CHILDREN IN RESIDENTIAL CARE: AN EVALUATION OF CURRENT PRACTICE AND RECOMMENDATIONS FOR DIFFERENTIAL PLACEMENTS

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DECLARATION

Unless specifically indicated to the contrary, this dissertation is the original work of the writer.

ABSTRACT

The historical and societal origins of child abuse and neglect are reviewed with particular reference to the South African context and to those factors that place children at risk for delayed development and clinical symptoms. At particular risk are children placed in residential care. In view of the inadequacies in current child care practice, the present services to children require urgent appraisal. Permanency planning for the child's return to the community may be idealistic in the South African context and differential placement procedures are needed, retaining the option of long term residential care. With a view to providing children with the most appropriate living environment, the present research was undertaken. The research took the form of an exploratory demographic study of children in residential care in South Africa, exploring the relationships between demographic variables and categories of treatment needs (as reflected in behaviour). A questionnaire was designed and posted to 229 residential care facilities for children in South Africa, requesting information from the practice of these institutions, the questions relating to the research objectives. A response rate of 34.06% was obtained, with a 47.6% response rate from the Children's Homes surveyed. The mean percentages of the children represented in the responses were analysed. A number of significant variables emerged. There is disparity in the treatment needs reflected in Children's Homes and it appears that the present institutional arrangements are inadequate to meet these needs. Half of the children living in Children's Homes are ready to reenter the community, if alternative placement were available, and these children should be accommodated in small group, community-based homes. Living alongside these children are those with disturbed behaviour requiring containment and intensive professional intervention, (10% of all children in Children's Homes). Half of the children in Children's Homes are in their adolescent years, and programmes should be designed in recognition of their distinctive developmental needs. Amongst Black children placed in care, there appears to be a growing number of pre-school aged children. Children institutionalised at an early age are particularly vulnerable, and special programmes will need to be established in order to address the needs of this group.

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NOTE ON TERMINOLOGY

The term 'children' will be used to refer to children and youth or children and adolescents. The decision is based on making this dissertation reader-friendly; however the reader's attention is drawn to the fact that approximately 50% of children in residential care are in their adolescent years.

Although it is recognised that the terms used throughout this dissertation to designate race are offensive and prejudicial, the nature of this study has necessitated the use of such terms. Within all Welfare structures in South Africa, the allocation of children by racial categories is entrenched at all levels of functioning. Thus the term:

> **White** is used to denote people who fall under the jurisdiction of the House of Assembly and are of primarily European origin.
>
> **Black** is used to denote those people who fall under the jurisdiction of the Provincial Administrations and are of primarily African origin.
>
> **Indian** is used to denote those people who fall under the jurisdiction of the House of Delegates and are of primarily Asiatic origin.
>
> **Coloured** is used to denote those people who fall under the jurisdiction of the House of Representatives and are of primarily mixed origin.

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INTRODUCTION

Throughout the ages children have been cared for by people other than their parents for a variety of financial, personal and cultural reasons. Children are placed in substitute care in South Africa according to the Child Care Act (no.74 of 1983), either because they have "no parent or guardian" (section **14** (4)(a)) or because their parents are deemed to be "unfit" (section **14** (4)(b)). Conditions under which parents are found to be unfit include those where the parent or guardian:

> "(i) is mentally ill to such a degree that he is unable to provide for the physical, mental or social well-being of the child;
> (ii) has assaulted or ill-treated the child or allowed him to be assaulted or ill-treated;
> (iii) has caused or conduced to the seduction, abduction or prostitution of the child or the commission by the child of immoral acts;
> (iv) displays habits and behaviour which may seriously injure the physical, mental or social well-being of the child;
> (v) fails to maintain the child adequately;
> (vi) maintains the child in contravention of section 10;
> (vii) neglects the child or allows him to be neglected;
> (viii) cannot control the child properly so as to ensure proper behaviour such as regular school attendance;
> (ix) has abandoned the child; or
> (x) has no visible means of support."
>
> (Child Care Act, no.74, 1983, Section 14.4, p.18)

In other countries in the world the legislation for the protection of children cites similar conditions under which children may be legally removed from parental care (Kellmer-Pringle, 1975). Residential care represents one alternative when seeking substitute care for children legally removed from the care of their parents.

Whilst the earliest arrangements for the institutional care of children were far from satisfactory, over the years the social provisions for the residential care and treatment of children have, in theory at least, become increasingly attuned to the needs of the individual child. However, ideology and practice have not kept pace with one another. Whilst writers have hypothesised regarding which situation would ideally suit the individual needs of children in residential care, progress in terms of actual child care practice has been slow and discontinuous. A review of the literature reveals growing criticism of residential child care, as illustrated by the report of the Joint Commission on Mental Health of Children:

> "The present institutional arrangements for the residential care of disturbed children are inadequate in many ways, requiring a critical appraisal of both assumptions and procedures" (Joint Commission on Mental Health of Children, 1970, cited in Maluccio and Marlow, 1972, p.230).

In part these shortcomings may be attributed to the lack of available resources. The financial constraints placed on residential child care institutions are well documented, affecting every aspect of care: food, clothing, accommodation, educational opportunity and availability of skilled practitioners.

A further source of inadequacy is the fact that residential child care is a relatively new field, lacking a clearly articulated philosophy and methodology. Whereas practice wisdom has led to refinements in methodology in specific organisations, without empirical or theoretical support, these have not been extended to the general benefit of the field of residential child care. A fundamental problem in providing appropriate treatment alternatives for children in residential care, is a problem which is shared with the field of child and adolescent psychiatry, that is, that "we are in the realm of conjectures rather than certainties" (Righton,1989 p.4). Ultimately effective service delivery depends on accurate differential assessment of needs. As yet

little reliable, well-validated knowledge exists regarding the classification of child and adolescent problems, linked with effective approaches to treatment in residential care.

The present study represents an attempt to evaluate the treatment needs of children in residential care so that the limited financial resources can be utilised in the most effective way.

Ways of thinking about children, their problems, their care and their treatment have changed considerably throughout the centuries and even since the turn of the century with the advent of the study of child psychiatry and developmental psychology. These ideological changes have been accompanied by momentous changes in the legislation concerning the rights of children, and corresponding changes in the social provisions for the residential care of children. In Chapter One, these changes will be traced and discussed, providing a historical perspective of residential child care as it is practiced at the present time.

Chapter Two focusses on the literature which has emerged concerning residential child care as a distinct field of study, summarising some of the trends in philosophy, theory and methodology. An overall trend has been the shift from the custodial model of child care to the treatment model, and more recently the ecological model, incorporating the concept of permanency planning.

In Chapter Three the process of decision-making and permanency planning, is examined. The legal definition of an "unfit" parent evidently allows for children from vastly disparate economic, cultural and social backgrounds and manifesting a diverse range of treatment needs, to be placed alongside one another in residential care facilities. One of the challenges in residential child care practice, is the process of matching the right child to the right treatment programme, and to the

most appropriate permanent plan. If one is to match children to the child care programme that will benefit them most, one needs to be able to make predictions about their ability to cope and be sensitive to those factors that place them at risk. The relative impact of stress and protective factors is briefly considered, discussing the implications for residential child care programmes in South Africa. The process of differential placement depends upon a common language for the differential assessment and categorisation of children, their needs and their problems. The chapter closes with an evaluation of the assessment procedures currently operational in Children's Homes.

The process of differential placement was the foundation of the present research. The research was undertaken with the objective of surveying the population of residential child care facilities in South Africa. The respondents were requested to categorize children presently in residential care in South Africa in terms of their behaviour and treatment needs. This information forms the basis for recommendations for the future of residential child care practice in South Africa, with specific reference to differential placement.

CHAPTER ONE

1. RESIDENTIAL CHILD CARE - A HISTORICAL PERSPECTIVE

Introduction

Despite the view that you can never plan the future by the past (Warren, 1971), historical analysis can make a contribution to the understanding of current issues (Parry-Jones, 1989). On the one hand, recent trends and considerations in residential child care, are clarified in the light of the past management of problems and the evolution of child study and child care services. On the other hand, historical information about attitudes held towards children, may help us to avoid repeating destructive cycles. The words of the philosopher George Santayana, "He who forgets the past is condemned to repeat it" (cited in Achenbach, 1982, p.10), are nowhere more apparent than in the history of child-rearing.

1.1 Societal Changing Attitudes towards Children

A review of the literature on the history of childhood confirms that childhood neglect is not a new social phenomenon. Many of our fairy stories, myths and legends have common themes of abandonment, infanticide, exposure, sacrifice, incarceration, rejection and physical cruelty towards children. For centuries children have been battered, maimed, mutilated, starved, abandoned and killed by their caretakers. Motives behind such acts have included killing as a form of ritual sacrifice to the gods; for example, to ensure the durability of a building, a child would be buried alive under the foundations (Smith, 1975). Harsh physical punishment was used to expel evil spirits, to educate, to maintain discipline; mutilation occurred to arouse pity for children

put out to beg (de Mause, 1976). As a means of family planning or to avoid dishonour after an illegitimate birth, the infant would be abandoned, exposed to the elements and left to die, or killed (Smith, 1975), practices which persist in South Africa today (Burman and Reynolds, 1986; UNICEF, 1993).

It is only in the past twenty-five years that research in Britain and the United States has shown us how widespread is the incidence and prevalence of abusive behaviour by parents towards their children (Righton,1989). Since the term 'baby-battering' was first used in the 1960s, "we have been compelled with bewildering speed to recognise the existence of an immense variety of abuse and neglect, both physical and emotional" (ibid. p.3), affecting children of all ages.

The changing patterns of childhood experience, childrearing practices, parent-child relations and sex-roles in marriage, provide a background against which the continued abuse and neglect of children as well as the apparently widening range of social, emotional, educational, behavioural and psychiatric problems of children may be more clearly understood. The history of childhood and the evolution of the family have been popular themes for historical research (Aries, 1962; de Mause, 1976; Newson and Newson, 1974; Shorter, 1976; Stone, 1979; Suransky, 1982; Pollock, 1983; Postman, 1985; James and Prout, 1990). Child care philosophy has been shaped and reshaped by society's changing values and attitudes towards children (Mannoni,1967; Riley, 1983). Caring and helping services to children and their families have evolved from these historical changes. Residential child care has emerged as one form of intervention for those children who have suffered abuse and neglect within their families.

1.1.1 The History of Childhood

Many historians subscribe to the view articulated by Philippe Aries (1962), that the concept of childhood is a relatively new phenomenon. Aries states that until the seventeenth

century, there was no special emphasis on childhood as a separate phase of the life cycle. Children were regarded as miniature adults from the age of seven, when they no longer required the special care and attention of infancy. The mortality rate amongst young children was very high, often due to neglect and ignorance of the child's needs (Shorter, 1976; Stone, 1979).

During the seventeenth century, with the great changes in attitudes and morals brought about by the Reformation, the notion of the 'special innocence' of childhood gained acceptance. However, the predominant child care philosophy was that children needed to be subdued into a state of humility and obedience. Children were exploited for their labour and were introduced to adult economic responsibilities as early as possible (Aries, 1962; Stone, 1979; Pollock, 1983; Postman, 1985). During the eighteenth century with industrialisation, children of the poorer classes, vagrant and orphan children were handed over as labourers to mill-owners and later to mines. From the age of seven, children worked a twelve or fifteen hour day, including night shifts, and lived in apprentice houses attached to the factories (Stone, 1979).

In the western world this pattern persisted until major changes in the status of children began to take place with the humanitarian reform movement of the nineteenth century. These changes are evident in literature where for the first time children became the focus of romantic interest and attention (Coveney,1967). Charles Dickens wrote about the appalling conditions that prevailed, and his work was influential in pricking the conscience of the nation. Legislation gradually restricted child labour, and compulsory elementary education was introduced in Britain by the Education Act of 1876 (Parry-Jones, 1989). With the lengthening of dependence upon parents, childrearing practices changed, becoming more sympathetic to the needs of children. Interest in individual differences and the deterministic significance of early life experiences, grew.

De Mause (1976), examining successive generations of parent-child interactions, suggests six modes of parent-child relations, representing

> "a continuous sequence of closer approaches between parent and child as generation after generation of parents slowly overcame their anxieties and began to develop the capacity to identify and satisfy the needs of their children" (de Mause, 1976, p.3).

Whilst de Mause's theory is fraught with contradictions and inconsistencies, as a catalogue of cruel and neglectful child-care practices throughout the ages, it makes interesting reading, particularly in the light of present-day inhumanity to children, often necessitating substitute care (Miller, 1981;1983). Briefly, de Mause's modes of parent-child relations, may be described as follows:

1. **Infanticidal Mode (Antiquity to Fourth Century A.D.):** Parents resolved conflicts in taking care of their children by killing them. Death wishes towards children were likewise expressed by mutilating them for begging.
2. **Abandonment Mode (Fourth Century to Thirteenth Century A.D.):** Parents resorted to abandoning children in order to escape their conflictual feeling toward them. This occurred by delivering them to the care of "wet-nurses" or foster families as well as by selling them.
3. **Ambivalent Mode (Fourteenth to Seventeenth Century A.D.):** Children were regarded as naturally evil and therefore requiring harsh treatment so that they could be moulded into shape.
4. **Intrusive Mode (Eighteenth Century A.D.):** Parents, having refined their means of controlling children (e.g. toilet training), regarded them as less threatening and thus true empathy began to be possible. Child-rearing was still regarded as a process of "conquering".
5. **Socialisation Mode (Nineteenth Century to mid-Twentieth Century A.D.):** Influenced by Skinner's writings on behaviourism and Freud's work on the channelling of impulses, child-rearing began to focus on training, guiding and teaching socialised behaviour.
6. **Helping Mode (Begins mid-Twentieth Century):** Parenting becomes a process of the parent serving the child rather than the other way around. Parents are encouraged to empathise with the child's needs and help to fulfil them (Ginott, 1965). Striking and scolding children is frowned upon.

Some of the historical modes of parent-child relations described, are still in evidence today, and are particularly relevant within the South African context. The ancient procedure of child abandonment is still frequently employed in many countries as a personal solution to child-rearing problems. In September 1983, the New York Times reported that "every month in Brazil more than 100 infants are left in police stations, hospitals or on downtown streets by mothers apparently hoping that the outside world has more capacity to care for them than they do" (Kadushin and Martin, 1988, p.54). Even infanticide still exists. Lyon (1985, cited in Kadushin and Martin, 1988) reviewed the sizable number of deformed or defective infants allowed to die despite the medical technology available to prolong their lives.

1.1.2 Twentieth Century Trends

De Mause's theory that things have become better and better, is disputed by Stone(1979) who suggests that

> "the only steady linear change over the last four hundred years seems to have been a growing concern for children, although the actual treatment has oscillated cyclically between the permissive and the repressive" (p.13).

This process has placed increasing demands upon parents, who have turned for advice on childrearing to the everchanging and expanding literature concerned with parenthood and training of children.

Newson and Newson (1974) trace the cultural aspects of childrearing in the English-speaking world over the past one hundred years. Whilst in the developing world, the infant mortality rate continues to pose the greatest concern for parents (UNICEF, 1991), in the industrialised world, the dilemma facing parents has shifted from an emphasis on physical survival to an emphasis on moral growth (Nineteenth and early Twentieth Century), to a concern with psychological development. In other words, the current concern is not 'will I rear this child?', but 'how shall I rear him?'

Newson and Newson describe the prevailing Medical Morality of the 1920s when, as part of the Mental Hygienist movement, it was believed that young children should be taught self-control and the regularity of habits and 'mawkish' motherly affection was frowned upon. In comparison, the 'Fun' Morality of Dr. Spock some thirty years later legitimised the child's wants as well as the child's physical needs for the first time (ibid.). With Bowlby's (1951) work on attachment and the dangers of maternal deprivation, the prevailing morality became 'child-centred', with much attention focused on the family's potential for generating adverse effects in its children (Parry-Jones, 1989).

If one accepts de Mause's theory of the evolution of parent-child relations, one is led to speculate whether the increased societal expectations of parents that they should be 'empathic' and 'helpful', has created profound feelings of inadequacy, helplessness and guilt. Newson and Newson (1974) assert that parental good intentions of adopting the Helping Mode (de Mause, 1976), "tend to degenerate into an exasperated scream of 'get on and DO it!'" (Newson and Newson, 1974,p.77) when faced with children who remain uncooperative in spite of friendly verbal explanations.

Busfield (1974) describes how cultural and ideological pressures interlink, creating a situation where having children is often an inevitable event. Without any selection in terms of 'suitability', the majority of adults become parents. In primitive cultures and prior to the Twentieth Century in western civilization, the main influences whilst 'growing up' were a combination of parents, relatives, neighbours and teachers, thereby conveying a consistent set of ideas and beliefs regarding values, parental roles and child-rearing practices (Hubert,1974). With the breakdown of the extended family, parents have had to rely to a far greater extent upon their own resources, acquiring parenting skills from the available literature and by 'trial and error'. This,

together with the 'assault' upon parents and children by the mass media with diverse values and attitudes, has contributed to a situation of ignorance and uncertainty (Goulart, 1970). Goulart is particularly pessimistic regarding the effects of exploitation of children as 'consumers' by the mass media, and the consequent undermining of parental influence and authority.

Feelings of powerlessness, inadequacy and confusion, together with the incursion of specialised agencies to fulfil some of the family's functions, may have resulted in an 'abandonment' of another kind, through alcoholism and neglect and the relinquishing of parental duties to substitute caretakers.

Child abuse and neglect are the most common factors necessitating the removal of children from their families and resulting in their placement in substitute care. A detailed review of the literature concerning the causes of child abuse and neglect would be beyond the scope of the present thesis. The causes of child abuse and neglect are not simple, and as we have seen, the roots of violence and neglect in child-rearing lie deep within the history of our society (Miller, 1981;1983). Most writers acknowledge that social circumstances, including the presence of stressors on the one hand and the absence of supports on the other, coupled with certain characteristics of the family, the parent and the child, can induce the abuse pattern (Steele,1980; Gil, 1983; Killian and Willows, 1988). Gil (1983), in addressing the causes of child abuse, acknowledges that most adults involved in reported incidents of child abuse as perpetrators fell within the range of normality from a psychiatric perspective. He focuses upon the "dominant tendencies of our social philosophy", in particular the assumptions, values, attitudes, traditions and practices concerning child-rearing, parental responsibilities, human relationships and the rights and status of children. He refers to the social stressors of poverty, unemployment, size of family, distance (physical

and/or emotional) from families of origin, type of mate and education; but emphasises that children are abused in comfortable and affluent homes as well, the abuse being triggered by feelings of insecurity, frustration and tension originating in every day life events.

> "Parenthood is characterised by an irreversibility not commensurate with any other relationship. It is impossible to divorce your children. Beyond infancy, giving them up for adoption or foster care is not socially acceptable. Assuming one is fortunate enough to bear a physically and mentally healthy child, there is still the possibility of personality clashes. How can you know if you will like each other?" (Movius, in Savells and Cross, 1978, p.310)

1.1.3 Summary

In summary, many historians when tracing the changing attitudes towards children and childrearing, support the theory that childhood has finally emerged in the Twentieth Century as a distinct stage in human development associated with special rights and needs. Whilst it is certainly true that society no longer sanctions abusive and neglectful child-rearing practices, they still prevail. Reported cases of child abuse in New York City alone, have quadrupled from 600,000 to 2,4 million in the last ten years (UNICEF, 1991). And most writers still assert that reported cases represent only the 'tip of the iceberg', a fraction of the actual incidence. Child welfare services, social welfare policy and legislation, and social provisions for the residential care and treatment of children, represent the continued need to protect children from their parents.

1.2 Legislation and Social Policy

The policy on welfare services to families and children in any society, is a statement about that society and how it views its most important resource - its children (Riley, 1983). In first world countries, a broad historical trend exists towards the limitation by State agencies of the once near-absolute

rights of parents over their children (Fox Harding, 1989). From the earlier status of the child as a "chattel to his or her parents who had absolute right to the child's services and earnings and control over the child's person and possession" (Kadushin and Martin, 1988, p.51), most societies have come to recognise the child as an independent entity entitled to certain freedoms and rights and to protection of his or her best interest and welfare.

This section traces the evolution of legislation and social policy affecting children, primarily focusing upon the South African developments but highlighting contemporary issues in the light of International children's rights legislation. Whilst developments in South Africa have been influenced by the progress in western countries, they reflect the distinctive cultural and socio-political features of the South African context, which have resulted in problems specific to this situation. A thorough understanding of these problems is essential when interpreting the outcome of the present study.

1.2.1 A Brief Historical Background

Potgieter (1973) reviews the historical development of welfare services in South Africa. Organised welfare in South Africa is a feature of the second half of the Nineteenth and Twentieth Centuries. At the turn of the Century, the "Gold Rush", with the resulting urbanisation and attendant human casualties of all ages, together with the widespread consequences of the Anglo Boer War, added impetus to the urgent need for more adequate services to destitute and neglected children; until this time this role had been undertaken primarily by the various Churches.

After the Act of the Union in 1910, rationalisation and co-ordination at a Government level resulted in the first comprehensive, national legislation concerning the care of children, the "Wet ter Bescherming van Kinderen", passed in 1913. Herein provision was made for the statutory referral to

Children's Homes of children in need of care. The homes needed to be registered, and were subject to inspection , originally by the Department of Prisons and subsequently, in 1917 , by the Department of Education (Roberts, 1981). The South African National Council for Child Welfare was formed in 1924, to co-ordinate and advance the goals of the child welfare movement of which residential child care was a part. With the growing interest in the welfare of children and improving standards of care, the Children's Act of 1937 was promulgated. Children's Homes were placed under the administration of the Department of Social Welfare, which was established in the same year.

1.2.2 Social Welfare Policy in South Africa

Between 1940 and the present time, welfare services to children in South Africa have become numerous and increasingly complex (Giles, 1982). On the basis of many enquiries and committees, more and more services to children have been legislated, and organisations established for the care of those suffering from special conditions such as epilepsy and other mental and physical handicaps. Whilst services have thus become more adequate, the proliferation of State Departments has led to increasing difficulty in co-ordination and delivering effective services, as well as insuring that comparable services are provided for all South Africans. The principles of racial differentiation and privatisation in social welfare have emerged as two of the cornerstones of the South African social welfare system (Riga, 1988; Patel and Schmidt, 1989). These two principles will be examined briefly in terms of their implications for service delivery to children under the present welfare system.

1.2.2.1 Racial Differentiation

Racial differentiation refers to apartheid in social service delivery with a separate State department responsible for each race group. This is a system that is both costly and unwieldy, making the task of co-ordinating and delivering effective services increasingly difficult. Whilst "this

fragmentation at State level creates many problems" (Starke, 1982, cited in Giles, 1982, p.9), inequality in the allocation of and access to welfare resources for all South Africans, is the problem most directly affecting residential child care. In assessing existing residential care services to children in South Africa, and planning for future more appropriate intervention, facts and figures regarding these disparities are essential. However, as the present author discovered, gathering up-to-date information is a difficult task, in view of the fact that some fourteen different departments must be contacted to secure figures.

1.2.2.2 Privatisation in Social Welfare

Privatisation of social welfare is State policy. The government has stated that South Africa is not a welfare state, and that it upholds "the concept of partnership between the private sector and the State" (Riga, 1988). This means that the individual, the community, the voluntary sector and private enterprise should meet social welfare needs whilst the State will play a "supportive, co-ordinating, monitoring and a social policy role" (Patel and Schmidt, 1989); and, in reality, that those communities and individuals who are in the greatest need, will have the least resources to finance services. Thus an inverse law of care applies.

1.2.2.3 Implications of Policy for Residential Child Care

The problems created by these fundamental principles of racial differentiation and privatisation, are highlighted by the escalating economic and political crises in the country. There is an increasing demand for child care services at a time when the private sector budgets for social services are shrinking; and at a time when the State is stepping out of financing services, calling on private organisations and private enterprise for their assistance. Many Child Welfare societies have had to freeze posts for social workers due to lack of finance, and limit their services to those which are State subsidised. Preventative and development programmes in

the field of child care are therefore halted at a time when they are most urgently needed.

The problems created by the principles of racial differentiation and privatisation, may be illustrated by the circumstances facing residential care for Black children in South Africa. During the first decade of apartheid rule, 1950 - 1960, expenditure on Whites was more than double that on Blacks. However there have been dramatic increases in the welfare expenditure on Blacks, Coloureds and Indians during the 1990s with corresponding proportional reduction in White welfare expenditure (UNICEF, 1993). "If equity in spending is taken as allocating welfare budgets in proportion to population ratios, then the present allocation still remains inequitable, as Whites make up 13.4% of the total population, Coloureds 8.7%, Indians 2.5% and Africans 75.2%" (ibid., p.95). Whilst there have been increases in overall welfare expenditure for the Black population, increases in State expenditure on Black child welfare have been nominal (see TABLE 1). The following amounts were allocated to child welfare in the years 1990 - 1992.

TABLE 1: STATE EXPENDITURE ON CHILD WELFARE 1990 - 1992
Percent of the Budget per Race Group

	1990	1991	1992	Percent of Population of Children under 19yrs
Black	11%	16%	17%	80.0%
Coloured	47%	47%	48%	8.3%
Indian	12%	12%	11%	2.3%
White	30%	25%	24%	8.8%

Note : The above figures exclude the Independent Homelands (Source: SAIRR 1991; SAIRR 1992; SAIRR 1993; cited in UNICEF, 1993, p.96)

The disparities amongst the different race groups are great given that Black children are the majority, comprising 80% of the population of children under 19 years. Expenditure on Coloured children was much higher relative to other groups,

possibly due to political pressures exerted on the House of Representatives in Parliament (ibid.). It also appears that this department has tried to move away from the White welfare model, where spending on the aged tended to dominate (Lund, 1992; cited in UNICEF, 1993).

In terms of the State subsidisation to Children's Homes this inequality in the allocation of resources is further illustrated (see TABLE 2). The State grants per child to Children's Homes in July 1991, indicate the legacy of disparity in available resources as a result of racial differentiation in State welfare policy. In 1991, the government spent six times more on Children's Homes for Whites than Blacks (UNICEF, 1993). Whilst parity has recently been achieved, the inadequacies of past funding arrangements have made it difficult for these Children's Homes to implement treatment programmes and to finance the training of child care workers. These inadequacies will take many years to overcome.

TABLE 2: MONTHLY STATE GRANTS PER CHILD TO CHILDREN'S HOMES

	July, 1991	January, 1994
Black	R374 per month	R785 per month
Coloured	R500 per month	R785 per month
Indian	R617 per month	R785 per month
White	R571 per month	R785 per month

Source : Personal communication with Department of Health Services and Welfare, House of Assemblies.

The implications for welfare expenditure of achieving parity, if White expenditure is taken as the norm, are that there would need to be an increase of 182% in child welfare spending (SAIRR, 1992; cited in UNICEF, 1993). It is likely, therefore that the White Children's Homes will receive relatively less State funding than they have been accustomed to.

The situation for Black children in residential care is even

more desperate when we consider the effects of privatisation. At present there are very few Children's Homes for Black children administered by the State (Patel and Schmidt, 1989). In fact, there are very few Children's Homes for Black children at all, those that exist being run by private institutions such as the churches and private welfare organisations. The situation is illustrated by the percentage of each race group living in Children's Homes in South Africa in July 1991, using the figures of the Population Census 1991 (Central Statistical Service, 1992; cited in UNICEF, 1993) (see TABLE 3).

TABLE 3:CHILDREN LIVING IN CHILDREN'S HOMES, JULY 1991

	Number in Children's Homes	Population of South Africa	Percent in Children's Homes per Race Group
Black	1 855	28 352 144	0,00478%
Coloured	2 548	3 285 717	0,079%
Indian	306	986 620	0,032%
White	5 222	5 068 112	0,131%
Total	9 931	37 692 611	0,24678%

Source : UNICEF,1993; Personal Communication with the Director of the Pietermaritzburg Child and Family Welfare Society, Willows,C.,(1991).

There is a great need for residential care of Black children due to the destructive effects of apartheid on family life (Burman and Reynolds, 1986; Craig, 1986; Cock et.al, 1986; Campbell, 1989; Patel and Schmidt, 1989; UNICEF, 1993), together with the effects of civil unrest and the high rate of abandonment of Black children. Black Children's Homes are hopelessly overcrowded. Children are frequently detained in police cells for criminal offences because there are insufficient Places of Safety for them.

There is a shortage of 62 000 places in Children's Homes for Black, Indian and Coloured children (SAIRR, 1992; cited in UNICEF, 1993). Until recently, Black children could not be

placed in Indian, Coloured or White institutions, even if vacancies existed, because of racial considerations. Those facilities that integrated their services experienced difficulties in securing State grants for children of race groups other than that for which the Children's Home had been registered. Yet the government, whilst offering the lowest State grant per child to the population group with the fewest resources and the greatest need, has called upon private organisations and private enterprise to assist in the provision of services.

In recent years, the South African National Council for Child and Family Welfare (the title of the South African National Council for Child Welfare since 1974) together with a number of progressive social service organisations, have strongly protested the effects of racial differentiation on service delivery, calling for the protection of all children against all forms of discrimination (Giles,1982; Patel and Schmidt, 1989).

The Report of the Committee of Inquiry into Child Mental Health Care Services for Children published by the Department of National Health and Population Development (1988) commented on the concerns regarding racial differentiation and privatisation, acknowledging the lack of psychological and psychiatric services to children, and offering a number of recommendations (Biderman-Pam, 1989). Those recommendations relevant to residential child care are summarised:

1. The institution of a national programme for the promotion of physical, mental and social welfare of the child.
2. Preventative measures to control expenditure on substitute care, emphasising the following principles which may promote savings:
    * making facilities available for all population groups together prevents duplication;
    * co-ordinating services between the fields of health, education and social welfare;

* emphasising utilisation of community services.

