to ensure his wholeness as a person.

6. To provide working models for acceptable behaviour patterns.

7. To repair social, psychological, emotional and educational damage caused by the child's previous experience.

8. To provide a programme whereby the child can make a confident transition into the world of employment, higher education, marriage and family life and enjoy normal social interaction.

9. To provide a base of social knowledge regarding the existing authority and other structures.

10. To develop a healthy independence based on self discipline and control, self confidence and competence, discernment and realism.

11. To provide necessary supportive services and specializations.

Residential care, as defined by the Child Welfare League of America (1966), has as its purpose, to provide group care and treatment for children whose needs cannot at the time, be adequately met in a family; and it should offer opportunities for a wide variety of experiences through a group living programme and specialized services, that can be selectively used, in accordance with an individualized plan for each child.

This definition also clearly indicates that children coming in to care, need much more than shelter and food. Residential care should:

1. Foster normal maturation

2. Correct or modify the effect of previous, unsatisfactory experiences.

3. Attempt to ameliorate special and emotional problems interfering with the child's development and functioning.

Roberts (1985) cautions the Children's Home staff that children enter care with the scars of traumatic experiences and need to be dealt with in a special manner in order to provide them with the opportunity to adapt to their new environment.

Residential care has changed as the values and needs of societies have changed. The practice of current residential programmes for children could be regarded as the product of a significant historical process.

1.2 HISTORICAL DEVELOPMENT OF RESIDENTIAL CARE:

Institutional care for children was recorded as early as the 4th century, when shelter and food was offered by convents and monasteries.

In England, by 1878, there were fifty philanthropic societies for children in London alone and many important charities started about this time including Dr. Barnardo's and the National Children's Homes. Children were also cared for in workhouses where the focus was on productivity and the protection of society, rather than care for the child and his specific needs. Frequently, large institutions accommodated over two hundred children with very little attention from staff who lacked both the necessary skills and training.

In the United States, documentation reflects that a group of children, whose parents were massacred, received shelter and protection from nuns in 1729.

The Children's Aid Society at Bombay, began to take vagrant children into residential care in 1927 and in 1948 the State passed a Children's Act giving juvenile courts the power to place children into residential care until the age of majority. These were children who were abandoned, orphaned, destitute, delinquent or who were ill treated by their parents. In 1958, the Bombay Women's and Children's Institutions Rules laid down standards regarding accommodation, health education and training.

In 1967, S.O.S. Villages were initiated by the Indian Government specifically to provide an alternative to large institutions for destitute children.

In Columbia, The Institute of Family Welfare was established in 1968 to protect children, especially those of the low income classes, and to guarantee and preserve the stability of the family. It is estimated that there are about 400 000 abandoned children in Columbia, and just over 400 institutions take care of 56 000 of the children - approximately 14 per cent of the total.

We also detect a shift in the reasons for caring for destitute, deprived and delinquent children through the years. Changes were also evident in the patterns of residential care as there were definite movements away from the larger institutions towards smaller, individual and group homes.

The earliest residential establishments for children recognized the children's need for food, clothing and shelter, and provided them with nothing else.

However, during the 19th century, other elements were added such as the need for moral training and education.

Stroud (1973) stated that it was not really until the development of the child guidance service in the 1920's, the study of children in establishments during the Second World War and finally the work by Dr. Bowlby, that the two elements in the emotional life of children, which are particularly important in the present context, were identified. These were briefly, the emotional disturbance produced by separation from parents, and the emotional stunting produced by prolonged residence in arid institutions.

It would be unfair to imply that all staff in these institutions were unfeeling, harsh or cruel. The difficulty was that the homes had developed in such a way and with so much emphasis on order, cleanliness and the basic provision of food, shelter, protection, moral and educational training, that personal relationships, affection, fondling and intimacy were all very difficult to develop even if it was not deliberately discouraged.

However, there was a movement to develop more homely children's establishments with closer contact between the staff and children.

With the upgrading and development of foster care programmes, particularly in England, the need to recognize and respond to the emotional problems of children in care also emerged.

The focus of residential child care practice then shifted towards rehabilitation, treatment and evaluation of children and the problems which they experience and present with. Previously, the children's institutions were regarded as impersonal, sterile and isolated places, which housed 'naughty' children. Stroud (1973), referred to the guilt which is engendered around the need for establishments such as childrens' homes. He stated that it was an indication of society's failure to control the forces which disrupt families.

A further development has been the introduction of an interdisciplinary team, who are responsible for devising treatment programmes for children in care.

Ramasar (1972), claimed that residential child care facilities have developed through the following phases:

1. The care of children in almshouses, which took the form of large congregrate facilities for society's misfits and outcasts.

2. A movement toward child centred institutions which arose from an awareness of the psychic damage to children which occurred in large, impersonalised institutions.

3. The development of facilities which provide temporary care and treatment for children who have needs that can only be met by a group living programme and specialized services planned in accordance with individual needs.

Residential child care has certainly changed in many ways through the years, and this should be viewed as an ongoing process with a need for regular evaluation and reassessment of the objectives, goals and purposes.

1.2.1 Residential Care in South Africa: A Historical Perspective

Until the beginning of the century, South Africans of all population groups belonged mainly to a rural society. In this society, the extended family cared for those children whose parents were unable to do so. However, this position changed drastically for particularly the 'white' group after 1902 as a result of:

1. the development of mining towns
2. the aftermath of the Boer war
3. impoverization of the rural Afrikaner as a result of drought and Rinderpest.

It was during this era that the first Children's Homes for so-called white children were erected, under the auspices of the Dutch Reformed Church. The first Children's Home was erected in 1814 and they undertook to care for orphans who had been born in wedlock only. The Lutheran, Roman Catholic and Dutch Reformed Churches frequently co-operated to provide the shelter, food and education which these destitute children needed. These homes were also separated racially later and the various communities became more aware of the needs of their children, particularly with the economic crisis after the Second World War and the escalating urbanization. It was also considered the 'correct policy' that Black children should be cared for in their homelands and even today, very few Children's Homes for Black children exist in the cities.

In 1913, the first legislation dealing with children in substitute care was enacted and it also provided for the registration and inspection of Children's Homes.

Subsequently, some institutions were closed down because of the appalling conditions. The facilities were rudimentary and inadequate and staff were generally not equipped for the job.

In 1932, the Carnegie Report on the Poor White Question recommended that only adequately trained staff should be appointed as principals of Children's Homes in order to upgrade the service to children.

During this era, the need for professional social workers on the staff of Children's Homes was also recognized.

During 1940, an attempt was made to motivate the establishment of smaller group homes in order to move away from the sterile, large institutions.

Despite the growing concern and focus on the type of childrens' institutions and how it provided for the children, little progress was made.

As recent as 1964, an investigation by the Department of Welfare and Pensions on the standard of qualifications of Children's Home staff, reflected that two principals only had a standard six education, while more than 20% only had standard eight and about one third were matriculated. Only two principals were qualified social workers.

Currently, some pressure is being put on Children's Homes to develop programmes which provide treatment and care for smaller groups of children. Increasingly, use is being made of the cottage system and group homes where a more intimate, homely atmosphere can be created and maintained. Although as recent as 1975 records still indicated that some Children's Homes were catering for one hundred or even two hundred children despite the call to create a smaller, more homely setting.

Residential care, according to Riga (1988), is no longer seen by the state departments as the 'last resort' but as a placement of choice which meets the needs of a specific child. Residential care is also seen as having a dual responsibility - that of care and treatment.

Organizations have been established in order to provide ongoing training, support and accountability for care staff working with children in residential care. The National Association of Child Care Workers was established in 1975 and purports to be committed to the highest possible standards of care and treatment for children in residential settings. Monthly journals are published and consultancy services offered to these residential facilities for children.

The last decade has clearly indicated positive developments in the residential child care field in South Africa. The researcher is inclined to agree with Levine (1988), that we are also in the fortunate position of being able to learn from the experience and literature of other countries.

1.2.2 Legislation and Residential Care in South Africa:

The legal framework in residential child care is complex, particularly in the South African context where the legal system is based on components of differentiation.

Mabusela (1988), argued that constitutional realities made it impossible for the Department of Justice to offer equal and identical services to all the children who go through the system.

In South Africa, there are approximately 10 million children of whom 8 million are African and 70% of these children live in rural areas. Health is defined by the World Health Organization as a state of mental, physical and social wellbeing and does not only mean the absence of disease or illness. We could also regard health as a state of wellbeing and effective functioning satisfactory to the child and its environment.

However, in South Africa, health is closely related to race, for it is racial legislation which would determine the nutrition, medical care, education, housing, welfare services and community resources which would be available to a particular child.

The same applied to the child who requires substitute care. It is of crucial importance that we understand the broader context and implications of the legal system for children in South Africa.

Mabusela (1988), argues that many practical problems are experienced by social workers who have to work with Commissioners of Child Welfare and Magistrates who tend to interpret the prevailing laws in their own way.

The Child Care Act of 1983 governs the handling of children, irrespective of the region in which they may be located, but the interpretation and application thereof differs from province to province. The Commissioners of Child Welfare are not specifically trained to deal with child care matters which complicates the issue even more.

The fiscal policy and legislation of the South African Government is based on racial differentiation and prejudice. Subsequently, funding of child care programmes is also frequently adversely affected.

Levine, Loffel and Wright (1988) have suggested that the current legislation governing children in South Africa represents a leap backwards for those involved in residential care.

Many practitioners have experienced the application of the Child Care Act (1983) as clumsy and filled with many gaps.

However, legislation does offer the child in substitute care some protection as the Children's Homes has a legal responsibility and accountability for treatment and care to the child committed to the residential setting.

The relevant South African legislation applicable to the child and the Children's Home is provided in annexure F for further reference.

2. THE CHILD CARE WORKER:

Davis (1982), stated that residential staff should be professional workers developing attitudes, creating environments and upholding only those practices that will reduce the distance between the living styles of those in care and people living more or less successfully in their own homes.

This vision of residential care practice can become a reality, despite the differences in formal qualifications which the child care staff may possess. There are many examples of practice which is being upgraded and improved regularly in local Children's Homes. However, it is clear that the child care worker does possess unique abilities, skill and expertize which could be utilized more effectively when adequate supervision and training is provided on an ongoing basis.

Child care workers are frequently told to provide the type of care to the children admitted to the Children's Home which they would provide to their own children. The starting point for real care is the acknowledgement and acceptance that it is not their child and that the child is in substitute care, not in his parental home or environment.

The Child Care Worker, according to James (1968) has three major responsibilities:

1. The Child Care Worker has to create with the children an atmosphere similar to the normal family home, where each child is treated as an unique individual with recognition of his needs.

2. The Child Care Worker has to adjust and cope in living and working with colleagues, who may differ remarkably from themselves.

3. They also have to function within a policy and philosophical framework which is determined by the management of the Children's Home.

Some independence is provided to the child care worker by the very unique nature of their task. They are also accountable to the management of the Children's Home for many activities. They are expected to receive visitors, keep the rules of the fire drill, do shopping, take children to day hospitals and clinics and be prepared to attend conferences and workshops. These are all in addition to the formidable task of providing quality care for the child in the Children's Home.

The demands made on the Child Care Worker range from an expectancy that they would possess adequate home-making qualities, a knowledge of all aspects of physical care to having a skilled understanding of individual needs of a group of children, who often vary in age and background.

In addition to the management's expectations of Child Care Workers, several other adults may be involved for instance, Social Workers, magistrates, school teachers and nursing staff in meeting the needs of children in care. Often these persons have their own views of the role of the Child Care Worker and how the children or their problems should be handled.

The current movement in Residential Child Care, is to recognize both the difficulties and the rewards of being in the 'frontline' and attempts are also made to develop and enhance the building of a child care profession.

However, professionalization can be painful - Child Care Workers must be provided with the opportunities to acquire skills, expertise and knowledge which would enable them to render a 'professional' service to the needy, disturbed children in care. Whilst the professional status of Child Care Workers is no guarantee that they are able to provide a meaningful relationship to the child in care, it could enhance their current functioning and provide the recognition which is lacking.

2.1 CHILD CARE POLICY AND PHILOSOPHY:

Mortimore and Mortimore (1985), called for the need for a coherent unified policy on child care, and for effective parent involvement, all of which could make the influence of institutions for children more positive - benign rather than malignant.

Although Goffman (1961), stressed the similarity of institutional regimes, later work by others has emphasized the diversity amongst even those with similar functions (Tizard et al, 1975; Mortimore, 1978).

A number of studies have not only identified differences, but have demonstrated that differences have an effect on the behaviour of the residents. Custodial child care institutions have been found to vary in the amount of control exerted in facilities and in the atmosphere (Milham et al, 1978).

These well documented differences in the internal process of institutions have been shown to be related to differences in outcome, that is, in the development and behaviour of the inmates.

Cawson & Martell (1979) suggested that many of the problems experienced with delinquent adolescents in institutional care are produced by some poor establishments rather than being intrinsic to the young people. Moreover, many young people had a worse record after discharge from a secure accommodation than previous histories suggested.

One is faced with the question: How would policymakers develop institutions for the future? Some of these suggestions would call for a change in government policies, particularly in the South African context, where the criterion of race is used to develop services or programmes. Structural and organizational changes along with changes in attitudes regarding service delivery to children in care could also be propagated.

Children's rights and the utilization of a 'watchdog' to ensure that children are treated with some regard is a good starting point.

McPherson (1987), claimed that the 'U.N. Universal Declaration of Human Rights' contained the very important principle, i.e. that 'mankind owes to the child the best it has to give'. This also meant that every child was entitled to, amongst others, have a happy childhood, receive education which would be free and compulsory and receive special treatment or care when it was needed.

Gannon (1980: 36 - 40) noted the following basic principles which have been developed in a so-called Charter of Rights for Children in Care:

1. The child in care has a right to individual respect and consideration, even though his rights and needs will be closely associated with those of others.

2. The child in care has a right to be looked after by skilled adults who have been specifically selected and who have a commitment to the understanding and meeting of his individual needs.

3. Before a child is admitted to care, an assessment of his family and home environment should be undertaken which will include the preparation of the child and his family for the admission, and their participation in the plans that are made.

4. The child in care has the right to live in an environment which is conducive to his emotional, physical, social and intellectual development.

5. The child in care has a right to individual attention which shows recognition of and respect for his unique identity.

6. The child in care has a right to information concerning his circumstances and to participate in the planning of his future.

7. The child in care has a right to administrative standards and procedures within his caring agency which will protect his interests.

8. The child in care has a right to the protection of the law.

When the policy is determined for a particular Children's Home, the assumption is held that the principles contained in this Charter of Rights for Children in Care are adhered to in some way or the other.

At the Sixth Biennial National Conference of the National Association of Child Care Workers of South Africa, Riga (1988) stated that the South African Government's policy was based on the following principles:

1. South Africa is not a welfare state.

2. The concept of a partnership between the private sector and the State.

3. The importance of family life as the nucleus of society.

4. The legislation applicable to child care was:

   4.1 The Child Care Act, No. 74 of 1983.
   4.2 The National Welfare Act, No. 100 of 1978.
   4.3 Circular No. 6 of 1987.
   4.4 The Criminal Procedures Act, No. 51 of 1977.

Riga also emphasized that the State no longer regarded residential care as the last resort, but now recognized that it was one component in the continuum of care which is provided by the community and the State.

The dual responsibility of care and treatment was spelled out and it is also reflected in the current legislation (Child Care Act, 1983).

McPherson (1987) argues that changing economic and social conditions put both communities and families under stress. This not only undermines existing capacities for ensuring the welfare of children, but places new demands on traditional forms of child care.

The policymakers, government departments and the State, then, should be attempting to address evils which c ntribute to increasing poverty on broader levels as well.

Social policy cannot be considered in isolation from different peoples and their needs, yet this is no mandate to offer a service delivery programme based on racial or cultural prejudice and differentiation. The idea that where community and family structures are more or less intact, the welfare of children is secure, is naive. One cannot assume that children are safe, having their basic needs met or are being educated, protected and loved. Child welfare policies, should contain the following fundamental objectives:

1. To protect children from external threats.

2. To ensure the normal and full development of every child both physically and psycho-socially.

3. To assist children to become fully integrated into their society.

The field of Residential Child Care, operates against the background of a specific policy and political ideology which affects and shape the philosophy and practice offered to the children in their care.

Despite the differentiation regarding philosophy and policies about child care, the basic rights of children provide fair guidelines as to the kind of practice which should be developed for children in need of care, protection or treatment.

2.2 TRAINING FOR CHILD CARE WORKERS:

The quality of residential care is inevitably and extricably bound up with the quality of the residential staff. (Dinnage & Pringle, 1969).

The tasks of the care staff, i.e. the Child Care Worker, is so demanding and formidable that some training for it must be regarded as being absolutely essential. Residential work calls for high skills in making relationships at many different levels, including some which have to be built with parents of the child in care, however foolish, hostile or destructive their behaviour may be.

The need for training of Child Care Workers is essential and we need to move away from the naive and misleading over-simplification that affection and common sense are sufficient by themselves. The age old cliché 'I've raised three well adjusted children without the necessary training' is no license to work with emotionally disturbed and hurting children in care.

Whittaker & Trieschman (1972) cautions that the Children's Home is not a boarding school or substitute family - at least it should not be regarded as such. It is, however, a special kind of group living that for every hour of the day, provides help, support, understanding and hopefully, a passage out from the inner darkness and hate, to which the child has become so accustomed. Residential care should be a safe place where the restless and pained child can articulate his pain in whatever fashion and be heard and helped. In helping the child, this does not refer to permissiveness, but an opportunity for the healing process to be initiated.

The Child Care Worker then, should be capable of acting consciously and purposefully in order to be of assistance to the child in care. For this, the Child Care Worker requires a variety of skills and at least some knowledge base or frame of reference.

Clearly what is needed is the formation of a conceptual design for the role and practice of a professionally responsible person, who will manage the 'curriculum', who will inter-relate the helping processes of both the group and the individual, who will also integrate the totality of each child and, lastly, who will be broadly concerned with integrating the child with his own ecological system. This would be the Child Care Worker with a clear task definition (Herbert Barness, 1985).

Powis (1988), emphasized that each child care setting should develop its own goals for in-service training in order to equip Child Care Workers for their task. It is also emphasized that the role of the in-service training is not to fulfil all the educational and training needs of the staff.

Apart from the in-service training which should be geared at direct, work-related training, Child Care Workers should be encouraged to obtain further training and skill acquisition. The De Meyer Commission (1982), concluded that there was a need for opportunities for the staff of Children's Homes to obtain further academic qualifications. There was also a need for specialized training and knowledge for care staff working in the Residential Child Care field.

Many management teams in residential care echo this call for upgraded qualifications, yet opportunities for acquiring the formal training very often is sadly lacking. The Child Care Worker is described as 'the hub of the wheel' of Residential Child Care by Maier (1972). It is also recognized that, though the child may have significantly close links with other key team members, i.e. social worker, or principal, the Child Care Worker's influence on the child could either sanction or negate the impact of anybody else (Maier, 1970).

