Managing Children
With Mental Health Disorders
In Child and Youth Care Centres

By

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Acknowledgements

First and foremost I thank the Lord for his Guidance and Presence in completing this research study. His Hand can be seen in this report.

Secondly I thank my parents, Willie en Renette Allers. Dad and Mom; thank you for the upmost patience, tolerance and support you had and provided to me night after night and day after day. Thank you for believing in me. It means more to me than you could ever imagine. I love you guys!

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I would not have been able to complete this study without the assistance of the Lord and the mentioned people.

Thank you.
Opsomming

'n Geestesgesonde kind ontwikkel op sielkundige, emosionele, kreatiewe, intellektuele en geestelike vlak (Dwivedi & Harper, 2004). Daarom is die navorser van mening dat die geestesgesondheid van kinders 'n integrale deel van hulle suksesvolle ontwikkeling uitmaak. Dit blyk egter dat daar sekere uitdagings aan verbonde is om in die behoeftes van kinders met probleme in terme van hulle geestesgesondheid te voldoen. Dikwels as gevolg van 'n tekort aan vaardighede, toon kinderversorgers, maatskaplike werkers en ander personeel van kinder- en jeugsorgsentra 'n basiese tekort aan kennis en hulpmiddels om kinders in hulle sorg wat met geestesgesondheidsprobleme presenteer, voldoende te versorg.

Hierdie studie ondersoek die geïdentifiseerde leemte in dienslewering en wat daaraan gedoen kan word. Dit poog om die kenmerke van 'n kind met 'n geestesgesondheidsprobleem te beskryf, vas te stel watter behoeftes daar bestaan en te identifiseer watter riglyne daar bestaan om in hierdie behoeftes te kan voorsien. In die nagaan van hierdie riglyne word die rolle van verskillende rolspelers op verskillende ekosystemiese vlakke ondersoek. Hierdie ondersoek word ondernem deur slegs van kwalitatiewe navorsingsmetodes gebruik te maak.

'n Literatuurstudie ondersoek heel eerste relevante literatuur op maatskaplike werk, geestesgesonde, psigiatriese en wetgewende gebied. Tweedens word fokusgroepes geloods met sleutelrolspelers wat werk met kinders met geestesgesondheidsprobleme. Hierdie twee bronne voorsien die navorser van inligting met betrekking tot die doel en doelwitte van hierdie studie.

Die hoofdoel van hierdie studie is om 'n bestuursprogram daar te stel vir hoofstroom- en gespesialiseerde kinder- en jeugsorgsentra, oor hoe om optimaal vir kinders met geestesgesondheidsprobleme te kan sorg. Wanneer hierdie doel bereik word, behoort dit 'n besondere bydrae te kan lewer op die gebied van maatskaplike sorg aan kinders. Nie alleen kan so 'n program 'n rol speel in die bevordering van die geestesgesondheid van kinders in kinder- en jeugsorgsentrums nie, maar dit kan ook die basis verskaf vir verdere ontwikkeling in hierdie verband.
Abstract

A child that is mentally healthy develops psychologically, emotionally, creatively, intellectually and spiritually (Dwivedi & Harper, 2004). Therefore the researcher is of the opinion that the mental health of children is integral in successful development. It was however observed that there are challenges associated with providing for the needs of children with mental health problems. Often attributed to a lack of knowledge, child care workers, social workers and other staff appear to not have the necessary skills, knowledge and resources to deal appropriately with children with mental health problems in child and youth care centres.

This study therefore investigates the identified gap in service delivery, and what could be done to minimise it. It attempts to explore the characteristics of a child with a mental health problem, what their emanating needs are, and what guidelines exist that may help to provide for the identified needs. In exploring these guidelines, the roles of different role-players involved on different ecosystemic levels, are also explored. This exploration is conducted by utilising qualitative research methods only. A literature study firstly explores relevant social work, mental health, psychiatric and legislative literature. Secondly, focus groups are conducted with key role-players that work with children with mental health problems. These two sources provide the researcher with information pertaining to the objectives and goal of this research study.

The ultimate goal of this study is to provide a management programme to mainstream and specialised child and youth care centres, on how to care optimally for children with mental health problems. When this goal is achieved, the field of social work amid children will benefit tremendously. Not only can such a programme assist in the enhancement of the mental health of children in child and youth care centres, but it may provide the foundation for future development in this
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One in five South Africans suffer from a mental disorder severe enough to affect their lives significantly. Roughly 25% of all general practitioners’ patients are ill due to psychiatric rather than general medical conditions. Nevertheless, thousands of South Africans would rather die than admit that they suffer from some sort of mental illness. One of the greatest obstacles to preventing mental illness, and improving services and treatment, is ignorance (http://www.scienceinafrica.co.za).

Chapter 1
Motivation for the study

1.1. Introduction:

Close observation of children with mental health disorders in a residential care setting in South Africa, led the researcher to become acutely aware of the challenges associated with providing for these children’s needs, and consequently managing their behaviour. Further preliminary research on these challenges at a local forum for residential facilities (Children’s Home Forum, 2008), confirmed that most role-players in child and youth care centres face similar challenges. Often attributed to a lack of knowledge, child care workers, social workers and other staff appear to not have the necessary skills, knowledge and resources to deal appropriately with children with mental health problems in child and youth care centres.

A gap in service delivery was identified when specific programmes addressing the needs of children with mental health problems in child and youth care centres couldn’t be found. The White Paper for Social Welfare (1997), states that services to youth in care facilities are to be rendered by the Government, private institutions and non-governmental providers of services. Kibel and Wagstaff (2001), are however of the opinion that child mental health services are amongst the most underdeveloped, due in large part to the low status offered to women, children and mental health issues, and to the late development of the discipline of Social Work.

According to Dwivedi and Harper (2004), the absence of mental health service models for vulnerable children and young people has been noted by other studies.
Service deficits are related to a number of factors, particularly the mobility of vulnerable children, and their lack of family and social stability, which result in poor access to and engagement with generic child and adolescent mental health services.

To be able to study and describe the above mentioned gap in social services, and the problem of ignorance from staff of child and youth care centres (related to the unidentified and consequent unmet needs of children with mental health problems), this study aims (in terms of the ecosystemic approach), to answer four main research questions:

- What are the characteristics of a child with a mental health problem?
- What are the emanating needs of children with a mental health problem?
- What guidelines exist that may help to provide for the identified needs?
- In what way can child and youth care centres be equipped and what guidelines (in the form of a programme) can be put in place in order to provide for these needs?

This chapter provides an introduction to the abovementioned study. Aspects pertaining information regarding the study will be discussed hereunder.

1.2. Motivation for the study:

This study is motivated by the abovementioned gap in service delivery, for individual children with mental health problems residing in child and youth care centres. After close observation in a residential facility, the researcher noticed that the children with mental health problems concerned present with:

- physical challenges – mostly neurological;
- cognitive challenges – regarding education;
- psychosocial challenges – generally not socialising well with biological parents, child care workers and peers in the home.

The researcher became aware that it is the environment (child and youth care centre), in which the child resides, that seems to not provide adequately for the child’s needs, that may be the cause of these challenges. Seeing that the
environment and the systems involved in the environment are the cause for concern, a theory relevant to a systemic approach (with a subdivision of a person-in-environment fit), is consequently the foundation for the conducting of this research study.

The individual child with a mental health problem finds him/herself at the centre of all systems embedded in the larger environment of a child and youth care centre. All these systems affect the way in which the individual will cope with challenging situations and adapt in a residential facility.

Seeing that no specific programmes could be found that identify or address the needs of children with mental health problems in a child and youth care centre, the researcher was motivated to conduct a research study on the micro, meso, exo and macro levels applicable to the children concerned. Such a study could identify ecosystemic guidelines to be implemented in a child and youth care centre. These guidelines may assist in improved coping, adaptation and, more than that, mental health of the children concerned.

1.3. Goal and objectives of the study:

Based on the need for guidelines which may assist in improving the mental health of the children concerned in child and youth care centres, the goal of this research study was formulated as follows: To provide a management programme – summarising plans which contain guidelines to be conducted in a specific manner (Odendal, Schoonees, Swanepoel, DuToit & Boysen, 2004) – to mainstream and specialised child and youth care centres, on how to care optimally for children with mental disorders.

Objectives that have to be reached before guidelines for a programme could be summarised, are as follow:

- To explore and reach a full understanding of the characteristics and needs of a child with a mental health problem by means of a comprehensive literature study.
• To conclude the above understanding with the help of opinions from certain key role-players in residential facilities about the said needs and guidelines on managing children with mental health problems.
• To formulate a range of guidelines based on the information gained from the above two phases.

Note that the above goal and objectives are executed through use of the ecosystemic approach.

1.4. Definition of terms:

For the purposes of this study, the following terms are identified:

1.4.1. Mental illnesses & mental health:

The term mental illness refers collectively to all diagnosable mental disorders. The U.S. Surgeon General (1999) states that mental disorders are health conditions that are characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning. Mental health disorders are varied and involve both chronic conditions and short term episodes. These disorders interfere with daily functioning, such as education and employment (Dumaine, 2003).

Mental disorders are diagnosed through the use of the Diagnostic and Statistical Manual (DSM-IV). “The DSM-IV is designed as a multi-axial scheme. Its axes are as follows:

I. Clinical disorders and other conditions that may be a focus of clinical attention.
II. Personality disorders.
III. General medical conditions.
IV. Psychosocial and environmental problems.
V. Global assessment of functioning” (Barker, 2004, p. 17).
Because of the enormous amount of mental disorders classified in the DSM, it is impossible to focus on each individually. Therefore this study focuses on categories of mental health disorders usually presenting in children in child and youth care centres.

The development of effective ecosystemic guidelines to provide for the needs of children with one or more of these mental health problems, may assist in improving their mental health. Mental health refers to the total well-being of an individual. This includes physical and psychological health as well as healthy social functioning (The White Paper, 1997). The US Surgeon General (1999) further states that mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity.

The importance of a mentally healthy child is highlighted by Dwivedi and Harper, (2004, p. 17) “Children who are mentally healthy will have the ability to:

- develop psychologically, emotionally, creatively, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships;
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and learn;
- develop a sense of right and wrong;
- face problems and setbacks and learn from them, in ways appropriate for that child’s age."

As this study is based on the ecosystemic perspective, the individual child with a mental health problem should not be the only focus though. The foundation theory of this study necessitates a look at the environment this child finds him/herself in as well. As mentioned, the environment is a child and youth care centre.
1.4.2. Child and youth care centres:

As seen above, the goal of this research study is to provide a management programme to *mainstream and specialised child and youth care centres*. Part of the problem identified by the researcher, is that it seems as though there are no child and youth care centres in Gauteng that specialises in the care of children with mental health problems. In other words, no specialised child and youth care centres could be found.

It seems as though all the child and youth care centres in Gauteng are mainstream facilities. In other words, they seem to not be specialised in terms of caring for children with mental health problems specifically.

Irrespectively, “a child and youth care centre is a facility for the provision of residential care to more than six children outside the child’s family environment in accordance with a residential care programme suited for the children in the facility. A child and youth care centre must offer a therapeutic programme designed for the residential care of children outside the family environment” (Children’s Act 38 of 2005). Unless specific definition is necessary, the researcher focuses on child and youth care centres in general throughout this study.

At the outset of the research, the researcher was not aware of what the reason is for not finding specific programmes addressing the needs of children with mental health problems in child and youth care centres. Is it because child and youth care centres do not pay attention to government legislation, or is it because the actual services are lacking.

It appears as if human resources and specialised professionals are for instance necessary to implement the services pertaining in management programmes for children with mental health problems. This study describes and suggests certain role-players to form part of service rendering in a residential facility, in terms of an ecosystemic perspective.
Krueger (2004) focused on systems and staff employed in child and youth care centres specifically. He states that child and youth care organisations are human systems whose success depends upon the ability of the people in all the systems connected with the agency, to participate in solving problems and in pursuing a set of common goals.

By providing ecosystemic guidelines, this study aims to equip role-players involved in the life of a child with a mental health problem with the necessary knowledge and skills to effectively care for them. As mentioned all these role-players fall into different ecosystemic levels, from where they are able to implement diverse ecosystemic guidelines. Amongst others, this is the reason for the majority of this study focusing on the ecosystemic perspective.

1.4.3. Theoretical base – Ecosystemic perspective:

The ecosystems approach builds on general systems theory and the ecological perspective (Segal, Gerdes & Steiner, 2007). Donald, Lazarus and Lolwana (2004) further define this perspective by stating that different levels of systems in the social context are seen to influence, and be influenced by one another in a continuous process of dynamic balance, tension and interplay. Systems and subsystems interact with other systems above, below, or next to them. In addition, each level of system has its own subsystems, which can be seen as functioning in particular ways.

The ecosystemic perspective serves two important tasks in this study:

I. The broad framework of systems/ecological approach allows for identifying all diverse, complex factors associated with a social welfare problem or an individual problem (Ambrosino, Hefferman, Shuttlesworth & Ambrosino, 2008). The researcher identified the problem as the unidentified and consequent unmet needs of children with mental health problems in a child and youth care centre. Within a typical ecosystems approach, this proves to cause even more problems on a physical, cognitive and psychosocial level.

II. Therefore Ambrosino, Hefferman, Shuttlesworth and Ambrosino (2008) state that it helps to understand how all factors interact to contribute to the situation, and determine an intervention strategy or strategies. This study utilises this
approach to identify the needs of a child, and to put guidelines in place on a micro, meso, exo and macro level, to provide for those needs.

The micro (biological parents, child care workers and peers), meso (social workers, teachers, therapists and other role-players), exo (legislation) and macro (broad environment – child and youth care centre), is studied by means of a literature review in the following chapter. For clarification purposes, the following terms are defined:

The Children’s Act 38 of 2005 states that a child is only a major upon the age of 18 years. With regards to this study, a specific focus is given to children with mental health problems in a child and youth care centre. A child with a mental health problem is a child seen as suffering from one or more mental health problems and/or disorders. The researcher refers to mental health problems as those behavioural problems a child presents with, that appear to be characteristic of a specific mental health disorder. These children haven’t necessarily been assessed and diagnosed with a specific disorder by an appropriate professional. The researcher sometimes refers to mental health disorders, and not problems, as some children might have been diagnosed with a specific disorder by the relevant professional.

A child, irrespective of his/her mental health status, should have someone caring for him/her. The Children’s Act 38 of 2005 states that a caregiver is any person other than a parent or guardian, who factually cares for a child and includes amongst others:

- A person who cares for a child with the implied or expressed consent of a parent/guardian. Consent from parents or guardians are not needed if a child is placed in a child and youth care centre with a valid court order.
- A person who cares for a child whilst the child is in temporary safe care. The researcher is of the opinion that a child care worker falls under this category.
- The person at the head of a child and youth care centre where a child has been placed.
A child and youth care worker who cares for a child who is without appropriate family care in the community.

According to the researcher’s observations, the child care worker is the main caregiver of a child in a child and youth care centre. Child care workers assume responsibility for the physical, emotional and educational care of a child. Therefore attention would be paid to these role-players. It is however important to note the involvement of biological parents, and the fact that child care workers can never replace a child’s biological parents.

The Children’s Act 38 of 2005 states that a parent is in relation to a child, including the adoptive parent of a child, but excludes:

- the biological father of a child conceived through the rape of or incest with the child’s mother;
- any person who is biologically related to the child’s mother;
- any person who is biologically related to a child by reason only of being a gamete donor for purposes of artificial fertilisation;
- a parent whose parental responsibilities and rights in respect of a child have been terminated.

Observations by the researcher proved that some of the children in residential care facilities’ biological parents are involved in their lives, and others not. When biological parents are involved, it is crucial for them to form part of interventions that will take place with regards to that child. The researcher feels that cooperation is necessary between all parties to act in the best interest of a child, and to improve his/her mental health.

1.5. Research methodology:

This research study is implemented by making use of descriptive qualitative research methods only. Firstly an in-depth literature review is conducted. According to Grinnell and Unrau (2005) a literature review intended for the goal as intended with this study, will firstly learn more about the scope of the problem, and secondly learn what
answers exist for general research questions. Therefore the researcher attempts to get answers to the following research questions:

- What are the characteristics of children with mental health problems?
- What are their care needs and what guidelines exist to provide for the identified needs?

The literature retrieval will also form the basis for the development of a questionnaire to be implemented with focus groups.

Non-probability sampling, specifically target sampling is used to get a sample of social workers and child care workers for the focus groups. De Vos, Strydom, Fouché and Delport (2005) state that target sampling is a purposeful, systematic method by which controlled lists of specified populations within geographical districts are developed and plans are developed to recruit adequate numbers of cases within each of the targets.

The researcher identifies which child and youth care centres in Gauteng have children with mental health problems. This is done through the use of controlled lists of child and youth care centres in Gauteng. Social workers and child care workers who work with children with mental health problems, consequently form part of the sample. Social workers employed at psychiatric hospitals in Gauteng are also invited to form part of the empirical study, as they can provide additional information on caring for and managing the needs of children with a mental health problem and/or disorder.

Focus groups are conducted with the social workers and child care workers in the sample. Focus groups produce data of interest to researchers. They produce qualitative data that provide insights into the attitudes, perceptions and opinions of participants. These results are solicited through open-ended questions (Krueger, 1994). The opinions of social workers and child care workers regarding the characteristics, care needs and guidelines to provide for these needs would thus be retrieved through implementation of the focus groups.
Because of time constraints and the nature of focus groups, social worker and child care worker groups will be run simultaneously. The researcher is of the opinion that the homogeneity of the group members will motivate them to share opinions.

Data collected from the focus groups is analysed consistent with recognised analysis methodology associated with thematic analysis. Further coding of the data should take place, which may necessitate changes in plan. Data is evaluated for usefulness and centrality. An external coder will be utilised to promote trustworthiness of analysis of data.

Information analysed and integrated from the literature review and focus groups, is utilised as a basis for the development of a proposed programme (research report). This proposed programme should contain guidelines on effective ecosystemic care that promotes coping, adaptation, and ultimately, the mental health of children with mental health problems in child and youth care centres.

1.6. Ethical considerations:

Confidentiality should be adhered to while conducting the research. According to the Code of Ethics for social workers, they should discuss with parties the nature of confidentiality (South African Council for Service Professions, n.d.). Names of children in child and youth care centres are not utilised in the report. The names of social workers and child care workers are not utilised either. Data collected is reported through making use of the child and youth care centre’s name.

Data collection has to be implemented with informed consent from respondents. Social workers and child care workers should have a good understanding of what they are consenting to while partaking in focus groups. Grinnell and Unrau (2005), state that consent is valid only when participants truly understand the nature of the research and evaluation activity, possible benefits and associated risks.

While implementing research, social diversity should be kept in mind. According to Grinnell and Unrau (2005, p. 36), social workers must ensure that their samples sufficiently represent – while methodologically appropriate and sound – diverse
groups and clientele. Studies based on narrowly drawn and culturally homogeneous samples are less likely to yield information consistent with social work’s ethical obligations to address issues of diversity and social justice. Therefore focus groups are conducted with diverse groups of social workers and child care workers.

No other ethical considerations are identified.

1.7. Contents of chapters:

Chapter one – Introduction to the study
This includes the motivation, the goals and objectives, the research methodology and ethical considerations of the study.

Chapter two – Literature review
The nature of the study necessitates an exploration of literature from a variety of disciplines, including social work, psychology, mental health, human rights studies and different theoretical perspectives. The literature studied is discussed in this chapter.

Chapter three – Research methodology
Research and sampling methods are discussed in this chapter.

Chapter four – Data analysis
Data collected during implementation of the research, is analysed and presented in this chapter.

Chapter five – Mental health problems – needs and guidelines
Data collected during implementation of a literature review and focus groups, are analysed further, integrated and presented as a framework to guide the development of a programme for mainstream and specialised child and youth care centres.

Chapter six - Conclusions and recommendations
Based on the above, conclusions and recommendations are made for future implementation of the developed guidelines.
1.8. Conclusion:

A gap in service delivery was identified when no specific programmes addressing developmental and mental health needs of children in child and youth care centres could be found. Therefore the researcher feels strongly that a programme should be developed that can provide for the needs of children with mental health problems. The goal of this programme should be to optimise the mental health of the children concerned.

Attention should be paid to what the characteristics of children with mental health problems are, what their care needs are, and what guidelines can be put in place to provide for these needs, by conducting a literature review. The literature review is conducted in terms of an ecosystemic approach, and is presented in the following chapter.
Chapter 2
Literature study

2.1.) Introduction:

A gap that was identified in social work service delivery was mentioned in the first chapter. This gap has to do with specific programmes addressing the needs of children with mental health problems and/or disorders in child and youth care centres. This gap motivated the researcher to study the characteristics and emanating needs of children with mental health problems in child and youth care centres. The researcher is of the opinion that a programme should be developed that contains ecosystemic guidelines to provide for the identified needs. She feels that these guidelines may assist in improved coping and adaptation of the children concerned. This may consequently lead to a person-in-environment fit, and, more than that, mental health.

The researcher perceives that the mental health of its client base is a primary social work focus. DuBois and Miley (2005, p. 347) state that “today, social workers are among the main providers of mental health inpatient and outpatient services for individuals who evidence acute or chronic mental disorders. Almost 40% of all NASW members identify mental health as their primary area of practice”.

Kirst-Ashman (2003, p. 330) states that “social workers can play an important role in helping people live healthy lifestyles and seek the health services and resources they need. Practitioners can empower people by facilitating their pursuit of physical, mental and social wellbeing”. The social worker employed at a residential facility is one of the most important and focused upon role-players in this study. As a social worker, the researcher attempts to, through implementation of this study, take on a key role in the provision of mental health services. Other role-players are deliberated too. Child care workers are a good example of such deliberations.

In order to develop guidelines that will be implemented by role-players as stated above, which will provide for the needs of children with mental health problems, a
study into existing ones, is necessary. Therefore previous research and literature written on the same or similar topics were studied. The researcher found very little research conducted on children in the social work system. It appears as if children with mental problems (in child and youth care centres), and pertaining matters in South Africa, are under-researched. Baumann (2008) summarised challenges facing research on mental health in South Africa. He states that psychiatrists working in tertiary academic hospitals are usually faced with major and burdensome clinical, teaching and administrative tasks that usually take precedence over research. Major sources of research funding have generally been insufficient, particularly for clinician-researchers.

Kibel and Wagstaff (2001) also studied and summarised child mental health research in South Africa. They paid attention to: behaviour problems in pre-school children, common functional problems, serious psychological disorders, adolescents and its related psychology, and child mental health services in general. In their studies there were no references made to children who reside in child and youth care centres. Therefore the effect that child and youth care centres (as an environment) may have on children’s already ill mental health, seems not to have been explored in South Africa. The researcher did however find a lot of research completed on the mental health of children in general. This study attempts to combine this information with suggestions from social work literature and professionals.

This chapter presents existing literature similar to that discussed above. The literature review conducted, forms part of qualitative research. It will:

- help to learn more about the scope of the research problem;
- help to learn what answers already exist for general research questions (Grinnell & Unrau, 2005).

Therefore the general research questions as stated in Chapter 1, partially receive answers in this second chapter. To retrieve partial answers, the researcher study and discuss, amongst others, themes related to terms defined in the previous chapter. Some of these themes are; the ecosystemic approach, the individual child
with a mental health problem, role-players involved on all system levels surrounding the child concerned, government policy, and the broader environment – which is the child and youth care centre.

The realistic social work answers that don’t already exist for general research questions should be retrieved from participants in focus groups (empirical research). Therefore the literature review also forms the foundation for the development of questions pertaining to the qualitative questionnaire for empirical research to be conducted.

After empirical data collection, this literature review can further be used to:

- attempt to explain differences between current findings and existing knowledge;
- specify how current findings advance knowledge (Grinnell & Unrau, 2005).

In a nutshell, the purpose of this literature review is to present collected data of previous research conducted on the topic of children with mental health problems in child and youth care centres, in terms of the ecosystemic perspective. Literature discussed attempts to provide initial guidelines on effective ecosystemic orientated care that promotes coping and successful adaptation for the children concerned. This in turn should lead to a good person-in-environment fit, and, more than that, improved mental health.

Terms mentioned in the paragraph above, are discussed and clarified in the following presentation of the foundation theoretical perspective of this study:

2.2. Ecosystemic perspective:

As mentioned the ecosystemic perspective is the central theoretical orientation to this study. Kirst-Ashman (2003), states that this theory is particularly relevant to social work. Therefore it takes precedence and guides other matters to be discussed in this chapter. In general this study attempts to discuss the needs of the children
concerned, and develop initial guidelines which can provide for these needs, in terms of this perspective.

Before the characteristics and emanating needs of children with mental disorders in residential facilities are described, it is necessary to introduce basic terms related to the ecosystemic perspective.

2.2.1. Systems:

The researcher regards “systems” as the most important term. Kirst-Ashman (2003) states that social work refers primarily to social systems composed of people. Kirst-Ashman (2000), states that a system is a set of elements that are orderly, interrelated and a functional whole.

The researcher is of the opinion that systems in an environment all interact and have an effect on the individual child and his/her mental health, and vice versa. Therefore the study of the environment (child and youth care centre), and what services are rendered in this environment, and which ones are needed by the children concerned, is necessary for the researcher to see in what way effective ecosystemic orientated guidelines can be developed to provide for these service needs.

Shaffer (2002) defines environment as a set of nested structures, each inside the next. The developing person is said to be at the centre of and embedded in several environmental systems, ranging from immediate settings, such as the family, to more remote contexts, such as the broader culture. Each of these systems is thought to interact with the others and with the individual to influence mental health in important ways. For the purposes of this study, the environment is seen as a child and youth care centre. There are some structures in this environment, the first and most important the individual child with a mental health problem. Some other systems envelop this child.

The systems that envelop the child have characteristics that distinguish one system from another. These distinguishing characteristics include their patterns of
relationships, their purposes and attributes their members have in common. Systems applicable to this study are as follow:

2.2.1.1. Micro level systems:

At any point in life, the microsystem consists of the people and objects in an individual's immediate environment. These are the people closest to a child, such as caregivers or siblings and/or peers (Kail & Cavanaugh, 2007). The micro system for children in residential care consists of child care workers and other children who reside in the same environment. Although these children’s biological parents aren’t involved in their day-to-day lives, some of them are to some extent still part of the child’s life, and therefore the microsystem.

Donald, Lazarus and Lolwana (2004) further state that micro systems involve patterns of daily activities, roles and relationships. It is at this level that key proximal interactions occur. The researcher is therefore of the opinion that what happens in the child’s immediate environment and how people closest to him/her treat him/her, will influence his/her mental health.

Interventions on micro level define themselves through activities or practices that aim to promote, build on, increase or foster primarily individuals’ strengths, resourcefulness or resilience (Reynolds, Muston, Heller, Leach, McCormick, Wallcraft & Walsh, 2009). Therefore programmes that manage micro interventions and parties involved in the everyday lives of a child with a mental health problem can have a positive or negative affect on his/her mental health.

This study attempts to develop guidelines that could be implemented on the micro level (individual child with a mental health problem), primarily. These micro level guidelines and interventions include the overall care of the individual child; physical care (e.g. food and shelter), cognitive care (e.g. adequate stimulation and appropriate education) and psychosocial care (e.g. disciplining and relationship building).
2.2.1.2. Meso level systems:

These systems consist of connected microsystems. The mesosystem provides connections across microsystems, because what happens in one microsystem is likely to influence others (Kail & Cavanaugh, 2007). As would be seen later in this chapter, children’s mental health could for instance be affected adversely by the quality of relationships in the micro system.

In designing restorative interventions for individual children, the focus is therefore usually on relationships in the microsystem and mesosystem. This study specifically focuses on relationships with role-players that the child is in regular contact with.

2.2.1.3. Exo level systems:

According to Kail and Cavanaugh (2007) exosystems refer to social settings that a person may not experience first-hand, but that still influence development. For example, changes in government policy may have an impact on a child and his mental health.

Government policy for instance state that children with mental disorders in child and youth care centres must receive appropriate mental health services (Mental Health Act, 2005). As the researcher is of the opinion that no specific programmes exist, this study proposes that the services pertaining in these guidelines, are not rendered.

2.2.1.4. Macro level systems:

The broadest environmental context is the macrosystem; the subcultures and cultures in which the microsystem, mesosystem and exosystem are embedded (Kail & Cavanaugh, 2007). “This level of system is equivalent to what we have referred to as the social system as a whole” (Donald, Lazarus & Lolwana, 2004, p. 52).

The macrosystem is really a broad ideology that dictates how children should be treated, what they should be taught, and the goals for which they should strive (Shaffer, 2002). The researcher feels that when a programme for residential facilities
containing guidelines is in place, it will define how children should be treated, what should be taught, and for what they should strive. This programme should be implemented under the umbrella of the macro environment – the child and youth care centre.

2.2.1.5. Subsystems:

As mentioned by Shaffer (2002), several smaller systems exist in bigger ones. Such systems are referred to as subsystems. A subsystem is a secondary or subordinate system. It may be thought of as a smaller system within a larger system (Kirst-Ashman, 2000). “This means that systems are subsystems of other systems while simultaneously having competent parts or subsystems” (DuBois & Miley, 2005, p. 59).

Related to this study, the micro system for instance consists of the persons residing in a child and youth care centre. There are different subsystems in this larger one, two for instance being children that have been diagnosed with a mental disorder and those who have not (also referred to as peers). Other subsystems in the micro system are the child care workers and biological parents.

2.2.2. Roles of systems and subsystems:

These and other subsystems involved in the environment have different roles. Kirst-Ashman (2000), states that a role is a socially expected behaviour pattern determined by an individual’s status and expectations in a particular group or society. Each individual involved in a system assumes a role within that system.

Child care workers and biological parents for instance assume the role of caregivers. The researcher observed that currently children with mental disorders assume the role of “difficult children” in the home. In this study children who do not present with mental health problems, but reside in the facility, are referred to as peers.
2.2.3. Interdependence:

The researcher perceived that some of these systems are dependent on one another, just as children are dependent on their caregivers. Kirst-Ashman (2000) refers to this as interdependence. Interdependence is the mutual reliance of each person upon another. She further states that individuals are interdependent upon each other for input, energy, services and consistency.

The researcher for instance perceived that children in a residential care facility are reliant on their caregivers. Consequently she feels that the extent to which these role-players allow an individual child to be reliant on him/her, will have an influence (positive or negative), on the child’s outlook on life. The researcher is of the opinion that interdependence therefore plays a big role in the formation of relationships between the caregivers and the child.

2.2.4. Relationships:

Good, sustaining, supportive relationships between all subsystems and role-players are, according to the researcher, necessary for positive influences in a child’s life and overall mental health. Kirst-Ashman (2000), states that a relationship is the mutual emotional exchange, dynamic interaction and affective, cognitive and behavioural connection that exists between two or more persons or systems. Relationships may exist between systems of any size. The researcher feels that those relationships occurring on the micro level are the most relevant regarding the effect it will have on a child’s mental health.

2.2.5. Interface:

Thus, this interface should be focused upon during assessments and interventions. An interface is the point of contact between different systems including individuals, families, groups, organisations or communities (Kirst-Ashman, 2000). In this study, the interfaces of importance are the micro and meso levels, where proximal interactions take place.
Thus, as mentioned, this study attempts to provide guidelines on effective ecosystemic care to children with mental health problems by focusing on interactions and possible interventions between the individual and his/her direct environment – the child and youth care centre. This environment consists of the subsystems; caregivers, biological parents and peers. The nature of these relationships is discussed later in this chapter.

2.2.6. Transactions:

The interactions that the mentioned subsystems have are discussed by DuBois and Miley (2005). They state that, through give and take, systems borrow and share, consume and dispose, and accept and reject their own resources and the resources of other systems. These exchanges of resources are called transactions, or the process through which systems exchange information and energy. They further state that this give and take involves input, output and feedback:

2.2.6.1. Input:

According to Kirst-Ashman (2000), positive inputs are needed to achieve optimal mental health. Input is the energy, information, or communication flow received from other systems (Kirst-Ashman, 2000). Therefore ecosystemic orientated guidelines should pay attention to what energy, information and communication can be utilised effectively in improving the mental health of a child in a residential facility, and from which systems and system levels to retrieve these.

Biological parents may for instance help to manage the behaviour of a child who longs to have contact with them. Possible inputs identified by literature and key role-players, will be integrated and transferred into guidelines that can help the child cope with difficult life experiences, and to adapt in a child and youth care centre. This coping and adaptation would be a product of inputs, as discussed by Kirst-Ashman (2000).
2.2.6.2. Output:

Output is what happens to input after it’s gone through and been processed by some system. An issue that communities, organisations and groups continue to address is the importance of evaluating whether a system’s outputs are worth its inputs (Kirst-Ashman, 2000).

Did interventions and/or services granted, have an effect on the child and was it positive or negative? Will eco-systemic orientated guidelines indeed promote coping and adaptation? This answer can only be anticipated, but will be confirmed after implementation of such a programme.

The researcher is however of the opinion that constant evaluation is necessary for an organisation to establish whether its inputs are worth its outputs. Therefore she suggests for residential facilities to evaluate whether developed programmes are effective in addressing the coping, adaptation, and consequently mental health of the children concerned.

2.2.6.3. Feedback:

The researcher states that evaluations provide feedback. Feedback is a special form of input where a system receives information about that system’s own performance. As a result of negative feedback, the system can choose to correct any deviations or mistakes and return to a more homeostatic state. Positive feedback, also valuable, is the informational input a system receives about what it is doing correctly in order to maintain itself and thrive (Kirst-Ashman, 2000).

The researcher consequently feels that it is necessary to continuously evaluate a system’s performance and give appropriate feedback. Should rectifications be necessary to existing guidelines, it should be rectified and evaluated again. The researcher feels strongly that programmes in child and youth care centres should ultimately provide ecosystemic guidelines that can assist in the coping, adaptation and mental health of children with mental health problems. There are however numerous ways in which to achieve this ultimate goal.
2.2.7. *Equifinality*:

These many different means to achieve the same end are referred to as *equifinality*. In any particular situation, alternatives do exist (Kirst- Ashman, 2000). An aggressive child with a conduct disorder will supposedly achieve mental health through cognitive behaviour therapy and medication. A sad, depressed child will on the other hand perhaps reach mental health more effectively through talking therapy and medication.

This research study attempts to explore these many different means in which mental health can be gained for individual children with different mental health challenges. Overall, the researcher however suggests keeping to three basic concepts of the ecosystemic perspective; coping, adaptation, and person-environment fit. For children to reach optimum mental health, coping and adaptation is necessary.

2.2.8. *Coping*:

Coping is a form of adaptation where efforts to regulate immobilising, negative feelings and problem solving strategies are applied to handle the demands posed by life stressors (Kirst-Ashman, 2000). According to Atonovsky (1980) in Gray and Zide (2000), the most basic category of coping resources consists of beliefs and attitudes toward life. Other mechanisms include the person’s knowledge, successful experiences with life tasks, and cognitive capacities and the ability to reason; the ability to control and use emotional affective responses to stress; and skills to carry out planned action, which usually comes from past successful experiences.

The researcher is of the opinion that to the best possible extent, these coping skills should be taught to all children in child and youth care centres. A large percentage of these children went through negative life experiences, and some might not be able to cope with it.

Children with mental health problems on the other hand, have the challenges of their disorders to deal with on top of negative life stressors. Therefore the researcher feels
that coping is more challenging for such children. As mentioned above, coping is also seen as a form of adaptation.

2.2.9. Adaptation:

Kirst-Ashman (2000), states that adaptation is the capacity to adjust to surrounding environmental conditions. It implies an on-going process of change. A person must adapt to new conditions and circumstances in order to continue functioning effectively. DuBois and Miley (2005) refer to adaptation as a dynamic process between people and their environments as people grow, achieve competence, and make contributions to others (DuBois & Miley, 2005).

Gray and Zide (2000) simply state that adaptations are regarded as the continuous, change-orientated, cognitive, sensory-perceptual, and behavioural processes people use to sustain or raise the level of fit between themselves and their environment. Therefore the researcher is of the opinion that coping differs from adaptation in that adaptation involves the fit with the environment. With coping the individual child is focussed upon in terms of his/her ability to regulate negative life experiences. The researcher feels that if a child can cope with negative life experiences (which come from one’s environment), he/she will be able to raise the level of fit between him/herself and his/her environment.

Some interventions might however be necessary for a child to be able to cope. The researcher is for instance of the opinion that a child with mental health problems needs additional interventions in comparison with his/her peers. If effective eco-systemic guidelines can be developed for children with mental health problems, and they are orientated towards care that promotes coping and adaptation, it may lead to a good person-environment-fit.

2.2.10. Person-in-environment-fit:

Kirst-Ashman (2000) refers to a person-in-environment-fit as the extent to which an individual’s or a collective group’s needs, rights, goals and capacities match or fit the environment’s abilities to meet that person’s or group’s physical, social and cultural
needs. The researcher perceived that the person and environment fit between children with mental health problems and residential facilities are currently not positive. It appears as if children with mental health problems struggle to adapt in mainstream homes, due to the environment’s inability to meet their needs.

2.2.11. Ecosystems in general:

According to Gray and Zide (2000) the ecosystemic perspective views people as moving through a series of life transitions that require environmental support and coping skills. Stress may result if there is not a good fit between internal and external demands and resources. Therefore the practitioners should look at those interactions that either promote or inhibit growth and development. One should work collaboratively with children to mobilise strengths and coping, locate resources and explore opportunities within the child’s environment that may pave the way for the child to achieve success rather than being powerless or disenfranchised.