3. Effective facilities for the diagnosis, evaluation and treatment of children with mental health problems.
4. Greater co-ordination of services.
5. The establishment of an Interdepartmental Consultative Committee to facilitate the formation of one welfare body for all population groups.
6. Parity and even distribution of services between the population groups.

With the political changes in South Africa since 1991, there has been gradual progress towards the achievement of these objectives. At the time of writing this dissertation, the amalgamation of welfare services is still in planning.

Summarising the evolution of child welfare services in South Africa, it is evident that the impact of the structures of apartheid has resulted in a number of fundamental problems in present State welfare policy. Among these, in contradiction of human rights legislation, are persistent injustices towards children on the basis of race. Reliance upon the private sector for funding has proven counter-productive in the inception of appropriate child care services where they are most crucial. It is suggested that under the circumstances, the availability of comparative demographic data describing existing residential care services and the needs of the children living there, may facilitate future programmes in child care for the benefit of all.

1.2.3 International Children's Rights

At the dawn of the 1900's, Swedish sociologist Ellen Key predicted that the Twentieth Century would be known as 'The Century of the Child,' (cited in Brendtro et al., 1990, p.1) and indeed this century has witnessed tremendous developments in child care, in education and a growing recognition of the special and distinctive needs and rights of children. The major tenet of contemporary rights and welfare thinking is

that "regulation of child life should give priority to making childhood a carefree, safe, secure and happy phase of human existence" (Boyden, 1990, p.185).

The first international statement of the need to extend particular care to the child, was in the Geneva Declaration of the Rights of the Child of 1924, in which it was stated that:

> "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth" (UNICEF, 1991, p.78).

Parental power, previously exercised in domination over the child in the interests of parents, has come to be defined as:

> "a series of rights and obligations on the part of both parents which are to be exercised for the good of the child and which are balanced by a sense of correlative rights and obligations on the part of the child" (United Nations, 1968, in Kadushin and Martin, 1988, p.51).

The Convention on the Rights of the Child was adopted by the General Assembly of the United Nations on November 20th 1989, and by 1991 had been signed by over 130 nations (UNICEF, 1991). South Africa signed the Convention in December, 1993. The Convention speaks to three basic rights of the child. It speaks of the right to survival, a right which is presently denied to fourteen million children each year, and calls for rapid intervention to prevent those deaths. It speaks also of the right to development, a right at present denied to all those children who are malnourished, to those children who have no opportunity to receive education and "engage in play and recreational activities appropriate to their age", and to "those who do not have the freedom to receive and to express information and ideas" (ibid.p.35). Lastly it speaks of the right to protection, a right which is denied to millions of children who exist in "especially difficult circumstances"; who are used in wars, who are exploited at work, who are physically and sexually abused, who are abducted, who suffer imprisonment, who are abandoned on the streets, who suffer

mental cruelty or who are the victims of violence and drug abuse.

"Basic protection for the lives and the normal growth of all the world's children is not only the greatest of all humanitarian causes; it is also the greatest of all practical investments" (UNICEF, 1991, p.7) in the future economic prosperity, political stability, and environmental integrity of the human race.

> "If compassion were not enough to encourage our attention to the plight of our children, self-interest should be" (Time Magazine, 1990, cited in ibid.p.31).

In spite of this trend towards advocacy for children's rights, a study of the literature relating to recent child care legislation, policy and practice, suggests two potentially conflicting value positions concerning the roles and rights of parents, versus the roles and rights of the State in the child care situation (Kadushin and Martin, 1988; Fox Harding, 1989). Views diverge on the central question of the rights of parents to custody and control of their children in relation to the right of the State via courts and social work agencies to intervene in the parent-child relationship, "to remove children from their parents, to allocate their care and control to other parties, and to determine their subsequent upbringing" (Fox Harding, 1989, p.23)

The beliefs of welfare and rights practitioners about the activities and experiences suitable for a 'happy childhood' may differ radically from those of parents and children. From the point of view of the former, children absent from school and children at work or living on the streets are considered legitimate targets for State intervention, since these circumstances are considered to signify family or personal dysfunction. For countless children in the Third World, these supposedly pathological behaviour patterns are integral to normal socialization, since "the development of precocious

mechanisms for survival" (Boyden, 1990, p.208) is a socio-economic and cultural necessity.

More important still, some of the measures for protecting children embodied in both international rights legislation and in national welfare policy and advocated on humanitarian grounds "have the effect of isolating children further from their family and community and increasing their social and economic disadvantage" (ibid. p.208). Unfortunately limited resources often dictate the responses to the problems, which consequently involve elements of containment and correction. Innovative responses combining an awareness of the needs of children, with sensitivity to customary law and practice, are rare.

> "In this respect, the move to set global standards for childhood and common policies for child welfare may be far from the enlightened step anticipated by its proponents" (ibid. p. 208).

1.3 Social Provisions for the Residential Care of Children

Ainsworth and Fulcher (1981) outline the historical development of institutional care services, highlighting characteristics of the social policy environment which have influenced the development of residential care services as we know them today. This historical analysis highlights the relationship between social care and social control. Whilst the emphasis on one dimension or the other may have changed over time and across different child welfare services, both care and control still feature in the residential care and treatment of children.

1.3.1 The History of Residential Child Care Services

From 27 BC and prior to the late Eighteenth Century, the period termed by Ainsworth and Fulcher (1981, p.5) the **"Era of Exclusion-Confinement"**, social policy emphasised the social control of 'deviant' and unproductive members of the community, including destitute or vagrant children. Whilst

there existed a limited number of institutions designated exclusively for the custody of children, the more typical pattern was to have the children requiring institutional care consigned to live in mixed almshouses alongside other deprived groups in the population, "the aged, the insane, the feebleminded, and the diseased" (Abbott, 1938, p.4, cited in Kadushin and Martin, 1988, p.673).

With the emergence of the Industrial Revolution, more institutions began to be built, now specialising in "the Mad (insanity and mental deficiency), the Bad (criminals), the Morally Weak (unemployed and the poor) and the Unprotected (orphans and homeless waifs)" (Kadushin and Martin, 1988). Ainsworth and Fulcher (1981) refer to this period as the **"Era of Institution-Building"**. From the Eighteenth Century institutions exclusively concerned with the care of children began to be established. As yet no State authority had the duty of providing care and protection for abandoned and destitute children, and the responsibility often fell to religious groups, voluntary organisations and individual philanthropists.

1.3.2 Residential Child Care in the Twentieth Century

Until the Twentieth Century, residential institutions were large and impersonal, providing primarily control and custodial care, separating children from community life. Hoffman (1988, p.3), refers to this 'custodial' phase as Phase One in the historical development of the philosophy and practice of residential child care.

As an awareness grew of the many and diverse special needs of children in residential institutions, so too did the professional interest in providing remediation and treatment. In the 1920s, the Mental Hygiene Movement was developed in the U.S.A. The movement's goals were to raise the standards of care, educate the public about mental illness, and prevent mental illness. Efforts were made to understand and respond

appropriately to juvenile offenders, looking at their problems not only from the point of view of treatment, but also as a way of learning about the aetiology of mental disorders and their possible prevention. An ensuing recognition of the significance of the family and the cultural milieu, led to a move away from large impersonal institutions, towards smaller family style units. This is referred to by Hoffman (1988) as Phase Two in the development of group care. The 'cottages' were quite large by today's standards, but the intent was to create a family atmosphere and 'house-parents' were employed to look after the children. The dominant philosophy remained one of long-term custodial care, but with the emphasis on recreating as far as possible a family living experience.

A growing emphasis on early detection and treatment of problems inevitably created a need for diagnostic and treatment facilities. Thus, in the late 1920s the Child Guidance Movement was established, initially in the U.S.A.. Child Guidance Clinics were developed, creating a model of inter-disciplinary collaboration by psychologists, psychiatric social workers and psychiatrists. Phase Three, referred to by Hoffman (1988) as the Psychological Phase and by Ainsworth and Fulcher (1981) as the **"Welfare/Treatment Era"**, was marked by the application of organisational and treatment concepts from the emerging Child Guidance Movement, to child care. These included the use of psychological tests, the concept of professionals working together under psychiatric leadership, and the description of child care and child treatment functions.

During the 1930s, child care institutions of many different types could be found; tremendous variation existed in terms of the size of the buildings and the competence, training and experience of staff. In the late 1940s through to the late 1960s, the pioneering work of Bruno Bettleheim and Fritz Redl developed the concept of the therapeutic potential of the total 'life space' of the child living in residential care.

This approach to treatment, known as milieu therapy, is still a cornerstone of residential child care practice.

Phase Four (Hoffman,1988) brings the history of residential care to the present and is known as the Ecological or Environmental Phase. Attention is increasingly focused on establishing links between the residential institution and the wider community, and on forming a close partnership between the parents and the child care team, thereby facilitating the child's return to the community. Rather than trying to simulate a family home within the institution, the placement in residential care is viewed, wherever possible as a pathway back to the community. Treatment is focused on the family as a whole. Ainsworth and Fulcher (1981) refer to this as the **"Justice Era"** in view of the fact that this move towards de-institutionalisation of residential care followed the enactment of major social legislation in Britain, North America and elsewhere, emphasising individual initiative, individual legal rights and the principle of social fairness.

Over the past thirty years, in response to the criticism directed towards large institutions, a whole new generation of residential services has emerged emphasising small group living units located within the community (Ainsworth and Fulcher, 1981). Such units are designed to eliminate many of the negative effects of institutional living, and to maximise individual attention and personalised care. In these smaller group living units, social skills and life skills may be taught using everyday living situations.

> "A principal influence in the movement from larger to smaller facilities could be related to the greater appreciation of processes in child health and development. Another major influence can be identified as economics" (Ainsworth and Fulcher, 1981, p.3).

Another important aspect of this phase is the professionalisation of child care workers. The late 1960s saw the establishment of the first Association of Child Care

Workers in America. Since then further associations have been formed and have joined together in a national co-ordinating body, the National Organisation of Child Care Worker Associations (Hoffman, 1988).

1.3.3 The Child Care Movement in South Africa

1951 saw the birth of the Child Care movement in South Africa, as distinct from the Child Welfare movement. In that year a national conference on Children's Homes was held in Kimberly. One of the conference resolutions centred on the training of child care workers in an attempt to upgrade standards of care. A handbook for Children's Homes was published, and in 1968, a two-year correspondence course was offered to child care workers through the Technical College (Roberts,1981; Hoffman, 1988). Thereafter, the growth and advancement of the child care movement in South Africa may be attributed to two significant events; the formation of the National Association of Child Care Workers, and the de Meyer Committee of Enquiry (1982).

1.3.3.1 The National Association of Child Care Workers

In 1975, at a conference in Pretoria, the National Association of Child Care Workers (NACCW) was formed. Since its inception, the NACCW has addressed the training of child care personnel, has organised biennial conferences and has administered the publication of the monthly journal, The Child Care Worker. In 1988, the Institute of Child Care was launched under the auspices of the NACCW. This reflected a concern with the professional accountability of child care personnel, and an awareness of the need for an established code of ethics and standards of practice. In 1993 provision was made for a professional register of child care workers.

Largely as a direct result of the work of the NACCW, child care practice in South Africa has developed beyond that of any other country in Africa. The education and training opportunities available to child care personnel in South

Africa are impressive. The publication The Child Care Worker has gained recognition in Britain and the U.S.A.

A critical analysis of the contribution made by the NACCW to the field of child care in South Africa, suggests that its significance is limited by the heavy reliance upon a first world model. A review of The Child Care Worker journal, reveals a paucity of research material originating in South Africa, and a distinct bias towards philosophy and practice of Euro-American derivation. In their training programmes and at their conferences, the NACCW tend to prescribe the use of highly specialised procedures borrowed from Britain and America. These have not been sufficiently adapted to the South African context, and few Children's Homes have the resources (manpower or finance), to implement them. In particular, Black children in residential care are likely to be less responsive to North-American or European-derived theory and practice which they experience as shaped by bourgeois values and ideology. Through both a class-based analysis and a culture-based analysis, such differences can render child care and treatment practices ineffective.

1.3.3.2 The De Meyer Committee Report

A notable milestone in the development of the child care movement in South Africa, was the establishment in 1980 of the "Department of Health Services and Welfare Committee of Enquiry into Certain Aspects of Child Care" under the chairmanship of Mr. O.A. de Meyer (Department of Health Services and Welfare, 1982). The report published two years later, (known as the de Meyer Committee Report), contains recommendations regarding facilities for care in Children's Homes in South Africa, focusing on such issues as the management of Children's Homes, registration with and inspection by the State Department and the employment and training of staff. The necessity for an individualised treatment programme for each child, was emphasised (ibid.)

1.4 Summary

Over the past one hundred years, the developments in ideology, in policy and in residential child care services has been immense. A critical review of the present situation suggests that ongoing revision and transformation are essential. This is particularly true of the situation in South Africa. The apartheid system has left child care services in South Africa with many unhappy legacies which will be tremendously difficult to overcome. In spite of these difficulties, there are a number of pressing issues pertaining to residential child care which must be addressed, including:

1. The equalisation for all children in need of residential care, of the standards of the facilities and services offered (Hoffman, 1988); and the use of all facilities by all children, thus preventing duplication and making resources available to those children for whom resources are inadequate.
2. The development of a body of research and literature based on the South African experience of residential child care. Training programmes for child care personnel need to address the particular constraints imposed by the South African political and economic context.

CHAPTER TWO

2. AN OVERVIEW OF THE LITERATURE IN RESIDENTIAL CHILD CARE

Introduction

It needs to be stressed that a disciplined analysis of residential child care is difficult. Two constraints arise. Firstly, residential provision is subject to considerable variation (Waterhouse, 1989a). Residential institutions serve children in each of society's four major resource systems: health care, education, social welfare and justice (Ainsworth and Fulcher, 1981). Examples of each include: residential institutions for the mentally ill or mentally retarded; boarding schools for normal as well as learning disabled children; orphanages and Children's Homes; reformatories and juvenile prisons (ibid.). Considerable overlap exists between each system, social welfare services, for example, accommodating children with a variety of special needs: psychiatric disturbance, learning difficulties, delinquency. In each system, with variations in emphasis, the services have traditionally included physical and social care, instruction, guardianship and control (ibid.).

> "Traditionally, residential care has contributed to the whole field of child welfare a diversity of services which has yet to be equalled by other forms of provision" (Waterhouse, 1989b, p.181).

Over the past twenty years residential care services have changed and expanded and now also include residential treatment, community-based group living and a range of day services. These changes have been brought about in part by economic conditions, by advances in technology, and by changes in legislation (Riley, 1983). These innovations have not been consistently applied in practice resulting in further disparity between services.

Whilst the majority of residential services rely on public funding and are monitored by the state, an influential contribution is made by the voluntary and private sector, and therefore the internal policy of one Children's Home may differ from another depending on personal belief, personnel and resource constraints, access to professional services and exposure to training. The rate at which services are upgraded and expanded will differ accordingly. This can result in vast disparity in the services available from one organisation to another, a situation which is highlighted in South Africa as a result of the history of disparity in state funding for the various race groups.

A further constraint when analyzing residential child care arises because revisions in nomenclature accompanying innovations in services have not been consistently applied.

> "The evidence of change can be found in the diverse language contained in the group care literature, such as: protection, remediation, rehabilitation, life skill development, care, control, punishment, education, re-education, special education, retraining, treatment and therapy" (Burford, 1985, p.107).

The absence of a shared terminology confounds every aspect of child care study and restricts comparison between services (Waterhouse, 1989b). Consequently explicating the role of the residential care facility is a complex undertaking. For this reason it is necessary to clarify the terms of reference that will be used in the remainder of this dissertation.

Kadushin and Martin (1988) define the children's institution as a "twenty-four hour residential facility in which a group of unrelated children live together in the care of a group of unrelated adults"(p.669).

Among the different kinds of institutions serving different kinds of children, are the following:

1. Institutions that perceive their role as providing a home for dependent and neglected children. These are the modern analogy to the old orphanage, and they are a

provision of the social welfare system. In South Africa, such institutions are known as Children's Homes.

2. Institutions designed as small living units, based in the community and accommodating a limited number of children who are unable to live in their own homes with the goal of maximising the opportunity for community experiences and socialisation. These are known as group home services, off campus homes, community homes and group homes. In South Africa, these units fall under the provisions of Children's Homes in terms of state policy and funding.
3. Institutions that provide specialized services for mentally and physically handicapped children.
4. Institutions for the confinement and rehabilitation of conduct-disordered children and adolescents. In South Africa, two types exist: Reform Schools, falling under the jurisdiction of the criminal justice system and accommodating children who have been through the criminal courts; and Child Care Schools (also known as Industrial Schools) accommodating children requiring containment but who have been placed under the provisions of the Child Care Act (No.74 of 1983). At the time of the research Schools of Industries were promoting a change in name to 'Child Care School', with the intention of destigmatising their role and promoting a more caring image. They have subsequently reverted to the name School of Industries or Industrial School. For this reason the questionnaire refers to Child Care School, whereas the term School of Industries is more commonly used.
5. Institutions that provide emergency short-term containment and care. Assessment and observation facilitate planning for appropriate care and placement. In South Africa, such facilities are known as Places of Safety.
6. Institutions that provide treatment for emotionally disturbed children and their families. They are known as residential treatment centres. In South Africa due to the

absence of any facility providing both substitute care and specialised treatment, this role is fulfilled by the other available institutions; Children's Homes, Child Care Schools and Places of Safety (Biderman-Pam, 1989).

Collectively, these institutions are variously termed 'child care facilities', 'child-caring institutions', 'residential centres', 'residential child care services', 'group care services' and 'places of care'.

Along with the changes in child care practice over the years, different building designs have been favoured. In the custodial era, many Children's Homes resembled hospitals and children were accommodated in large open dormitories. With the growing recognition of the needs of children and their need for private space, smaller living units were built with provision for individual bedrooms. Many of these were contained in the same 'Block' with central kitchen and laundry facilities. Those institutions that have built their premises within the past thirty years, have favoured the cottage system i.e. separate cottage style living units on a large campus, and this preference was endorsed by the de Meyer Committee (de Meyer, 1982). The committee also recommended the promotion of Off Campus group homes on an experimental basis. These terms are used in the remainder of this dissertation to denote the design of the building.

Different terms are used in the literature to denote the primary caregiver, each reflecting the 'meaning' attributed to this role. The members of the child care team who directly care for the children are referred to as child care workers, house parents, educateurs, residential social workers, group care practitioners and life-space counsellors. The term child care worker is generally favoured in South Africa and will be used in this dissertation; and the term child care practitioner is used in a general way to refer to any member of the child care team (social worker, psychologist, principal

or child care worker).

As a result of the diversity in services and inconsistency in the use of terminology, residential child care remains a field in search of a distinct occupational identity, a guiding philosophy and a clearly articulated methodology. As a contribution towards the reassessment of residential child care and with a view to explicating theory and practice the influential literature is reviewed and the major professional concerns and issues are highlighted.

2.1 Towards a Philosophy of Residential Child Care

Lack of clarity of purpose has confounded attempts to identify an agreed value base and coherent guidelines for residential child care practice (Ainsworth and Fulcher, 1981).

> "Until recently, it can be said that personal belief - whether drawn from ideological or religious origins - has provided the prevalent guidelines for group care practice" (Ainsworth and Fulcher, 1981, p.10).

Residential child care practitioners, in search of a theory to support and guide their work, have traditionally borrowed the language and concepts from better established disciplines, particularly Social Work and Psychology. The relevance of such theory is often questionable. Brendtro et al. (1990) summarise the predicament:

> "Our field seems to be caught in a dilemma where those who research and write don't understand practice while gifted practitioners don't believe they have the time or talent to write" (Brendtro et al., 1990, p.1).

Over the past thirty years, there has been a steadily growing body of literature identifying the special therapeutic characteristics of residential group care environments and supporting the practice of residential child care as a specialised service. There are signs of renewed respect for the importance of 'practice wisdom' in developing models for

effective intervention (Whittaker, 1979; Brendtro et al., 1990).

2.2 Goals and Functions of Residential Child Care

The disparate influences of the four major resource systems have given rise to four different goals of care: treatment, control, teaching and nurturing, each applied with differing emphasis from one organisation to the next (Fulcher and Ainsworth, 1985). Whilst each of these goals is relevant, there is a need for residential child care practitioners to clarify their own goals and functions, taking cognisance of the views of the children themselves (National Children's Bureau, 1977).

Whittaker (1979) suggests that the central question in constructing "piece by piece from the ground up" (p.89) an overall theory of residential child care, is "How can these children be helped?" (Whittaker, 1979, p.90). Various theoretical approaches have emerged over the past thirty years each with their own interpretation of the most helpful ingredients of residential care. There is, however general consensus regarding the essential role of the residential care facility: to care for children and to equip them with skills in relating and coping so that they will be able to successfully re-enter the community. Towards fulfilling this role, various goals and functions have been articulated in the literature.

Parker (1966; 1980; 1988) notes five primary goals of residential care: care, rehabilitation, education, preparation for independence and preservation, the fulfilment of the child's right to continuity in family relationships. The first three represent traditional well-established goals. The latter two break relatively new ground, taking into account young people and children's needs to remain in contact with their families and to prepare for future citizenship.

Towards the achievement of these goals, residential child care facilities perform certain functions. Waterhouse (1989b) lists three functions of residential care which make a significant contribution to the larger system of child welfare services: assessment, containment and supplementation. Treatment has also come to be regarded in some sectors as a primary function of residential care.

2.2.1 Assessment

Residential establishments are well suited to assessing the psychological, social and educational needs of children because of the opportunity for twenty-four hour observation and because the institution, unlike foster care or adoption, allows for objective assessment "without necessarily demanding loyalty and attachment between residents and caregivers" (ibid., p.175). This function is performed by a range of residential services with observation and assessment centres, and in South Africa, Places of Safety are especially earmarked for this purpose.

2.2.2 Containment

Containment takes place in residential care facilities on two levels. Firstly, residential care is the main resource for children and adolescents who depart abruptly from other placements such as foster care or adoption, providing these children with accommodation and support. Containment also refers to the provision of physical security for those children and adolescents who pose a risk to themselves or others, or who commit delinquent acts. In South Africa, Places of Safety provide for both these levels of containment. Conduct problems requiring containment in the latter sense, are generally referred to as Child Care Schools or Reform Schools. Where a child needs secure structures and close supervision but is able to regularly attend school in the community, such children may benefit from the measure of containment provided by Children's Homes. Parker (1988) notes that most children in need of containment are equally needful

of re-educative and therapeutic experiences.

2.2.3 Treatment

Historically, residential care has pioneered therapeutic ways of helping children who are emotionally damaged as a result of their experiences. Such interventions have relied on the residential context as a means for providing a comprehensive environment in which to understand and respond to children's psychological needs (Waterhouse, 1989b).

2.2.4 Supplementation

Residential establishments, as central institutions, are increasingly performing an important supplementary function by hosting on their premises variety of services in addition to those which are exclusively residential, for example day-care services, after-care services, weekend and evening 'respite' care for children of families in crisis, parent training and support groups. Supplementation also refers to the contribution made by residential care towards the implementation of other child welfare services. For example, the Children's Home may provide transitional care, intermediate treatment and preparation for children entering other placements or pending return to their families.

Although some institutions offer a specialised service emphasising one of these functions in their programme; for example, Places of Safety provide for assessment and observation, Child Care Schools provide containment, and residential treatment centres are primarily concerned with treatment, "none of these functions is the exclusive prerogative of one type of residential establishment" (ibid., p. 175). In most instances child care facilities must remain eclectic and perform all of these functions to some degree depending upon the immediate needs of the individual child. Whilst this eclecticism often arises out of necessity due to the lack of available resources, it creates a number of practical problems:

1. Many diverse needs are represented amongst the children living in the same facility and in trying to be all things to all children, neither assessment nor containment nor treatment is given the consideration it deserves.
2. Day-to-day routines and activities are disrupted by those disturbed children whose specific needs for intensive treatment and behavioural management are not being met.

The need to appreciate which goal is of primary importance for a particular child at a particular time has received insufficient attention in the literature. The process of matching the child's needs to a particular service is an issues which is discussed in detail in the following chapter.

2.3 Theoretical Models of Residential Child Care

The various theoretical models of residential child care operationalise these goals and functions in different ways. Four prevailing models of residential child care have emerged over the years: the custodial model of care, the pedagogic model, the treatment model and the ecological model. While this review is selective, the approaches considered are at least representative of the major sets of ideas that have influenced residential care.

2.3.1 The Custodial Model of Care

In the history of the development of residential child care, the earliest institutions provided for the long-term custodial care of children (Donzelot, 1979; Riley, 1983). The change to cottage style institutions marked the move towards recreating family conditions within the institutional setting, but the primary goal was still that of providing long term substitute care.

Over the past sixty years the demand for long-term custodial care has diminished as supportive welfare services have

developed and as children with more severe problems have entered residential care. Furthermore, the literature exposing the damaging effects of institutional living (Bowlby, 1951; Goffman, 1961), raised serious questions concerning the advisability of any kind of institutional care for children. Residential care settings were therefore motivated to work overtime to convert their facilities and their public images to the more fashionable and acceptable 'residential treatment centre' (Wolins, 1965). The custodial model came to be regarded as outmoded and inadequate.

An interesting innovation in recent years is a renewed recognition of the importance of custodial care. The focus upon treatment had resulted in practitioners underplaying the significance of physical care, regarding custodial tasks as menial or non-professional, instead of recognising that demonstrating a concern for the child's physical welfare provides opportunity for intensive relationship-building and can provide significant entry points into feelings, anxieties, and values (Barnes and Kelman, 1974).

> "The simple facts of the matter are that there are a large number of children who either have no homes to go to, or are unsuited for and, more importantly, cannot benefit from community living without the supports only available in group care. Child care is the only profession willing and capable of meeting the comprehensive, long-term, 24-hour-a-day custodial and developmental needs of these children. The other professions are too specialised or would not or could not do that kind of work. If ever there is a child care 'turf', this is it" (Durkin, 1988, p.364).

Clearly these physical and developmental needs can be met more successfully in smaller, community-based living units, hence the trend towards Off Campus group homes.

2.3.2 The Pedagogic Model

The pedagogic model is the cornerstone of residential care throughout Europe. The role of the educateur is central to the approach. The educateur is the closest person to the child

from the time of rising in the morning to going to bed at night. The educateur reaches the child through a 'curriculum' of daily group living, by:

1. capitalising on situations that arise in order to generate learning through discussion and problem-solving;
2. designing activities that will be interesting, fun and will give the child the opportunity for positive self expression (Barnes and Kelman, 1974).

In the course of daily life events and through planned activities the educateur and the child can arrive at shared interests, mutual respect and understanding, and positive channelling of energy. The model is an integrative one allowing the child to make a strong investment in a competent individual who can help him in all his interactions and activities. The model is developmentally based rather than pathology based, concerned with developing normal behaviour rather than treating problem behaviour. The physical and emotional involvement that the educateur achieves with the child in various activities, is aimed at helping the child to develop age-appropriate behaviour.

The educateur movement had its inception in Europe during the Second World War, which produced a large number of neglected and abandoned children. Residential centres were established for the care of these children and it was soon realised that there was an urgent need for trained youth workers to serve as model adults and substitute parents. When the model was introduced amongst child care workers in America (Linton, 1969), a change was observed in both problem definition and problem response:

> "problems began to be viewed as issues and stresses in living requiring interaction and education rather than as eruptions of pathology requiring structured intrapsychic intervention. Episodes shifted from being viewed as management crises and were regarded as valued opportunities for support, for limit setting and for guidance and empathy" (Barnes and Kelman, 1974, p.14).

2.3.3 The Treatment Approach

Influenced by the trend towards deinstitutionalisation, the child guidance movement and child psychiatry, the emphasis shifted from residential care to residential treatment. The pioneering work of Bruno Bettelheim (1950; 1955; 1967; 1987) contributed immeasurably to the development of residential treatment of disturbed children, particularly through emphasis on the role of group living. He emphasised the unique rehabilitation potential which lay in the residential institution through the opportunity for consistent twenty-four hour care. These ideas were developed further by Fritz Redl (1959; 1962; Redl and Wineman, 1967). Redl focused on the delinquent child and was interested in the interplay between individual and group dynamics and in the group's potential as a medium for changing anti-social behaviour.

It is generally agreed that a residential treatment centre consists of a therapeutic programme for children whose emotional problems preclude treatment in the community on an outpatient basis (Barker, 1974; Lyman et al., 1989). Confusion arises in the literature through the use of the term 'residential treatment' to refer to:

1. an aspect of child care, an option on the continuum of child care services available to all children entering residential child care.
2. the service provided by a specialised unit.

Adler (1968: cited in Maluccio and Marlow, 1972), Weber (1972) and Lyman et al.(1989) enumerate the following specific characteristics of residential treatment centres:

1. Residential treatment centres do not intend to provide a substitute home where maladaptive behaviours are tolerated and contained; the goal of placement is change.
2. Residential treatment centres have admission criteria by which they define the range of emotional disturbance which they believe their particular programme can change.
3. Residential treatment centres use diagnostic procedures

to describe and classify the child's problems.

4. The tools of treatment are individual, group and environmental techniques. Social group work has contributed substantially to the development of residential treatment (Maier, 1965; Maluccio and Marlow, 1972).
5. The major therapeutic objectives are resolution of intra-psychic conflict, development of insight, and reorganisation of the child's personality (Maluccio and Marlow, 1972).
6. Residential treatment centres have a team of clinically-trained personnel, skilled in diagnosis, assessment, individual and group therapy. Planning and evaluation of the child's treatment are jointly undertaken by the team.
7. The child care worker fulfils a custodial or parenting role during the hours of the day when the child is not in direct therapy.
8. Parents may be required to participate actively in the child's programme with a view to the child's successful return to the family, however Maluccio and Marlow (1972) note that although the importance of parental involvement in treatment has been acknowledged as an ideal, residential treatment centres have remained child-centred in their approach.
9. Group living is a fundamental aspect of treatment.
10. The structure, order and consistency of the programme and the positive relationships between staff and children should provide the necessary security and control.