Kadushin (1967) emphasized that while the professional staff perform diagnostic and treatment planning activities, it is the Child Care Worker who in direct, intimate, continuous contact with the child, implements the plan, organizing the child's life.

Roberts (1985) stated that the degree to which the children adapt and benefit from being in care, largely depends on the input by the Child Care Worker.

Their task is psychologically taxing and emotionally demanding, hence it is essential that adequate training programmes be made available to the Child Care Workers.

If Child Care Workers are not provided with the support and skills which they require, a repetition of the child neglect or maltreatment may very likely reoccur. Over-worked and exhausted Child Care Workers may also be least able to resist the impulses of using harsh discipline in order to elicit compliant, obedient behaviour.

Lack of adequate training, could also contribute towards care staff encasing themselves with an aura of 'busy activity'. The activities could only involve domestic routines, rituals and task in order to avoid the emotionally demanding engagement with disturbed and hurting children.

Many accounts given by young people who had grown up in care reflect that the child care workers were frequently less responsive to their needs for comfort, attention and care (Kahan, 1979).

During these training programmes, the Child Care Workers should also be advised about the needs of children in care in order to promote a deeper understanding of their problems and behaviour.

Konopka (1974), emphasized that if we wanted to understand the problems of children in institutions, we should realize that they are different for each child and that we cannot draw a picture that will fit everyone.

Training for Child Care Workers must include practical skills training which could meet the needs of many 'how to .... ' questions which the child care worker is faced with in the daily routine.

However, for the purposes of this study, the major focus would be to highlight the need for ongoing training and supervision.

2.3 SUPERVISION FOR CHILD CARE WORKERS:

It is useful and important for the Children's Home to possess a set of assumptions about their understanding of residential care, which has been developed or gleaned from theory and practice. These models or beliefs would naturally make sense for themselves and their staff members in the environment which is familiar to them; despite the commonality which may exist universally.

Workers should have a basic knowledge and understanding of the normal development of children, before any other teaching or training can be provided in other areas related to their tasks. Unless the Child Care Worker understands the normal needs and life cycle tasks of children, one cannot begin to convey any ideas about 'abnormality' or pathology!

The need for supervision has been recognized in residential child care, particularly because of the demanding and formidable task of caring for difficult, disturbed and often, traumatized children, who belong to other people. Child care staff have to be guided in coming to grips with the complexity of their tasks and issues in running programmes for the children in care. Child Care Workers also need guidance in developing their understanding of how the organization expresses its aims through the policies or philosophy which is held. An important task in supervision of the Child Care Worker is also to promote an atmosphere where the worker can extend his knowledge and subsequently, take responsibility for meeting identified growth needs.

A working relationship between the supervisor and the Child Care Worker is essential before the supervision process can occur. Since there are differences in orientations, qualifications and possibly, expertise, a common language must be developed in order for supervision to be efficacious.

For the supervision to be of value, it should be recognized and treated as a priority, which would imply that specific times should be organized for supervision of child care staff, albeit peer group or individual supervision. Time structuring is very difficult in the Children's Home, particularly if important visitors are expected and units or rooms need to be attended to or when unforeseen emergencies occur. Nevertheless an effort should be made to ensure that supervision is part of the programming and practice in the residential care unit.

Supervision could be used to provide support, understanding and recognition to the staff member who is committed and interested in the task of caring for the child, yet lacks the sophisticated 'bag of tricks' which makes the task less formidable. When Child Care Workers are not engaged in a meaningful supervisory structure, they could feel isolated, undervalued and unsupported.

However, the role of a supervisory structure is to support the Child Care Worker not to restrict them in their practice. The Social Worker, by the nature of her role in the Children's Home, is the most suitable to provide supervision on an ongoing basis. The Social Worker also has the task of selecting the most appropriate supervision model which would meet the needs of the residential staff team and ultimately improve the service to the children. Specific models of supervision could be used differentially in response to the needs of the staff and the Children's Home.

It is also important to bear in mind that the goal of supervision is to provide a better service to clients by helping the workers to develop their skills and expertise. The supervisory milieu should be designed as a safe sanctuary, private, uninterrupted by phone calls or visitors and with an atmosphere conducive to exploration of one's input and creativity as part of the professional growth.

Supervision should not be regarded as a mechanical process, it does require a positive working relationship which is based on trust, respect and mutuality. The development of self awareness is also the responsibility of supervision. This development is parallel to insight objectives of psychotherapy. The supervisory context is also similar in many essential characteristics to the therapeutic context. Both situations involve ongoing, intimate, highly cathected, dyadic relationships in an effort at exerting interpersonal influence to effect change made by one member of the dyad toward the other.

It is important that the supervisor develop self awareness in the Residential Child Care Worker without actually therapizing the worker. Differences should be recognized between therapy and supervision. The supervisor has the task of helping the worker to become a better care worker not a better person!

In a sense, the supervisor has the task of becoming more of a teacher, yet less than a therapist. This also demands sensitive and difficult decisions like always being aware that professional concern does not lean towards personal intrusiveness.

Despite this, the supervisor should still be able to deal directly and realistically with transference issues which interfere with the task of caring for a particular child or group of children.

The supervisor also has the task of discerning when a problem is purely personal or when it is a task related issue. It is difficult, though somewhat simplistic and artificial to maintain a rigid boundary between personal and professional issues in supervising the Child Care Worker.

The supervisor also has the responsibility of helping the Child Care Worker to adjust to job related stresses. The Child Care Worker should be helped to feel comfortable, satisfied, happy and have a sense of psychological well being in the supervisory setting.

In summary, supervision of the Child Care Worker should be aimed at the development of knowledge and skills which they possess, in order to allow them to do their job efficiently and effectively. The interaction between the social worker-cum-supervisor and the Child Care Worker is also aimed at promoting worker competence.

The supervisor's role is to support, encourage, impart information and listen to workers. The major functions would also include:

1. Teaching
2. Administration
3. Enabling

Supervisory practice, then, may be envisaged as a two-way process - a positive relationship is built upon the supervisor's creative blend of the administrative, educational and supportive functions and the Child Care Worker's creative use of supervision in order to deliver the best possible services to the children in the Children's Home.

Part of the supervision experience would also mean that power and authority issues, transference and counter-transference, would have to be dealt with. For the purposes of this study, the focus will be on the need for and the importance of providing ongoing supervision to the Child Care Worker, who is faced with a formidable task of caring for demanding, difficult children.

3. THE ROLE OF THE RESIDENTIAL SOCIAL WORKER:

3.1 THE SOCIAL WORKER AND THE CHILD CARE WORKER:

A memorandum drawn up by the National Welfare Board on the duties of Social Workers in Children's Homes, was issued by the Department of Health and Welfare in 1976. The Social Worker, in terms of this memorandum is exclusively responsible for professional services to the children in the Children's Home.

Although it is also the responsibility of the Social Worker to ensure the creation, promotion and maintenance of a therapeutic milieu, this could never be achieved, without enlisting the skills and expertise of the Child Care Worker. This would be even more impossible, if the principal and management committee did not sanction or agree with the development of a therapeutic milieu.

The Residential Child Care Social Worker has tasks and responsibilities towards both the child in care and the staff team, of which she is a member. The Social Worker, also has the task of ascertaining that the child care staff possesses or acquires the tools of their trade.

It is highlighted in the literature that the success and efficacy of any Children's Home is largely dependent upon the ability of the Child Care Workers to perform their care tasks in a competent and efficient manner.

The Child Care Worker, then, has clear needs for respect, recognition, appreciation and achievement, which the Social Worker must take cognizance of. Child Care Workers frequently possess abundant skills, expertise and practical know-how, but they lack the sophisticated language and labels which professionals tend to brandish about.

The Child Care Worker must be guided by the Social Worker through the supervision process to evaluate their practice and effectiveness in a meaningful way. In order to provide the relationship, the support and teaching components inherent in supervision, the Social Worker should firstly possess the supervisory knowledge and expertise. Secondly, the Social Worker should be receiving some supervision herself.

Much rivalry and problems could occur in the relationship between the Social Worker and Child Care Worker, but these problems could be addressed by developing a sound, professional relationship. This relationship would be based upon a mutual respect, understanding and tolerance of the different foci of their respective tasks.

Barrett (1988), identified a 'gulf which exists between child care and social work professionals'. He also emphasized that one could refer to the Child Care Worker as the specialist while the Social Worker would be the generalist, because of the differences in their task and roles.

The Child Care Worker's dealings with the child also lends itself to the development of a closer, more intimate relationship, than the Social Worker would have. The Child Care Worker nearly assumes a parental role compared to the role which the Social Worker would fulfil.

The Social Worker should also be involved in some way or the other with the training of care staff. If training programmes exist and material is taught by other members of team or consultants, the Social Worker could be involved in the practical application and integration of theory and practice.

Ainsworth and Fulcher (1981) argued that training of group care personnel must equip personnel with the material and knowledge which would enable them to provide the type of sensitive social care which is essential for human existence.

The Social Worker, by virtue of her close liaison with both the children and care staff, is in a position to advise what the training needs or provisions are at a given point in time.

Phillips and Davies (1980), mentioned that all too often, training is viewed as little more than a pleasant interlude for staff where they can be given a break from the daily pressures of their routine. They argue that the quality of staff and the service they render is dependent upon recruitment, motivation and training. The children are totally dependent upon the Child Care Staff and the service which they render. This holds the implication that Social Workers could provide feedback about learning needs in order for training programmes to be useful and not develop into mere peripheral activities, which are out of touch with the realities of the Child Care tasks, problems and needs.

The ongoing training of the Child Care Staff should be viewed as part of the overall programme at the Children's Home. It should be seen as a vehicle to promote proved service to the children in our care.

Training programmes, albeit on or off the premises, can be of little value if processes are not developed to monitor the integration of practice and theory in the actual work place.

Hopefully, this study will highlight the fact that the Child Care Workers must receive training and supervision in order to enhance their functioning in the field of Residential Child Care.

3.2 THE SOCIAL WORKER AND THE PARENTS OF CHILDREN IN CARE:

Unfortunately, many staff members in the Children's Home are not family oriented for several reasons. Services to the family are seen by and large as the responsibility of the referring agency or the agency responsible for the family reconstruction programme. Often, the inadequate or lack of appropriate reconstruction service programmes are severely critized. Few of the critics have ever stepped in 'to put their money where their mouths are'. The residential Social Worker and the care staff can render a valuable service to the family of the child in care, without necessarily encroaching on the territory of the agencies responsible for reconstruction services or programmes.

Whittaker (1979), stated that success in treatment depended substantially on the ability to involve the parents as full and equal partners in the helping process.

Avery (1975) also highlighted that the goal was to strengthen the family unit by helping the parents deal with unresolved conflicts, feelings of inadequacy, loneliness and/or lack of confidence - thereby enhancing their capacity and ability to provide good Child Care.

We need to understand the different ways families and parents of the children in care present themselves. Irrespective of how they present themselves, particularly at the Children's Home, their expectations are that they will be accused or attacked because they are bad, inadequate parents. The facts are that they may have been addressed in an accusatory way, perhaps by other helping networks during the process of having their children removed from home. The Social Worker needs to reach out and create an atmosphere where the parents can talk about their frustrations and problems, without necessarily being encouraged to manipulate or split the residential Social Worker and other involved agencies.

Frequently, the fear of rejection and abandonment contribute to the resistance to engagement in the therapeutic process. The parents' feelings of guilt and anger also prevents them from establishing a trusting relationship. When parents start projecting these feelings of anger, inadequacy and guilt by being critical, negativistic and sometimes hostile towards care staff, the Social Worker needs to address this in a mature, yet understanding manner. It is important for the Social Worker not to be trapped into a collusion with the parent in order to avoid getting 'involved' in the treatment programme.

Misunderstandings should be discussed openly, whilst the parents' nagging sense of inferiority is diminished with reassurance that the worker accepts them with all their limitations.

The Social Worker needs to acknowledge that some of the parents, like some of the children, tend to provoke rejection of them. It may also occur that the parents put the Social Worker into a role of a good parent, particularly when they desire closer relationship yet they are apprehensive about being hurt or abandoned by the Social Worker.

The Social Worker may also have to allow some dependancy in order to assist the parent in developing more appropriate parenting skills and techniques by the modelling exercised by the Social Worker. The legitimate needs of the parent must be acknowledged in order for the Social Worker to move parents into assuming more responsibility for themselves, their problems and subsequently, their children.

Many parents of children in care, tend to be isolated, see themselves as inadequate and hopeless. The Social Worker needs to assess ways that the parent can get involved in the treatment programme without sabotaging the needs of the child in care.

The Social Worker in residential care, then, acts as a mediator between the parents, the child and the care staff. It is vitally important that care staff share some of the treatment goals, aspirations and plans for not only the child, but also the parent. The relationship between the care worker and the parent is also nurtured, supervised and guided by the Social Worker during its initial stages.

In summary, the Social Worker should acknowledge that one cannot work with the child in isolation. Simmons, Gumpert and Rothman (1973), found that the more involved the parents are in the child's placement, the more positive the growth was by both the parents and the child. The residential Social Worker can play an important role in helping parents to accept the child's placement, to see the positive elements in it, and to address their feelings of anger; inferiority, guilt, ambivalence and inadequacy by recognizing their continued importance in the child's life.

The Social Worker could also provide parents with the opportunity of group therapy where they could be connected to other parents who share some commonality.

Although the referring agency is responsible for the reconstruction services to the family, the agency and residential Social Worker must contract roles, tasks and boundaries. Hatchuel (1986) argued that tension develops between these Social Workers because of high caseloads which prevents the agency Social Worker of either establishing a meaningful relationship or contact with the family or denying that some relationship still exists between parent and child.

Further problems can arise out of the poor communication between the agency and residential Social Workers. Ward (1975), noted that 'When a person is admitted to care, a clear decision about the future roles of both field and residential workers should be an integral part of the intervention plan.

This is probably one of the most crucial issues of residential social work, yet its constant denial too often results in a lack of serious plans for movement towards the objectives of the treatment programme ... clearly a central feature of every residential programme must involve formal definition about what the field worker intends to do, when he intends to do it, and what he hopes to achieve'.

Reconstruction services are inadequate, yet the residential Social Worker or the management of the Children's Home should not use this as a rationale for apathetic inactivity regarding the involvement of parents of children in our care. The residential Social Worker has a much more intimate, working knowledge of both the child, family and current dynamics which enables her to render a much more effective counselling programme to the child and its parents.

Irrespective of current legislation which determine that reconstruction of the family is the sole responsibility of the agency Social Worker, the residential Social Worker must develop and explore avenues which could be utilized to develop some outreach programme directed at the parents of children in care!

Children cannot be treated in a vacuum, this certainly means much more than the occasional telephonic contact with the agency Social Worker to enquire about reconstruction services.

3.3 THE SOCIAL WORKER AND THE CHILD IN RESIDENTIAL CARE:

Walton and Elliot (1980), said that residential care is in an important transitional phase, moving from a period in which the major task has been to overcome the negative effects of institutional life, to a future where the overriding tasks will be to maximize the positive potential of residential living within a continuum of personal services.

This sums up what part of the residential Social Worker's tasks and responsibilities are in respect of the residents of the Children's Home. Broadly speaking, the Social Workers' activities toward the child would include an assessment or diagnosis of problems and a treatment programme which would be followed through with consistent evaluation and examination of its relevance and efficacy.

Elliot (1980) highlights that the residential Social Worker should also encourage resident participation i.e. the child could be involved in some way or the other in setting treatment goals or devising the treatment programme.

Ward (1977) argues that residential care admission represents a breakdown, not only between the child and society with all its constituents, but also a personal experience of a breakdown.

Hence, the Social Worker in Residential Child Care also needs to assist the child in working with problems, both related to the boundaries within the residential care facility and those related across the boundaries of the residential care unit, i.e. schools, family or other significant ties which were severed when the child was admitted to the Children's Home.

Involvement across the boundaries is a core activity in residential care aiming to enable the residents to cope more effectively with themselves and their environment.

Whatever the reasons are for admission to the Children's Home, once the child is admitted, his individual and other needs should be carefully considered. It is difficult to base assessments and subsequent treatment programmes on the initial contact upon admission, but tentative plans are made whilst the child is allowed some time to adapt to his new, often frightening environment.

Careful preparation of both members and children at the Children's Home, can reduce much of the suffering and discomfort which the child experiences upon admission. If the Social Worker can arrange pre-admission visits for the newcomer with the referring agency, it could alleviate some of the anxiety.

The residential Social Worker must know that children can remain unsettled and difficult for as long as the problems of his home, family and his relationship with a parent remain unsolved or negativistic. The 'unsettlement' manifests itself in various ways, i.e. overt delinquency, hostility, aggressiveness, poor concentration and scholastic abilities, temper tantrums or bedwetting.

Also many of the children have suffered so much neglect, maltreatment or indifference in their own homes and from their own parents, that they enter residential care severely deprived, disturbed and maladjusted.

Some children who present specific problems, will require particular skills in handling. The Social Worker, together with the care staff, would explore avenues and develop the skills or acquire the needed knowledge to address the needs and problems of specific children. It could also be discovered that particular problems need to be attended to outside of the orbit of the residential care centre and the Social Worker could make referrals to child guidance clinics, psychiatric facilities, specialist educational help, or medical treatment. Referrals are discussed with the staff team and a decision made which would serve the needs or problems of the child most efficiently.

A structured programme which would involve ongoing group, individual or play therapy sessions, should be provided to meet the needs of the children at various times.

The Social Worker must develop and establish an integrated practice which would be available to the residents of the Children's Home. The group therapy programme, not only for the children, but also for the parents of the children in care, can be utilized in a very powerful way. Resistant and negativistic children who resent the placement at the Children's Home, can be engaged more readily in a therapy programme with the Social Worker when they notice that their parents also attend group sessions. This seems to address the feelings of ambivalence and betrayal which some children experience whilst adapting to staff at the Children's Home, towards the parents.

All children in the Children's Home will not need the service of a structured social work programme, but there will be children who are more traumatized by past experiences and who will need the safety and warmth of group, play or individual therapy sessions.

The residential Social Worker's responsibility towards the child in care clearly centres on assessing the needs and problems, providing the mechanisms which can address it most effectively and to use the experience of group living as a positive catalyst.

In summary, children are coming into residential care with problems of disturbed and maladaptive behaviour and functioning. Everyone involved in the Residential Child Care field must now question whether they will 'remain on the sideline' merely providing for the basic needs or whether they will upgrade or develop appropriate Child Care practices and philosophies in order to meet the challenges provided by this 'new breed of residents'.

Stevenson (1988) stated that attitudes and values are a combination of the personal and the professional. These may be explicitly formulated or 'taken for granted' and not conceptualized unless challenged or they may be powerful but unconscious. It would appear that as Child Care specialists and practitioners, the time has come for our values and attitudes regarding what is needed and how best these needs can be met of the children both currently in care and those who will still enter the world of Residential Child Care, to be articulated and operationalized.

An essential argument this study hopes to address, is the critical evaluation of precisely how resources are being utilized to address the myriad of needs which the child in care has. There are resources within the Children's Home, which could be developed to provide a more effective and meaningful service to children.