Part of this chapter will therefore focus on what guidelines literature suggest to promote coping, adaptation and, more than that, the person-environment-fit between children with mental health problems in residential facilities. This may lead to improved mental health of the children concerned.

2.2.12. Mental health:

Greenspan (1997) states that mental health means to have warm, satisfying relationships, being able to cope with expected stresses and being successful in school and later in one's life. It means to be joyful and happy and yet also tolerate and experience deep levels of loss and sorrow when life’s circumstances are challenging.

Seeing that different ecosystemic levels interact and influence the individual child and his/her mental health, the following part of this chapter will focus on these levels. Kirst-Ashman (2003), states that focusing on people’s functioning within the environmental context is an important thrust of social work. A focus on the environment, means looking not only at individuals themselves, but also at their
involvement with family members, the political system, and agencies providing services within the community. How the client and the problem fit into the larger scheme of things is critical. Matters related to the micro level (thus the individual child and persons in his/her direct environment), take precedence.

2.3. Micro level (Individual child with mental health problem and/or disorder):

As mentioned the child is embedded at the centre of the micro environment. According to the researcher this micro environment (for a child with a mental health problem in a residential facility), consists of his/her caregivers (biological parents, child care workers and/or peers). Therefore the individual child with a mental health problem, the relevant subsystems (role-players), and pertaining matters are discussed in this section.

2.3.1. Individual child with a mental health problem:

As discussed in the preceding chapter, the researcher refers to the children concerned as children with mental health problems, as some may have not been diagnosed with a mental disorder as yet. The researcher however deems it necessary for a child to be diagnosed with a disorder (if he/she has one), as opposed to being labelled as a child with a mental health problem. Specific diagnoses of specific mental health disorders can result in appropriate treatment and provision for the child’s individual needs.

Dumaine (2003) defines mental health disorders as disorders that interfere with daily functioning, such as education and employment. The researcher feels it is of importance to know where mental disorders emanate from. Having knowledge about the causation, will determine its management (Kibel & Wagstaff, 2001). Wagstaff (2003) identifies the following factors:

i. Biological: Genetic transmission, diseases of nervous system, etc.

ii. Psychosocial: Poor coping skills, poor social skills, etc.

iii. Social: Factors related to family and factors related to community and environment.
Thio (2007) expands on the above by referring to organic and functional disorders. According to him both types may show the same symptoms, but they can be differentiated on the basis of their underlying causes. Organic disorder is caused by damage to the brain. Functional disorder is believed to result from psychological and social factors, such as unpleasant childhood experiences.

As mentioned earlier the researcher is of the opinion that children who reside in child and youth care centres, have had negative life experiences. Lewis (2002, p. 1097) confirms this by stating that “children in residential treatment often have been exposed directly or indirectly to traumatising physical and sexual abuse”. The researcher is consequently of the opinion that children with mental disorders in residential care, would largely suffer from functional disorders. She feels that it is therefore important for the broader system not to fail children further by contributing to more negative childhood experiences.

Negative childhood experiences may include physical, sexual, emotional abuse and/or neglect. Kirst-Ashman and Hull (2002), state that there are a number of ways in which children can be abused or neglected. The umbrella term that may be used to include all of them, is child maltreatment. Maltreatment includes physical abuse, adequate care and nourishment, deprivation of adequate medical care, insufficient encouragement to attend school consistently, exploitation by being forced to work too hard or too long, exposure to unwholesome or demoralising circumstances, sexual abuse and emotional abuse and neglect.

These are (according to observations by the researcher) the main reasons for children being removed from their biological parents or primary caregivers in the Southern African context. The researcher feels that child and youth care centres should opt towards care that does not include any form of maltreatment as stated above.

The researcher strongly feels that a child’s development should be kept in mind while considering the above. Each individual’s childhood experiences have an impact on their development, and thus mental health. Segal, Gerdes and Steiner (2007) highlight the importance of how certain environments and systems in these
environments affect a child’s development. They state that in addition to studying a client and his interaction with the environment, it is also important to understand theories about how human beings develop throughout their lives.

Maier (1965) defines development as an evolitional process based upon a universally experienced sequence of biological, psychological, and social events. The researcher perceived that as development takes place, children move from one stage of development to the next. “A stage of development is a period of life distinguished by a specific underlying structure expressed by certain behaviours. Some characteristics distinguish and differentiate each stage from the stages that precede and succeed it” (Pillari, 1998, p. 3). Therefore the researcher feels that certain characteristics will accompany different stages of development.

Stages of development are defined as follow:

- **Infancy** is the first stage and refers to children from birth up to the age of 2 years. “During infancy, rapid growth and development occurs” (Dwivedi & Harper, 2004, p. 30). The researcher is of the opinion that mental health problems will be hard to characterise during this stage.

- **Ages 2 – 5 years** are identified as early childhood. According to Pillari (1998), you find two distinctive features of development at the beginning of this stage: 1. The range of individual differences becomes more apparent. 2. The range of activities gradually shifts from those dominated by biological forces to those influenced by the forces of cognitive, social and affective domains. Observations by the researcher showed that during this stage, a child with mental health problems might begin to act “different” in relation to his/her peers. Mental health problems are still difficult to identify though.

- **Dwivedi and Harper (2004) identify middle childhood as ages 6 – 11 years.** “Middle childhood is a time of growth: cognitive, moral, and academic. Many issues arise as children learn the skills they need to cope with life at home and in school” (Pillari, 1998, p. 142). The researcher noticed (probably because children have other challenges during this stage as well), that mental health problems usually present themselves fully during this stage.
• The last developmental stage is adolescence (age 12 – 18 years). “Adolescence is traditionally viewed as a period of great change and transition. This includes biological factors, such as reaching puberty; psychological factors, such as further cognitive, intellectual and moral development; and finally social factors, such as societal expectations” (Dwivedi & Harper, 2004, p. 42). Upon these challenges usually experienced by adolescents, children with a mental health problem struggle with issues pertaining to it as well. The researcher feels that by this stage, a child should have been diagnosed if he/she presented with mental health problems, and a stabilised treatment plan must have been developed.

Except for developmental stages, areas of development are considered as well.

2.3.1.1. Physical development:

Seifert, Hoffnung and Hoffnung (2000), state that physical development is the area of human development concerned primarily with physical changes such as growth, motor skill development, and basic aspects of perception.

Significant to the ecosystems perspective, Pillari (1998) states that biological characteristics and environmental factors must work together for optimal physical development to be enhanced. Any negative interference from the inside such as neurobiological problems or hormonal imbalance, or from the outside such as improper diet or lack of stimulation, can turn the positive growth cycle into a negative one.

A lack of nutrition can for instance result in severe impairment. Emotional deprivation may also inhibit growth (Kibel & Wagstaff, 2001). Because of abuse and neglect, many children in residential care have physical health problems such as poor nutrition, dental problems and frequent infections (Lewis, 2002). The researcher therefore argues that it is important for children to receive appropriate nutrition and stimulation from their caregivers to grow physically. She feels that this developmental area is not much concerned with mental health, but that it is an important aspect of survival for any child. Therefore it is a basic human need that has to be provided for, by a child and youth care centre.
Because of children’s sometimes poor physical state, primary health care services are important attributes and can be utilised in providing for needs. The researcher feels that besides general health care, primary health care practitioners may help with the prescription and monitoring of psychoactive medication as well. Barker (2004), states that psychoactive drugs have an established place in the treatment of mental health problems in children. They are part of a comprehensive treatment plan that takes into account all factors that have an impact on the child’s condition.

This medication should however be prescribed by the appropriate professional. Baumann (2008), states that the prescription of psychotropic drugs for children would be considered only after careful evaluation by a clinician experienced in child psychopharmacology. He further feels that medication should not be used in isolation but as part of a comprehensive management plan that includes psychological and social components. This author suggests for staff of a child and youth care centre to conduct therapy, and focus on other developmental areas as well, while implementing pharmacotherapy.

2.3.1.2. Cognitive development:

The researcher is of the opinion that an important developmental area to focus upon is cognitive development. She has observed that children with mental health problems usually experience cognitive delays, and therefore academic challenges. Cognitive development should thus be examined through assessment.

According to Seifert, Hoffnung and Hoffnung (2000), cognitive development is the area of human development concerned with cognition. It also involves all psychological processes by which individuals learn and think about their environment.

Kail and Cavanaugh (2007), summarise cognitive development as follows:

- **Birth – 2 years**: Infants’ knowledge of the world is based on senses and motor skills. By the end of this period they use mental representation. The researcher is of the opinion that during this developmental stage, a child is in need of a solid foundation to build future development on. This should be
provided by caregivers and other professionals if necessary. The researcher however observed that it is difficult to notice delays at such an early age.

- **2 – 6 years:** The child learns how to use symbols such as words and numbers to represent aspects of the world, but relates to the world only through his/her perspective. Here the researcher feels that delays can be noticed, especially if the child attends nursery school. The child relates to the world only through his/her perspective, which means that any influences may cause a distorted view of the world. It can interfere with normal development, and thus a child’s mental health.

- **7 years – early adolescence:** Child understands and applies logical operations to experiences provided they are focused on here and now. The researcher perceived that most cognitive delays are noticed during this developmental stage. Therefore problems detected here should be approached with these delays and the mental health of the child in mind.

- **Adolescence and beyond:** An adolescent thinks abstractly, deals with hypothetical situations, and speculates about what may be possible. The researcher however feels that if a child has a mental health problem, this developmental stage may be a difficult one to overcome. Adolescent challenges have to be dealt with upon that of a mental health problem, which, according to the researcher, must have been diagnosed by this stage.

The researcher observed that children with mental health problems in child and youth care centres usually suffer from cognitive development delays and/or learning disabilities. Except for severe delays and/or learning disabilities, children display disruptive behaviour in class. Because of this staff members of mainstream schools are usually of the opinion that these children cannot function in a mainstream school. Lewis (2002), states that a special on-grounds school setting is usually required. Some of the characteristics of such a school include staff members who are skilled in special educational assessments, a low teacher-student ratio, specialised learning equipment and a curriculum designed to captivate the children’s interest and motivate them to learn.
CBR (n.d.) agrees with the above by stating that in this environment, there should be a teacher that is able to cope with the behaviour of children with mental disorders. The teacher to child ratio should be small to ensure individualised attention, educational goals, plans and learning tasks. The researcher therefore suggests for a child with a mental health problem to attend such a special school setting should the child not cope with attendance in a mainstream school, or his/her teachers are not able to cope with having the child in his/her classroom.

The researcher further perceived that teachers have negative attitudes to children with difficult behaviour and mental health problems. Sexson (2005) states that children who feel labelled by teachers and believe that teachers have negative expectations of them, do not achieve or behave at the same levels as students who have a more positive relationship with their teachers.

Therefore the researcher is of the opinion that everyone involved in schooling these children, should not label them, but rather focus on their strengths. A child’s strengths should however first be identified. It can only be identified by professionals who complete educational assessments. The researcher feels that these assessments would also be able to identify whether a child can remain in mainstream schooling, or if he/she should be transferred to a specialised schooling programme.

2.3.1.3. Psychosocial development:

The researcher feels that this developmental area pertains to information most relevant and applicable to children with mental health problems. Seifert, Hoffnung and Hoffnung (2000, p. 5), state that “psychosocial development is the area of human development concerned primarily with personality, social knowledge and skills and emotions”.

Psychosocial milestones (according to Erikson’s perspective), are summarised by Barker (2004) as follow:

- During infancy the child develops basic trust, coming to experience the world as a place that is nurturing, reliable and trustworthy. This is considered to be the basis
for the development of the capacity for intimacy. There are great advances in social behaviour and responsiveness. Bonding between the child and the familiar caretaking figures take place. Therefore the researcher feels that this is the most critical period in the healthy development of psychosocial aspects. As a social worker, the researcher however noticed that during this developmental stage, children are still with their primary caregivers, where they are exposed to negative childhood experiences. Therefore a child, who resides in a child and youth care centre, usually did not have these basic foundations established. This may influence a child’s mental health.

- During **early childhood** the child develops a sense of autonomy (a sense of being in control of oneself, as opposed to entertaining feelings of shame and doubt). They also develop a sense of initiative (the feeling of being able to do many exciting, even almost magical things, as opposed to feeling frightened or guilty about taking the initiative). The child also makes an advance in socialisation – acquiring many more of the skills required to live as a member of a family group. Here the researcher observed that the negative foundation which was established in the preceding stage, only builds forth; whether the child is still in the care of his/her primary caregivers, or in a child and youth care centre. The researcher is of the opinion that currently, some child and youth care centres are not equipped to overcome this negative foundation. If it is not overcome, it may lead to more serious consequences – mental health problems.

- During **middle childhood** children develop a sense of industry versus inferiority. Children may fail to learn what they need to at this time of life, and thus develop feelings of inferiority and failure. Because of all the negative feedback a child of this age has already received, he/she may experience more senses of failure than inferiority. As mentioned earlier, this is the stage where most mental health problems present themselves, and therefore a lot of psychosocial problems might accompany them.

- During **adolescence** the focus is mainly on achievement of a firm sense of identity and socialisation with peers. The researcher feels that if a child’s problems and strengths have been identified by this stage, it can assist the child in developing healthy psychosocial habits.
As this developmental area pertains to information most relevant to mental health, the researcher feels that it is the most important for this study. As with the previously discussed developmental areas, care from caregivers has a mammoth effect on the development of a child. In caring for a child, social interactions unavoidably take place.

As noted, social interactions from caregivers towards a child lay the foundation for future social interactions the child will have. Therefore the researcher regards it of the utmost importance for children to experience positive proximal, social interactions and consequently attachments, with his/her caregivers and peers in his/her direct (micro) environment.

2.3.2. Caregivers, biological parents and/or peers and relationships:

As mentioned the micro level consists of the people in a child’s direct environment. They were identified as the child care workers and biological parents (referred to as caregivers), and peers.

2.3.2.1. Biological parents:

Observations from the researcher in a child and youth care centre, and studies of Erikson’s theory, proved that biological parents had the most influence on a child’s mental health up to the date that he/she was admitted into the child and youth care centre. The researcher feels that from this point forward, the residential facility plays a part in the future determination of the child’s mental health status.

The researcher noticed that in some cases biological parents stay involved with their child, while others are never seen or heard of again. In both instances, the parents still have a direct bearing on the child’s future mental health status as well. As seen in the above section, children’s early interactions with primary caregivers set the pace for their ability to attach and interact with others throughout their entire lives (Boss & Masiker-Nickel, 1997). The researcher feels that if biological parents remain part of the child’s microsystem, they should be involved in positive interactions and
interventions that will be implemented. Contact with the biological parents cannot be refused.

Friesen, Kruzich, Robinson, Jivanjee, Pullmann and Bowles (2005) studied the contact that children who reside in residential facilities have with their biological parents. They confirmed that contact was often limited. They are of the opinion that limitations on parent-child contact are a concern in light of preserving children’s attachments as a foundation for the capacity to form caring relationships throughout life. They also state that withholding contact is destructive to the child’s relationships with, and commitment to, caregivers and agency staff. The researcher agrees with the said authors, and the Children’s Act 38 of 2005, that contact with the biological parent(s) should only occur if it is in the best interest of a child. The researcher for instance suggests that, should a child’s behaviour deteriorate because of it, it should be terminated.

If biological parents can however assist in improving a child’s behaviour and/or mental health, the researcher feels that their help should be utilised. Friesen, Kruzich, Robinson, Jivanjee, Pullmann and Bowles (2005), state that studies proved on-going contact with caregivers is related to positive behaviour of children in care, the child’s ability to adapt to care, and more rapid family reunification. Because of this reason, positive interactions should not be terminated.

A child with a mental health problem’s siblings should also be taken into consideration when discussing contact that the child should or should not have with his/her biological family. MacLean (2004) feels strongly that where siblings are unable to live together, contact between them is very important. Sibling relationships are usually the longest relationships in life and research shows that most of us view them positively. Positive ties should be maintained between siblings, particularly where they live apart. The researcher noted that sometimes children, who have been removed from their home, are separated from their sibling. The researcher however again concludes and agrees with the Children’s Act 38 of 2005, that some form of contact should be kept between siblings, especially if it would be in the best interest of all systems involved.
Irrespective of the above, the researcher perceived that the biological family is not involved in the direct, everyday lives of a child in a residential facility. Therefore special attention is paid to the primary caregivers – child care workers. Note however that suggested guidelines are also applicable to biological parents who are still involved in a child’s life, and the researcher suggests for both systems to pay attention to it. Therefore child care workers and biological parents are collectively referred to as caregivers.

2.3.2.2. Child care workers:

Firstly and in conjunction with the above, Gannom and Beukes (1996) remind child care workers of the following aspects in caring for children in alternative care:

- As a child care worker you can never replace a child’s parents.
- If parents are involved, the child care worker’s task is to not only care for the child, but to support and strengthen the child’s relationship with his parents.
- Child care workers should never imagine that “out of sight out of mind” will help a child forget parents and home. The child may be physically separated from his/her parents, but emotionally he/she is still entwined with them.
- It is difficult to make progress with a child if his/her parents are not also included in the consideration and treatment plan.

The researcher feels that the above points are very important for child care workers to note before they attempt to care for a child in a residential facility. The child care worker should realise that the biological parents are always an important consideration, and that, should the parents still be involved, caring would be a collective process.

The researcher however agrees with Lewis (2002) when he states that especially child care workers play a very important role in the lives of children in residential care. The workers’ use of good-enough parenting allows them to serve as role models for the children. The author states that child care workers should offer a structured environment that constitutes a therapeutic milieu.
Therefore Dishion and Stormshack (2007) are of the opinion that as much as possible, interventions with children attempt to engage caregivers to lead the change process. Therefore the researcher suggests for child care workers to be involved in the assessment and planning procedures that commence upon admission of the individual child. The researcher has observed that social workers aren’t as involved in the fulltime care and observance of a child, as a child care worker is. Therefore their inputs are of pivotal importance when conclusions are made regarding the future care and treatment plan of a child.

Dishion and Stormshack (2007) further mention that although interventions may target multiple systems such as schools and families, we assume that change would be more enduring if caregivers are successfully engaged in the process of attempting to change their own interactions with the child, and if they are made more aware of the child’s behavioural and emotional needs. This study attempts to explore what the needs of children with mental health problems are, in order to provide guidelines on how to improve their mental health through implementation of, amongst others, effective interaction between caregiver and child.

The researcher argues that guidelines will mostly be implemented by the caregivers of the child. The manner in which this is done is also important. Fenske (2005) is of the opinion that whether or not other individuals within a residential environment are supportive, can determine whether caregiver-child relationships enhance or undermine a child’s mental health. It is consequently assumed that children should have support from biological parents, child care workers and peers. As seen with psychosocial development, Tomlinson (2000) is of the opinion that children must have a living experience of a trustworthy and nurturing world. It is the experience a child care worker offers in a programme, which has the capacity to modify a child’s internal working model of the world.

Somasundram (2005) tells about Denise Masson who was a child in care and who went on to become a child care worker. Denise experienced internalised acceptance in relationships she had with caregivers. She states that one could be in a relationship and interaction in another person’s life for a short period of time, but the experience of that relationship could last a lifetime. Denise feels a child care worker
should be present, engaging, caring and self-aware in the critical role they play in growing young people.

To implement the said interventions, Somasundram (2005) suggests “hanging out” with the child. The author feels that this provides the opportunity to experience each other in different contexts. It shows an aspect of concern, care and wanting to spend time with the child. This results in a formation of bonds and close attachments and involvement in each other. As seen in the previous section close attachments and involvement in a child’s life can assist him/her to develop optimal mental health. The respect, involvement, attachment experience and genuine understanding that we have to offer to young people are critical to help youth develop a different view of them, and experience themselves as capable (Somasundram, 2005).

The researcher is of the opinion that a child and his/her problem behaviour should not be ignored. Somasundram (2005) states that ignoring this behaviour often results in a therapeutic waste of time, energy, and is physically and emotionally draining. Hanging out with young people can provide the opportunity to meet this need without young people actively seeking ways to gain the attention of the child care worker.

Hanging out can also provide a good assessment of young people’s strengths and developmental areas. Communication skills are modelled. Young people may feel that they can discuss their concerns, fears and worries with each other and their child care worker (Somasundram, 2005). The researcher is therefore of the opinion that child care workers should spend individual, quality time with children, through just “being with them”. In this manner secure attachments may be built in which the child will feel comfortable to discuss concerns.

According to Brendtro (2006) children should further be treated with dignity and worth. Discipline should respect the child’s potential for positive development and preclude acts of superiority and dehumanisation. The researcher is of the opinion that positive reinforcement would be the most effective disciplinary technique for children with mental health problems. In implementing such disciplinary techniques, there is a focus on the child’s strengths and not the negative behaviour he/she displays because of the mental health problem.
Dishion and Stormshack (2007), state that this essential practice involves the contingent positive reaction to a child’s demonstration of a new skill, positive behaviour or clear effort. Positive reactions may include a tangible reward such as a sticker (for young children), an affectionate hug, praise, or a preferred treat or activity. In adolescence, positive reinforcement may involve rewards for good grades or behaviour. The reward should be pleasant for the child and should motivate the child to continue the positive behaviour.

Other general activities implemented and managed by child care workers may assist a child with a mental health problem. Longo (2006) suggests the following:

- Help the child evaluate activities that are producing a problem. Perhaps the child finds it difficult to complete two different tasks at one time. Caregivers can consider giving only one instruction at a time.
- Spend time with a child every day, even if it is 10 to 45 minutes. This shared time will help adults better understand the child’s needs.
- Encourage the child to develop a skill or hobby, something that will help him/her relax. Perhaps the child enjoys and finds it relaxing to work in the garden.
- Help the child to develop positive friendships.
- Facilitate activities (therapy, support groups etc.). (Longo, 2006).

The researcher observed that staff members of child and youth care centres do not just magically “know” about such guidelines and how to implement them. Therefore the researcher feels that biological parents, child care workers and peers should receive psycho-education (Semple, Smyth, Burns, Darjee & McIntosh, 2005) on the needs of children with mental health problems, and how to provide for these needs. Barth (2009) refers to these as parent training programmes. Barth (2009) discusses a programme specifically developed by a team of British researchers. Elements of it are as follows:

- Early intervention results in better and more durable outcomes for children.
  
  *Therefore the researcher suggests for a child to be assessed as soon as he/she is admitted into the child and youth care centre.*

- Interventions should have multiple components, such as a variety of referral routes for families and more than one method of delivery. *The researcher feels*
that the child should be referred to specialists that can provide for their individual needs as identified in the assessment.

- Group work is preferred over individual work, unless the problems are severe or entrenched. The decision should, according to the researcher, be based on the needs of the child. Perhaps general skills training can be done in groups, but individual therapeutic issues in individual sessions.

- Interventions should be delivered by appropriately trained and skilled staff. The researcher for instance feels that children with mental health problems should be treated by professionals trained to implement specific interventions.

- Behavioural interventions that focus on specific parenting skills and practical tips for changing more complex parenting behaviours and affecting child behaviours are considered effective. According to the researcher this is focused more on the caregivers.

2.3.2.3. Peers:

As mentioned, peers are also an integral part of the micro level. The researcher is of the opinion that peers should also receive psycho-education on mental health issues. As soon as peers are educated on what may be expected from a child with a mental health problem, the child without the disorder might have a better sense of how to manage situations. This might cause children with mental health problems to not be rejected by his/her peers, and supportive relationships may develop.

Dishion and Stormshack (2007) state that peers are relevant to social development and well-being. They are of the opinion that inattention to peer influence in the design or execution of an intervention can undermine otherwise effective interventions and, in some situations, result in increases in problem behaviour. According to the researcher this highlights the importance of an ecosystems approach to be followed. As peers form part of the micro environment of a child with a mental health problem, due consideration should be given to the effect the mentioned child can have on a peer without a mental health problem, and vice versa.
The researcher observed that, largely because of ignorance, peers usually reject a child with a mental health problem. Peers are for instance afraid of being physically harmed by a child with a mental health problem that causes him/her to be aggressive. Therefore they choose to not be in this child’s presence.

To address this, Dishion and Stormshack (2007) are of the opinion that from an ecological perspective, individual adjustment is embedded within relationship dynamics, and so interventions to improve mental health must necessarily assess and motivate change in these social interactions to improve both problem behaviour and emotional adjustment. They propose family centred therapy to address all aspects of social interactions with peers, but the researcher feels that the reality is that the environment of a child and youth care centre, and big number of peers, would not allow for such an intervention to take place. Therefore the researcher feels that the mentioned psycho-education programmes may be effective when implemented in a group setting.

NAMI – National Alliance on Mental Illness (2007), states that psycho-education programmes are designed to achieve improved outcomes for people living with mental illness by building partnerships among consumers, families, providers and other support networks. Through relationships building, education, collaboration and problem solving, these programmes help caregivers and children to:

- learn more about mental illness and effective treatment options;
- master new and effective ways to manage the illness;
- provide social support and encouragement for each other;
- teach caregivers to reduce stress and to take care of themselves.

The researcher suggests for psycho-educational groups (for staff of a child and youth care centre and children residing there), to for instance be implemented between residential facilities in the same magisterial areas. It can assist in support amongst each other, and the acquisition of knowledge.

Psychosocial aspects between children are also of importance. MacLean (2004), states that friends are of importance. Children help each other a great deal and
adults should be aware of friends as actual or potential resources for resolving difficulties. Close relationships with peers can increase self-esteem and reduce some of the negative effects of maltreatment on children’s development. A study discussed by MacLean (2004) shows that there is evidence that young people develop supportive and sometimes long lasting friendships with their peers in care. These friendships should generally be supported.

When these extremely important relationship aspects are considered, the question then arises: When should a child with a mental health problem be separated from his/her peers in a mainstream child and youth care centre, by means of transference to a specialised home?

The Department of Social Development, in the document titled “guidelines for mainstreaming of disability in statutory social work” (n.d.), suggests inclusion of children with mental health problems in mainstream homes. They state that inclusion is the process of taking necessary steps to ensure that every person is given an equality of opportunity to develop socially, to learn, to work and to enjoy community life. It implies a shift from an individual change model to a system change model that emphasises that society has to change to accommodate diversity, to accommodate all people (Guidelines for the mainstreaming of disability in statutory social work, n.d.). Therefore the researcher is of the opinion that services should be geared towards including children with mental health problems in mainstream residential facilities, while individualising takes place through providing for unique needs.

The researcher suggests for staff of child and youth care centres to be aware of a child’s needs and how to provide for them. Throughout implementation of tasks and responsibilities, it is important for caregivers and other role-players to keep the best interest of the child in mind. They must attempt to provide for the physical, cognitive and psychosocial needs of children with a mental health problem though effective eco-systemic orientated care. As mentioned earlier, this may promote coping, adaptation and a good person-environment-fit.
Except for the subsystems discussed in the preceding information, the individual child counts for the bigger percentage of this study. Therefore a focus on the individual child and his/her mental health problem is given in the following section.

2.3.3. Mental health problems:

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) defines all mental disorders and lists each one’s symptoms. Observations by the researcher proved that there are certain mental health disorder categories that usually present in children that reside in child and youth care centres. The identified categories are; conduct and oppositional disorders, attention deficit disorders, mood disorders, anxiety disorders and psychotic disorders. These disorders are discussed as follows:

2.3.3.1. Conduct and oppositional disorders:

Durand and Barlow (2003) define these disorders as behaviours that violate society's norms. Symptoms of the disorder vary with age as the individual develops increased physical strength, cognitive abilities and sexual maturity. The onset of these disorders may occur as early as the preschool years, but the first significant symptoms usually emerge during the period from middle childhood through middle adolescence. Onset is rare after age 16 years (The American Psychiatric Association, 2000).

Burke (2009), the American Psychiatric Association (2000) and the Department of Social Development (n.d.) – identify the following characteristics of children with conduct and oppositional disorders:
Table 1: Characteristics of conduct and oppositional defiance disorders in children

<table>
<thead>
<tr>
<th>Developmental stage</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>• None</td>
</tr>
<tr>
<td>Early childhood</td>
<td>• None</td>
</tr>
</tbody>
</table>
| Middle childhood    | • Negative and antagonistic behaviour  
                        • Rebellion                        
                        • Non-compliance                    
                        • Serious violation of rules       
                        • Negative impact on social and emotional wellbeing  
                        • Loosing temper, being angry and argumentative  
                        • Easily annoyed and purposefully annoy others  
                        • Aggression to people and animals  
                        • Destruction to property  
                        • Deceitfulness  
                        • Truancy  
                        • Lying and/or stealing  
                        • Absconding  
                        • Fire setting  
                        • Lack of remorse  
                        • Bullying, threatening and intimidating |
| Adolescence         | • Vindictiveness                   
                        • Criminal activities               
                        • Juvenile delinquency              |

The section on developmental areas focused on physical, cognitive and psychosocial aspects. Therefore these sections are discussed under these themes.

*Psychosocial* factors that play a role in conduct and oppositional disorders are identified by Burke (2009). According to him caregivers are more likely to make fewer positive and more negative statements toward children with conduct/oppositional disorders, use harsh methods of punishment, fail to supervise or monitor children on a regular basis, perceive the behavioural problems of children to be intentional, present with poor problem-solving skills, and abuse or neglect children. Children often do not receive adequate support.
The researcher confirms this statement, and observed that children with behavioural problems are treated negatively by their caregivers. This lack of support and inadequate manner of managing these children, leads to behaviour deterioration.

Besides the way that caregivers act towards a child with these disorders, the children themselves tend to misinterpret social cues that are ambiguous. Not only does this impact on their social relations, but poor communication problems and misinterpretation tend to escalate hostility as well (Burke, 2009). There are good reasons to believe that the cognitions of children with conduct disorders are in various ways distorted and deficient. They may be unable to think of different ways of handling social situations or of understanding the consequences of various possible courses of action (Barker, 2004). Therefore the researcher is of the opinion that the child would benefit from psycho-education on the characteristics of his/her disorder, and how to manage these characteristics appropriately. Caregivers would also benefit from psycho-education to teach them appropriate ways to manage the needs of this child.

Barker (2004) refers to parent management training specifically. He states that this training has been evaluated and seen to be effective in improving problems experienced with these children. Its essence is the training of parents so that they interact with their children in ways that tend to lessen the children’s deviant behaviours (Barker, 2004). As both caregivers (child care workers and biological parents) have interactions with and influence the child with a mental health problem in a residential facility, both subsystems should receive this type of psycho-education.

NAMI (2011b), states that problem solving skills can also insist in improving interpersonal problems. “It offers children alternative ways of understanding social situations and of responding to them. They practice their newfound skills and earn rewards as they develop new, better responses to solving problems” (Barker, 2004, p. 55-56).

Irrespectively, Moretti, Holland, Moore and McKay (2005) state that it is essential to any intervention programme targeting severe conduct disorders, to embody a multi-
systemic perspective as such approaches have shown considerable promise in producing positive treatment effects. NAMI (2011b) suggests such a general approach to treatment:

- Parent training helps caregivers develop effective child behaviour management skills, including limit setting, enforcing consequences, reinforcing positive behaviours and enhancing behaviours at home and school.
- Anger coping therapy reduces future conduct problems, delinquency and substance abuse by promoting self-instruction and awareness.
- Mentoring connects a child with an adult to increase his/her healthy activity and involvement in school and the community.
- Cognitive behaviour therapy teaches youth how to notice, take account of and ultimately change thinking and behaviours that negatively impact their feelings.

The above are some general guidelines that could assist in the psycho-social needs of children with conduct disorders. The researcher perceived that some cognitive interventions are necessary as well. On the cognitive side, impaired verbal ability and reading problems are found more often in children with conduct disorders than in the general population. Barker (2004) is further of the opinion that tackling this often yields dividends. As the child’s reading skills improve, self-confidence may increase and the child may become less sensitive to the slights of others. Some individual interventions are however needed for a child with a conduct or oppositional disorder to improve his reading. The researcher suggests for the child to undergo an educational assessment to determine his/her educational needs. Interventions should consequently provide for these needs.

The researcher feels that medicinal treatment falls under the physical part of treatment, as it has an influence on neurological aspects and thus some bodily functions as well. According to Semple, Smyth, Burns, Darjee and McIntosh (2005), medication is a necessary part of treatment, especially if there are comorbid disorders present. According to Barker (2004) drugs have at best a limited role in treating conduct disorders, except when it is associated with problems of attention and hyperactivity. Stimulant medications using methylphenidate or dexamphetamine
may improve attention span and reduce hyperactivity, and sometimes this leads to a reduction in the conduct disorder symptoms.

In conclusion on conduct and oppositional disorders, Burke (2009) states that behaviour of children with these disorders is more extreme, differing from the behaviours of others of the same developmental age in the sense that they are much more than just a phase that will pass in time.

The researcher is of the opinion that services rendered to a child with a conduct or oppositional disorder, take place on micro and meso level mostly. On the micro level caregivers and peers should be taught skills on how to treat these children. These children’s needs have to firstly be identified to know how to provide for them. Some services are required from the meso level as well. It includes special schooling, different kinds of therapy, and pharmacotherapy.

2.3.3.2. Attention-deficit disorders:

Some children are strikingly more active than others. When the degree of activity reaches a certain level, children are deemed hyperactive. Often associated with hyperactivity is a short attention span (Barker, 2004). Barker (2004) further states that these are children who present with motor hyperactivity, restlessness, impaired attention spans and impulsivity. Although readily distractible, they usually attend only briefly to distracting stimuli. Other characteristics as identified by Barker (2004), the American Psychiatric Association (2000), NAMI (2011c) and Gray and Zide (2000) are as follows:
Table 2: Characteristics of attention deficit disorders in children

<table>
<thead>
<tr>
<th>Developmental stage</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>None</td>
</tr>
<tr>
<td>Early childhood</td>
<td>Restlessness</td>
</tr>
<tr>
<td></td>
<td>Readily distractible</td>
</tr>
<tr>
<td></td>
<td>Sleep disturbance</td>
</tr>
<tr>
<td></td>
<td>Unable to play quietly</td>
</tr>
<tr>
<td></td>
<td>Excessive moving</td>
</tr>
<tr>
<td></td>
<td>Difficult to contain</td>
</tr>
<tr>
<td>Middle childhood</td>
<td>Impulsivity</td>
</tr>
<tr>
<td></td>
<td>Fails to respond to disciplinary methods</td>
</tr>
<tr>
<td></td>
<td>Fidgeting</td>
</tr>
<tr>
<td></td>
<td>Talking excessively</td>
</tr>
<tr>
<td></td>
<td>Continually interrupting</td>
</tr>
<tr>
<td></td>
<td>Cannot organise</td>
</tr>
<tr>
<td></td>
<td>Forgetful</td>
</tr>
<tr>
<td></td>
<td>Difficulty with peer relationships and developing friendships</td>
</tr>
<tr>
<td></td>
<td>Not finishing homework or making a lot of mistakes</td>
</tr>
<tr>
<td></td>
<td>Never slowing down</td>
</tr>
<tr>
<td></td>
<td>Being exhausting or demanding</td>
</tr>
<tr>
<td></td>
<td>Displaying extreme physical agitation</td>
</tr>
<tr>
<td></td>
<td>Not listening or following through with instructions</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Fidgetiness</td>
</tr>
<tr>
<td></td>
<td>Inner feeling of jitteriness or restlessness</td>
</tr>
</tbody>
</table>

The American Psychiatric Association (2000) identifies more age-specific characteristics:

- It states that before four or five years it is difficult to establish diagnoses. The disorder is not readily observed because young children typically experience few demands for sustained attention. They might move excessively and typically are difficult to contain.

- During middle childhood inattention affects school work. Impulsivity leads to breaking of familial, interpersonal and educational rules. Symptoms of ADHD are most prominent during elementary grades. As children mature, symptoms usually become less conspicuous.
By early adolescence signs of excessive gross motor activity are less common and symptoms may be confined to fidgetiness or an inner feeling of jitteriness or restlessness.

Some of the above characteristics cause certain psychosocial challenges. As children appear to be non-compliant and fail to complete tasks, they might be blamed and even punished for their misdeeds by caregivers and/or teachers. Barker (2004), states that this may lead to secondary emotional problems. The author is further of the opinion that peers of children with attention-deficit disorders become irritated with them. The result may be that aggressive behaviour between the child and they develop (Barker, 2004).

In summary Burke (2009) states that usually children with attention deficits place substantial stress on their caregivers and others in the environment. Caregivers may start to see themselves as less skilled and knowledgeable than others. This may lead to feelings of helplessness and even depression amongst caregivers. Some peers might also feel responsible for the child with attention deficit disorders. They may feel obligated to help with homework or to keep him/her busy while the caregiver takes a break. They may also feel that the peer with attention deficits gets all the attention and he/she is neglected. Therefore the researcher feels that attention deficit disorders may not be as serious as the previous disorder discussed, but the effect it may have on peers in the home can be immense. This fact should not be denied, and these peers should also receive the needed support.

NAMI (2011b) provides caregivers with the following general guidelines on supporting the child with ADHD specifically:

- Maintain a positive attitude. Focus on the child’s strengths and successes.
- Create and maintain structure. Get a regular schedule of tasks each day. (A supportive structure for your child to know what to expect).
- Communicate rules and expectations: Write these down and paste it where the child can see it. Explain consequences when rules are broken and praise the child when they are obeyed. Rewards should be immediate experiences and activities with a caregiver to encourage bonding and connection.
• Encourage movement and sleep. Children living with ADHD who exercise often sleep better which can greatly reduce the symptoms of ADHD.
• Focus on social skills. Model social skills to the child.
• Work with the child’s school. Effective collaboration and communication between home and school promise to create a sense of structure and consistency.