These criteria, somewhat idealistically, describe some of the elements which set residential treatment centres apart from other residential child care facilities, and in the process define residential treatment itself. Weber (1972) emphasises the distinctive therapeutic role of residential treatment centres:

> "They do not simply house, feed and clothe; they treat. They do not simply contain behaviour; they

> help children change it. They do not protect society from its deviants; they seek to return them as productive citizens. They do not serve only those who have no place else to be, or those with whom everybody else has failed; they provide a treatment of choice" (p.12)

Residential treatment centres have fallen under criticism primarily because of the adherence to the medical model, and consequently the emphasis on pathology and on correcting maladaptive behaviour. The limited relevance of diagnosis is elaborated in Chapter Three.

With the move towards the professionalisation of the child care worker the treatment approach has been rejected on the basis that it does not recognise the child care worker as the primary practitioner and the primary agent of change. The treatment model assumes that therapeutic change takes place during visits to clinicians. Linton (1969) contrasts the treatment model with the European "educateur" model, in which a highly trained child care worker "programs the child's free time and serves as a role model" (p.128), and the routines in the child's day - wake-ups, mealtimes, bedtimes - are important opportunities to help children learn and change.

In a landmark publication, The Other 23 Hours, Trieschman, Whittaker and Brendtro (1969) emphasised that the child care worker, living with the child for the twenty-three hours apart from the therapy hour, is the most important person to the child; and these hours hold tremendous therapeutic potential. In the last twenty years writers have proclaimed the therapeutic use of routines and activities to be the real substance of child care philosophy and practice.

2.3.4 The Ecological Approach

More recently, another model of care has greatly influenced child care practice. With the changing emphasis in psychiatric and psychological services towards community-based care, the impact of the treatment environment, the living

group and the broader social context came to be recognised as significant factors in the therapeutic process, giving rise to an ecological approach to residential child care. The significance of the treatment environment, has been steadily recognised in the literature since Bettelheim and Sylvester (1948) introduced the concept of the 'therapeutic milieu' in the 1940s. The concept of the 'therapeutic milieu' refers to a daily living environment which is empowering, supportive, and caring, both of the individual and the group.

Since the 1960s, interest has developed in the application of sociological theories to residential treatment settings, particularly systems theory, small-group theory and organizational theory. Living groups have been analyzed from a sociological perspective, demonstrating the impact of various subsystems and subcultures on child care workers as well as children (Maluccio and Marlow, 1972).

In 1979, Brofenbrenner proposed an ecological model of development in which the concept of environment is broadened from that of the immediate stimulus situation to one that encompasses the wider society to which the person belongs and the social forces which exist in that society. His approach also embodies the important notion that changes in the larger systems of the society in which the person lives (the macrosystem i.e.the pattern of culture, the politics and economy of that society), will affect the smaller systems such as the home, the school (microsystem) and the relationships between elements in the microsystem i.e. parent-child relationships, parent-teacher relationships, etc.

The ecology of human development is the study of how a whole society functions to raise the children who will eventually take their place within that society. Within an ecological framework, the balance of environmental forces is not the only determinant of human development. The character of the individual is significant in view of the fact that individuals

and their environments are regarded as

> "mutually shaping systems, each changing over time, each adapting in response to changes in the other" (Garbarino, 1982, p.16).

Garbarino describes the concept of opportunity and risk for development, depending upon the individual's mental and physical characteristics and the type of environment one inhabits (see further Chapter Three). The ecological perspective emphasises the quality of linkages between the individual and outside systems, notably the family, the school, the neighbourhood, the peer group (known as the mesosystem). These linkages have an important implications for residential care, indicating that more time needs to be invested in creating social support networks for children and their families, and less time in direct treatment of children (Whittaker, 1979; Garbarino, 1982; Beker and Eisikovits, 1991).

In contrast with the treatment model, the ecological perspective focuses on health, on building strengths and competencies, rather than on curing pathology. In harmony with the educateur model, the goal of intervention is the achievement of age-appropriate development. Treatment takes place in the daily life-space interactions between the child and significant adults and peers. In terms of the ecological model, the success or failure of residential care placements has less to do with the presenting problem or the type of treatment offered, but is largely a function of the supports available in the post treatment community environment. The approach is relevant to the South African context for a number of reasons:

1. It enables practitioners to understand more clearly the relationships between children, their families and their environments and to identify sources of support as well as stress and conflict (Garbarino, 1982). This is important when maintaining these links whilst the child is in care, and when preparing a child to return home.
2. This approach is particularly useful when considering the

effects of the macrosystem of the society on the individual, and the influence of the broader social context on the outcome of residential child care. As described, the Apartheid system was historically a significant macro-system influence and its effects will persist for many years to come.

2.4 A Process Model of Residential Child Care

At each stage in the care process, a different goal takes precedence, and there is a different priority for intervention. In terms of this process model, the various theoretical models are not in opposition to one another, but reflect a continuum of the care process. Beedel (1970) suggested a process model of care based on the basic tasks of parenting, dividing these into three categories: holding, to denote the type of care, comfort and control that is given to a child upon entering care; nurturing, referring to basic socialisation and the development of personal skills; and the development of personal integrity, involving both therapy and education in preparing the child for independent adulthood.

Hoghughi (1978; Hoghughi et al.,1980; Hoghughi et al., 1988) has formulated a process model of residential care in which the functions of care form part of a sequence of interventions with each child, from admission through until discharge: management, care, assessment and treatment. The first two stages are similar to Beedel's concepts of holding and nurturing. This process model is widely taught and followed in South Africa.

The stages in this process are determined by the child's behaviour, capabilities and treatment needs. Each child will move through the care process at their own pace. It is essentially the child's capacity to benefit from the service provided at each stage of care that has determined the behavioural categories used in the present research.

2.5 The Concept of Programming in Residential Child Care

The concept of an individualised, recorded treatment programme is fundamental to every aspect of intervention with children in residential care, from the time of admission up until and often beyond their return to the community. The concept of programming essentially refers to the process of differential planning for children, and the elements of a programme are:

1. Documentation of an identified need, which may refer either to a specific problem or to a normal developmental requirement.
2. Documentation of treatment goals and objectives.
3. A detailed plan of the specific activities designed to achieve the identified goals (who, what, when, etc)
4. Documentation of the criteria by which the programme will be monitored and evaluated (Fulcher and Ainsworth, 1985)

Programming in residential child care takes place on four levels, each of which is interdependent and interrelated to the other. These four levels are:

Level 1. Legislative, regulating and funding arrangements by which services are supplied.

Level 2. The global description of activity within an organization e.g. Seven-day residential treatment programme for adolescent girls.

Level 3. The Individual Treatment or Development Programme.

Level 4. Activity Programme: the description of the activity which takes place in the formal or informal group e.g. living group or treatment group.

These levels are compatible with the idea of interlinking systems in the ecological model (ibid.) A fundamental principle underlying the concept of programming in residential child care, is that every child placed in substitute care has the right to an effective, efficient, individualised programme which facilitates development according to the needs, goals, potential and pace of the child. The present research was

undertaken in the quest for more efficient and effective programming procedures for children in residential care.

2.6 Current Trends in Residential Child Care: Philosophy and Practice

Philosophy and practice are shaped by changes in the needs of the population served. These needs are determined by the prevailing social and economic climate (Riley, 1983). Summarising these changes, Kadushin and Martin (1988) note the following major trends in child care institutions in North America in recent years:

1. Fewer referrals of children due to the expansion of supportive services and alternative placements (see Chapter Three on Permanency Planning).
2. Children referred for residential care are more likely to have severe problems (Jonsson,1972), and are more often

   > "those who are so disturbed or who come from a situation so disorganised that even supportive and supplementary care would not permit them to be kept in their own homes or in foster homes" (Kadushin and Martin, 1988, p.719).
3. Changes in intake policies and treatment programmes to accommodate these more difficult children, necessitating the shift from custodial care to treatment. Some residential institutions have responded by establishing intensive treatment units.
4. Expanded use of the institution as a specialised resource rather than as an undifferentiated facility for all children needing substitute care. Recognising the different needs and problems represented amongst children entering care, one organization can provide different types of services so that children with common problems and needs may live together in a specialised unit, transferring to the next type of service when they are ready. This is in line with a growing commitment to the child's need for continuity of care, and may assist children in moving timeously out of residential care.

5. Including families in the treatment planning and service-provision aspects of residential child care.
6. Efforts to de-institutionalise the Children's Home and to involve parents more actively in the programme have resulted in an increase in community-based group homes.
7. Increased professionalisation and training of child care workers, motivated by:

   "the increasing complexity of the demands made on child care staff, fostered by the transfer from a custodial to a treatment focus, increased attention to the broader context in which children's problems develop, insistence on the need for greater contact with parents, and the demands that the worker be skilled in contacts with a variety of members of the community" (Kadushin and Martin, 1988, p.721).
8. Successful racial integration of segregated institutions.

Similar trends may be identified in other countries, including South Africa. In order to meet the various challenges impinging from the different models and from the changing needs in substitute care one needs to use programming in a coherent way:

1. Firstly, at an individual level by identifying the child's needs and goals, planning the process of the child's stay in residential care and planning for the child to return to the community.
2. Secondly, at the institutional level by planning appropriate services to meet the diverse needs of children in residential care. This level of programming was the basis of the present research and dissertation.

Whilst the specific social context will determine specific objectives, the need for the development of a truly comprehensive, coordinated and community-based network of treatment resources to meet the varied needs of children with emotional problems, is an over-riding theme in child care literature over the past thirty years (Maluccio and Marlow, 1972).

CHAPTER THREE

3. DECISION-MAKING IN CHILD CARE

Introduction

In spite of the developments in theory and practice, residential care is no substitute for the experience of living in a caring family. Numerous studies of child development emphasise the importance of continuity and security in parent-child relationships and of stability in living arrangements. Central psychological issues include the child's need to develop his or her identity, to achieve a sense of belonging, to establish meaningful relationships with people, and to deal successfully with developmental tasks (Kellmer-Pringle, 1975; Schaffer, 1990). Planning for a child's secure placement with their own family or a foster family is therefore an important aspect of every child's individual treatment programme. This has come to be known as permanency planning.

Decision-making when matching children with placements is a complex undertaking. Some children will never successfully return to their natural families; some are destined to fail in foster placements. Obstacles to the success of placements need to be examined. The study of developmental psychopathology provides a useful framework for understanding child-related barriers to successful placements, for predicting when problems are likely to arise, for recognizing individual vulnerability and for planning treatment. Developmental psychopathologists focus upon group trends and individual variations, with a special interest in factors that place some children at risk for dysfunction (Knopf, 1979; Achenbach, 1982; Cicchetti et al., 1988). From this perspective, one can begin to deduce the characteristics (developmental age; cognitive ability; temperament; behaviour problems) of those

children who are more likely to require long term residential care and plan accordingly.

3.1 Permanency Planning

Permanency planning represents the movement to promote plans ensuring stability in the lives of children found to be in need of substitute care. This movement has shaped the philosophy and theory, goals and services of child welfare agencies in recent years. Permanency planning may be defined as "the systematic process of taking prompt, decisive, goal-directed action to maintain children in their own homes or to place them permanently with other families" (Maluccio et al., 1986, p.(i)).

In other words, permanency planning encompasses both prevention and rehabilitation. The term was originally used to support the need to arrange adoptive placements for children in long-term foster care who could not be returned to their own families (Kadushin and Martin, 1988). Subsequently, permanency planning efforts have focused on a concern with the prompt return of the child to the natural family, or alternatively, the provision of another type of permanent home.

3.1.1 The Theoretical Foundations of Permanency Planning

The permanency planning movement is based on various theoretical premises, particularly from the field of child developmental psychology. Hess (1982, in Maluccio et al., 1986) stresses that the whole rationale behind permanency planning is that all children need a stable and continuous nurturing relationship in order to develop physically, socially, emotionally, intellectually, and morally. Conditions affecting the process and quality of parent-child attachment and thus child development, include:

* **Continuity**: the parent's consistent, constant, and predictable availability in the child's life;
* **Stability**: a nurturing environment that supports the parent-child relationship.

* **Mutuality**: mutually rewarding parent-child interactions. (Hess, 1982; in Maluccio et al., 1986)

Some writers emphasise the significance of the biological family, underscoring the importance of the biological tie. Bowlby (1951) was the first writer to advance a clear position on the mother-child relationship as fundamental to mental health, advocating that the infant should experience a warm, intimate and continuous relationship with his mother "in which both find satisfaction and enjoyment"(Bowlby, 1951, p.11). Failure to establish a secure emotional attachment relationship, and similarly, a major break in that relationship may be experienced as highly distressing and will constitute considerable trauma, followed by difficulties in interpersonal relationships and social interactions (Spitz, 1945; Spitz and Wolf, 1946; Bowlby, 1951;1966; Erikson, 1963).

Other writers have argued the importance of 'the psychological parent', highlighting the child's need for consistent care, and recommending the use of 'professional parents' whenever necessary. Goldstein, Freud and Solnit (1973; 1979) advocate legislation to provide each child with a permanent relationship to those adults who have functioned psychologically as his or her own parents, i.e. through "day-to-day interaction, companionship, and shared experiences" (Goldstein et al., 1973, p.19). They argue that the role of the psychological parent can be fulfilled by the biological parent or by the adoptive parent or by any other caring adult,

> "but never by an absent, inactive adult, whatever his biological or legal relationship to the child may be" (ibid., p.19).

Bowlby's later formulations regarding partial maternal deprivation, considering the effects of inconsistency in parent-child relationships and the impact of parent substitutes have been of great theoretical importance and have influenced many workers in the field. Yarrow (1961, cited in Riess, 1972), has identified four types of maternal

deprivation:

* institutionalisation
* separation from the mother or mother substitute
* multiple mothering (as found in *kibbutzim* and in institutional care)
* distortions in the quality of mothering, e.g. rejection, overprotection.

In most instances these types occur in combination rather than separately. Responsible decision-making in child placement requires a thorough understanding of the impact of each of these experiences. The effects of institutionalisation and multiple mothering are elaborated in section 3.2.

Goldstein, Freud and Solnit (1973) examine the impact of separations as they affect children at each stage of development. They argue that in infancy and toddlerhood, attachments are as damaged by separation as they are promoted by constant, uninterrupted care and attention from a significant adult. Separation will not only result in distress and anxiety, but also in setbacks in the quality of trust in future relationships. For young children under the age of five, separation may detrimentally affect recently acquired achievements such as toilet-training and speech. The authors suggest that for school-age children, separation from parental figures will disrupt the process of identification, subsequently impairing moral development and socialisation. Even adolescents who may seem to desire the discontinuation of parental relationships, need to feel that separation is a matter of their own choice and control, otherwise such separation will be experienced as rejection and abandonment. They (ibid.) contend that children who suffered repeated separations may continue the cycle by abandoning their own children.

Winnicott (1972; 1974; 1976; 1986) studied the impact of various distortions in the quality of mothering, and the processes implicated in the development of the child's

relatedness with others. Winnicott stresses a number of essential processes in child-rearing which depend upon the availability of a 'good-enough' mother (Winnicott, 1974; 1976; 1986). If the infant is to successfully achieve a sense of self, a feeling of confidence in their environment and a belief in the reliability of the world, these processes are essential to the mother-child relationship:

* holding
* reciprocal communication
* accurate empathy and sensitivity to the infant's needs and feelings
* continuity of care.

When these conditions are unfavourable, the infant experiences anxiety, confusion disintegration. Unable to establish certainty of being, the developing personality proceeds on a pattern of "reacting to the unpredictable and forever starting again" (Winnicott, 1986, p.154). Winnicott provides a useful understanding of the processes towards health and pathology commonly impinging upon children in substitute care.

> "I find it useful to divide the world of people into two classes. There are those who were never 'let down' as babies and who are to that extent candidates for the enjoyment of life and of living. There are those who did suffer traumatic experience of the kind that result from environmental let down, and who must carry with them all their lives the memories (or the material for memories) of the state they were in at moments of disaster. These are candidates for lives of storm and stress and perhaps illness" (Winnicott, 1986,p.31).

Her formulation of the essential processes in child-rearing has important implications for the necessary ingredients of substitute care, especially the care of infants. In South Africa where many children are abandoned in infancy or left orphaned in infancy, the questions surrounding attachment and separation are critical.

Rutter's (1981) reinterpretation of Bowlby's theory of

attachment, has challenged the assumption that where bonding has not occurred in the first year of life, the negative effects are enduring and irreversible. This introduces the possibility of treatment and raises the following important research questions:

* How much experience does bonding take?
* At what age does bonding occur?
* How early in infancy does separation from a mother or other permanent caretaker have an impact on children and cause them to develop symptoms of disorder?
* What will these symptoms of disorder look like at various stages of the child's development?
* How can amelioration and reversibility be attained?
* How readily and completely can amelioration and reversibility be attained?

"Studies have been numerous and of varying degrees of experimental exactitude" (Riess, 1972, p.1185). Whilst clarity has not been achieved, these questions have a critical bearing on decision-making with regard to the placement and treatment of infants and children in substitute care, whether in foster care, adoption or residential care.

3.1.2 Return to Family

The permanency planning movement emphasises the significance of the biological family and the primacy of parent-child attachment. Wherever possible the family of origin is the placement of choice (Kadushin and Martin, 1988).

> "We always act on the supposition that until proven otherwise, the best place for the child is in his or her own home" (ibid., p.83).

This maxim applies whenever state intervention is considered, whether it concerns children at risk of placement or already in substitute care.

Recently, the "minimally acceptable parenting" criterion has replaced the "child's best interest" test as the guiding

rationale in state intervention (ibid.). The best interest doctrine required that the worker evaluate the best possible living situation and attempt to secure this for the child. This doctrine has been criticized as both unfair and unrealistic, in view of the fact that it often results in the imposition of middle-class standards of child-rearing on poor families. This doctrine also means that child welfare families are required to prove that they are able to provide the best possible environment for their children, a standard that is not demanded of the remainder of the community.

3.1.2.1 Obstacles to Family Reunification

Despite the growing acknowledgement of the family of origin as the placement of choice, a review of the literature reveals numerous obstacles to the child's successful return to the natural family. These obstacles may be summarised as follows (Kadushin and Martin, 1988; Maluccio et al., 1986):

1. **systemic barriers**, e.g. legal and policy constraints or lack of supports to parents; deeply held social values and policies have advocated on behalf of the needs of individual children, but have failed to address the critical role that families play in children's lives.

2. **worker-related barriers**, e.g. negative attitude towards biological parents; inadequate training, supervision and support in the provision of home-based services and in placement prevention; stress and uncertainty when confronted with critical decisions regarding the impact of parent behaviour on a child's well-being; high case loads.

3. **parent-related barriers**, e.g. serious illness; lack of motivation; poor parenting skills; financial issues.

4. **child-related barriers**, e.g. severe physical impairment or psychiatric disturbance; child's behaviour problems; the child's need for continued therapy or evaluation; the child's negative attitude towards returning home; the child's attachment to the substitute home.

3.1.2.2 Evaluation

Studies show that the longer a child has been in substitute care, the less likely it is that he or she will return to the natural family (Kadushin and Martin,1988). Without considerable support, natural parents lose motivation to

maintain regular contact with their children, finding agency-based visits with their children both stressful and unsatisfactory. Many families gradually reorganise their lives without their children, and then find it difficult to welcome the idea of the child's return to their care.

Once children have been reunited with their natural families, studies have indicated that these families need considerable social supports and concrete services in such areas as health, education, employment, recreation, and income (Kadushin and Martin, 1988; Maluccio et al., 1986). Follow-up studies have shown that a substantial proportion of children placed in such 'permanent plans' will enter another system, such as the mental health system, or will re-enter the child welfare system and are likely to remain in care indefinitely. Many of these are older children or youth, returning from substitute care to their biological families (ibid.). Every effort needs to be made to identify and support these particularly vulnerable children and their families.

3.1.3 Foster Care

In terms of the permanency planning ethic, foster care is considered to be a short-term treatment resource for the child while their family struggles to remedy the problems that led to removal and placement. The Child Welfare League of America (1959; in Kadushin and Martin, 1988) defines foster care as

> "A child welfare service which provides substitute family care for a planned period for a child when his own family cannot care for him for a temporary or extended period and when adoption is neither desirable or possible" (p.344).

Foster care is therefore unlike adoptive placement which implies a permanent substitution of one home for another, one family for another. Whilst the foster parents will have legal custody i.e. the right and duty to feed, clothe, shelter and care for the child, the natural parent will retain legal guardianship. Although many long term foster placements

become *de facto* adoptions, as long as the birth parents retain legal guardianship of the child, there is a possibility that the child will eventually return to their care.

Foster care is generally regarded as the prefered option when placing children in substitute care. In the last twenty years, with the focus on permanency planning, foster care has been subject to criticism, in view of the fact that children are left 'in limbo' with regard to their legal status. Many children "drift toward unplanned long-term care", while others move from one failed placement to the next (Kadushin and Martin, 1988, p.352). These problems have resulted in legislation requiring regular review procedures to ensure more systematic planning and accountability (ibid.).

One solution to the achievement of permanence which has been proposed, involves changing the law regarding the termination of parental rights so that a foster child who is unlikely to return home can be freed for adoption. In many countries legal provision has been made whereby "permanently neglected" children can now more frequently be freed for adoption. However, in practice, within the court system the rights of the natural parent are still all but absolute, even when they conflict with the child's need for permanence.

3.1.3.1 Obstacles to Long-term Foster Placement

A review of the literature reveals a number of obstacles to a child's 'permanent' placement in foster care. These include barriers to effecting placement as well as those factors which typically result in the failure of placements.

1. **Systemic barriers** e.g. legal and policy constraints impede or prevent termination of parental rights; inadequate legal protection of the child's right to permanence; lack of legal status for foster parents; inadequate foster grants

2. **Worker-related barriers** e.g. anticipated opposition by the parents in response to long-term foster placement; inadequate skill, experience and training in the assessment, selection and ongoing support of suitable

foster families; high case loads; frequent turnover; limited choices and time constraints when matching children and foster families

3. **Foster Parent-related barriers** e.g. reluctance to cooperate with natural parents; lack of available foster parents; unrealistic expectations

4. **Parent-related barriers** e.g. parental whereabouts are unknown; active opposition; continued interest in the child however vague, disruptive or intermittent;

5. **Child-related barriers** e.g.'difficult to care for children';retardation; emotional disturbance; children requiring ongoing specialist treatment; adolescents; separation from siblings; feelings of divided loyalty to parent figures.

3.1.3.2 Evaluation

In reviewing the results of longitudinal studies evaluating the effects of foster care, Maluccio et al.(1986) stress the complexities involved in this type of evaluative research, and the inconclusive nature of the findings. Whilst many writers refer to the psychological damage resulting from the tenuous, impermanent situation in which foster children find themselves, the existing follow-up studies of adults who were placed in foster care, do not support the conclusion that such care is damaging (Festinger, 1983,in Maluccio et al., 1986; Triseliotis, 1980). Triseliotis concludes that

> "people who grow up in long-term foster homes, within which they are wanted and integrated as part of the family, generally do well" (Triseliotis, 1980, p.156).

The nature of foster care suggests that it is a feasible resource for the child who is capable of participating in and contributing to normal family and community living. The recent literature recommends foster care as the placement of choice for all children under six requiring substitute care (Parker, 1966; Rutter, 1975; Schaffer, 1990).

Maluccio et al.(1986) emphasise the critical need for current follow-up research on post-placement functioning if foster placements are to provide a viable 'permanent' home for children in need of substitute care. A systematic procedure

needs to be developed whereby those children most likely to succeed in foster homes, may be identified. Similarly absent in the literature is a standardised profile of a suitable foster family matched to the characteristics of a specific child. In practice, however, placement decisions are more often determined by the availability of foster parents rather than by ideal considerations.

3.1.4 Residential Child Care and Permanency Planning

The child care institution is the second alternative when seeking total substitute care for children who cannot remain in their parents home. The child care institution is not intended to provide the child with a permanent home. Like the foster home, the child care institution provides temporary substitute care; however, it does so in a group setting.

In terms of the permanency planning ethic, the child care institution should be a stepping stone en route to a permanent placement in the community, whether with the natural family or in long term foster care, preferably resulting in adoption. In practice, however, as a result of the many obstacles to these permanent alternatives as examined above, frequently what begins as a short term placement, develops into long term residential care.

In those cases where the child cannot be returned home or cannot be placed for adoption or long-term foster care, the only available permanent home may be within the institutional setting. It is then the responsibility of the institution to ensure that, as far as possible, children have the opportunity to experience continuous, stable and mutually rewarding 'parent-child' relationships. Wherever possible children should remain in regular contact with their natural families and should experience family living. These fundamental conditions for developing satisfying relationships as independent adults would form the basis of the child's individual treatment plan.

3.1.5 Permanency Planning in the South African Context

The concept of permanency planning is closely linked with treatment programming and both concepts are now reinforced in South Africa by child care legislation (Child Care Act, No.74, 1983, Regulation 31(a) and Regulation 33(2)). Both programming and permanency planning emphasise that every intervention with children should be purposeful and planned. A significant change in the Child Care Act (No.74, 1983) as compared with earlier legislation, was the emphasis on a maximum two-year stay for each child (ibid. Section 16). Thereafter the social worker is required to submit a written report motivating for the child's stay to be extended for a further two-year period. Hence the possibility of the child returning to the community, whether to a foster placement or to their own family, is always prominent in the minds of child care practitioners.

The growing emphasis upon individualised treatment and permanency planning for children in residential care represents an important shift in policy. This should result in a more thoughtful and planned approach to treatment with fewer children spending their entire childhood in residential care. Many children coming into Children's Homes in South Africa could undoubtedly benefit from short-term treatment and return successfully to the community if a suitable placement were available. However much depends upon the availability of resources. The practical considerations are summarised:

1. Residential care is undeniably the most costly form of substitute care (Pietermaritzburg Child and Family Welfare Society Annual Report, 1990). Highly specialised treatment programmes are even more costly in the short term. Approaches that require highly trained professional staff and high staff-child ratios, such as the Pedagogic model and the Treatment model (see Chapter Two) require generous funding. The financial constraints placed on Children's Homes by privatisation, have already been described.
2. Intensive short term treatment programmes assume that at

the end of their treatment programme the child will have somewhere to go. This assumption requires either a "reconstructed" natural family, or a willing and suitable foster family. As described in Chapter One, with privatisation many child care and social work services have been reduced rather than extended (Patel and Schmidt, 1989).

3. There are a growing number of children in South Africa, particularly Black and Coloured children, for whom the Children's Home is the only permanent plan. Increasing numbers of children are permanently abandoned by their natural families who cannot be traced let alone "reconstructed". Few suitable Black or Coloured foster applicants are available (Cock et al., 1986) for a number of cultural and economic reasons. The limited availability of foster families, is aggravated by inadequate State grants to foster parents (see Table 4). Whilst relative parity in State grants has recently been achieved, the grants remain inadequate as compared with the actual costs of caring for a child.

TABLE 4: MONTHLY STATE FOSTER CARE GRANTS 1987/1988 AND 1992/1993

	1987/1988	1992/1993
Black	R79	R210
Coloured	R123	R244
Indian	R123	R229
White	R153	R229

Source: UNICEF, 1993

These factors individually or in combination, frequently defeat the philosophy of short term treatment and permanent placement beyond the Children's Home. In practice, residential care facilities should acknowledge the inevitability of long-term care and plan accordingly, evaluating the potentially harmful effects and identifying essential therapeutic factors.

3.2 Evaluating Residential Child Care

Delineating the effects of institutional living is a complex undertaking. Any problems observed amongst children living in residential care could have resulted from constitutional differences, from rejecting and neglectful experiences prior to the placement in residential care, from the trauma of separation from their parents, or could constitute a specific effect of children's home conditions, which if improved might yield different results. The studies on institutionalisation suffer from several methodological difficulties, such as the lack of specific data on early maternal care and inadequate information on the individual personality characteristics of the subjects. Thus,

> "findings are based on retrospective analyses which have been narrowly directed toward verification of clinical hunches" (Riess, 1972, p.1186).

As a treatment population sharing some similar life experiences, we may expect that children living in residential care will present with some typical symptoms, and that certain problems of childhood will be more prevalent (Stricklin, 1972). Wolkind and Rutter (1973) stress the importance of determining "which experiences have which effects" (p.97). They caution against making hasty assumptions about the harmful influence of being 'in care', in view of the fact that it is "probable that long exposure to family discord and other disadvantageous living conditions are more important" (ibid, p.103). From a thorough review of the literature, some of the common variables influencing the development of problems amongst children in residential care, may be summarised as follows:

* Complications of Pregnancy and Birth

* Lack of opportunity for attachment

* Maternal Deprivation:
  - Institutionalisation
  - Maternal Separation
  - Multiple Mothering
  - Distortions in the Quality of Mothering

* Pathogenic Child-rearing Practices
  - Child Maltreatment (Abuse and Neglect)
  - Defective Role Models and Socialization

* Socioeconomic and Cultural Disadvantage

* Traumatic Events

It is beyond the scope of this thesis to describe the symptoms that might be associated with each of these stressful experiences. What is relevant here is to create an awareness of those stressors which would place children in residential care at particular risk of developing problems, whether educational, emotional or interactional. In section 3.3, some of these stressful life experiences are considered in terms of the implications for child care in South Africa.

Longitudinal studies have established that not all children who experience institutional care will manifest with maladaptive behaviour. Examining risk and protective factors in the child's response to institutional care, Yarrow suggests the significance of the quality and quantity of sensory input, constitutional differences as well as varying sensitivities at different developmental stages (Yarrow, 1969; cited in Riess, 1972). In section 3.3, the issues of vulnerability and resilience are elaborated. In view of these complexities, the findings on the effects of residential child care should be interpreted with caution and then only in the light of long-term outcomes.