It is also hoped that this study will highlight the importance of supervision and training for care staff, who, after all, have the most powerful position in influencing the residents of the Children's Home. There is a link between quality of work and the degree or availability of supervision and training. There is a need to create a more effective framework of supervision and training for staff in the Children's Home.

CHAPTER 5

TREATMENT FOR CHILDREN

CHAPTER 5 TREATMENT FOR CHILDREN

1. INTRODUCTION:

This section of the study will focus primarily on the treatment of children with particular reference to the Social Worker. The nature of treatment programmes and methods which are applicable to work with children and which is relevant to working with children in care will be described.

The twentieth century is the century of children - a century that is addressing the needs and rights of children as well as the child as a future citizen. The recent local publication of the Proceedings of the Sixth Biennial National Conference of the National Association of Child Care Workers, (South Africa), so aptly entitled 'Today's Child - Tomorrow's Adult' (1988) highlights this heightened interest.

Winnicott (1987) argued that the social work task in relation to children, particularly, is a formidable one, not only because of the statutory obligations and responsibilities, but also due to the emotional task of helping children experience and face various crises. She also emphasizes that children need to be recognized and known as people in their own right, with their unique way of expressing themselves, in order to develop into 'whole' human beings.

Crompton (1980) stated that the twentieth century Social Worker must develop an awareness of her own attitude and beliefs about children in order to develop her understanding and insight of children and their problems. The Social Worker should be sensitive to and be aware of the various philosophies and beliefs about children and their problems which are evident in the child care field. She is also responsible for developing appropriate communication techniques in relation to the children with whom she works.

It is vitally important that some understanding of normal development is acquired before any attempts are made to address abnormality and pathology. The Social Worker must acquaint herself with normal developmental phases and psychosocial or psychosexual crises which the child will encounter in the developmental process. Acknowledging the nature and relation of the parents' role in the difficulties which the child is experiencing is essential.

1.1 PARENTING AND PARENTING FAILURE:

The issue of parenting and parenting failure should be regarded as a reality and not as a mere abstract phenomenon by the Social Worker working with children.

In order to recognize the presence of parenting failure, we need to have clarity on what society's expectations and criteria are for adequate or appropriate parenting. Parents are expected to provide an environment which has an atmosphere of security, which would subsequently nurture the child's potential to unfold and develop. The child also needs to explore his environment in safety and with some freedom. Parents are also expected to provide their children with opportunities to be educated, socialized and to receive medical care when it is needed.

When these expectations are violated and a link is located between the parental behaviour and the child's presenting problems, we can safely assume that parenting failure is evident.

Bentovin and Bingley (1987) highlighted the importance of a family functioning assessment in order to identify whether parenting failure is present. They emphasize the need for an evaluation of the affective states, type of communication, the boundaries, alliances, relationships and family competence which pervades the family functioning. An investigation of the family's relationship to its environment and its stability could further enable the Social Worker to make a sound diagnosis which is based on a thorough assessment of the family functioning.

Problems of parenting can be more fully understood and addressed if the Social Worker can place them in the context of an assessment which involves the complete family unit and by focusing on these aspects of family functioning.

1.2 PARENT-CHILD RELATIONSHIPS AND EARLY DEVELOPMENT:

Mothering has much to do with the survival of the human species as well as that of the individual. The infant is immature and dependent and without a caring adult, would die.

The basis for the baby's early emotional experiences is the mother's built-in drive to nurture and protect her infant, who develops and matures in the reciprocal relationship with its mother.

Parenthood develops and unfolds alongside the development of children and preparation for this important role was once acquired in childhood and adolescence by living in large families. Research has shown that training and preparation for childbirth and the early weeks of parenthood help to promote spontaneous delivery and enhances the parents' feelings for the newborn baby and their willingness to be fully involved with its care. Bonding is the term which has been used to describe the parents' feelings and capacity to nurture.

Harris (1987), emphasized that it is important that practitioners move from vague, over-generalised dogma i.e. 'Bowlby thinks that mothers and babies should not be separated' to a sound, working knowledge of developmental theoretical constructs.

In describing the importance of early development, Freud (1970: 58-59) stated that:

> 'All advantages of a later family life may be wasted on a child who has lacked a warm and satisfying mother relationship in the first instance. In this earliest partnership, the demands are all on one side (the infant's), while the obligations are all on the other (the mother's)... If she proves a gratifying and accommodating provider for his pressing needs, he begins to love, not only his experiences of wish fulfilment, but her person. Thereby the infant's original stage of self-centredness is changed into an attitude of emotional interest in his environment, and he becomes capable of loving, first the mother and after her - the father and other important figures in his external world. The relationship of a mother to her infant is an exacting one'.

The relationship with the mother or primary caregiver, is an exacting one and holds many implications for future parenting and caregiving.

1.3 GOOD-ENOUGH PARENTING

Winnnicott (1965) used the term 'good enough' to indicate that 'perfect parents' do not exist. The 'good enough' parents rear their children with success and enjoyment despite the difficulties which are experienced. The care they provide is 'good enough' and it enables their children to develop skills and use opportunities creatively. Rutter (1982) rephrased the term 'adequate mothering' and defined it as:

1. A loving relationship
2. This leads to attachment
3. It is unbroken
4. Provides adequate stimulation
5. Mothering is provided by one parent
6. Usually occurs in the child's own home

Essentially, this type of parenting would mean that the parents provide a 'facilitating environment for each child in order to promote the child's development'. Thus the child's needs are really put first in nearly all major plans and decisions which the family must take.

As professionals working with children and their families, we have to recognise what the major purpose of the family is in relation to children. We can summarize the main functions of the family as:

1. To promote growth and physical health
2. To provide scope for emotional experience
3. To preserve the art of motherhood
4. To teach appropriate behaviour

Assessing the parenting capacity and subsequently making a recommendation which is in the child's best interest is a difficult tasks. It is important that we develop assessment tools and strategies in our dealing with children and their parents in order to provide a more effective service when problems occur in the parenting process.

2. DEVELOPMENTAL THEORIES AND THEIR RELEVANCE FOR PRACTICE WITH CHILDREN:

Maier (1965) emphasizes that professional helping requires a theoretical frame of reference which includes human development and the intent to apply the theoretical understanding to all aspects of the helping activities.

It is also highlighted in literature that every individual is in a continual state of developmental change, despite unique individual patterns. It is important to consider the implications of these developmental processes and dynamics, when attempts are made to change the child's maladaptive behaviour or personality.

Barker (1979) states that psychiatric disorders in childhood and adolescence must be evaluated against the background of the normal process of development from helpless infant to independent adult.

Hence, the child's age and social setting must be taken into account when maladaptive emotional, social or intellectual functioning is being investigated. One cannot do this assessment and decide upon an appropriate intervention programme unless something is known about the theoretical underpinnings of child development.

Although many significant theories of child development exist, this study will highlight the work of Bowlby (1979), and his views on the making and breaking of emotional bonds which are important processes in child development. This approach seems to emphasize the importance of meaningful relationship building with children by their caregivers.

The views of Bowlby (1979) also support the writer's ideas about the important role which caregivers play in the management of children in care. Furthermore, they promote a more insightful understanding of the many problems which these children experience and present. Hence, the knowledge and understanding of the postulates of attachment theory is of relevance to the nature of management and treatment programmes for abused and neglected children in care.

Attachment theory propagates that many forms of psychiatric disturbance can be attributed either to deviations in the forming of attachment behaviour or, more rarely, to the failure of such development. This attachment refers to the tendency of the human being to make strong affectional bonds with significant others. Attachment has come to mean the child's feelings for its mother and later, other family members. This attachment to the primary caregiver, usually the mother, forms the basis for future relationships. If this is conflictual, it could become very difficult to form other satisfying relationships. Whilst attachment behaviour is evident during early childhood, it is known to characterize human beings from the cradle to the grave.

The attachment behaviour includes crying and calling which elicit care, following and clinging and also strong protest when the child is left alone or with strangers. With age, the frequency and intensity of this behaviour decreases steadily. The key tenet, then, is that a strong causal relationship exists between the individual's experiences with his parents and his eventual capacity to establish affectual bonds.

Bowlby cautions that attachment behaviour is distinct from both feeding and sexual behaviour, yet it is of equal significance in the human life. The attachment figure is commonly referred to as the mother and the person presenting the attachment behaviour, would be the child, irrespective of whether the attachment behaviour occurs in adult life and functioning. When the child is able to explore his environment, the assumption is held that the mother is providing a secure base and this pattern of behaviour will most likely occur throughout the child's life into adulthood.

In adulthood, this secure base could be the family of origin or a new base which he has created for himself. It is important, in terms of this perspective, that we recognize the loneliness and rootlessness which exists when this base is lacking or inadequate.

The behaviour of parents or primary caregivers is complementary to attachment behaviour. The caregiver should firstly be available and responsive to the child and secondly, be willing to intervene when the child's behaviour or attitude is inappropriate. The attachment figure, albeit the parent or any other caregiver, should develop an intuitive, sympathetic understanding of the child's attachment behaviour and a willingness to contain and change the unacceptable behaviour. It should also be remembered that one of the common sources of a child's anger is the frustration of his desire for love and care and that his anxiety commonly reflects uncertainty about the consistency of the parents' availability. Research has indicated that children who receive this kind of caregiving grow up to be more secure and self reliant and present as more trusting, co-operative and helpful towards others.

When pathogenic parenting occurs, the child may live in constant anxiety and subsequently have a low threshold for manifesting attachment behaviour. This condition is referred to as the anxious attachment while contrary to this, the compulsive self reliant picture may emerge. Instead of seeking love and care of others, the person attempts to be self reliant, independent, irrespective of the consequences. Bowlby (1979) claims that the compulsive self-reliant individual is more apt to crack under stress and could present with psychosomatic symptoms or depression.

Bowlby (in Batty, 1987 : 64-65) identified the following as symptoms of pathogenic parenting:

1. One or both parents are consistently unresponsive to the child's care. They also elicit behaviour and/or actively disparage and reject the child.

2. Discontinuity of parenting, which occurs more or less frequently and it could include periods in hospital or institutions.

3. Persistent threats by parents not to love a child, used as a means of controlling him.

4. Threats by parents to abandon the family, used either as a method of disciplining the child or as a way of coercing spouse.

5. Threats by one parent either to desert or even kill the other or else to commit suicide (each of them more common than might be supposed).

6. Inducing a child to feel guilty by claiming that his behaviour is or will be responsible for the parents' illness or death.

In addition to this, the parent, usually the mother, may pressurize the child to be an attachment figure for her, thus inverting the normal relationship. When children are treated in this way, they could become over conscientious, guilt-ridden and anxiously attached. The compulsive self reliance may be manifested eventually in a pattern of compulsive caregiving, where the person is always giving care, yet never receiving it. Often the one selected is a 'lame duck' who may initially welcome the care provided. The care is frequently extended over and beyond the period of need.

The case history of this caregiver usually reflects a mother who, due to either depression or other disabilities was unable to care for the child, instead needed caring for and often demanded assistance with younger siblings. The child grows up behaving as if the only affectional bond available is that care which he gives to others, he also disbelieves that he can receive care from anybody. Bowlby mentions that often children who grow up in institutions from a very young age also develop in this manner.

Disturbances of parenting behavour also occur when the parent views the child as a replica of himself, especially those aspects which he finds intolerable and unacceptable. The discipline and behaviour towards the child could be crude, violent, censorius or sarcastic.

The attachment theory emphasizes that whatever inadequate experiences and pathological parenting the child is exposed to, is carried with him into his adult life and manifests itself in the problems presented in childhood, adolescence and adulthood.

2.1 IMPLICATIONS OF ATTACHMENT THEORY FOR PRACTICE WITH CHILDREN:

The worker faced with the child presenting or experiencing problems, must determine in the assessment whether the problems are related or applicable to the attachment theory. Thus assessment must include a thorough, though tactful, exploration as a detailed case history and profile is developed.

It is desirable that one should have a knowledge of deviant patterns of attachment and caregiving behaviour and of the pathogenic family experiences which had contributed to the situation. Some cognisance should also be taken of information that is frequently omitted, falsified or suppressed.

It is also necessary to involve family members of the child in order to develop a clinical picture. The utilization of traditional interviewing methods only may be inadequate. The practitioner should also use family therapy sessions, conjoint interviews and therapeutic strategies which would be most suitable to assist in the assessment of the child.

The residential Social Worker must continually promote a deeper understanding and awareness of the important role which the caregivers fulfil in their management of children in care. The child careworker must be taught about the importance of maternal and other deprivation in the early stages of the child's development and also how this deprivation affects the current functioning of the child.

The major tenets of the attachment theory can also provide some understanding and acceptance of children who persistently act in a negativistic, hostile or self reliant manner.

Much has been said in the previous chapter about the role of the residential care Social Worker in relation to the child care staff and their tasks in this regard.

3. METHODS OF TREATMENT FOR CHILDREN:

3.1 INTRODUCTION:

Since many of the problems either presented or experienced by children are multifactorial in origin, a variety of treatment approaches must be used. The selection of an appropriate treatment method or approach will largely be dictated by the child's needs, age, sex and history.

Although growth and development usually occur in a more or less orderly sequence from conception to maturity, the complexity of these intricate, though natural processes and the interplay thereof, must be considered when a specific intervention is needed. Hence, the Social Worker selects a treatment method which is appropriate for the child, albeit a latency age child, adolescent or toddler.

Treatment approaches may involve:

Group Therapy
Individual Therapy
Use of Play Therapy

3.2 GROUP THERAPY:

Children of all ages can be treated rather effectively in group therapy. As with individual therapy, there are a variety of approaches which demand different techniques and skills, depending upon the age and needs of the group members.

The members of a group can assist one another through their interaction and modelling which they can provide for one another. The activity or programme planning is geared to the needs of the group members, purpose of the meeting and the commonality which could exist amongst them. Play could be used as a valuable tool in facilitating growth for members in group therapy sessions.

The group therapist has the responsibility and the task of facilitating and promoting a helpful interchange by using the dynamic group processes inherent in the group itself. Children can be moved to building up problem solving skills and a repertoire of much needed coping strategies. With particular reference to residential child care, group therapy can be a treatment of choice since it could involve and cater for the diverse age groups of children who are in care. This would also provide the Social Worker with an opportunity of having contact with many children, who would not readily respond in an one to one relationship.

3.3 INDIVIDUAL THERAPY:

Winnicott (1987) stated that is is very important that we, as Social Workers, get in touch with the child's real self, what they feel about themselves, their lives. We also need to help the children we see in individual sessions to remain in contact with themselves and to maintain a sense of their own unique identity and worth in relation to other people.

Frequently, practitioners are unable, incapable or reluctant to allow the child to connect with the suffering, the loss and sadness which they experience. An effort is made, all too often to seduce the child away from the reality of their feelings by offering various distractions of one kind or another. It is important that the child who needs intervention and support be given the message that he is understood, accepted with whatever feelings he presents himself with.

Our presence, as professionals, in the child's life must be clarified in terms which the child can understand and relate to. We need to develop an appropriate approach in order to create an atmosphere of acceptance and warmth.

Barker (1979: 217-218) suggests that the following principles be used when we do individual work with children:

1. Never criticize the child. Children must be accepted as they are. Acceptance of children does not imply approval of all they do. If a child's symptoms are the expression of repressed anxiety or hostility, disapproving attitudes in the therapist are likely to make the anxiety or hostility and symptoms worse.

2. Most children do not come for treatment of their own accord. The child may have been threatened or scared by the parent or caregiver with the worker/practitioner.

3. Do not plunge straight into a discussion of the symptoms unless these are raised by the child.

4. Try to understand the child's feelings and view of the world.

5. Remember that limits have to be set. While the free expression of feelings is to be encouraged, there are naturally things the child cannot be permitted to do.

3.4 THE USE OF PLAY THERAPY WITH CHILDREN:

In young children, communication usually occurs through play, hence the term 'play therapy'. Rutter (1975) cautions that play itself does not constitute play therapy, rather it provides a mode of communication.

Piaget (1979) has identified several developmental phases of play which is of significance in using play therapy as a treatment method. There are also several approaches to understanding the significance of play in the development of children which include:

1. Psycho-analytic view of Play
2. Behaviouristic Approach
3. Gestalt and Field Theory View
4. The Organismic view in terms of Piagerian Theory
5. Existentialistic view of Play

In her classic views on the use of Play with Children, Axline (1947) stated that children are offered the opportunity to play out their problems, as adults are given the chance to speak out their difficulties.

She also claims that this method provides the child with a chance to help itself. The direction and responsibility is left to the child in play therapy with the therapist occupying a very 'passive role'. The theoretical assumption is that each person possesses the inner motivating power to attain maturity, self actualization and self realization. To attain maturity, the child needs freedom and development space. In this freedom, the child must be allowed to accept himself, since the therapist can only accept him as he presents himself to the therapist.

There are also clear principles determining whether a play session or play therapy session is being held with the child. In play therapy too, the child's repressions are spontaneously brought to the surface and he learns to cope with and control them.

Play therapy, then, would not be appropriate for older children, but is the treatment of choice with the very young child who presents with problems.

Lieberman (1979) highlights that a basic foundation for any treatment modality is a sound knowledge of human needs and individual dynamics. The practitioner must assess how best that particular child and its family can be helped, after which a specific treatment method can be decided upon. The choice of a treatment modality does depend on an understanding of the client's real need and its relationship to the total family dynamics if a family is available. Similarly, the client's need and its unique features will also determine the duration of the treatment.

Lieberman (1979) concludes that social work intervention with any one child or any one adult cannot completely repair the damage caused by an inadequate environment. But everyone needs someone to turn to for support and comfort in time of need.

There is no guarantee that the intervention will make the difference in the life of a particular child, yet this does not exempt any practitioner from delivering the best service available in an effort to assist the child.

The writer has demonstrated that the attachment theory propounded by Bowlby clearly indicates the vital role which the caregivers can play in the lives of children needing care and treatment.

In summary, treatment of the child demands specific knowledge and understanding of children and the ability to communicate and work with them, regardless of the modality applied.

This study hopes to rejuvenate the idea that caregivers can make the difference for the child who has been admitted to residential care.

CHAPTER 6

RESEARCH METHODOLOGY AND DESIGN

CHAPTER 6 RESEARCH METHODOLOGY AND DESIGN

1. INTRODUCTION:

The assumption that specifically devised treatment programmes exist for the abused child in residential care, which include some involvement of the Child Care Worker, the residential Social Worker and the child's parents, formed the basis for this study.

The study also focused on whether the Child Care Workers were being trained and supervised in performing their tasks in relation to the child in care.

2. RESEARCH QUESTIONS:

1. What is the nature of the Treatment Programme for the abused child in the Children's Home?

2. Are the Child Care Workers involved with the Social Worker in devising and implementing the Treatment Programme?

3. Does the Treatment Programme at the Children's Home involve the abused child's parents/significant caregiver?

4. Does the Child Care Worker receive supervision and training?

3. RESEARCH DESIGN:

The researcher decided to do a preliminary study on the care and treatment of abused children in residential settings which would highlight an area that is growing in importance in the work with children in residential care. However, the researcher acknowledges her awareness that much more exploration and investigation is needed to satisfy most of the gaps which still exist in this sphere of child care.