Except for the above guidelines, Barker (2004) is of the opinion that operant conditioning programmes can improve attention span and decrease impulsive behaviour of children with attention deficits. Cognitive behavioural approaches can sometimes help children with poor impulse control. Stimulants (e.g. Ritalin) and dextroamphetamine are usually utilised in treatment of ADHD (Semple, Smyth, Burns, Darjee & McIntosh, 2005).

Cognitive aspects should also be considered, and Barker (2004) is of the opinion that children with ADHD fail to respond to disciplinary measures used by their teachers, and may disrupt the class and be noisy and over-talkative. NAMI (2011b) confirms this by stating that children living with ADHD often:
• perform better one-on-one than in groups;
• have trouble paying attention to details and often daydreams;
• avoid or dislike activities that require sustained attention;
• are highly distractible, forgetful, absent-minded, careless and disorganised; and
• speak out of turn and talk excessively.

Barker (2004) is of the opinion that a rational treatment plan can be developed only on the basis of a comprehensive assessment of the child and his situation at school. It is necessary to establish the type and severity of the child’s motor activity and/or attention problems.

Barker (2004) states that designing a school programme for them that capitalises on their strengths, and does not demand feats of concentration and sustained attention of which they are incapable, can greatly facilitate their progress. Some require individual or small group teaching.
Homework and tasks that have to be completed at home with the caregivers should also be considered. A child with ADHD can be assisted in the following manners when completing homework:

- Keep a daily planner.
- Offer praise, incentives or rewards when homework is done well.
- Divide big assignments into smaller tasks.
- Limit distractions while the child is busy with homework.
- Work with the child to fix mistakes when appropriate.
- Acknowledge that the child’s best is good enough (NAMI, 2011b).

There are again, a lot of interacting factors, systems and levels to be taken into account for children with attention deficit disorders. The child has an effect on the way the caregiver responds to him/her, and vice versa. Therefore, relationships and interactions on the meso level (especially with teachers) are an important consideration. These children need a lot of support and understanding from people in his/her environment. The researcher strongly suggests close monitoring when a child has been diagnosed with an attention deficit disorder. Observations proved that these disorders may precede more serious and complex disorders if left untreated.

2.3.3.3. Mood disorders:

Roberts and Alessi (n.d.) state that the term depression describes emotional distress across a broad continuum, from simple sadness to medical illness. Gray and Zide (2008) state that mood disorders refer to a group of emotional disturbances characterised by serious and persistent difficulty maintaining an even and productive emotional state.

Semple, Smyth, Burns, Darjee and McIntosh (2005), Roberts and Alessi (n.d.) and Burke (2009), identify the other characteristics of mood disorders:
Table 3: Characteristics of mood disorders in children

<table>
<thead>
<tr>
<th>Developmental stage</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>• Failure to thrive</td>
</tr>
<tr>
<td></td>
<td>• Separation anxiety</td>
</tr>
<tr>
<td></td>
<td>• Apathy</td>
</tr>
<tr>
<td></td>
<td>• Poor feeding</td>
</tr>
<tr>
<td>Early childhood</td>
<td>• Tantrums</td>
</tr>
<tr>
<td></td>
<td>• Depressed mood</td>
</tr>
<tr>
<td></td>
<td>• Loss of interest or pleasure</td>
</tr>
<tr>
<td>Middle childhood</td>
<td>• Aggression</td>
</tr>
<tr>
<td></td>
<td>• Hyperactivity</td>
</tr>
<tr>
<td></td>
<td>• Poor school performance</td>
</tr>
<tr>
<td></td>
<td>• Sleep disturbances</td>
</tr>
<tr>
<td></td>
<td>• Low self-esteem</td>
</tr>
<tr>
<td></td>
<td>• Fatigue or loss of energy</td>
</tr>
<tr>
<td></td>
<td>• Psychomotor retardation</td>
</tr>
<tr>
<td></td>
<td>• Psychomotor agitation</td>
</tr>
<tr>
<td></td>
<td>• Social withdrawal</td>
</tr>
<tr>
<td></td>
<td>• Sadness</td>
</tr>
<tr>
<td></td>
<td>• Worthlessness</td>
</tr>
<tr>
<td></td>
<td>• Academic failure</td>
</tr>
<tr>
<td></td>
<td>• Regressed behaviour</td>
</tr>
<tr>
<td>Adolescence</td>
<td>• Irritability</td>
</tr>
<tr>
<td></td>
<td>• Substance abuse</td>
</tr>
<tr>
<td></td>
<td>• School refusal</td>
</tr>
<tr>
<td></td>
<td>• Psychotic symptoms</td>
</tr>
<tr>
<td></td>
<td>• Defiance and conduct problems</td>
</tr>
<tr>
<td></td>
<td>• Melancholia</td>
</tr>
<tr>
<td></td>
<td>• Low self-esteem</td>
</tr>
<tr>
<td></td>
<td>• Suicide acts</td>
</tr>
</tbody>
</table>

According to NAMI (2011a) there is no single cause for major depression. Psychological, biological and environmental factors may contribute to its development. Depression may begin at any age, with an average age at onset in the mid-20’s. Epidemiological data suggest that the age at onset is decreasing for those born more recently (The American Psychiatric Association, 2000). This is perhaps
the reason for most literature on depression focusing on adolescents with depression only.

Schor (1996) is however of the opinion that because many youngsters are often unable to articulate their feelings, childhood depression can be difficult to identify. He suggests for caregivers to be on the lookout for subtle changes, as well as dramatic shifts, in a child's normal mood and behaviour. Therefore the earlier statements made regarding the relationship between the child and the caregiver, are suggestive that the relationship be strong and good. Only if the caregiver has a good sustaining relationship with a child, the changes would be noticed.

Caregivers should however also keep in mind that, like adults, children can feel emotionally down at times. However, if these feelings persist or interfere with normal activities, some form of depression may be present. Current literature suggests that depression would be most noticeable with the onset of adolescence.

According to Graber and Brooks-Gunn (2003) the transition into adolescence has been defined by physical changes of puberty, school changes from primary to high school environment, cognitive changes with increased ability to understand cause and effect and think about the future. The biological, social and personal challenges may be overwhelming for some children. Therefore the researcher suggests for caregivers to be on the lookout for any characteristics of depression during the critical stage of adolescents specifically.

The study completed by Graber and Brooks-Gunn (2003) suggests that depression problems are associated with dysfunction in multiple domains of the children’s lives. The researcher regards the psychosocial domain as the most important.

Barker (2004) reports on secure attachments and depression. He confirms that the emotional availability of caregivers is believed to foster secure bonds. The existence of such bonds may make it more likely that the child will use that relationship for support in times of stress. Insecure attachment may therefore be a risk factor for the development of depressive symptoms. A secure bond with a child care worker may let the child first seek refuge with the child care worker, before he/she considers
suicide. Therefore this is considered as very important. Social workers can assist child care workers and children to build and sustain such bonds.

A significant characteristic of a child with a mood disorder is that they sometimes socially withdraw themselves from others. Burke (2009) is of the opinion that social withdrawal includes a marked reduction in interpersonal contact with caregivers and peers. The severity may vary from irritability with others to total social withdrawal. The researcher feels that if a child care worker is attentive to the social interaction of the child, he/she will notice if the child has something that troubles him/her. It is probably because of this significant characteristic that NAMI (2010) states that the most common treatments for depression are psychosocial interventions (also called talk therapy), medication, or a combination of both.

NAMI (2010) is of the opinion that psychological interventions (referred to above as talk therapy), may include individual therapy (CBT), caregiver guidance, or group therapy (social skills training). Interventions may occur in a therapist’s office, in school, in the context of a day treatment programme, or most intensively, a hospital. The day treatment and hospital settings provide for special education and therapeutic interventions to be coordinated amongst members of an interdisciplinary team.

Barlow and Durand (2005) for instance specifically explore the possibility of interpersonal psychotherapy for treatment of mood disorders. After identifying the life stressors that seem to precipitate the depression, the therapist and patient work collaboratively on the patient’s current interpersonal problems. Typically, this includes one or more of four interpersonal issues:

- Dealing with interpersonal role disputes (such as conflict with peers).
- Adjusting to the loss of a relationship (these children experience being removed from their parents as a loss).
- Acquiring new relationships.
- Identifying and correcting deficits in social skills that prevent the child from initiating or maintaining important relationships.
The researcher is of the opinion that the above challenges the child experiences with regards to social interactions may be addressed through such interventions.

The document “Guidelines for the management and placement of children with special needs in residential facilities” (n.d.) summarises treatment for children with depression by stating that you should encourage the client to engage in activities, discourage isolation, praise the child where appropriate, and focus on the child’s strengths. The researcher agrees with this approach, and suggests for staff of child and youth care centres to follow a programme applicable to it. The researcher however suggests for the caregiver of the child to look beyond psychosocial areas, and address cognitive ones as well.

Barker (2004) states that intervention in school may be necessary to deal with problems the child has there, such as bullying, peer relationship difficulties and academic problems. Burke (2009) is however of the opinion that cognitive functions such as memory and orientation usually remain intact. Therefore the researcher feels that specialised schooling might not be such a big prerequisite as with other disorders. Additional interventions might be necessary to address peer relationship problems and other difficulties at school.

On the physical level with regards to pharmacotherapy, selective serotonin uptake inhibitors are generally considered to be the safest and most effective in the treatment of mood disorders. Literature suggests that when medication proves to be effective, it should be continued for a long period and then discontinued slowly while the child is monitored for signs of recurrence. It is important that patients do not stop taking these drugs as soon as they feel better, since relapse is then probable (Barker, 2004).

The researcher is of the opinion that all staff should adhere to the correct manners and time periods in which to administer medication. She suggests for all staff (especially child care workers who would give the child the medication), to be properly trained on the administration thereof, and for all role-players to effectively monitor the effects the medication has on the child.
Barker (2004) suggests for all the above treatment to take place in a low-stimulus environment, and the use of sedative medications for the management of acute states of mania. Suitable drugs include lorazepam, chlorpromazine and clonapenthixol. Once a child has stabilised a mood stabiliser is indicated. Lithium has long been used.

As could be seen children with mood disorders should be closely supported and monitored by all role-players in their direct micro environment. A child with depression especially needs a significant adult to form a sustaining attachment with. This person should provide support when needed. Other services must be utilised from the meso level as well. The researcher has noticed that a psychiatrist can for instance prescribe the necessary medication. Wilens (2004) is however of the opinion that who provides what type of care for the child will vary, depending on the child’s location, the health care plan, and the availability of specialists.

2.3.3.4. Anxiety disorders:

The essential feature of anxiety disorders is a persisting high level of anxiety, out of proportion to any stress the subject is facing. The anxiety may be expressed either directly or indirectly (Barker, 2004). Symptoms may include nightmares relating to a traumatic event, outbursts of anger and irritability, poor concentration, over-concern with safety, clinging behaviour, and repetition of the traumatic event during play (The Department of Social Development, n.d.).

Perspectives from the field of Child and Youth Care (n.d.) state that mental health problems are arguably the leading health problems children face after infancy. It states that, unlike many other conditions, anxiety disorder often goes unnoticed by caregivers. Characteristics that could be looked out for are defined by Gray and Zide (2000) and Semple, Smyth, Burns, Darjee and McIntosh (2005):
Table 4: Characteristics of anxiety disorders in children

<table>
<thead>
<tr>
<th>Developmental stage</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>None</td>
</tr>
<tr>
<td>Early childhood</td>
<td>- Crying</td>
</tr>
<tr>
<td></td>
<td>- Sleeplessness</td>
</tr>
<tr>
<td></td>
<td>- Irritability</td>
</tr>
<tr>
<td></td>
<td>- Separation anxiety</td>
</tr>
<tr>
<td>Middle childhood</td>
<td>- Aggression (fight)</td>
</tr>
<tr>
<td></td>
<td>- Escape (flight)</td>
</tr>
<tr>
<td></td>
<td>- Avoidance</td>
</tr>
<tr>
<td></td>
<td>- Thoughts of imminent danger</td>
</tr>
<tr>
<td></td>
<td>- Physical symptoms such as nausea, abdominal pain, headache and vomiting</td>
</tr>
<tr>
<td></td>
<td>- Feelings of fear, distress, apprehension and uneasiness</td>
</tr>
<tr>
<td></td>
<td>- Perception of powerlessness in face of danger</td>
</tr>
<tr>
<td></td>
<td>- Intense watchfulness or hyper vigilance</td>
</tr>
<tr>
<td>Adolescence</td>
<td>- Poor performance</td>
</tr>
</tbody>
</table>

The American Psychiatric Association (2000) states that although over half of those presenting for treatment for anxiety disorders report onset in middle childhood or adolescence, onset occurring after age 20 years is not uncommon. The researcher is however of the opinion that a few children present with some of the characteristics discussed above. It might be that children are just not diagnosed with this disorder until later in their lives. The reason why children develop such disorders is, according to the researcher, the incorrect management of a child (perhaps discipline with violence).

According to Barker (2004) there is reason to believe that parenting behaviours and the emotional environment play their part in determining whether children develop anxiety disorders. Insecure or anxious attachment for instance tends to lead to anxiety and emotional insecurity in children. Here the importance of a secure attachment in the development of mental health is again highlighted. The researcher is of the opinion that children, who were removed from their primary caregivers, did not have a secure attachment with them. As mentioned, this may also lead to anxiety. It however seems as if this disorder is difficult to diagnose in young children.
Semple, Smyth, Burns, Darjee and McIntosh (2005) state that as a result of changing developmental and cognitive abilities during childhood, the content of normal fears and anxieties shift from concerns about external things to abstract internalised anxieties. It is thus these internalised anxieties that separate children with a mental health problem (specifically related to anxiety) from a child without. Therefore the researcher suggests for professionals to assess whether the child is experiencing normal or abnormal anxieties.

The document “perspectives from the field of child and youth care” (2009) states that the following can also be done to stop the cycle of anxiety disorders going unnoticed:

- Look at the context of the child’s daily life. Is it competitive or cooperative, isolating or insulating, hostile or hospitable? The researcher is for instance of the opinion that if the child’s caregivers expect too much of him/her, it may cause unnecessary anxieties.
- As caregivers we need to learn what triggers exist for anxiety, and how to cope with them. These coping skills should be taught to children. A child, who has been abused by his/her screaming, drunken father, might become anxious when he/she hears someone talking loudly. It in other words triggers the anxiety. Certain therapies might be introduced to help the child overcome these triggers.
- Offer supportive, secure environments to children. The researcher feels that staff of a child and youth care centre should prove to the child that he/she can be trusted.

The Department of Social Development (n.d.) further suggests encouraging feelings of safety and security within the institution, increasing physical activities, encouraging the play of sports and referring to a psychologist for assessment and management. The researcher feels that this will prevent the child from isolating him/herself from others. Activities and sports they are good in can build the child’s self-esteem. Assessment and identification of needs of the child should precede guidelines to help provide for these needs.

The researcher agrees with Barker (2004) when he states that a child with anxiety would benefit from therapy. He feels that individual therapy may be conducted to
address certain symptoms of anxiety disorders. One such therapy is behaviour therapy. The essence of this approach is the gradual introduction of the phobic object or situation while the subject is in a state of relaxation. Cognitive behavioural therapy (CBT) is also often an effective treatment for anxiety disorders. The researcher however reminds staff of child and youth care centres that all children differ, and what works for one might not work for the other.

Certain pharmacotherapy interventions should also address each specific child’s needs. Barker (2004) states that pharmacologically benzodiazepine drugs such as lorazepam, alprazolam and diazepam may provide short-term symptomatic relief for panic disorders and generalised anxiety disorders, but their use for more than a few weeks at most is not advisable. Various antidepressants have been shown to be of value in the treatment of anxiety disorders. Semple, Smyth, Burns, Darjee and McIntosh (2005) are of opinion that SSRI’s are first-line agents to use in this case. The researcher however remains of the opinion that only qualified professionals should prescribe such medication.

Not much is said about the educational progress of children with anxiety disorders. Therefore the researcher assumes that children with anxiety disorders do not generally need specialised education, unless other cognitive challenges are identified. In severe cases, a child might for instance have a fear of leaving the house to go to school, which can obviously hinder his/her, academic performance.

As seen above anxiety disorder appears to sometimes go by unidentified and untreated. If there is no support for a child with an anxiety disorder, he/she might never realise that their fears and/or worries are not justified by reality. If identified and diagnosed by an appropriate professional on the meso level, therapy should be conducted – consistent with a treatment plan developed by a multidisciplinary team on the micro (child care workers, biological parents and peers) and meso (social worker, teacher, therapist, psychiatrist) levels.
2.3.3.5. Psychotic disorders:

Symptoms that may characterise psychotic disorders are mentioned by Gray and Zide (2000), Barker (2004) and the Department of Social Development (n.d.):

Table 5: Characteristics of psychotic disorders in children

<table>
<thead>
<tr>
<th>Developmental stage</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>• None</td>
</tr>
<tr>
<td>Early childhood</td>
<td>• None associated with psychosis specifically</td>
</tr>
<tr>
<td>Middle childhood</td>
<td>• Disorganised speech</td>
</tr>
<tr>
<td></td>
<td>• Thought withdrawal</td>
</tr>
<tr>
<td></td>
<td>• Thought broadcasting</td>
</tr>
<tr>
<td></td>
<td>• Perplexity</td>
</tr>
<tr>
<td></td>
<td>• Depressive and euphoric mood changes</td>
</tr>
<tr>
<td>Adolescence</td>
<td>• Delusions (false and fixed beliefs based on incorrect deductions or misrepresentation of the person’s reality)</td>
</tr>
<tr>
<td></td>
<td>• Hallucinations (experiences of sensory events without environmental stimulation)</td>
</tr>
<tr>
<td></td>
<td>• Altered contact with reality</td>
</tr>
<tr>
<td></td>
<td>• Hearing voices and/or seeing things others cannot see</td>
</tr>
<tr>
<td></td>
<td>• Bizarre behaviour (refers to a pattern of conduct or demeanour far removed from normal and expected experiences)</td>
</tr>
<tr>
<td></td>
<td>• Poor hygiene</td>
</tr>
<tr>
<td></td>
<td>• Inappropriately dressed</td>
</tr>
<tr>
<td></td>
<td>• Somatic passivity experiences</td>
</tr>
<tr>
<td></td>
<td>• Disturbance of perceptions</td>
</tr>
<tr>
<td></td>
<td>• Feelings of emotional impoverishment</td>
</tr>
<tr>
<td></td>
<td>• Disorganised behaviour (involves physical actions that appear to be goal directed e.g. pacing excitedly)</td>
</tr>
<tr>
<td></td>
<td>• Flat effect is exhibited by gazing with vacant eyes</td>
</tr>
<tr>
<td></td>
<td>• Abolition involves the inability to make goal directed choices and the expression of little or no interest in activities</td>
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</table>

In clarification of the above, the American Psychiatric Association, 2000, states that the onset of schizophrenia typically occurs between the late teens and mid 30’s, with onset prior to adolescence rare. Although the literature state that onset of schizophrenia in early and middle childhood is rare, the researcher perceived that
some children present with characteristics similar to the identified during middle childhood. Consequently the importance of relevant assessments is again highlighted. One should ensure whether the child is presenting with problem behaviour, or if he/she might be presenting with the onset of schizophrenia.

Semple, Smyth, Burns, Darjee and McIntosh (2005), states that the assessment of a child with these types of symptoms requires extreme care and thoroughness. In diagnoses the child is assessed to see if he/she presents with certain characteristics applicable to a psychotic disorder.

Semple, Smyth, Burns, Darjee and McIntosh (2005) confirms the above by stating that psychotic illnesses are rare in children and present a particular challenge in both diagnoses and treatment. Very young children under six years have preoperational cognitions and thus reality testing is blurred by a range of normal fantasy material. Imagined friends, transient hallucinations under stress and loose associations may all occur as part of the normal spectrum of childhood experience.

According to the American Psychiatric Association (2000) the onset may be abrupt or insidious, but the majority of individuals display some type of prodromal phase manifested by the slow and gradual development of a variety of signs and symptoms (e.g. social withdrawal, loss of interest in school, deterioration in hygiene and grooming, unusual behaviour, outbursts of anger). The researcher perceived that these characteristics can already present themselves by middle childhood, as mentioned in Table 5.

The researcher further feels that psychosocially schizophrenia interferes with almost every aspect of a person’s intrapersonal world. It disrupts how they see their social environment, the manner in which they speak and think (Gray & Zide, 2000). From an ecosystemic viewpoint, the researcher is of the opinion that this disruption from the child’s point of view may disrupt reactions from caregivers and peers in the micro environment as well. Therefore people, who reside in the direct environment of this child, should be deliberated.
Jordaan (2009), in Burke (2009), feels that the impact of these syndromes on the lives of the infected individuals and their families are disastrous; it usually results in lifelong impairment and disability. Individuals and caregivers bear direct financial and emotional costs. Costs to society are significant considering the loss of human potential, the financial impact of treatment, hospitalisation and the disability benefits that result.

“A broad approach to treatment is also necessary. Environmental or psychological stress factors and other challenges that the child faces must be addressed. Traditional psychotherapy is not effective, but cognitive behavioural methods and social skills training may be. The provision of a calm environment with suitable control of expressed emotion is desirable. Communication problems should be addressed. Day-treatment programmes are sometimes helpful, and in acute phases of the condition inpatient admission may be needed” (Barker, 2004, p. 112-113).

Semple, Smyth, Burns, Darjee and McIntosh (2005) state that, with these disorders, the child will benefit from work with people in his/her environment and a focus on psycho-educational skills, and problem-solving strategies and cognitive behavioural therapy. The researcher however feels that the consequences this disorder bear, can only be addressed by an appropriate professional – a psychiatrist. She feels that it is typically the psychiatrists’ role to perform the considered treatment: the use of antipsychotic drugs, psychosocial measures, educational measures and long-term management (Barker, 2004).

The researcher states that the use of medication should be monitored by caregivers in direct micro environment. Case managers (social workers) on the meso level, should engage all systems for the child to visit the psychiatrist. The Department of Social Development (n.d.) state that it is very important to ensure that the child complies with the use of medication and appointments with psychiatrists.

If available, specialised schooling is also suggested. Most children with psychotic disorders do not perform well in regular class room settings. They are usually best taught in a small class setting by staff trained to work with emotionally disturbed
children, and using a curriculum tailored to their level of cognitive functioning (Barker, 2004).

Therefore the researcher feels that these children would best be taught at the residential facility with a teacher that will be able to manage the individual child with his/her severe mental health problem, and this child’s extensive educational needs. Therefore this professional (who will act on the meso level), would have to be appropriately knowledgeable in the field of mental health and education to children with special needs.

It seems as if the prognosis for children with psychotic disorders is negative. The researcher perceived that these children’s disruptive behaviour can harm those in his/her immediate environment to a much bigger extent than discussed by literature. Therefore professional treatment by psychiatrists, and when necessary hospitalisation, are important considerations suggested to child and youth care centres by the researcher.

2.3.4. Summary of this section:

In the preceding section the researcher discussed some needs of the individual child with a mental health problem. It is one of the basic goals of child welfare to provide for or to meet these needs. Kirst-Ashman (2003) specifically states that some of the goals of child welfare include:

- Meet vulnerable children’s unmet emotional, behavioural and health needs. The researcher highlighted some important needs that a child with a mental health problem has. It was divided under physical, educational and psychosocial needs.
- Providing adequate resources so that children can develop and thrive in a healthy, nurturing social environment. The researcher suggests for child and youth care centres to provide adequate resources to provide for the needs of the children. She confirms that this residential facility should be healthy and nurturing. Such an environment might be conducive to the overall mental health of a child. Certain ecosystemic guidelines should however be
implemented in this environment, that can improve the coping and adaptation of the child.

Hereunder the researcher summarises some guidelines provided by literature:

i. *Prevention:* The researcher is of the opinion that prevention includes high quality care of children in child and youth care centres. Good quality care takes into consideration the physical, cognitive, and psychosocial needs of all children.

ii. *Early identification and intervention:* Part of prevention, is early identification and intervention (Kirst-Ashman, 2003). A child being admitted to a child and youth care centre with an existing mental health problem may benefit from early identification of a negative mental health status. The researcher strongly feels that a child’s mental health status can only be known if he/she is assessed. Therefore the researcher suggests for staff of a child and youth care centre to assess a child upon admission. Interventions (based on the outcomes of the assessment) may be effective in preventing the problem from increasing.

iii. *Therapeutic services:* The researcher feels that therapeutic services are part of a comprehensive treatment plan for the individual child and his/her unique needs. As seen this can exist of different kinds of individual and group therapy. Traditional modes of psychotherapy have a definite place in residential and mental health treatment (Lewis, 2002).

iv. *Pharmacotherapy:* As mentioned pharmacotherapy plays an integral part in the treatment of certain mental health problems. Baumann (2008) however states that the best interests of the child must always be critical in any decision around medication (Baumann, 2008). The researcher feels that the use of medication should be monitored closely by all relevant role-players.

v. *Crisis services:* Crisis management interventions should be in place for when a child’s mental health state reaches a point where he/she is capable of harming him/herself and/or others. Child care workers should know what to do and who to contact in such a situation. The researcher feels that at this point a child should
be hospitalised. Barker (2004) confirms this by stating that admission may be indicated because the child’s behaviour is so disturbed that management elsewhere is impractical and/or there is a serious risk of suicide or harm to others.

vi. **Inpatient treatment:** As with the above, Wilens (2004) states that when children are potentially dangerous to either themselves or to others, they should be hospitalised. The following symptoms should be taken into account in assessing whether a child should be hospitalised or not; when the child’s condition rapidly deteriorates, when there are inadequate resources to manage them safely at home or in the community, when there is severe behavioural medication reaction, unstable eating disorders, or the inability to complete further comprehensive assessment on an outpatient basis.

vii. **Outpatient treatment:** “Most inpatient units admit children and adolescents for fairly short periods, as part of a larger, on-going treatment plan” (Barker, 2004, p. 206). The researcher earlier mentioned that inpatient treatment for children in South Africa is only temporary, and therefore the child should receive outpatient treatment when stabilised and discharged from inpatient treatment. She suggests for this to include a combination of all the above interventions and services coordinated by the child and youth care centre.

viii. **School based programmes:** As mentioned most of the children concerned struggle to cope with and adapt to the demands of mainstream schooling. These programmes may consist of remedial teaching, changes in the educational methods being used, transfer to a more suitable school or class, or some combination of these measures (Barker, 2004).

While some or all of the above guidelines are implemented with the individual child only, consideration should also be given to relationships and social interactions outside of the child’s direct environment. This is where meso level aspects play an important role.
2.4. Meso level:

The micro systems involved in a child with a mental health problem's immediate environment have already been discussed (biological parents, child care workers and peers). Other subsystems are involved in a child’s life, but on a meso level. The researcher is of the opinion that these role-players are involved in managing one or more of the micro level indicators of effective ecosystemic orientated care.

Summers (2003) lists individuals that must be part of an interdisciplinary team in a residential facility:

- A social worker and/or case manager.
• A teacher.
• The appropriate counsellor or therapist.
• Any other person who is important to the child that can contribute to an effective service plan (e.g. a speech therapist).

2.4.1. **Social worker and/or case manager:**

The researcher feels that social workers play crucial roles in child and youth care centres and therefore the life of an individual child residing there. They assist the child care workers in their day-to-day tasks. Krueger (2004) for instance states that it is the worker’s task to prevent, teach, support and correct with strategies that are appropriate for the current level of physical, cognitive and psychosocial development at which a child is functioning. Therefore the researcher feels that social workers are supposed to be up to date with information on the mental health of children. The social worker can transfer this knowledge to biological parents and/or child care workers, and if and when necessary, children with mental health problems and peers.

The researcher also feels that social workers are important links between children in the residential facility and services rendered outside of it. Therefore social workers need the skill; networking. Social intervention requires a thorough working knowledge of what resources are suitable for which mental health users, under what circumstances. Networking will help promote an awareness of where resources are depleted and where they are more available. Resources, especially those that offer residential care, require strong psychiatric support for referral to specialised care when residents need it (Baumann, 2008).

A list of services and/or specialists that a child can be referred to in Gauteng is attached (Appendix A). The researcher observed that it is important for a social worker to have good communicative relationships with role-players who provide mental health services outside of the facility. This ensures that the proper services would be rendered and the possibility of misunderstandings is minimised.
For the same reasons good communicative relationships with child care workers and biological parents are necessary. The researcher feels that this would result in the social worker having knowledge of the child and his/her situation, which is necessary to effectively manage the child’s needs and social work case (referred to as case management).

Summers (2003) focuses on case management with individuals with mental health problems specifically. Case managers bring clients into the system with an assessment of what they need, develop an individual plan, link clients to the appropriate services, and monitor clients’ progress and changing needs. They provide valuable information and observations to other members of the team (Lewis, 2002). Case management further requires a single professional or at least a single facility that keeps track of the progress or otherwise of the child and follows up referrals, reports and treatment decisions, as well as providing monitoring and a single contact point for caregivers (Baumann, 2008).

According to the researcher social workers (acting as case managers) will be the first professional to assess a child and his/her mental health status upon admission into a child and youth care centre. Social workers should also be the last professional, who plans, and then implements (with cooperation of relevant role-players), an individual plan for each child as stated in the preceding paragraph.

Kibel and Wagstaff (2001) suggest the following information to be collected during the initial assessment:

- **History**: Most important areas are presenting complaints; current functioning; developmental history; family history, functioning and relationships and environmental stress.
- **Examination**: Physical and mental status of the child and family members if family members are available and involved.
- **Special investigations**: Principle sources are class teacher’s report; relevant medical investigations; psychological testing; occupational therapy assessment and speech therapy assessment.
The role of bio-psychosocial factors. These factors include biological, psychological (which entails thoughts, emotions, and behaviours), and social factors. All these factors play a significant role in human functioning in the context of disease or illness (www.wikipedia.org).

Differential diagnoses. A differential diagnosis is a systematic diagnostic method used to identify the presence of an entity where multiple alternatives are possible (and the process may be termed differential diagnostic procedure) (www.wikipedia.org).

Summers (2003), is of the opinion that your intake assessment paves the way for the development of a sound treatment plan. The researcher is of the opinion that other professionals (to be discussed this section), are responsible for additional assessments (physical, cognitive, and psychological), if and when needed. She suggests for social workers to, based on the information of all assessments, make conclusions regarding the care and treatment of every individual child in the child and youth care centre. The researcher reminds the social worker to constantly consider the observations of child care workers as well. Child care workers are also suggested to be involved in the assessment, planning and treatment procedures.

The researcher feels that except for initial and concluding assessments, on-going evaluation and management of every child’s case and mental health status is crucial.

Based on the above, the researcher is of the opinion that the social worker forms a very important link between a child with a mental health problem, his/her caregivers, peers, and services provided by role-players outside the facility. The social workers’ initial and concluding assessments will pave the way for the appropriate treatment of a child.

2.4.2. Teachers:

Teachers interact with children on a daily basis, and as was seen in previous sections, teachers can have positive and negative effects on children’s mental health. Based on observations and literature studied, the researcher feels that
teachers working with a child with a mental health problem should be knowledgeable about the challenges involved. These teachers should be willing to live up to these challenges, and be able to manage difficult children and their behaviour.

Educational aspects were touched upon when cognitive development was discussed. Additional points the researcher deems necessary to focus on, are for instance those discussed by Donald, Lazarus and Lolwana (2004). They state that the following guidelines can be followed in teaching a child with a mental health problem:

- Be systematic and patient in teaching. In particular, teachers should be prepared to repeat often, to break work up into small steps and to be as concrete as possible in explanations and demonstrations.
- Establishing a clear routine for daily learning activities will help the child to feel more secure.
- Special attention should be given to the attention span of a child.
- The principles of mastery learning, where the child is given as many repetitions, as long as is needed, to really master the skill or concept, are of importance here.
- Modelling and helping a child to use basic but more effective ways of remembering and problem-solving can have positive ripple effects on other scholastic and everyday tasks, as well as general intellectual functioning.

As noted earlier and assumed from the above guidelines, teachers need specialised training to be able to deal appropriately with a child with a mental health problem. It is further clear that these children need individualised education.

Unfortunately it cannot take place in mainstream schools in South Africa, simply because the child to teacher ratio is too large. Consequences are that the child does not receive the necessary educational inputs. As seen earlier children might feel inferior about educational challenges, and it affect his/her relationships with his/her peer.
The researcher is afraid that in the long run these children might drop out of school, as they are not motivated to stay there, and adequate skills for employment were never obtained. Therefore the training a teacher has and stance he/she takes towards a child with a mental health problem, can affect that child's future.

2.4.3. Therapists:

The researcher is of the opinion that appropriate therapists are necessary to help develop and implement successful intervention plans containing specifications on what kind of therapy an individual child should receive. Social workers can also act as a therapist to the child. The researcher is however of the opinion that social workers are not fully trained to manage mental health problems, and therefore issues regarding the disorder itself should rather be addressed by the appropriate mental health professionals.

According to Pumariega and Winters (2003), child psychiatrists for instance have critical roles in the treatment of children with serious emotional disturbances. They provide effective diagnostic evaluation for children with disorders and can serve as clinical consultants to other professionals in interdisciplinary treatment teams in the construction, implementation and re-evaluation of treatment plans. They initiate pharmacotherapy and, when the child’s condition is stabilised, the transition of care can be guided to medical professionals, or pharmacotherapy and even psychotherapy can be continued for children with more serious conditions.

Lewis (2002) further states that the role of a psychiatrist in a residential facility would be, amongst others:

- Participate in case conferences with team members.
- Direct psychiatric evaluation of children. The researcher feels that before appropriate treatment can begin, proper diagnoses should be made. This can only be done by an evaluation.
- Monitoring of patients on psychotropic medications. Child care workers can provide the needed feedback to the psychiatrist.
The researcher is therefore of the opinion that the psychiatrist plays an important role in the conducting of individualised interventions. Besides specialised social workers and psychiatrists that can render psychotherapy, cognitive behaviour therapy, or any other mental health intervention needed, a child with a mental health problem may have more extensive needs upon those related to his/her disorder.

Therefore other role-players may form part of the meso level as well.

2.4.4. Other role-players:

Examples of additional services that a child with a mental health problem may be in need of are:

- A speech therapist to assist with delays in speech.
- An occupational therapist to assist with other developmental delays.
- A primary health care practitioner that may assist with primary mental health care and/or physical medical care.
- Persons who provide additional education in the form of extra classes.

The researcher notes that not every child will receive services from either or all of these role-players. Their involvement in an individual child’s meso level system would depend on the child’s needs. Note however that all role-players should continuously be aware of interventions and progress/lapses of a child, and inform each other of it. In other words, all role-players should interact and exchange transactions. If this is done successfully, cohesiveness between all these role-players is achieved. Jones, Cooper and Ferguson (2008) justly state that an important aspect is that transactions should take place inter-professionally. No one should act alone.

2.4.5. Cohesiveness between all role-players:

It is evident that there are a few role-players involved in caring for and managing the needs of a child with a mental health problem in a child and youth care centre. All these role-players interact with one another and the individual child. The researcher
feels that cohesiveness is necessary for successful implementation of comprehensive treatment plans.

Each role-player however has their own responsibilities and functions as a separate subsystem inside the mesosystem. Still all have a collective goal to reach, which is to provide effective ecosystemic care to children with mental health problems in residential facilities. Johnson (1982) in Lewis (2002) describes measures that promote cohesiveness between all staff members:

- Meetings to discuss process issues.
- Leadership skills.
- Clear lines of authority and role expectations.
- Training programmes.
- Total team participation.
- Prompt expressions of support, concern and empathy.

In summary, Michael (2006) is of the opinion that it is imperative for children that the care they receive is consistent, competent and responsive to their needs. The environment created by staff must be as such that the identified needs of these children can be met.

**2.4.6. Summary of meso level:**

Role-players not discussed in the microsystem, but identified as compulsory to the mesosystem of a child with a mental health problem, are:

- **Social workers:** They serve a three-fold purpose. They are the first professionals to assess the mental health status of a child when he/she enters a child and youth care centre. They should be able to refer children to appropriate service providers if necessary. They act as a link between the child and the child care workers and other role-players involved in a child’s life, teaching and guiding them.
- **Teachers:** Help children to gain academic achievement. Children with mental health problems are suggested to be educated by teachers specialising in the
education for the children concerned. Teachers serve an important assessment role in children’s pharmacotherapy and the effectiveness thereof.

- **Therapists:** They conduct the necessary therapy with the child with a mental health problem. Usually a social worker deals with therapeutic issues regarding a child’s removal from his biological family. Psychiatrists can conduct psychotherapy and initiate pharmacotherapy.

- Any other *significant person* who can render specialised services to a child in need of it also functions on this level. All role-players on the meso level must work in collaboration towards the collective goal of attempting to assist a child with a mental health problem in coping and adaptation in a child and youth care centre.

![Figure 2: Summary of interventions necessary on the meso level](Copyright Y Allers 2011)

### 2.5. Exo level:

As mentioned the exo level consists of settings a person may not experience first-hand, but it still has an influence on his/her functioning. An applicable example is, in this case, government policy.
The researcher argues that South African legislation regarding service rendering to children with mental disorders, is in place. It however appears as if child and youth care centres have not been able to practically implement policy guidelines, because of a lack of skilled professionals and specialised programmes. Legislation regarding the topic was studied. Existing policy guidelines seem to summarise the guidelines of effective ecosystemic orientated care already provided in this literature review.