3.2.1 Admission into Care: the last resort

A review of the literature suggests that agency social workers and even child care workers associate the placement of children in residential care with failure and believe that good social work practice means avoiding the use of residential care (Fisher et al., 1986; Waterhouse, 1989a). Often the decision to place children in residential care is seen as a last resort and placement is delayed until it becomes a matter of urgency (Waterhouse, 1989a).

Social workers appear to have a pessimistic view of residential care and do not expect that children will benefit from placement. Fisher et al.(1986) found that agency social workers were critical of the residential experience. They complained of frequent staff changes resulting in a lack of consistency between child care workers and inadequate control of children. Waterhouse (1989a) argues that this pessimism arises as a result of a prevailing ideology of the need and right of children to belong to families. This ideology has arisen to some extent through 'Bowlbyism', the belief in the primacy of the mother-child relationship (Riley, 1983).

There are numerous barriers to family reunification. The longer a child remains in care, the less likely it is that they will return to their natural family. And yet the "moral and political appeal of 'a family for every child'" (Waterhouse, 1989a, p.104) has perpetuated the illusion that sooner or later every child will return home. Consequently many children spend long years 'in waiting'.

A second factor disfavouring residential care, is the cost. Community-based services are less costly and in Britain and the United States this motivated a political initiative to reduce spending on institutional care. In South Africa residential care is undeniably the most costly form of substitute care (Pietermaritzburg Child and Family Welfare Society, 1990).

Thirdly, as family life has changed so has the standard by which parents are judged as fit or unfit. "If children on the outside of public care could be brought up, for example, in single-parent families, then so too could children on the inside" (Waterhouse, 1989a, p.104). This change has supported a preference for placement in substitute family care rather than institutional care, and the standards for accepting foster parents have relaxed (ibid). In South Africa this effect has been highlighted by the racial integration of

social work agencies. For the first time social workers are applying the Child Care Act across all race groups. The definition of an untenable situation is relative; and it has been suggested that exposure to more extreme conditions of poverty, neglect and deprivation has made social workers more tolerant of parental inadequacies. Children who were removed ten years ago would remain at home by today's standards, or would find placement with a family member. This has contributed to the situation where residential care is viewed as a last resort.

Despite this tendency, the need for residential care for children has not diminished. In South Africa this is because facilities for black children were grossly inadequate in the past, and sociocultural stressors have resulted in an increase in the number of abandoned and homeless children (UNICEF,1993)

In reviewing the literature, two general circumstances are identified where it should be anticipated that a child who cannot remain in the parent's home, will require long-term residential care:

1. **the 'special needs child'** or **'difficult to care for child'** e.g. children with severe mental or physical handicaps; children requiring intensive medical care; severely traumatised and disturbed children. Such children may tax any family beyond its limits (Kadushin and Martin). Add to this the situation where willing and suitable foster parents are in short supply, and return to the biological family is unlikely in view of other social stresses and limited resources, and long-term residential care or hospitalisation becomes virtually inevitable.
2. **The 'hard to place child'**. Children may be hard to place for two main reasons. Firstly, those children who are unappealing to the average foster parent, whether due to social stigma or to the anticipated problems in caring for such children. And secondly, those children for whom

there are no biological family or foster family resources within their communities. This situation arises when there are large numbers of abandoned children within an impoverished community.

Whereas in the former situation, lack of 'placeability' arises due to characteristics of the child, the latter situation refers to attitudes, beliefs and values in society that render certain children unappealing. An example of the latter situation is that of a Black child where the available foster parents are predominantly White. This is a common problem facing social workers in South Africa where there are large numbers of Black children requiring substitute care, and very few placement resources within the Black community, whether with a family member or in foster care. Until the recent repeal of section 40 of the Child Care Act (no.74 of 1973) it was illegal for a child to be fostered or adopted by a family of a different race. The implications of cross-cultural placements in South Africa are not yet known, however the literature emerging from Britain teaches us that this is an option which much be explored with much discretion (Small, 1989).

Many children prove both 'difficult to care for' and 'hard to place'. An example of a hard-to-place child which is increasingly manifest, is the situation of the child with HIV\AIDS. Such children may in the long term also prove to be 'difficult to care for'. In the case of children orphaned by AIDS, long-term residential care is frequently the only alternative available (UNICEF, 1993).

A less obvious example of a 'hard to place child' which is now receiving acknowledgement in the literature, is that of the adolescent in need of substitute care (Muller and Steyn, 1990). Children between the ages of eleven and eighteen years are seldom placed successfully in foster care, since

"they often present a serious challenge to their

> substitute parents: problems of adolescence are likely to be accentuated and hard for adults to accommodate" (Parker, 1980,p.158).

Long-term foster placements are more vulnerable to break-down when a foster child becomes a teenager, and it would seem that the right placement for a young child may not be the right placement for the same child in adolescence. Studies show that adolescents frequently experience difficulties in adapting to foster care, perhaps finding a new parental relationship too intense at a time when their psycho-social need is the achievement of autonomy (Levinson and Minty, 1992).

Whereas foster parents and social workers described 29% of younger children as difficult to place, 49% of the adolescent group was perceived this way (Hornby and Collins, 1981; in Kadushin and Martin, 1988). As compared with their younger counterparts, adolescents are more likely to be in need of substitute care because of their own personal difficulties, behaviour problems, emotional disturbance or substance abuse. Even skilled foster parents are understandably daunted at the prospect of welcoming a troubled teenager into their family.

Children displaying severe behaviour disturbance will stress any family situation, and it is likely that they would need both intensive treatment and substitute care, therefore requiring residential placement in a child care institution which provides specialised treatment. In South Africa the resources for the in-patient psychiatric care of children are totally inadequate (Biderman-Pam, 1989), and in many instances the residential child care institution is the only setting which offers substitute care as well as treatment.

The above examples illustrate the need to retain the option of long-term residential care when seeking placement for a child in substitute care. These represent instances where the child care institution is likely to be the only resort.

3.2.2 In Defense of Residential Child Care

Despite the tendency to view residential child care as a last resort, there are distinct therapeutic features of the child care institution as compared with other forms of substitute care. The fact that residential care is provided on a twenty-four hour basis in a group care facility creates some unique advantages that may be used for the benefit of some children. The therapeutic aspects inherent in the residential care facility have been interpreted in various ways according to the different prevailing theoretical models presented in Chapter Two. Three therapeutic factors are consistently cited: the programmatic and structural elements of the institution; the group culture; and the child care worker-child relationship. These same factors create some potential disadvantages, and many of these have been described by children who have lived in residential care (National Children's Bureau, 1977). Both the positive and the negative aspects of this type of service must be evaluated in order to determine whether it is appropriate for a particular child.

3.2.2.1 Institutional Programmes and Structures

Institutional living requires rules, regulations and routines and these may be an advantage, particularly for children who lack self-control (Kadushin and Martin, 1988). Explicit and predictable structure may be reassuring to the child who has been removed from a chaotic and unpredictable home situation. Through programming, daily activities can be designed to meet the child's needs and capabilities, serving to build existing strengths and overcome inadequacies. Through programming, the child's contact with their family can be carefully regulated and monitored.

These same aspects may be counter-therapeutic. Some children may come to depend on the outside structures and will become 'institutionalised', functioning effectively in the institutional setting but not in their family or within the community (Barker, 1974), as Bowlby observed:

> "A special note of warning must be sounded regarding children who respond apathetically or by cheerful undiscriminating friendliness, since people ignorant of these principles of mental health are habitually deceived by them. Often they are quiet, obedient, easy to manage, well-mannered and orderly, and physically healthy; many of them even appear happy. So long as they remain in the institution there is no obvious ground for concern, yet when they leave they go to pieces, and it is evident that their adjustment had a hollow quality and was not based on a real growth of the personality" (Bowlby, 1951, p.25).

Children may not receive individualised care and attention (Goffman, 1961). There are stigmas associated with living in a Children's Home. Rules may over-protect and hinder normal development.

> "What happens is this: you get invited to stay overnight with a friend. The staff know them and think it's alright, but they say, 'I'll have to get your social worker's permission'. Then you wait for three weeks and maybe the social worker visits your friend's family to check everything's okay, maybe he doesn't. Anyway after three weeks it's too late. Kids in care lose lots of friends that way. It's very hard to explain to people" (National Children's Bureau, 1977, p.23).

3.2.2.2 The Group Culture

Lennox (1982) stresses the "total group therapy potential of the residential community for children" (p.1). Lennox states that living and working in a residential setting we are inevitably involved in a gigantic and continuous 'group experience', and the primary task of the group is:

> "the creation of a cohesive group which will enable its members to grow and develop into happy, fulfilled, and adequately socialized members of the various other groups - home, school, society - in which they have to survive" (ibid., p.1).

Where the group culture is positive, through identification with the peer group, a difficult child may become more conforming. Adolescents are particularly responsive to group pressure (Beker and Eisikovits, 1991). Problems arise when the group encourages and supports disruptive behaviour. Adolescents are particularly vulnerable to threat of rejection

by the peer group should they refuse to conform (Fisher, 1986). Kadushin and Martin (1988) refer to this effect as "secondary deviance" in response to "peer group contagion". Lack of privacy is another factor frequently cited by children who have lived in residential care.

3.2.2.3 The Child Care Worker - Child Relationship

Kadushin and Martin (1988) maintain that because the child shares the child care worker with many other children it is possible to maintain a 'safe' psychological distance and to develop the relationship at the pace of the child. This is compared with the primary relationship in either a foster care placement or with one's own family. These relationships would place demands on the child at a time when they cannot cope with emotional intensity. This may be particularly relevant in adolescence when mistrust of adults is heightened. Within the institution there is a great variety of parenting figures and a greater chance that children will find somebody with whom they wish to identify. Many models of residential care, including the pedagogic model rely heavily on the therapeutic benefits of the child care worker-child dyad (Barnes and Kelman, 1974).

High staff turnover and lack of continuity of relationships are the negative aspects of institutional living. The children can also manipulate one adult against another unless teamwork is closely observed. Basckin (1986), explores the advantages and disadvantages of multi-parenting as a model of socialisation for children in care. For the purposes of the present research, suffice it to say that children living in residential care will inevitably experience many different substitute caretakers. Longitudinal research is needed in order to establish the impact that this factor will have upon their future relationships and their general social adaptation.

3.3 Residential Care: Matching Services with Needs

An evaluation of the therapeutic components inherant in residential living suggests that there are those children for whom the child care institution, despite the potential problems, is the placement of choice. Whilst this notion is not readily accepted within the permanency planning movement, it is beginning to receive attention and to become clarified in recent studies, that there are some children who, by virtue of their personality, temperament, developmental stage or due to pathology, will adjust reasonably well within an institution, but not within a family (Parker, 1980; Levinson and Minty,1992).

1. There are indications that residential care may be well-suited to the care of adolescents. In adolescence the search for a new permanent parental home is likely to conflict with other psychosocial developmental tasks (Levinson and Minty, 1992).
2. Children who have significant inter-personal difficulties (withdrawal, excessive dependency, manipulative behaviour, disruptive behaviour) are less likely to 'fail' in residential care than in a family (Whittaker, 1979).
3. Children whose lives have lacked structure and predictability are relieved to live in a situation where every aspect of their lives is regulated.
4. Children who have had to take on adult roles and responsibilities at an early age, may benefit from living and playing amongst their peers (Wolff, 1981).

Institutional placement is generally contra-indicated for the care of infants and very young children. These children are too young too benefit from group living and need the intensive relationship and continuity of care that are more likely to be available in a family (Kadushin and Martin, 1988).

3.3.1 Vulnerability, Resilience and Protective Factors

Planning for the long-term residential care of children is complicated by the diversity of needs and problems that is represented amongst children in care. Planning is further complicated by yet another source of diversity: the individual vulnerability and resilience of each child in response to similar life circumstances, and in response to growing up in institutional care. Whilst some children who have been neglected or maltreated and placed in substitute care will manifest with psychopathological symptoms, many grow up to engage in meaningful relationships, become loving parents and lead productive work lives.

The interesting research question is to determine which individual, family, and environmental factors are operative in shielding some children from the potentially damaging effects of growing up in institutional care. A number of researchers are beginning to address the issue of mediating variables and risk factors as a way to explain why some children appear to function well and others do less well in the face of adverse circumstances. Rutter (1975; 1979) originally coined the idea of protective factors, which are defined as follows:

> "those attributes of persons, environments, situations, and events that..... provide resistance to risk and foster outcomes marked by patterns of adaptation and competence" (Garmezy, 1983, p.73).

In contrast, vulnerability factors tend to increase the effects of stressors and contribute to children's risk for psychological dysfunction (Rutter, 1989). The concepts of vulnerability and resilience are compatible with an ecological understanding of development (as described in Chapter Two), stress and protective factors originating within the individual and arising from the meso-system, the exo-system and the macro-system (Bronfenbrenner, 1979).

Studies have provided relatively consistent evidence of variables that influence children's response to adversity by

protecting or making them more vulnerable. Familial vulnerability factors associated with a child's risk for psychiatric disorder include marital discord, low socioeconomic status, large family size with overcrowding, paternal criminality, maternal psychiatric disorder, admission of the child into substitute care through the welfare services (Wolkind and Rutter, 1973; Garmezy, 1983; Goodyer, 1990; Ledingham, 1990).

A constellation of factors protecting children from psychiatric risk have also been identified by various researchers (Garmezy and Nuechterlein, 1972; Pines, 1979; Garmezy, 1981; cited in Rosenberg and Germain, 1987; Werner and Smith, 1982). Summarising these research findings, Garbarino et al. (1991;1992) offer a comprehensive analysis of protective factors, individual and environmental, that lead to pro-social behaviour and adaptability in the face of developmental and environmental stressors.

1. Traits of Resilient Children

* **Older children** are better able to cope with stress; children who first experience trauma under the age of eleven years were more likely to develop symptoms.
* **Secure experiences in early childhood**, particularly in the first five years of life.
* **Girls** are less vulnerable than boys
* **Cognitive competence** (at least average intelligence), through the enhanced ability to understand situations and people, adapt spontaneously to situations, find creative solutions to problems and communicate wants and needs.
* **Positive temperament and flexibility** are some of the character traits developed in early childhood associated with resilience. Such children are humourous, affectionate, good-natured, and are more likely to generate attention and warmth from care-givers.
* **Actively trying to cope with stress**, rather than just reacting; and temperamental characteristics that favour active coping (involvement in activity, goal orientation, self-discipline, strong sense of personal control and responsibility). Whilst some children are naturally better able to cope, "children can learn this active coping style" (Garbarino et al., 1991, p.19)
* **Positive social responsiveness** and sociability, rather than passive withdrawal. Resilient children are more popular with peers and adults.
* **Positive self-esteem** and a corresponding self-confidence

in their inner resources as well as in support from outside resources.

* **"Representational competence"** (Garbarino et al., 1991; 1992). This concept refers to the ability to make sense of threatening experiences, an important factor in helping children to master stress.

2. Environmental Protective Factors

* **A stable emotional relationship.** If a child has experienced unconditional love and affection from at least one "accepting, sensitive, available and responsive" caregiver (Garbarino et al.., 1992), they will be more likely to cope with difficult circumstances and form new relationships; even if the child suffers the loss of this caregiver, the recollection of positive attachment provides a basis for future trusting relationships (Garmezy and Rutter, 1983).
* **Positive role models** and in particular those who model active coping and problem solving.
* **A supportive educational environment** where the child has the opportunity to experience success, and where constructive coping is reinforced. Through supportive education traumatised children can regain faith in their own competence and in their potential to become participating and contributing members of society.
* **A network of social supports.** Where the extended family is intact, coping is facilitated and particularly where supportive adults (or older siblings) are good listeners and encourage self-expression (Werner and Smith, 1982).
* **An integrated well-organised community,** significant factors including the support and guidance for parents and a prevailing ideology that supports individual human rights and active coping.
* **Continuity of values, language, culture and religion.** Garbarino et al. (1991; 1992) emphasise that whilst this is not fully understood, these factors contribute towards a worldview that makes sense of traumatic experience, whether in political, social or religious terms and this is a strong determinant of coping.

The factors that enable children to rise above their circumstances hold particular significance for the role of the residential care facility. As a therapeutic context, the residential child care facilities should provide those qualities that strengthen traumatised children in their capacity to cope. In designing treatment strategies, those individual character traits that facilitate coping should be taught and encouraged. From a developmental perspective, intervention with children must aim to help them reach developmental milestones. This is in keeping with the European

'educateur' model of child care which emphasises the remedial and educational aspects of treatment (see Chapter Two).

3.3.2 Implications for Residential Child Care in South Africa

These tasks may be particularly complex and challenging when applied to children entering residential care in South Africa.

1. Many children in South Africa have endured exceptionally difficult circumstances which deny them their most basic human rights, for example: exposure to violence and unrest; detention; abandonment; separation from parents; (Biderman-Pam, 1989; UNICEF,1993). As a result some problems are more prevalent amongst South African children, for example:
   * Street Children
   * Children with Conduct Disorders
   * Abuse of dependence-producing substances
   * Teenage pregnancy (UNICEF, 1993).
2. Many of the community protective factors cited by Garbarino et al.(1991) are conspicuously absent from community life in South Africa. The legacy of apartheid has resulted in a context where human rights are limited, and many members of society are discouraged and disempowered on the one hand, defensive and angry on the other. Many children in South Africa do not enjoy the benefits of education (UNICEF, 1993). Many children live apart from their parents (a situation entrenched by the system of domestic workers living apart from their families). Although some communities may have a strong network of support and shared responsibility for the care of displaced children, children in residential care need to be strengthened to cope independently.

In section 3.2 stressful experiences common to children in care were identified. A number of these developmental and environmental stressors may place children entering substitute care in South Africa at particular risk for developmental delays and maladaptive symptoms.

3.3.2.1 Socioeconomic and Cultural Disadvantage

In South Africa, poverty and cultural deprivation are "closely related to race, for it is racial legislation which determines nutrition, medical care, education, housing, community resources, employment and often family cohesion" (Molteno et al., 1986, p.43). The health of rural African and under-privileged Coloured and Indian children is comparable to that in the poorest developing countries (ibid.), placing these children at particular risk for complications of pregnancy and birth, and thus for acquiring brain damage and the attendant physical, behavioural and learning deficits. Whilst some learning disabilities have their origin in brain injury and others are inherited, a further causative and aggravating factor affecting socioeconomically disadvantaged children, is the deficient stimulation of intelligence and language. These children are also at higher risk for experiencing family disruption, separation and placement in substitute care. Cultural disadvantages that were in operation in an impoverished home environment lacking in stimulation, persist once the child is placed in a Children's Home where poor staff-child ratios and restrictive budgets diminish the chance that language and cognitive deficits will be remediated.

Consequently, while these children may achieve high levels of self-care and of practical and social competence (knowing how to undertake household tasks, shopping and taking care of themselves physically) in view of the fact that they have taken care of themselves and sometimes their siblings from an early age, their verbal skills are relatively poor (Wolff, 1981). When language development is retarded, this is a major cause of poor achievement at school. Research has established that poor scholastic achievement is a common problem amongst children living in residential care in South Africa (Giles, 1988). This situation is aggravated where the remediation programmes provided by the state educational departments are inadequate, as is the case in South Africa.

"The lack of special classes and of a variety of

educational and vocational programmes, particularly in senior schools serving the more deprived communities, must surely pose a barrier to children in care which many fail to overcome" (Giles, 1988, p.73).

This reinforces the cycle of disadvantage. For these children, their chance of securing a reasonable dignified job with a living wage, is significantly reduced. School failure can itself operate as a stressor, exacerbating other anxieties and emotional problems and compounding other disadvantages.

> "Failure at school for whatever reason is one of the major stresses in childhood which can set the stage for lifelong feelings of inferiority" (Wolff, 1981, p.150).

3.3.2.2 Defective Role Models and Socialization

Children model themselves on their parents, learning from them how to manage their own relationships. Whether this process is understood in terms of learning theory and consequently imitation, or in terms of identification with the parents, the fact remains that when a parent is absent or when parents are deviant in their behaviour, children are at risk of becoming disturbed themselves (Wolff, 1981), for experiencing difficulties in establishing appropriate autonomy and in the expression of aggression and self-control (Beiser, 1972).

Quite different circumstances, inadequate socialization on the one hand and deviant identification on the other, may bring about similar behaviour problems in children, namely: truancy, aggression, defiance, delinquency, inadequate inner controls and lack of effective conscience development. Research has identified a relationship between social class and delinquent behaviour, but also a marked sex trend, boys far outnumbering girls (Beiser, 1972).

In South Africa, the influence of the one-parent family structure as a variable affecting the mental health of children, is considerable. The divorce rate in White families

is extremely high, one in three marriages ending in divorce where two thirds of these couples had children (Burman and Fuchs. 1986). Amongst Black families the female-headed household is the norm. The high rate of births to unmarried Black women, and seasonal and migrant labour practices have contributed to the situation where many Black children are raised in fatherless families (Preston-Whyte and Louw, 1986). In South Africa, therefore, the impact of the absence of the father upon the child's socialisation, is an important variable affecting many children in the general population, and certainly many of the children who are placed in substitute care. Although the one-parent family is not synonymous with the disengaged, disorganised multi-problem family, there is some evidence that in fatherless families, particularly when other social stressors exist, mothers may feel threatened by the excessive demands and react by disengagement (Beiser, 1972). Mothers report spending significantly less time with their sons than their daughters, and exerting more supervision over daughters than sons (ibid.) There is also some evidence that control of behaviour is more affected by the same-sex than the opposite-sex parent, which would put boys of fatherless families at a disadvantage (ibid.). These factors would lead one to predict what is indeed the case - a higher rate of problematic, asocial behaviour amongst boys than girls (ibid.). A hypothesis of the present research is that this trend will be apparent amongst those children placed in residential care in South Africa.

3.3.2.3 Child Maltreatment and Traumatic Experiences

The experience of separation from one's parents is significant traumatic event affecting children coming into residential care, which can lead to interpersonal problems and behavioural disorders. Beiser (1972) describes a set of social conditions characteristic of what he calls sociocultural disintegration, which seem to be regularly associated with an increased risk of experiencing significant separations.

"Sociocultural disintegration refers to a breakdown

> in the functioning of a social system and is characterised by maternal deprivation, lack of a sense of community, a weak and fragmented network of communication, lack of patterns of leadership and followership, and a high frequency of interpersonal hostility" (Beiser, 1972, p.164).

Whilst poverty or low socioeconomic class relates to the occurrence of sociocultural disintegration, the conditions are not synonymous. Beiser refers to the "culture of poverty"-the functional malaise of a community, with concomitant failures in many aspects of community life, including effective socialisation of the young" (Beiser, 1972, p.164). Under such conditions families reflect the general disorganisation of the larger community. Adults are more likely to suffer from psychiatric disturbance and physical ill health, and may die at a relatively young age due to illness, suicide and community violence. Children will experience numerous traumatic separations through divorce, family disintegration and death of parents. This perspective is particularly significant when applied to the South African context where many communities would fit the description given for sociocultural disintegration (Burman and Reynolds, 1986).

Traumatic episodes commonly experienced by children coming into alternative care would also include exposure to family violence and sexual or physical assault. Certain sociocultural variables have been associated with abusive parenting, and social stress is a definite determining factor in child abuse. Straker and Jacobson (1977) provide an environmental family dynamic perspective of the factors contributing to child abuse. Factors such as overcrowding, lack of community resources, lack of access to recreational outlets, a violent environment and many other factors characteristic of impoverished communities, have been cited in the literature. Related problems include illegitimacy, marital difficulties, divorce, mobility of families, social isolation of families, unemployment and alcohol abuse. When one considers the prevalence of these stress factors affecting families in South

Africa, children in South Africa may be at particular risk for experiencing physical, emotional and sexual abuse (Burman and Reynolds, 1986).

Malone (1966; 1967; cited in Beiser, 1972) suggests that children who are exposed to constant and real threats of physical harm may develop a "danger orientation" as a consequence (Beiser, 1972, p.167). This is characterised by mistrust, caution, tension, servility to authority figures, hypervigilance, and a literalness of imitation, learning and thinking. Many children coming into institutional care display these behaviours which may also resemble the diagnosis for Post Traumatic Stress Disorder (known as PTSD; see DSM.III-R, 1987).

Garbarino et al. (1991) distinguish between acute, traumatic experiences which may push children beyond their limits of coping and result in responses such as those described for PTSD, and trauma as a daily condition of life. The effects of day-to-day terror are not yet well established in the literature, some children experiencing profound sadness and depression, others developing a revenge-orientation, becoming desensitized to cruelty and death, and perpetuating a 'continuum of brutality' in the belief that "anything is possible; nothing is prohibited" (ibid., p.23). Other children emerge from these circumstances with enhanced moral sensitivity and maturity (ibid.).

The literature concerning the effects of violence, separation and other traumatic experiences upon children contains important recommendations for the kinds of emotional stability and support that are required if substitute care arrangements are to ameliorate the impact of these stressors. There are important implications for treating traumatised children:

> "They may come through the challenge of facing danger with an enhanced capacity to see the world with sensitivity and moral astuteness. This can happen if adults help them process their

> experiences, heal their pain, and help put those painful experiences in a humanistic framework that refuses to dehumanize the enemy and instead encourages the development of empathy" (Garbarino et al. 1991, p.27).

3.3.3 Evaluation

The developmental perspective on child psychopathology has important implications for residential child care, in terms of defining and understanding problems, in predicting when they are likely to arise, in recognising individual predisposition to developing symptoms and in planning for treatment.

In South Africa, developmental and environmental stressors and the absence of community supports are factors placing some children at particular risk of developing behavioural problems, and thus requiring intensive management and residential treatment. Living alongside these children will be those who were removed for financial reasons or reasons of parental inadequacy. Whilst they may have educational deficits, they would most likely need stable and secure custodial care. Whether they would receive this whilst living amongst troubled and uncontrollable children is questionable. Children's Homes in South Africa are faced with the daunting challenge of providing appropriate services for the diverse range of needs represented amongst children placed in their care.

3.4 Methods of Assessment in Residential Child Care

The process of decision-making in permanency planning and differential placement depends on the assessment of the child, their present level of functioning together with their potential to succeed in a given placement, balanced against the risk factors predisposing the child to failure.

One of the difficulties facing practitioners in the treatment of children in residential care, is the problem of a 'common

language' for the description and identification of behaviours requiring intervention. Although we need to be sensitive to the possible dangers of labelling children, it is necessary to conduct some form of assessment in order to identify which children are needing which type of intervention (Saayman, 1985).

Whilst the existing classification systems may provide trained personnel with an economical way of communicating about children's problems, when considered in the context of residential child care, the value of psychiatric diagnosis is questionable. Child care workers are usually not trained in psychiatric diagnosis. A psychiatric label may be misleading, resulting in prejudicial judgement of the child's behaviour, compounding the disadvantage already suffered by the child. The child care worker may feel inadequate to help the child, preferring to leave it to the 'professionals' (Wolff, 1981).

The cross-cultural relevance of classification systems is contentious (Korber, 1990; Slonim, 1991), as is their usefulness as a basis for planning treatment intervention.
Wolff (1981) emphasises that we must be clear about the purposes of assessment and ensure that wherever assessments are used they will help those adults who work closely with the child (child care worker, teacher, parents) to understand the child, "so that the child's apparently senseless and aggravating behaviour becomes meaningful" (Wolff, 1981, p.58). And furthermore, assessments need to be linked to practice, resulting in more sensitive and helpful handling of the child and, wherever possible, in remediation.

If assessments of children in residential care are to meet these criteria, they need to evaluate children's behaviour, both adaptive and maladaptive, in the light of:

* the child's chronological age and expected developmental tasks;
* the child's response to developmental and environmental

deprivations and stressors;

* personality and inherited characteristics which increase either the child's vulnerability or their resilience;
* treatment needs and goals.

The practice of residential child care would benefit greatly from the availability of a system whereby such descriptive information could be summarised and ordered.

A comprehensive assessment would include evaluations from all significant adults (child care worker parent, teacher), as well as a self-evaluation by the older child. Children behave differently in different environments and different adults view different behaviours as problematic (Wolff, 1981). Sometimes the child will report feelings of anxiety or depression which had not been recognised by anybody else. Also valuable where specific concerns exist, is the information which can be obtained by certain formal assessment procedures, such as intellectual, educational, neuropsychological and projective assessments. These may be used to verify hypotheses arising from other behavioural evaluations.

Assessment procedures used in residential care settings typically rely upon descriptions of the child's behaviour and corresponding treatment needs in the various areas of their functioning: physical/medical; cognitive/educational; sociocultural/familial; social skills and relationships; anti-social behaviour and personality/temperament (Hoghughi, 1980). Often such assessments have taken the form of problem checklists and symptom counts. Many such symptom counts have been shown to reliably and validly identify groups of disturbed children, and to correlate with other measures (Rutter et al., 1988). However, "a symptom count cannot tell one how troubled a particular child, his parents or teachers really are" (Wolff, 1981, p.59) and much qualitative information will inevitably be lost. Symptom counts also focus on problems and on maladaptive behaviour, and the child's competencies, which are in fact the best medium for

intervention, may go unrecognised.

While it may be true that "there is no substitute for listening to what the children themselves, their parents and their teachers have to say" (Wolff, 1981, p.59), an assessment procedure by which such information can be structured and standardised would greatly benefit the process of assessment of children in residential care.

Wolff (1981), despite her stated reservations regarding the identification of disturbed children, has acknowledged that the recognition of emotional and conduct disorders for research purposes is quite a different matter.

> "We need to find out how we can improve the environment as a whole so that fewer psychiatric disturbances occur" (p.59).