Since time was limited, it was decided to use a structured questionnaire during an interview in order to obtain answers to the research questions.

Letters were sent to Children's Homes which qualified in terms of specific selection criteria, requesting permission from the principal to allow the Social Worker and a Child Care Worker to participate in the study.

3.1 SAMPLING:

Although the researcher is aware that the literature (Grinell, 1981, Eckhardt and Erman, 1977) emphasizes that no guarantee can be made that a sample is always representative of the population, an attempt was made to draw a fairly representative sample of the Children's Homes which qualified in terms of the selection criteria.

A list of all the Children's Homes and residential facilities for children in the Western Cape Region was obtained from the Chairman of the National Association of Child Care Workers, Cape Town. This list was studied in consultation with the Life Line Directory of Services (Life Line, 1982) to determine the population from which a sample could be drawn.

The sample was then determined in terms of the following selection criteria:

1. Staff includes the employment of a fulltime, registered Social Worker.

2. The Children's Home is registered in terms of existing legislation and is governed by their licence to accept abused and neglected children into care.

3. The Children's Home has been in operation for a period exceeding two years.

The selection criteria were based on the following assumptions:

1. Treatment Programmes have to be planned and constructed in consultation with a registered Social Worker in terms of the Child Care Act No. 74 of 1983.

2. The Children's Homes not operating for at least 2 years, unless specifically erected for the care and treatment of abused children, would not normally have reached this level of functioning in order to fulfil the stated criteria for this study.

The researcher decided to include all the Children's Homes in the Western Cape which qualified regarding the abovementioned criteria. Hence, the sampling could be described as convenience sampling, also referred to as 'The Take'em Where You Find Them' sample by Cozby (1981).

A letter was sent to the Principals of the 17 selected Children's Homes, requesting permission for the Social Worker and Child Care Worker to participate in the study, with a brief explanation of the proposed study (See Appendix A).

The principals were all contacted within a fortnight after the letters had been posted. The rationale for the telephonic follow up interview was based on the researcher's own involvement in a Children's Home for the past seven years, and an understanding of the demanding schedules and pressures on the eve of the mid-year school vacation and the possibility that the request had perhaps been put aside to be dealt with later.

3.2 RESPONSES TO THE LETTER:

Subsequent to the letter sent to 17 Children's Homes and the follow-up telephonic interview with the principals, the following emerged:

3.3 REASONS FOR NON-PARTICIPATION:

Two Principals expressed their willingness to participate, but were prevented from doing so since they did not employ a full time Social Worker.

One Social Worker responded on behalf of the principal and management committee that the request would only be considered after copies of the questionnaire were presented for inspection prior to the preliminary interview.

One principal sent a letter informing the researcher that the Children's Home had been closed down, but requested that their keen interest and enthusiasm in similar projects be noted.

One Children's Home could not be contacted since it was evident that the Children's Home had closed for the school vacation.

The Principal of **one** Children's Home expressed great interest and enthusiasm to participate in the study after the end of August when the Social Worker returned from an overseas holiday. However, the research study would be completed by the end of July.

One principal expressed an interest to participate in the study and agreed to contact the researcher within a week. All efforts to contact the principal were futile and the assumption was made that more urgent matters must have contributed to the delay and silence.

One principal expressed an interest, but thought that their residential unit did not really cater for abused children and thus felt unsure about the time vested in such an exercise.

3.4 RESPONSES OF CHILDRENS' HOMES PARTICIPATING IN THE STUDY:

The researcher also found herself responding to the same type of theme which seemed to pervade the telephonic follow-up interviews. The principals expressed some apprehension about the researcher enquiring about the nature of the treatment programmes for the abused child in the Children's Home. It also seemed evident that the erroneous belief was held that the researcher wanted to know the detailed contents of the treatment programme for abused children in care. There was also need to reassure the principals that the investigation was a preliminary one into an area that is becoming increasingingly topical and one which the researcher has often wondered about. Most principals seemed more amenable to arranging a time for an interview after clarity was gained about the researcher's intent.

Following this, it became clear that some personal contact with the principal was essential prior to any interviews with either the Social Worker or the Child Care Worker.

The following issues needed to be reinforced during the telephonic follow-up interview:

1. The study was a preliminary, descriptive study and no judgement or comparison was being made with existing programmes at Children's Homes.

2. The study proposed to explore what was being done with abused children; was it different to practices with children who are in care for reasons other than abuse; who were doing it and whether the people concerned were being assisted through training or supervision to perform the tasks.

3.5 PRINCIPALS WILLING TO PARTICIPATE IN THE STUDY:

Seven principals who agreed to participate in the study raised questions during the telephonic interview about confidentiality, anonymity and whether staff members would be quoted or identified; whether some feedback would be provided regarding the findings and recommendations of the study.

4. PRELIMINARY INTERVIEW:

Preliminary interviews, which were informal and unstructured, were held with the principal and in some instances with the principal and Social Worker about the proposed study.

The issues which were raised during the follow-up telephonic interview, were discussed fully and clarified. Some defensiveness was noted, prior to the clarification of issues related to specifically, confidentiality and anonymity.

During these interviews, most of the principals expressed the willingness to participate in research projects which made a helpful and constructive contribution to services for children, generally, and more specifically, to residential child care. The principals also felt that children were coming into Children's Homes with severe emotional and behavioural disturbances, which needed much more knowledge and skills.

The researcher also informed the principals of her own involvement in the residential Child Carefield in order to explain the background of the study. It was also necessary to make a definite statement of intent about confidentiality in the light of this involvement. One principal, who initially articulated a hesitancy about participating in research studies related to treatment programmes, changed his thinking after the preliminary interview.

After these preliminary interviews, the researcher decided to select two Children's Homes at random from the 7 Children's Homes who were willing to participate in order to test the questionnaire in a Pilot Study.

5. PILOT STUDY:

Interviews were held with the Social Workers and Child Care Workers at the two selected Children's Homes in Cape Town, in order to test the effectiveness of the questionnaire. The items on the questionnaire were divided into 2 sections:

SECTION A:

Focused on the Social Worker and the items explored the following: (See Appendix B).

1. Admission procedures of the Children's Home.
2. Policy and Child Care Philosophy of the Children's Home.
3. Involvement of the Parents in the Children's Home.
4. Training of Child Care Staff.
5. Supervision of Child Care staff.

SECTION B:

Focused on the Child Care Worker and the questions explored the following areas:

1. Admission of new children to the Children's Home.
2. Treatment and management of children cared for by the Child Care Worker.
3. Training of Child Care Staff.
4. Supervision of Child Care Staff.

It was clear that the items contained in the two sections of the questionnaire reflected much overlapping, confusion and repetitiveness. The questionnaire was developed further and subsequently presented in the present abbreviated form. (See Appendix B + C).

6. THE QUESTIONNAIRE:

The measuring instrument in the research study was a questionnaire, which was used strictly in a structured interview. The contents of the questionnaire were the following:

SECTION A: DIRECTED AT THE SOCIAL WORKER:

1. ADMISSION OF CHILDREN TO THE CHILDRENS' HOME:

The first two items were directed at how many children the Children's Home was registered for and how many children were presently in the Children's Home.
Selection criteria was explored as well as the Child Care Worker's involvement, if at all, in the admission of new children to the Children's Home. An effort was also made to determine whether pre-admission interviews were held with the child and or family prior to admission.

2. POLICY AND CHILD CARE PHILOSOPHY:

Twelve items were listed under this section and the researcher attempted to explore the residential Child Caremodel, the philosophy and policy of the Children's Home, as well as the Child Care Worker's knowledge or awareness of the policy, philosophy or rationale for the type of residential care offered. Items about the disciplinary practices and its supervision were also included in this section.

3. TREATMENT:

Fifteen questions were included in this part of the questionnaire. The items were geared at establishing whether treatment programmes for the children in care were planned, the time the planning occurred, whether the Child Carestaff were involved in the planning. An exploration was also made in this section of the questionnaire about the treatment methods used with abused children and whether this differed for children who did not have an abuse history.

4. VISITATION BY PARENTS:

Eight items explored whether the parents were encouraged to visit their children at the Children's Home; who the most significant contact person was during the visits and whether specific procedures applied to parents who wanted to visit their children. Some exploration was also done to determine whether different procedures and arrangements existed for the abusive parent who wanted to visit their child.

5. TRAINING:

Nine items explored whether in-service training was provided for Child Care Workers and whether opportunities existed for the care staff to receive some training and teaching to equip them for their tasks.

Several items explored whether other resources were utilized in providing the training to care staff which were specifically directed at case management, such as regular case conferences on the premises.

6. SUPERVISION:

Thirteen items comprised this section of the questionnaire. The researcher wanted to ascertain whether the care staff were receiving supervision to enable them to cope with the demanding tasks as well as whether some support and understanding was provided. Items were also included to determine whether the supervision sessions involved decision-making regarding treatment planning and goals, feedback about the social work programme with the child, the care Worker's contact and relationship with the parent. Items explored whether the Social Worker assisted the care staff to develop techniques and skills to cope in relationship building with the parents of children, particularly the abusive parent.

SECTION B:

This part of the questionnaire was directed at the Child Care Worker and the following categories were included:

1. ADMISSION:

Four items were included in this part of the questionnaire which basically explored whether the Child Care Worker was involved in any way in the admission of newcomers to the Children's Home. Questions were raised about the age range of the children in the careWorkers's group and whether the careWorker was aware of a history of abuse.

2. TREATMENT OF CHILDREN IN CARE:

Twelve items were included regarding the treatment and management of children. Some of the items were directed at establishing whether any contact existed between the Child Care Worker and the parents of children, albeit abusive or non-abusive parents.

Specific items were also directed at establishing whether the Child Care Worker viewed the abused child and his/her problems as different to those presented by children who were not abused. Questions were also asked about the Child Care Worker's involvement in major decisions affecting the lives of the children in their care and in the planning of treatment programmes.

3. TRAINING:

Ten questions probed whether the Child Care Worker received training on the premises, whether these training programmes were compulsory and whether the Child Care Worker found these training programmes helpful or not.

Items explored whether the training programmes included child abuse awareness or not, whether the Child Care Workers possessed qualifications relevant to Child Careand what other resources were consulted, if at all, to satisfy additional learning needs.

4. SUPERVISION:

Seven questions were included in this part of the questionnaire to determine whether the Child Care Worker received supervision, what type of supervision and by whom. Item No. 5 explored the views about the usefulness of the supervision by the Child Care Worker (See Appendix B), whilst item 6 explored whether the Child Care Worker could use the supervision to understand underlying dynamics i.e. transferential elements, in the carer-child relationship.

The section on Policy and Philosophy was not included in the questionnaire with the Child Care Worker, since some of the items relating to policy and philosophy were included in the abovementioned categories.

7. THE STRUCTURED INTERVIEW:

The questionnaire was used during the interviews with the Social Worker and the Child Care Workers. The items on the questionnaire were followed strictly, although some time was spent discussing other issues which frequently related to the question. Both the Child Care Worker and the Social Worker were asked whether there were any objections about the researcher recording in writing the responses during the interview.

The interview with the Social Worker lasted for approximately one hour, while the interview with the Child Care Worker lasted for approximately 45 minutes. Initially some time was spent clarifying any issues relating to the study, outlining the definition of abuse applicable to the study and alleviating some of the anxiety experienced by the Child Care Workers particularly.

It was also clear that the Child Care Workers frequently seemed uncomfortable in the interviewing situation and apprehensive about the researcher's intent.

8. LIMITATIONS OF THE STUDY:

It should be noted that there are specific limitations in the study, which must be considered in terms of the applicability and generalizability of any findings and results. The major limitations are the following:

1. SAMPLE SIZE:

The sample is very small (seven Children's Homes) which makes it difficult to generalize results and findings to the population of Children's Homes in Cape Town. The sample is certainly not typical and representative of all Children's Homes. The study is further confined to a small percentage of Children's Homes situated in the Magisterial districts of Cape Town, Wynberg and Goodwood.

2. VARIABLES:

Several other variables such as: race, political beliefs, geographic settings, religion, finance or affiliation to particular associations or support groups, may be relevant to the various factors which influence the functioning of and service provided by the Children's Home.

Although the researcher is aware of the many extraneous variables which could be of significance, this was not focused on in the study and could be explored in further research.

3. RESEARCHER BIAS AND PREJUDICE:

Every effort has been made by the researcher to remain as professional and objective as possible. The researcher also wants to mention that she has been and is employed as a Social Worker in a Children's Home for the past seven years and the possibility of bias and its effect on the objectivity, if left unchecked is acknowledged.

4. PRELIMINARY AND DESCRIPTIVE INVESTIGATION:

This study is a preliminary investigation and much more exploratory research still needs to be done around the areas focused upon by the researcher.

CHAPTER 7

ANALYSIS OF THE FINDINGS

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1. INTRODUCTION:

The study set out to discover whether specific treatment programmes existed for abused children in Children's Homes; if some involvement of the child's parents were planned for; as well as the role of the Child Care Worker in the treatment planning and process. In addition, the study purported to find answers to the questions whether the Child Care Workers were being trained and/or supervized to enable them to perform their tasks adequately.

The findings and discussions in this study are not intended to leave the reader under the impression that this is characteristic of all Child Care staff or Social Workers employed at Children's Homes in South Africa. As mentioned previously, the findings and discussion is confined to the limited, selected sample which was used in this study. The data presented only reflect the five Children's Homes which participated in the actual study. The two Children's Homes involved in the pilot study are not reflected in any of the tables.

2. FINDINGS OF THE QUESTIONNAIRE : INTERVIEW WITH THE SOCIAL WORKER:

2.1 INTRODUCTION:

2.1.1 Characteristics of the sample:

The researcher regards the qualifications and the length of employment of the Social Workers, who participated in the study, as significant factors.

The following presents some facts about the above:

TABLE I : QUALIFICATIONS OF THE SOCIAL WORKERS

No. of Social Workers	Qualifications
3	BA Social Work Degree
1	Honours in Social Work
1	Masters Degree

Three Social Workers possessed the BA Social Work Degree, while one Social Worker had completed an Honours Degree and another the Masters Degree in Social Work. The Social Worker with the Masters Degree, also held the post of principal at the Children's Home.

TABLE 2 : LENGTH OF EMPLOYMENT AT THE CHILDREN'S HOME

Period	No. of Social Workers
0 - 12 Months	1
1 - 2 Years	2
3 - 5 Years	1
6 - 10 Years	1

Two Social Workers were employed at the Children's Home for 9 and 18 months respectively, while the remaining 3 Social Workers were employed at the Children's Homes for periods of 2, 5, and 9 years respectively. The two Social Workers who were employed for longer than 3 years, indicated that these periods were uninterrupted periods of employment.

TABLE 3 : SIZE OF THE CHILDREN'S HOMES:

Children's Homes	Registered For	Present Number of Children In Care
A	60	39
B	140	140
C	60	60
D	20	14
E	50	15

Two Children's Homes were registered for the care of 60 children and one Children's Home had 39 children, while the other had 60 children in care.

One Children's Home had 140 children in care and was registered for the same number of children. The remaining two Children's Homes were registered to provide care for 20 and 50 children respectively, while there were 14 and 15 children in care.

3. ADMISSION PROCEDURES AT THE CHILDREN'S HOME:

3.1 SELECTION CRITERIA:

TABLE 4 : SELECTION CRITERIA WHICH INFLUENCED THE ADMISSION OF NEW CHILDREN

Sex	Age	Geog. Factors	Reli-gion	IQ	Severe Psych-iatric Problems	Phys/ Mental H/Cap
1		1	1	1	1	1
	1			1	1	1
1	1				1	1

Four of the Children's Homes included in the sample, reflected that specific selection criteria existed for the admission of children to the Children's Home. One Children's Home did not have a formalized selection criteria, but generally admitted most children referred for residential care.

One Children's Home included religion as a factor in the selection criteria. Two Children's Homes included IQ as important in the selection criteria and children with a lower than the stipulated IQ were not admitted. Three Children's Homes would not admit children who presented with severe psychological or psychiatric problems. Three Children's Homes would not admit children who are physically or mentally handicapped. In two Children's Homes, age was important while one Children's Home only admitted children from a specific geographic setting.

3.2 NUMBER OF ABUSED CHILDREN IN THE CHILDREN'S HOME:

TABLE 5

Children's Homes	Number of Children In Care	% of Abused Children
A	14	90%
B	15	100%
C	140	3,6%
D	60	45%
E	39	80%

Three Social Workers said that approximately 80, 90 and 100% of the children in the Children's Homes were admitted because of some form of abuse. One Social Worker felt that neglect and deprivation were not abuse and said that only 5 children had been admitted because of physical and sexual abuse. The remaining Social Worker said that the last 10 children admitted to the Children's Home were admitted because of abuse while 15 cases of sexual abuse were disclosed after the admission of the children, while these were not included in the reasons for admission into residential care.

3.3 PRE-ADMISSION INTERVIEWS AND CONTACT WITH THE CHILD AND/OR FAMILY:

Three Children's Homes used pre-admission interviews with the child and its family and the referring Social Worker regularly, unless the circumstances prevented this completely. Two Children's Homes attempted to do pre-admission interviews whenever it was possible or feasible. Two Children's Homes which used the pre-admission interviews, viewed it as compulsory prior to admitting any newcomer. All the Children's Homes used the Social Worker to conduct these pre-admission interviews.

4. POLICY AND CHILD CARE PHILOSOPHY:

4.1 CHILD CARE WORKER - CHILD RATIO:

TABLE 6

Children's Home	No. of Children In Care	No. of Children Reg. For	CCW-Child Ratio	Residential Model Used at Children's Home
A	60	60	3 - 20	Cottage System
B	29	60	1 - 12	Dormitory
C	20	14	1 - 10	Community Homes
D	15	50	1 - 2	Unit + Satellite Homes
E	140	140	1 - 25	Dormitory

One Children's Home had 1 Child Care Worker to 25 children, but were in the process of moving to a 1-10 ratio. One Children's Home had one Child Care Worker to 2 children, while another Children's Home had a 1-12 ratio. The remaining Children's Home had 3 Child Care Workers to 20 children.

4.2 RESIDENTIAL MODEL UTILIZED:

Two Children's Homes used the dormitory model of residential care, with a Child Care Worker-child ratio of 1-12 and 1-25 respectively. One Children's Home used the cottage system with a ratio of 3-20 while the remaining two Children's Homes used the Community/Group homes and unit or satellite homes with a ratio of 1-10 and 1-2 respectively.

4.3 PHILOSOPHY OF THE CHILDREN'S HOME:

All the Children's Homes in the study responded that they adopted and practiced a specific philosophy on child care.

Two Social Workers described their philosophy as being based on relationship therapy, while 2 Social Workers said that their philosophy and practice were based on creating and using a therapeutic milieu, while the remaining Social Worker described their philosophy and practice as being based on a peer group system and the belief that all children can be helped.