Section 28(1) of the Constitution (1996) for instance states that all children in South Africa are entitled to:

- a name and nationality;
- family or parental care or appropriate alternative care if removed from the family;
- basic nutrition;
- basic health care services and social services;
- protection from maltreatment, neglect, abuse and exploitation.

The researcher interprets that children have the right for their physiological, educational and psychosocial needs (as discussed) to be provided for, in a caring environment.

The White Paper for Social Welfare (1997) supports the above, basic rights of children by stating that social welfare programmes should protect all human rights and promote equality of opportunity and the participation of all people. The researcher perceived that currently children with mental health problems do not receive equal services and opportunity of participation in mainstream child and youth care centres, as it seems as if there are no specific programmes developed to provide for their needs.

From a further social welfare perspective, section 194(2) of the Children’s Act 38 of 2005 states that norms and standards of child and youth care centres are, amongst others:

- Residential care programme. *No specialised programmes addressing mental health could be found in the Gauteng Province.*
• Developmental programmes. *Some mainstream programmes do provide for developmental stages and areas.*

• Protection from abuse and neglect. *As mentioned children shouldn't be exposed to further abuse and/or neglect.*

• Assessment of children. *For which a multi-disciplinary team is needed to develop a treatment plan.*

• Access to and provision of adequate health care. *The researcher observed that a few private mental health services provided are not financially accessible to children in child and youth care centres.*

• Access to schooling, education and early childhood development. *As discussed children with mental health disorders usually need specialised schooling.*

• Security measures for child and youth care centres. *With the stance of children with aggressive behaviour, how safe are the other children in the home? What security measures can be taken?*

• Measures for the separation of children in secure care programmes from children in other programmes. *The above once again confirm that children with mental disorders are meant to receive specialised services, irrespective of living in a mainstream or specialised residential facility. Therefore the researcher feels that a suggested programme should be able to be implemented in both.*

From a mental health point of view, the Mental Health Act aims to protect the rights of mentally ill people specifically. This includes the right to dignified and humane treatment, freedom from discrimination in terms of access to all forms of treatment, the right to privacy and confidentiality, the right to protection from physical or psychological abuse and the right to adequate information about their clinical status (Baumann, 2008).

The following literature from the Health Systems Trust (2008), provides some explanations for why the services as stated by policies are perhaps not being rendered: While South Africa has made significant strides at the level of policy and legislation, thus bringing the country in line with other countries around the world that
have made similar efforts at integration, there have been a number of challenges. Integration of mental health into the primary health care system without adequate community participation and involvement, limited resources, lack of infrastructure and political will, amongst other factors, poses a serious threat to the realisation of the planned principles.

The researcher remains of the opinion that these services are not practically implemented because of a lack of skills, knowledge and resources. In summary the researcher feels that the following three primary policies must be taken into account when developing a programme and/or rendering services to children with mental health problems in child and youth care centres in South Africa:

- **Constitution (1996):** The Constitution provides for the most basic physiological needs of children to be met. The researcher agrees that a child’s need for food and shelter should be met without any exceptions.

- **Social Welfare (White Paper of Social Welfare, 1997 and Children’s Act 38 of 2005):** Social welfare policies state that children are entitled to specialised services to be rendered to them in the form of specific programmes. This includes the right to not be isolated from mainstream homes.

- **Mental Health Act 17 of 2002:** This act states that a child with a mental health problem has the right to be treated humanely and with dignity. They should be protected from physical and/or emotional abuse and any form of discrimination.
All of the aspects discussed thus far (micro, meso and exo levels) are embedded in the macro system – in this case the child and youth care centre as a whole.

2.6. Macro level:

According to Kirst-Ashman (2000) the macro environment involves the conditions, circumstances and human interactions that encompass human beings. Thus, the broader environment (child and youth care centre), that a child with a mental health problem reside in and it’s relevant systems and interactions.

As mentioned earlier it is the broad ideology that dictates how children should be treated, what they should be taught, and the goals for which they should strive (Shaffer, 2002). In summary therefore, effective eco-systemic orientated care guidelines to children with a mental health problem in a residential facility graphically present as follows:
Figure 4: Summary of interventions necessary on the macro level (child and youth care centre as a whole)
Copyright Y Allers 2011
This study views the child with a mental health problem systemically. Kirst-Ashman (2003), states that a target of change is the system that social workers need to change or influence in order to accomplish goals. In this chapter different targets of change were identified in terms of the ecosystemic perspective.

The first and foremost target of change focussed upon, is the individual child who is embedded in the micro, meso, exo and macro levels of a child and youth care centre. This individual child has individual and unique needs that should be provided for by individual treatment plans. These needs are largely provided for by subsystems in the child’s direct environment – biological parents (if involved), child care workers and peers. These key role-players, who have proximal interactions with the child, can therefore influence the individual child’s coping, adaptation and, more than that, mental health. Therefore some guidelines were discussed on how interactions can be utilised to receive positive outputs and feedback. The most important guidelines are regarded as early identification and intervention, therapy, pharmacotherapy and school based programmes.

Other role-players are found on the meso level, which is regarded as the second target of change. Role-players like social workers, teachers, therapists and significant others can also have an influence on how the child adapts to his/her environment. These role-players are not necessarily involved in the child’s everyday lives, but they help the child with a mental health problem in a residential facility cope with negative life experiences and adapt to the residential and school environment. Role-players on micro and meso levels should work collaboratively in achieving this goal, as every transaction by every subsystem influences another.

Except for role-players that implement certain services and consequently have a direct bearing on the child’s mental health, the exo level can have an indirect effect when policies are taken into consideration. Policies are however not regarded as a target of change. The researcher feels that policy guidelines regarding service rendering to children with mental health problems in child and youth care centres are in place. They appear to not be practically implemented however. The reason being, that there is a lack of resources. Therefore the researcher deems it necessary for

All the identified and suggested guidelines should be implemented in the broader context of the macro level – thus the child and youth care centre as presented in the above figure. As a whole, this is seen as the last target of change. The child and youth care centre is a residential facility for children to reside in after being removed from the care of their biological parents because of maltreatment. The researcher feels that these facilities are not providing for the needs of children with mental health problems, and that effective ecosystemic guidelines should be put into place to address this.

2.7. Conclusions:

The researcher is of the opinion that this research study is primarily based on social work and a well-known social work perspective – the ecosystems theory. Kirst-Ashman (2003) is of the opinion that social work practitioners (e.g. the researcher), are equipped with a repertoire of skills to help them identify and examine problems. They then make choices about where their efforts can be best directed. As in this study, social work targets the environment (child and youth care centre) encompassing clients (children with mental health problems who reside there), for change.

This study attempts to provide effective ecosystemic orientated care that promotes coping and adaptation of a child with a mental health problem in a residential facility by paying attention to systems involved. Consequently improved coping and adaptation may lead to a good person-environment-fit. This in turn may optimise the children concerned’s mental health.

This literature review provided the researcher with such an initial programme. An initial programme with ecosystemic guidelines that can be utilised in an attempt to improve the mental health status of children suffering from mental health problems in child and youth care centres across Gauteng is suggested as follows:
**Step 1:** The researcher suggests for the social worker to assess a child upon admission into a child and youth care centre. If the social worker is of the opinion that the child does not present with a mental health problem, the mainstream programme can be continued. If he/she however feels that the child might present with a mental health problem, step 2 should be followed.

**Step 2:** In this step the additional assessments as mentioned earlier, are implemented. The researcher feels that child care workers should (after a few days’ observation) provide the social worker with feedback on the child’s behaviour. Secondly a physical examination can be done to rule out any physical causes for problem behaviour. An educational assessment is necessary to evaluate the child’s cognitive stance and academic abilities. If there are problems noted, it should receive further specialised attention. Lastly a psychiatric evaluation will establish if a child has a mental health disorder, and if he/she does, he/she will be diagnosed with one or more. The social worker is then responsible to continue with step 3.

**Step 3:** The researcher suggests for social workers to gather information on all above assessments, and to integrate the findings and evaluations made by each role-player. The social worker is then responsible to (in conjunction with the child care worker) develop an individual care and treatment plan for that child. The researcher suggests for staff of a child and youth care centre to, after psycho-education of all parties, implement guidelines that will provide for the needs of a child with a specific mental health disorder.
Figure 5: Summary of assessment process and initial programme to be implemented for effective ecosystemic orientated care of children with mental health problems in child and youth care centres

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Except for the above initial programme, this chapter (literature review as part of qualitative research), provided a basis for the empirical study (remaining of qualitative research) to be conducted. Therefore the methodology chapter will follow.
Chapter 3
Methodology

3.1. Introduction:

The literature review in the preceding chapter (first part of qualitative research), learned more about the answers that already exist for general research questions. The research questions partially answered through the implementation of a literature review were:

1. What are the characteristics of a child with a mental health problem?
2. What are consequently identified as the needs of children with mental health problems in a child and youth care centre?
3. What guidelines exist that may help to provide for the identified needs?
4. In what way can child and youth care centres be equipped and what guidelines (in the form of a programme) can be put in place in order to provide for these needs?

From the previous chapters – introduction to the study and literature review – it was established that the goal of this study is to provide a management programme to mainstream and specialised child and youth care centres, on how to care optimally for children with mental health problems. The researcher feels that the information retrieved in the literature review is not sufficient to provide for such a programme. Some aspects of these questions remain unanswered.

In this chapter the researcher will retrieve information on answers that do not already exist for general research questions, from key role-players in focus groups (empirical research). The researcher is in need of specific information which will compliment and add to information collected from the previous chapter. For this, the researcher needs the opinions of people who actually work with the children concerned.

Based on the literature review, the researcher developed a questionnaire to be implemented with social workers and child care workers who work with children with mental health problems in child and youth care centres. Steward, Shamdasani and
Rook (2007), state that this interview schedule sets the agenda for a focus group discussion. They suggest for it to grow directly from the research questions that were the impetus for the research.

Grinnell and Unrau (2005) are further of the opinion that after empirical data collection, the literature review can be used to attempt to explain differences between current findings and existing knowledge, and specify how current findings advance knowledge. Therefore the researcher plans to compare and integrate existing knowledge (retrieved from literature), with opinions from key role-players (retrieved from focus groups). In this manner the assessment process and initial programme summarised in Figure 5, might be enriched.

As mentioned in Chapter 1, this empirical research study is implemented by making use of descriptive qualitative research methods only. Research approaches and designs, sampling techniques, data collection and analysis methods are amongst the key points discussed in this chapter.

3.2. Research approach and design:

As mentioned this study attempts to describe the characteristics of children with mental health problems, and to identify their emanating needs. Research conducted should describe effective eco-systemic guidelines to ultimately improve the mental health of the said children. This research study is therefore descriptive in nature.

According to De Vos, Strydom, Fouché and Delport (2005), descriptive research presents a picture of the specific details of a situation, social setting or relationship and focuses on ‘how’ and ‘why’ questions. The researcher, therefore, begins with a well-defined subject and conducts research to describe it accurately. It can have a basic or applied research goal and can be qualitative or quantitative in nature. In qualitative studies, description is more likely to refer to a more intensive examination of phenomena and their deeper meanings, thus leading to thicker description. Thicker description of children with mental health problems in a residential facility, takes place through two research approaches.
As mentioned, the first research approach utilised in this study, is a literature review. The literature review forms the basis for an initial programme containing guidelines, and the development of an interview schedule with focus groups of social workers and child care workers. De Vos, Strydom, Fouché and Delport (2005) state that focus groups are group interviews. They are a means of better understanding how people feel or think about an issue, product or service. Participants are selected because they have certain characteristics in common that relate to the topic of the focus group. In this second research approach, participants will form part of the focus group on the basis that they work with children that have a mental health problem, and that reside in a residential facility.

In this study focus groups are conducted to retrieve and better understand the opinions of social workers and child care workers on the characteristics and needs of children with mental health problems in residential facilities. Their opinions regarding possible effective ecosystemic guidelines to be developed are also of importance. De Vos, Strydom, Fouché and Delport (2005) are of the opinion that focus groups are the ideal research approach to follow when such information is required. They state that focus groups allow the researcher to investigate a multitude of perceptions in a defined area of interest. They are useful when multiple viewpoints or responses are needed on a specific topic.

According to Krueger (1994), the process of conducting a focus group study consists of three phases: planning the study, conducting the interviews, and analysing and reporting. The researcher discusses these points hereunder:

3.2.1. Planning the focus group interviews:

Krueger (1994), states that the planning phase is critical for successful focus group interviews. In this phase, the researcher gives consideration to the purpose of the study as well as the users of the information. The researcher then develops a plan that will guide the remainder of the research process.

Krueger (1994) states that planning begins by reflecting on the purpose of the study. The purpose of this study is ultimately to develop effective ecosystemic guidelines
that can be implemented in child and youth care centres. These guidelines may improve coping, adaptation and ultimately the mental health of children with mental health problems in these facilities. Before this can be attained, information is needed – some of it already gained through the implementation of a literature review – and some still to be gained through implementation of the focus groups.

Information to be produced by focus groups (consisting of social workers and child care workers that work with children with mental health problems in child and youth care centres), are:

- The characteristics a child presents with when he/she has a mental health problem/disorder.
- What are consequently identified as the needs of children with a mental health problem in a child and youth care centre?
- Suggested guidelines which may help to provide for the identified needs.
- In what way can child and youth care centres be equipped and what guidelines (in the form of a programme) can be put in place in order to provide for these needs?

As mentioned, an interview schedule was developed to elicit the above information. Stewart, Shamdasani and Rook (2007), state that the key element in the design of a successful focus group is the formulation of questions. Questions serve as the agenda for the group discussion, and a good question will elicit substantial interaction among group members.

Krueger (1994) provides the researcher with some categories of questions to help with their formulation:

- **Opening question**: “This is the round robin question that everyone answers at the beginning of the focus groups. It is designed to be answered rather quickly and to identify characteristics that the participants have in common. It is preferable for these questions to be factual as opposed to attitude-or opinion-based questions” (Krueger, 1994, p. 54). The researcher plans to here ask the respondents in the focus group to
introduce themselves to the remainder of the group, and to state at which residential facility they are employed.

- **Introductory questions:** “These are the questions that introduce the general topic of discussion and/or provide participants an opportunity to reflect on past experiences and their connection with the overall topic. Usually these questions are not critical to the analysis and are intended to foster conversation and interaction among the participants” (Krueger, 1994, p. 54). The researcher wants to get the participants’ view on what they regard as a mental health problem.

- **Transition questions:** Krueger (1994, p. 54) states that “these questions move the conversation into the key questions that drive the study. The transition questions help the participants envision the topic in a broader scope. They serve as the logical link between the introductory questions and the key questions. During these transition questions, the participants are becoming aware of how others view the topic”. Here the researcher would ask the group to reflect on the number of children in each residential facility and types of mental health problems these children present with.

- **Key questions:** Krueger (1994, p. 54) feels that “these questions drive the study. He states that typically, there are two to five questions in this category. These are usually the first questions to be developed and also the ones that require the greater attention in the subsequent analysis”. Here the researcher wants to establish what the opinions of the key role-players are regarding the characteristics and care needs of children with mental disorders, and what guidelines they think can be put in place to improve coping, adaptation and ultimately mental health of children with mental health problems in a child and youth care centre.

- **Ending questions:** These questions bring closure to the discussion, enable participants to reflect back on previous comments, and are critical to the analysis. A round robin manner can be implemented again by asking participants to state their final position on critical areas of concern. After a summary given by the moderator, the participants should be asked if they deem it as an adequate summary. Following the summary question, the moderator gives a short overview of the purpose of the study. Following
this overview the moderator asks the final question: “Have we missed anything?” For this question to work effectively there must be sufficient time remaining at the conclusion of the focus group. This question is of particular importance at the beginning of a series of focus groups as insurance that the questioning routes is logical and complete (Krueger, 1994).

The researcher developed questions based on the literature review conducted in the first chapter, and on the above guidelines. Appendix B (1) (the interview schedule), is attached to this document. The researcher plans to use these questions during implementation of the focus groups.

3.2.2. Conducting the focus group interviews:

The planned interview schedule should then be implemented. Hereunder the researcher plans the implementation (conducting) of the focus groups.

The conducting phase consists of moderating the focus groups (Krueger, 1994). He further states that occasionally the moderator will choose to take on a specific role in the focus group interview. This role or style is selected because it creates an ambience that influences how the participants share information. The researcher will attempt to be the seeker of wisdom in the conducting of the focus groups.

Krueger (1994, p. 105) states that this moderator is out to obtain understanding, insight, and wisdom. This moderator assumes that the participants have that wisdom and if asked the right questions, they will share it. This moderator may have considerable knowledge or expertise in the topic of discussion. Although the researcher has knowledge on the topic of children with mental health problems, she would like for role-players to share their knowledge and wisdom with her.

Their knowledge and thus what the participants in the group say during the discussions constitute the essential data in focus groups (De Vos, Strydom, Fouché & Delport, 2005). The researcher plans to collect data by making use of a video recorder. She is of the opinion that essential data cannot get lost if recorded. Padgett
(2008) however states that some researchers prefer to have either a scribe or note-taker. Either way, complications may arise when trying to distinguish speakers without revealing their identity – some moderators ask members to adopt a pseudonym or number at the outset and use it each time they speak.

The researcher is of the opinion that when the participants introduce themselves to the remainder of the groups, it will be recorded on the video recorder, and therefore the researcher will be aware of the participant’s identity. Non-verbal cues from respondents can be observed with the use of this footage, and therefore the researcher feels that a scribe or note-taker is not necessary.

In beginning the focus group discussion, Krueger (1994) is of opinion that the first few moments are critical. In a brief time the moderator must create a thoughtful, permissive atmosphere, provide the ground rules, and set the tone of the discussion. Excessive formality and rigidity can stifle the interaction among participants. By contrast, too much informality and humour can cause problems in that participants might not take the discussion seriously. The recommended pattern for introducing the group discussion includes these stages:

1. The welcome.
2. The overview of the topic.
3. The ground rules. The researcher feels that three basic rules should apply; no mobile phones allowed disturbing the group, respect for each other and each other’s opinions, and confidentiality of what is discussed in the group.
4. The first question.

The researcher plans to follow the above steps during implementation of the focus groups. After the first question, the others as stated on the planned interview schedule will be utilised to guide discussions. The last question also serves as a finishing to the group.

The researcher plans to run social worker groups and child care worker groups simultaneously. The researcher finds it worthwhile to note that people feel relatively empowered and supported in a group situation where they are surrounded by others. They may also be more likely to share experiences and feelings in the presence of
people whom they perceive to be like themselves in some way (De Vos, Strydom, Fouché & Delport, 2005). Hopefully social workers and child care workers will feel more empowered and supported having other social workers and child care workers in the group.

The researcher feels that there is time constraints involved when social worker groups and child care worker groups are run separately. Social workers have big case loads and child care workers have children to care for.

3.2.3. Analysis and reporting of focus group interviews:

The analysis/reporting phase is the final aspect of the focus group process. The data are analysed and the results are reported (Krueger, 1994). He further states that the researcher is the detective looking for trends and patterns that occur across the various groups. The analysis process begins with assembling the raw materials and getting an overview or total picture of the entire process. The researcher's role in the analysis covers a continuum with assembly of raw data on one extreme and interpretative comment on the other. The analysis process involves consideration of words, tone, context, nonverbals, internal consistency, frequency, extensiveness, intensity, specificity of responses and big ideas. Data reduction strategies are essential in analysis.

Krueger (1994) further states that reporting must be targeted to the audience and appropriate for the purpose of the study. Written reports begin with a framework that can include raw data, a descriptive summary, or an interpretative approach. The style of the report should match the capability of the analyst and the needs of the audience.

The researcher plans to analyse data according to recognised analysis methodology, and to report on it accordingly. These aspects are discussed under a separate section in this chapter.
3.3. Research population and sampling strategy:

De Vos, Strydom, Fouché and Delport (2005) state that a population is defined as a set of entities in which all the measurements of interest to the practitioner or researcher are represented. Krueger and Neumann (2006) are further of the opinion that the large pool is the population. To define the population, a researcher specifies the unit being sampled, the geographical location, and the temporal boundaries of the population. According to them a researcher operationalises a population by developing a specific list that closely approximates all the elements in the population.

In this study the researcher specified the unit to be sampled (residential facilities), the geographical location (Gauteng), and the temporal boundaries of the population. Thereafter a list was developed which closely approximates all residential facilities in the Gauteng Province. The researcher attempted to find all registered child and youth care centres in the said province. The Department of Social Development was approached during these attempts.

De Vos, Strydom, Fouché and Delport (2005) further state that the term “sample” always implies the simultaneous existence of a population or universe of which the sample is a smaller section or a set of individuals selected from a population. In this study the smaller set of individuals selected from the larger population, is staff employed in residential facilities that work specifically with children with mental health problems.

The sample of staff employed at residential facilities that work specifically with children with mental health problems, was obtained through purposive sampling (more specifically target sampling). Padgett (2008) states that as a general rule, qualitative researchers use purposive sampling – a deliberate process of selecting respondents based on their ability to provide the needed information. Krueger and Neumann (2006) state that the principle with purposive sampling is to get all possible cases that fit particular criteria, using various methods.

The method that is utilised, is one identified by De Vos, Strydom, Fouché and Delport (2005). With this method controlled lists of specified populations within
geographical districts are developed and detailed plans are designed to recruit adequate numbers of cases within each of the targets.

The researcher identifies which residential facilities in Gauteng work with children with mental health problems. This is done through the use of controlled lists of residential facilities in Gauteng. The list of residential facilities in Gauteng (Appendix C) is attached to this document. The researcher developed this list and retrieved the e-mail addresses of all social workers employed at residential facilities in the Gauteng Province. Once their e-mail addresses are identified, two e-mails are sent to each social worker. Examples of these letters (e-mail format) are attached to this document (Appendix D).

Some social workers then respond to the researcher via e-mail, stating that they do work with children with mental health problems in their facilities, and that they and child care workers at the facilities are interested in participating in future research conducted on this topic (including the focus groups).

Social workers and child care workers who work with children with confirmed mental disorders, consequently form part of the sample. Note that this sample includes social workers employed at psychiatric hospitals, providing that the hospital has a residential part for children. After contacting psychiatric hospitals in the Gauteng area, the researcher established that only Weskoppies and TARA Hospitals have temporary residential facilities for children with diagnosed mental health disorders. These social workers are invited to the focus group to share their expertise on the topic.

De Vos, Strydom, Fouché and Delport (2005) state that usually the purpose of focus groups is to describe how certain people feel or think about something – people that have certain things in common. Therefore homogeneity of the group members is also important. If participants perceive each other as fundamentally similar, they will spend less time explaining themselves to each other and more time discussing the issues at hand. Participants are therefore chosen to fit in with the group’s demographic. The researcher prefers for social workers and child care workers to
attend the focus groups. She is of the opinion that they will then spend less time explaining themselves.

The researcher however feels that all the mentioned planning should be tested before implementation. Literature also suggests undergoing a pilot study before the actual implementation of the plan as discussed above, with the actual sample.

3.4. Pilot study:

A pilot study as described by De Vos, Strydom, Fouché and Delport (2005) complements this study. According to them it commences with a literature study, which puts the experience of various experts on the table. Thereafter, the researcher should obtain an overview of the concrete field of investigation, which should finally be complemented by a thorough study of a few cases.

With regards to this study, the literature study was already discussed in Chapter 2. This includes information on ecosystemic care for children with mental disorders in residential facilities. Individual mental health disorders, different role-players and their responsibilities, and the effect this may have on a child’s mental health, were clarified. An initial programme with guidelines to be implemented that may improve coping, adaptation and ultimately mental health of the children concerned, were identified. The researcher identified some gaps in this study, which may be filled by information from key role-players through implementation of an empirical study. A pilot study commences before the implementation of the actual focus groups.

Krueger and Neumann (2006) suggest for the researcher to develop a draft or preliminary version of a measure and try it before applying the final version. A developed semi-structured schedule of questions is implemented with social workers and child care workers where she is currently employed – The Bethany House Trust – in the form of a focus group. These experts (who work with children that have mental health disorders), “can help the researcher to delineate the problem more sharply and gain valuable information on the more technical and practical aspects of the prospective research endeavour” (De Vos, Strydom, Fouché & Delport, 2005, p. 208). Therefore these role-players will be able to tell the researcher if the planned
schedule of questions to be conducted with focus groups is correct or if some changes are needed. Interviews with experts serve a two-fold purpose. Firstly it brings unknown perspectives to the fore, and secondly, it confirms or rejects the researcher’s own views (De Vos, Strydom, Fouché & Delport, 2005).

The pilot study can alert a prospective researcher to possible unforeseen problems which may emerge during the main investigation. It can also improve the success and effectiveness of the investigation. Respondents will be asked to comment on the wording of the question, the sequence of the questions, possible redundant questions, and missing and confusing questions (De Vos, Strydom, Fouché & Delport, 2005). Should the respondents of this pilot study agree that some changes have to be made to the interview schedule, it will be done.

Not only can implementation of a pilot study assist in confirming whether the correct measures are to be taken, but it also improves the reliability of a study (Krueger & Neumann, 2006).

3.5. Reliability and trustworthiness:

According to De Vos, Strydom, Fouché and Delport (2005) when the reprocessing of the data is completed, the trustworthiness and reliability of the material should be established in order to respond as objectively as possible to the research questions formulated at the beginning of the present analysis. Therefore the material (data) retrieved from focus groups should respond objectively to the questions of characteristics and emanating needs of children with mental health problems in residential facilities, and possible guidelines on how to provide for these needs.

Krueger and Neumann (2006) are however of the opinion that reliability also means that the method of conducting a study, or the results from it, can be reproduced or replicated by other researchers. According to Alasuutari, Bickman and Brannon (2009) reliability refers to the accuracy or precision of a measurement instrument. Therefore this study’s findings would have to be retrieved and reported in such a manner that similar results are retrieved when it is conducted again, by a different
researcher. The researcher would attempt to report retrieved information objectively by not allowing her own biased opinions to interfere with opinions from respondents.

Validity and trustworthiness is further ensured by utilising an external coder to objectively analyse data collected. The external coder’s findings will be compared with the findings of the researcher. Common ground is found where results of the analysis do not correspond.

Krueger (1994) specifically focuses on the validity of focus groups, and states that focus groups are valid if they are used carefully for a problem that is suitable for such an inquiry. Validity depends not only on the procedures used, but also on context. It is the degree to which the procedure really measures what it proposes to measure. As a summary on the above Krueger (1994) states that the problem of validity can be minimised through the pilot test. The researcher feels that the pilot study as discussed in the preceding section will test whether the study measures what it proposes to, thus further improving validity.

After the pilot study (and rectifications as/if necessary), the actual focus groups would be run as planned in a previous section. Thereafter data must be analysed. A plan for analysis of data follows.

3.6. Data analysis:

Krueger and Neumann (2006) state that in general, data analysis means a search for patterns in data – recurrent behaviours, objects, or a body of knowledge. Once a pattern is identified, it is interpreted in terms of social theory or the setting in which it occurred.

Data collected during the implementation of focus groups, will be analysed according to recognised analysis methodology. In summary “analysis begins by going back to the purpose of the study. What is collected, though possibly subject to some constraints, represents the reality of the experiences of the group members. The aim of analysis is to look for trends and patterns that reappear within a single focus group or among various focus groups. The basis for analysis is transcripts, tapes, notes
and memory. The critical ingredients of qualitative analysis are that it must be systematic, sequential, verifiable and continuous; requires time; is jeopardised by delay; seeks to enlighten; should entertain alternative explanations; is improved by feedback; and is a process of comparison” (De Vos, Strydom, Fouché & Delport, 2005, p. 311).

Krueger (1994) is of the opinion that a guiding principle of analysis is to provide enlightenment, to lift the level of understanding to a new plateau. At times, focus groups point out what researchers do not already know, but in other situations they confirm earlier suspicions and hunches. The analyst should ponder what new information is provided by the focus group. As mentioned some gaps exist in information retrieved from literature. Therefore key questions are asked to attempt to fill these gaps, and answers to these questions will be pondered upon.

Krueger (1994) however feels that not all questions deserve analysis at the same level, indeed some may be “throw away” questions that are designed to help set the stage of discussion for participants, as opposed to collecting new insights (earlier referred to as opening questions). The challenge to the researcher is to place primary attention on questions that are at the foundation of the study. Therefore the information retrieved through key questions will take precedence.

As indicated by De Vos, Strydom, Fouché and Delport (2005), focus group analysis combines many different elements of qualitative research. Therefore the researcher feels that qualitative data analysis is of importance. The mentioned authors set out some guidelines to follow with regards to qualitative data analysis, which will be followed in this study.

3.6.1. Planning for recording of data:

The researcher should plan for the recording of data in a systematic manner that is appropriate to the setting, participants, or both. That will facilitate analysis, before data collection commences (De Vos, Strydom, Fouché & Delport, 2005).
Planning for the recording of data was already discussed. This involved the development of an interview schedule. As mentioned the actual recording is done through use of a video recorder.

3.6.2. Data collection and preliminary analyses:

Data analysis in a qualitative inquiry necessitates a two-fold approach. The first aspect involves data analysis at the research site during data collection. The second aspect involves data analysis away from the site, following a period of data collection. Data collection and analysis thus go hand in hand in order to build a coherent interpretation of the data (De Vos, Strydom, Fouché & Delport, 2005).

While implementing focus groups the researcher already take written and mental notes of discussions. These notes will be combined with analysis away from the site, which is discussed hereunder.

3.6.3. Managing or organising data:

This is the first step in analysis away from the site. At an early stage in the analysis process, researchers organise their data into file folders, index cards or computer files. Besides organising files, researchers convert their files to appropriate text units, e.g. a word, a sentence, an entire story, for analysis either by hand or by computer. Transcribing notes or interviews offers another point of transition between data collection and analysis, as part of data management and preparation (De Vos, Strydom, Fouché & Delport, 2005). The video recorder used will enable the researcher to upload the data onto a computer. Recorded interviews will then be transcribed into written words on the computer.

Because such a big amount of data is collected during implementation of focus groups, and the study’s focus is on qualitative data, abridged transcripts will be developed. Transcripts will be printed out to allow for the following step to take place.
3.6.4. **Reading and writing memos:**

After the organisation and conversion of the data, researchers continue analysis by getting a feeling for the whole database. Reading through the data forces the researcher to become familiar with the data in intimate ways. During the reading process, the researcher can list on note cards the data available, perform the minor editing necessary to make field notes retrievable, and generally clean up what seems overwhelming and unmanageable. Writing memos in the margins of field notes or transcripts helps this initial process of exploring a database (De Vos, Strydom, Fouché & Delport, 2005).

Memos in the margin of the printed transcripts will allow the researcher to continue with generating categories, themes and patterns in data. Starter codes from Chapter 2:

- characteristics of children with a mental health problem,
- their emanating needs,
- and guidelines to provide for these needs,

form the basis of generating categories and themes. Analysis will not be limited to these categories and themes though, and new findings and opinions will also be noted. This forms part of and flows into the following step.

3.6.5. **Generating categories, themes and patterns:**

Krueger (1994) indicates that category formation represents the heart of qualitative data analysis. Krueger (1994) further states that the identification of salient themes, recurring ideas or language, and patterns of belief, that link people and settings together, are the most intellectually challenging phase of data analysis. This phase can integrate the entire endeavour. Here the researcher does not search for the exhaustive and mutually exclusive categories of the statistician, but instead identifies the salient, grounded categories of meaning held by participants in the setting.

As a popular form of analysis, classification involves identifying five or six general sub-themes, represented by segments of data. The process involves winnowing the
data, reducing it to a small, manageable set of themes to write into the final narrative. Interpretation involves making sense of the data, the lessons learnt (De Vos, Strydom, Fouché & Delport, 2005). It is at this point that the researcher starts to identify what the views of social workers and child care workers are regarding the management of children with mental disorders in child and youth care centres. This includes characteristics and emanating needs of a child with a mental health problem, and ecosystemic guidelines to provide for these needs.

3.6.6. Coding the data:

The researcher then applies a coding scheme to those categories and themes, and diligently and thoroughly marks passages in the data using the codes. Codes may take several forms: abbreviations of key words, coloured dots, and numbers – the choice of the researcher. As the researcher codes the data, new understandings may well emerge, necessitating changes in the original plan (De Vos, Strydom, Fouché & Delport, 2005).

Different categories and/or themes will be coded by making use of coloured dots. Padgett (2008) refers to this stage as the most commonly used analytic procedure in qualitative research. “At the outset, coding involves close and repeated readings of the transcript in search of meaning units that are descriptively labelled so that they may serve as building blocks for broader conceptualisation”.

3.6.7. Testing emergent understandings:

The researcher begins the process of evaluating the plausibility of her developing understandings and exploring them through the data. This entails a search through the data during which the researcher challenges the understanding, searches for negative instances of the patterns and incorporates these into larger constructs, as necessary. Part of this phase is evaluating the data for their usefulness and centrality. The researcher should determine how useful the data are in illuminating the questions being explored and how central they are to the story that is unfolding about the social phenomenon being studied (De Vos, Strydom, Fouché & Delport, 2005).
Data collected during focus groups would be evaluated for usefulness and centrality with regards to initial research questions and the goal of the study, which is to provide a management programme to mainstream and specialised child and youth care centres, on how to care optimally for children with mental health problems.

3.6.8. Searching for alternative explanations:

As the researcher discovers categories and patterns in the data, she should engage in critically challenging the very patterns that seem so apparent. The researcher should search for other, plausible explanations for these data and the linkages among them. Alternative explanations always exist; the researcher must search for, identify and describe them, and demonstrate why the explanation offered is the most plausible of all (De Vos, Strydom, Fouché & Delport, 2005). Here the researcher should thus be careful to find objective explanations provided by the social workers and child care workers, and not report on bias opinions and starter codes only.

3.6.9. Writing the report:

In the final phase the researcher presents the data; a packaging of what was found (De Vos, Strydom, Fouché & Delport, 2005). The researcher plans to use information analysed and integrated from the literature review, and information retrieved from focus groups, for the development of a proposed programme (research report). The researcher is of the opinion that the initial programme developed in Chapter 2 can therefore be edited and enriched with data collected and analysed during empirical research.

3.7. Ethical issues:

The researcher noticed that no research study can be conducted without considering ethical issues. Ethical issues identified by the researcher, are privacy, anonymity and confidentiality, informed consent and social diversity.
3.7.1. Privacy, anonymity and confidentiality:

Krueger and Neumann (2006) are of the opinion that researchers invade a person’s privacy when they probe into beliefs, backgrounds, and behaviours in a way that reveals intimate private details. The ethical social work researcher violates privacy only to the minimum degree necessary and only for legitimate research purposes. In addition, he/she protects the information on research subjects from public disclosure. During implementation of this research study the researcher will however not pay attention to the backgrounds and behaviours of participants in focus groups. Information retrieved will also not be made public.

To protect the children with mental health problems being discussed during focus groups, the researcher decided to not utilise their names in the report. The names of neither social workers nor child care workers are utilised either. If necessary data collected are reported through making use of the residential facility’s name. “Researchers protect privacy by not disclosing a subject’s identity after information is gathered. Anonymity means that subjects remain anonymous or nameless” (Krueger & Neumann, 2006, p. 107). During implementation of focus groups, the researcher discusses confidentiality and anonymity.

Padgett (2008) is of the opinion that qualitative researchers cannot offer the anonymity or safety in numbers that quantitative researchers can. They must, however, provide virtually ironclad guarantees of confidentiality. This means that every effort is made to ensure the identities of participants are never revealed or linked to the information they provide without their permission. Breaches of confidentiality – one of the utmost violations of trust – are undertaken only in dire circumstances in which there are serious risks of harm to self or others, particularly children.

According to the Code of Ethics for social workers, they should discuss with parties the nature of confidentiality (South African Council for Service Professions, n.d.). Krueger and Neumann (2006) state that confidentiality is when information that has names attached to it, is held in confidence or kept secret from the public.
3.7.2. Informed consent:

Data collection has to be implemented with informed consent from respondents. Social workers and child care workers should have a good understanding of what they are consenting to while partaking in focus groups. Grinnell and Unrau (2005), state that consent is valid only when participants truly understand the nature of the research and evaluation activity, possible benefits and associated risks.

Krueger and Neumann (2006) state that respondents need to know what they are being asked to participate in so that they can make an informed decision. Subjects can become aware of their rights and what they are getting involved in when they read and sign a statement giving informed consent, a written agreement to participate given by subjects after they learn something about the research procedure.

Padgett (2008) provides certain elements of informed consent:

- A brief description of the study and its procedures as they involve participants. Full identification of the researcher's identity and of the sponsoring organisation (if any), including an address or telephone number for future contacts.
- An assurance that participation is voluntary and the respondent has the right to withdraw at any time without penalty or loss of services.
- An assurance of strict confidentiality.

It is also necessary to get explicit consent to audiotape interviews, along with assurances that participants may request that all or part of such recordings be withdrawn from the study (Padgett, 2008).

The researcher developed such an agreement where the respondent in a focus group is informed about the research procedure, and asked to participate in the research project. The form is attached to this document – Appendix E.
3.7.3. Social diversity:

While implementing research, social diversity should be kept in mind. According to Grinnell and Unrau (2005, p. 36), social workers must ensure that their samples sufficiently represent, when methodologically appropriate and sound, diverse groups and clientele. Studies based on narrowly drawn and culturally homogeneous samples are less likely to yield information consistent with social work’s ethical obligations to address issues of diversity and social justice.