With the intention of providing more appropriate residential care services, the present research seeks to ascertain the trend of treatment needs and developmental needs represented amongst children living in care facilities in South Africa. This process would have been greatly facilitated had there been a standardised assessment procedure with which all child care practitioners were familiar and which they were trained to use. In the absence of such a procedure, behavioural categories were designed by the researcher. Whilst these were descriptive of behaviour, the real foundation of these categories was the stage in the treatment process, that was deemed to be most appropriate to the child's needs and behaviours at that time. Stages in the process of residential care and treatment are relatively well defined in the literature. As already described in Chapter Two, these stages were fundamental to the models described by such writers as Beedel (1970) and Hoghughi (1980; 1988), and have been reinforced through the concept of programming. Most child care practitioners would presumably be well-versed in recognising the stage in the intervention process that each child has reached, as evidenced by their behaviour.

CHAPTER FOUR

4. AIM OF THE PRESENT STUDY

Introduction

Nearly every day immediate and long-term plans and arrangements are made on behalf of children in residential care. But the understanding of the different psychological and treatment needs of children in residential care, remains limited. The present researcher believes that along with the other professional groups, clinical psychologists have a contribution to make towards understanding and planning appropriately for children in residential care. Clinical Psychologists are frequently asked to assist in placement decisions on behalf of children in care. When called upon for their treatment recommendations, they are "faced with deficits in existing bodies of knowledge on which to base clinical practice" (Stricklin, 1972, p.2). This challenge is further emphasised when considered in the context of a multi-disciplinary team, and the accompanying responsibility to contribute to the "general expertise of the professional group" (ibid.). It is in response to these challenges that the present research is undertaken.

4.1 Statement of the Problem

> "In order to succeed research must be guided by a clear statement of the problem or issue to be addressed by the research" (Dixon et al., 1987, p 47).

Children in residential care present with many varied individual treatment needs. However, no clear diagnostic categories or assessment procedures yet exist as a basis for either designing specialised treatment programmes or as a basis for permanency planning. A comprehensive study of the

current literature and available research reveals that this is a problem facing child care practitioners all over the world (Matek, 1964; Giles, 1982;1985; Maluccio et al., 1986; Schaffer, 1990).

The situation is, however, exacerbated in South Africa where child care facilities are required to be all things to all children. This circumstance has arisen for three reasons:

1. The criteria used when placing children in alternative care have little to do with their treatment needs. In South Africa, the criteria determining placement in residential care facilities revolve around such factors as race, age, gender, religion, locality and ultimately the existence of vacancies, but not other more psychologically relevant terms. Therefore institutions are required to meet a diverse range of psychological, emotional, educational and social needs within one residential setting.
2. Most residential care facilities do not specialise in terms of their admission criteria and treatment objectives. Burford (1985) emphasises that it is counter-productive if "teams operate on the assumption that their programme is best for all or even most youngsters" (p.130). In 1982 in South Africa the de Meyer Commission acknowledged the concept of an individual treatment programme designed to meet the needs of each child (de Meyer, 1982, p.37, section 13.11), but also emphasised the impact of the physical structure of the institution on the outcome of treatment programmes (de Meyer, 1982, p.28, section 9.23 and section 9.27). It is essential that residential care facilities begin to specialise in terms of those treatment needs that they are best able to accommodate and meet.
3. For many children in residential care in South Africa, no permanent alternative placement exists. Every child care professional would like to view the children's home as a 'pathway to permanence'. In reality, the children's home

is for many children the only available home, and often for reasons of age or race or parental inadequacy and not because of any behavioural or emotional problem requiring treatment. This intensifies the problem of the diversity of needs all under one roof, severely traumatised and disturbed children living alongside relatively well-adjusted children who simply have no other home.

The present study arose in response to the decision of two Children's Homes in Pietermaritzburg to amalgamate and specialise in their treatment services to children in residential care. Although the child care practitioners concerned felt that 'intuitively' they could reach consensus regarding the appropriate placement of children with whom they were already familiar, the predictive validity of this approach for the ultimate success of the placement, was most uncertain. Such guesswork would not be helpful in the instance of new admissions on whom very little information was available. It was intended that the present study would suggest assessment typologies which may be used in matching children with appropriate resources.

4.2 Rationale for the Study

The present study is aimed at determining the existing pattern of treatment needs among children legally removed from parental care and presently living in residential child care facilities in South Africa.

Very little research and literature exists regarding children living in residential care in South Africa. "A search of South African publications in 1983 revealed that to date there had been no local epidemiological studies and no local outcome studies" (Giles, 1985, p.3). The process of providing appropriate alternative care is inseparable from the prevailing social context. For this reason, recent demographic data across all population groups of children in

residential care is urgently required.

In the present study, the needs of children presently represented in residential care facilities in South Africa were investigated on the basis of:

1. Four behavioural categories (descriptively defined), as subjectively assessed by a member of the child care team at each institution.
2. Demographic data including: age, gender, race, language.

With a view to determining the nature of the treatment services rendered by residential child care institutions in South Africa, the study also investigated:

1. The type of institution: Place of Safety; Children's Home; School of Industries (see Chapter Two for a definition of these terms).
2. The type of building: dormitory, block, cottage, group home (see Chapter 2 for definition of these terms).

In summary, the investigation was designed to provide the beginnings of an answer to two questions:

1. What sort of children with what treatment needs and in what number are presently living in the various places of residential child care in South Africa? This information will yield indications of the sorts of placement/treatment facilities which need to be provided for these children.
2. How reliable is our present placement practice in discriminating between the different treatment needs of children placed in residential care? When considering the three types of places of residential care to which children may be referred in South Africa i.e. Places of Safety, Schools of Industries and Children's Homes, do their populations reflect clear and distinct differences in the nature and extent of the children's problems?

It is intended that this study will contribute towards the

improvement of present arrangements for the residential care of children by providing guidelines as to the kinds of services required.

4.3 Statement of Purpose

In stating the purpose of research it is important to distinguish between research that is descriptive and that which is explanatory. This research is largely exploratory and descriptive in nature. For this purpose, therefore, a statement of the research objective is the most appropriate way of focusing and clarifying the intent of the research. The following research objectives were delineated:

1. To obtain demographic data in order to explore the relationship between the treatment needs of children in residential care in South Africa, and the following categorical variables: sex, age, race, type of institution, design of building.
2. To clarify relevant variables and generate hypotheses for future research.
3. To develop data towards the establishment of a system of classifying children in residential care according to their needs.

The main aim of the dissertation was exploratory in nature, therefore true hypothesis testing would be inappropriate. However a thorough review of the literature has suggested a number of tentative hypotheses regarding the expected trends amongst children in residential care:

Hypothesis 1: The treatment needs of children in residential care in South Africa are diverse, and the present institutional structures fail to meet the diversity of needs.

Hypothesis 2: It is likely that due to socio-political factors which tend to disfavour Black children (e.g. abandonment and HIV), there will be a higher preponderance of Black children in the 0-2 year age group. (Conversely, although not directly assessed in this study, White and Coloured Children aged 0 -

2 years are more likely to be accommodated in foster care.)

Hypothesis 3: The adolescent age group (13 to 18 years) will be over-represented in residential care facilities relative to other age groups.

Hypothesis 4: There is likely to be a higher number of adolescents living in residential care and a significantly higher rate of behavioural problems amongst this group. The literature suggests that adolescent boys in particular may prove to be difficult to manage.

Hypothesis 5: The incidence of behavioural problems in the children is likely to be related to the style of building, as it is hypothesised that certain types of buildings are more conducive to pathology. More specifically it is believed that the cottage style home is least likely to provoke maladaptive behaviour.

Hypothesis 6: Due to the enhanced skills of professional workers (social workers or psychologists), it is likely that the professional workers are better equipped to distinguish between different treatment needs of children in residential care and to recognise behaviour that is of concern (e.g. developmental delay; psychiatric symptoms).

CHAPTER FIVE

5. DESIGN OF THE STUDY

Introduction

In the terms described by Beiser (1972), the present research is descriptive rather than explanatory. The study focuses on the characteristics of a specific treatment group - children living in various residential care facilities - exploring the relationship between various categories of behaviour and certain demographic variables, for the purpose of identifying trends.

In order to meet the stated objectives of this study, it was necessary to adopt a combination of methodologies: an exploratory demographic study (Dixon et al., 1987, p.108) and a comparative study (ibid, p.114). Dixon et al.(1987) state that if the research question is simply "what is happening" then an exploratory demographic study will suffice; however the purpose of this study was also to compare whether or not there were differences between the care facilities and the children in care for the relevant variables.

The present exploratory demographic study was conducted via a postal survey schedule. Marsh (1982) defines the survey method as the process of "drawing inferences from already existing variance in populations by a rigorous process of comparison" (Marsh, 1982, p.7). Thus essentially a survey technique which focuses broadly on the treatment needs of children in residential care was used, and the data collected was subsequently analyzed to also answer the comparative issues of child care in South Africa.

Hoinville et al.(1977) recommend the following phases in the

process of designing a survey study:

1. Qualitative work - an exploratory phase to help in the design of the questionnaire content and its construction. A pilot investigation is recommended as part of this process. (ibid. p.51; p.130)

2. Questionnaire construction - deciding on the questions to be asked, the precise wording, the sequence of questions and the lay-out.

3. Sampling - the task of determining the subject sample to be surveyed, the size of the sample and the method of selection.

4. Data Collection - in this case, designing the postal survey procedure.

5. Data preparation and Classification - preparing the raw data for analysis and interpretation.

This procedure was followed in the present study and is described in this chapter.

5.1. Pilot Investigation

Due to the exploratory nature of the study it was necessary to conduct a pilot investigation into the nature of residential child care facilities in South Africa, and initially in Pietermaritzburg in particular. The major motivation underlying the present study was the decision taken by two Children's Homes in Pietermaritzburg to amalgamate and specialize in their services to the children in their care. This decision was based on the belief that the needs of many children in care are not adequately met by the existing facilities. The current allocation of children to a specific residential setting was based on such criteria as race, age, sex, religion and ultimately the existence of vacancies within the Children's Home. The placement was therefore not made according to the specific needs of the child nor according to the particular character of the individual institution. It was further noted that Pietermaritzburg contains limited resources in terms of expertise, volunteers and finance. It was strongly felt thereforee that the utilization of these resources should

be for the optimum benefit of all children in care in a co-ordinated and co-operative manner.

5.1.1. Design of Pilot Study

As an initial step in operationalizing these ideals it was necessary to systematically investigate the population of children in care in Pietermaritzburg, according to the following variables: age, sex, behavioural category (descriptively defined).

TABLE 5: DEFINITIONS OF BEHAVIOURAL CATEGORIES USED IN THE PILOT STUDY

Group 1:
1. Children recently admitted from chaotic family backgrounds where no assessment had been undertaken prior to admission; 2. Children having difficulty adjusting to the institutional order; 3. Children whose treatment is essentially behaviour control; 4. Children who need intensive assessment to enable treatment objectives to be formulated. Note: Group 1 largely comprises children who are likely to need assessment and/or behavioural control. Furthermore, had a Place of Safety existed in the Pietermaritzburg region, they are likely to have been accommodated there.
Group 2
Children presently involved in treatment programmes and who are as yet unable to cope with the emotional intensity of smaller family units.
Group 3
Children who have received treatment and although they may still be receiving ongoing professional intervention, they are able to adapt to a simulated family environment. Their needs are primarily for socialization, life skills acquisition, for independence and for enhancement of self esteem. These children could be transferred from the Children's Home if their own families were ready to receive them or if foster families were available.

The behavioural categories were defined by two professionals experienced in the area of residential child care and who were familiar with the general trends in the available literature. The one person, a clinical psychologist, was the Director of Child and Family Welfare in the city whilst the other was the present researcher, who had held the post of Programme Director at the larger of the two institutions for the last 4 years.

The behavioural categories decided upon were determined by the roles undertaken by the Children's Home in the process of providing residential care, namely:

1. The admission and assessment of troubled children and the formulation of a treatment programme.
2. The implementation and on-going evaluation of individual treatment programme for each child.
3. The provision of an environment enabling the successful return of the child to the community (with the options of own home, foster care or independent living).

With the above three services in mind the three behavioural categories were operationally defined as in Table 5.

Although the decision had only been taken to amalgamate two of the Children's Homes in the Pietermaritzburg area, an additional Children's Home in the area was also surveyed as it was hoped that at a later stage they too would consider the advantages of a possible amalgamation. It is perhaps necessary to note that a further two Children's Homes in the area were excluded from the pilot investigation: one of the Homes appeared to be meeting the needs of a different population group in that the children in their care were placed privately by their parents; whilst the other Home was due to close in the near future due to financial restraints and all the children currently accommodated in this home were nearing the end of their education and were ready to be returned to the community.

Steps were taken to familiarize the Management Team at each of the Children's Homes with the behavioural categories described above. They were then required to classify each of the children currently in their care according to the categories, and also to stipulate age and sex.

5.1.2 Results of the Pilot Study

The results of this somewhat rough and unsophisticated survey were then analyzed and the following general trends were noted (see Table 6).

TABLE 6: NUMBER OF CHILDREN BY BEHAVIOURAL CATEGORY AND CHILDREN'S HOME IN THE PILOT STUDY

BEHAVIOUR CATEGORY	CH 1	CH 2	CH 3	TOTAL	PERCENTAGE
GROUP 1	7	3	11	21	14.7%
GROUP 2	6	16	22	44	30.8%
GROUP 3	39	12	27	78	54.5%
TOTAL	52	31	60	143	100.0%

Note: CH refers to Children's Home

There were 143 children resident in the three Children's Homes surveyed. Due to the prevailing political climate, the children in all three of these homes were of the White race group (it would have been impossible to amalgamate with Homes catering to the needs of other race groups at the time of the investigation due to the division existing in the provision of Welfare Services).

5.1.3. Discussion of Results of the Pilot Study

At first glance it is evident that over half of the children resident in the three Children's Homes surveyed, were being accommodated primarily because no alternative family home was available. The principal service rendered by the Children's Homes was thereforee attempting to approximate a simulated family home within an institutional setting, as a total of 54,5% of the children were rated as falling with Group 3 (those ready to re-enter the community and without significant

residential treatment needs). It was also noted as significant that one of the Children's Homes excluded from the investigation was about to close but was only accommodating children who met the criteria of Group 3.

At the other end of the scale 14.7% of the children investigated required a service more closely aligned to that offered by a Place of Safety/Assessment Centre, i.e. Group 1 children. In the light of the specialized nature of this service it is a concern that these needs were not being adequately met due to the lack of appropriately trained staff and facilities conducive to the service.

The residual 30,8% of children investigated can be considered correctly placed in terms of the accepted role and objectives of Children's Homes, as defined in the Child Care Act No. 74 of 1983 (see Introduction).

It was further noted that each of the three children's Homes were currently accommodating children with diverse needs, each attempting to cater to the needs of children in each of the three behavioural categories discussed above.

During this pilot investigation, it became evident that the Group A children in fact comprised of two subgroups i.e. recent admissions who were requiring assessment as well as those children who were evidencing behavioural problems of a relatively severe nature and requiring intensive behavioural management and control. Therefore in the larger study, it was necessary to redefine the categories.

It is of interest to note at this stage, that the results of this investigation yielded proposals for the future of child care in the Pietermaritzburg region. It appeared that there were two options available:

1. Firstly, that each home could attempt to continue to provide for the needs of children in each of the

categories. However it was evident that each Home would need to upgrade it's assessment facilities and it's ability to provide for a broad range of treatment programmes, as well as meeting the challenge of approximating a family living environment for those children requiring long term residential care. With the current restraint on resources of personnel and finances, this option did not seem viable.

2. Secondly, Children's Homes could agree to amalgamate and specialize in their services in terms of the above three groups. Children would then be required to progress from one Home to another at each level of their own assessed needs.

A number of advantages and disadvantages of the second option were recognized. The main disadvantages of such an arrangement were considered to be:

1. The possible destabilizing effect of moving children from one home to another.
2. Siblings with different treatment needs may have to be split according to the needs of the individual child.
3. This arrangement may prove to be more stressful for staff as children with particular attachment needs and behavioural problems would be concentrated in one facility.
4. It was possible that children with similar needs could accentuate the difficulties experienced by the individual child and the accumulated effect of acting-out behaviour may become evident.
5. The individual Children's Homes may regret the loss of identity, tradition, loyalty and character.

The following advantages of the second option offering specialized facilities were considered to be:

1. For the Child:

* Children would be treated according to their individual needs.

* Progression from one Children's Home to another may be encouraged to be interpreted as a move ahead and therefore serve as a motivator and benefit the child's self-esteem.
* It has traditionally been found, that the "difficult child" tended to monopolize the Child Care worker's time and disrupt the entire group's adaptive functioning. In the traditional system, there was a tendency for a less demanding child to be overlooked and neglected by the Child Care Worker who had his/her time cut out controlling and seeing to the needs of the more "difficult child".

2. For the Personnel:

* Since personnel could be recruited, trained and deployed from a central administrative office, they could be more appropriately placed in terms of their interest and skill.
* Within a larger organization there is more opportunity for advancement.
* Greater support structures and training facilities would contribute to a more stable work group (See Chapter 3 in terms of the effects of the high turn-over rate of staff).
* It would more easily be possible to meet the devote time to group programmes and projects if the objectives of the group were more clearly homogenous and delineated.

3. Financial Advantages:

* In terms of the States proposed method of financing Welfare programmes (de Meyer, 1982), the concept of progressive home systems would be more likely to increase the State subsidy through optimum use of resources and greater clarity of purpose.
* It was believed that the concept would more readily appeal to the private sector in that it is more logical, rational and marketable. The private sector is relied upon for their financial support.
* As there would no longer be a need to duplicate services,

it was envisaged that the second option made sound economic sense. There would not be a need for duplication of professional services nor of some specialized equipment and other facilities.

It was decided at a combined meeting of all interested parties to propose the adoption of the second alternative. In brief outline, it was decided by two of the Homes to specialize service delivery in terms of Home A developing a full assessment and treatment facility as well as a secure and structured environment. It would therefore be necessary to provide personnel in this Home who were skilled in assessment procedures and had some familiarity with implementation of treatment programmes. On the other hand, Home B would largely meet the demands of containment and behavioural management of those children engaging in acting out or destructive behaviour. There would need to be a low staff to child ratio and the facilities would need to provide for safety, restraint and control. It was noted that there was a need for a further facility to accommodate to those children who were classified as Group 3 and simply required re-integration into the community. The option considered to provide this facility was community-based Off Campus Homes. It was envisaged that these homes could offer social skills training programmes, greater self-sufficiency and responsibility for children in such areas as community involvement, budgeting and domestic skills.

5.2 The Present Investigation

The results obtained in the Pietermaritzburg pilot study needed to be assessed in the context of child care nationally in order to ascertain whether the trends noted were reflected throughout South Africa. It was decided that a questionnaire would be distributed by post to all institutions registered to care for children in South Africa, requesting information from their existing practice. The study would thus be far more inclusive and representative than the pilot study in which

only Children's Homes, and only those registered to care for white children, had been surveyed. In the pilot study the influence of the variables of age, gender and language of the children, the type of building and the professional designation of the respondent had not been considered.

5.3 Questionnaire Construction

In a demographic study of this nature, using the postal survey method, much depends on the questionnaire itself in determining the level of response. The questionnaire must clearly define the subject matter of the survey, explain the task required of the respondents, and its appearance will act as either an incentive or a deterrent to completion (Hoinville et al., 1977).

5.3.1 Content

The first concern in constructing the questionnaire is the matter of the content. Which questions will need to be asked in order to obtain the information which will fulfil the research objectives?

In keeping with the research objectives already stated, the variables to be investigated were sex, race, age, language, type of institution, and type of building. These variables were to be analyzed in relation to the various categories of treatment needs amongst children in residential care. The questionnaire was designed so that the respondent would be required to complete factual information and numerical data pertaining to the existing population of children resident in the institution, but would also need to give a subjective evaluation of the variation in treatment needs represented amongst those children. A copy of the questionnaire is to be found in Appendix B.

The respondent was asked to complete the identifying details of the institution including the name, address and telephone

number, and the following details regarding the children for whom the institution was registered; the number of children, the gender of the children, the population group (race) and language group. At the time of the survey it was illegal to accommodate any child who was not of the race, gender, age or language group stipulated in the State registration of the institution. Because of the fundamental divisions in the State welfare departments, most institutions were registered to exclusively accommodate one specific race group. The respondent was also asked to calculate the number of children, boys and girls, in each of 5 specified age groups, 0 - 18 years, who were presently in residence. From a review of the literature and from an awareness of current social forces in South Africa, one may expect some significant variation in these factors amongst children placed in residential care.

The respondent was asked to indicate the type of institution. The categories listed in the questionnaire are those stipulated in the Child Care Act no.74, 1983. These are defined in Chapter Two. The question regarding the type of institution was considered relevant in view of the fact that it is supposedly on the basis of their treatment needs that children placed in residential care by the courts are designated to the various available institutions. A central question in this investigation is whether the existing placement procedures effectively differentiate between the treatment needs of children requiring substitute care. Although the situation in Children's Homes was the primary consideration because of the implications for the planned amalgamation of Children's Homes in Pietermaritzburg, other types of institutions provide a source of comparison.

A question was included requiring the respondent to indicate the type of building design which would best describe the institution concerned. The alternatives given are those terms used in State publications: Dormitory, Block, Cottage, and Off Campus Home (see Chapter Two for a definition of these terms).

It was hypothesised that the level of problematic behaviour displayed by children in institutional care would vary according to the design of the building, some buildings promoting pro-social behaviour by providing a more homely and comfortable environment. The Pietermaritzburg team who were planning to amalgamate, were particularly interested in the Off Campus Group Home concept as it was planned that houses in the community would be purchased to accommodate those children without significant treatment needs who were ready for family living.

In constructing the questionnaire for the national survey, the design used in the pilot study was further revised in terms of the behavioural categories used to classify the treatment needs of children in places of care. On the basis of feedback from the pilot study, it was decided to extend the number of categories from three to four, by subdividing the group termed Group 1. The rationale behind this decision arose in discussion regarding which treatment facilities would be ideally suited to meet which treatment needs. It was recognised that it would not be ideal to mix those children who were new admissions and requiring assessment with those children who were already identified as needing strict behavioural management. Places of Safety in South Africa have traditionally fulfilled both a 'detention' and an 'assessment' role (de Meyer, 1982). This situation has resulted in additional trauma to children newly admitted from their families, in view of the fact that they are immediately exposed to disruptive and disturbed conduct from those children placed for the purpose of containment.

The De Meyer Committee in their Inquiry into Certain Aspects of Child Care (de Meyer, 1982), acknowledged these concerns.

> "When the classification of children in a place of safety is discussed, the first consideration is the desirability of the physical separation of children who face criminal charges (detention cases) from children alleged to be in need of care (safety

> cases).".....
> ...." children who are purely in need of care are exposed to negative influences, intimidation and exploitation by juvenile offenders, absconders from schools of industries and other institutions and children with deep-rooted social pathology.".......
> ..... "The group of children with serious behavioural deviations are a disturbing element in the functioning of any institution. On the one hand they impede the effective treatment of the other children and on the other hand it is difficult to give intensive attention to them while they are part of the bigger moderate group" de Meyer, 1982, p.13).

In designing the national study, it was considered important to ascertain the percentage of children nation-wide who fell into the category requiring behavioural management in order to plan for the specific treatment needs of this group.

TABLE 7: DEFINITIONS OF THE BEHAVIOURAL CATEGORIES USED IN THE NATIONAL STUDY

Category A
Children recently admitted from chaotic family backgrounds for whom treatment goals need to be established. Children requiring short-term management, care and observation. Children requiring emergency shelter.
Category B
Children who are disturbed in their behaviour to such an extent that it is difficult to implement treatment programmes. Treatment is thereforee primarily aimed at intensive behaviour management and containment (e.g. absconding, drug abuse, destructive and aggressive behaviour, psychiatric disturbance, sexual acting out)
Category C
Children who are participating in specific treatment programmes and requiring professional services (e.g. Psychologist, Remedial Teacher). Intensive reconstruction services are important in terms of permanency planning.
Category D
The "Holding Group". Those children ready to experience close family living, and who would be socially and emotionally able to enter their own or foster family if such were available.

The behavioural categories in the study were described in the questionnaire in such a way that the following determinants of treatment needs would be incorporated in the definitions provided: period since admission; degree of assessment completed; priority focus of treatment intervention; frequency and intensity of disturbed behaviour; evidence of pro-social behaviour. The behavioural categories in the study were therefore operationally defined as in Table 7. In the questionnaire, the respondent was asked to classify the children resident in the institution in terms of their needs as outlined in the categories, and to provide the total number of children in each category.

Since the categorization of children requires a subjective evaluation on the part of the respondent, and in view of the fact that "subjective evaluations are much more readily susceptible to biases on the part of raters than are overt behavioural measures" (Kent et al., 1974; cited in Kazdin, 1980, p.369), it was important to know the position held in the organisation by the respondent. The researcher hypothesised that a social worker or psychologist would possess greater skill in differentiating between the various treatment needs of the children with whom they work, than would a person in an administrative position. For this reason the respondent was asked to state their position in the organisation.

5.3.2 Format

"The most daunting problem in a postal survey is to ensure that the response level will be high enough to give confidence that the respondents are reasonably representative of the total population sampled" (Hoinville et al., 1977, p.130). There are two main challenges facing the researcher in designing a postal survey. Firstly, respondents are relied upon to accurately complete the questionnaire, aided only by written explanations and instructions. Secondly, the researcher relies entirely upon the introductory letter and

the questionnaire itself to motivate the completion and return of the questionnaire.

In designing the format of the questionnaire, the main consideration was how to maximise the rate of response whilst ensuring that the required information would be obtained in order to achieve the research objectives already stated. Dixon et al.(1987) in outlining the requirements of a questionnaire, emphasise the need to keep it brief, clear and simple. For this reason the questionnaire primarily takes the form of "fixed-choice responses" (Marsh, 1982, p.6) where options are ticked by the respondent, and very little written information is required. The first few questions are straightforward and simple in order to encourage the respondent to continue with completing the questionnaire (Hoinville et al., 1977)

Dixon et al.(1987) caution against the use of "colourful and emotive language" (p.84), in view of the fact that this could suggest a value bias on the part of the researcher. Anything a respondent may particularly dislike about the wording or emphasis of the questions may deter them from completing the questionnaire (Hoinville et al., 1977). Every effort was made in the wording of the questions and in the descriptions of the behavioural categories to avoid the suggestion of a value bias which could cause the respondent to feel that their child care practice may be criticised, and they would thereforee be predisposed to respond defensively and less honestly, or not at all. The descriptions and terms used throughout the questionnaire are those that would be commonly understood by child care practitioners.

A covering letter accompanied the questionnaire in order to explain to the recipients the aim and purpose of the survey, and to request their cooperation (see Appendix A). Kazdin (1980) recommends that cooperation and honesty are maximised when the purposes of the research are clarified and recipients

are assured of the importance of their participation in the research to their profession or discipline, regardless of the content of their response. In this case, if recipients are assured that the research will in no way be used to infer bad practice, they will be less apprehensive of being evaluated and more willing to give their honest cooperation.

In clarifying the objectives of the research some brief background was given in the covering letter regarding the Pietermaritzburg proposal for amalgamation. The four categories used to classify treatment needs of children were briefly introduced and explained. Whilst the practical and ethical problems of categorising children were acknowledged, recipients were assured that the ultimate objective was the advancement of Child Care Services. It was stated that the published results and a conference presentation would provide feedback and further clarification of the research objectives.

Hoinville et al.(1977) recommend the inclusion of "an invitation to comment on the subject of the study or the questionnaire" and a message of thanks for the assistance given (p.130). Both were included in the covering letter.

5.4 Subject Sample

The questionnaire was posted to all 'Places of Care' throughout South Africa registered to care for children.
For the purposes of the research, a 'Place of Care' is defined as in the Child Care Act no.74, 1983, as follows:

> " 'Place of Care' means any building or premises maintained or used, whether for profit or otherwise, for the reception, protection and temporary or partial care of more than six children apart from their parents, but does not include any boarding school, school hostel or any establishment which is maintained and used mainly for the tuition or training of children and which is controlled by or which has been registered or approved by the State, including a provincial administration" (Child Care Act no. 74, 1983, Sec. 1, p.6.).

An address list was obtained from the National Association of Child Care Workers, entitled 'Directory of Children's Institutions in South Africa', and a questionnaire was sent to each of the 229 institutions listed. At the time of the survey there were 103 registered Children's Homes in South Africa, the remaining institutions consisting of Schools of Industries, Places of Safety and Reform Schools. These institutions represented children placed from every State and Provincial Welfare Department, in terms of the racial divisions determined by State Welfare legislation.

5.4.1 Subjects

The subjects in the study were the children resident in each 'Place of Care' investigated. No information was given regarding individual children, however this population of children would have certain distinct characteristics by virtue of their legal removal from their parents' care and placement by the Children's Court in a 'Place of Care' in terms of the Child Care Act no.74, 1983 (see Introduction for the terms of the Act).

These circumstances may create some common problems and treatment needs among children legally placed by the courts in residential institutions. However, the Act's definition of an "unfit" parent, evidently allows for children from vastly disparate economic, cultural and social backgrounds and manifesting a diverse range of treatment needs to be placed alongside one another in the various 'Places of Care'. The practical treatment problems created by such disparity are raised in Chapter Three.

The subjects in this study represent children of all races, religions and language groups, boys and girls, and ranging in age from 0-18 years. Although the Child Care Act (no.74, 1983) defines a child as "any person under the age of 18 years (Child Care Act, no.74, 1983, section 1, p.4), in view

of the fact that it is possible to extend the order of stay beyond the age of 18 years (ibid., section 33.3), an age category was included for children over the age of 18 years.

5.4.2 Methods of Selection

In view of the fact that questionnaires were sent to all the children's institutions listed, the eventual sample size was determined by the number of replies received within eight weeks from the date of distribution. This was, thereforee, a 'self- selected sample' (Kazdin, 1980, p.315).