5. TREATMENT:

5.1 TREATMENT PLANNING:

Two Social Workers said that treatment planning was done immediately after the child's admission to the Children's Home. The remaining three Social Workers said that treatment programmes were only developed after the adjustment period, one Social Worker said that this could be 2 months. One Social Worker said that goal setting was directed at orientating the child before any treatment goals were set.

5.2 RECORDING OF TREATMENT PROGRAMMES:

Four Social Workers said that the treatment programmes were formalized and documented in the child's personal file. The remaining Social Worker said that the treatment planning was 'not really' recorded in the child's personal file.

5.3 PLANNING OF TREATMENT PROGRAMMES:

5.3.1 Involvement in Planning:

Three Social Workers said that an interdisciplinary team consisting of psychologists, nursing staff, principal, Social Worker and the care staff were involved in the treatment planning. One Social Worker said that programmes were planned by herself and discussed briefly with specific Child Care Workers.

The remaining Social Worker said that the treatment planning was done conjointly by the principal, Social Worker and care staff.

5.4 TREATMENT METHODS WITH ABUSED CHILDREN:

5.4.1 Selection of Treatment Method:

Two Social Workers said that a combination of individual and group therapy is used for both abused and non-abused children. Two Social Workers said that an eclectic approach was maintained in the selection of a treatment method for the abused child while one Social Worker said that the history of the child and the presenting problems would be considered in the selection of a treatment method.

Four Social Workers said that the treatment methods were not different because of an abuse history, while one Social Worker said that the abused child's treatment would differ from that of the non-abused child.

5.5 PROBLEMS PRESENTED BY ABUSED CHILDREN:

The following problems were identified as the major problems by the Social Workers involved in the study:

TABLE 7

Problems Identified	No. of Children's Homes which Regarded it As a Major Problem
Sexual Promiscuity	3
Abusive Language	2
Absconding	1
Drug Dependency	1
Pilfering and Lying	3
Negativistic and Hostile Behaviour	1
Withdrawn Behaviour	2

Three Social Workers regarded sexual promiscuity as a common problem presented by abused children. Two Social Workers regarded the use of abusive language as a common problem, while one Social Worker regarded absconding as a common feature. Two Social Workers identified withdrawn behaviour and one Social Worker regarded the negativistic and hostile behaviour as typical of the abused child.

6. PARENT INVOLVEMENT:

Three Social Workers said that the parents were involved in the treatment programme at the Children's Home. One Social Worker said that the parents were aware of the programmes at the Children's Home. The remaining Social Worker said that the parents were not involved in the treatment programme, but that they were welcome to visit the children at any reasonable time. Three Children's Homes catered for the involvement of the parents in group sessions, quarterly meetings and weekly family suppers, while the remaining two Children's Homes maintained an informal contact with the parents.

6.1 THE ABUSIVE PARENT:

Three Children's Homes did not have specific programmes for the abusive parent, while the remaining two Children's Homes had some programme for the abusive parents. The Social Workers in both instances, were responsible for maintaining these programmes.

6.2 VISITATION BY PARENTS:

All five Children's Homes involved in the study said that the parents were encouraged to maintain contact or visit the child at the Child Care facility. Four Children's Homes did not have specific visitation procedures and practiced an open door policy while the remaining Children's Home had specific visitation times and procedures.

6.3 ABUSIVE PARENTS AND VISITATION:

One Children's Home did not permit holiday leave placements for abused children, but the abuser could visit at the Children's Home for supervised visits. One Children's Home only allowed the abuser access to the child once the abuse had been acknowledged by the abuser, particularly in the case of sexual abuse. Three Children's Homes would allow the abuser to visit the child, but supervision of staff would be arranged.

Contact between the abuser and the child was dependent on how the child was progressing in care, according to two Social Workers. Three Children's Homes would establish contact between the abused and its parent as soon as possible after admission.

Four Social Workers said that the houseparent or the staff who are on duty at a given time, would be the most significant contact person for the parent who visits. One Children's Home requested that all visitors report to a central place before children are called.

7. TRAINING:

7.1 IN-SERVICE TRAINING:

Four Children's Homes had an in-service training programme, which is held on the premises at the Children's Home. One Children's Home did not provide in-service training because of the limited number of staff members. Three of the in-service training programmes included child abuse awareness, while the remaining Children's Home did not include child abuse awareness in the programme.

One Children's Home shared the tasks related to the in-service training programme amongst an interdisciplinary team consisting of psychologists, Social Workers and the principal. One Children's Home had the in-service training programme arranged by the principal while the remaining two Children's Homes had the in-service training programme organized by the Social Worker and the principal.

7.2 CASE REVIEWS AND CONFERENCES:

Only one Children's Home did not have case conferences or case reviews. Two Children's Homes had weekly case conferences, while one Children's Home had a case conference every fortnight. The remaining Children's Home had case conferences and reviews every six months.

TABLE 8

TRAINING OF CHILD CARE WORKERS

CHILDREN'S HOMES	In service Training	Child Abuse Awareness	Person Responsible for Teaching	Compulsory Qualification in Child Care	Attendance of Work-Shops Conferences	Case Reviews & Conferences Etc.	Application of Theory : Monitored	Other Resources Consulted	Regular Care Staff Meetings
A	X	X	Principal	X	X	6 Monthly	Behaviour Child Care Administrator in supervision	NACCW Community resources	X
B	X	X	Team	X	X	Weekly	Supervision + Treatment Planning Meetings	NACCW Community	X
C	X	-	Principal + Consultants	No - but encouraged	No -	No	Supervision + Informal contact	-	X
D	No	-	-	No - but encouraged	X	Weekly	-	NACCW Community resources	-
E	X	X	S/W + Principal Consultants	Preferred to Compulsory	X	Fortnightly	Supervision Staff + Treatment Planning Meetings	Community resources	X

X = Presence
- = Absence

7.3 MONITORING THE INTEGRATION OF THEORY AND PRACTICE:

All 4 Children's Homes used the supervision sessions or structures, such as treatment planning meetings and staff groups to monitor the integration of theory and practice. One Children's Home used the senior Child Care Worker to provide the supervision and monitoring of the integration of theory and practice. One Children's Home also used informal discussions to monitor the application of theoretical perspectives.

7.4 ADDITIONAL RESOURCES:

Three Children's Homes were affiliated to the National Association of Child Care Workers and identified the organization as a resource, in addition to in-service training.

Other community resources such as the Child Care information centre, child guidance clinics, libraries and the attendence of workshops and seminars, were identified by 4 Children's Homes.

7.5 REGULAR CHILD CARE STAFF MEETINGS:

Four Social Workers said that regular Child Care staff meetings were held on the premises, while one Social Worker said that Child Care staff meetings were not held.

7.6 SUPERVISION:

The five Children's Homes included in the sample, all indicated that Child Care Workers received regular supervision. Three Children's Homes said that the Social Workers supervized the Child Care Workers, while the remaining 2 Children's Homes indicated that a senior Child Care Worker and the vice-principal provided supervision respectively.

Two Children's Homes used both group and individual supervision for the care staff, while the remaining 2 Children's Homes used individual supervision only. One Social Worker could not give an account of what supervision model was used since she was not involved in the supervision of Child Care staff at all.

TABLE 9 : SUPERVISION

Childrens' Homes	Supervision	Supervised By	Time	Group	Individual
A	x	S/W	Weekly	-	x
B	x	S/W	Weekly	x	x
C	x	S/W	Weekly	-	x
D	x	V/Principal	?	?	?
E	x	Senior CCW	Weekly	x	x

X = Indicates presence of supervisor

7.7 CONTACT BETWEEN CHILD CARE WORKERS AND THE PARENTS OF CHILDREN:

Four Social Workers indicated that the Child Care Workers were helped to develop skills and techniques in reaching out to abusive and other parents. One Social Worker said that this was irrelevant since the Child Care Workers did not have a meaningful contact with or access to the parent.

Four Social Workers also said that systems were built into the routine to allow the Child Care Workers to both provide and receive feedback regarding contact with the parents.

Three Social Workers indicated that item 6.10 which explored the development of the Child Care Worker's understanding of underlying dynamics in the carer-child relationship was addressed in supervision, while one Social Worker could not give an account of what issues were addressed in the supervision held by the vice principal.

The remaining Social Worker indicated that it was often not necessary to address transferential elements in the carer-child relationship, although the other two items 6.10 (a) and (b) were always included.

8. FINDINGS FROM THE QUESTIONNAIRE:

8.1 INTERVIEW WITH THE CHILD CARE WORKERS:

The following profile emerged from the structured interview during which a questionnaire was used.

8.1.1 Qualifications of the Child Care Workers Involved in the Study

TABLE 10

Child Care Worker		School Standard	Qualifications Relevant To Child Care
Male	Female		
1	-	Matric	Dip. in Res. Child Care (Technikon)
-	1	Std 8	Dip. in Soc. Work + BQCC
-	1	Matric	Final Year Student - Dip. in Res. Child Care (Technikon) & Specialized Training (Overseas) in work with Handicapped Children.
-	1	Matric	Final Year Student - Dip. in Res. Child Care (Technikon)

All the Child Care Workers (5) included in the sample possessed qualifications relevant to Child Care or associated fields of practice. 2 Child care Workers were completing the National Higher Diploma in Residential Child Care at the Technikon, while 1 Child Care Worker had already completed the course successfully. 1 Child care Worker possessed a Diploma in Social Work which was obtained at a college in addition to completing the Basic Qualification in Child Care run under the auspices of the National Association of Child Care Workers, Cape Town and 1 Child Care Worker was a matriculant who completed the Basic Qualification in Child Care Course.

8.1.2 Experience and Length of Service of the Child Care Workers

TABLE 11

Length of Service at Present Childrens' Home	Child Care Workers	Previously Employed at Children's Home In A Different Capacity
0 - 2 Yrs	1	-
3 - 5 Yrs	2	-
6 - 10 Yrs	-	-
11 - 15 Yrs	1	Employed as part time relief Worker
16 - 20 Yrs	1	Employed as assistant cook

The Child Care Workers who had been nominated to participate in the study by either the Social Worker or the principal, were all employed at the Children's Homes for periods exceeding one year. One Child Care Worker had been with the Children's Home for 14 years, although in a different capacity. One Child Care Worker had worked for the Children's Home for 17 years after starting as an assistant cook. The other 3 Child Care Workers, were employed for 2, 3 and 5 years respectively.

9. ADMISSION PROCEDURES:

All the Child Care Workers in the sample said that they were involved in some way or the other, with the admission of new children to the Children's Home. The involvement, however, varied from being consulted by the principal about taking in the newcomer to assisting with the orientation of the child to its new environment. One Child Care Worker identified her involvement with newcomers as the participation in staff meetings when the major issues were highlighted from the case history. The involvement appeared to be either direct or indirect in the admission of new children to the Children's Home. One Child Care Worker indicated that there was no real involvement in the admission procedures. Two Child Care Workers participated in case conferences or admissions meetings involving several other staff members.

Only 1 Child Care Worker was involved in the pre-admission interview which was held with newcomers and the Social Worker. Child care Workers in the study seemed to be either directly or indirectly involved with the admission of newcomers to the Children's Homes.

TABLE 12 INVOLVEMENT OF CHILD CARE WORKERS IN THE ADMISSION OF NEW CHILDREN TO THE CHILDREN'S HOME

Nature of Involvement	No. of CCW
Not really involved in the admission of Children	1
Assists in the orientation of the newcomer	1
Only involved with newcomers admitted to specific group/cottage/unit	1
Consulted about the most suitable place/ unit/group in the Children's Home	1
Participates in group/individual case discussion prior to admission	2
Involved in pre-admission interview held with prospective newcomer	1

9.1 KNOWLEDGE OF ABUSE HISTORY:

With the exception of one Child Care Worker, all the other Child Care Workers intimated that abuse and neglect was evident in one way or the other in the childrens' history upon admission. One Child Care Worker did not see neglect and deprivation as part of the child abuse syndrome.

10. TREATMENT OF CHILDREN:

10.1 PARTICIPATION IN TREATMENT PROGRAMME PLANNING:

Four Child Care Workers were actively involved in the treatment programme planning.

Two Child Care Workers were included in special treatment planning groups which consisted of an interdisciplinary group. One Child Care Worker felt that the structure at the Children's Home did not really cater for involvement of the care staff in treatment planning.

10.2 ACCESS TO CASE MATERIAL AND FILES:

Four Child Care Workers indicated that they had direct access to the personal files of the children, in consultation with the Social Worker. One Child Care Worker responded that the case material and file content was too confidential and access was not allowed.

Two Child Care Workers said that they had access to any case material, upon request, from the Social Worker.

11. PARENT INVOLVEMENT:

The Child Care Workers in the sample described their contact with the parents as being frequent and informal. One Child Care Worker encouraged parent involvement by allowing the parents to telephone their children to her private living quarters on a weekly basis. One Child Care Worker attempted to involve parents at case reviews. While two Child Care Workers met with parents during formalized structures for parents.

All the Child Care Workers identified feedback about the child's progress, behaviour and adjustment, and about the child's health as major reasons for maintaining some contact with the parents. All the Child Care Workers in the sample stated that attempts to involve the parents in the programme for the children did not differ drastically, if at all, for the abusive parent.

The following problems were identified as the major difficulties which the Child Care Workers experienced in their contact with the abusive parent:

1. Parents often tended to be unreliable.
2. Apathy, uninvolvement and disinterest.
3. Tendency to abdicate all parental responsibility.
4. Frequently present splitting and manipulative behaviour between the staff and children at the Children's Home.
5. Parents tend to become rivalrous with the CCW when their younger children are in care.

The Child Care Workers noted that more reaching out was required in their contact with the abusive parent, but generally no significant differences existed between abusive and non-abusive parents.

12. PROBLEMS IDENTIFIED IN ABUSED CHILDREN;

The following problems were identified as outstanding difficulties in dealing with abused children in residential care:

1. Identity problems
2. Withdrawn and Sullen attitudes
3. Aggression
4. Sexual Promiscuity
5. Scholastic Problems
6. Communication Problems
7. Relationship Problems

All the Child Care Workers in the sample noted that these problems were presented with much more frequency and intensity than by children who did not have an abuse history.

13. TRAINING:

13.1 IN-SERVICE TRAINING:

Four Child Care Workers attended a weekly or fortnightly in-service training programme on the premises of the Children's Home. One Child Care Worker did not attend in-service training because the staff numbers were too small to warrant a training programme.

13.2 ATTENDANCE OF IN-SERVICE TRAINING:

The Child Care Workers who attend the in-service training all responded that these training sessions were compulsory. Three Child Care Workers said that child abuse awareness was addressed in the in-service training programme while one Child Care Worker said that child abuse awareness was 'not really' included in the teaching programme. Four Child Care Workers saw the in-service training sessions as being helpful, practical and stimulating.

13.3 PERSONS RESPONSIBLE FOR TEACHING ON IN-SERVICE TRAINING PROGRAMMES:

The following persons were identified as the key people responsible for providing in-service training:

1. Principal of the Children's Home
2. Social Worker
3. Programme Director
4. Psychologists
5. Consultants

The tasks related to the in-service training programme seem to be shared primarily between the principal and the Social Worker, with consultants' and psychologists' services being used in addition to this.

13.4 OTHER RESOURCES WHICH ARE CONSULTED BY CARE STAFF:

One Child Care Worker expressed an interest to consult other resources to increase knowledge and skills in residential child care, but felt that the geographic setting of the Children's Home lent itself to isolation. Four Child Care Workers identified the following resources which were used to broaden their knowledge about their tasks:

1. Workshops, conferences and seminars on Child Care and related topics
2. Child care associations
3. Literature
4. Community Resources: Child Care Information Centre

13.5 SUPERVISION:

All the Child Care Workers included in the sample said that they attended weekly, individual supervision. Two Child Care Workers identified their supervisors as the vice-principal and the senior Child Care Workers, respectively. One Child Care Worker received both environmental supervision and case management supervision.

Generally, supervision is provided by the Social Worker. 3 Child care Workers said that they also participated in group supervision, whilst one Child Care Worker explained that the shift meetings served the same purpose.

Four of the Child Care Workers described the supervision sessions as being helpful and informative while one Child Care Worker described supervision sessions as being satisfactory.

CHAPTER 8

EVALUATION OF THE FINDINGS

CHAPTER 8 EVALUATION OF FINDINGS:

INTRODUCTION:

The evaluation of the findings of this study must be regarded against the background of a limited sample, which does not allow for generalizability.

The results may be skewed for several reasons. The Child Care workers who were nominated to participate in the study, were perceived as being senior in position, expertise and skill. Subsequently, the length of the service or the qualifications and their perception of the programmes at the Children's Home may not be representative of all Child Care workers in South Africa.

It should also be remembered that the Children's Homes involved in the study, were willing to participate, expose their activities and make a contribution to the field of child care. These variables may provide a skewed picture of the universe of Children's Homes, since many Children's Homes were reluctant to participate in the study for various reasons. (See Chapter 7).

The possibility does exist that the Children's Homes involved in this study have attained a sophisticated level of functioning which may or may not necessarily be true of every other Children's Home.

The geographic setting of these Children's Homes may also be a factor since many resources are centralized in the Cape Town area which allows these Children's Homes easier access to various resources and consultancy services.

1. CHILD CARE POLICY AND PHILOSOPHY:

1.1 RESIDENTIAL CARE MODELS:

The study by Hatchuel (1982), indicated that there are still traces in South Africa of the outdated custodial model of residential care. Ward (1977), also called this the institutionalization model which she described as the 'dustbin syndrome'. However, there is a trend to develop smaller units in the residential care field and this is manifested in the increasing use of the cottage system, satellite and group homes which are community based.

The findings of this study highlighted the current trend to move away from the institutionalization facility to developing more treatment-oriented facilities with upgraded programmes and better trained staff members.

The fact that remnants of the custodial model exist, was highlighted by the Child Care worker-child ratio of 1-25 children in one Children's Home included in the study. However, the staff and management realized that this was not the ideal and buildings were being erected in order to adopt the cottage system. The interplay between the residential model utilized and the nature of the treatment programmes in general were also strongly evident. It was clear that the larger institution did not lend itself to promoting closer liaison between staff members, children and care staff or care staff and the parents of children.

This study definitely touched on the very emphatic move to smaller, treatment-oriented units, which are being based in the community. The size of the Children's Home, the numbers for which it is registered and the actual numbers of children are also indicators of the move away from custodial type residential settings for children. Although the sample was very small, a clear picture emerged in this regard. Three of the five Children's Homes had less children it was registered for. Children were often involved in group homes, satellite homes or independent living projects which affected the total number of actual residents in the Children's Home.

The researcher is of the opinion that the careworker should ideally have 6-8 children with whom some quality work could be done. The careworker would also be helped to develop use of self and generally to be more capable of performing the task more efficiently.

1.2 ADMISSIONS PROCEDURES:

This study reflected that the careworkers were involved in the admission of new children to the Children's Home either directly, or indirectly. In some Children's Homes, specific protocol existed which facilitated the involvement of the Child Care worker in the entire admissions procedures. However, there still appears to be vague areas in the admission to the Children's Home, where specific expectations and tasks for the Child Care worker would expedite the newcomer's orientation to his/her strange environment. This is particularly relevant when children are admitted with a known child abuse history. The literature emphasizes the importance of the new child having at least one significant contact person in the Children's Home during the initial phases of his admission to the residential facility.