The researcher invites social workers and child care workers to the focus groups. As respondents will in a way join the research study by stating that they want to form part of the focus groups themselves, the researcher does not have much control over their cultural backgrounds. From observation of the diverse staff employed at child and youth care centres the researcher is however of the opinion that the sample will be socially diverse.

A possible problem identified by the researcher regarding this specific issue, is that different social/cultural groups may have different opinions regarding mental health problems and its origins. The researcher attempts to solve this dilemma by discussing opinions and views during implementation of focus groups.

3.8. Conclusion:

This chapter provided a basis for the conducting of the empirical research study. The researcher planned to conduct focus groups by firstly focussing on the development of an interview schedule. The manner, in which this schedule and the groups will be conducted, was also identified. The planning for analysis and reporting of data was also discussed.

The researcher further explained the sampling (target sampling) process. A pilot study is planned to test the planned focus group study. The following chapter reports on the actual implantation of all plans implemented as planned in this chapter.
Note that the empirical study attempts to add to the assessment process and initial programme developed in Chapter 2. After completion of an empirical study as planned above, this programme would attempt to provide effective ecosystemic orientated care that promotes coping and adaptation to a child with a mental health problem in a residential facility. Improved coping and adaptation leads to a good person-environment-fit. This in turn optimises the children concerned’s mental health.
Chapter 4
Data analysis

4.1. Introduction:

The literature review (first part of qualitative research) presented in Chapter 2 learned more about the scope of the research problem and what answers already exist for general research questions (Grinnell & Unrau, 2005). The general questions partially answered through implementation of a literature review, and which planned (as discussed in the preceding chapter) to further be answered in discussions with focus groups, were:

- What are the characteristics of a child with a mental health problem?
- What are consequently identified as the needs of a child with mental health problems in a residential care facility?
- What guidelines exist that may help to provide for the identified needs?
- In what way can child and youth care centres be equipped and what guidelines (in the form of a programme) can be put in place in order to provide for these needs?

Based on the planning in Chapter 3, a pilot study and actual focus groups were conducted to better understand the opinions of social workers and child care workers on the above mentioned questions. De Vos, Strydom, Fouché and Delport (2005) are of the opinion that focus groups are the ideal research approach to follow when such information is required.

In this chapter, the implementation of the pilot study and focus group interviews is discussed. Data collected from focus groups (elicited with the help of developed questions), are analysed according to recognised analysis methodology as discussed in the previous chapter.

Creswell (1998) in De Vos, Strydom, Fouché and Delport (2005) believes that the process of data analysis and interpretation can best be represented by a data analysis spiral. The researcher moves in analytic circles rather than using a fixed
linear approach. One enters with data (from video tapes) and exits with an account or a narrative. In this chapter the researcher begins the analysis process by firstly reporting on the pilot study, and thereafter transcribing the results into readable data.

The process of analysis is completed with specific categories, themes, and subthemes that emanated from focus group discussions. It is only in the following chapter where the researcher exits the data analysis spiral, when she presents data collected (from focus groups) and integrated literature discussed in Chapter 2, and additional readings. Thus this chapter will only form the foundation to state how implementation of the planned research endeavour went.

The researcher developed the following summative table to graphically present the process that was followed:

Table 6: Implementation of pilot study and focus groups

<table>
<thead>
<tr>
<th>Study</th>
<th>Date &amp; Time</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot study</td>
<td>30 May 2011 (14:00)</td>
<td>The Bethany House Trust</td>
</tr>
<tr>
<td>Group 1 (West Rand)</td>
<td>9 June 2011 (9:30)</td>
<td>The Bethany House Trust</td>
</tr>
<tr>
<td>Group 2 (West Rand)</td>
<td>9 June 2011 (12:30)</td>
<td>The Bethany House Trust</td>
</tr>
<tr>
<td>Group 3 (Pretoria)</td>
<td>10 June 2011 (10:00)</td>
<td>Umephi</td>
</tr>
</tbody>
</table>

As planned and seen in the above table, the pilot study had to first be conducted (De Vos, Strydom, Fouché & Delport, 2005).

4.2. Pilot study analysis:

The researcher conducted a pilot focus group with social workers and child care workers where she is currently employed – The Bethany House Trust – with an initially developed semi-structured schedule of questions (Appendix B (1)). These experts who work with children that have mental health disorders, “helped the researcher to delineate the problem more sharply and gain valuable information on the more technical and practical aspects of the prospective research endeavour” (De Vos, Strydom, Fouché & Delport, 2005, p. 208). Therefore these role-players were able to tell the researcher if the initially developed schedule of questions to be
conducted with the actual focus groups were correct, or if some changes to the schedule were necessary.

The participants who took part in the pilot study were two social workers and two child care workers. The researcher is of the opinion that during implementation of the pilot study these key role-players were able to provide the researcher with information regarding the characteristics, emanating needs and guidelines to provide for the needs of children with mental health problems. This confirms that most of the questions were developed in the correct manner.

After implementation of the pilot focus group, the researcher asked the respondents to comment on the wording of the questions, the sequence of the questions, possible redundant questions, and missing and confusing questions (De Vos, Strydom, Fouché & Delport, 2005). The participants suggested for some questions to be changed to accommodate all future participating members of the actual focus groups. The child care workers and social workers were of the opinion that some questions were too complex for comprehension by all members. One question was redundant. Questions as they were — according to Appendix B (1) — and the manner in which they changed — Appendix B (2) — are as follow:

Question number one remained unchanged. The question of what the respondents’ names and work titles were and at which residential facility they were employed, was useful in introducing the different members to one another, and for the other members to “identify characteristics that they have in common” (Krueger, 1994, p. 54).

The introductory question which is to clarify what the respondents regard as a mental health problem is deemed to be sufficient. The participants of the pilot study however felt that part of the introduction should be for the researcher (moderator of focus group), to define what mental health disorders are. The definition as stated by Dumaine (2003) will be given. He defines mental health disorders as disorders that interfere with daily functioning, such as education and employment (Dumaine, 2003). The researcher will then give examples of mental health disorders. Disorders like attention deficit disorder, bipolar disorder, depression etc. will be mentioned, and not
the specific five categories discussed in the literature review. This shows that the researcher is not attempting to influence the opinions of participants. After referring to this definition the researcher and participants of the pilot study are of the opinion that the participants will have an idea of what the researcher is referring to when talking about mental health problems and/or disorders.

Question number three asked what the number of children was that social workers and child care workers have worked with recently (past 12 months), that presented with a mental health problem. This question was regarded as redundant. The participants of the pilot study and researcher agreed that this answer will be elicited from discussions emerging from other questions such as the following:

“What was the most common mental health problems observed?” This question’s wording was changed to: “What kind of mental health problems were observed?”

Another transition question is then asked to move the conversation into the key questions that drive the study (Krueger, 1994). This transition question was not changed, and asks: “Based on the three most common mental health problems that according to you, children in residential facilities present with; what are in your opinion, the characteristics of these disorders?” The three most common disorders are written onto a flipchart board, and in this manner the participants (confirmation from pilot study), are able to better remember and identify the characteristics of each of the identified disorders.

The other transition question asked remained unchanged as well: “Based on the characteristics identified by you, what according to you are the needs emanating from this?”

Key questions, which drive the study (Krueger, 1994), were then asked in the following manner:

- What effective ecosystemic guidelines in your opinion, can be put in place on a micro level (individual child with mental health problem and people in his/her direct environment) to ensure that children with mental health problems’ needs are provided for in a residential facility?
What effective ecosystemic guidelines in your opinion, can be put in place on a meso level (interacting micro systems) to ensure that children with mental health problems’ needs are provided for in a residential facility?

What effective ecosystemic guidelines in your opinion, can be put in place on an exo level (legislation) to ensure that children with mental health problems’ needs are provided for in a residential facility?

What effective ecosystemic guidelines in your opinion, can be put in place on a macro level (child and youth care centre) to ensure that children with mental health problems’ needs are provided for in a residential facility?

The researcher observed and participants of the pilot study were of the opinion that these questions were too complex for them to comprehend, as they are not knowledgeable on the ecosystemic perspective, or understand the terms accompanied by it. Therefore a definition of the ecosystemic perspective and a short explanation of the different system levels involved, will be given to the participants of actual focus groups, before the questions are asked as follows:

What guidelines in your opinion, can be put in place on a micro level (individual child with mental health problem and people in his/her direct environment) to ensure that these children’s needs are provided for in a residential facility?

What guidelines in your opinion, can be put in place on a meso level (interacting micro systems) to ensure that these children’s needs are provided for in a residential facility?

What guidelines in your opinion, can be put in place on an exo level (legislation) to ensure that these children’s needs are provided for in a residential facility?

The researcher feels that another key question to this study and the outcomes of it is to know what the participant’s opinions are regarding mainstream or specialised residential facilities for children with mental health problems. Therefore the question is asked: “Should you have a choice between caring for a child with a mental health
problem in your mainstream facility would you, or would you prefer to send the child to a specialised home? Discuss.” This question remained unchanged.

Ending questions bring closure to the discussion and enable participants to reflect back on previous comments (Krueger, 1994). The unchanged ending question is asked as follows: “State in one sentence what are, according to you, the critical areas of concern regarding children with mental health problems in child and youth care centres.” To ensure that nothing was missed and that the researcher did not attempt to influence the opinions of participants, the researcher terminates the focus group discussions by asking if anything had been missed. The researcher feels that these ending questions worked well in ending the focus group conducted during the pilot study.

As previously mentioned, the pilot study does not only assist the researcher in finalisation of the interview schedule, but it can also alert a prospective researcher to possible unforeseen problems which may emerge during the main investigation. It can also improve the success and effectiveness of the investigation (De Vos, Strydom, Fouché & Delport, 2005). The participants of the pilot study group don’t foresee any possible problems which may emerge during the main investigation.

As the simultaneous implementation of social worker and child care worker groups were looked at briefly in the methodology chapter, the researcher asked the child care workers how they felt responding to questions with social workers present in the group. According to them this did not make them feel uncomfortable. On the contrary they stated that they experienced it as a positive manner to disclose their opinions, and also to learn from skilled social work professionals.

The participants of the pilot study focus group are of the opinion that social workers and child care workers working with children with mental health problems in child and youth care centres would be able to provide the researcher with information pertaining to the objectives of this study.

Therefore the researcher continued the research endeavour with the implementation of the actual focus groups.
4.3. Conducting of the focus groups (Main study):

As explained in Chapter 3, the main study (actual focus groups) was planned to be conducted in a particular way with the final sample of social workers and child care workers who work with children with mental health problems. Not all went according to plan however, and some unforeseen problems arose.

After a final invitation was sent and the sampling process completed, 16 respondents confirmed attendance for focus groups. The researcher is of the opinion that if a social worker and child care worker represents a child and youth care centre, the planned number of 32 respondents would fit perfectly into three groups, with an average of ten persons in each group. An analysis of responses from each child and youth care centre, and the actual attendees, is represented on the list of child and youth care centres. Refer to Appendix C.

Unforeseen problems that arose during implementation of the focus groups are as follows:

- With the first two focus groups, some of the members who confirmed attendance were absent. A total of ten child and youth care centres were represented during the implementation of all three groups. The groups however still had more than six members each in it. According to De Vos, Strydom, Fouché and Delport (2005), focus groups usually include six to ten participants. The researcher observed that this group size allowed for everyone to participate, while a wide range of responses was still elicited.

- With the third planned group, only one member of the 10 who confirmed their attendance, attended. The researcher had no control over the absent members, and conducted the same questionnaire with this one participant, but on a one-to-one interview basis. De Vos, Strydom, Fouché and Delport (2005) specifically refer to open-ended or guided interviews. They state that the latter is used when the information required is about a certain topic, and while the structure of the topic is known, the answers cannot be anticipated. The guided interview is ideal for obtaining comprehensive and comparable data. The researcher feels that comprehensive and comparable data were
retrieved from this individual participant, and that this data can still be utilised and compared to data retrieved from the two focus groups. The interview is also a qualitative data collection method and therefore data will be analysed in the same manner as the data of the focus groups – according to qualitative data analysis methodology discussed in the previous chapter.

- As seen in the third chapter, the plan was for only social workers and child care workers who work with children with mental health problems, to partake in the focus group discussions. Participants however used their own discretion, and other role-players attended the groups as well. All participants were however homogeneous in that they, in some way, work with children with mental health problems, in child and youth care centres. Some of these other role-players were however not able to respond to questions. On the other hand, some role-players (e.g. directors of the child and youth care centre), were able to respond to questions just as well as social workers or child care workers. The researcher however tried to keep all participants part of discussions and attempted to get as much as possible information from each and every person.

- Because of time constraints and children that have to be cared for at the residential facilities, (as mentioned in the previous chapter), very few child care workers were able to attend the focus group, and social workers spoke on their behalf. The researcher however attempted to elicit as much as possible information from the child care workers who did attend the meetings.

- The researcher invited social workers from psychiatric units with residential units for children, to be part of the sample as well. They did not respond to any correspondence. They did not attend the groups as planned. Unfortunately their expert opinions will consequently not form part of this research study. This is deemed as a limitation to the study, as these participants would have been the experts in available programmes for children with mental health problems. It did however not diminish the value of the study.
As seen, the unforeseen problems that arose were managed as best as possible. The researcher remained of the opinion that data retrieved from the participants who were present, were valuable and relevant to this research study.

In general the researcher is also of the opinion that the sampling process indicated the need for services regarding children with mental health problems in residential facilities in Gauteng. Initially a total of 21 child and youth care centres indicated that they are interested in research to be conducted on this topic, as they work with children with mental health problems. That is 30% of the population. Unfortunately, as stated, not all facilities confirmed and attended the focus group discussions. The total of ten facilities that did partake in the discussions, were passionate about the topic of children with mental health problems in child and youth care centres. They represented 10% of the population (all child and youth care centres in Gauteng).

Should a person refer to the 21 child and youth care centres (that indicated they work with children with mental health problems), as the population, and the actual ten facilities that were represented, the sample formed 47.62% of the population. According to the researcher this is a good representative number, and she therefore feels that data retrieved will be representative of all child and youth care centres that work with children with mental health problems.

Krueger and Neuman (2006) refer to this as representative reliability. They state that it is reliability across subpopulations (child and youth care centres that work with children with mental health problems). It addresses the question “Does the indicator deliver the same answer when applied to different groups?” The researcher is of the opinion that the same answers were delivered when applied to all child and youth care centres that took part in focus groups. The researcher feels that the results of this study does not have to be representative of the other child and youth care centres in Gauteng, as they do not work with children with mental health problems.

As seen above the researcher feels that data retrieved are reliable and trustworthy. De Vos, Strydom, Fouché and Delport (2005) state that in general the data retrieved from focus group’s trustworthiness and reliability should be established in order to respond as objectively as possible to the research questions formulated at the
beginning of the present analysis. The researcher feels that despite the mentioned challenges experienced, data retrieved responded objectively to the mentioned research questions.

Krueger and Neumann (2006) are of the opinion that reliability further means that the method of conducting a study or the results from it can be reproduced or replicated by other researchers. The researcher noticed that the data collected from different focus groups corresponded most of the time, without the researcher influencing the participants to give specific answers. Therefore she is of the opinion that should this study be conducted by another researcher, similar results will be retrieved.

Trustworthiness and validity were further ensured by utilising an external coder to objectively analyse data collected. The external coder’s findings were compared to the findings of the researcher. Common ground was found where results of analysis didn’t correspond.

Data retrieved (from the two focus groups and one interview), have been transcribed and analysed according to the following steps:

4.4. Analysis of data retrieved:

Management and organising of data retrieved from focus groups were the first steps in the data analysis spiral. Because of a large amount of data collected during implementation of focus groups, and the study’s focus on qualitative data, abridged (summarised) transcripts are developed. Transcripts are printed out to allow for the following step to take place.

The researcher read the transcripts to get a feel for the whole database. Memos were written in the margins of the transcripts. This helped the initial process of exploring the database (De Vos, Strydom, Fouché & Delport, 2005). Memos in the margin of the printed transcripts allow the researcher to continue with generating categories, themes and patterns in data. Category formation represents the heart of qualitative data analysis. Here the researcher identifies the salient, grounded categories of meaning held by participants in the setting. Interpretation involves
making sense of the data, the lessons learnt (De Vos, Strydom, Fouché & Delport, 2005).

The following starter codes formed the basis of generating these categories, themes and patterns in data. These starter codes were generated from Chapter 2:

- Characteristics of children with a mental health problem.
- Their emanating needs.
- Guidelines to provide for these needs.

Analysis was however not limited to these categories and themes only, and new findings and opinions were also noted. Categories are also coded. In this study, data are coded by utilising coloured dots and stars. At the outset, coding involves close and repeated readings of the transcript in search of meaning units that are descriptively labelled so that they may serve as building blocks for broader conceptualisation (Padgett, 2008). The type and colour code utilised for each subtheme and category, are indicated next to them.

Based on data retrieved and analysed as stated above, categories, themes and subthemes were identified as follow:

1. Mental health problems (Red dots):
   1.1. Attention deficit disorders
   1.2. Conduct and oppositional defiance disorders
   1.3. Depression
   1.4. Sexualised disorders
   1.5. Psychosis.

2. Needs of individual child with mental health problem in a child and youth care centre:
   2.1. Individual needs (Yellow dots)
   2.2. Disciplinary needs (Blue dots)
   2.3. Training needs (Orange dots)
   2.4. Therapeutic needs (Pink dots)
   2.5. Medicinal needs (Purple dots)
   2.6. Educational needs (Green dots).
3. Ecosystemic orientated guidelines:
   3.1. Micro level (Yellow stars)
   3.2. Meso level (Blue stars)
   3.3. Exo level (Red stars)
   3.4. Macro level (Green stars).

The above mentioned categories and themes are presented and discussed in-depth in Chapter 5. This discussion combines information from the literature review, the data from focus groups, and additional literature.

During implementation of the above, the researcher began the process of evaluating the plausibility of her developing understandings and exploring them through the data. Part of this phase was evaluating the data for their usefulness and centrality (De Vos, Strydom, Fouché & Delport, 2005). Data collected during focus groups are evaluated for usefulness and centrality with regards to initial research questions, starter codes and the goal of the study, which is to provide a management programme to mainstream and specialised child and youth care centres, on how to care optimally for children with mental health problems.

As the researcher discovers categories and patterns in the data, she engages in critically challenging the very patterns that seemed so apparent. The researcher should search for other, plausible explanations for the data and the linkages among it (De Vos, Strydom, Fouché & Delport, 2005). In discussions in Chapter 5 the researcher carefully finds objective explanations provided by the participants, and not report on biased opinions and starter codes only.

In the final phase the researcher presents the data (De Vos, Strydom, Fouché & Delport, 2005). Information analysed and integrated from the literature review and focus groups, is utilised as a basis for the development of a proposed programme (research report), as will be seen in the following chapter.
4.5. Ethical issues:

Ethical issues considered by the researcher during implementation of this research study were anonymity, confidentiality, informed consent and social diversity.

As described in Chapter 3, names of participants of the focus groups are not mentioned in the research report. It was also stated that names of children discussed during the focus groups, will not be given. There were however not any mention of children’s names in any of the groups/interviews. In this way anonymity was ensured. In doing this, confidentiality is ensured as well. The researcher also asked the participants of the groups to keep information discussed during the group, confidential.

Data collection took place with informed consent from the participants. The researcher explained the nature and goal of the focus group to the participants before the group began. She also explained the use of the video recorder utilised for recordings. Members signed informed consent forms (Appendix E).

As respondents indirectly formed part of the research study by stating that they want to attend focus group interviews, the researcher did not have much control over their cultural backgrounds. Irrespective of this, social workers, child care workers and other role-players from different cultural backgrounds attended the groups. Opinions regarding mental health problems and related topics were discussed during the conducting of the groups, and therefore diverse opinions which may emanate due to different social and cultural backgrounds received attention.

4.6. Conclusion:

In this chapter, the implementation of empirical research was presented. During empirical research the researcher attempted to retrieve the opinions of social workers and child care workers (and unforeseen other role-players) on the following:

- The characteristics of a child with a mental health problem.
The consequent needs of children with a mental health problem in a child and youth care centre.
The guidelines that exist which may help to provide for the identified needs.
The way in which child and youth care centres can be equipped and what guidelines (in the form of a programme) can be put in place in order to provide for these needs.

The pilot study was conducted, and the respondents were positive that the developed plan for the conducting of the main focus groups was sufficient. Some unforeseen problems however arose during implementation of the main study, but the researcher managed them appropriately. Consequently the researcher is of the opinion that data collected during the pilot study, focus group 1, and focus group 2, are valuable and useful in this study. Although the last group was conducted on the basis of a one-on-one interview, the researcher feels that the data collected from this participant cannot be dismissed.

The researcher transcribed and analysed data retrieved from the above mentioned participants and groups, and certain themes and categories were identified for further investigation and clarification. In the following chapter the researcher describes, integrates and presents these categories and themes with the help of complementary literature. This presentation will revolve around improving the coping and adaptation of children with mental health problems in child and youth care centres through providing effective ecosystemic orientated guidelines to be implemented in such facilities.
Chapter 5
Mental health problems – Needs and guidelines

5.1. Introduction:

In the first chapter the motivation and consequent goals and objectives of this study were discussed. In the second chapter special attention was paid to literature pertaining information on social work, mental health and human rights studies. The planning and reporting on implementation of the empirical part of this research study was discussed in Chapters 3 and 4. Descriptive qualitative research methods were the only methods utilised during implementation of the empirical study. Focus groups were conducted to better understand the opinions of social workers and child care workers on the characteristics and emanating needs of a child with a mental health problem, and suggested guidelines which may help to provide for the identified needs.

The researcher transcribed and analysed data retrieved from focus groups in Chapter 4. As seen in the said chapter, certain themes and categories were identified for further investigation and clarification. In this chapter the researcher integrates, describes and presents identified categories and themes from Chapter 4 (taking data analysis into consideration) through use of a literature control.

The three main categories were identified as; mental health problems/disorders, the individual needs of the child with a mental health problem, and suggested guidelines. Certain subthemes emanating from the empirical study differ from themes discussed in Chapter 2. These differences are also pointed out in this chapter.

The new aspects identified by participants that partook in focus group discussions and interviews, necessitates an exploration of new literature. The presentation in this chapter will therefore involve the combination of all previously touched on matters – those from literature – and those from key role players who work with children with mental health disorders in residential facilities.
In doing the above, the researcher constantly keeps the goal of the study in mind. It is important to remember that this study works towards the provision of a management programme to mainstream and specialised child and youth care centres, on how to care optimally for children with mental health problems.

After completion of this chapter, the researcher therefore attempts to advance the initial assessment process and programme, developed in Chapter 2. This chapter presents all findings as a framework to guide the development of a final programme for child and youth care centres. This programme should provide effective ecosystemic orientated care that promotes coping and adaptation of a child with a mental health problem in a residential facility. The researcher feels that improved coping and adaptation leads to a good person-environment-fit. This in turn may optimise the mental health of the children concerned.

As participants of focus groups agreed on certain mental health problems/disorders usually presenting in children in child and youth care centres, the presentation in this chapter will focus on the characteristics and emanating individual needs of a child in terms of a specific mental health problem/disorder. Further discussions then centres around suggested guidelines to provide for the identified needs of each of these disorders.

Some general aspects however came forth during focus group discussions. The researcher feels that these general aspects serve as an introduction to more specific mental health disorders.

5.2. Mental health problems/disorders in general:

In the literature review mental health disorders were defined as disorders that interfere with daily functioning, such as education and employment (Dumaine, 2003). Participants in the focus groups defined mental health problems/disorders as a psychiatric problem diagnosed by a psychiatrist. There was an immense focus on behavioural problems, and participants stated that a child with a mental health problem’s behaviour is abnormal in relation to that of other children. They also refer to it as strange or difficult behaviour, which there is no specific reason for, and for
which children cannot accept responsibility. They feel that these children are unable to cope like others, and that the above mentioned types of behaviour cannot be remedied by normal therapy or interventions.

In summary the participants’ definition of a child with a mental health problem, is a child that “just stands out” and with which child and youth care centres are “just stuck”. Participants’ frustrations confirm the need for specialised interventions in the form of ecosystemic guidelines, which can be implemented in order for the children concerned to reach improved coping and adaptation, which in turn can lead to a good person-environment-fit and mental health.

Before the specific mental health disorders, its characteristics, emanating needs, and suggested guidelines are discussed, the researcher presents general needs of children with mental health problems in child and youth care centres, identified by focus group participants:

Table 7: General needs of children with mental health problems in child and youth care centres

<table>
<thead>
<tr>
<th>Type of need</th>
<th>Identified by participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual needs</td>
<td>• Unconditional acceptance.</td>
</tr>
<tr>
<td></td>
<td>• Unconditional love “One of our greatest emotional and psychological needs is love. Without love, psychological problems are bound to increase. Love is a healer. It has been described as the best prescription” (Association for Youth, Children and Natural Psychology – AYCNP, 2006, p. 56).</td>
</tr>
<tr>
<td></td>
<td>• Patience and tolerance.</td>
</tr>
<tr>
<td></td>
<td>• Individual, undivided attention. “Caregivers need to spend time with their children” (AYCNP, 2006, p. 57).</td>
</tr>
<tr>
<td></td>
<td>• Decision making within certain boundaries.</td>
</tr>
<tr>
<td></td>
<td>• A secure attachment with a significant other (to belong). Cain (2006) states that attachment is defined as the deep and enduring connection established between a child and a caregiver in the first years of life.</td>
</tr>
<tr>
<td></td>
<td>• Personal and physical safety.</td>
</tr>
<tr>
<td></td>
<td>• Trust.</td>
</tr>
<tr>
<td></td>
<td>• Supportive environment.</td>
</tr>
<tr>
<td></td>
<td>• Partaking in physical activities, sports and/or hobbies.</td>
</tr>
<tr>
<td>Type of need</td>
<td>Identified by participants</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Individualised intervention plans.</td>
<td></td>
</tr>
<tr>
<td>Therapy.</td>
<td></td>
</tr>
<tr>
<td>Integration into surrounding communities.</td>
<td></td>
</tr>
<tr>
<td>For all of the above needs to be provided and supported by biological parents where applicable.</td>
<td></td>
</tr>
<tr>
<td>Disciplinary needs</td>
<td>Positive reinforcement.</td>
</tr>
<tr>
<td>Teaching appropriate boundaries.</td>
<td></td>
</tr>
<tr>
<td>Establish routine and structured environment.</td>
<td></td>
</tr>
<tr>
<td>Training needs</td>
<td>Education on specific disorder (psycho-education).</td>
</tr>
<tr>
<td>Emotional intelligence.</td>
<td></td>
</tr>
<tr>
<td>Values.</td>
<td></td>
</tr>
<tr>
<td>Life skills.</td>
<td></td>
</tr>
<tr>
<td>Therapeutic needs</td>
<td>Psychotherapy – such as cognitive behaviour therapy (CBT) – for specific symptoms of specific disorders (may include group therapy).</td>
</tr>
<tr>
<td>Therapy to address individual therapeutic needs.</td>
<td></td>
</tr>
<tr>
<td>Emotional intelligence.</td>
<td></td>
</tr>
<tr>
<td>Medicinal needs</td>
<td>Necessary to reduce symptoms of specific disorder.</td>
</tr>
<tr>
<td>Educational needs</td>
<td>Child needs individual attention – found in special schooling.</td>
</tr>
<tr>
<td>Individual stimulation (according to individual need) to develop appropriate milestones.</td>
<td></td>
</tr>
<tr>
<td>Grant and Van Acker (2000) state that the school must represent a setting that is free from physical and psychological harm for all students. Beyond ensuring safety, the school should play an important role in helping students develop a positive identity.</td>
<td></td>
</tr>
</tbody>
</table>

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Literature and participants of focus groups identified general guidelines on how to provide for the above general needs. It is presented in Table 8:

Table 8: General guidelines to provide for general needs of children with mental health problems in a child and youth care centre

<table>
<thead>
<tr>
<th>Ecosystemic level</th>
<th>Guidelines as suggested by literature and/or focus group participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro level</td>
<td>Participants are of the opinion that a child’s individual needs can be provided for by firstly having trained, committed and passionate staff members with patience and tolerance to work with and unconditionally</td>
</tr>
</tbody>
</table>
love and accept a child with a mental health problem.

- Participants are also of the opinion that caregivers should demonstrate unconditional acceptance towards the child. The child’s behaviour is what should be regarded as the problem, and not the child him/herself.

- Some child care workers are of the opinion that the child should be treated as if it is his/her own child. Righton (2005) refers to basic human qualities that are required of a child care worker. Nurturing, strengthening and letting go, need to be supplemented with some or all of these qualities: emotional stability and resilience, that is not readily shaken but also open to learning from experience, a capacity to manage stress in self and others, a sense of the worth of one’s self and one’s work, not arrogance but a solid belief that what I have to give is OK, a range of practical abilities and an ability to share them, an ability to take children seriously – and humorously – as people in their own right, with as much right to say in their lives as staff themselves, and powers of sharp analysis and synthesis.

- To implement the above, a smaller staff:child ratio is necessary – suggested number of 1:3. In this manner individual attention can be provided and children can receive needed love and affection.

- Focus group participants are of the opinion that you may further provide for a child’s individual needs by spending quality time with him/her.

- In providing for the above individual needs, the child might be able to build a secure bond and attachment with the caregiver. Green and Chee (1997) state that children are at their best emotionally if able to talk and confide with an accepting adult. What they want is a supporter who believes in them. Cain (2006) suggests attachment therapy to establish this.

- Note, however, that the “caregiver” may not only include the child care worker, but also the biological parents of a child. Green and Chee (1997) state that a child needs to belong, feel loved, accepted and enjoyed by family and friends. It is of immense importance to the emotional health of both adults and children (Green & Chee, 1997).

- Focus group participants felt strongly about the involvement of biological parents. They are of the opinion, and it was already stated by literature, that parents may assist in the road to improved mental health and behaviour of a child with a mental health problem. Participants feel that biological parents will be cooperative if the staff of the residential facility
<table>
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<tr>
<th>Ecosystemic level</th>
<th>Guidelines as suggested by literature and/or focus group participants</th>
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<tbody>
<tr>
<td></td>
<td>are accepting of them, and attempt to build a good relationship with them.</td>
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<td></td>
<td>• Focus group participants suggested for child care workers and biological parents (if the biological parents are involved and it is appropriate), to be trained and given knowledge on aspects pertaining to mental health problems. They feel that this will empower caregivers to care for the children better, as they would know why the children react the way he/she does, and how to deal with these reactions.</td>
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<td></td>
<td>• Focus group participants further suggest for peers of a child who reside in a mainstream child and youth care centre to also be educated on mental health problems and its surrounding complications. Some participants are of the opinion that this will help a child to not reject the child with a mental health problem because of his/her behaviour. Understandably some participants do not agree with this, and state that they have experienced that peers still reject the child with a mental health problem, as they are physically and emotionally hurting their peers.</td>
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<td></td>
<td>• Some individual children also have a need for specialised and individualised schooling. This need should be established by implementing the necessary educational assessments by appropriate professionals. Based on results from these assessments, a child should receive appropriate schooling. It is important to note that teachers should have knowledge about mental health problems, and must interact appropriately with children.</td>
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<td></td>
<td>• Structured and routine environments can be provided by educating child care workers and/or biological parents on how to act as strong disciplinary figures, who set clear boundaries.</td>
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<tr>
<td></td>
<td>• A focus on positive discipline is needed in most cases. Cawood (2007) states that one should focus on the positives. We all need to hear or feel something positive about ourselves every day.</td>
</tr>
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<td></td>
<td>• For a further focus on strengths, and also to not let a child feel isolated, it is suggested for the child to be integrated into the local community by partaking in activities, sports and/or hobbies.</td>
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<td></td>
<td>• Individualised treatment plans seem to be an important aspect in determining what other services a child with a specific background, and mental health problem, should receive.</td>
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<td>• Assessments should be done in order to ensure that the correct treatment plan is composed, and that the child’s extensive therapeutic needs are provided for.</td>
</tr>
<tr>
<td>Ecosystemic level</td>
<td>Guidelines as suggested by literature and/or focus group participants</td>
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<td></td>
<td>- Pharmacotherapy is regarded as an additional approach to therapy for a child with a mental health problem.</td>
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<td></td>
<td>- Every child would be able to handle his/her emotions and behaviour better if they are educated on the manner how to do it. This would include education on the specific mental health problem they present with.</td>
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<td></td>
<td>- Other educational groups may teach a child emotional intelligence, appropriate values and life skills, and an awareness of self. According to NAMI (2007), problem solving skills may improve interpersonal problems exhibited by these children. It can offer children alternative ways of understanding social situations, and of responding to them. Barker (2004) links this with positive discipline as mentioned above, by stating that children can practice their newfound skills and earn rewards as they develop new, better responses to solving problems. The researcher is further of the opinion that when children are emotionally intelligent, they will be able to identify emotions experienced, and how to appropriately deal with this emotion.</td>
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<table>
<thead>
<tr>
<th>Meso level</th>
<th>Focus group participants suggest for the following role-players to be involved in the care of a child with a mental health problem:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- <strong>Social workers:</strong> As seen in the previous literature review, social workers should be responsible for the initial assessments of a child admitted in a child and youth care centre, and thereafter referrals to appropriate professionals. They also complete necessary social welfare case management, and link the child to appropriate services. He/she work with and delegate child care workers, biological parents, peers and all other role-players involved to provide for the child’s individual and unique needs.</td>
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<td></td>
<td>- <strong>Teachers:</strong> According to focus group participants the child should receive individual attention and/or schooling from teachers qualified to provide such schooling. These teachers should be knowledgeable on mental health problems, on top of knowing how to provide for the individual child’s unique educational needs. Teachers should also work on a strengths based approach, and not make schooling more unpleasant for a child that already struggles.</td>
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<tr>
<td></td>
<td>- <strong>Therapists:</strong> Therapists are responsible to render the needed therapeutic services to a child (can include social workers or psychologists). Focus group participants are of the opinion that</td>
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</table>
Ecosystemic level

Guidelines as suggested by literature and/or focus group participants

- These role-players should also have a sound knowledge of mental health problems and how to address these, in conjunction with other challenges that have to be overcome by children in child and youth care centres.
  - Other role-players: A psychiatrist is necessary to prescribe the needed medication to a child with a specific disorder. Committed, long-term volunteers were also suggested to work with a child on an individual basis where individual care is not as accessible. General medical practitioners can provide medical and even primary health care services.
  - One participant felt that the overall wellness of all staff working with this child (micro and meso level), should be taken care of – in other words that staff wellness should be considered. The researcher feels that this includes the child care worker to recognise his/her emotions. Their emotions filter through to the children and affect their own performance. The child care worker should use supervision, staff support and outsiders for this if necessary (Isaacson, 2002).

Exo level

- The participants are of the opinion that there are no problems with current legislation regarding children with mental health problems.
- All however feel that resources to provide for these children’s needs are not available. Therefore they suggest for resources to be made available by Government Departments, as child and youth care centres fall under the Department of Social Development.
- Some participants also state that collaboration between all Government Departments – Health, Social Development and Education – would help in implementation of policy guidelines.

Macro level

- Participants feel that children have a right to not be isolated from mainstream care.
- They are however of opinion that if the child’s behaviour has a negative impact on the people in his/her direct environment, he/she should be transferred to a specialised programme.
- Some suggest fundraising to fund specialised services.
- Others feel that the child’s needs may be provided for, when there is enough staff employed.

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One participant of the focus groups felt that a child needs to be “self-aware”. There was a specific reference to the Gestalt therapy: “A basic assumption of Gestalt therapy is that individuals have the capacity to self-regulate when they are aware of what is happening in and around them” (Corey, 2009, p. 200). As seen throughout this research study, the Gestalt therapy was not a consideration, but the researcher regards it as noteworthy.

Mackewn (1997) states that the primary goal of Gestalt therapy is the development of awareness through a sustained enquiry into children’s subjective experience, honouring all aspects of their being and their circumstance, rather than just focusing on their problems or symptoms. It is important to establish a sense of rapport and model attention to awareness. Corey (2009) confirms this by stating that Gestalt therapy is an approach created on the premise that individuals must be understood in the context of their on-going relationship with the environment. The initial goal is for clients to gain awareness of what they are experiencing and how they are doing it. By becoming aware, clients become able to make informed choices and thus to live a more meaningful existence.

Therefore the participant and the researcher assume that if a child has self-awareness with regards to his/her mental health problem, the child will be knowledgeable enough to make better choices (for instance with regards to reactions when provoked).

Relevant aspects of this approach are discussed in the report that follows. The greater part of the report however focuses on relevant social work and mental health literature.

The needs and suggested ecosystemic guidelines in the tables above focus on children with mental health problems in general. As seen in the previous chapters, and as established by participants, children present with different disorders, and certain aspects of each of these disorders should be handled in different manners.

Participants from focus groups identified five mental health problems/disorders that usually present in children in child and youth care centres. These disorders do not
correlate fully with disorders discussed in Chapter 2. The participants for instance not once mentioned anxiety disorders (probably because it is so under diagnosed in children), but instead focused on problems with unusual/inappropriate sexual behaviour.