5.4.3 Sample Size

TABLE 8: AN ANALYSIS OF THE SUBJECT SAMPLE: TYPE OF INSTITUTION BY RACE GROUP

TYPE OF INSTITUTION	WHITE n= **40**	COLOURED n= **9**	BLACK n= **10**	INDIAN n= **3**	MIXED n= **5**	**TOTAL n= 67**
Children's Home	n= 32 1844	n= 5 762	n= 6 471	n= 2 145	n= 4 78	n= **49** **3303**
Child Care School	n= 2	n= 1	n= 1	n= 1		n= **5** **600**
Place of Safety	n= 2	n= 1	n= 1			n= **4** **315**
Reform School		n= 1	n= 1			n= **2** **457**
Other	n= 4	n= 1	n= 1		n= 1	n= **7** **912**
TOTAL	**2620**	**1604**	**898**	**259**	**201**	n= **67** **5587**
Not applicable						n= **10**
duplicated information						n= **1**
TOTAL						**n= 78**

Note: n= the number of returns (i.e. Institutions represented in the sample). The total number of children represented in those returns is included in the totals and in the case of Children's Homes for further analysis of the response rate.

Of the 229 questionnaires sent, 78 replies were received, a 34,06% response. The response rate from 103 Children's Homes

was a total of 49 (47,6%). Of the total number of replies there were 10 that were considered to be 'not applicable' to the present study. These were returns from institutions that did not meet the criteria stipulated for Places of Care, as defined above. Some of these returns were from boarding schools whilst others had converted their services to adult care. The replies are represented in Table 8.

In the 'other' group there were returns from highly specialised facilities, for example providing residential care for deaf, or autistic children. Among the returns analysed were those that suffered from 'item non-response' (see the discussion on the limitations of the study, Chapter Eight).

The total number of children for whom data has been analysed is 5587 of whom 3303 were resident in Children's Homes. Whilst it appears that the number of returns for some race groups was too small to be representative of that group (e.g. Indian Children's Homes) and other groups are over-represented in the sample (e.g. White Children's Homes) the response rate needs to be understood in terms of the disparity in the provision of residential care services across the various race groups (see Table 9).

TABLE 9: NUMBERS AND PERCENTAGES OF CHILDREN IN VARIOUS TYPES OF INSTITUTIONAL CARE IN SOUTH AFRICA

TYPE OF INSTITUTION	BLACK	COLOURED	INDIAN	WHITE	TOTAL
Children's Home	1855 (19%)	2548 (26%)	306 (3%)	5222 (53%)	9931
Child Care School	330 (9%)	1120 (30%)	90 (2%)	2150 (58%)	3690
Place of Safety	1289 (41%)	715 (23%)	120 (4%)	995 (32%)	3119
Reform School	216 (15%)	970 (68%)	0	250 (17%)	1436
TOTAL	3690	5353	516	8617	18176

Source: NACCW offices, 1991.

The table illustrates which groups have the greater provision. In Children's Homes and Child Care Schools, White children utilise more than half of the available resources. In Reform Schools, 68% of the children are Coloured. These disparities are emphasised in the light of the population distribution across the various race groups in South Africa (see Chapter One, TABLE 3). Using these figures, the response rate in terms of the percentage of the total number of children in institutional care that is represented in the sample, is as follows: Black, 24.3%; Coloured, 30%; Indian, 50.2%; White, 30.4%. When these percentages are analysed for those children in Children's Homes, the following percentages of children are represented in the sample: Black, 25.4%; Coloured, 29.9%; Indian, 47.4%; White, 35%. The sample represents 33.3% (one third) of all children in Children's Homes in South Africa, and 30.7% of all children in residential care.

5.5 Summary of Methodology

On the basis of a pilot investigation conducted amongst three Children's Homes in the in the Pietermaritzburg area, a questionnaire was constructed and posted to 229 residential care facilities for children in South Africa. The questionnaire requested information from the practice of these institutions, the questions relating to the research objectives. The respondents were required to give both factual information related to the variables under investigation and a subjective evaluation of the treatment needs represented amongst the children presently resident in their institution. They were asked to return the completed questionnaires in the envelope provided within four weeks. A total response rate of 34.06% was obtained, with a 47.6% response rate from the Children's Homes surveyed. These replies provide information on approximately one third of all children living in Children's Homes in South Africa, and on 30,7% of all those living in residential care at the time of the study.

CHAPTER SIX

6. RESULTS

6.1 The Statistical Analysis of the Data

In view of the fact that the investigation concerned the population of various child care facilities, rather than individual children, the data was converted into the percentages of children in each facility, according to:

1. Age Category
2. Behaviour Category

For the purposes of analysing the data, the returns were grouped according to common variables: type of institution, race group, sexes in residence, building design, language, and signer of the questionnaire. The mean percentages were calculated for these groups and the variance between the groups in terms of age category and behaviour category, was analysed.

In some cases the means represented the results of many returns e.g. White Children's Homes (n=32), in other instances the mean percentage would represent only one or two returns e.g. Reform Schools (n=2). For this reason all the tables presented summarising the results, use the mean percentages as the main source of comparison, but also indicate the number of returns and the number of children represented in each group of returns.

Many of the variables influencing age and behaviour are analysed for the Children's Home group only. This is for three reasons:

1. Firstly, the Children's Home sample was of primary interest to the researchers because the research had been

undertaken with the specific aim of devising appropriate programmes for Children's Homes.

2. Secondly, once it became evident that the type of institution was a significant source of variance both for age and behaviour, the influence of other variables could be more clearly seen if the Children's Home sample were analysed separately.
3. Thirdly the number of returns was far greater for Children's Homes than for any other type of institution, enabling the researcher to break this group down for further analysis of other variables. With the intention of removing the other sources of variance, the results of only the White Children's Homes were analysed to examine the specific effect of the design of the building. This group was also investigated in terms of the possible influence of the predominant language as it was speculated that there would be corresponding cultural influences which may impact upon children's behaviour.

In this study, the trends are best represented in tables and graphs, facilitating a descriptive analysis of the results. Graphs are presented where the variance proved to be significant as an illustration of the pattern of variance.

The analysis of variance statistical tests were conducted on the mean percentages in order to establish whether the variance between groups was statistically significant. A two way analysis of variance was conducted with the weighted drawing score as the dependent variable using the SPSS/PC+ Statistical Package. This package was selected as it automatically corrects for unbalanced cell frequencies (as is evident in Tables 11,13,15,17,19,21,23,25,27; see Appendix C).

Because the number of returns in some of the groups was very small (e.g. one Occupational Therapist as signer; one Off Campus home represented amongst the style of building), these returns were either excluded from the analysis of variance, or

the results were combined with another subgroup. The decision of whether to exclude or to combine groups was justified in each instance, as far as possible avoiding bias in the outcome.

6.2 Presentation and Discussion of Results

6.2.1 Behaviour Categories and Associated Variables

The national study confirmed many of the trends which were apparent in the pilot study and also confirmed Hypothesis 1, stating that in terms of the total population of children living in places of care in South Africa, the treatment needs are diverse. This diversity was evident in all the types of institutions (see Figure 1): the children requiring community living representing the largest group in care. These results are explicated when the separate types of Institutions are discussed (section 6.2.1.1).

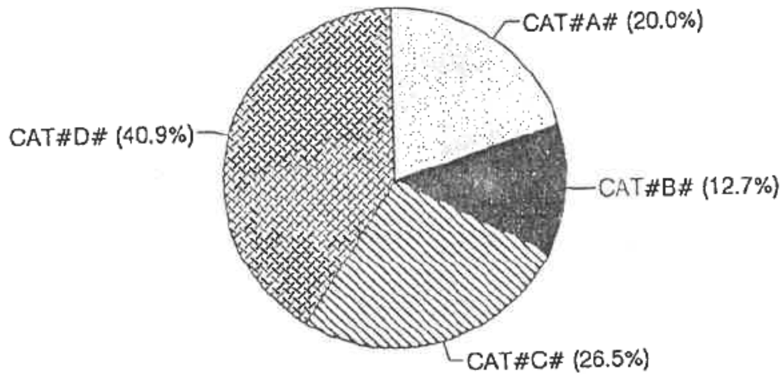
Similar diversity was evident when considering the Children's Home sample (see Figure 2), where it seemed that they were indeed trying to be all things to all children. These trends are similar to those revealed in the Pilot Study, and the percentages of children in each behavioural category, is similar. This tends to confirm that approximately half the children living in Children's Homes in South Africa are considered ready to be accommodated in families.

The second largest percentage represented in Children's Homes, is the number of children in category C (24.5%), the group who are engaged in treatment programmes. In South Africa the emphasis in terms of state legislation and training is upon Children's Homes developing treatment programmes for individual children. Despite this commitment, the research reveals that only one in four children is actively involved in such a programme. Many consider this to be the primary function of a children's home. Such a programme depends upon realistic resources and an appropriate staff/child ratio.

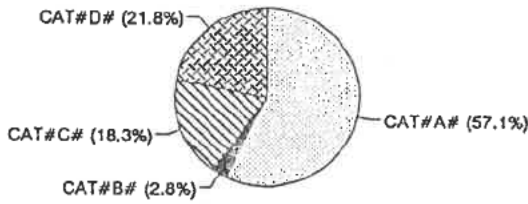
FIGURE 1: ALL CASES: TYPES OF INSTITUTION: BEHAVIOUR CATEGORY

CAT#A# recently admitted
CAT#B# disturbed behaviour
CAT#C# treatment programme
CAT#D# holding group

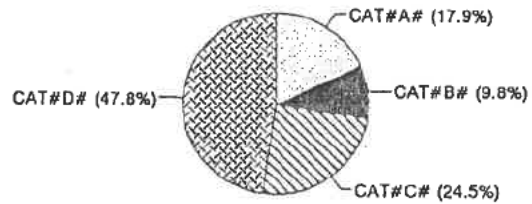
ALL CASES



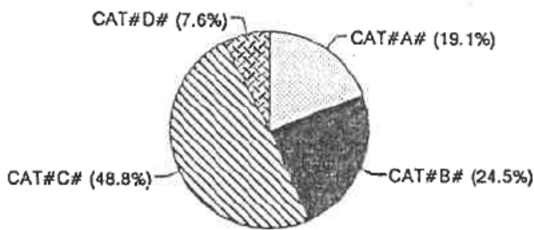
Place of Safety



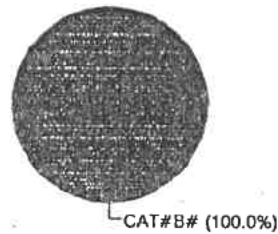
Children's Homes



Child Care School



Reform School



Other

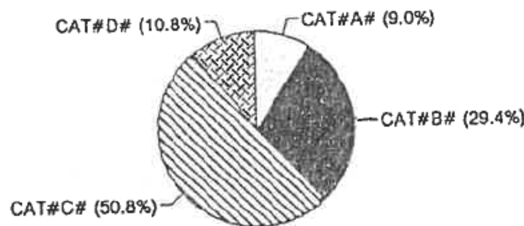


TABLE 10: ALL CASES: TYPE OF INSTITUTION: BEHAVIOUR CATEGORY. Means and Percentages

	TOTAL		PLACES OF SAFETY		CHILDREN'S HOME		CHILD CARE SCHOOL		REFORM SCHOOLS		OTHER	
	n=67		n=4		n=49		n=5		n=2		n=7	
	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
CAT#A# recently admitted	18.8%	834	57.1%	182	17.9%	558	19.1%	69	0.0%	0	3.0%	25
CAT#B# disturbed behaviour	11.9%	963	2.8%	9	9.8%	296	24.5%	158	100.0%	457	9.8%	43
CAT#C# treatment programme	24.9%	1278	18.3%	57	24.5%	790	48.8%	318	0.0%	0	16.9%	54
CAT#D# holding group	38.4%	1811	21.8%	67	47.8%	1659	7.6%	55	0.0%	0	3.6%	30
TOTAL	94.0%	4886	100.0%	315	100.0%	3303	100.0%	600	100.0%	457	* 33.3%	152

*due to missing data in these returns, 6% of the total sample is missing.

Experience in direct child care work shows that a minority of children in a unit demand the bulk of the child care worker's time and effort. 9.8% of children in Children's Homes were deemed to be category B children (those children displaying marked behaviour disturbance). This would constitute at least one such difficult child in every living unit of ten children, fitting closely with the exasperated plea from many child care workers, "I spend 90% of my time dealing with 10% of the children". The effort of containing the behaviour of even one difficult child detracts from the treatment and socialisation programmes needed for children in categories C and D.

This explains why children without major problems develop secondary symptoms associated with long term institutionalisation: low self esteem, lack of motivation and initiative, poor scholastic achievement, poor life skills, inadequate socialisation. The imbalance of time investment also encourages children to 'act out' to gain the attention they need.

The admission/assessment group, category A, comprises 17.9% of children in the children's home group. This percentage indicates that Children's Homes must review their traditional role and update their services to include provision for the assessment and observation of children. There is evidently a need within Children's Homes to undertake careful assessment of children, perhaps with the assistance of other professionals. This, however, would be beyond the financial resources of many institutions.

6.2.1.1 Behaviour Category by Type of Institution

Figure 1 presents a comparison between the population of children in care in Children's Homes, in Places of Safety, in Child Care Schools, and in Reform Schools. The group referred to as 'Other', whilst considered to be atypical of places of care accepting children placed by the Children's Courts, these homes accommodate children with specific handicaps, is

included for the purposes of comparison. Whilst these 'Other' facilities appear to have a lower admission rate, the behaviour problem and treatment categories of behaviour are represented in similar proportions to the Children's home group. The number of children in category D is however lower. This may well be due to the fact that many of these children may be considered to be unsuitable for return home because of their specialised treatment needs.

When considering the behaviour categories as represented in all child care facilities (see Table 10), the returns from the Reform Schools, Child Care Schools and Places of Safety were predictable in terms of their stated role and function. It would appear that the categories used had therefore proved to be a successful way of describing the different services required in order to meet the diverse needs of children in residential care, and had served to discriminate successfully between the behavioural categories where the source of variance was the type of institution (see Table 11; Appendix C). The 2-way Analysis of Variance revealed significant main effects for category A, the admissions group (p=.011), and category B, the disturbed behaviour group (p=.003), and category D, the 'holding' group (p=.001), but were not significant for category C, the treatment programme group. It is likely that there would be less variation between groups in the case of category C in view of the fact that all facilities would provide treatment to some degree.

In the Reform School sample, 100% of children were in the group needing containment. In the Child Care School group, 24.5% of children were deemed to be in category B, needing containment and 48.8%, in category C, in treatment programmes. It would appear that 7.6% of children in Child Care Schools, (category D), could be placed in less restrictive environments.

Similarly the 57.1% requiring assessment at Places of Safety

is understandable although this figure is a little lower than anticipated in view of the fact that Places of Safety are designed to provide short term observation and assessment. Of considerable concern is the fact that 21.8% of children (nearly one in four) in these institutions are considered to be ready to live in the community. Perhaps the failure to place these children either in Children's Homes or back into the community, reflects the lack of adequate child care facilities. This is in fact born out by personal experience in the field: many children remain in Places of Safety for up to a year, whereas the service is designed to accommodated children for a maximum period of three months only.

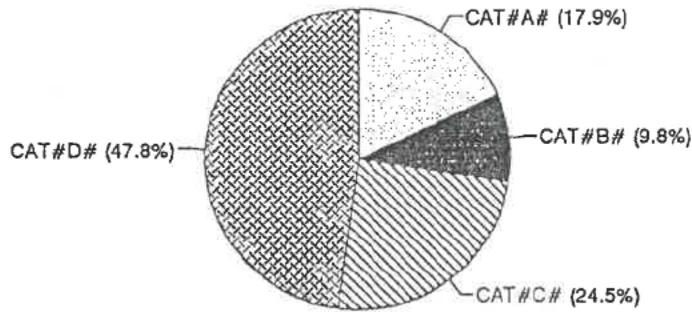
Comparing the figures of the population of children in various places of care in South Africa (see Table 10), it is evident that there is a high proportion of children who have been removed from their families living in Places of Safety, particularly in the Black population group where the number of children in Places of Safety is almost the same as the number in Children's Homes, and this reflects the retarded policy in the provision of services for Black children.

These figures confirm the second part of Hypothesis 1, i.e. that the present institutional structures fail to meet the diversity of needs, and consequently there appears to be considerable deviation from their designated function in order to accommodate children who would better be placed in Children's Homes or in community-based facilities. This is most evident in the Places of Safety where lack of facilities for children who are ready to be transferred has resulted in the provision of a service that approximates that of a Children's Home, thereby focusing some of the staff's attention away from their stated goal of assessing children.

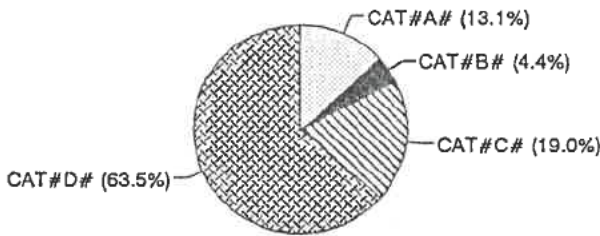
FIGURE 2: ALL CHILDREN'S HOMES: RACE GROUP: BEHAVIOUR CATEGORY

ALL CHILDREN'S HOMES

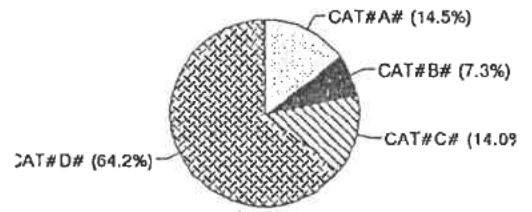
CAT#A# recently admitted
CAT#B# disturbed behaviour
CAT#C# treatment programme
CAT#D# holding group



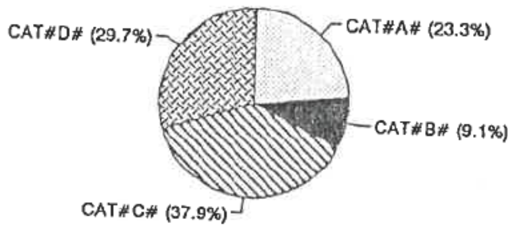
Black Children's Homes



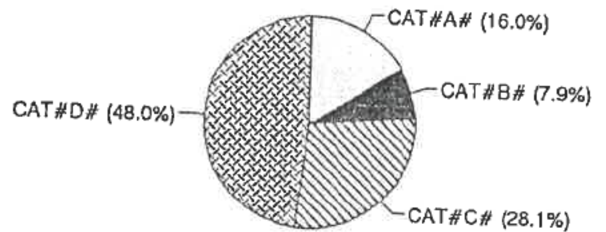
Coloured Children's Homes



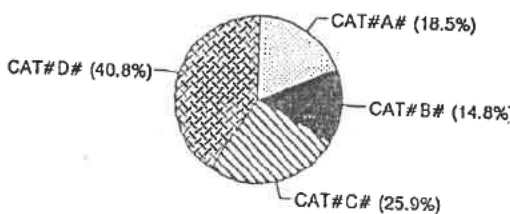
Indian Children's Homes



White Children's Homes



Mixed Children's Homes



Street Children

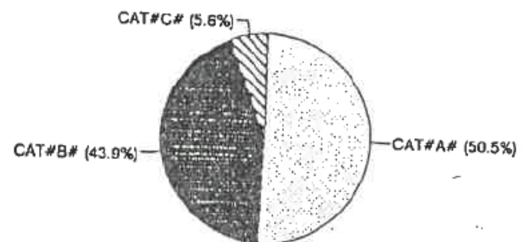


TABLE 12: ALL CHILDREN'S HOMES: RACE GROUP: BEHAVIOUR CATEGORY. Means and Percentages

	TOTAL		BLACK		COLOURED		INDIAN		WHITE		MIXED		STREET CHILDREN	
	n=49		n=6		n=5		n=2		n=32		n=1		n=3	
	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
CAT#A# recently admitted	17.9%	558	13.1%	65	14.5%	42	23.3%	42	16.0%	239	18.5%	5	50.5%	26
CAT#B# disturbed behaviour	9.8%	296	4.4%	23	7.3%	103	9.1%	13	7.9%	132	14.8%	4	43.9%	21
CAT#C# treatment programme	24.5%	790	19.0%	86	14.0%	69	37.9%	54	28.1%	570	25.9%	7	5.6%	4
CAT#D# holding group	47.8%	1659	63.5%	297	64.2%	409	29.7%	36	48.0%	906	40.8%	11	0.0%	0
TOTAL	100.0%	3303	100.0%	471	100.0%	623	100.0%	145	100.0%	1847	100.0%	27	100.0%	51

6.1.2 Behaviour Category by Race Group

In view of the fact that the type of institution was clearly a source of variance, only the Children's Home group is analysed for the effect of race. For example, one would speculate that in the overall sample, the percentage of behaviour disturbance among Coloured children would be considerably higher because of the fact that 457 children were in one Coloured reformatory, all of whom were categorised as requiring intensive management.

In analysing these returns it was decided that it would be appropriate to maintain the street children sample as a separate group within the Children's Homes sample, in view of the very distinct behavioural characteristics of this group. Had these been combined, the percentages from the other returns would have been contaminated and become misleading. The group referred to in Table 8 (see Chapter 5) as 'Mixed'(see Table 12) i.e. accommodating more than one race group, has been split accordingly into 'Street Children' and 'Mixed'. Figure 2 illustrates a comparison between proportion of children in each behaviour category according to race group.

Whilst the researcher had suggested no hypothesis linking behaviour and race at the outset of the study, when the source of variation was race group, the 2-way Analysis of Variance for the mean percentage of children in each behavioural category, revealed significant main effects for category B, ($p=.001$) and for category D, ($p=.015$) (see Table 13, Appendix C).

Therefore it appears that the mean percentage of children in Children's Homes manifesting behaviour disturbance, differs according to race. This variation is highlighted in Figure 2, where a comparison between the populations of Children's Homes on the basis of race, is presented, and in Table 12 which shows the means and percentages and the numbers of children

represented in each group of returns.

When the behavioural categories are viewed in terms of race group (see Table 12), the percentage of category D children, those children awaiting return to the community, varies from 48% in the case of White Children's Homes to 64% in the case of Black and Coloured Children's Homes. The variance between race groups was statistically significant for this group, at the .037 level of significance. This variance may be attributed in part to two factors:

1. The influence of the street children sample (see Table 12) where there were no children reflected in the 'holding' group. As might have been predicted from the 'drop in' nature of street children shelters and the nomadic lifestyle of the street children themselves, half (50.5%) of this group were regarded as meeting the criteria for category A. Only 5.6% were in regular treatment programmes, the remainder presented with behaviour problems (43.9% in category B).
2. Disparity in community resources to reintegrate these children within their communities. The relatively poor standard of living of the disadvantaged Black community and in the past, the hopelessly inadequate foster grants arising through the policy of differential funding, can be cited as some of the reasons why it is difficult to move these children.

The difficulty in moving children is confirmed by the experience of agency social workers who struggle to place children in residential care (Muller and Steyn, 1990). Whilst this situation arises partly due to the dearth of Children's Homes for the Black and Coloured population groups, it is exacerbated when children remain in care for extended periods of time because they have nowhere else to go.

In view of the fact that it is unlikely that socio-cultural factors will change, Children's Homes must face the reality

that for some children the permanent plan will be to remain in the institution. The mean percentages show that this group of children comprises at least half of the children in Children's Homes. For these children the optimum placement would be within facilities approximating family units.

Whilst category C is the second largest group, when one examines the various race groups, there are few children in Black and Coloured Children's Homes (19% and 14% respectively) benefiting from treatment. This is of particular concern in view of the fact that individual treatment programming is a fundamental aspect of the service provided by Children' Homes, and this has been reinforced by legislation (see Child Care Act, No.74, 1983). Increased funding for these homes and the provision of professional services would appear to be priorities. However when one examines the expenditure on Child Welfare in the Coloured sector (see Table 1, Chapter 1), the low mean percentage of children in treatment (14.0%) could indicate:

1. That treatment programmes are not regarded as a priority;
2. That resources are too limited to permit treatment facilities;
3. That many children in Coloured Children's Homes have successfully undergone treatment, and are now ready to enter the community, but no alternative placements exists.

When considering the overall picture in the Coloured Children's Homes, the number of children in category D (awaiting community placement) is high (64.2%), suggesting the last interpretation may be true.

In the Indian Children's Homes which have always received relatively generous funding from the House of Delegates, the mean percentage of children in treatment programmes is 37.9%, 15% higher that the average for all Children's Homes and 10% higher than in White Children's Homes. This would suggest that treatment programmes do receive priority attention, and that

funding is available for these programmes. The number of children awaiting community placement is relatively low in the Indian sample, possibly indicating that once children have completed their treatment programmes, the Indian Children's homes are relatively successful in finding placement for them in the community. The extended family resources and the networks for multi-parenting are traditionally well established in the Indian community relative to other population groups (Burman and Reynolds, 1986). The reader's attention is drawn to the fact that although only 2 returns are included in the sample of Indian Children's Homes, these returns represent 47.4% of Indian children in Children's Homes.

The admission/assessment group, category A, comprises 17.9% of children in the Children's Homes sample, but the discrepancy between the race groups is relatively large (13.1% - 23.3%) although this variance was not statistically significant (see Table 13, Appendix C). In view of the fact that some Children's Homes only accept children for placement once they have been observed and assessed in a Place of Safety, whilst others must serve as a Place of Safety within their community, such variation is understandable. In the Indian group, the admissions group is relatively larger than in the other groups (see Table 12) at 23.3%. This is consistent with the idea that these Children's Homes are able to send children home more easily and therefore create vacancies for new admissions. Where the number of children in 'holding' is high, there will be few vacancies as in the case of the Black Children's Homes, where the category A mean percentage is 13.1%.

The variation between race groups for category B, children manifesting behaviour disturbance and requiring containment, was statistically significant at the .001 level of significance. The percentage of category B children was smaller in the case of the Black Children's Homes (4.4%), and 43.9% in the case of street children. The criterion for

determining behaviour disturbance may vary from facility to facility, depending upon the latitude of tolerance.

This latitude varies on the basis of:

1. Cultural norms. For example in cultures where truancy or substance abuse are common, these may not be regarded as behaviours requiring containment, and practitioners may define these behaviours as relatively easy to handle as compared with other anti-social or violent behaviours.
2. The training and orientation of child care practitioners. Biderman-Pam (1989) suggests that with training, practitioners gain a heightened sensitivity to the severity of behaviour problems, therefore categorising more children as needing intensive intervention. Due to lack of resources and geographic isolation from training programmes, personnel in Black Children's Homes may lack this kind of training, accounting for the lower number of category B children identified.

6.2.1.3 Behaviour Category by Sexes in Residence

The children's home returns were analysed in terms of the possible impact upon behaviour of the sexes in residence i.e.'boys and girls' or 'boys only' or 'girls only' (see Table 14). Prior to the de Meyer investigation (de Meyer, 1982), when applying for State registration Children's Homes could demarcate their service in terms of the age and sex of the children they would admit to their programmes, many preferring to accommodate children of the same sex. The de Meyer Committee found that the practice of maintaining homes for either boys or girls "has a very bad effect on the children" and "that children from the same family should be placed in the same Children's Home" (de Meyer, 1982, p.32). It was recommended that "no new Children's Homes be registered with restrictions in respect of age and/or sex" (ibid.). Although no Hypothesis was stated in terms of the sexes in residence, this variable merited explication in view of the possible

negative impact suggested by de Meyer (ibid.) on children of the same sex residing together. It was, however, stated in Hypothesis 4 that boys would manifest with more behaviours requiring management and containment. This was based on the literature suggesting that more problems of delinquency are evident amongst boys (Beiser, 1972). It is speculated that peer group influences may generate more management problems where large groups of boys are living together.

The means and percentages for the Children's Homes grouped according to sexes in residence are shown in Table 14. It is apparent that the demarcation according to sex has remained an aspect of child care practice despite the De Meyer recommendations, although the majority of Homes were integrated on the basis of sex (n=31) (see Table 14).

TABLE 14: ALL CHILDREN'S HOMES: SEXES IN RESIDENCE: BEHAVIOUR CATEGORY

	TOTAL		BOYS AND GIRLS		BOYS		GIRLS	
	n=49		n=31		n=14		n=4	
	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
CAT#A# recently admitted	17.9%	558	12.3%	382	33.8%	153	6.3%	23
CAT#B# disturbed behaviour	9.8%	296	7.4%	215	15.1%	59	9.8%	22
CAT#C# treatment programme	24.5%	790	27.5%	624	18.9%	114	20.6%	52
CAT#D# holding group	47.8%	1659	52.8%	1354	32.2%	200	63.3%	105
TOTAL	100.0%	3303	100.0%	2575	100.0%	526	100.0%	202

As had been speculated, in 'boys only' Children's Homes the percentage of category B children was higher at 15.1% than either the 'boys and girls' homes (7.4%) or the 'girls only' homes (9.8%). However, this did not prove to be statistically significant (see Table 15, Appendix C).

The admissions group, category A was proportionally larger in the boys only Children's Homes at 33.8%. The 2-way Analysis of Variance revealed significant main effects for category A, (p=.007), and category D, (p= .037). Whilst this was an unexpected outcome, it may indicate a higher rate of new admissions in 'boys only' Children's Homes. This is supported by the fact that in the boys only facilities, the 'holding' group is relatively small at 32.2%, 15% lower than the mean for all Children's Homes. One might speculate that boys move out of Children's Homes more rapidly, leaving vacancies for new admissions. This situation could arise because:

1. boys living in 'boys only' Children's Homes spend a shorter time in care and are then ready to return to the community. This would be difficult to explain, or;
2. boys from these institutions move on to other institutions such as Child Care Schools.

The latter is in keeping with the idea that boys prove to be more difficult to manage than girls.

In contrast, the 'girls only' Children's Homes present the opposite distribution of behaviour: a low percentage of admission/assessment girls (6.3%; 11.5% lower than the mean) and a high percentage (63.3%) of girls waiting to return to the community.