Roberts (1985) referred to the importance of considering the scars left by traumatic experiences when children enter residential care. Frequently, staff at the Children's Home do not regard the activities both prior and upon admission as the commencement of treatment.

Treatment for the child commences when the decision is made to admit him/her to the residential facility and the importance of the initial contact and reception must be considered. There is a need for the Child Care worker to have a meaningful participation in the admission of children, particularly since the child would spend the best part of his residential treatment with the Child Care worker. It also provides a starting point for the establishment of some rapport and relationship upon which the overall management of the child will be based.

The Social Worker and the Child Care worker should be included in the decision making and admission of children to the Children's Homes. Both have respective, though complementary, roles and tasks to fulfil. The majority of Social Workers involved in the study, allowed the Child Care worker relative access to most admissions documentation and case material though it seems as if the belief is also held that the case material frequently contains highly confidential matters which should not be disclosed to the care staff or any other staff member, except the principal or psychologist, if one is available. Child Care workers should have access to the case material pertaining to the child in their care if they are going to be developing an understanding and management strategy in order to cope with the child or its problems.

The researcher is of the opinion that the professional staff involved in the admission of new children to the Children's Home should provide the structure, opportunities and atmosphere which are conducive to learning and acquisition of skills for the Child Care worker. Important issues such as confidentiality, maintaining a non-judgmental attitude and acceptance of children, can be taught easier by the modelling which could be provided through the joint participation. This is a stepping stone to engaging the Child Care worker in the treatment process for the child entering residential care.

1.3 MATCHING OF CHILDREN AND CHILD CARE WORKERS:

The responses about the matching of children with specific Child Care workers were varied. One Social Worker argued that it was not fair to promote matching and bonding with a particular staff member because of the inherent dangers of the high staff turnover. The general trend seems to reflect that other criteria are often of more importance than matching the needs and personality of a newcomer with the expertise and skill of a particular Child Care worker.

The more important factors were the age of the child, availability of accommodation and the sex of the child. It seemed though, that the significance of the case history was considered when major decision making about the child and its placement was being considered.

At the expense of practising a dogmatic approach, the researcher would suggest that occasionally some matching is necessary. Particularly when the known abused child is received into care and is experiencing difficulty coping with the traumatic experience, careful selection must be made of a Child Care worker. The personality of both the child and the Child Care worker must be considered in special circumstances, though it seems as if several Children's Homes have adequate structures which would facilitate for an evaluation or reappraisal if the placement of a particular child with a Child Care worker is problematic.

1.4 DISCIPLINING OF CHILDREN:

Changes in the perspective of how children in care should be treated was evident in the responses to the way the children were disciplined. It appears that corporal punishment is used in a small measure and certainly as a last resort. One Social Worker said that the policy of the Children's Home stipulated the immediate dismissal of any staff worker who physically punished a child.

The Principal and Social Worker appear to be the authority figures in the discipline of children. As a last resort, children are referred to the Social Worker or the principal. Other forms of punishment include the deprivation of privileges and 'gating', which generally take into account the case history and personality of the child. In the sample, no evidence of uniform punishment was indicated and the researcher developed the picture that discipline and punishment was tailored to meet individual 'needs'. No differentiation per se, is made between children with a known abuse history and children who do not have an abuse history.

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The general trend appears to be geared at guiding children to internalize values and share in assuming responsibility for inappropriate behaviour.

2. TREATMENT:

2.1 PLANNING AND TREATMENT PROGRAMMES:

The Social Workers all indicated that a treatment plan existed for each of the children in the Children's Home. The findings revealed that more and more use is being made of specially formed treatment planning groups which consists of an interdisciplinary team. These treatment planning groups have specialized tasks and duties such as treatment formulation on both long and short term basis and the evaluation of treatment programmes.

It is evident that some provisional treatment programme is necessary which is based on the information collected, prior to the child's admission, about his family background, psycho-social history, educational, medical and developmental history. However, the Social Workers generally did not always formalize or document this provisional planning.

The researcher is of the opinion that much of the anxiety, apprehension and defensiveness by the Social Workers about the existence of a formalized treatment programme could be related to the stipulations of the Child Care Act No. 74 of 1983, which compels the Social Worker to document a treatment plan for every child in care.

Yet the literature clearly indicates that the child needs at least some time to settle into his new environment before a reflection of his true self begins to emerge. However, provisional planning is important and some documentation should exist which could also be used later to evaluate or review the child's adjustment and progress whilst in care.

It is of significance that no real differences exist in the treatment planning for the child with an abuse history. The rationale provided by both the Social Workers and the Child Care workers is that the case history of every child is considered when decision-making and planning occurs. Despite this, the abused child was perceived to present specific difficulties which would warrant specific methods of management and containment.

Differences which existed in the treatment planning for abused children frequently included the referral to a psychiatric facility or for medical follow-through particularly when the child's physical injuries needed medical attention.

2.2 PARTICIPATION OF CHILD CARE WORKERS:

Child Care workers participated in varying degrees in the planning of treatment programmes. Their involvement ranged from an active participation to merely being consulted about the adjustment of children in their care.

An ambivalence about the nature of the involvement seemed evident and this was clearly reflected in the degree to which the Child Care workers were engaged in the planning of the treatment programme. The tendency prevails to include the Child Care worker in the application of a treatment programme, rather than in the planning stages. However, it is encouraging to note that there are changes in this regard and particular Children's Homes are enabling their Child Care staff to develop planning and decision-making skills and techniques by involving them in structures such as treatment planning committees, where they also work with an interdisciplinary team.

This development is vital, particularly since the literature on residential Child Care emphatically reminds us that the Child Care worker can either promote, retard or hinder the most sophisticated, upgraded policy and philosophy of Child Care practice in Children's Homes.

2.3 TREATMENT METHODS:

The overall picture created about the specific treatment methods which are practised in the Children's Home, is that the Social Workers adopted a generic and eclectic approach. The presenting problems and the case history were considered in selecting the treatment method, yet no sophistication existed in this area!

Several Social Workers appeared to experience difficulty in describing the treatment approach which influenced the selection of specific treatment methods. Other Social Workers in the study referred to their practice as being generic and based upon an eclectic approach. The treatment method also seemed influenced by several other variables such as a time factor, limited numbers of children for a group or structured programmes which existed at the Children's Home. Individual work seemd to be the treatment method of choice, while attempts were made to use group therapy in some instances.

No specific treatment methods were identified for the child with an abuse history, although the Social Workers clearly stated that the history was taken into account when treatment planning was done. There appeared to be more emphasis on using the group living experience to promote individual growth and development.

Although the sample size is of significance, it clearly emerged that group therapy was under-utilized in Children's Homes for several reasons. There are no known treatment modalities which have specifically been designed to help the abused child only, but the available treatment methods can be used wisely in order to provide some assistance to children who are experiencing problems.

The study clearly highlighted that the case history was taken in consideration before any treatment programme was executed. Hence, abused children do not necessarily receive a different type of treatment, since children are assessed individually.

The Social Workers and Child Care workers involved in the study are of the opinion that most children who are admitted for residential treatment have suffered abuse one way or the other prior to admission.

The selection of treatment methods is also influenced by the fact that not all the children in care require intervention or treatment. For some children, the group living experience and the relationship with a significant person is therapeutic and containing.

It would be of interest to explore in another study to what extent and why Social Workers in residential care tend to use individual work with children more extensively than group therapy. Particularly in the light of contributions made about the value of group therapy in residential settings by people like Bruno Bettelheim, Henry Maier, Fritz Redl and Gisela Konopka. There are differences though in using the actual group living experience as a therapeutic tool and group work therapy.

Social workers involved in the study, seemed actively engaged in many other administrative related tasks, which limited the time for actual therapy with the children. Frequently, the Social Workers really only had access to children for approximately 2 hours in the afternoon between the domestic routines, sport, social activities and study time. This is clearly an area which should be examined since it definitely affects the limited choice of treatment modalities adversely. Invariably some child will have to wait until the next day or the day thereafter to address pressing problems.

2.4 INVOLVEMENT OF THE PARENTS : TREATMENT PROGRAMME:

Most Social Workers articulated that children could not be treated in a vacuum or in isolation of their parents. Yet, very little, except in two instances, was done to actively involve the parents in structured programmes.

Again, no significant differences existed between the abusive and non-abusive parent. Formalized structures to cater for the parent involvement was sadly lacking, although many Child Care workers attempted in some way or the other to involve the parents in their 'programme'.

The literature describes the abusive parent as needing much nurturance, acceptance and understanding before one could attempt to engage them in any meaningful practice or therapy. Although attempts are made to promote some understanding and acceptance of the parent, many more specific efforts are needed to develop effective programmes for them.

The rationale is provided that the work with the families of the children in care is the domain of the referring agency. This may be true and legal, yet the resources in the Children's Home can be utilized effectively to assist the parent and thereby, possibly expedite the return of the child to its family unit.

This study has highlighted that frequently the careworker is the most significant contact person for the parent. The careworker must be assisted further to develop the skills in building a meaningful relationship with the parent - not a mere superficial liaison! The Child Care worker can play a very significant role, but is often thwarted and stopped because of the apprehension that the territory of the Social Worker is being invaded.

Child Care Workers do not possess the knowledge base or the skills to embark on therapy with the parents, but they can be guided to mobilize the resources and skills which they possess, by virtue of their training and expertise to collaborate with the rest of the therapeutic team in working with the parents of the child in care.

By promoting the participation of the Child Care Worker in the work with the parents of children, some of the mysticism about the Social Worker's input regarding the parents, could also be dispelled. Frequently, Social Workers are endowed with 'magical powers' which leads to the expectation that the parents will be functioning adequately after one or two sessions of therapy!

This is certainly one area where the alliance between the Care Worker and the Social Worker can be used to promote the aims of the residential care treatment i.e. attempts to expedite the reintegration of the child into a family unit which functions in an improved manner.

3. SUPERVISION:

The literature on residential Child Care highlights the importance of supervision for the Child Care staff, in order for them be to guided, supported and educated in their work with the children.

It is evident that some form of supervision is being provided to the care staff to enable them to develop the skill, expertise and knowledge in meeting the needs of children who are emotionally disturbed and deprived.

Although the overall picture gained in this study may be skewed for several reasons, it seems as if the need for ongoing supervision in residential care is being recognized. However, differences still exist about what is to be discussed in supervision, how it should be done and who should be doing it. Some Care Workers have referred to supervision as 'snooper-vision' which indicates much underlying dynamics. The literature emphasizes that an important task of supervision in residential care is to promote an atmosphere where the Child Care Worker can extend his knowledge and subsequently cope more efficiently with the demanding, traumatized children in care.

The comments on 'snooper-vision' also hints at the inherent power/authority issues in the Social Worker - Care Worker relationship. This has serious implications for how the supervisory relationship is developed, utilized and approached by both the Care Worker and the Social Worker. The supervisory relationship should facilitate the discussion of power issues, and ways of addressing it in order to provide growth and teaching through modelling. The implication is also that Care Workers assume the 'so-called professionals' do not really understand the difficulties and demands of being in the firing line. Professional staff are seen to be unavailable after a specific time when an entirely different picture of the child may be presented.

Most of the Child Care Workers acknowledged that they could use the supervision session to understand transferential elements, underlying dynamics in the carer-child relationship, yet they reflected a feeling of not being understood, nurtured or given the affirmation and recognition which they needed.

It must be recognized that both the Care Worker and the Social Worker have specific skills and expertise which are complementary. Hence, the Social Worker and the Care Worker should use the supervision structure to cement the commonality and complemetary aspects related to their tasks and roles. The Social Worker and the Care Worker should be seen as allies, rather than 'snoopers' or intruders on one another's territories.

The question is also raised: Who should supervise the Care Workers in their tasks with the children? The Social Worker by virtue of her training should possess a knowledge base and skills of supervision which would enable her to render adequate supervision for the Care Worker. However, a study by Hatchuel (1982), found Social Workers in residential care settings to be recent graduates with limited experiences and skills in supervision, particularly in relation to student training. The Social Workers involved in this study were relatively experienced and certainly not recent graduates, but this is no guarantee that adequate supervision skills are being used.

Supervision of care staff need not only be the responsibility of the Social Worker, provided that specialised, adequate training in supervision has been acquired. In one of the Children's Homes included in the sample, supervision was done by a senior Child Care Worker, who possessed a knowledge of supervision. Whilst at another Children's Home, the supervision of Child Care Workers was done by a specifically appointed supervisor.

The supervision of Child Care is essential and it demands specific skills and knowledge which would ultimately improve the service to the child in care. It has also been highlighted in discussions with the Care Workers that the children coming into care are difficult to handle, demanding and frequently staff are left with feelings of impotency. Supervision is essential and must provide the recognition, nurturance and affirmation which the Care Worker needs in order to attempt to meet the needs of emotionally greedy, needy children.

The researcher is of the opinion that the gap which exists between Social Workers and the care staff, could be narrowed by Social Workers critically re-appraising the nature of the supervision which is being provided to care staff. The Child Care Worker must be empowered with the belief that they are not on the 'firing line' on their own and unsupported.

The Care Workers do possess particular skills and expertise which could enable them to participate more fully in what is regarded as 'therapeutic activities' previously seen as the domain of the Social Worker. The supervision process is a stepping stone to sharing some of these therapeutic tasks and activities.

4. TRAINING:

The importance of a comprehensive training programme is directly related to the practice of residential care. This study has reflected that the quality of Child Care training is evident in the practice with the children in care.

This sample is not representative of the entire universe of Child Care Workers, yet it clearly indicates that Child Care Workers are no longer poorly trained and more in need of sheltered employment or accommodation, which previously seemed to be the prevailing thoughts about many Child Care Workers.

Training is certainly one of the areas that is being attended to most diligently, yet training must be given on two levels i.e. an in-service training whch is tailored to the specific setting at the Children's Home and training on a broader level, which would allow care staff to make linkages, recognize commonality and universal themes.

However, training programmes should also cater for some kind of supervision training, particularly as debates continue about the establishment of a middle management system which could include senior Child Care personnel.

The training programmes which are currently provided seem sophisticated, upgraded and a social knowledge base can be established which would make the Care Worker's contribution much more meaningful.

Sadly, an ambivalence is clearly detectable about allowing Child Care Workers to obtain additional training particularly if it is outside the premises of the Children's Home. Child Care Workers are encouraged to obtain additional qualifications, yet there is the inherent risk that the fully trained Child Care Worker may be lured away to more prosperous surroundings, which in turn, relates to the high turnover of care staff in the Children's Home. Again, the time is approaching for protocol and procedures to be stipulated on a broader level as the Child Care fraternity becomes more knowledgeable and develops an assertiveness about the recognition and affirmation which has been lacking for a long time.

Child Care staff are being trained, yet many other areas must be explored as they develop their knowledge base and skills. Specialised training is necessary to cope with emotionally disturbed and traumatized children. It is also becoming important to build into training programmes, exercises on self awareness and the development of personal strengths in order to cope with the demands of providing nurturance.

Parallel to this, one needs to examine the adequacy of the knowledge base and skills which the residential care Social Worker needs in order to cope with the demands of the task at hand.

As the Child Care Worker develops an awareness of self, limitations, resources and the need for regular evaluation of efficacy, the Social Worker needs to engage in a similar practice. The treatment modalities or theoretical approach which guides intervention must be evaluated regularly and changed when necessary. It is significant that the prevailing treatment method used, certainly in the Children's Homes involved in the study, is individual work. Individual work as pointed out, in the chapter on treatment methods for children, is valuable, yet other treatment modalities can also be explored with particular children.

The Social Worker must continually be improving her diagnostic treatment and assessment acumen in order to provide an effective service delivery programme to the children in care. Particular clinical skills and knowledge is necessary in the light of the children entering residential care with many serious pathologies which requires more than support, understanding and warmth.

5. MANAGEMENT AND TREATMENT OF ABUSED CHILDREN IN RESIDENTIAL CARE:

This study has clearly highlighted that no significant differences exist in both the approach to and service provided for abused children and their parents in comparison with children who do not have a known child abuse history.

The minor differences are located in the degree in which collateral resources are utilized to assist the child and its parents. Children who are admitted because of a severe child abuse history are usually referred to child guidance clinics, clinical psychologists or psychiatric facilities for further follow-up. The major mode of intervention in the residential setting appears to be based on relationship therapy, providing a safe, secure and hopefully positive environment for the abused child. Problems which are symptomatic of an underlying pathology are treated in the same manner as those presented by any other child who is in care.

From the picture gained through this study, it appears that the Children's Home is not really participating in or initiating programmes which could be seen to either break the cycle of abuse or to restore the parent-child relationship in a significant way. The problems presented by the children, and specifically abused children, are contained or tolerated. which is in keeping with the dictates of practising milieu therapy, or referred elsewhere if the resources in the Children's Home prove to be inadequate.

The apathy and disinterest of the abusive parent is not really challenged through the practice of formalised structures, although sterling efforts are made to involve the parents in some way.

As mentioned previously in this study, there are valid reasons for the absence of programmes for abusive parents, yet there are resources in the Children's Home which could be utilized more fully.

As residential care develops into a more treatment orientated milieu approach, more focus should be directed on the parent and specific ways to challenge the disinterest, the apathy and hostility. Like the children, these are symptoms of underlying pathological feelings and images of themselves.

The abusive parent lacks the initiative, will or ability to reach out, therefore the nurturance and reaching out must be done by others. It is the researcher's opinion that programmes which have meaning and value in the field of residential care, could lose sight of one important component i.e. the parent. As sophisticated treatment approaches, management strategies and coping skills are developed by the team in the Children's Home for the residents of the home, this needs to include the parent as much as possible.

Limited work is done at the Children's Homes which include conjoint sessions between the child and the parent, unless a crisis situation, usually related to school or medical issues arises.

The question is also raised about the utilization of treatment modalities which would not only provide access to a number of children and their parents, but also allow the clients to establish linkages with people experiencing similar problems. Group Therapy is effective in reaching these objectives, if the necessary skills and knowledge exists, yet there appears to be a limited use of it in the Children's Homes included in the sample.

The Children's Home can fulfil a vital role in breaking the cycle of abuse by utilizing the resources fully which it possesses. Hatchuel (1982), recommended in her study that Social Workers working in Children's Homes should be encouraged to acquire post-graduate qualifications, in particular psychiatric social work, in order to equip themselves academically for the task of providing adequate treatment to disturbed children.

The residential Social Worker who does acquire training in psychiatric social work is also in a better position to make appropriate diagnoses, and to identify debilitating pathologies which require further expertise.

The Social Worker could provide more meaningful supervision and training to Child Care Workers if she felt secure about having the necessary skills and knowledge which is needed.

As the Child Care Worker develops intervention skills, more social work related tasks can be allocated to the Care Worker and the role of the Social Worker would be geared to teaching, training and educating the Child Care Worker in addition to the support which is usually provided.

In addition, Social Workers in residential settings, should use research in order to contribute to the establishment of a sound knowledge base on residential social work.