Based on feedback received from focus group participants, the researcher arrived at the following disorders, its unique characteristics, specific emanating needs and suggested ecosystemic guidelines to be implemented with each:

5.3. Conduct and oppositional defiance disorders:

From the results of focus groups, it seems as if conduct and oppositional defiance disorders are one of the most common categories of mental health problems found in children within child and youth care centres. Participants regard this category of disorders as serious. Burke (2009) justly states that behaviour of children with these disorders is more extreme, differing from the behaviours of others of the same developmental age, such that they are much more than just a phase that will pass in time. Further literature defined conduct and oppositional defiance disorders as behaviours that violate society’s norms (The American Psychiatric Association, 2000).

5.3.1. Characteristics:

Literature by Burke (2009), the American Psychiatric Association (2000) and the guidelines for the management and placement of children with special needs in residential facilities – The Department of Social Development (n.d.), identify the following characteristics of children with conduct and oppositional disorders in the first column of the table:

<table>
<thead>
<tr>
<th>Characteristics as identified by literature</th>
<th>Characteristics as identified by focus group participants</th>
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<tbody>
<tr>
<td>• Destruction to property</td>
<td>• Destructive behaviour (e.g. arson)</td>
</tr>
<tr>
<td>• Fire setting</td>
<td>• Damaging of property or objects</td>
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Table 9: Comparison of conduct and oppositional defiance disorder characteristics
### Characteristics as identified by literature

- Loosing temper, being angry and argumentative
- Aggressiveness and anger bursts (e.g. chasing others with knives)
- Looses internal control
- Aggression to people and animals
- Self-harm and harm to others
- Lying and/or stealing
- Lying
- Stealing
- Rebellion
- Serious violation of rules
- Acting out (e.g. extreme behaviours like just screaming and swearing)
- Sexual acting out behaviour
- Not respecting others
- Stubbornness
- Non-compliance
- Defiant behaviour (do not accept authority)
- Bullying, threatening and intimidating
- Bullying
- Deceitfulness
- Manipulating people and situations
- Threatening people
- Lack of remorse
- No conscience
- No empathy for others
- Absconding
- Absconding
- Truancy
- Cannot cope in mainstream school
- Easily annoyed and purposefully annoy others
- Impulsivity
- Criminal activities
- Juvenile delinquency
- Negative impact on social and emotional wellbeing

### Characteristics as identified by focus group participants

- Lying
- Stealing
- Rebellion
- Serious violation of rules
- Acting out (e.g. extreme behaviours like just screaming and swearing)
- Sexual acting out behaviour
- Not respecting others
- Stubbornness
- Defiant behaviour (do not accept authority)
- Bullying
- Manipulating people and situations
- Threatening people
- No conscience
- No empathy for others
- Cannot cope in mainstream school
- Impulsivity

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*Note that the colour blocks in the above and following tables, indicate the differences occurred between literature and the opinions of focus group participants.*

The researcher perceived that because key role-players works with children with conduct and oppositional defiance disorders regularly, characteristics were provided that correlate closely with those found in literature. When comparing the characteristics of a child with conduct and/or oppositional defiance disorder, with
general needs identified earlier in this chapter and previous literature, the following needs that are supposed to be addressed, seem to emanate from these characteristics:

5.3.1.1. Individual needs:

The above characteristics illustrate that the behaviour of children with conduct and oppositional defiance disorder, is extremely negative. Therefore literature (Burke, 2009) mentioned, and focus group participants confirmed, that people in the child’s direct environment find it challenging to provide for the child’s basic, individual needs (love, attention, acceptance, patience, etc.) as identified in Table 5.

During implementation of this research study, it was found that caregivers find it challenging to unconditionally accept and love a child who presents with such extremely negative behaviour. It appears as if patience and tolerance of caregivers run out. Therefore it consequently seems as if these children never form a secure attachment with a significant other. He/she never feels that he/she belongs.

Howe (2009) feels that insecure attachments form when the caregiver is not “good enough”. Ambivalent attachments and avoidant attachments are examples of insecure attachments that may form because of this. Insecure attachments lead to even more behaviour problems. Because these children never enjoyed emotional atonement, they are less likely to be able to understand and regulate their emotions and arousal. If their psychological needs have not been the subject of much interest or curiosity by harsh or disinterested caregivers, children find it difficult to monitor and make sense, not just of their own thoughts and feelings, but also those of other people.

Therefore it seems as if children with conduct and oppositional defiance disorder, not only have a need for an attachment with a caring adult, but they must be taught skills on how to understand and regulate their emotions and arousal.

The researcher is of the opinion that to establish good bonding and attachment with children with conduct and oppositional defiance disorder, individual time and
attention are necessary. As already mentioned and confirmed by participants of focus groups, it is difficult to provide for these individual needs, when the staff:child ratio is large. Therefore it appears as if children with conduct and oppositional defiance disorders should be in a facility where staff has the ability to spend quality time with them, and to consequently work on building a secure bond and attachment.

5.3.1.2. Therapeutic needs:

As mentioned in Chapter 2, the researcher is of the opinion that children, who reside in a child and youth care centre, were exposed to negative childhood experiences, which caused them to be removed from their homes and primary caregivers. Therefore a child is in need of therapy to resolve issues surrounding these negative childhood experiences, and the removal from home. The researcher perceived that a child with conduct and oppositional defiance disorder should receive psychotherapy (CBT, psycho-education, breathing, relaxation and grounding techniques), to address his/her behavioural characteristics and/or problems as well.

One of the behavioural characteristics identified by participants, and which they see as a great concern, is the anger that the child presents with. Therefore they feel that the personal and physical safety of not only the individual child with the mental health disorder, but also that of his/her caregivers and peers, is in jeopardy. Therefore the researcher suggests (if the child presents with such characteristics), for social workers to link the child with therapists that can address his/her aggressive behaviour.

Stein and Chowdhury (2006) suggest that if anger is a major issue, it may prove easier for a neutral person, such as a clinical psychologist, to help in resolving the problem. This could include cognitive behaviour therapy sessions in which the child is taught how to monitor his/her emotions, and how to actively change any thoughts which lead to angry feelings and acting out behaviours.

Weisz (2004) states that it is often possible to spot flash points at which behaviour gets out of control. He also states that one of the most common is the burst of anger, during which rational problem solving and self-control are abandoned, and
aggressive behaviour erupts. Weisz (2004) suggests two approaches that may help in minimising angrieness and aggressiveness:

- **Anger control training with stress inoculation:** Therapists first try to help children understand the nature, causes, and consequences of anger, especially their own. Then therapy builds on the notion of stress inoculation. Young people are exposed to manageable doses of provocations, in response to which they practice their coping skills, guided by the therapists. The programme is designed to reduce angry, explosive behaviour by increasing understanding of the behaviour and by providing practice in the use of tailor-made coping skills.

- **Anger coping programmes** however put more emphasis on live and video modelling, on immersion in problem-solving skills, and on weekly experience in setting specific behavioural goals and monitoring whether they are attained. An overall aim is to enhance children’s cognitive processing of their stressful encounters, and strengthen their ability to plan effective and adaptive responses.

Simmons and Griffiths (2010) also feel that helping a child to identify coping strategies is a good place to start. They identify psycho-education as a coping strategy, as it may help the child to recognise symptoms and realise what is happening to the body. Other coping techniques are identified as follows:

- **Breathing techniques:** These techniques can be practiced so that the child is better able to control his/her breathing when required. The main task is to slow down the breathing, and allow it to be controlled and relaxed.

- **Relaxation techniques:** Some involve lying down, closing the eyes and imagining a really lovely or safe place and using all the senses to give reality to the scene. Other relaxation techniques are more active and involve the client tensing and relaxing various parts of their body. It is called progressive muscle relaxation.

- **Grounding techniques:** These can help the child to bring anxiety levels down and help to get back in contact with the environment again.
The researcher highlights how other behaviour problems and/or characteristics can be addressed by paying attention to needs other than those already mentioned:

5.3.1.3. Disciplinary needs:

Literature in Chapter 2 proved that caregivers are more likely to make fewer positive and more negative statements toward children with these disorders, use harsh methods of punishment, perceive the behavioural problems of children to be intentional and abuse or neglect children (Burke, 2009). Therefore the researcher is of the opinion that careful consideration should be given when these – or any other child for that matter – are disciplined.

Discipline is defined as:

- Training expected to produce a specific character or pattern of behaviour, especially training that produces moral or mental improvement.
- Controlled behaviour resulting from disciplinary training.
- Punishment intended to correct or train.
- A set of rules or methods.
- A branch of knowledge or teaching (http://thefreedictionary.com).

Participants of focus groups stressed that children with conduct and oppositional defiance disorders need structured and routine environments to help with rebellion and non-compliance. Cawood (2007) justly states that difficult children respond very positively to routines that are predictable and structured. To reach structured and routine environments that can assist in minimising rebellion and non-compliance, the researcher suggests a combination of authoritative and positive discipline techniques.

The researcher observed that a strong authority figure is necessary to discipline a child who presents with conduct and oppositional defiance disorders. Cawood (2007), states that when a child responds to firm, clear and consistent rules and boundaries, adult authority is being established.
The researcher feels that children however need to know what rules exist before consequences are enforced. Therefore the establishment of rules is priority. Cawood (2007) states that when we put limits in place for children, in the context of our loving relationships with them, we are putting in place the building blocks for the development of their sense of self-discipline. The author states that children need to experience the boundaries we put in place and then to make choices regarding whether they choose to cooperate – or face the consequences if they decide not to. To the researcher it appears as if a child with conduct and oppositional defiance disorder will probably decide not to cooperate.

If this happens, McNamara and McNamara (2000) suggest the use of verbal reprimands. They suggest keeping these reprimands small and to the point. Too much discussion of the inappropriate behaviour may only serve to increase or maintain it. A simple “no”, “enough” or “stop” will suffice as opposed to a long discussion (McNamara & McNamara, 2000).

McNamara and McNamara (2000) are of the opinion that many times verbal reprimands may go unheeded as well, and the caregiver needs to move to removal of privileges. They state that this should be carried out in a well-thought-out manner, and the ground rules should be discussed with the child. He/she should know that if he/she engages in a specified behaviour, he/she will not get certain rewards. When children therefore display certain undesirable behaviours, reinforcements are unattainable.

Green and Chee (1997) are of the opinion that once we start taking away privileges, we are moving from the positive part of discipline into the realms of punishment. For privilege withdrawal to be effective, the privilege must be something the child depends on for pleasure, for example loss of television time. In using this technique, do not get too heavy and do not prolong things. If the child perceives the punishment as unreasonable, they may overreact, and behave worse.

The researcher is however of the opinion that a lesser focus on the negative, and a focus on more positive aspects and the strengths of a child, might assist in improving the child’s behaviour as well. An immense focus was paid to these kinds of positive
disciplining techniques during focus groups. McNamara and McNamara (2000) state that if a child does something that pleases you and you praise him/her for it, he/she might do it again. These authors identify a step-by-step guide to deliver praise:

i. Make a list of all appropriate behaviours the child engages in, no matter how simple they appear to be.

ii. Every time the child displays the targeted behaviour, the caregiver should say and/or do something positive. It is helpful if you can be specific in your praise.

iii. Praise should be delivered only after the child displays the appropriate behaviour. A link between the behaviour and the consequence should be established.

iv. Praise should be delivered very often in the beginning of a behavioural programme. This continuous reinforcement serves to strengthen behaviour. As the behaviour occurs more often, you can gradually reduce praise.

v. Praise should be delivered immediately after the behaviour occurs.

vi. Praise should be genuine.

The researcher found that praise is also referred to as reinforcement and/or reinforcers. These can also be utilised to encourage good behaviour. “Reinforcement is defined as anything that increases the strength of a specific behaviour” (McNamara & McNamara, 2000). Reinforcers may take on different forms such as verbal reinforcers (“great”, “well done”) or physical reinforcers (hugs, kisses, etc.). Material reinforcers such as toys or snacks can be given. Activity reinforcers like a trip to the park or zoo can also be utilised (McNamara & McNamara, 2000). The researcher is of the opinion that the behaviour of children with conduct and oppositional defiance disorders’ might improve if such positive disciplinary techniques are utilised. For those instances where it does prove successful, the researcher suggests for caregivers to use reprimands and the taking away of privileges.

In summary, Cawood (2007) provides a general model of effective discipline. This author suggests for caregivers to:

- State the rule, limit or expectation simply and clearly. (*The child is not allowed to hit another*).
• Try using an assertive I-message. (*I do not think it is a good idea for you to hit that boy/girl*).

• Give a choice. (*You can choose to not listen to me, and hit him/her, or you can listen to me, and walk away. I can help you to solve your frustrations*).

• Allow the consequence of the child’s choice. (*See if the child hits the boy/girl*).

• Show the child that you understand how he/she feels. (*I understand that you are angry with the boy/girl because he/she took your toy. Hitting him/her is however not an effective way in which to deal with your frustration*).

• For those behaviours that praise will not be effective for, punishment is suggested. The first is to ignore inappropriate behaviour. The idea is that reinforcement occurs in the child’s environment and the absence of this reinforcement (ignoring) will encourage the child to engage in the appropriate behaviour to receive reinforcement. A child should get attention when engaging in desirable, not undesirable, behaviour.

The researcher feels that there are some skills that have to be taught to children with conduct and oppositional defiance disorders. She feels that if a child is taught these skills in an efficient manner, disciplining will take place more easily.

5.3.1.4. Training needs:

In Chapter 2 it was briefly mentioned that a child would benefit from psycho-education. With this help, a child may become knowledgeable about aspects of their behaviour, emotions and/or mental health problem – in this case conduct and oppositional defiance disorders. The combination of such education and other skills might be conducive to the overall mental health of a child.

The researcher and members of focus groups believe that general life skills and values training might help to improve these children’s behaviour. As can be seen in table 9, children with conduct and oppositional defiance disorders need guidance on specific issues like having empathy for others, having a conscience and remorse for negative deeds, respecting others and submitting to authority, and building a positive self-esteem.
Social skills training is one skill that for instance has to be taught to a child with conduct and oppositional defiance disorder. Mash and Wolfe (2002), state that the skills or behaviours that are missing, or could be improved, should first be identified. Complex behaviours might be broken down into smaller component parts. The desired behaviour or skill might be demonstrated. Learning by observing other people is most effective if the observed behaviour clearly gets results or is carried out by someone who is respected and successful. Competent displays of the new behaviour should be praised and reinforced. Howe (2009) confirms that children learn a lot, not always good things, from just watching their parents or peers – modelling. Therefore caregivers can also help in teaching children appropriate social skills. Except for social skills, literature suggests for children with conduct and oppositional defiance to learn problem solving skills as well.

Problem solving skills can be taught to children to help them solve problems experienced in more effective ways. Cawood (2007) suggests for caregivers to have a discussion with the child on the problems experienced. The idea is not to take over the child’s problem, but rather to encourage the child to find his or her own solution. Mash and Wolfe (2002) refer to a more complex form of problem solving. They identify key features of cognitive problem-solving skills training:

- It emphasises the child’s thinking, although the behaviours that result from thinking are also viewed as important.
- Self-statements are used to direct attention to aspects of the problem that lead to effective solutions.
- Treatment uses structured tasks, which include games, school, activities, or stories.
- The child learns to apply cognitive problem-solving skills to real-life situations.
- The therapist plays an active role in treatment, giving examples of the cognitive processes and providing feedback and praise.
- Treatment combines modelling, practice, role playing, behavioural contracts, reinforcement, and mild punishments.
- Treatment emphasises the extension of problem solving to the child’s everyday life through the use of homework assignments and caregiver involvement.
The researcher is therefore of the opinion that if a child with conduct and oppositional defiance disorder can be taught such problem behaviour skills, they will be able to solve problems in a more effective and appropriate manner. Rather than hitting a child who took his/her toy, the child can decide to rather discuss his/her problem with the caregiver.

Aside from general skills training, children with conduct and oppositional defiance disorders should engage in educational and academic skills training as well.

5.3.1.5. Educational needs:

Focus group participants were of the opinion that a child with conduct and oppositional defiance disorder cannot cope in mainstream school, largely because of their difficult behaviour. In Chapter 2 of this research study, Barker (2004) stated that impaired verbal ability and reading problems are found more often in children with conduct disorders than in the general population. Mash and Wolfe (2002) confirm that children with conduct problems display high rates of academic underachievement, grade retention, special education placement, school dropout, suspension, and expulsion.

An aspect of children with conduct and oppositional defiance disorders is that they skip school. The researcher argues that a child, who commits truancy, might indirectly show that he/she is not coping with the demands of mainstream schooling, therefore not attending. When truancy is a concern, she suggests for caregivers to pay attention to the child’s school performance.

Children might not be coping with their school work, but the possibility also exists that they are experiencing problems with their school teachers. Cawood (2007) is of the opinion that how teachers talk, tells a child how they feel about him/her. Their statements affect the child’s self-esteem and self-worth. To a large extent, their language determines the child’s destiny. Therefore the researcher feels that it is important for teachers to be sensitive in the way they treat a child with a conduct and oppositional disorder. Linking back to what was said earlier; teachers will only know
the correct manner to treat this child, when they have had proper training on this topic.

The researcher feels that the only way in which to establish if an individual child needs specialised and/or individualised schooling is by conducting an assessment with relevant role-players. Educational psychologists will be able to provide a full report on the child’s current functioning and what he/she needs in order to perform academically.

These children might be able to perform academically, but because of certain behavioural problems, they struggle to focus in classrooms. Medicinal interventions can assist in these and other behavioural challenges.

5.3.1.6. Medicinal needs:

The researcher and participants of focus groups are of the opinion that all the above mentioned behaviour and symptoms of conduct/oppositional defiance disorders, need to be contained and managed through pharmacotherapy. Semple, Smyth, Burns, Darjee and McIntosh (2005) confirmed this in Chapter 2 already, by stating that medication is a necessary part of treatment.

“Neuroleptics, lithium, anticonvulsants and stimulants have been used in the treatment of children with conduct and oppositional defiance disorders. Neuroleptics are the most commonly used drugs to treat aggressive behaviour. Lithium is a mood stabiliser that reduces aggressive behaviour with fewer side effects than the neuroleptics. The anticonvulsant carbamazepine also helps reduce aggressive behaviours with minimal effect on cognitive functions. Stimulant medications can also be effective in reducing impulsivity in children with conduct problems and co-occurring ADHD” (Mash & Wolfe, 2002, p. 160).
5.3.2. Ecosystemic guidelines:

5.3.2.1. Micro level:

Based on the above characteristics and needs of a child with conduct and oppositional defiance disorders, the researcher feels that the individual child should receive services tailored to fit their individual needs. As could be seen from literature and focus group information, the only way a child’s individual needs like love, attention, affection, attachment etc. could be provided for, is by having a small staff to child ratio. Because of these specific children’s extreme behaviour and the constant supervision and attention they need, the researcher is of the opinion that this is an important consideration.

As could be seen above, a focus on the negative is not conducive to the mental health of the child with conduct and oppositional defiance disorders. Therefore a focus on positive discipline can serve as a preventative measure for bad behaviour and an encourager for good behaviour. When bad behaviour does however take place, it can be addressed by following certain suggested techniques.

The researcher perceives that from a disciplinary perspective, children with conduct and oppositional defiance disorders should have tight boundaries and clear consequences for each in place. The caregiver of the child (will be primarily the child care worker as he/she works with the child every day, 24 hours a day) is responsible to act as a strong authority figure and thus implement disciplinary techniques as discussed above.

As seen above, this child has a large need for different kinds of therapy to be conducted by appropriate professionals. Trauma therapy, anger management, cognitive behaviour therapy, etc. can be provided by different role-players as discussed under the meso level of this section. These and/or other role-players to also be discussed, will also be responsible to implement training on problem solving skills, emotional intelligence, mental health problems, life skills and values. For appropriate time-management of these role-players, the researcher suggests for training on general issues to take place inside a group setting.
Green and Chee (1997) provide general tips for the management of a child with oppositional and/or conduct disorder:

- **Always avoid head-on confrontations.** Use offhand tones, cool responses and looking away, and give time for hostility to reduce.

- **Side-step impulsive rages.** These children are impulsive and aggressive, so try to slow down, rather than stir up, the situation. Give them space by suggesting alternative options or just walk away for a moment. Let them feel they have a say.

- **Avoid arguing.** Allow them a few minutes of uninterrupted time to have their say. Listen attentively but set ground rules. They have a right to express themselves but this right is lost if they scream or become verbally abusive.

- **Avoid Mexican stand-offs.** Do not back the child into a corner or leave them no way to save face. Do not moralise. Show other solutions that might work out for them.

- **Use distractibility to your advantage.** Jump positively on anything that is good, praise can divert from the main problem. Encourage any improvement but do not expect a total turnaround.

- **Be on the same team.** If there are any gains, be in it with them. Let them feel they are to some extent in control.

- **Remember that they do care.** Often they are too stubborn to admit they are wrong and that they need help.

- **Help them to trust the world.** These children believe the world is as hostile as them. They need to see that the world can treat them well.

Certain role-players are necessary in achieving the above.

**5.3.2.2. Meso level:**

In Chapter 2 different role-players were identified that may assist a child with a mental health problem to cope better, and to improve adaptation in a residential care facility.
Social workers should coordinate general services as discussed above, ensuring that the child receives services necessary to address presenting symptoms of conduct and oppositional defiance disorders.

Social workers may also act as a therapist to a child. One of the participants of the focus groups however felt strongly that the training of social workers is not efficient enough to provide for this child’s extensive therapeutic needs. Social workers are for instance not trained on how to implement cognitive behavioural therapy. The researcher agrees that this child’s therapeutic needs should thus be addressed by a psychologist or psychiatrist. Either of these therapists can provide the child with knowledge and training on their disorders, and teach them necessary skills and values.

As mentioned it is important for teachers to have a good knowledge on the symptoms and challenges of a child with this category of disorders, as this will help in the management of it. The teacher should not label the child as a difficult or naughty child because of their behaviour.

5.3.2.3. Exo level:

The participants of focus groups did not have extensive opinions regarding this level of service rendering with regards to any of the disorders. The possibility exists that they are not knowledgeable regarding acts and policies, and therefore did not feel free to discuss the issue at hand.

Participants did however verbalise that they are of the opinion that a lack of resources (both financial and with regards to human resources), might be the reason for government legislation to not be implemented as stated in acts and policies.

5.3.2.4. Macro level:

The researcher observed that the participants of focus groups were in two minds with regards to including or excluding a child with a conduct and oppositional defiance disorder in a mainstream child and youth care centre. Members stated that
it would be conducive to the overall wellbeing of a child when he/she feels that they are not being rejected by being isolated from mainstream homes, by placing them into specialised care.

On the other hand, participants stated that a child with behaviour as severe as discussed above, cannot be accommodated in a mainstream centre, and that they should be transferred to specialised care programmes. They felt that these children do not only hold a physical, but also an emotional threat for his/her caregivers and peers when in a mainstream home.

Resources to be made available for children with conduct and oppositional defiance disorders can therefore be summarised as follows:
5.4. Attention Deficit Disorders:

Participants from focus groups see ADHD as one of the most common disorders found in children in child and youth care centres. They generally refer to this child as the one that is difficult in school, and who does not want to sit still.

Green and Chee (1997) also states that when we talk about ADHD we refer to a slight but demonstrable difference in normal brain function that causes a clever child to underachieve academically and who behave poorly, despite receiving the highest standard of parenting. They are further of the opinion that ADHD presents in two
ways; impulsive, poorly self-monitored behaviour (referred to as hyperactive-impulse behaviour); and problems of attention, short-term memory and learning (attention deficit-learning weakness). A child may present with one of these in isolation, but most ADHD children have a mixture of both.

5.4.1. Characteristics:

Barker (2004), the American Psychiatric Association (2000), NAMI (2011b), Gray and Zide (2000) and Green and Chee (1997) identify characteristics of ADHD as follows:

Table 10: Comparison of ADHD characteristics

<table>
<thead>
<tr>
<th>Characteristics as identified by literature</th>
<th>Characteristics as identified by focus group participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Readily distractible</td>
<td>• Short attention span</td>
</tr>
<tr>
<td>• Not finishing homework or making a lot of mistakes</td>
<td>• Not completing tasks</td>
</tr>
<tr>
<td>• Not listening or following through with instructions.</td>
<td>• Not listening when spoken to</td>
</tr>
<tr>
<td>• Fails to respond to disciplinary methods</td>
<td>• Being stubborn</td>
</tr>
<tr>
<td>• Impulsivity</td>
<td>• Lack of inner control and/or impulse control</td>
</tr>
<tr>
<td>• Restlessness</td>
<td>• Cannot stop talking, sit still or fidget</td>
</tr>
<tr>
<td>• Unable to play quietly</td>
<td></td>
</tr>
<tr>
<td>• Excessive moving</td>
<td></td>
</tr>
<tr>
<td>• Difficult to contain</td>
<td></td>
</tr>
<tr>
<td>• Fidgeting</td>
<td></td>
</tr>
<tr>
<td>• Talking excessively</td>
<td></td>
</tr>
<tr>
<td>• Continually interrupting</td>
<td></td>
</tr>
<tr>
<td>• Never slowing down</td>
<td></td>
</tr>
<tr>
<td>• Being exhausting or demanding</td>
<td></td>
</tr>
<tr>
<td>• Displaying extreme physical agitation</td>
<td></td>
</tr>
<tr>
<td>• Inner feeling of jitteriness or restlessness</td>
<td></td>
</tr>
<tr>
<td>• Sleep disturbance</td>
<td></td>
</tr>
<tr>
<td>• Learning disabilities</td>
<td>• Cannot cope in a mainstream school</td>
</tr>
<tr>
<td>• Forgetful</td>
<td></td>
</tr>
</tbody>
</table>
Green and Chee (1997) refer to additional ADHD vulnerabilities, as opposed to characteristics:

- Copes badly with change-over times.
- Overreacts to playground teasing.
- Is slow to copy down information.
- Forgets homework books.
- Forgets messages for home.
- Have difficulty starting projects.
- Needs tight structure for homework.
- Is easily led, quickly blamed.
- Gets lost, falls behind, and loses interest.
- May show dramatic deterioration of behaviour and learning as medication levels drop off.

According to McNamara and McNamara (2000) the only way to decide whether or not a child has ADHD is to have him/her evaluated by a group of professionals who look at all aspects of a child’s development and behaviour. This team, according to them, should consist of a medical doctor, a psychologist, a special educator, and a social worker.

As seen in the previous section, the above characteristics all have underlying needs. The following needs were identified by the researcher, participants of focus groups, and literature:

<table>
<thead>
<tr>
<th>Characteristics as identified by literature</th>
<th>Characteristics as identified by focus group participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cannot organise</td>
<td>• Struggle to fit into routine and/or structured environment</td>
</tr>
<tr>
<td></td>
<td>• Attention seeking behaviour:</td>
</tr>
<tr>
<td></td>
<td>• Lying</td>
</tr>
<tr>
<td></td>
<td>• Aggression</td>
</tr>
<tr>
<td>• Difficulty with peer relationships and developing friendships</td>
<td></td>
</tr>
</tbody>
</table>
5.4.1.1. Individual needs:

As identified, all children have some basic, general needs like love, attention, acceptance, etc. These need to be provided for as stated in the general guidelines (Table 7). It however seems as if children with ADHD’s need for individual attention and help is much higher than that of a child without. In literature already discussed in Chapter 2, it was indeed established that usually children with attention-deficits place substantial stress on their caregivers and others in the environment (Burke, 2009).

The researcher is of the opinion that because of the above, and other reasons, children with ADHD need caregivers that can offer a lot of patience and tolerance. Green and Chee (1997) for instance state that poor impulse control leaves the ADHD child both physically and verbally accident-prone. They frequently trip, fall, act stupid and put their feet in their mouth. ADD children nag at and demand of their caregivers from dawn to dusk. This incessant pressure generates great tension.

Green and Chee (1997) further state that a child with ADHD can be immensely irritating, but most are sensitive and inwardly they wish to please. They state that nice kids remain nice when accepted as they are, given realistic limits, guided, rewarded, enjoyed and loved. They do not want to be managed by force or fear; they need a caregiver who is a supporter, a believer and a friend.

Therefore the researcher feels that it is important for caregivers to receive training and knowledge on how to manage these children and their behaviour. Caregiver management training provides caregivers with a variety of skills to help them:

- Manage their child’s oppositional and non-compliant behaviour.
- Cope with the emotional difficulties of raising a child with ADHD.
- Contain the problem so that it does not worsen.
- Keep the problem from adversely affecting other family members (Mash & Wolfe, 2002).
Weisz (2004) feels that when caregivers are trained on the above aspects, they should also understand why children misbehave. The author identifies four causal components that should be kept in mind:

- **Child characteristics:** May include attention problems, impulsivity, or irritability that shows up as early as infancy in the form of difficult temperament.

- **Caregiver characteristics:** Caregivers may have temperamental characteristics, difficulties with attention span or impulse control, or propensities toward patterns of personality or psychopathology that contribute to their child’s difficulties.

- **Situational factors, environmental contingencies:** Children may misbehave in order to escape from unpleasant conditions or demands.

- **Family stressors:** The caregivers’ personal problems, financial difficulties, job tension, and problems created by the child’s peers.

The above considerations are however not enough, and Weisz (2004) further states that caregivers should be taught how to pay attention. The basic idea is that the way caregivers allocate their attention when they interact with the children has a powerful impact on subsequent child behaviour. Caregivers are encouraged to set aside 15 - 20 minutes a day as special time to be with the child alone to engage in an activity of the child’s choosing, and to use the time to attend totally to the child’s activity – watching it, appreciating it, and occasionally narrating and praising it, while avoiding questions, commands, criticism, or control of the child. These kinds of activities refer back to the initially discussed concept of “hanging out” with children, in Chapter 2.

The researcher is of the opinion that by paying attention to the above needs and how to provide for them, some problem behaviour might already minimise. The researcher and participants of focus groups however observed that children can further benefit from physical activities, sports and/or hobbies. McNamara and McNamara (2000), state that it is important to recognise that some children with ADHD will never work off their excessive energy. Sports can provide wonderful experiences for physical activity and social interaction if they are appropriate for the child or adolescent with ADHD. Caregivers need to consider the behaviours the child displays and the demands of a particular sport and decide if it is a good fit.
When looking at hobbies, McNamara and McNamara (2000) state that a wonderful thing about hobbies, is that children and adolescents can become experts in them. By developing a hobby children can acquire knowledge and skills for which they are perceived as competent, as an expert in one particular area of interest. Therefore the researcher suggests for caregivers and other role-players to identify what the child is interested in, and if he/she can “become an expert” in this activity. If the child can achieve in it, the activity should be encouraged. The researcher feels that in doing this, the strengths of the child are focused upon (an important consideration during focus group discussions).

AYCNP (2006) is also of the opinion that regular outdoor activities such as playing in the park, hiking, camping, jumping rope, biking, skating, skateboarding, brisk walking and jogging can help children to overcome the symptoms associated with ADHD and depression. The researcher therefore states that it might be a good idea for caregivers to include in their daily schedules, a physical activity that can be enjoyed outdoors.

Green and Chee (1997) add to the above and suggest for children with ADHD to partake in the following sports and/or hobbies:

- **Swimming**: Not only is it an outlet for energy, it also provides a socially useful interest which they will still have in adulthood.
- **Football and other team sports**: Success in this sport brings about a great boost to their self-esteem.
- **Bicycles**: For many, bikes give space, freedom and an escape from the frustrations of life.
- **Fishing**: Fishing gives space and is free from social stress.
- **Judo**: This teaches organisation and anticipation, and has the right amount of interest and discipline to keep the attention of the usually inattentive.
- **Athletics, gymnastics and dancing**: These give a great outlet for all the ADHD energy.
- **Hobbies, crafts and interest**: Caregivers need to be on the lookout for new activities and interests all the time.
The researcher feels that all of the above needs should be provided in a structured and routine environment, which can only be established by disciplining.

5.4.1.2. Disciplinary needs:

Focus group participants were of the opinion that these children like structure and routine the least of all, but that this is actually something they need. The researcher is of the opinion that this can be established through implementation of the correct disciplinary manners. “A need for structure is many times important in the ADHD child, who likes to have a fixed framework to direct their day. If their equilibrium is thrown by anything different, it will set them off. If you want peace, keep to routine” (Green & Chee, 1997).

McNamara and McNamara (2000, p. 83 - 84) therefore state that “effective programmes for children with ADHD provide a great deal of structure. Structure does not imply rigidity. Rather a structured approach is one in which children know exactly what is expected of them, which behaviours are acceptable and unacceptable, what the consequences are for each behaviour, and what the time frame is for each expected behaviour.”

These authors suggest for caregivers to establish some kind of schedule. The schedule will vary tremendously for each child or adolescent, depending on his/her age, the severity of the disorder and his/her interests. The idea is to create some structure by adhering to a schedule. The structure you provide can bring about a sense of order in a chaotic world (McNamara & McNamara, 2000, p. 83-84).

The researcher suggests for caregivers to establish a daily schedule when working with a child with ADHD. From where they wake up, get up, brush their teeth, wash their faces, get dressed, eat breakfast, go to school, etc. The schedule should be continued after the child returns from school (eat lunch, do homework, play outside, bath, eat dinner etc.). It seems as if this can provide ADHD children with the structure that they need. The researcher is of the opinion that even though the child is in a mainstream residential facility, the same schedule can be applied to all children residing there.
McNamara and McNamara (2000) take structure further by stating that it also implies a certain amount of organisation. Clothes, objects, school items, and so forth, should be stored in the same place. Therefore limits and a certain structure should be set for this as well. The researcher feels that children can also learn responsibility when they have to keep their own cupboards in order. Weekly inspection can be held, and the child whose cupboard is the neatest, can for instance receive a reward.

Back to the basics of discipline and the importance of setting limits for children with ADHD, McNamara and McNamara (2000) state that when limits are set in a fair and reasonable manner, they allow us to know exactly what is expected of us. This is especially true for children with ADHD. When limits are set, children and adolescents with ADHD do not have to guess what the rules are because they are presented to them in a clear manner that is explicitly stated.

The researcher observed that sometimes rules are not set in the correct manner. We may sometimes have unreasonable expectancies of children. McNamara and McNamara (2000, p. 78) state that when making rules, caregivers should try to: “make them as positive as possible. Make rules specific. This allows for little interpretation. Use as few rules as you can. Too many rules are confusing and difficult to follow. Be sure the consequences of behaviour, either contrary to or in accordance with the rules, are explicit”.

Green and Chee (1997) further state that rules need to be drawn up in advance, created at a time of calm, and not made in the heat of battle. They need to be simple, fair, few in number and clearly understood. Rules need to be enforced. The researcher is of the opinion that one of the biggest mistakes made by child care workers is the lack of consistency with regards to discipline.

McNamara and McNamara (2000) state that it is important that specific consequences always occur for specific behaviours, that rules are uniformly adhered to, and that there is agreement on these issues by all caregivers. As mentioned in Chapter 2, there may be different child care workers caring for children at different times, as they change shifts. The researcher feels that it is extremely important for all
child care workers to utilise the same disciplinary techniques, and to always follow through with consequences of rules not adhered to by children.

Earlier NAMI (2011b) mentioned that caregivers should communicate rules and expectations to children living with ADHD. These should be written down and pasted where the child can see it. Consequences when rules are broken should be explained, and the child should be praised when the rules are obeyed.

McNamara and McNamara (2000) refer to the above rules and consequences, routine and structure, as behavioural techniques. They state that generally speaking, caregivers who use this approach attempt to arrange the environment of the home in such a way that specific consequences will increase behaviours (reinforcement) and specific consequences will decrease behaviours (punishment). As mentioned, participants of focus groups continuously focused on positive disciplining for children with mental health problems. Therefore the researcher pays attention to positive disciplinary techniques that can be utilised in managing children with ADHD.

McNamara and McNamara (2000) refer to praise as a manner in which to reward good behaviour. They are of the opinion that praise will not be effective for all behaviour associated with ADHD. Additional reinforcers may have to be used. Green and Chee (1997) however mean if we reward the right behaviour, it should happen more frequently. The secret of behaviour modification is to reinforce with small, frequent rewards. A key idea is for caregivers to “catch a child being good”, and respond with attention and praise (Weisz, 2004).

To encourage the best behaviour, caregivers can use hard, soft or cumulative rewards. A hard reward is something tangible such as money, food or a special privilege. Soft rewards are praise, enthusiasm or a show of parental pride. Cumulative refers to the collection of stars, stamps or tokens, each given for a small period of good behaviour, and eventually adding up to a major prize. Hard and soft rewards lose their effect unless they are specific and regularly repeated. When a reward is used long term, the pay-off must vary as this element of change prevents loss of interest or an increase in demands. Some ADHD behaviours respond best to
on-going awards, and for them Green and Chee (1997) suggest to motivate with tokens and stars.

Barker (2004) referred to the above positive disciplinary techniques as operant conditioning programmes. According to him it can improve attention span and decrease impulsive behaviour of children with attention deficits. Howe (2009) also states that classical or respondent conditioning shows us how a stimulus can produce a new behaviour or eliminate an undesired behaviour. He feels that from a child’s point of view, any recognition, acknowledgement or interest is better than none. Caregiver attention nearly always acts as a reinforcer. If the caregiver responds or supplies recognition, acknowledgement or interest only when the child misbehaves, in effect they are reinforcing naughty and unwanted behaviour.