The significance of variance between groups in respect of the 'holding' group was .037, suggesting that the sexes in residence is a significant source of variance in this group. Muller and Steyn (1990) in an investigation of the placeability of children, found that adolescent girls with and

without behaviour problems were more difficult to place in residential care than their male peers confirming the idea that girls remain in 'holding' for longer periods of time thus blocking new admissions into these facilities. It would be interesting to investigate the ages of the girls in 'holding' in view of the fact that girls may remain longer in residential care whilst they are completing their education. This is suggested by the prevailing ideology that girls are in greater need of protection.

In view of the unknown influence of the age of the children concerned, these results must be interpreted with caution as other variables such as a bias in the mean age of the children in residence could possibly affect the general pattern of behaviour, behaviours typical of a certain developmental stage tending to dominate. 'Boys only' facilities typically accommodate a higher number of teenage boys, whereas Children's Homes accommodating young children more usually accommodate both sexes because of a preference for keeping siblings together, particularly when they are placed at a young age.

One would expect a higher rate of behaviour disturbance amongst adolescent children, and boys in particular (Beiser, 1972), and this expectation was stated as a hypothesis of the present research. Unfortunately, because the data concerns the population group within an institution, rather than individual children, it is difficult to establish a clear link between age and behaviour.

Furthermore, the data concerning the pattern of behaviour represented in a given set of institutions cannot easily be explained. For example, a high percentage of behaviour problem children in a 'boys only' facility, could mean that in terms of their admission criteria, a 'boys only' facility is more likely to accept troubled children. Conversely, social workers may favour a single sex environment when placing

troubled boys. Or one might conclude that boys are more likely to influence one another and act out in a delinquent way when living amongst their same sex peers. The literature supports the idea of 'contamination' i.e. when children with similar problems are living together the frequency and intensity of problem behaviour is amplified. One would expect that the reverse situation would also apply i.e. that in an environment where the peer group is well-behaved, pro-social behaviour is encouraged. The peer group and the group dynamics are powerful forces in residential care, for better and for worse as described in Chapter Three. Further research is indicated to clarify these findings.

6.2.1.4 Behaviour Category by Design of Building

The data was also analysed in terms of the impact of the environment, one of the determinants of 'therapeutic milieu' (Bettleheim, 1967), upon the behaviour of the children in residence (see Table 16). A hypothesis of the present research (See Hypothesis 5) was that behaviour problems will be less prevalent when children are living in a cottage style building. Here the analysis was restricted to White Children's Homes only so as to limit interference of other variables influencing behaviour, such as type of institution and race group.

The mixed design Children's Homes were not a homogenous group and were therefore excluded from the analysis of variance test (see Table 17, Appendix C), as was the Off Campus Home group, because the returns were too few to be considered representative (n=1). It was also thought that this group would influence the variance in category D as all children in the return from the Off Campus Home, as might be expected, were in the group awaiting return to the community. The data indicates that the percentage of category D children is 20.0% higher when children are living in a cottage style home rather than in a dormitory or block style of building (see Table 16).

TABLE 16: ALL WHITE CHILDREN'S HOMES: BUILDING DESIGN: BEHAVIOUR CATEGORY. Means and Percentages

	TOTAL		DORMITORY		BLOCK		COTTAGE		OFF CAMPUS		MIXED DESIGN	
	n=32		n=5		n=12		n=11		n=1		n=3	
	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
CAT#A# recently admitted	16.0%	239	12.3%	37	27.1%	106	10.5%	91	0.0%	0	3.2%	5
CAT#B# disturbed behaviour	7.9%	132	13.8%	41	6.8%	29	4.5%	41	0.0%	0	17.5%	21
CAT#C# treatment programme	28.1%	570	33.4%	105	26.2%	133	25.4%	181	0.0%	0	45.7%	151
CAT#D# holding group	48.0%	906	40.5%	96	39.9%	183	59.6%	571	100.0%	10	33.6%	46
TOTAL	100.0%	1847	100.0%	279	100.0%	451	100.0%	884	100.0%	10	100.0%	223

While variance between groups for category D did not emerge as statistically significant, the trend supports the Hypothesis. Similarly, the dormitory style Children's Homes yielded a higher percentage of category B children (13.8%), this being 9.3% higher than the percentage of disturbed children identified from the cottage design of Children's Home and 6% higher than the mean. For category B, the group needing containment, the design of the building as a source of variance was approaching statistical significance at the .057 level of statistical significance.

This trend cannot be explained simply in terms of the effect of building design behaviour. Another explanation could be that the Children's Homes that have upgraded their buildings to the cottage system, also provide more professional and comprehensive treatment services.

7.2.1.5 Behaviour Category by Language

TABLE 18: ALL WHITE CHILDREN'S HOMES: LANGUAGE: BEHAVIOUR CATEGORY

	TOTAL n=32		AFRIKAANS n=8		ENGLISH n=13		AFR/ENG n=11	
	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
CAT#A# recently admitted	16.0%	79	18.8%	79	16.6%	94	13.2%	66
CAT#B# disturbed behaviour	7.9%	17	2.3%	17	10.9%	67	8.5%	48
CAT#C# treatment programme	28.1%	570	27.0%	225	23.4%	116	34.3%	229
CAT#D# holding group	48.0%	906	51.9%	432	49.1%	232	44.0%	242
TOTAL	100.0%	1572	100.0%	753	100.0%	509	100.0%	585

The relationship between the language group and the pattern of behaviour was analysed for the White Children's Homes (see Table 18). Whilst no hypothesis was stated linking language and behaviour, it was speculated that language may impact upon the 'milieu' or group 'culture'.

The returns were evenly distributed between the 3 groups: Afrikaans (n=8), English (n=13) and Afrikaans/English (n=11). Although de Meyer (1982) recommends that children should be placed with due regard for culture and language, where the language distribution in a community is mixed, the Children's Home in that community will need to offer a bilingual service. Children's Homes will be influenced by the prevailing sociocultural context in a number of ways:

1. In terms of the availability of resources. Children's Homes rely on financial support from the communities in which they are situated,
2. In terms of prevailing attitudes and financial status, the context would also determine the availability of foster parents; and
3. The latitude of tolerance for delinquent behaviour arising amongst the residents of the Children's Home.

Within the Children's Home context itself, the prevailing language and hence the culture would influence the latitude of tolerance in terms of:

1. admissions criteria;
2. models of discipline;
3. perseverance with difficult children before the decision is taken to transfer them to other resources.

Although no statistically significant trends emerged (see Table 19, Appendix C), there appears to be some variance on the basis of language in respect of disturbed behaviour (significance of F .087). The percentage of category B children in Afrikaans Children's Homes is only 2.3% as compared with the mean of the total Children's Home sample

(7.9%) (see Table 18). One could speculate whether some of the above factors determined that there were a relatively low number of difficult children in the Afrikaans sample.

Another possible interpretation is that the Afrikaans Children's Homes provide a more effective treatment service. It may also be significant that 5 out of the 8 Afrikaans Children's Homes represented, provided cottage style accommodation, the remainder providing block style accommodation. None of the Children's Homes in the Afrikaans group were in dormitory style units which appear to be associated with a higher percentage of behaviour disturbance. Whilst difficult to establish, experience in the field suggests that under Apartheid rule, there may have been disparate funding to Afrikaans White Children's Homes, assisting with the provision of treatment services.

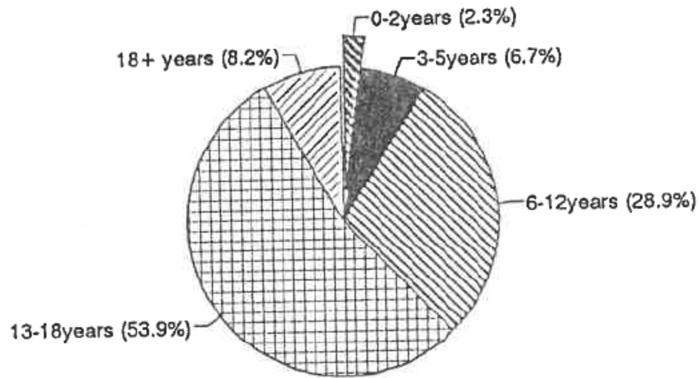
In view of the fact that the percentage of disturbed children is lower even than that which Beiser (1972) has suggested we should expect for a normal population, one could speculate whether this is a realistic reflection of the situation. Some of the other factors resulting in the identification of relatively few difficult children have been discussed. i.e. lack of staff training; certain 'problem' behaviours regarded as the 'norm'. Respondent bias could also account for the fact that the group of disturbed children was so low. These respondents may have felt particularly defensive of their treatment services and may have been unwilling to acknowledge behaviour problems amongst the children in their care.

6.2.2 Age Categories and Associated Variables

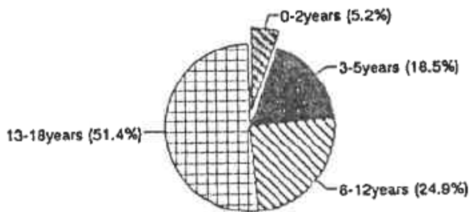
The ages of the children represented in the sample were analysed in terms of the ten age/gender categories as defined in the questionnaire, and in terms of the relationship of age to race group and to type of institution (see Tables 20, 22; Figures 3, 4).

FIGURE 3: ALL CASES: TYPE OF INSTITUTION: AGE CATEGORY

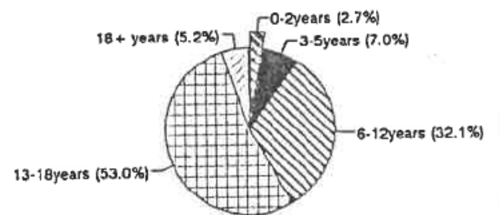
ALL CASES



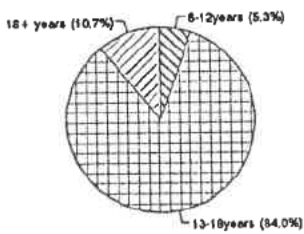
Place of Safety



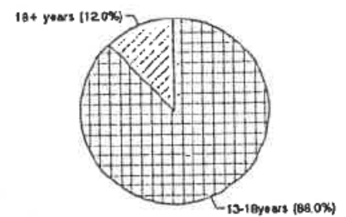
Children's Home



Child Care School



Reform School



Other

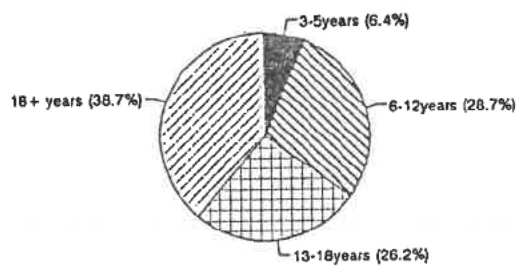


TABLE 20: ALL CASES: TYPE OF INSTITUTION: AGE CATEGORY. Means and Percentages

		TOTAL		PLACES OF SAFETY		CHILDREN'S HOMES		CHILD CARE SCHOOL		REFORM SCHOOLS		OTHER	
		(n=67)		(n=4)		(n=49)		(n=5)		(n=2)		(n=7)	
		MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
0-2yrs	boy	1.2%	62	3.0%	9	1.4%	53	0.0%	0	0.0%	0	0.0%	0
	girl	1.1%	55	2.1%	6	1.3%	49	0.0%	0	0.0%	0	0.0%	0
	total	2.3%	117	5.1%	15	2.7%	102	0.0%	0	0.0%	0	0.0%	0
3-5yrs	boy	3.9%	214	9.5%	21	4.1%	156	0.0%	0	0.0%	0	4.0%	37
	girl	2.8%	160	8.7%	19	2.9%	119	0.0%	0	0.0%	0	2.4%	22
	total	6.7%	374	18.2%	40	7.0%	275	0.0%	0	0.0%	0	6.4%	59
6-12yrs	boy	17.8%	861	14.9%	33	19.8%	656	5.3%	17	0.0%	0	15.6%	155
	girl	11.1%	592	9.7%	21	12.3%	438	0.0%	0	0.0%	0	13.1%	133
	total	28.9%	1453	24.6%	54	32.1%	1094	5.3%	17	0.0%	0	28.7%	288
13-18yrs	boy	34.8%	1948	31.2%	77	33.0%	973	65.1%	404	88.0%	402	12.8%	92
	girl	19.1%	928	19.5%	49	20.0%	676	18.9%	108	0.0%	0	13.4%	98
	total	53.9%	2876	50.7%	126	53.0%	1649	84.0%	512	88.0%	402	26.2%	190
18+ yrs	boy	5.5%	307	0.0%	0	3.6%	107	9.6%	65	12.0%	55	22.6%	80
	girl	2.7%	165	0.0%	0	1.6%	76	1.1%	6	0.0%	0	16.1%	83
	total	8.2%	472	0.0%	0	5.2%	183	10.7%	71	12.0%	55	38.7%	163
TOTAL	BOY	63.2%	3563	58.6%	180	61.9%	1945	80.0%	486	100.0%	457	55.0%	495
	GIRL	36.8%	2024	40.0%	135	38.1%	1358	20.0%	114	0.0%	0	45.0%	417
	TOTAL	100.0%	5587	98.6%	315	100.0%	3303	100.0%	600	100.0%	457	100.0%	912

When considering all cases, the majority of children living in residential care facilities fall in the 13-18 year age group. This finding supported Hypothesis 3, which states that the adolescent age group will be over-represented in residential care facilities relative to other age groups. This trend is consistent with similar research conducted in England (Waterhouse, 1989b). This may arise because of the difficulties securing community placements for children in their adolescent years. The mean percentage for this age group was 53.8%, and 34.7% of these were boys. Correlations between age and behaviour category were not investigated but we could speculate that this could prove to be a significant factor.

6.2.2.1 Age Category by Type of Institution

The 2-way Analysis of Variance (see Table 21, Appendix C) revealed significant main effects for children aged 6-12 years, (p= .001) and for children ages 13-18 years (p= .013).For the Children's Home group alone the percentages for the 13-18 year group were 53% and 33% respectively (see Table 20). Hence the majority of children in Children's Homes and in all child care facilities, are teenagers.

As might be expected in terms of their role, the percentage of 13-18 year-olds in Child Care Schools rises to 84%, 65% of whom were boys. In view of the fact that younger children with behaviour problems are generally maintained in Children's Homes, as very few Child Care Schools exist specialising in the care of primary school children, the percentage of children under the age of 13 years is very low (5.3%). Similarly, there were no children under the age of 13 years in the Reform Schools (see Figure 3).

The significant variance in the younger age groups is explained when considering that nearly half of all children in the Places of Safety sample were 0 - 12 years old. One child out of four in Places of Safety is in the 0 - 5 years age

group. It is likely that this figure was influenced by the Black Places of Safety where many young children are placed for emergency care. Nearly half of all Black children in residential care live in Places of Safety (see Table 9), and due to the lack of available Children's Homes, many of these children remain in Places of Safety for years. This is of particular concern when considering the vulnerability of children under the age of 5 years when living in institutional care (see Chapter Three).

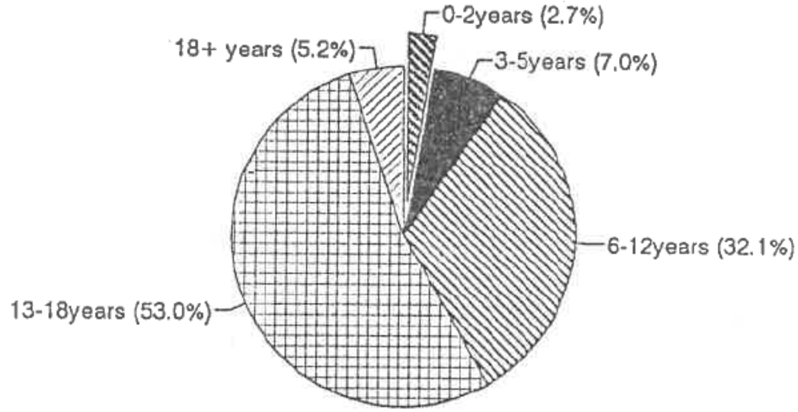
6.2.2.2 Age Category by Race Group

The analysis of race group as a source of variance was conducted on the Children's Home Sample only in view of the fact that the type of institution was a source of variance. In the Children's Homes, variation between race groups existed in the pre-school age groups (see Figure 4; see Table 22). There was a large group of pre-school children living in Black Children's Homes (14.4% in the 0-2 year group as compared with a mean of 2.7%; and 20.2% in the 3-5 year age group as compared with a mean of 7.0%).

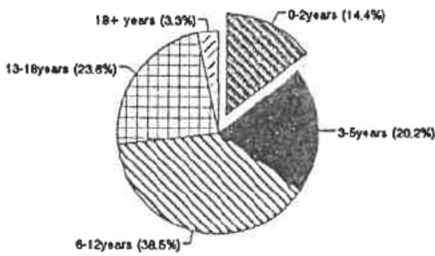
The 2-way Analysis of Variance (see Table 23, Appendix C) revealed significant main effects for ages 0-2 years, (p=.000), and ages 3-5 years, (p=.010), and for ages 13-18 years, (p= .005). This supported Hypothesis 6 which states that it is likely that due to socio-political factors which tend to disfavour black children, there will be a higher preponderance of Black children in the 0-2 year age group.
This trend had been predicted in view of the growing number of abandoned black babies, and the increasing problem of HIV/Aids orphans. The trend also highlights the difficulties in recruiting foster parents in the Black population groups. It is likely that a further source of variance in this age group is the fact that White pre-school children are more easily placed in foster care.

FIGURE 4: ALL CHILDREN'S HOMES: RACE GROUP: AGE CATEGORY

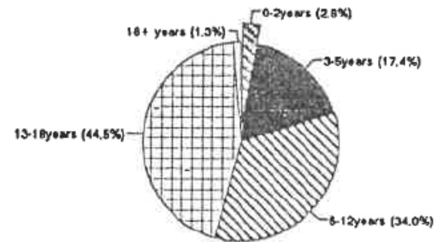
ALL CHILDREN'S HOMES



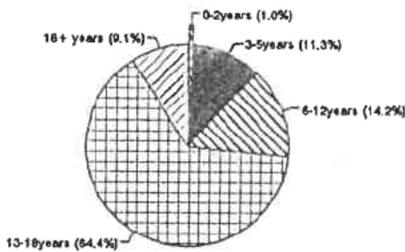
Black Children's Homes



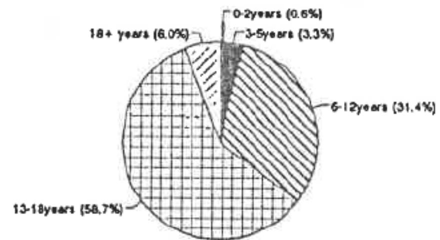
Coloured Children's Homes



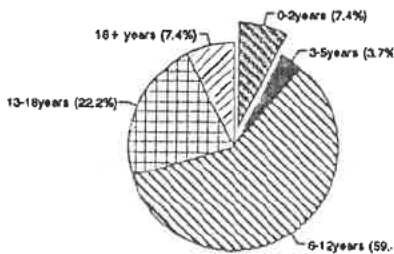
Indian Children's Homes



White Children's Homes



Mixed Children's Home



Street Children

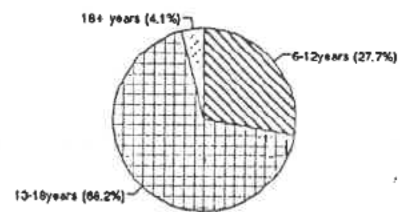


TABLE 22: ALL CHILDREN'S HOMES: RACE GROUP: AGE CATEGORY. Means and Percentages

		TOTAL		BLACK		COLOURED		INDIAN		WHITE		MIXED		STREET CHILDREN	
		n=49		n=6		n=5		n=2		n=32		n=1		n=3	
		MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
0-2yrs	boy	1.4%	53	7.4%	34	1.2%	8	0.5%	1	0.4%	9	3.7%	1	0.0%	0
	girl	1.3%	49	7.0%	34	1.6%	8	0.5%	1	0.2%	5	3.7%	1	0.0%	0
	total	2.7%	102	14.4%	68	2.8%	16	1.0%	2	0.6%	14	7.4%	2	0.0%	0
3-5yrs	boy	4.1%	156	12.9%	68	8.6%	34	3.9%	8	2.1%	45	3.7%	1	0.0%	0
	girl	2.9%	119	7.3%	38	8.8%	42	7.4%	15	1.2%	24	0.0%	0	0.0%	0
	total	7.0%	275	20.2%	106	17.4%	76	11.3%	23	3.3%	69	3.7%	1	0.0%	0
6-12yrs	boy	19.8%	656	24.2%	108	24.2%	180	9.8%	16	18.3%	334	18.5%	5	27.7%	13
	girl	12.3%	438	14.3%	65	9.8%	101	4.4%	9	13.1%	252	40.8%	11	0.0%	0
	total	32.1%	1094	38.5%	173	34.0%	281	14.2%	25	31.4%	586	59.3%	16	27.7%	13
13-18yrs	boy	33.0%	973	13.5%	62	29.2%	244	56.1%	61	33.6%	571	0.0%	0	68.2%	35
	girl	20.0%	676	10.1%	46	15.3%	138	8.3%	17	25.1%	466	22.2%	6	0.0%	0
	total	53.0%	1649	23.6%	108	44.5%	382	64.4%	78	58.7%	1037	22.2%	6	68.2%	35
18+ yrs	boy	3.6%	107	1.9%	9	0.4%	2	6.6%	12	4.2%	81	0.0%	0	4.1%	3
	girl	1.6%	76	1.4%	7	0.9%	5	2.5%	5	1.8%	57	7.4%	2	0.0%	0
	total	5.2%	183	3.3%	16	1.3%	7	9.1%	17	6.0%	138	7.4%	2	4.1%	3
TOTAL	BOY	61.9%	1945	59.9%	281	63.6%	468	76.9%	98	58.6%	1040	25.9%	7	100.0%	51
	GIRL	38.1%	1358	40.1%	190	36.4%	294	23.1%	47	41.4%	804	74.1%	20	0.0%	0
	TOTAL	100.0%	3303	100.0%	471	100.0%	762	100.0%	145	100.0%	1844	100.0%	27	100.0%	51

Few Black and Coloured children over 18 years were represented in the Children's Homes sample (3.3% and 1.3% respectively). This is in part explained by disparate regulations regarding children in care as would be refused an extension of the order of their stay after the age of 18 years, due to the pressure for vacancies. The extension of the order of stay (Child Care Act No.74, 1983; section 33) is motivated on the basis of pursuing full-time education. Giles (1988) investigated the scholastic progress of children in residential care and found that 40% of Coloured children are between 2 and 4 years behind their age level at school and that one in twenty are 5 years behind. With this kind of backlog it is unlikely that these children would persevere with their education beyond the age of eighteen years. This could account for the very low numbers of Coloured children in the 18+ age group. In the relatively affluent White Children's Homes and Indian Children's Homes the number of children in this age group was higher at 6.0% and 9.1%.

6.2.3 Training of Respondent/Signer

One of the stated limitations in the design of the study is the reliance upon subjective assessments from unknown respondents. It was recognised that a possible source of variance in the categorisation of the children according to behaviour, could be the designation and hence the training and experience of the respondent.

It was hypothesised (see Hypothesis 6) that the trained professional workers (social worker, psychologist) would be more likely to distinguish between different treatment needs of children in care, and through their training recognise symptoms (developmental delays, psychiatric symptoms etc.). This may result in a greater tendency to categorise children as either disturbed in their behaviour or in need of treatment.

TABLE 24: ALL CASES: SIGNER: BEHAVIOUR CATEGORY. Means and Percentages

	TOTAL		SOCIAL WORKER		PRINCIPAL		CHILD CARE WORKER		PSYCHOLOGIST		OCCUPATIONAL TH.		SECRETARY		UNKNOWN	
	n=67		n=26		n=28		n=2		n=4		n=1		n=1		n=4	
	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
CAT#A# recently admitted	18.8%	834	20.2%	379	16.9%	256	54.8%	90	4.5%	22	18.0%	25	0.0%	0	20.7%	62
CAT#B# disturbed behaviour	11.9%	963	9.3%	169	11.0%	189	8.7%	9	48.4%	530	28.1%	39	0.0%	0	8.6%	27
CAT#C# treatment programme	24.9%	1278	27.3%	497	24.5%	438	3.8%	4	38.8%	239	32.3%	45	0.0%	0	16.4%	55
CAT#D# holding group	38.4%	1811	43.2%	968	40.4%	643	32.7%	34	8.3%	40	21.6%	30	0.0%	0	29.4%	96
TOTAL	* 94.0%	4886	100.0%	2013	* 92.8%	1526	100.0%	137	100.0%	831	100.0%	139	0.0%	0	* 75.1%	240

due to missing data in these returns, 6% of all cases are missing

TABLE 26: ALL CHILDREN'S HOMES: SIGNER: BEHAVIOUR CATEGORY. Means and Percentages

	TOTAL		SOCIAL WORKER		PRINCIPAL		CHILD CARE WORK		PSYCHOLOGIST		OCCUPATIONAL TH.		SECRETARY		UNKNOWN	
	n=49		n=25		n=20		n=1		n=0		n=0		n=0		n=3	
	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM	MEAN %	SUM
CAT#A# recently admitted	17.9%	558	18.6%	337	16.1%	154	9.6%	5							27.6%	62
CAT#B# disturbed behaviour	9.8%	296	9.6%	169	9.4%	91	17.3%	9							11.4%	27
CAT#C# treatment programm	24.5%	790	27.7%	484	21.7%	247	7.7%	4							21.8%	55
CAT#D# holding group	47.8%	1659	44.1%	952	52.8%	577	65.4%	34							39.2%	96
TOTAL	100.0%	3303	100.0%	1942	100.0%	1069	100.0%	52	0	0	0	0	0	0	100.0%	240

The two largest groups of signer across all cases, the social worker (n=26) and the Principal (n=28), appeared to agree to a large extent upon the criteria for the behavioural categories (see Table 24) in that the percentages given to each category are similar to one another, but also similar to the overall percentages for each behaviour across all cases.

The 2-way Analysis of Variance (see Table 25, Appendix C), revealed significant main effects for identifying behaviour disturbance (p= .010). The other behavioural categories were not significant.

The returns completed by psychologists show a definite bias in the direction of category B (48.4%) and category C (38.8%). This group of respondents viewed only 8.3% of all children as meeting the criteria for category D ('holding' group).
This would seem to indicate a large discrepancy in the way in which psychologists view the children with whom they work. This tends to support Hypothesis 6 which states that due to the enhanced skills of professional workers they will be better equipped to distinguish between different treatment needs of children. A review of the literature also lends support to the hypothesis. Beiser (1972) reviews descriptive research into behaviour disturbance amongst children in the general population as well as in treatment groups. When teachers were asked to identify 'seriously disturbed' children in their classes, approximately 8.0% were consistently identified, across a number of different studies. This figure closely approximates the mean percentage of children in category B in Children's Homes as identified in the present research (9.8%). As one might expect the percentage amongst the children's home group is slightly higher. Beiser (1972) reports that in one study, the teachers were trained in recognising symptoms of disturbance. Subsequently when problem children were identified, the percentage trebled, suggesting that training in symptom recognition will increase the percentage of problem children identified.

A confounding variable in the present research is the fact that bias may exist due to the fact that the type of institution where a psychologist is employed may be more likely to accommodate problem children. In South Africa, at present, only Places of Safety or Child Care Schools or Reform Schools receive a state subsidy for the post of a psychologist, although some Children's Homes employ a psychologist using private funding. The percentage of problem children would be inflated in the case of either the Child Care School or the Reform School. In order to check whether, in fact, this factor had influenced the data, the same figures were assessed for the children's home group only (see Table 26).

It is apparent that there was no data in the children's home sample which had been completed by a psychologist. This would lead us to interpret with caution the bias evident in the returns completed by the psychologists as they may accurately reflect a more troubled population of children, rather than a tendency on the part of psychologists to view children in clinical terms.

Considering only the Children's Home sample, 45 out of 49 returns were completed by either the social worker or the principal (see Table 26). The consistency between these returns is high, the social workers' returns appearing to favour a category C classification by 6%, and the principals' returns favouring category D by 9%. This high level of consistency, is supported by the analysis of variance between respondents in the Children's Home sample (see Table 27, Appendix C). The 2-way Analysis of Variance revealed no significant main effects. This is positive in that it appears that the results within the Children's Homes sample at least, are not significantly confounded by respondent bias. It would also suggest that these respondents had similarly interpreted the definition of the behavioural categories.

CHAPTER SEVEN

7. DISCUSSION

7.1 Limitations of the Study

7.1.1 Limitations in the Design of the Study

Whilst much has been written in criticism of the survey method in general (Marsh, 1982), postal surveys allow respondents time to reflect on the questions and time to consult their records so that they can give more considered or precise answers (Hoinville et al., 1977). These factors were considered to be advantageous for the collection of reliable data in the present investigation.

7.1.1.1 Self-selection and Non-response

The primary weakness of postal surveys concerns the reliance upon self-selection in achieving the final subject sample and the associated problem of non-response. Non-response in postal surveys takes two forms: failure to return the questionnaire, and failure to answer one or more of the questions. The latter which is usually referred to as "item non-response" (Hoinville et al., 1977, p.137), was evident in approximately 6% of all returns. These returns have been included in the sample, analysing whatever information was given. Items particularly affected were those related to behavioural categories. One third of the returns grouped as 'other' commented that these categories did not apply to their inmates who had been placed in care for specific disabilities.

In this research the main concern regarding non-response is the more common and important problem of failure to respond at all.

"Unless the characteristics of non-respondents are identical to those of respondents, the achieved sample will contain bias. And the bias will be serious when the characteristics of non-respondents are related to the subject under study" (Hoinville et al., 1977, p.6).