CHAPTER 9

CONCLUSIONS AND RECOMMENDATIONS

CHAPTER 9 CONCLUSIONS AND RECOMMENDATIONS:

The findings of this study clearly indicate that although traces of the custodial model of residential care is evident in South Africa, there is still a movement towards providing a treatment-orientated service to children requiring residential care and treatment.

The study also alerts one to the different type of child who is now being admitted to residential settings compared to the earlier period of custodial care. Children enter residential care currently with more maladaptive and disturbed behaviour, which requires a realistic though sophisticated treatment/management approach and practice. This approach needs to be holistic if the Children's Home wants to provide meaningful intervention to not only the child, but also the parents of the child. Children cannot be treated in isolation from the parents or significant caregivers with whom the child will probably share its life after residential care and treatment. The Children's Home is in the position to fulfil an important bridge building role between the child and its parents.

The findings of this study concur with those of Hatchuel (1982) regarding the role which the Social Worker assumes in the treatment for the child in residential care. The therapeutic or clinical approach to the management and treatment of children is largely stimulated, developed or suggested by the Social Worker. Although increasing use is being made of an interdisciplinary team consisting of nursing staff, psychologists and remedial teachers, the Social Worker is still largely responsible for linking the Children's Home and its children to the appropriate resources which are available in the community and elsewhere.

Further, it is evident that those involved in the residential treatment of children, albeit abused or non-abused children, do consider the case history, the needs and problems of the child when general management and treatment strategies are devised.

Unless children are specifically admitted with a known abuse history, very little emphasis is placed on underlying problems related to the reasons for the child's admission.

It also appears as if the current presenting problems are addressed in intervention, rather than providing treatment which would enable the child to work through past traumas and experiences. The tendency is to refer the child to resources outside the Children's Home, perceived to be the specialists in handling some problems associated with abuse.

Acknowledgements are made and an awareness does exist in that the abused child tends to reflect problems which are much more exaggerated than those presented by children who do not have a known abuse history. Specific intervention protocol does not exist at the Children's Home to address the needs and problems of the abused child and the abusive parent. If the Children's Home is going to attempt to break the future cycle of abuse, specific treatment strategies are essential. Furthermore, the intervention must include both the abused and the abuser. In cases where the abused child has been severely traumatized and clearly needs specialised or psychiatric intervention, referrals must be arranged. Yet there are abused children who could receive the assistance which they need from the staff members who understand and are familiar to them.

Limited input is provided for the abusive and other parents of children. There is an acknowledgement that the abusive parents are hard to reach, difficult and apathetic, yet very little is done to actively enlist their participation in the treatment of the child. Although attempts are made to stimulate their participation and interest, the attempts appear to lack the determination and consistency which are needed to reach out to the parents, whether they are abusive or not. The abused child particularly could be much more amenable and co-operative in the treatment process if the child observes that its parent is also being considered, respected and included in some form of intervention. The ambivalence and sense of betrayal which abused children frequently experience after the removal from home, can be addressed effectively if the parent is seen to be included in the residential treatment programme.

The Child Care Workers seem to be key contact persons when the parents visit their children and this contact can be developed to reach out to the parents of children in care, in a more meaningful way. The discomfort and guilt which the Care Worker can experience when faced with the abusive parent who is intimidated by the way the Child Care Worker responds to and cares for the abused child, can be addressed in supervision and training.

This could also be used to emphasise the need for reaching out to the abusive parent. The Child Care Worker can be seen as less of a threat, than the Social Worker or principal who is associated with authority and power. This is particularly relevant when the abused child is admitted to residential care directly from another facility such as the hospital.

This study has also highlighted the need for ongoing training and supervision for all staff directly involved with the care of the children. Although supervision particularly is provided and some attempts are made to upgrade supervision skills, much more is required. Supervision cannot only include support, understanding and guidance for the Child Care Worker by the Social Worker. The Child Care Worker must be encouraged to develop their skills, set growth goals for themselves and be continually educated about the underlying problems, needs and behaviour of both the children in care and their parents. Supervision and training must include child abuse awareness which could enhance the staff members' understanding, insight and management of abused children, their parents and the difficulties enountered in working with them.

Residential care has progressed and attempts are being made to provide an upgraded efficient service to the children in care. However, there are many areas and learning gaps which need to be attended to. The possibility exists that there is an increased awareness of childrens' pathologies currently because of the more treatment orientated milieu approach as compared to the earlier custodial model, where children were regarded as being deviant rather than disturbed. This awareness, which many allude to, also contains the implication that much more is needed from the persons involved in residential child care. The quality of residential care and treatment programmes must continually be upgraded and translated into practice. The danger exists that programmes for children and their parents are planned, yet abandoned very soon after the team is faced with a resistant, apathetic group of children and/or parents.

The quality of residential care certainly does not belong to one discipline or profession only. This should be a shared enterprise amongst all those persons and groups involved in the field of child care.

1. RECOMMENDATIONS:

In this section of the study, two areas will be addressed, namely recommendations for direct practice with children in care and the implications for future research.

1.1 TREATMENT AND MANAGEMENT OF ABUSED CHILDREN IN RESIDENTIAL CARE:

1. The direct service staff in residential treatment settings must receive specialised training to effectively manage abused children and their parents.

2. It is vitally important for those Care Workers or any staff members who are involved with abused children to be sensitized in supervision and training sessions; how their personal values and attitudes affect their work with the abused and the abuser must be confronted.

3. The care staff must be guided and educated in developing appropriate treatment techniques which are based on their assessment and observation of behavioural and/or psychological problems and needs of children.

4. The therapeutic team at the Children's Home must continually examine the potential roles each staff member might play in promoting and meeting the overall treatment goals for all children in care at the residential unit.

5. The use of an interdisciplinary team can promote a more effective service delivery programme.

6. The Residential Social Worker must continually upgrade interviewing skills, treatment strategies, educational intervention and evaluate the treatment effectiveness. In addition to this, the Social Worker should explore the possibilities of utilising treatment methods which research has proved to be effective in the treatment of children and their families.

7. The Social Worker should also assume some responsibility for mobilizing resources, the resources of the Children's Home or those available in the community. The development of outreach programmes such as a child safeline, parent aide service or providing educational programmes on the prevention, detection and management of child abuse could be one way of mobilizing and integrating resources to combate future child abuse.

8. The Social Worker also needs to recognize and more importantly, deal with the resistance or barriers which exist in working with the abused and the abuser.

9. The Social Worker should, in addition to the above, promote the development of protocol which facilitates for the Child Care Workers' involvement in areas such as the admission of children, selection and overall management of the abused child.

10. The efficacy of the nature and type of supervision which is provided to the child care staff, must be evaluated periodically in order to keep abreast with the development of new ideas, knowledge and management skills.

2. IMPLICATIONS FOR FUTURE RESEARCH:

The findings of this study appear to indicate that the following areas may require further in-depth exploration:

1. The nature and content of treatment programmes for children in residential care.

2. The interplay between the length of service, qualifications of both the Child Care Worker and the Social Worker and the quality of the residential treatment offered to children in care.

3. The association with and the effects of an association or membership with the NACCW and/or similar organisations on the quality of the residential care provided.

4. The importance and the effects of providing supervision and/or training for the Child Care Worker.

5. Investigation into the most effective size of the Children's Home and the Child Care Worker-child ratio.

6. A profile of Child Care Workers, including their level of education, training, previous experiences, personalities and reasons for entering the residential child care field.

7. Follow-up studies of abused children who have been returned to their parents after being involved in residential child treatment programmes.

8. An investigation on the extent to which Children's Homes are using community based programmes such as satellite and group homes and its efficacy.

9. Research on the personalities, behaviour and overall adjustment of abused children in residential care.

APPENDICES

APPENDIX A

School of Social Work
University of Cape Town
Private Bag
RONDEBOSCH
7700

07 June 1988

Dear Sir/Madam

RESEARCH - MANAGEMENT OF ABUSED CHILDREN IN CHILDREN'S HOMES

I am currently completing the M Soc Sc Clinical Social Work Course at the abovenamed university. In fulfilment of the course requirements, I am doing a preliminary investigation on the role which the Children's Homes play in the management of abused children.

I would like to request permission to include your Children's Home in this study.

An attempt will be made to describe and explore the type of treatment and management which the Children's Homes offer to abused children and their parents. I would like to emphasise that this is a descriptive and preliminary investigation in order to highlight the role which the Children's Home can play in the treatment and management of child abuse.

This study will involve an interview with both the Social Worker and Senior Houseparent at your Children's Home during which a structured interview would be used.

I will contact you telephonically during the third week of June to discuss any questions you may have about the proposed study and to negotiate interviewing arrangements.

Your co-operation would be deeply appreciated.

Thanking you.

Yours faithfully

MARCEL LONDT (MRS)

APPENDIX B

INTERVIEW SCHEDULE A - SOCIAL WORKER

NAME OF ORGANISATION:

SOCIAL WORKER:

LENGTH OF SERVICE:

QUALIFICATIONS (HIGHEST):

DATE OF INTERVIEW:

1. ADMISSION:

1.1 How many children are presently in your Children's Home?

1.2 How many children is the Children's Home registered for?

1.3 Does the Children's Home have specific selection criteria?

1.4 If it does, what are the selection criteria?

1.5 Approximately how many children in the Children's Home have been admitted because of a child abuse history?

1.6 Are child care staff informed about the reasons for admission?

1.7 If they are, who would inform them about the reasons for admission?

1.8 Apart from the usual statutory documents, are other specific records requested from referring agencies prior to the child's admission?

1.9 Are pre-admission interviews conducted at the Children's Home with the child and family or a member of the family, with the referring Social Worker?

1.10 Who conducts the interviews?

1.11 Are visits to the Children's Home arranged for the child prior to the admission?

1.12 Would admission procedures for the abused child be different to those of non-abused children? If so, in what way would it differ?

2. POLICY AND CHILD CARE PHILOSOPHY:

2.1 What residential care system is used at the Children's Home?

a) Cottage

b) Dormitory

c) Unit

d) Family Group Systems

2.2 What is the ratio of the Child Care Worker to child in your Children's Home?

2.3 Does specific criteria apply or exist in matching the newcomer with the Child Care Worker?

2.4 If so, what criteria?

2.5 What would be the most appropriate in the placement of newcomers with a specific Child Care Worker?

a) Availability of accommodation

b) Expertise of houseparent

c) Age of child

d) Specific problem presented or case history at admission

e) Sex of child

2.6 Does the Children's Home adopt and practice a specific, clearly formalised child care philosophy?

2.7 If so, what are the major tenets of this philosophy?

2.8 Are the Child Care Workers aware of or knowledgeable about the philosophy held by the Children's Home?

2.9 Do specific views exist regarding the punishment of children?

2.10 Would punishment differ for the child with an abuse history?

2.11 Who is responsible for enforcing discipline of children at the Children's Home?

2.12 Is the enforcement of discipline of all children supervised, and by whom?

3. TREATMENT:

3.1 Are treatment programmes for all children planned upon admission?

3.2 Who would be involved in devising the treatment programme?

3.3 Are these programmes formalised and documented in the child's personal file?

3.4 Are specific treatment methods used with abused children?

3.5 Does this differ from the methods used with children who were not admitted with a child abuse history?

3.6 What is the treatment of choice regarding the abused child?

a) Group therapy

b) Individual therapy

c) Play therapy

d) Referrals to psychiatric units and/or child guidance clinics

3.7 Are abused children treated in isolation from other children in care, i.e.:

a) Groups for abused children only

b) Accommodation

c) Specific care staff for abused children only

3.8 Are the Child Care Workers advised and/or consulted about goals in therapy with the abused child?

3.9 What are the most common problems presented in the Children's Home by the abused child?

3.10 Are the parents of children involved in the treatment programme for children in care?

3.11 In which way are the parents involved in the programme at the Children's Home?

3.12 Does a structural programme exist for parent involvement?

3.13 Please indicate which apply regarding work with the parents of the children in the Children's Home:

a) Group for parents

b) Family, marital or couple therapy

c) Referrals to welfare agencies responsible for reconstruction service programmes

3.14 Does a specific programme exist for the abusive parent?

3.15 If so, who assumes the most responsibility for maintaining the programme?

4. VISITATION BY PARENTS:

4.1 Are parents encouraged to maintain contact with their children at the Children's Home?

4.2 Does specific procedures exist for visitation of the children by parents. If so, what are the procedures?

4.3 Are parents familiarised with their rights and responsibilities as parents of children in care?

4.4 Who assumes responsibility for this?

4.5 Are Child Care Workers and staff familiarised with the rights of the parents of children in care?

4.6 Do specific differences apply in the visitation of children by abusive parents? If so, what are the differences?

4.7 How soon after admission is contact between the abused child and its parents arranged?

4.8 Who is the most significant contact person for the parent during visiting times at the Children's Home?

5. TRAINING:

5.1 Does the Children's Home have an intensive, comprehensive training programme on its premises for the child care staff? And does it include child abuse awareness?

5.2 If an in-service training programme does exist, who does the actual in-service training?

5.3 If it does exist, what other resources are consulted?

5.4 Is it compulsory for Child Care Workers to either possess or acquire specific training in child care?

5.5 Do opportunities exist for Child Care Workers to obtain additional qualifications?

5.6 If an in-service training programme exists, does the Children's Home have a built-in system of monitoring the context and application of material transmitted during the training programme?

5.7 How often are case conferences held for the child care staff on the premises of the Children's Home?

5.8 Which of the following does the Children's Home have built into its routine?

a) Regular child care staff meetings

b) Meetings between staff and children

c) Family/unit/dormitory meetings between children and care staff

d) Regular supervision for all residential care staff

5.9 Who supervises the Child Care Workers?

6. SUPERVISION:

6.1 Does formalised supervision sessions exist for child care workers?

6.2 Is the Social Worker responsible for, or involved in this supervision?

6.3 Are the Child Care Workers motivated to develop an individual care plan for every child in their care?

6.4 Are Child Care Workers involved in most major decisions regarding the children in their care?

6.5 Are individual goals for the abused child different to goals for non-abused children?

6.6 Do the feelings of the Child Care Worker toward the abusive parent get addressed in supervision?

6.7 Is the Child Care Worker supported and encouraged to establish a meaningful relationship with the difficult abusive parent?

6.8 Is the Child Care Worker assisted through various techniques to understand the abusive parent? If so, are any of the following used:

a) Role play
b) Study of case material relating to the abusive parent

6.9 Is the Child Care Worker assisted to develop skills and techniques in reaching out to the abusive parent?

6.10 Are attempts made to develop the Child Care Worker's understanding of:

a) Transferrential elements in the carer-child relationship

b) Underlying dynamic in behaviour of child and staff

c) Abused child's ambivalent feelings toward the abuser

6.11 Does a system exist where ongoing feedback is provided regarding the Child Care Worker's contact with parents of all children in care?

6.12 Is feedback provided to the Child Care Worker on an ongoing basis regarding the child's progress in the social work treatment programme which is held on the premises?

6.13 What supervision model is used at the Children's Home to support, monitor or assist child care staff?

APPENDIX C

INTERVIEW SCHEDULE B - CHILD CARE WORKER

NAME OF ORGANISATION:

SOCIAL WORKER:

LENGTH OF SERVICE:

QUALIFICATIONS (HIGHEST):

DATE OF INTERVIEW:

1. ADMISSION:

1.1 How many children are you responsible for in your cottage/unit/dormitory?

1.2 What is the age range of the children?

1.3 Are you involved in any way in the admission procedures of newcomers?

1.4 Approximately how many children in your unit was admitted with a child abuse history?

2. TREATMENT OF CHILDREN IN CARE:

2.1 Do you participate in planning the treatment of the children admitted to your group?

2.2 Do you have access to the case histories and personal files of the children in your care?

2.3 Are you consulted about major decisions regarding the children in your unit?

2.4 Are the parents of the children involved in the programme at the Children's Home? If so, how are they involved?

2.5 How often do you, as child care worker, have contact with the parents of the children?

2.6 How do you attempt to involve the parent in the programmes for the children?

2.7 What do you regard as a major problem in your contact with parents of children?

2.8 What do you regard as a major difficulty in your contact with the abusive parent?

2.9 Is the abusive parent involved in a different way in the programmes for the children in your care?

2.10 Do you receive ongoing feedback from the Social Worker regarding therapy with both abused and non-abused children?

2.11 What do you regard as the major problem presented by abused children in your care?

2.12 Is this different to the problems presented by non-abused children?

3. TRAINING:

3.1 Does an in-service training programme exist on the premises?

3.2 If so, who is responsible for the leading of the programme?

3.3 Do you possess qualifications relevant to child care?

3.4 How often are training programmes attended at the Children's Home?

3.5 Are training programmes compulsory?

3.6 Do you find the material taught useful and practical for the management and understanding of difficult children and their behaviour?

3.7 Does training include child abuse awareness?

3.8 What other resources do you consult to develop your skill and understanding of the child care task?

3.9 What would you regard as the most outstanding problem presented by abused children in your group of children?

3.10 Are you affiliated to any other organisations, societies or clubs relevant to residential child care?

4. SUPERVISION:

4.1 Do you attend individual supervision sessions?

4.2 Who provides the supervision?

4.3 Is group supervision used for child care workers?

4.4 How often do you participate in individual supervision sessions?

4.5 Do you find these sessions:

a) Helpful and informative

b) Helpful

c) Satisfactory

d) Not really necessary

4.6 Are you able to understand your own feelings, needs and how it affects the carer-child relationship through supervision?

4.7 Do you feel more supported, confident and competent to deal with problematic behaviour after attending supervision sessions?

APPENDIX D

LIST OF CHILDREN'S HOMES TO WHICH LETTERS WERE SENT

1. Atlantis Children's Home, Atlantis
2. Annie Starck Village, Athlone
3. Boy's Town, Kenilworth
4. Boy's Town, Duin-en-Dal, Phillipi
5. Durbanville Children's Home, Durbanville
6. George and Annie Starck Children's Homes
7. Heatherdale Children's Home, Belgravia Estate
8. Frederich Schweizer Home, Kenilworth
9. Habibia Children's Home
10. Holy Cross Orphanage, Parow
11. St. Michael's Children's Home, Plumstead
12. St. John's Hostel, Cape Town
13. St. George's Home for Girls - Wynberg
14. Nazareth House, Vredehoek
15. Marsh Memorial Homes, Rondebosch
16. Oranjia Jewish Children's Home, Oranjezicht
17. Suid-Afrikaanse Kinderhuis

APPENDIX E

LIST OF CHILDREN'S HOMES WHICH PARTICIPATED IN THE STUDY

1. Annie Starck Village, Athlone
2. Boys Town, The Dingle, Kenilworth
3. Boys Town, Duin-en-Dal, Phillipi
4. Durbanville Children's Home, Durbanville
5. Nazareth House, Vredehoek
6. St. John's Hostel, Tamboerskloof
7. Oranjia Jewish Children's Home, Oranjezicht

APPENDIX F

SOUTH AFRICAN LEGISLATION RELEVANT TO RESIDENTIAL CHILD CARE

the children's court assistant, be served on the respondent.