In a nutshell, Green and Chee (1997) summarise successful discipline for children with ADHD:

- All the effective behavioural treatments for ADHD involve living by routine, rewarding the good and taking a step back from confrontation.
- Do not lock horns with an ADHD child and then increase the pressure. This produces a battle of wills, two angry parties, opposition, resentment and damage to relationships.
- Do not argue. Do not get heated. Do not escalate. Use a matter-of-fact, unemotional, controlled voice.
- Give yourself room to manoeuvre: State the rule, count to three, use time out, give choices and do not force them into a cul-de-sac.
- Reward the positive side, catch them being good!

Except for a prearranged discipline plan, the ADHD child should also have an individualised therapeutic plan to follow.

5.4.1.3. Therapeutic needs:

From characteristics identified by literature and the participants, it seems as if children with ADHD do not have specific therapeutic needs (such as the anger
management therapy needed for conduct and oppositional defiance). The researcher is of the opinion that they (like any other child placed in a child and youth care centre), would have been exposed to negative childhood experiences (some very traumatic), and that this has to be worked through by the appropriate professional.

Green and Chee (1997) however feel that today most child psychiatrists see play therapy, with an inattentive, unthinking child, to be of little value. Formal family therapy is generally unhelpful, though clever psychiatrists use a less structured approach to help all members of a family work together to support their ADHD child or sibling.

Other specialists tend to disagree, and AYCNP (2006) is of the opinion that art – and more so art therapy – can address something that lacks with some children who have ADHD or other disabilities. Art can instil creativity and satisfy a child’s need for visual stimulation in a gentle way.

Children with ADHD however have the challenges of their disorder to deal with as well, and Barker (2004) states that psychotherapy approaches are also useful. He for instance states that cognitive behavioural approaches can sometimes help children with poor impulse control. With cognitive behaviour therapy the hope is that the cognitively trained child will then teach themselves to step back a pace, and self-regulate their own behaviour (Green & Chee, 1997). Therefore the researcher hopes that if an ADHD child is receiving cognitive behavioural therapy, he/she will make a conscious decision to stop inappropriate behaviour – thereby adhering to rules set up through disciplining. Stein and Chowdhury (2006) refer back to consistency, and state that CBT needs to be applied consistently over a sustained period of time.

Focusing more on the individual characteristics and needs of the child, participants of focus groups and the researcher feel that children with ADHD have developmental delays and struggle with school work. Green and Chee (1997) state that occupational therapy, together with stimulant medication, may help the child with neatness and accuracy of school work. A short period spent with an enthusiastic occupational therapist can help a child to make the best of what they have got, and at the same time give a great boost to self-confidence. Stein and Chowdhury (2006)
state that an occupational therapist may help a child to develop the essential skills necessary for coping with day-to-day life as well.

Previous literature by NAMI (2011c) suggested to maintain a positive attitude and to focus on the child’s strengths and successes. Therefore the researcher suggests for all therapy to be conducted on a strengths-based manner. According to Howe (2009), strengths-based social work insists that those with whom we work are far more than the labels society confers on them. Strengths perspectives not only demand that we see the person behind the label, but that we also recognise that the individual has potential, has strengths, and it is these strengths that must be recognised, acknowledged and released.

5.4.1.4. Training needs:

As mentioned it would be conducive to the overall behaviour of a child when he/she is knowledgeable about certain aspects pertaining to their behaviour, emotions and/or mental health problem – attention deficit disorders. Besides this psycho-education, Green and Chee (1997) specifically referred to teaching children with ADHD social skills. The researcher is of the opinion that this type of training might help with one of the challenges these children struggle with – to make friends.

Social skills training can help children to think how their words and behaviour are reinforced; when they behave badly they are asked to reflect on how this affects others (Green & Chee, 1997). McNamara and McNamara (2000) further state that social skills are the ability to understand how your behaviour affects others. They state that social skills can be taught through:

- **Providing instruction:** Caregivers must be as explicit as possible when describing the social skills they want their child to develop. Social skills training forces us to identify exactly what the components of appropriate social behaviour are and to describe them in a clear, unambiguous manner to children. It may be helpful to list skills on a chart to be kept in a visible space.

- **Present a model:** At first you demonstrate and the child copies your behaviour. Keep it simple.
• **Rehearse:** By rehearsing social skills children are able to act out and practice the newly developed skill in a controlled environment. For children with ADHD, the most effective type of rehearsal is verbal and motor responding. Talk through each step of the skill and allow the child to perform it. Role playing can also be employed at this stage.

• **Provide feedback:** Without information about their performance, most children with ADHD would not know how they did. This feedback is critical to the success of a social skills training programme.

• **Practice:** Once the child has performed the behaviour alone, that is, without any assistance from the caregiver, he/she is ready to practice it under different conditions.

The researcher and participants of focus groups are of the opinion that general life skills and general values training might be conducive to the overall improvement of these children’s behaviour as well. Again, children who present with severe cases of ADHD should take medication to contain their behaviour.

**5.4.1.5. Medicinal needs:**

Focus group participants feel that a child with ADHD can control his/her behaviour without the use of medication. In contrast Green and Chee (1997) are of the opinion that stimulant medication is pivotal in the treatment of ADHD. Stimulants help a child to focus, listen and be reached. McNamara and McNamara (2000), state that medications can dramatically improve attention span and reduce hyperactive and impulsive behaviour. Psycho-stimulants have been used to treat ADHD in children since the 1940’s. Antidepressants, although used less frequently to treat ADHD, have been shown to be quite effective for the management of this disorder in some children. Preston, O’Neal and Talaga (2006) confirm this by stating that three classes of medications have been shown through empirical methods to be effective in the treatment of ADHD: stimulants, certain antidepressants, and alpha-2 adrenergic agonists.
Mash and Wolfe (2002) confirms that stimulant medication helps to manage ADHD symptoms at school and home. Stimulants work by raising the dopamine level of the brain (AYCNP, 2006). Professional people tend to agree, and Semple, Smyth, Burns, Darjee and McIntosh (2005) state that stimulants (e.g. Ritalin) and dextroamphetamine are usually utilised in treatment of ADHD.

Antidepressants certainly may be helpful in reducing mood symptoms. Certain classes of antidepressants have also been shown to have positive effects on core ADHD symptoms (Preston, O’Neal & Talaga, 2006). AYCNP (2006) is however of the opinion that antidepressants have many side-effects and therefore, some psychiatrists and medical doctors have taken the viewpoint of using antidepressants only as a last resort in cases where there is a serious crisis in terms of danger to the client. The drug is used only as a temporary stop-gap until other issues such as lifestyle or trauma that might be contributing to the depression can be addressed, and never for more than a few months or as a lifestyle drug.

Alpha-2 Adrenergic Agonists like clonidine and guanfacine may be used to treat core ADHD symptoms. They are more effective in reducing irritability, aggression, and impulsivity and promoting sedation. It is also the treatment of choice for comorbid tics (Preston, O’Neal & Talaga, 2006). “Clonidine is usually prescribed for the treatment of high blood pressure in adults, but it has also been found to be useful in reducing tics and hyperactive behaviour in children and adolescents. However, clonidine does not effectively improve concentration or inattention. Side-effects of the medication include; low blood pressure, depression and sedation” (Stein & Chowdhury, 2006, p. 250).

AYCNP (2006) also refers to amphetamines. They state that amphetamines are widely prescribed for children in treatment for ADHD symptoms. Methylphenidate, most commonly prescribed as Ritalin, or in a long-lasting formula, Concerta, is the most well-known medication for treating ADHD.

The researcher is of the opinion that the use of this medication should be prescribed and monitored closely by the appropriate professional. She feels that medicinal treatment starts with diagnoses, and the establishing of the disorder’s severity.
McNamara and McNamara (2002), state that the specific dose of medicine must be determined for each child. They state that, generally, the higher the dose, the greater the effect and side effects. To ensure proper dosage, regular monitoring at different levels should be done.

5.4.1.6. Educational needs:

Participants of focus groups are of the opinion that children with ADHD should receive special and individual schooling (due to their inattention, hyperactivity and learning disabilities). Mash and Wolfe (2002) state that most children with ADHD experience severe difficulties in school, regardless of whether or not they have a specific learning disorder. They may have lower productivity, grades, and scores on achievement tests. They may also fail to advance in grade, or have more frequent placements in special education classes.

ADHD is a long-term condition which affects learning and behaviour right through the school years. Teachers of ADHD children tell just that at school, the child is distractible, disruptive and needs one-to-one supervision to achieve. Teachers are confused when a clever child behaves poorly and under functions for intellect (Green & Chee, 1997). Literature from Barker (2004), mentioned in Chapter 2, states that children with ADHD fail to respond to disciplinary measures used by their teachers, and may disrupt the class and be noisy and over-talkative.

Because of the above disruptive behaviour, one of the participants stated that these children are commonly labelled as the “difficult and naughty” children by their teachers, and therefore have a negative connotation with school. Green and Chee (1997) are however of the opinion that an ADHD child is not difficult, but that he/she just act before he/she thinks.

If the ADHD child is placed with an inflexible, uninsightful teacher, the adult stands on their pride and may escalate a trivial behaviour to the point of school suspension. The ideal teacher is firm, flexible and knows when to back off. The ADHD child needs to know they are accepted and appreciated, but at the same time the teacher is definitely in charge (Green & Chee, 1997). The researcher therefore stresses the
importance of the teacher that has to be aware of the child's mental health status, and manners in which to manage this child.

Besides for the teacher's attitude towards the child, consideration should be given to other aspects in the classroom. The researcher feels that the individual child's ability should for instance be measured before other interventions will be successful. Barker (2004) suggested a rational treatment plan to be developed only on the basis of a comprehensive assessment of the child and his situation at school. It is necessary to establish the type and severity of the child's motor activity and/or attention problems. Designing a school programme for them that capitalises on their strengths, and does not demand feats of concentration and sustained attention of which they are incapable, can greatly facilitate their progress. The researcher is of the opinion that mainstream South African schools cannot provide such education to an individual child with ADHD, mainly because of the large numbers of children in classes. Therefore the researcher suggests for a child with ADHD to be schooled at home, with a specialised teacher.

"Research has shown that home/school reward-based systems and contingency management programmes are effective. However, academic targets must be achievable and praise should be given for their completion. Individual work tailored to the child's needs can take place outside of lessons with a focus on improving concentration, social skills, self-awareness and anger management" (Stein & Chowdhury, 2006, p. 86).

The importance of the correct school environment was illustrated by literature from Chapter 2. It indicated that investigations into a child's inattention and/or hyperactivity levels usually start when a teacher suggests for a child to be assessed. AYCNP (2006), states that ADHD most frequently is initially addressed through the school system.

When a child is not schooled in a specialised programme as suggested by the researcher, other suggestions are made: Stein and Chowdhury (2006) state that it is important to involve the school at an early stage, since they can be invaluable in monitoring responses to medication and possible side-effects. NAMI (2011b)
suggests working with the child’s school. This organisation feels that effective collaboration and communication between home and school promises to create a sense of structure and consistency. Green and Chee (1997) also suggest for caregivers to communicate with the school by trying to talk to the teacher at least every two weeks and if necessary have a message book operating between school and home.

The researcher further notes some practical tips to teachers and caregivers on how a child’s attention can be increased:

- Animated – enthusiastic teaching style.
- Cue words to alert attention.
- Be brief and to the point.
- Instruct in simple steps.
- Vary voice, tone, volume and teaching methods.
- Ask questions and get feedback (Green & Chee, 1997).

Green and Chee (1997) also set out some general guidelines for a teacher on how to organise the classroom setup:

- **Rules**: The ADHD child must know what is expected and where they stand. There should be a small number of clearly stated rules and regular reminders.
- **Routine**: The ADHD child needs routine and copes poorly with unexpected surprises.
- **Lists**: Ticking off the completed tasks provides structure and gives a feeling of achievement.
- **Planning and self-monitoring**: Includes activities similar to the above point. As seen, the ADHD child does not like unexpected events.
- **Teaching about sequence**: The ADHD child will benefit from being taught how to organise.
- **Self-talk**: Talking aloud is not welcomed by teachers, but for some teenagers and adults it greatly improves accuracy.
- **A framework**: When a child is forgetful and disorganised they need to work from a framework.
• **Breaking into chunks:** When the whole task seems impossibly big, it must be broken into a sequence of steps or small parts.

• **An overview:** If a child starts with an overview in their head, the fine detail is easier to handle.

• **Time allocation:** From the primary school years on, prioritising and time allocation are techniques that must be taught.

A summary of all the above characteristics and needs follows:

5.4.2. **Ecosystemic guidelines:**

5.4.2.1. **Micro level:**

Just as in the section on children with conduct and oppositional defiance, the researcher is of the opinion that children should receive services to provide for their general individual needs. Manners in which to do this were already highlighted. One aspect that seems to stand out with regards to the individual needs of children with ADHD is that they and the disorder they present with should be accepted.

Green and Chee (1997, p. 57) state that “ADHD is real. It’s in the child’s brain, and in the short term ADHD is not going to go away. Until this fact is accepted and allowances are made, you will not make any progress with a child. Accepting that a child has ADHD and adapting your attitudes accordingly are the first steps in successful parenting”.

In summary on the above aspects, Green and Chee (1997) state that treatment of ADHD involves behavioural advice, support at school and the use of stimulant medication. The author further states that without the impulsive actions, lack of listening, and general disorganisation of ADHD will sabotage the best behavioural programme. Medication allows the child to self-monitor, plan their response and be reached by reason. For most behavioural therapists, it is medication that turns a good programme into one that is brilliant.
As the peers that reside in the home with the child with ADHD fall under this level, the researcher finds it noteworthy to mention that peers will be affected. They will experience a wide range of emotions that may change throughout their lifetime. Therefore McNamara and McNamara (2000) suggest some guidelines to follow for peers who live with a child with ADHD:

- **Accept their feelings**: Do not deny that the child with ADHD will have some impact on his/her peers.
- **Do not try to make them feel guilty for not having ADHD**: Caregivers were overheard when they said “You should be thankful that you’re not –”. Most kids probably do not think in terms of having or not having difficulties.
- **Try to spend special time with peers**: Caring for a child with ADHD takes a lot of time. Caregivers should try, however, to come up with some special time for siblings as well.

All the summarised needs, characteristics and suggested guidelines on how to provide for these needs, are provided for by key role-players.

**5.4.2.2. Meso level:**

As could be seen in this section, and as stated by focus group participants, children with ADHD should receive specialised services from specialised professionals. “ADHD is a multi-factorial condition of which there is limited evidence of sustained improvement when support relies on provision from a single service provider. To achieve effective support for children with ADHD medical, educational and social services need to work together to ensure they provide coordinated services that meet the evolving needs of the child” (Hughes & Cooper, 2007, p. 51).

Earlier McNamara and McNamara (2000) also stated that an interdisciplinary team should evaluate a child to establish if he/she has ADHD or not. This team, according to them, should consist of a medical doctor, a psychologist, a special educator, and a social worker. As identified in Chapter 2, these role-players should cooperate to reach the collective goal of establishing if a child is diagnosed with this disorder or
not. These role-players can assist in treating the child’s characteristics or behaviour problems, and other role-players like occupational therapists can contribute as well.

McNamara and McNamara (2000) identify specific tasks set out for every role-player in this multi-disciplinary team:

- The *neurologist* should evaluate the functioning of the central nervous system.
- A *psychologist* will evaluate the intellectual and social-emotional functioning of the child. The psychologist will look for disorders such as learning disabilities, emotional disturbances, or other psychological or psychiatric disorders that may exist with ADHD.
- A *special educator* will administer a battery of tests to explore the existence of a learning disability or other school related disorders.
- The *social worker* will meet with the family to obtain information about the child’s social history including birth information, developmental milestones, family dynamics, medical information, and school placement. The social worker will also explore the behaviour of the child at home and at school in order to acquire information that would help determine the cause of ADHD.

The above authors did not identify the role of *teachers* in this multi-disciplinary team. As children with ADHD find school attendance so negative and need support from their teachers (Barker, 2004), a focus on educational aspects rendered by teachers is highlighted. The right teacher for an ADHD child is:

- Enthusiastic, interested.
- Firm but flexible.
- Avoids escalation, knows when to back off.
- A good attendance record.
- Welcoming – supportive (Green & Chee, 1997).

On a meso level the necessary trauma, play, family, behavioural, and occupational therapy can be conducted by the appropriate professionals involved.
5.4.2.3. *Exo level:*

As mentioned previously, this level of services were not extensively discussed. The researcher perceived that limited resources (e.g. funding), exist.

5.4.2.4. *Macro level:*

It generally seemed as if participants of focus groups agreed that a child with ADHD should be transferred to specialised care and programmes. They feel that as these children demand so much attention and time, it indirectly influences other children in the home negatively. Exceptions were made where children use medication that is effective in the minimising of hyperactive and impulsive behaviour.

Resources to be made available for a child with ADHD can therefore be summarised as follows:
5.5. Depression:

Depression was identified by focus group participants to be one of those categories of disorders usually presenting in children in child and youth care centres. It seemed as if key role-players who work with these children were extremely concerned about the self-harming behaviour and social isolation that they present with. In Chapter 2 depression was discussed under the category of mood disorders. It stated that “mood disorders refer to a group of emotional disturbances characterised by serious and persistent difficulty maintaining an even, productive emotional state” (Gray & Zide, 2008, p. 86).
Alessi (1993), states that the term depression is used to describe a wide range of human experiences. Some people become extremely depressed, resulting in difficulties in concentration, insomnia, weight loss or gain, self-deprecation, and, in some cases, a desire to hurt oneself or others. Depression may be fleeting, or persist for prolonged periods.

She further states that statistics show we are losing far too many youths to depression. She feels that every day, thousands of children and adolescents suffer from depression. These are not just “sad kids”. They need help. Psychiatrists and psychologists, teachers, therapists, and caregivers all need to learn about the problem and learn what they can do to help. The researcher therefore briefly notes certain aspects regarding the characteristics and needs of a child with depression.

5.5.1. Characteristics:

Semple, Smyth, Burns, Darjee and McIntosh (2005), Roberts and Alessi (n.d.) and Burke (2009) identify characteristics of depression:

<table>
<thead>
<tr>
<th>Characteristics as identified by literature</th>
<th>Characteristics as identified by focus group participants</th>
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<tbody>
<tr>
<td>• Separation anxiety</td>
<td>• Isolation from others</td>
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<tr>
<td>• Social withdrawal</td>
<td>• Eating problems</td>
</tr>
<tr>
<td>• Poor feeding</td>
<td>• Self-harm and self-destructive behaviour</td>
</tr>
<tr>
<td>• Suicide acts</td>
<td>• Substance abuse</td>
</tr>
<tr>
<td>• Substance abuse</td>
<td>• Emotionally draining</td>
</tr>
<tr>
<td>• Apathy</td>
<td>• Sometimes misdiagnosed as conduct disorder in younger children</td>
</tr>
<tr>
<td>• Tantrums</td>
<td></td>
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<tr>
<td>• Depressed mood</td>
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<tr>
<td>• Sadness</td>
<td></td>
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<tr>
<td>• Worthlessness</td>
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<tr>
<td>• Regressed behaviour</td>
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<tr>
<td>• Irritability</td>
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<tr>
<td>• Aggression</td>
<td></td>
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<tr>
<td>• Hyperactivity</td>
<td></td>
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<tr>
<td>• School refusal</td>
<td></td>
</tr>
<tr>
<td>Characteristics as identified by literature</td>
<td>Characteristics as identified by focus group participants</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>• Defiance and conduct problems</td>
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<tr>
<td>• Loss of interest or pleasure</td>
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<tr>
<td>• Poor school performance</td>
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<td>• Academic failure</td>
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<tr>
<td>• Sleep disturbances</td>
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<tr>
<td>• Low self-esteem</td>
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<td>• Fatigue or loss of energy</td>
<td></td>
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<tr>
<td>• Psychomotor retardation</td>
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<tr>
<td>• Psychomotor agitation</td>
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Although some of the above characteristics identified by literature correspond with characteristics of the previous two disorders, it appears to be less hostile in nature, in the sense that these children seem to be less aggressive and angry, but more sad and “tired”. Weisz (2004) states that some depressed children lead sedentary lives. They withdraw from social interactions, shy away from sports, or otherwise deprive themselves of activities that could improve their mood.

Preston, O’Neal and Talaga (2006) state that the most common signs of depression are irritability, social withdrawal, anhedonia, low self-esteem, themes of death, suicide, or self-destruction appearing in play, and vegetative symptoms (such as sleep disturbance). Other common symptoms include school failure, loneliness, sadness and low energy.

Schor (1996), states that because many youngsters are often unable to articulate their feelings, childhood depression can be difficult to identify. To complicate matters, the warning signs of childhood depression do not necessarily mirror the classic symptoms that occur in adulthood. As a result, experts advise parents, teachers, and other adults to be on the lookout for subtle changes – as well as dramatic shifts – in a child’s normal mood and behaviour.
5.5.1.1. Individual needs:

The researcher feels that aside from the general, basic needs that have to be provided for, a child with depression has unique and more dutiful needs. The above characteristics state that the individual child with depression needs constant reassurance and motivation to want to continue with life, and the everyday expectancies thereof.

Howe (2009) means that motivation is the incentive or drive to do whatever is necessary to achieve the required goals. He confirms that poor motivation is a symptom of depression, and so particular attention should be given to motivational problems in clients presenting with low mood or a diagnosis of depression.

In giving attention to the above, the researcher is of the opinion that the caregiver and child with depression should have a secure bond and attachment. She is of the opinion that if the caregiver does not know the child very well, he/she will not be able to notice when a child has a negative, depressed mood and/or something that is hindering him/her. This may lead to more serious consequences, such as suicide. Guetzloe (2005) confirms that a number of studies have showed that children with depression are at high risk for suicidal behaviour.

5.5.1.2. Disciplinary needs:

The researcher is of the opinion that great care should be taken in disciplining a child with depression. She argues that a harsh punishment might just send the child over the verge to commit suicide. One participant of the focus groups for instance stated that a girl she works with attempted to commit suicide after being disciplined about a strife she had with another child in the residential facility.

Because of this reason, and also because the child with depression should constantly be motivated, the researcher again suggests for a positive reinforcement disciplinary technique to be followed. In this way the child’s self-esteem would not decrease, and feelings of worthlessness would not increase. AYCNP (2006)
recommends focusing on the positive and building on it with the child, rather than belittling or ridiculing.

The researcher however feels that strong boundaries and consequences should be put in place for these children to not have the expectancy that they can do whatever they want “because they are ill” and “should be treated like glass”.

Fox (2003) however states that there should be a focus on disciplining, and not punishing. According to this author, punishment damages a sense of self-worth. He states that it is not true that children enjoy misbehaving, and that they experience punishment as positive. Learning new ways to behave and handle emotions and difficult situations, learning more about themselves, learning that someone cares enough to struggle with them to help them change; feels good.

Discipline allows the development of personal competence, and the sustaining of positive relationships with important adults, building a sense of worth and value (Fox, 2003). The researcher feels that the building of such positive self-worth and value can also be established through the use of therapy.

5.5.1.3. Therapeutic needs:

The characteristics identified above, show that for a depressed child, it is extremely important to receive diverse kinds of therapy to address their diverse therapeutic needs. Children who were removed from their primary caregivers, who present with depression, were exposed to different negative childhood experiences, and therefore not each of their treatment plans will be the same. The researcher is of the opinion that firstly the child would have to deal with whatever the traumatic experiences are that he/she experienced prior to being removed from his/her primary caregivers. The researcher feels that once these have been addressed; there should be a focus on other triggers and other aspects surrounding the depression.

Barlow and Durand (2005) identify the possibility of psychotherapy for children with depression. Stein and Chowdhury (2006) state that child psychotherapy is not strictly concerned with the external functioning of the child, such as practical, familial and
social behaviours. Instead, because it gives priority to the presence and influence of the unconscious in the child’s conflicts, child psychotherapy places the internal world of the child at the heart of treatment. The first and foremost psychotherapy discussed by the researcher, is cognitive behavioural therapy.

In Chapter 2 Barlow and Durand (2005) stated that children are taught to examine carefully their thought processes while they are depressed, and to recognise depressive errors in thinking. Weisz (2004), states that child depression can involve problems in mood and emotion, problems in cognitive style, and problems in behaviour and skill development. Problems of each type are targeted in cognitive-behavioural treatment.

In CBT, therapists work with depressed children to deal with problems of sadness and irritability, partly by focusing on how the children think, and partly by addressing deficits in behavioural skills. Treatment involves correcting cognitive errors and substituting less depressing and more realistic thoughts and appraisals. These skills could be taught through individual therapy implemented by qualified therapists. Cognitive behavioural therapy combines elements from the behaviour and cognitive therapies (Barlow & Durand, 2005).

Mash and Wolfe (2002) state that behaviour therapy on its own aims to increase behaviours that elicit positive reinforcement, and reduce punishment, from the environment. Behaviour therapy may involve teaching social and other coping skills, and using anxiety management training and relaxation training.

Mash and Wolfe (2002) state that on its own, cognitive therapy focuses on helping the youngster with depression to become more aware of pessimistic and negative thoughts, depressogenic beliefs and biases, casual attributes of self-blame for failure, and a lack of self-acknowledgement for success. Once these depressogenic thought patterns are recognised, the child is taught to change from a negative, pessimistic view to a more positive, optimistic one.

As stated earlier, some depressed children may harbour suicidal wishes. Cognitive therapy strategies may include exposing the child’s ambivalence, generating
alternatives, and reducing problems to manageable proportions. If the child can develop alternative views of a problem, alternative courses of action can be developed. This can result not only in a client feeling better but also behaving in more effective ways (Corey, 2009). This therapy might for instance therefore prevent a child from attempting to commit suicide.

With regards to other means of therapy, the researcher refers back to motivation. Simmons and Griffiths (2010) state that it is important to consider that children with poor motivation, might not even be consciously aware of the things that are holding them back. A model is identified that provides a useful framework for understanding client motivation. This model is very relevant for the CBT therapist because it proposes that change-related therapy is unlikely to be successful unless the client is at the appropriate motivational stage. The stages of the model are identified as follows:

- **Pre-contemplation:** In this stage the child is either unaware that he/she has a problem behaviour, or is aware but unwilling to change it. The child is unmotivated to make changes as he/she does not believe that they have a problem. Children in this stage are unlikely to present for psychological therapy unless it has been initiated by another person and the child feels obliged to attend. The researcher is of the opinion that a child in a child and youth care centre would not really have a choice in whether he/she wants to attend therapy or not. It is however important to note that the child will not work with the therapist and no significant changes will take place, if the child doesn’t have motivation to work on problem areas.

- **Contemplation:** Here the child “contemplates” making a change. The child has not actually made the decision to attempt change, but is aware of the issue. Perhaps the child now realises that therapy might help him/her to feel better about him/herself.

- **Preparation:** This child has made the decision to make the changes and is putting into place all the necessary preparations. The child might now make sure that he/she is done with his/her homework by the time the therapist wants to meet with him/her.
• **Action:** This is the stage when the child actually puts the change into action. *At this point role-players might start to see changes in the child’s self-esteem.*

• **Maintenance:** This might require a lot of energy, especially to start with. The person might feel more comfortable with their old way of being. It involves sticking to a different way of life, when the old patterns can feel more comfortable. Maintenance can be more challenging if important others have failed to make the change, or are unsupportive of the change that the child has made. *The child might find it much easier to not want to get out of bed and go to school the morning that he/she has to write a test at school.*

• **Relapse:** This does not necessarily occur. The client fails to maintain the change and the old issue re-emerges. The child might start again at the beginning of the cycle following a relapse, or it is possible that they will skip to a later stage directly from relapse.

Therefore the researcher feels that the child’s motivation should be assessed before he/she starts with any kind of therapy. The researcher is also of the opinion that during implementation of therapy, there should be a constant focus on the positive. “The strengths based social work approach shares an optimistic view of human nature. People have within them the answers to their own problems. Children should be helped to discover and exploit their own strengths in order to achieve their goals. The role of the social worker is to help children to mobilise their own resources, to boost strengths, and not treat weaknesses” (Howe, 2009, p. 86).

Howe (2009) further states that strengths-based social work not only demands that we see the child behind the label, but that we also recognise that the individual has potential, has strengths, and it is this potential and these strengths that must be recognised, acknowledged and realised. The researcher suggests for therapists to make the caregivers of the child aware of these strengths, in order for them to focus and build on it as well.

Howe (2009) identifies four questions that could be asked to discover a child’s strengths:
• Survival questions ask the child who has helped him/her in the past. Who has offered support, given advice?
• Exception questions invite children to wonder what was happening when things were going well.
• Possibility questions ask children about their hopes.
• Esteem questions include asking “When people say good things about you, what are they likely to say?”

A focus on the positive may also improve a child’s self-esteem. Mash and Wolfe (2002) state that almost all youngsters with depression experience low self-esteem, which is related to their depressed mood, and other depressive symptoms, such as low energy. Low self-esteem is also the symptom that is most specifically related to depression in adolescents. McNamara and McNamara (2000) suggest the following guidelines to increase a child’s self-esteem or positive feelings:
  • Praise for all appropriate behaviours.
  • Do not criticise the child for every minor inappropriate behaviour.
  • Refrain from global labels like “You are always crying”. Never compare their behaviour to that of their peers.
  • Keep expectations realistic.
  • Provide activities with success built in.

It is here that the researcher feels the Gestalt approach is relevant. Joyce and Sills (2010) found the following areas particularly relevant to working with depressed presentations (according to a Gestalt approach):
  • Increasing self and relational support: Many children have lost a sense or ability to make meaningful relational connection, have stopped seeing friends, feel alienated and find little value in social relations. There is a particular need to offer a steady embodied presence, to demonstrate inclusion and to provide a strong container for difficult or unmanageable feelings. A suggestion is to encourage contact with supportive friends or consideration of supportive activities. The researcher suggests for the caregiver to be the first pillar of support. Therapists can work to re-establish previous friendships, or build new ones.
• **Completing unfinished business**: There might be a need for the therapist to bring into awareness unresolved traumas and work on older issues. *This was already discussed at the beginning of this section – to work through previously negative childhood experiences.*

• **Identify unhelpful beliefs**: The depressed child usually has powerful negative interjects, core beliefs and repetitive thoughts. The authors suggest for therapists to deconstruct and challenge unhelpful interjects. *The child might believe that no one likes him/her. According to the Gestalt approach the therapist should challenge these beliefs.*

• **Attending to body process and breathing**: The body energy of the depressed child is usually low, retroflexed and collapsed. Work to enliven breathing and body sensation can be of great help. Relaxation and mindfulness techniques are increasingly being found to be helpful in the treatment of depression. *The researcher is of the opinion that the breathing, relaxation and grounding techniques are therefore applicable for depression as well.*

In the more severe forms of depression however, Joyce and Sills (2010) are of the opinion that there is often a need for the therapist to take specific courses of action that strongly deviate from usual Gestalt practice. A more behavioural and directive approach may often be necessary, with more focused interventions around risk and safety issues. Therefore the researcher is of the opinion that training needs are also an important consideration.

5.5.1.4. Training needs:

The researcher feels that during the above therapy, the child should, through implementation of psycho-education, also be taught aspects pertaining to the disorder they have – depression. In this way they might understand why at times they feel so unmotivated to get up in the morning, and not want to continue with life. The researcher is of the opinion that this training connects with a Gestalt approach where the child develops an awareness of him/herself. Weisz (2004) refers to affective education. He states that a logical first step in coping with depression is learning how to tell when one is depressed. The idea is that if children can recognise
when they are depressed, they can realise when to use the depression-coping skills they were taught in aspects of CBT.

The researcher and participants of focus groups are also of the opinion that general life skills and values training might be conducive to the overall improvement of these children’s behaviour as well. A child with depression should for instance learn appropriate ways in which to cope with negative life experiences. Apart from this, children need to learn appropriate ways in which to interact with others, and attempt to not isolate themselves.

Social skills training might assist the child in the challenge with interpersonal relationships. As seen one of the characteristics and something the focus group participants are concerned about, is that these children isolate themselves from others. Corcoran and Walsh (2006) refer to interpersonal therapy as a brief intervention focusing on how current interpersonal relationships have contributed to depression. This perspective considers interpersonal conflicts to be a major source of depression, and the goal of the social worker is to help the client repair these conflicts. This approach is described as therapeutic, but the researcher is of the opinion that it is a form of training that takes place in a therapeutic relationship.

Weisz (2004) adds to the above, and states that to combat social skills deficits, therapists shape interventions to fit the nuances of each child’s style. Interactions with the child in sessions, and observations of the child’s interactions with peers and behavioural patterns that are likely to have adverse social impact, are identified. The child and therapist role-play social situations, with the therapist first modelling appropriate behaviour and the child following suit. Socially effective behaviour is refined through coaching and corrective feedback. The training includes a focus on initiating and maintaining interactions as well as resolving conflict.

Weisz (2004) also suggests teaching children with depression problem solving skills. It is designed to help children both functionally and cognitively. Functionally, learning to solve problems may reduce the risk of repeated failure that can deepen the child’s depression. Depressed children may get locked into a few rigid and ineffective coping strategies, and training may help broaden their repertoire. Cognitively,
learning to solve problems effectively may help to counter the helplessness and hopelessness that often accompany depression. Weisz (2004) mentions seven steps of problem solving:

i. Define the problem.

ii. Brainstorm the generated possible solutions.

iii. Focus attention and energy on the task.

iv. Imagine the outcome of each potential action.

v. Weigh the consequences of each, and choose one course of action.

vi. Evaluate the outcome of the action after trying it.

vii. Reward oneself for success.

Per summary Howe (2009) states that problem solving is a technique which helps children identify the problems they are facing and then create potential solutions. Possible solutions are then studied in more detail and tailored to suit the individual situation, if appropriate. It can be a strategy that children weave into their everyday lives to help reduce stress and tension.

Blasé and Fixsen (2005) identify three different ways of teaching the above skills to children:

- **Reactive teaching**: Occurs in response to the moment-to-moment behaviour of a child.

- **Proactive teaching**: Occurs to help a youngster achieve developmental goals and to remediate deficits. Rather than waiting for a problem to occur, caregivers can use proactive teaching to work with a youth and teach the youngster a wide variety of social competencies to be utilised in a variety of situations and environments.

- **Intensive teaching**: Occurs in order to help a child overcome serious problems that could lead to placement in a more restrictive environment such as a locked facility for severely delinquent or emotionally disturbed youngsters.

The researcher is of the opinion that, in severe cases, children would not benefit from the above therapeutic and training inputs only. She feels that some of the children should, in conjunction with the above, receive pharmacotherapy.
5.5.1.5. Medicinal needs:

It seemed as though participants did not feel positive regarding the use of medication for children with depression, as they do not exhibit extreme aggressive and/or defiant behaviour. The researcher is however of opinion that medication is in some cases necessary to stabilise serotonin levels.

Roberts and Alessi (n.d.), describe the importance of medication by looking at the biological model of depression. They state that the illness involves a disturbance of a metabolic or chemical neurotransmitter system or systems. When all systems are operational, the mood maintains equilibrium. However, a problem in any one neurotransmission circuit resulting from the absence or excess of a substance required to make the neurotransmitter can cause an imbalance in mood.

Over-activity or under-activity of the neurotransmitter itself, or the availability of a receptor can disrupt the activity or functioning of the entire system. Three neurotransmitter systems, or chemical mood systems, have been thought to be important in the development of depressive disorders. These are serotonin, norepinephrine, and dopamine. Current antidepressants have actions in all three chemical mood systems, but to varying degrees.

Preston, O’Neal and Talaga (2006) confirm the above by stating that antidepressants are commonly listed in most psychopharmacology textbooks according to the neurotransmitters they target: SSRI’s (selective serotonin reuptake inhibitors), NRI’s (norepinephrine reuptake inhibitors), SNRI’s (serotonin and norepinephrine reuptake inhibitors), and atypical antidepressants (trazodone and mirtazapine).

“SSRI’s have been recommended as the first line of drug treatment for depression because they have fewer side effects, equal effectiveness, and greater convenience of use than antidepressants” (Mash & Wolfe, 2002, p. 224). Corcoran and Walsh (2006) are of the opinion that for depression, selective serotonin reuptake inhibitors have shown greater therapeutic effectiveness and fewer adverse effects than tricycle antidepressants.
Norepinephrine belongs to a group of neurotransmitters responsible for the body’s “fight of flight response” to stress. Problems of chemical supply, production, or breakdown can result in an underactive or malfunctioning norepinephrine system, which results in the symptoms of depression. Therefore the prescription of norepinephrine can balance the production or breakdown (Roberts & Alessi, n.d.).

Dopamine activity in the brain is tightly tied to such abstract behavioural functions as motivation and reward. Disturbances of dopamine regulation might result in mood disturbances and possibly disturbances of thought and perception, such as paranoia and hallucinations. The actions of antidepressants directed to dopamine chemistry might effectively bring relief of such depressive symptoms as low energy, emotional dulling, and poor appetite (Roberts & Alessi, n.d.).

In the general use of medication for children with depression, Barker (2004) suggested that medication should be continued for a long period and then discontinued slowly, while the child is monitored for signs of recurrence. “The general rule of thumb is to start with a low dose, and then increase the dose while carefully watching for signs of either a clinical response or the emergence of side effects. There are no established guidelines for how long to wait between dosage adjustments, although it is common practice to treat for a month to six weeks and then to increase the dose if there has been no sign of clinical improvement”.

If positive clinical responses occur, it is important to continue treatment with an antidepressant at the same dose for a minimum of six months after symptomatic improvement, followed then by gradual discontinuation (Preston, O’Neal & Talaga, 2006, p. 25).