Non-response is particularly important in postal surveys in view of the fact that there are generally no clues about the characteristics of the non-respondents and how they differ from respondents. Kazdin (1980) confirms that there are significant variables related to the issue of self-selection, and that respondents differ from non-respondents on a number of dimensions including intelligence, education, sociability and need for social approval. In addition to these factors Hoinville et al.(1977) suggest that respondents and particularly early respondents will tend to be:

* more favourably disposed towards the survey's aims or involved in the survey subject
* politically or socially active
* in the higher socio-economic groups
* receptive to new ideas
* rapid decision-makers
* high-achievers, especially educationally
* used to communicating by post

Non-respondents are more likely to "feel that they may be judged by the responses that they make" or "that they will be inadequate at supplying the information requested" (ibid. p.137). In the present study one may speculate whether some of these factors have affected the process of self-selection, and that the final sample may be biased in the direction of the more affluent, progressive and treatment-oriented organisations. Such a bias would similarly affect the population of children on whom ratings were received, in terms of the level of care provided and the degree of individualisation in the treatment programmes offered.

Kazdin (1980) suggests that the researcher should pursue

contact with non-respondents in order to gauge the reasons for non-response and induce cooperation, but points out that this could introduce further bias.

In the present investigation the rate of response was relatively low (34.06% of the total sample), whereas Hoinville et al.(1977) indicate that whilst the variation in response rates in postal surveys is great, they should commonly yield response rates between 60% and 80%. Whilst incentives and reminders may have improved the level of response, these strategies were not employed.

The results of the study are limited in terms of the small number of returns in some of the categories. Because some of the groups were very small i.e. Reform Schools (2), Places of Safety (4), these returns cannot be said to be representative of all such institutions. For example, White Reform Schools were not represented in the sample at all.

The response rate may have been improved had questionnaires been sent in Afrikaans, Zulu and Xhosa as well as English as recipients may have been deterred when required to complete the questionnaire in their second language. The questionnaire had been distributed in English because the training in residential child care in South Africa is primarily in English and the literature on residential child care practice is either American or British in origin.

Some of the concepts such as 'holding' or 'containment' would be difficult to translate. Many child care workers would understand the terms of the questionnaire whether or not this was their first language e.g. Afrikaans child care workers talk about 'cottages' and 'group homes'.

7.1.1.2 Subjective Evaluation

An inherent limitation in the design of the present study concerns the reliance upon subjective evaluation on the part

of respondents when determining how many children fit into a specific category. We are "assessing the opinions of individuals who are likely to have contact with the child" (Kazdin, 1980, p.367), and consequently our results may say more about the respondent rather than the child's actual behaviour and treatment needs. The inclusion of a specific child in a specific category will be determined by the degree of contact which the respondent experiences with the child, the respondent's own interpretation of the behavioural categories as described and his/her beliefs regarding acceptable behaviour amongst children. Kazdin (1980) emphasises that subjective evaluations in any research must be treated cautiously.

Whilst it is acknowledged that the operational definitions of the behavioural categories used in the questionnaire are brief descriptions and open to subjective interpretation, and that validity and reliability were not established, in the national study these descriptions served to provide the trends that had been expected in terms of the stated hypotheses. There appeared to be a high level of consensus between respondents in the Children's Homes sample, despite the bias anticipated.

7.1.1.3 Research Design

A fundamental aspect of the design of the study, which limits the information which it provides, is the fact that the subject group is really the institution, rather than the individual child in the institution. For this reason the results can only be interpreted in terms of the relative percentages of the categories in question. One cannot say anything about, for example, the relationship between age and behaviour disturbance or gender and behaviour, since the information supplied does not refer to individual children, but to the population of the institution. Should a Children's Home have a high percentage of adolescent boys and a high percentage of behaviour problems, there would be other variables that could possibly account for this (style of

building, treatment programme) and no way of establishing a direct link between teenage boys and problem behaviour. This not only limits extent to which the data can be interpreted, but also limits the accessibility of the data to statistical analysis. For this reason, one can only analyse the variance between groups in terms of percentages of children, rather than numbers of children.

Whilst future research is indicated in order to obtain more detailed information, the aims of the present study were to obtain demographic information about the various places of care in South Africa and this purpose was achieved.

7.2 Indications for Future Research

Residential child care in South Africa is in a state of transition, and demographic studies such as this one would be invaluable in order to keep abreast of all the changes. Whilst the variables explored in this study (age, race, behaviour) will continue to be of interest in assessing the impact of the many sociocultural changes in South Africa, future studies would benefit from more in-depth information regarding individual children, particularly:

* réason for placement;
* age at the time of placement;
* length of stay;
* prognosis for return to the community;
* treatment needs.

These factors would indicate the impact of sociocultural variables upon children and families resulting in the need for substitute care, and would also assist child care practitioners in providing an appropriate service.

A valuable contribution to the field would be a study to develop a reliable and valid instrument for the classification of children in residential care.

Of particular interest for future research, is the group of children that have been termed 'category B' children in the present study. Further research is needed to clarify the demographic characteristics of these children (age, sex, race), to identify common factors pertaining to their placement in care (reason for placement, length of stay, treatment programme), and to delineate problems that are characteristic of this group. Such research would further our understanding of those children in residential care who manifest severe psychological problems, would clarify risk and protective factors and would provide direction for treatment intervention.

Despite the stated limitations of the study, the descriptive behavioural categories proved to be an effective means of discriminating between groups of children living in residential care. For the purposes of future research some of the problems in the reliability of subjective evaluations may be counteracted in the research design, by the following procedures:

1. by clearly identifying the behaviour that is to be rated in the form of an observation checklist, and by making that which is to be observed countable.

2. by requiring more than one respondent to rate the behaviour.

3. by training respondents regarding the criteria under assessment and the observations required.

(Dixon et al., 1987)

Problems of non-response may be reduced if the aspect of confidentiality is stressed in the covering letter. Other strategies which might have been employed to raise response rates, include pre-survey contact with members of the sample, reminder letters or telephone calls to recipients who had not yet returned the questionnaire, and incentives (Hoinville et al., 1977).

There appeared to be some difficulties in the terminology used

in the questionnaire, which were only realised retrospectively and which would be useful for future researchers to bear in mind. Careful attention should be paid to clarifying the different levels of meaning of 'children in residence' as this applies to child care facilities (see Questionnaire, Appendix B). Respondents commented on their returns that they were unsure whether to answer in terms of:

1. the maximum number of children that the facility could accommodate in terms of the State registration;
2. the actual number of children in residence; or
3. the number of children physically present, in view of the fact that amongst Reform Schools and Child Care Schools many of the children who were registered there had absconded at the time the questionnaire was completed.

If this aspect is explained more clearly some useful additional information could be analysed, and in particular, the extent to which the present facilities are either under-utilised or inadequate, and the associated distributions. At the time of the research many White facilities were anxious about empty bed-spaces, whilst all Black facilities were full beyond their capacity. Such information would provide a sound rationale for integrating facilities for the benefit of all race groups.

7.3 Recommendations for Future Practice

The present study has served to confirm the dilemma facing child care practitioners in South Africa; the difficulty in providing for a diverse range of developmental and treatment needs under one roof.

In considering the significant age and behaviour trends, child care practitioners need to carefully evaluate the developmental needs of their residents and revise their services accordingly; and in particular the needs of the following groups:

1. **The Pre-school group**: There is a growing trend towards a greater number of infants and toddlers in residential care, particularly amongst Black children and it would be safe to predict that the number of preschool children (0-2 years; 3-5 years) requiring residential care may increase over the next few years. This age group already comprises 27% of children living in Black Children's Homes, and with the increase in HIV/Aids orphans and the lack of foster care facilities, preschool children entering care are more likely to need long-term placement.

   The review of the literature pertaining to the problems of childhood serves to caution against the placement of children under the age of five in residential care. In the case of children of this age group coming into care, every possible alternative placement should be explored. If there is no other alternative, then child care practitioners must acquaint themselves with the growing body of literature clarifying the environmental and intrapersonal factors that mediate risk in young children (see Chapter Three). These factors are priorities when programming for young children living in institutions.

2. **The Adolescent group**: The difficulty facing reconstruction agencies and foster care services in providing permanent placement, is the compounded by the fact that 60% of children living in Children's Homes are in their adolescent years. This trend is supported in the literature emerging from Britain and America where programmes are specifically designed for 'youth' (Brendtro et al., 1990; Beker and Eisikovits, 1991). In South Africa policy, procedures and programmes need to ensure that these children have the opportunity to achieve the normal tasks of this stage of development: i.e. affiliation with peers; participation in decision-making and goal-setting; responsibility; experiencing

the natural and logical consequences of their actions (Waterhouse, 1989a; Brendtro et al., 1990).

It is well known that few families apply to foster teenagers, and a number of factors reduce the likelihood of adolescents returning their families. Parents who have experienced difficulty in raising their children may be daunted at the prospect of receiving their teenage children back into their homes. Reconstruction workers tend to hesitate to recommend the return of a teenager who may destabilise the family. Teenagers themselves are often unwilling to risk the possible upheaval of a change in placement, and may, in fact enjoy the peer group camaraderie that exists in the children's home. In many ways the residential care facility is the 'placement of choice' for adolescents.

The goals set with adolescents should not involve raising hopes of family reunification which, if they were to materialise (Kadushin and Martin, 1988), may be more likely to fail with this age group. The primary goals of treatment programming should be self-worth, building lasting friendships and consolidating skills and interests for independent living.

3. **The 'Holding' Group:** ±50% of children living in residential care are needing a family living experience. Waterhouse (1989 a) cautions against the use of terminology that implies 'waiting' for something better to happen and a consequent sense of living 'on hold'. In view of the difficulties of securing lasting community placements for the majority of these children, many will remain in care for the duration of their education and until they become independent (see Chapter Three). Possible feelings of failure amongst these children because they are still in care, should be counteracted with status and privileges in recognition of the

responsibility they have shown through their good behaviour. Child care practitioners need to focus on positive, active programmes preparing these children for future independent living. At a time in South Africa when many child care workers equate training and professional status with 'treatment', the present study indicates that physical nurturing, routine activities and the teaching of life skills are the most appropriate forms of intervention with half of the children living in residential care.

Considering the needs of this group, it seems logical that facilities approximating family units are the optimum choice for at least half the children in care for whom residential care remains the 'permanent plan'.

4. The **'Disturbed'** Group: Approximately one in ten of the children living in children's homes require containment and intensive treatment for reasons of anti-social behaviour or psychiatric disturbance. Until such time that substitute care facilities specialising in psychiatric treatment are established in South Africa, these children will continue to live in Children's Homes. Where these children remain in Children's Homes, they dominate the time and attention of child care practitioners, to the detriment of those children in need of treatment and socialisation. This explains why many children without behaviour problems develop secondary symptoms associated with long term institutional care: low self esteem, lack of motivation and initiative, poor life skills, inadequate socialisation.

   The directors of residential care programmes are faced with one of two alternatives:

   1. Either to attempt to meet the treatment needs of this group - a costly exercise in terms of professional services and staff-child ratios; or

2. Revise their admission criteria so as to exclude problem children from their programmes.

In the absence of any state finance for the position of a psychologist or for higher staff-child ratios, rather than compromise their overall programme most Children's Homes have opted for the second alternative. Consequently in the absence of a more appropriate, resource, many troubled children are placed in Industrial Schools (Child Care Schools) alongside their delinquent and conduct disordered peers, where secondary contamination is likely compound their problems (Kadushin and Martin, 1988).

Advocacy at State level is needed in order to try to resolve these difficulties. Firstly, if State financial aid to indigent families increased, reconstruction would be a viable alternative for those families where poverty had motivated the removal. This would allow more 'category D' children to return home.

Secondly, the lack of residential mental health facilities for children is an issue which requires State intervention. This need applies to the 10% of children in Children's Homes needing specialised intensive treatment and containment, but also to the 18% of children needing assessment. The Department of Health and Population Development Committee of Enquiry into Child Mental Health Services for Children (1988) was established for this purpose. There are no easy solutions, and at a time when the State is endeavouring to reduce welfare expenditure, existing services will be required to meet this need.

There is clearly a need for Children's Homes to become equipped to offer a range of services including treatment and assessment. Considering the diverse needs of children in their care, Children's Homes are faced with three possible

alternatives:

1. To continue trying to meet the needs of all children in one facility;
2. To specialise in one or more of the identified functions: containment, assessment, treatment or community-based living, and restrict admissions accordingly;
3. For Children's Homes within a geographical area to work in cooperation with one another in providing a 'continuum of care'.

The advantages and disadvantages of each of these possibilities were considered in response to the outcome of the pilot study (see Chapter Five). The Pietermaritzburg Children's Homes took the decision to consolidate their resources and provide specialised living environments suited to the specific needs of each of the groups investigated. A single management team, staff structure and registration would allow the children to move between the specialist homes in accordance with their changing needs.

Other Children's Homes are encouraged to pursue this solution towards providing for the distinctive individual needs of children in residential care, in view of the financial advantages, the benefits for the children and for the personnel (see Chapter Five). A single homes administration can also incorporate Children's Homes registered to care for children of'other' race groups, thereby making a positive move towards breaking down the barriers of racial differentiation in welfare practice, and sharing resources for the benefit of all children

The preparation of children in residential care to become competent adults of the future, involves the development of individual treatment programmes and differential placement. By combining resources and offering specialised programmes, Children's Homes are able to maximise all resources towards this end.

CONCLUSION

The present dissertation provides an outline of the nature, scope and limitations of residential child care as a field of study and practice, with particular reference to the South African context. The present researcher believes that clinical psychologists have a valuable contribution to make towards generating an understanding of children in residential care and towards differential planning and placement.

Very little research and literature exists regarding children living in residential care in South Africa. From a review of the literature it is evident that many of the British and American models of residential child care have limited applicability in the South African situation. The study was undertaken with the aim of providing recommendations for appropriate residential care services to children in South Africa, particularly in the area of differential planning and placement.

Differential planning depends upon differential assessment of the population group. The postal survey was designed to clarify the distribution of developmental and treatment needs among children presently living in residential care in South Africa. Whilst acknowledging the limitations in the design of the study, the results obtained suggest that descriptive behavioural categories are an effective way of discriminating between groups of children with different treatment needs. The age categories used identified significant trends in the distribution of developmental needs amongst children living in residential care.

The results offer encouragement for further research in this area. At the present time there are rapid changes in State

welfare policy and in residential care. In order to assess the impact of these changes in the social context on the population of children in residential care, demographic studies should be updated regularly.

Although legislation and social welfare policy in South Africa have endorsed the concept of permanency planning, the outcome of the present study emphasises the need to retain the Children's Home: as a 'permanent plan' for those children who have no where else to go (50% of the group surveyed); and as a 'placement of choice' for children requiring containment, assessment and treatment.

The recommendations arising from this study indicate the need for differential planning or 'programming' on two levels: on an individual level, in facilitating the child's progress through the process of assessment, treatment and preparation for independence; and on an institutional level, in expanding the use of the institution as a specialised resource, rather than as an undifferentiated facility.

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PIETERMARITZBURG
CHILDREN'S HOMES / KINDERHUISE

PO Box 949 Pietermaritzburg 3200 Rep of South Africa
Phone 423214 (0331)

8 March 1989

Dear Colleague,

Research into Categories of Children presently in Residential Care in South Africa.

In October 1988, representatives of the staff and committees of children's homes in Pietermaritzburg met together with NACCW representatives to discuss a proposal for the rationalisation of Child Care Services in Pietermaritzburg.

An initial task is to attempt to "categorise children in terms of their needs (physical, environmental, psychological & social). We have devised four broad categories as described in the questionnaire.
Briefly stated these are;
A: Children needing urgent care and observation.
B: Children needing containment/management.
C: Children involved in intensive individual programmes as part of their treatment.
D: Children ready to return to the community.

With a view to clarifying the types of problems in children which would require each of the above treatment alternatives, we are writing to children's homes in South Africa' requesting that they assist us with information from their own practise.

Please consider each category of child as we have described them and provide us with the numbers of children in each category who were resident in your institution on 28 February 1989.

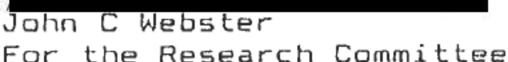
We fully understand the practical and ethical problems in this categorising children. However please be assured that our intentions are aimed at improving the Child Care service we offer and our published results will clarify our objectives.

Any comment outside of the questionnaire you wish to make will be gladly received.

Details of this research will be presented at the NACCW National Conference in Capetown during September 1989. Please return your completed questionnaire in the envelope provided before 31 March 1989.

Thank you for your assistance in this research.

Yours faithfully



John C Webster
For the Research Committee

Pietermaritzburg Children's Homes represents Staff members of
IB Child & Family Welfare Society, Hilltops Children's Home and Mary Cook Children's Home

rch Questionnaire "Categories of Children in Residential Care"
rmation as at 28 February 1989)

me of Institution ______________________
ddress ______________________ ______________________
ity ______________________ Code ______
hone No. ______________________

pe of Institution (Tick where appropriate)
Place of Safety __ Children's Home __ Child Care School __
Other (Please Specify) ______________________

pe of Building (Tick where appropriate)
Dormitory __ Block __ Cottage __ Off Campus Homes __

entifying Details

Population Group; Black __ Coloured __ Indian __ White __

Language (Specify) ______________________

Registered for; Both Sexes __ Boys __ Girls __ Total Number _____

Ages Registered for __-__
Number of children in each age group (as at 28 February 1989)
Boys 0-2 __ 3-5 __ 6-12 __ 13-18 __ 18+ __ Total ___
Girls 0-2 __ 3-5 __ 6-12 __ 13-18 __ 18+ __ Total ___

tegories of Children (Total number of children in each category)

Category A Children recently admitted from chaotic family backgrounds for whom treatment goals need to be established.Children requiring short-term management, care and observation.Children requiring emergency shelter.
Number of Children ___

Category B Children who are disturbed in their behaviour to such an extent that it is difficult to implement treatment programmes. Treatment is therefore primarily aimed at intensive behaviour management and containment (eg absconding, drug abuse, destructive and aggressive behaviour, psychiatric disturbance, sexual acting out)
Number of Children ___

Category C Children who are participating in specific treatment programmes and requiring professional services (eg Psychologist, Remedial Teacher). Intensive reconstruction services to family are important in terms of permanent planning.
Number of Children ___

Category D The "Holding Group". Those children ready to experience close family living, and who would be socially and emotionally able to enter their own or foster family if such were available.
Number of Children ___

me of person completing the questionnaire ______________________
sition in the organisation ______________________

gnature ______________________ Date ______________________

f you wish to add further comments please use the back of this form.

TABLE 11: ANALYSIS OF VARIANCE. ALL CASES: TYPE OF INSTITUTION: BEHAVIOUR CATEGORY

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT*A* PERCENT OF CHILDREN RECENT, CHAOTIC, ETC
BY TYPE*OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE*OF	5813.235	2	2906.618	4.875	.011
Residual	33385.955	56	596.178		
Total	39199.190	58	675.848		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT*B* PERCENT OF CHILDREN, DISTURBED BEHAVIOUR
BY TYPE*OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE*OF	4334.617	2	2167.308	6.624	.003
Residual	18322.386	56	327.185		
Total	22657.002	58	390.638		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT*C* PERCENT OF CHILDREN IN TREATMNT PROGRAMS
BY TYPE*OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE*OF	1632.461	2	816.230	1.499	.232
Residual	30496.513	56	544.581		
Total	32128.973	58	553.948		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT*D* PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY TYPE*OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE*OF	10896.473	2	5448.236	7.741	.001
Residual	39411.764	56	703.782		
Total	50308.237	58	867.383		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

TABLE 13: ANALYSIS OF VARIANCE. ALL CHILDREN'S HOMES: RACE GROUP: BEHAVIOUR CATEGORY

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#A# PERCENT OF CHILDREN RECENT, CHAOTIC, ETC
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	3560.431	5	712.086	1.349	.262
Residual	22698.085	43	527.862		
Total	26258.516	48	547.052		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#B# PERCENT OF CHILDREN, DISTURBED BEHAVIOUR
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	3845.953	5	769.191	5.389	.001
Residual	6137.610	43	142.735		
Total	9983.563	48	207.991		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#C# PERCENT OF CHILDREN IN TREATMNT PROGRAMS
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	2573.957	5	514.791	1.219	.317
Residual	18154.001	43	422.186		
Total	20727.958	48	431.832		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#D# PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	10388.526	5	2077.705	3.196	.015
Residual	27952.257	43	650.052		
Total	38340.783	48	798.766		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

TABLE 15: ANALYSIS OF VARIANCE. ALL CHILDREN'S HOMES: SEXES IN RESIDENCE: BEHAVIOUR CATEGORY

*** ANALYSIS OF VARIANCE ***
CAT*A* PERCENT OF CHILDREN RECENT, CHAOTIC, ETC
BY SEXES

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SEXES	5064.074	2	2532.037	5.495	.007
Residual	21194.442	46	460.749		
Total	26258.516	48	547.052		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

*** ANALYSIS OF VARIANCE ***
CAT*B* PERCENT OF CHILDREN, DISTURBED BEHAVIOUR
BY SEXES

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SEXES	565.846	2	282.923	1.382	.261
Residual	9417.718	46	204.733		
Total	9983.563	48	207.991		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

*** ANALYSIS OF VARIANCE ***
CAT*C* PERCENT OF CHILDREN IN TREATMNT PROGRAMS
BY SEXES

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SEXES	793.587	2	396.793	.916	.407
Residual	19934.371	46	433.356		
Total	20727.958	48	431.832		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

*** ANALYSIS OF VARIANCE ***
CAT*D* PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY SEXES

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SEXES	5115.176	2	2557.588	3.541	.037
Residual	33225.606	46	722.296		
Total	38340.783	48	798.766		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

TABLE 17: ANALYSIS OF VARIANCE. ALL WHITE CHILDREN'S HOMES: BUILDING DESIGN: BEHAVIOUR CATEGORY

*** CELL MEANS ***
CAT#D# PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY BUILDING
TOTAL POPULATION
47.74
(28)
BUILDING

1	2	3
40.54	39.84	59.64
(5)	(12)	(11)

*** ANALYSIS OF VARIANCE ***
CAT#A# PERCENT OF CHILDREN RECENT, CHAOTIC, ETC
BY BUILDING

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
BUILDING	1777.356	2	888.678	1.542	.234
Residual	14406.971	25	576.279		
Total	16184.326	27	599.419		

32 Cases were processed.
4 Cases (12.5 PCT) were missing.

*** ANALYSIS OF VARIANCE ***
CAT#B# PERCENT OF CHILDREN, DISTURBED BEHAVIOUR
BY BUILDING

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
BUILDING	298.082	2	149.041	3.230	.057
Residual	1153.425	25	46.137		
Total	1451.506	27	53.759		

32 Cases were processed.
4 Cases (12.5 PCT) were missing.

*** ANALYSIS OF VARIANCE ***
CAT#C# PERCENT OF CHILDREN IN TREATMNT PROGRAMS
BY BUILDING

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
BUILDING	237.894	2	118.947	.291	.750
Residual	10201.670	25	408.067		
Total	10439.564	27	386.651		

32 Cases were processed.
4 Cases (12.5 PCT) were missing.

*** ANALYSIS OF VARIANCE ***
CAT#D# PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY BUILDING

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
BUILDING	2564.023	2	1282.012	2.063	.148
Residual	15532.690	25	621.308		
Total	18096.714	27	670.249		

32 Cases were processed.
4 Cases (12.5 PCT) were missing.

TABLE 19: ANALYSIS OF VARIANCE. ALL WHITE CHILDREN'S HOMES: LANGUAGE: BEHAVIOUR CATEGORY

* * * A N A L Y S I S O F V A R I A N C E * * *
CAT#A# PERCENT OF CHILDREN RECENT, CHAOTIC, ETC
BY LANGUAGE

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
LANGUAGE	156.667	2	78.333	.134	.875
Residual	16939.606	29	584.124		
Total	17096.273	31	551.493		

32 Cases were processed.
0 Cases (.0 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
CAT#B# PERCENT OF CHILDREN, DISTURBED BEHAVIOUR
BY LANGUAGE

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
LANGUAGE	377.099	2	188.550	2.663	.087
Residual	2053.354	29	70.805		
Total	2430.453	31	78.402		

32 Cases were processed.
0 Cases (.0 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
CAT#C# PERCENT OF CHILDREN IN TREATMNT PROGRAMS
BY LANGUAGE

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
LANGUAGE	713.306	2	356.653	.641	.534
Residual	16127.732	29	556.129		
Total	16841.039	31	543.259		

32 Cases were processed.
0 Cases (.0 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
CAT#D# PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY LANGUAGE

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
LANGUAGE	303.794	2	151.897	.189	.829
Residual	23266.336	29	802.287		
Total	23570.130	31	760.327		

32 Cases were processed.
0 Cases (.0 PCT) were missing.

TABLE 21: ANALYSIS OF VARIANCE. ALL CASES: TYPE OF INSTITUTION: AGE CATEGORY

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL1# PERCENTAGE OF CHILDREN, 0-2 YEARS
BY TYPE#OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE#OF	91.240	2	45.620	1.207	.307
Residual	2079.374	55	37.807		
Total	2170.614	57	38.081		

67 Cases were processed.
9 Cases (13.4 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL2# PERCENTAGE OF CHILDREN, 3-5 YEARS
BY TYPE#OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE#OF	655.723	2	327.862	2.176	.123
Residual	8286.398	55	150.662		
Total	8942.122	57	156.879		

67 Cases were processed.
9 Cases (13.4 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL3# PERCENTAGE OF CHILDREN, 6-12 YEARS
BY TYPE#OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE#OF	4159.460	2	2079.730	7.364	.001
Residual	15532.532	55	282.410		
Total	19691.992	57	345.474		

67 Cases were processed.
9 Cases (13.4 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL4# PERCENTAGE OF CHILDREN, 13-18 YEARS
BY TYPE#OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE#OF	5468.022	2	2734.011	4.677	.013
Residual	32148.976	55	584.527		
Total	37616.998	57	659.947		

67 Cases were processed.
9 Cases (13.4 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL5# PERCENTAGE OF CHILDREN, 18+ YEARS
BY TYPE#OF

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
TYPE#OF	265.627	2	132.813	1.313	.277
Residual	5564.107	55	101.166		
Total	5829.734	57	102.276		

67 Cases were processed.
9 Cases (13.4 PCT) were missing.

TABLE 23: ANALYSIS OF VARIANCE. ALL CHILDREN'S HOMES: RACE GROUP: AGE CATEGORY

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL1# PERCENTAGE OF CHILDREN, 0-2 YEARS
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	1015.459	5	203.092	8.790	.000
Residual	993.494	43	23.105		
Total	2008.952	48	41.853		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL2# PERCENTAGE OF CHILDREN, 3-5 YEARS
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	2227.317	5	445.463	3.495	.010
Residual	5480.277	43	127.448		
Total	7707.594	48	160.575		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL3# PERCENTAGE OF CHILDREN, 6-12 YEARS
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	1717.789	5	343.558	1.248	.304
Residual	11837.282	43	275.286		
Total	13555.070	48	282.397		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL4# PERCENTAGE OF CHILDREN, 13-18 YEARS
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	8479.505	5	1695.901	4.004	.005
Residual	18211.398	43	423.521		
Total	26690.903	48	556.060		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

* * * A N A L Y S I S O F V A R I A N C E * * *
BOYGRL5# PERCENTAGE OF CHILDREN, 18+ YEARS
BY RACE#GRP

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
RACE#GRP	162.515	5	32.503	.292	.915
Residual	4790.424	43	111.405		
Total	4952.940	48	103.186		

49 Cases were processed.
0 Cases (.0 PCT) were missing.

TABLE 25: ANALYSIS OF VARIANCE. ALL CASES: SIGNER: BEHAVIOUR CATEGORY

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT#A# PERCENT OF CHILDREN RECENT, CHAOTIC, ETC
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	3356.612	3	1118.871	1.677	.182
Residual	36685.668	55	667.012		
Total	40042.280	58	690.384		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT#B# PERCENT OF CHILDREN, DISTURBED BEHAVIOUR
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	4229.134	3	1409.711	4.120	.010
Residual	18819.376	55	342.170		
Total	23048.510	58	397.388		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT#C# PERCENT OF CHILDREN IN TREATMNT PROGRAMS
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	1577.075	3	525.692	.859	.468
Residual	33660.040	55	612.001		
Total	35237.115	58	607.536		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

* * * A N A L Y S I S   O F   V A R I A N C E * * *
CAT#D# PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	3399.241	3	1133.080	1.211	.314
Residual	51441.020	55	935.291		
Total	54840.261	58	945.522		

67 Cases were processed.
8 Cases (11.9 PCT) were missing.

TABLE 27: ANALYSIS OF VARIANCE. ALL CHILDREN'S HOMES: SIGNER: BEHAVIOUR CATEGORY

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#A# PERCENT OF CHILDREN RECENT, CHAOTIC, ETC
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	131.126	2	65.563	.110	.896
Residual	25696.455	43	597.592		
Total	25827.582	45	573.946		

49 Cases were processed.
3 Cases (6.1 PCT) were missing.

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#B# PERCENT OF CHILDREN, DISTURBED BEHAVIOUR
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	59.549	2	29.774	.132	.876
Residual	9667.535	43	224.826		
Total	9727.084	45	216.157		

49 Cases were processed.
3 Cases (6.1 PCT) were missing.

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#C# PERCENT OF CHILDREN IN TREATMNT PROGRAMS
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	687.267	2	343.634	.740	.483
Residual	19955.610	43	464.084		
Total	20642.877	45	458.731		

49 Cases were processed.
3 Cases (6.1 PCT) were missing.

*** A N A L Y S I S   O F   V A R I A N C E ***
CAT#D# PERCENT OF CHILDREN, HOLDING GROUP, ETC.
BY SIGNER

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif of F
SIGNER	1129.861	2	564.930	.665	.519
Residual	36525.866	43	849.439		
Total	37655.727	45	836.794		

49 Cases were processed.
3 Cases (6.1 PCT) were missing.