(2) A contribution order or a provisional contribution order shall be made in the from of Form 18 and a certified copy thereof shall be handed to the respondent or be sent to him by registered mail.

(4) The clerk of the children's court or the magistrate's court, as the case may be, shall send a copy of the said contribution order to—

(a) the Director-General; and

(b) the social worker involved in the case.

(5) An order to an employer in terms of section 46 of the Act for the deduction of an amount from the wages of respondent in compliance with a contribution order shall be made in the form of Form 19.

CHILDREN'S HOMES AND PLACES OF CARE

Application for registration

30. (1) Application for registration of a children's home or place of eare in terms of section 30 (3) of the Act shall be made on a form obtainable from the Director-General and lodged with the Director-General.

(2) The application shall be accompanied, in the case of an application for the registration of—

(a) a children's home, by the constitution of the association of persons that will manage the children's home;

(b) a children's home or a place of care, by a certificate issued by the local authority within whose area the children's home or place of care is situated or is to be erected to the effect that the children's home or place of care, if an existing building is to be used, complies with all the structural and health requirements of the local authority, or, in the case of a children's home or place of care that is to be erected, that the plans for the said building or buildings have been approved by the local authority.

(3) A constitution referred to in subregulation (2) (a) shall contain at least the following particulars and stipulations:

(a) The name of the children's home and a description of the type of child to be cared for;

(b) the composition, powers and duties of the management and the executive committee or management committee, as the case may be;

(c) the powers of the management to delegate its authority with regard to punishment and discipline to the head of the children's home; and

(d) the procedure as regards the amendment of the constitution.

(4) A registration certificate in respect of a children's home or a place of care shall be issued in a form approved by the Director-General for that purpose.

Additional requirements with which a children's home shall comply

31. Subject to the provisions of the Act and these regulations no children's home shall be registered in terms of section 30 of the Act unless the Director-General is satisfied that proper arrangements have been made or will be made—

(a) 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;

(b) for the proper feeding and care of the said children; and

(c) to ensure that children who are of school-going age attend school.

(b) 'n assistent van 'n kinderhof gedoen word aan die respondent beteken word.

(2) 'n Kontribusie-order of 'n voorlopige kontribusie-order word in die vorm van Vorm 18 verleen, en 'n gewaarmerkte afskrif daarvan word aan die respondent oorhandig of per geregistreerde pos aan hom gestuur.

(4) Die klerk van die kinderhof of landdroshof, na gelang van die geval, moet 'n afskrif van die kontribusie-order stuur aan—

(a) die Direkteur-generaal; en

(b) die maatskaplike werker wat by die saak betrokke is.

(5) 'n Bevel aan 'n werkgewer kragtens artikel 46 van die Wet vir die aftrekking van 'n bedrag van die loon van 'n respondent ter voldoening aan 'n kontribusie-order word uitgereik in die vorm van Vorm 19.

KINDERHUISE EN VERSORGINGSOORDE

Aansoek om registrasie

30. (1) Aansoek om registrasie van 'n kinderhuis of 'n versorgingsoord kragtens artikel 30 (3) van die Wet word gedoen op 'n vorm wat van die Direkteur-generaal verkrygbaar is en word by die Direkteur-generaal ingedien.

(2) Die aansoek moet vergesel gaan, in die geval van 'n aansoek om die registrasie van—

(a) 'n kinderhuis, van die konstitusie van die vereniging van persone wat die kinderhuis sal bestuur;

(b) 'n kinderhuis of 'n versorgingsoord, van 'n sertifikaat uitgereik deur die plaaslike bestuur binne wie se gebied die kinderhuis of versorgingsoord geleë is of opgerig sal word, ten effekte dat die kinderhuis of versorgingsoord, indien van 'n bestaande gebou gebruik gemaak sal word, voldoen aan al die strukturele en gesondheidsvereistes van die plaaslike bestuur of, in die geval van 'n kinderhuis of 'n versorgingsoord wat nog opgerig moet word, dat die planne vir die betrokke gebou of geboue deur die plaaslike bestuur goedgekeur is.

(3) 'n Konstitusie bedoel in subregulasie (2) (a) moet minstens die volgende besonderhede en bepalings bevat:

(a) Die naam van die kinderhuis en 'n beskrywing van die tipe kind wat versorg sal word;

(b) die samestelling, bevoegdhede en pligte van die bestuur en die uitvoerende komitee of dagbestuur, na gelang van die geval;

(c) die bevoegdheid van die bestuur om sy gesag met betrekking tot tug en dissipline aan die hoof van die kinderhuis oor te dra;

(d) die prosedure met betrekking tot die wysiging van die konstitusie.

(4) 'n Registrasiesertifikaat ten opsigte van 'n kinderhuis of 'n versorgingsoord word uitgereik op 'n vorm wat die Direkteur-generaal vir dié doel goedkeur.

Bykomende vereistes waaraan kinderhuise moet voldoen

31. Behoudens die bepalings van die Wet en hierdie regulasies word geen kinderhuis kragtens artikel 30 van die Wet geregistreer nie, tensy die Direkteur-generaal oortuig is dat behoorlike reëlings getref is of getref sal word—

(a) vir die behandeling van die kinders in die kinderhuis deur 'n maatskaplike werker, geneesheer, psigiater of sielkundige wanneer sodanige behandeling nodig is;

(b) vir die behoorlike voeding en versorging van die kinders; en

(c) dat kinders wat skoolpligtig is, skool sal bywoon.

Maintenance of good order and discipline

32. (1) Any pupil in a children's home who—

(a) obstructs any persons in authority over him in the execution of his duties;

(b) refuses or fails to carry out or comply with a lawful order by any person in authority over him;

(c) incites, encourages or advises another pupil to create, cause or participate in any disturbance dissatisfaction or to commit any act of insubordination;

(d) incites or encourages any other pupil or person to acts of violence or endangers or interferes with the good order or administration of the children's home;

(e) without the consent of the owner thereof appropriates, uses or intentionally or through gross negligence damages or destroys any property not belonging to him;

(f) absconds from the children's home or is absent without leave;

(g) brings into the children's home or possesses any alcoholic drink or habit-forming drugs; or

(h) behaves in an improper manner inside or outside the children's home,

may be punished in accordance with the provisions of these regulations.

(2) Any punishment referred to in subregulation (1) shall be determined by the head of the children's home with due regard to the nature of the transgression, the age of the child and the instructions which the management of the children's home may give in case of a particular pupil or pupils in general: Provided that isolation, confinement or refusal of leave shall not be used as a form of punishment.

(3) Corporal punishment may not be inflicted on a girl and also not on a boy in respect of whom a social worker, psychologist or medical practitioner has forbidden the infliction of such punishment.

(4) Before any corporal punishment may be inflicted the head of the children's home, or, in his absence, a member of the staff designated by him, shall satisfy himself that the pupil on whom he intends to inflict corporal punishment will not be physically or mentally adversely affected by such punishment.

(5) Corporal punishment shall be inflicted with an instrument approved by the management for that purpose on the buttocks in the presence of a person designated by the management for that purpose.

(6) A boy receiving corporal punishment shall wear a shirt, trousers and underpants.

(7) Immediately after the infliction of punishment the following information shall be entered in a punishment register:

(a) The name of the pupil punished;

(b) the date and the nature of the transgression;

(c) the nature of the punishment inflicted; and

(d) the name of the person who inflicted the punishment and the person in whose presence the punishment was inflicted.

Registers and files to be kept by children's homes

33. (1) In addition to the punishment register referred to in regulation 32 (7) a register or registers shall be kept in a children's home in which shall be entered the following particulars of each child:

(a) His or her full name, sex, date of birth, identity number;

(b) names, addresses and telephone numbers of parents or blood relations;

(c) date of admission;

Handhawing van goeie orde en tug

32. (1) Enige leerling in 'n kinderhuis wat—

(a) iemand wat in gesag teenoor hom staan, dwarsboom in die uitvoering van sy pligte;

(b) weier of versuim om 'n wettige bevel van iemand wat in gesag teenoor hom staan, uit te voer of om daaraan te voldoen;

(c) 'n ander leerling aanhits, aanmoedig of aanraai om enige onrus of ontevredenheid te skep, te veroorsaak of daaraan deel te neem of enige daad van weerspannigheid te pleeg;

(d) enige ander leerling of persoon tot geweldadige optrede aanhits of aanmoedig of die goeie orde of administrasie van die kinderhuis in gevaar stel of bemoeilik;

(e) enige eiendom wat nie sy eie is nie, sonder die toestemming van die eienaar daarvan toe-eien, gebruik of opsetlik of deur growwe nalatigheid beskadig of vernietig;

(f) uit die kinderhuis wegloop of sonder toestemming daaruit afwesig is;

(g) enige alkoholiese drank of afhanklikheidsvormende middel in die kinderhuis inbring of besit; of

(h) hom buite of binne die kinderhuis op 'n onbetaamlike wyse gedra,

kan ooreenkomstig die bepalings van hierdie regulasies gestraf word.

(2) 'n Straf in subregulasie (1) bedoel, word deur die hoof van die kinderhuis bepaal met inagneming van die aard van die oortreding, die ouderdom van die kind en die opdragte wat die bestuur van die inrigting in die geval van 'n besondere leerling of leerlinge oor die algemeen gee: Met dien verstande dat afsondering, opsluiting of weerhouding van verlof nie as 'n straf aangewend mag word nie.

(3) Lyfstraf mag nie aan 'n dogter toegedien word nie, en ook nie aan 'n seun ten opsigte van wie 'n maatskaplike werker, sielkundige of geneesheer die toediening daarvan belet het nie.

(4) Alvorens lyfstraf toegedien word, moet die hoof van die inrigting of, in sy afwesigheid, 'n lid van die personeel deur hom aangewys, hom vergewis dat die leerling ten opsigte van wie hy voornemens is om lyfstraf toe te dien, nie liggaamlik of geestelik deur sodanige straf benadeel sal word nie.

(5) Lyfstraf word op die sitvlak toegedien in die teenwoordigheid van 'n persoon wat die bestuur vir dié doel aanwys, en met 'n instrument wat die bestuur goedkeur.

(6) 'n Seun wat lyfstraf ontvang, moet 'n hemp, broek en onderbroek aanhê.

(7) Onmiddellik na die oplegging van straf moet die volgende inligting in 'n strafregister aangeteken word:

(a) Die naam van die kind wat gestraf is;

(b) die datum en die aard van die oortreding;

(c) die aard van die straf opgelê; en

(d) die naam van die persoon wat die straf toegedien het en die persoon in wie se teenwoordigheid die straf toegedien is.

Registers en lêers wat kinderhuise moet byhou

33. (1) Benewens 'n strafregister bedoel in regulasie 32 (7) moet 'n register of registers in 'n kinderhuis bygehou word waarin die volgende besonderhede van elke kind aangeteken word:

(a) Sy volle naam, geslag, geboortedatum en identiteitsnommer;

(b) name, adresse en telefoonnommers van ouers of bloedverwante;

(c) datum van opname;

(d) date on which the court order or extension thereof expires in terms of which a child is detained;

(e) particulars of any leave of absence or any absence longer than one day and the reason for such absence; and

(f) in the case of a pupil who absconded from the children's home or who is a pupil referred to in section 38 (1) (b) of the Act, the date on which he so absconded or on which his leave of absence, referred to in section 38 (1) (b), expired, as the case may be, and if he returns or is returned to the children's home, the date on which he so returned or was brought back.

(2) A separate file shall be kept in a children's home in respect of each pupil in that children's home in which the following documents shall be filed:

(a) All documents relating to the pupil received at the time of his admission;

(b) all reports received from the school which the pupil attends or attended;

(c) all reports on any physical, psychiatric or clinical-psychological examination of the pupil and any report on the results of any treatment given;

(d) reports and notes from social workers and the staff of the children's home on the pupil;

(e) addresses where vacation leave was spent and how the leave turned out;

(f) the treatment programme for the pupil and any evaluation reports in regard thereto; and

(g) any other documents or correspondence relating to the pupil.

Register to be kept by a place of care

34. Every place of care registered under section 30 of the Act shall keep a register of children attending that place of care in which the following particulars in respect of each child shall be entered:

(a) The full name, date of birth and sex of the child;

(b) the date of his admission;

(c) the names, addresses and telephone numbers of his parents and foster parent;

(d) date on which care is terminated; and

(e) any other information regarding the child which the place of care may deem necessary or expedient to enter.

Notice of movement of pupils

35. A children's home shall notify the Director-General in the form of Form 20 immediately of the date of admission, discharge, abscondment or readmission, admission to or discharge from a hospital or any absence of a pupil from the children's home.

FINANCIAL ASSISTANCE FOR THE MAINTENANCE OF PUPILS AND CHILDREN

Foster parent grants

36. (1) An application for a contribution towards the maintenance of a foster child by his foster parent in terms of section 56 (1) (a) of the Act (hereinafter in this regulation referred to as "foster parent grant") shall be made in a form approved by the Director-General for this purpose.

(2) A foster parent grant shall amount to an amount determined by the Minister with the concurrence of the Minister of Finance and shall be payable from the first day of the month in which the child is placed in the custody of the foster parent and shall lapse at the end of the last month in which the child so remains in the custody of the foster parent concerned.

(d) datum waarop die hofbevel of die verlenging daarvan ingevolge waarvan die kind aangehou word, verstryk;

(e) besonderhede van enige afwesigheidsverlof of enige afwesigheid langer as een dag en die rede vir sodanige afwesigheid; en

(f) in die geval van 'n leerling wat uit die kinderhuis weggeloop het of wat 'n leerling is soos bedoel in artikel 38 (1) (b) van die Wet, die datum waarop hy aldus weggeloop het of waarop sy verlof tot afwesigheid bedoel in artikel 38 (1) (b) verstryk het, na gelang van die geval, en indien hy na die kinderhuis terugkeer het of teruggebring is, die datum waarop hy aldus teruggekeer het of teruggebring is.

(2) 'n Afsonderlike lêer moet in 'n kinderhuis bygehou word ten opsigte van elke leerling in daardie kinderhuis, waarin die volgende stukke gehaasseer moet word:

(a) Alle stukke wat betrekking het op die leerling wat ten tyde van sy opname ontvang is;

(b) alle verslae wat ontvang word van die skool wat die leerling bywoon of bygewoon het;

(c) alle verslae oor enige liggaamlike, psigiatriese of kliniese-sielkundige ondersoeke van die leerling, en enige verslag oor die resultate van enige behandeling wat toegepas is;

(d) verslae en notas van maatskaplike werkers en kinderhuispersoneel oor die leerling;

(e) adresse waar vakansieverlof deurgebring is, en hoe die verlof verloop het;

(f) die behandelingsprogram vir die leerling en enige evalueringsverslae daaromtrent; en

(g) enige ander stukke en korrespondensie oor die leerling.

Register wat deur 'n versorginsoord bygehou moet word

34. Elke versorgingsoord wat kragtens artikel 30 van die wet geregistreer is, moet 'n register hou van kinders wat daardie versorgingsoord bywoon, waarin die volgende besonderhede ten opsigte van elke kind aangeteken word:

(a) Die volle naam, geboortedatum en geslag van die kind;

(b) die datum van sy opneming;

(c) die name, adres en telefoonnommers van sy ouers en pleegouer;

(d) die datum waarop sy versorging beëindig word; en

(e) enige ander inligting wat die versorgingsoord nodig en dienstig ag om ten opsigte van die kind aan te teken.

Kennisgewing van beweging van leerlinge

35. 'n Kinderhuis moet die Direkteur-generaal onverwyld in die vorm van Vorm 20 verwittig van die datum van opneming, ontslag, wegloop of heropneming, opneming in of ontslag uit 'n hospitaal, of van enige afwesigheid van 'n leerling uit die kinderhuis.

GELDELIKE ONDERSTEUNING VIR ONDERHOUD VAN LEERLINGE EN KINDERS

Pleegouertoelaes

36. (1) 'n Aansoek om 'n bydrae tot die onderhoud van 'n pleegkind deur sy pleegouer ingevolge artikel 56 (1) (a) van die Wet (hierna in hierdie regulasie 'n "pleegouertoelae" genoem), word gedoen in 'n vorm wat deur die Direkteur-generaal vir dié doel goedgekeur is.

(2) 'n Pleegouertoelae beloop 'n bedrag wat die Minister met die instemming van die Minister van Finansies bepaal en is betaalbaar vanaf die eerste dag van die maand waarin die kind in die bewaring van die pleegouer geplaas is en verval aan die einde van die laaste maand waarin die kind aldus in die bewaring van die betrokke pleegouer bly.

(c) if the child is [illegible] in terms of section 30;

(d) if any grant or contribution payable by the Minister towards the maintenance of the child is discontinued.

(3) The provisions of subsection (1) shall not affect any obligation imposed by any other law on any person to care for or maintain any child.

Notification of injured and undernourished children.

42. (1) Every dentist, medical practitioner or nurse who examines or attends any child in circumstances giving rise to the suspicion that that child has been ill-treated, or suffers from any injury, single or multiple, the cause of which probably might have been deliberate, or is undernourished, shall immediately in the prescribed manner notify the Regional Director of Health and Welfare of the district in which the child happens to be, of those circumstances.

(2) On receipt of a notification in terms of subsection (1) the said Regional Director of Health and Welfare may issue a warrant in the prescribed form and manner for the removal of the child concerned to a place of safety or a hospital.

(3) The said Regional Director of Health and Welfare shall thereupon arrange that the child and his parents receive such prescribed treatment as the said Regional Director may determine.

(4) This section shall not exclude any other action against or treatment of the parent and his child in terms of this Act.

(5) Any dentist, medical practitioner or nurse who contravenes any provision of this section shall be guilty of an offence.

(6) No legal proceedings shall lie against any dentist, medical practitioner or nurse in respect of any notification given in good faith in accordance with this section.

CHAPTER 7

Contribution Orders

Children's court or magistrate's court may make contribution orders or provisional contribution orders.

43. (1) A contribution order may be made—

(a) by a children's court against a respondent residing, carrying on business or employed within the jurisdiction of that court, for the maintenance of a child brought before that court for the purpose of an inquiry in terms of section 13;

(b) by a magistrate's court against a respondent residing, carrying on business or employed within the jurisdiction of that court, for the maintenance of any child or any pupil,

and any such order shall have effect from the date on which it is made unless the court orders that it shall have effect from an earlier or later date.

(2) A provisional contribution order may be made against a respondent resident in any country which is a "proclaimed country" within the meaning of section 1 of the Reciprocal Enforcement of Maintenance Orders Act, 1963 (Act No. 80 of 1963), by a children's court for the maintenance of any child brought before that court for the purpose of an inquiry in terms of section 13 of this Act.

(3) Any children's court or magistrate's court in whose jurisdiction the respondent resides, carries on business or is employed may, after completion of the prescribed inquiry or on application of the respondent, vary, suspend or rescind a contribution order or revive the order after it has been rescinded.

(4) If any court other than the court which issued the contribution order concerned varies, suspends, rescinds or revives the contribution order in terms of subsection (3), the clerk of the first-mentioned court shall inform the clerk of the last-mentioned court immediately of such variation, suspension, rescission or revival.

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