In summary Roberts and Alessi (n.d.) state that medications are thought of as helpful in alleviating core depression symptoms sufficiently to facilitate the child’s ability to optimally benefit from non-medical interventions in the least restrictive setting possible.
5.5.1.6. Educational needs:

After studying relevant literature, and discussing this disorder in focus groups, the researcher is of the opinion that children with depression do not necessarily need to receive special or individual schooling. Burke (2009) is for instance of the opinion that cognitive functions such as memory and orientation usually remain intact with depression.

It was however noticed that these children do not have any motivation to attend school, and therefore the researcher feels that they need to be motivated to attend, and also to perform academically. The researcher feels that motivation starts with the caregivers, therapists, and teachers.

Guetzloe (2005) states that the educator’s most important contribution is the provision of a positive and supportive environment, components of which include satisfaction of basic needs, caring relationships with adults, and physical and psychological security.

Any inclusion in a child’s programme that serves to enhance feelings of self-worth, self-control and optimism has the potential for ameliorating feelings of depression. Aversive techniques such as punishment should be avoided to the extent possible.

Therefore the researcher feels that teachers should be aware of the child’s mental health status, and how to manage this child. Guetzloe (2005) further suggests for the educator to use instructional strategies that are both positive and effective so that the child will achieve success and enjoy the learning process.

5.5.2. Ecosystemic guidelines:

5.5.2.1. Micro level:

It appears as if a child with depression needs a lot of individual attention from a caring caregiver with whom he/she has a good attachment. Therefore the researcher would suggest for the child’s individual needs (of which attention is the largest) to be
provided for in an environment where there are not many other children who also want and need the attention of the caregiver. One participant for instance stated that a child with depression does not physically hurt another child, but indirectly they are “abusing” the other children in the home by “draining” all of the caregivers’ attention.

Because of this child’s sensitiveness, specific disciplinary techniques are suggested, of which positive reinforcement is the largest. Other measures should be undertaken for children that present with defiant and conduct behaviour as well.

The depressed child’s need for therapy with a professional person is important. Suggested therapy is trauma counselling and cognitive behaviour therapy. Certain skills training might also assist the child in acting appropriately in different social situations. These interventions should take place in conjunction with pharmacotherapy. Different role-players are needed to implement these services.

5.5.2.2. Meso level:

On a meso level the necessary trauma, cognitive behavioural and psychotherapy can be conducted by the appropriate professionals involved:

- **Social workers:** The researcher and participants of the focus groups feel that social workers do not have time for therapy upon all the other work that has to be completed (case management, training, etc.). Social workers can however link the child with the appropriate therapists when he/she cannot conduct it. Social workers should act as a support system to caregivers who work with children with depression.

- **Teachers:** As seen above, teachers have an extremely important role to play in the attendance of a child with depression. They should build a positive and supportive environment for this child.

- **Therapists:** Different therapists are needed to address the diverse needs of a child with depression. The researcher suggests for the social worker to link the child with a therapist that can conduct the needed therapy (trauma counselling, CBT, motivation, strengths based approach, Gestalt approach).
• **Other role-players:** One other role-player that may be involved in the care of a child with depression is a psychiatrist. He/she should firstly diagnose a child with depression, and thereafter develop an appropriate pharmacotherapy treatment plan.

5.5.2.3. **Exo level:**

The problem identified on this level, is, as mentioned earlier, a lack of resources to practically implement the discussed acts and policies.

5.5.2.4. **Macro level:**

It was observed that certain participants from focus groups feel that these children can be accommodated in a mainstream child and youth care centre. Others however state that these children are draining all the attention from child care workers, and that consequently there would be none left for the other children who never exhibit difficult behaviour.

Barker (2004) suggests for treatment of children with depression to take place in a low-stimulus environment. The researcher is of the opinion that a mainstream child and youth care centre, is not a low-stimulus environment. There are also children residing there with other mental health problems, and/or behavioural problems. There might also be children without any of the mentioned problems. Imagine putting an aggressive child with conduct and oppositional defiance disorder in the same home as a child with depression. The researcher feels that the child with depression will not be able to handle such a negative environment.

Resources to be made available for a child with depression can therefore be summarised as follows:
5.6. Psychosis:

Only one child and youth care centre represented in the focus groups, stated that they have children that were diagnosed with schizophrenia. Some other participants however stated that they do work with children who exhibit symptoms of these disorders. In Chapter 2, Barker (2004) stated that the essential feature of psychotic disorder is altered contact with reality.
Preston, O'Neal and Talaga (2006) are of the opinion that although psychotic disorders present relatively infrequently in childhood, they are usually a harbinger of lifelong illness. The most common diagnosis is schizophrenia.

5.6.1. Characteristics:

Literature by Barker (2004), the Department of Social Development (n.d.), the American Psychiatric Association (2000), Semple, Smyth, Burns, Darjee and McIntosh (2005), and Gray and Zide (2000) state that psychosis presents with the following characteristics in children:

Table 12: Comparison of schizophrenia characteristics

<table>
<thead>
<tr>
<th>Characteristics as identified by literature</th>
<th>Characteristics as identified by focus group participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Altered contact with reality</td>
<td>• Struggles to cope with general, every day expectancies</td>
</tr>
<tr>
<td>• Hearing voices, seeing things other people cannot see (hallucinations)</td>
<td>• Hearing of voices</td>
</tr>
<tr>
<td>• Disturbance of perceptions</td>
<td>• Aggressive</td>
</tr>
<tr>
<td>• Outbursts of anger</td>
<td>• Isolation from others</td>
</tr>
<tr>
<td>• Social withdrawal</td>
<td>• Cannot make friends</td>
</tr>
<tr>
<td>• Loss of interest in school</td>
<td>• Do not have any motivation</td>
</tr>
<tr>
<td>• Little or no interest in activities</td>
<td>• Sensory irritations</td>
</tr>
<tr>
<td>• Somatic passivity experiences</td>
<td>• Cannot function in a structured environment</td>
</tr>
<tr>
<td></td>
<td>• Medication has no impact on their behaviour</td>
</tr>
<tr>
<td></td>
<td>• Phobias hinder their functioning</td>
</tr>
<tr>
<td>• Poor hygiene</td>
<td></td>
</tr>
<tr>
<td>• Poorly groomed</td>
<td></td>
</tr>
<tr>
<td>• Depressive and euphoric mood changes</td>
<td></td>
</tr>
<tr>
<td>• Feelings of emotional impoverishment</td>
<td></td>
</tr>
<tr>
<td>• Disorganised speech</td>
<td></td>
</tr>
<tr>
<td>• Disorganised behaviour</td>
<td></td>
</tr>
</tbody>
</table>

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“The clinical picture of schizophrenia varies depending on the particular phase of the disorder. It is divided into three phases:

- During the **predromal phase**, children show deterioration in their level of functioning, or a failure to develop normally, without being actively psychotic. In this phase the child may show mostly negative symptoms such as a tendency toward isolation, blunted or flat affect, lack of initiative, and possibly a disruption of sleep patterns. Often the child’s school performance and personal hygiene deteriorates. This phase may last for months or years in children, making diagnoses difficult.

- During the **active phase**, the child shows psychotic symptoms with disorganised thinking, delusions, and hallucinations.

- In the **residual phase**, the child continues to be impaired, but without florid psychotic symptoms” (Preston, O’Neal & Talaga, 2006, p. 65).

In conjunction with the characteristics identified in the above table, Preston, O’Neal and Talaga (2006) are of the opinion that characterological schizophrenia symptoms include social isolation or alienation, marked feelings of inadequacy and poorly developed social skills. The participant, who works with children with schizophrenia, confirmed all the above symptoms. She feels that because of these children’s needs, they belong in a specialised programme or psychiatric hospital.

5.6.1.1. Individual needs:

Based on the above mentioned characteristics, and feedback retrieved from key role-players of child and youth care centres, the researcher feels that these children have extensive needs that cannot be provided for by people who are not trained to manage children with psychotic disorders. The researcher can imagine that a child with schizophrenia has the same individual needs as any other child – love, affection, attention, attachment, a supportive environment with caring caregivers, etc. It however appears as if a child with schizophrenia does not realise he/she has these needs, because they have lost touch with reality. It also appears as if these children have little trust in any person, making life difficult for someone who attempts to help the child.
The participants of focus groups and the researcher agree that caregivers of children with such serious mental health problems should have continuous support. Semple, Smyth, Burns, Darjee and McIntosh (2005) also stated that children would benefit from work with the people in his/her environment – thus the caregivers.

5.6.1.2. Disciplinary needs:

To the researcher it does not seem as if these children present with problem behaviour that can be addressed by just any disciplinary techniques. The researcher feels that perhaps the general approaches as discussed in the previous sections (setting boundaries, structure and routine), should be followed. Positive reinforcement can be utilised to reward good behaviour.

The researcher feels that tight boundaries should be in place, and the child should know what will happen, should he/she cross the boundaries. It might also be that a child with schizophrenia sees a disciplinary figure as a threat and someone that wants to hurt him/her. Therefore the way that these boundaries are enforced, should be taken note of.

Curwin and Mendler (2000) refer to the above type of disciplining as teaching responsibility. They state that it can be taught within a structure that is created with the following six strategies:

i. **Establish sensible limits**: Limits without choices teach obedience. Choices without limits teach chaos. There can be no true choice if there are no limits. Children cannot learn from natural consequences of their actions when they are allowed to make choices without limits. Limits draw the line between what is acceptable and what is not.

ii. **Confront misbehaviour with dignity**: Children must be confronted in a dignified way when they step beyond the boundaries.

iii. **Provide healthy, viable choices**: Real choices have at least two alternatives that are acceptable, and a teacher will have no preconceived preference for one or more of the alternatives. If we offer a choice that a child would never select, then it is not a real choice.
iv. *Help children learn from the consequences of their choices:* Consequences are the results of our choices. Consequences should be based on rules (limits) and guided by principles (values) that directly relate to and reinforce the reason for the rules. Without consequences, children learn that their choices are irrelevant, that their behaviour has no influence on themselves or others.

v. *Elicit a commitment to change:* Without a commitment to change from the child, there is little hope that any intervention will have lasting results. Adding our generous encouragement and support will increase the possibility of long-term change.

vi. *Develop a sense of remorse:* Without remorse, children are unlikely to have the will or commitment necessary for the sustained effort to change their behaviour whether someone is watching or not. For children to learn remorse, they must see others demonstrate it publicly and learn the value of remorse. In addition, remorse must be expected of them. Remorse comes from values, and values should be a major part of any model of behaviour change.

As seen previously, values are taught through therapeutic and training guidelines.

5.6.1.3. Therapeutic needs:

The researcher and the participants of the focus group are of the opinion that a child with schizophrenia will not have any improvements in their mental health or behaviour without the treatment of an appropriate professional. The researcher feels that only this role-player (perhaps a psychiatrist or psychologist), should be responsible for the implementation of all therapeutic interventions. These therapeutic interventions include the trauma counselling on issues experienced before removal from the child’s primary caregivers.

Barker (2004) noted that traditional psychotherapy is not effective, but cognitive behavioural methods and social skills training may be. Stein and Chowdhury (2006) suggest cognitive behavioural strategies as it may be useful in decreasing non-responsiveness to medication and in reducing psychotic phenomena such as hallucinations.
Corcoran and Walsh (2006) confirm that cognitive behavioural interventions are increasingly being used to treat people with schizophrenia. These interventions focus on modifying symptoms and their effects by adjusting their meaning to the individual. These strategies are based on the premise that current beliefs and attitudes largely mediate a person's affect and behaviour. With these interventions, practitioners do not generally attempt to “talk people out of” their delusions and hallucinations. Rather, clients are helped to modify dysfunctional assumptions about the self, the world, and the future; improve coping responses to stressful events and life challenges; re-label some psychotic experiences as symptoms rather than external reality; and improve social skills. Simmons and Griffiths (2010) confirm that interventions based on the CBT model aim to correct negative biases in thinking processes and behavioural reactions.

As mentioned, key role-players who work with children with schizophrenia, feel that children with this disorder should be admitted to a psychiatric hospital to be stabilised. Barker (2004) supports inpatient admission in acute phases of schizophrenia. Billick and Avram (2004) define the minimum psychiatric services that should be available in inpatient, partial hospitalisation, and residential treatment:

- Therapeutic milieu.
- Significant family involvement.
- Individual and group therapy.
- School programming.
- Specific therapies for comorbid disorders.
- Psychosocial skills training to improve social function.
- Collaboration with outside agencies in preparation for a safe discharge.

Corcoran and Walsh (2006) feel that group therapy is only effective in in-patient settings, but that there is little evidence for their effectiveness in stabilising people who are recently admitted and highly symptomatic. Therefore the researcher suggests for therapists who work with a child in a child and youth care centre, to only work with the child individually.
Stein and Chowdhury (2006) state that promising approaches to the psycho-social treatment of adult schizophrenia that merit evaluation for adolescents include family interventions (the researcher suggests for caregivers and children with disorder to attend), which emphasise psycho-education and coping skills, individual and group interventions designed to build life skills and competencies, and early interventions strategies. This and some of the other therapies offered and suggested to children with this disorder, involves training.

5.6.1.4. Training needs:

Literature from Chapter 2, suggested for children with schizophrenia to be trained on appropriate communication techniques and problem-solving strategies. The researcher and participants of focus groups are also of the opinion that general life skills and values training might be conducive to the overall improvement of these children's behaviour.

Corcoran and Walsh (2006) feel that social skills training is a type of cognitive behavioural intervention that addresses deficits in interpersonal relating that are frequently found among people with schizophrenia. It provides training on skills needed for successful everyday living. Therefore the researcher suggests for these children to undergo such training.

As mentioned it would also be conducive to the overall behaviour of a child when he/she is knowledgeable about certain aspects pertaining to their behaviour, emotions and/or mental health problem – schizophrenia.

5.6.1.5. Medicinal needs:

The researcher is of the opinion that a child with schizophrenia must receive pharmacotherapy. The Department of Social Development (n.d.) states that it is very important to ensure that the child with schizophrenia complies with the use of medication and appointments with psychiatrists. Corcoran and Walsh (2006) also state that medication is the primary intervention modality for people with schizophrenia. They are believed to have a relatively high concentration of the
neurotransmitter dopamine in nerve cell pathways extending into the cortex and limbic system.

Preston, O’Neal and Talaga (2006) confirm that schizophrenia presages chronic medication treatment. This condition is one of the most severe, and therefore most likely to require prompt pharmacological treatment to avoid serious consequences such as suicide.

They state that there are two main types of antipsychotic medication: traditional antipsychotics, also called neuroleptics, and the newer atypical antipsychotics.

“Antipsychotic medications should be considered at the first sign of psychotic symptoms, including disorganised behaviour. Often prompt initiation of treatment can help avoid the development of more florid psychosis. Early intervention is important because psychosis is associated with increased suicide risk, and some evidence suggests that the longer a person is psychotic, the more difficult it becomes to treat the psychosis” (Preston, O’Neal & Talaga, 2006).

“Despite limited research being available in early-onset schizophrenia, risperidone or olanzapine are commonly used” (Stein & Chowdhury, 2006, p. 174). Corcoran and Walsh (2006) state that risperidone has fewer adverse effects than the first-generation drugs. Olanzapine is an antagonist of all dopamine receptors, some serotonin receptors, and several other receptors.

After one of the above medications has been chosen, it can be started at a low dose. The dose is then gradually increased until a good response is achieved or side effects become intolerable (Preston, O’Neal & Talaga, 2006). Again, the researcher is of the opinion that pharmacotherapy can only take place under supervision of a psychiatrist.

5.6.1.6. Educational needs:

Focus group participants did not expand on schooling preferences for children with schizophrenia. Stein and Chowdhury (2006) are of the opinion that clear
consciousness and intellectual capacity are usually maintained in children with psychotic disorders, although certain cognitive deficits may evolve during the course of the illness.

In Chapter 2 it was noted that many children with this disorder, require special educational provisions. They are usually best taught in a small class setting by staff trained to work with emotionally disturbed children, using a curriculum tailored to their level of cognitive functioning (Baker, 2004).

Yeo, Wong, Gerken and Ansley (2005) for instance state that in the school setting, children who exhibit moderate to severe emotional and behaviour disorders are primarily served in special classes characterised by a high degree of structure and teacher monitoring. These children however need more intensive individual attention and close monitoring, typically beyond what an educational psychologist or counsellor could provide in the regular and special education settings.

Therefore the researcher suggests that a child with schizophrenia attend specialised or home schooling.

5.6.2. Ecosystemic guidelines:

5.6.2.1. Micro level:

The researcher perceives that the needs of children with schizophrenia differ very much from the previously discussed disorders. These children have needs that not any person can provide for.

The researcher is of the opinion that these children should be receiving full-time services tailored to provide for these individual needs, in a conducive setting.

Even though these children act odd, and it seems as if they cannot stand anyone or anything around them, the researcher strongly feels that there should still be a caregiver to provide for this child’s basic individual needs.
The researcher feels that a child with schizophrenia especially needs; unconditional acceptance and love, patience and tolerance, individual attention, someone to trust, a supportive environment and on top of that, specific needs (as discussed above), to be provided for.

This child should for instance receive specialised therapeutic and pharmacotherapeutic services. It was suggested that a child with schizophrenia would benefit from psycho-education on issues pertaining to communication techniques, problem solving strategies, social skills and aspects with regards to their disorder.

Special care should be paid to the types of disciplinary techniques implemented with these children, focusing on positive reinforcement.

As seen above, a child with schizophrenia struggles to deal with everyday expectancies – including school. Therefore special schooling is necessary.

5.6.2.2. Meso level:

The researcher is of the opinion that only qualified, professional social workers, teachers, therapists and other relevant role-players should work with a child with schizophrenia. She feels that if a person implements erroneous interventions, this child’s mental health might deteriorate terribly. Therefore the researcher feels that social workers should have specialised training on this subject, and should be able to transfer it to caregivers. The social worker should know what services this child needs, and where to find these services. Such specialised services include specialised schooling received from qualified teachers.

As mentioned the researcher is of the opinion that the most appropriate professional to handle this child’s therapeutic services, is a psychiatrist or psychologist. They can coordinate therapeutic services in conjunction with pharmacotherapy.
5.6.2.3 **Exo level:**

As there is such a big focus on in-patient treatment for children with schizophrenia, legislation with regards to admission to these facilities must be taken into account. The Mental Health Care Act 17 of 2002 states that child, adolescent and geriatrics facilities should be established to promote their mental health status and admission to care, treatment and rehabilitation.

It is however again argued that there are only two existing mental health facilities that work with children with mental health problems in Gauteng. The reason perhaps is because of a lack of funding and human resources.

5.6.2.4 **Macro level:**

As mentioned above, the researcher and participants of focus groups are of the opinion that these children cannot reside in a mainstream child and youth care centre, and that they have to be transferred to a specialised programme (preferably a psychiatric hospital). Barker (2004) feels that there should for instance be provision for a calm environment with suitable control of expressed emotion. The researcher feels that in a mainstream child and youth care centre, this would not be possible.

Resources to be made available for a child with schizophrenia can therefore be summarised as follows:
5.7. Sexual disorders:

Sexual disorders were not discussed in the literature study. Participants from different focus groups however feel that children in child and youth care centres often present with symptoms of these disorders.

The American Psychiatric Association (2000), states that sexual dysfunctions are characterised by disturbance in sexual desire, and in the psycho-physiological changes that characterise the sexual response cycle, and cause marked distress and interpersonal difficulty.
As this mental health problem/disorder was not discussed in the previous chapters, the researcher deems it necessary to explore where these disorders emanate from. According to Gil and Johnson (1993) children develop sexually from birth. They state that there are seven different lines of development: biological, sensual/erotic, behavioural, gender, cognitive, relationships and socialisation. They are however of the opinion that certain experiences may cause this development to be disrupted, thus leading to deviant sexual behaviour.

The researcher feels that one of the negative childhood experiences some children who are removed from their biological parents are exposed to is sexual abuse. Gil and Johnson (1993), state that confusion and anxiety can result when children’s genitalia and other parts of their bodies are used by others for their erotic satisfaction. If children’s genitalia become the focus of another’s attention, children begin to organise their lives around their own genitalia. Children may begin to seek out other opportunities for sexual experiences.

They further describe that children who live in unstable, unpredictable environments, frequently experience different states of physiological arousal. Unsure of what is going to happen when someone gets angry or caresses their genitals, children feel various types of physiological arousal that generally are incomprehensible to them. Many children seek to discharge the arousal as quickly as possible. Environmental factors and different feelings (e.g. loneliness, helplessness, rage etc.) are often paired so that children who feel sad, and recall a violent scene, feel aroused and seek to discharge the arousal immediately.

Because the pairing with high arousal has multiple elements, children may seek to discharge the arousal by acting in physically, sexually, or emotionally aggressive ways. Although some children seek to discharge high arousal by acting inwardly, children who molest have no models for doing so. Arousal is discharged against the environment, and most frequently against people, through physically, verbally, or sexually aggressive means (Gil & Johnson, 1993).

Therefore it seems as if dysfunctional sexual behaviour might arise when children are being sexually abused. The researcher is however of the opinion that not all
sexual behaviour is dysfunctional, and is therefore not diagnosed as sexual disorders.

Therefore this section continually reminds the reader of the difference between a child that has been sexually abused, and consequently presents with symptoms of these disorders (sexual dysfunctions), and a child who has been diagnosed with sexual disorders.

The researcher is for instance of the opinion that the characteristics identified by focus group participants, are characteristics they observed to be symptoms of some sexual dysfunctions. None of the children spoken about in focus groups, have however been diagnosed with an official sexual disorder.

For clarification purposes, Lamb (2006) provides a list of what makes sexual behaviour problematic:

- Play that is not mutual because one child is coerced, older, has much more power in the relationship, or tricks another child into playing a game.
- When not coercive, sexual behaviour that is a boundary violation, where someone else is made to feel uncomfortable when acted upon, asked to perform an act, or forced to watch an act.
- Does the behaviour look too persistent, compulsive, or obsessive in that it occurs in public places and/or the child seems not to have self-control? Is the child choosing to do this play or behaviour over other activities and interests?
- Is it harmful to the child physically, socially, or psychologically?
- Is it adult like or unusual in some other way?

All characteristics, needs and guidelines to be discussed hereunder are, according to the researcher, discussed in terms of problematic behaviour, irrespective of sexual dysfunctions or sexual disorders.
5.7.1. Characteristics:

Table 13: Sexual disorder and/or problem characteristics

<table>
<thead>
<tr>
<th>Characteristics as identified by focus group participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Promiscuous</td>
</tr>
<tr>
<td>• Impulsivity</td>
</tr>
<tr>
<td>• Risk taking</td>
</tr>
<tr>
<td>• No boundaries</td>
</tr>
<tr>
<td>• Disobedient</td>
</tr>
<tr>
<td>• Attention seeking behaviour</td>
</tr>
<tr>
<td>• Easily led</td>
</tr>
<tr>
<td>• Little capacity to make own decisions</td>
</tr>
<tr>
<td>• At times dissociation</td>
</tr>
</tbody>
</table>

As this disorder was not discussed at all in the preceding text, the researcher feels that qualitative data cannot go lost by summarising it in a table as with the other disorders. By discussing it in the following manner, literature is clarified appropriately.

In comparison with the characteristics in Table 13, literature differs somewhat with regards to the characteristics of sexual disorders. One of the sexual disorders presenting in children and which is identified by the American Psychiatric Association (2000), is paraphilias. It states that the essential features of a paraphilias are recurrent, intense sexually arousing fantasies, sexual urges, or behaviours generally involving 1) human objects, 2) the suffering or humiliation of oneself or one’s partner, or 3) children or other non-consenting persons that occur over a period of at least 6 months. Certain of the fantasies and behaviours associated with paraphilias may begin in childhood or early adolescence, but become better defined and elaborated during adolescence and early adulthood. Elaboration and revision of paraphilic fantasies may continue over the lifetime of the individual.

The American Psychiatric Association (2000) identifies some specific paraphilias disorders with its exhibitionism:
- **Exhibitionism**: Recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving the exposure of one’s genitals to an unsuspecting stranger.

- **Fetishism**: Recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving the use of non-living objects (e.g. female undergarments).

- **Frotteurism**: Recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving touching and rubbing against a non-consenting person.

It seems as if none of the sexual disorders specified in the American Psychiatric Association (2000) involves the specific characteristics as identified by participants of focus groups. Therefore the researcher feels that behaviour with such symptoms is not seen as a mental health disorder in children. As mentioned earlier, the researcher is of the opinion that children might present with sexually dysfunctional behaviour because of previous exposure (being sexually abused by others).

Perhaps because they also could not categorise characteristics children present with into a single sexual disorder, Gil and Johnson (1993) refer to sexually preoccupied children. They state that these children who bribe, cajole, and threaten other children into the sexual interactions, describe their behaviour as thriving for pleasurable feelings.

They often have more highly developed fantasies than other children who molest, and their fantasies do not seem to have the aggressive component, but mainly sexual and pleasurable aims. If they were molested, they often describe it as having been pleasurable. They do not want to stop the sexual behaviours (Gil & Johnson, 1993).

Characteristics identified by participants of focus groups seem to fall under this category of “sexually preoccupied children” who present with “sexually dysfunctional behaviour”. Johnson (2009) further states that there is a continuum of sexual behaviours in children, ranging from natural and healthy, to children who molest other children. The vast majority of children’s sexual behaviour is natural and
healthy, yet there are some whose behaviour is a sign of disturbance. Children with sexual behaviour problems can be divided into three groups:

i. Children who are sexually reactive

ii. Children who engage in extensive, mutual sexual behaviours

iii. Children who molest other children.

Johnson (2009) confirms that some children with sexual behaviour problems have experienced hands-on sexual abuse, but many have not. However, virtually all of the children have been overly exposed to adult sexuality.

The following sections on needs and suggested guidelines on how to provide for these needs, will be discussed in terms of diagnosed sexual disorders, and sexually preoccupied children who present with sexually dysfunctional behaviour, although the last is not regarded as a mental health disorder.

5.7.1.1. Individual needs:

Because of the need for attention and constant attention-seeking behaviour, it seems as if these children predominantly need not only attention, but love and acceptance. The researcher is of the opinion that it can only be given by caregivers who show this child that they love them, and give them unconditional acceptance. Therefore this caregiver would have to have a strong, healthy bond with the child. After immense responses from focus group participants, the researcher feels that children presenting with these characteristics test the patience and tolerance of a caregiver to the brim.

The researcher is of the opinion that most children, who have been sexually abused, do not know what healthy boundaries and relationships are. Therefore they present with inappropriate manners in which to attempt to receive attention and acceptance. The researcher observed that because children present with such behaviour, they usually do not get the opportunity to be transferred into another care option like foster care. Wickham and West (2002) state that research findings have shown that sexually abused children in substitute care are likely to spend longer in care than non-abused children.
The researcher consequently feels that the environment the child finds him/herself in (child and youth care centre), should be stable and secure, and provide for their needs. Johnson (2009) states that since children with sexual behaviour problems are confused about sex and sexuality, a stable and consistent home environment with healthy emotional, physical, and sexual boundaries needs to be established (Johnson, 2009).

Johnson (2009) suggests guidelines for providing such a healthy sexual environment. She suggests avoiding the following:

- Printed material with explicit sexual content and unsupervised or unlimited internet access.
- Television, radio shows, videos, or cable TV with sexual content.
- Shows and movies with aggression, violence, and destruction.
- Jokes about sex, the use of sexual remarks or innuendoes, or four letter words.
- Verbally or physically aggressive behaviours that are accompanied by sexual language or sexual innuendo. Due to many children with sexual behaviour problems having witnessed people getting out of control and hurting others, they may engage in some sexual or aggressive behaviour or sexually aggressive behaviour to manage their uncomfortable feelings.

The literature discussed above, confirms that children partly develop problematic sexualised behaviour because sexual abuse from perpetrators in some way, provided them pleasure and a feeling of love. Therefore the children might repeat sexual behaviour, in the need of feeling pleasure and love again. Johnson (2009), states that in the absence of close, supportive relationships with adults, the sexual behaviour is also a way of coping with feelings of abandonment, loss, and fear. The sexual behaviour is generally difficult to stop, as the children do not see it as wrong, but as a way of connecting and feeling emotionally safer.

The researcher feels that a child who molest might, after abusing a peer, feel connected and emotionally safer, but the peer has then been exposed to unwanted
abuse. Therefore Johnson (2009) specifies manners in which all children in a home can be kept safe:

- Children with sexual behaviour problems may need to be supervised while with other children.
- It is preferable that a child who molests not sleep in the same room with another child. If this is not possible, the child should not share a room with another child who is chronologically, developmentally, or emotionally less mature, or who is vulnerable to being abused.
- Children with sexual behaviour problems should not sleep in the same bed with other children or adults at any time.
- Children with sexual behaviour problems should not be left to care for other children, even for a short time.
- All bathroom activities should be done separately from other children and adults.
- Adults and children should not walk around without their clothes on.
- Caregivers should not have sexual intercourse when the child is in their presence, even if the child is asleep.
- If a child who has previously molested is in a home with other children, the other children should be told.

The researcher feels that the above guidelines should be implemented with care. Children with this behaviour should not feel as if they are treated unfairly in relation to other children. Staff of child and youth care centres should be careful to not isolate this child from everyday activities and his/her peers when supervising and separating them from peers.

In all of the above, the researcher is of the opinion that professionals involved should be sure of the origin of the child’s behaviour. Is the child presenting with the symptoms because he/she was sexually abused, or because they have a disorder? The presenting reason will lead to a difference in therapeutic treatment plans.
5.7.1.2. Therapeutic needs:

As mentioned, children who have been found to be sexually abused or exploited by their primary caregivers, are removed from these caregivers and placed into an alternative placement. Wickham and West (2002) state that taking a child away from home, often represents a crisis and a deep sense of failure and grief to the family members. When placed in alternative care the child too often feels a sense of loss, anger, confusion, shame, anxiety and sadness. Conversely, the child may be relieved (if sexually abused), which may intensify feelings of guilt, particularly if a sibling remains in danger. Children bring with them unresolved issues pertaining to sexual victimisation and other problems.

The researcher feels that if a child presents with symptoms of sexual disorders because he/she was exposed to, or were sexually abused, he/she would need therapy to work through the abuse that took place. Individual therapy can assist the child to explore and work through his/her internal conflicts, life events, and feelings, including fear, anger, confusion, anxiety, depression and abandonment. The therapeutic work will foster a greater attachment between the caregivers and the child. Healthy attachments to caring adults are fundamental to the mental health of the child. If there are multiple caregivers, all parental caregivers need to be part of the therapeutic process (Gil and Johnson, 1993).

Wickham and West (2002) state that when therapy is available, it is incumbent on all concerned to identify the issues that are to be worked on in the therapeutic setting. These issues might include any or a combination of the following:

- Abuse issues.
- Current disruptions, losses, separations.
- Earlier childhood issues.
- Psychopathology, such as depression and suicidal thoughts, anxiety and panic attacks, etc.
- Future plans, self-confidence.
- Family and social relationships.
Therefore the researcher suggests for a full assessment to be done. This assessment should establish which of the above issues need to receive attention. In this case, abuse issues will arise.

Wickham and West (2002) state that, with regards to therapeutic work with children who were sexually abused, there is consensus about four major areas of work:

i. Treating children as people in their own right, with space to express and explore their own concerns.

ii. Treatment of traumatic sexualisation, stigmatisation, betrayal and powerlessness with implications for self-image, cognitive work and ventilation of feelings.

iii. Helping the child to regain age appropriate functioning, self-confidence and self-respect, aided by therapeutic regression if necessary.

iv. Impacting on the child’s world by helping the child’s carers and school staff to respond effectively to the child’s needs (ecosystems theory).

The researcher feels that beside traumatic experiences that have to be worked through, the sexual behaviour problems should also receive attention through therapeutic interventions. Johnson (2009) feels that if a child is engaging in worrisome sexual behaviours, a thorough and accurate assessment of the child’s sexual behaviours is essential. When clinical assessments indicate that children’s sexualised behaviours are out of the range of age-appropriate sexual interest or behaviour, remain unresponsive to specific limits to decrease the behaviours, or gradually progress to molesting behaviours, professional interventions become necessary (Gil & Johnson, 1993). The problem behaviour these children characteristically present with should, according to the researcher, receive professional interventions.

Wickham and West (2002) suggest a creative approach to therapy. They state that for most children, play and creative techniques are natural methods of communication, and a way of working through issues that does not rely on the spoken word. Creative methods are usually enjoyable. They provide containment of emotion, enabling concrete expression of experience and feelings plus a natural distance and safety from the trauma. Unconscious material can be uncovered more
easily. Being creative is often cathartic for the abused child, and activities can also be continued at home. The researcher therefore suggests for children who have been sexually abused to attend play and/or art therapy. Treatment strategies should however reach what they are designed for: to both decrease the problematic sexual behaviour, and explore the underlying psychological concerns (Gil and Johnson, 1993).

Gil and Johnson (1993) see group therapy as the pivotal component of effective treatment. Family assessment and treatment have been found to be critical components of working with adolescent sex offenders, and may even have greater importance for the younger child in treatment for problematic sexual behaviours.

Johnson (2009) is of the opinion that group therapy is often an excellent resource for developing social skills, frustration tolerance, anger management, and impulse control in children with sexual behaviour problems. Wickham and West (2002) further state that many sexually abused children can benefit from group therapy. They feel that a child can benefit from hearing about the experiences of other children. Group members may provide examples of how other children have reacted to and coped with abuse. As a result, new perspectives and understanding can be gained, and the child’s array of coping mechanisms broadened. Children have the opportunity to observe different stages of the healing process and this can encourage and help them to anticipate what the future may hold. Therefore the researcher suggests the use of group therapy as well. Training needs can also be provided for in this area.

Except for all possible therapeutic interventions discussed above, the researcher found a model (that can reduce sexual behaviours), which could be implemented by a social workers and child care workers on a therapeutic level. Johnson (2009) developed this plan, which reduces one problematic sexual behaviour at a time. She suggests:

i. Make a list of all of the child’s sexual behaviours. Having this information greatly benefits treatment planning by determining the behaviours that need to be reduced.
ii. Study the sexual behaviours the child does to determine which are problematic.

iii. Caregivers should prioritise the problematic sexual behaviours that they think need changing and choose three.

iv. The caregivers, together with the child, select one sexual behaviour to modify.

v. With the child, decide how to refer to the problematic sexual behaviour in which the child is engaging. It is important to have simple, non-judgemental, straightforward vocabulary for discussing the problematic sexual behaviour with the child.

vi. The caregiver should then determine what triggers the selected problematic sexual behaviour. Look out with whom it occurs. What triggers the behaviour (certain places or things, people or relationships, feelings)? After these have been discovered, patterns will emerge.

vii. It is now important to find ways to modify, decrease, or work through identified patterns so they will no longer be triggers for the child’s behaviour.

viii. Together the caregiver and child work out the fine details of the plan and implement it. Verbal reminders and visual cues will help the child modify the selected behaviour. Agree on substitute behaviours that the child can do alone, and that the child can do with the caregiver. They provide the child with a healthy alternative behaviour. These behaviours should be agreed upon, written down and rehearsed.

ix. Determine if the child needs boundary restrictions and increased supervising for a period of time to allow the plan to work.

x. After implementation, carefully review and revise the plan. If the behaviour is not decreasing, the caregivers and child need to play detective again. If the behaviour has disappeared but re-emerge, look again for the triggers. The use of charts and reward systems can be helpful.

The researcher feels that the above therapeutic interventions link with disciplining these children (teaching them the difference between right and wrong). It is an integral part of treatment and managing the child’s behaviour.
5.7.1.3. Disciplinary needs:

The researcher is of the opinion that strong boundaries should be put in place with regards to stopping the child from engaging in a sexual activity. They should know exactly what will happen when they cross these boundaries. Consistency is important in enforcing these boundaries. The researcher feels strongly about these children having knowledge about what the consequences of their behaviour are. If a teenage boy for instance rapes a younger girl, he might be criminally charged, and/or the girl may fall pregnant.

The researcher is however of opinion, as stated in the previous section as well, that not only negative behaviour (in this case sexually inappropriate behaviour), should be focussed upon, but also good behaviour. Constant attention for such negative behaviour might for instance reinforce it.

The researcher feels that a focus on the child’s strengths might contribute to positive behaviour. Therefore positive disciplinary techniques are suggested as well.

The researcher remains of opinion that these children should be taught the difference between right and wrong. It can be done in a therapeutic environment, or through disciplining. Specific training needs should be focused upon though.

5.7.1.4. Training needs:

The researcher feels that training forms part of the disciplining of a child on appropriate boundaries and physical or sexual behaviour. She suggests for training guidelines to be implemented in groups. Johnson (2009) states that because of the confusion and anxiety children with sexual behaviour problems feel about sex and sexuality, the first step to resolving their problematic sexual behaviour is to stabilise their home environment and provide healthy models for sexuality and healthy sexual, physical and emotional boundaries. It is equally important to model and teach impulse control, affect regulation, frustration tolerance, and problem-solving. It is in this environment that children can feel safe and calm and learn the real meaning of love, caring and affection.
Johnson (2009) states that the child with sexual behaviour problems will profit greatly from learning skills pertaining to identification and expression of a range of feelings (the researcher feels that an emotional intelligence programme will help), impulse control/self-monitoring, thought stopping, anger management, and social skills.

Apart from the above skills the children have to learn, the researcher suggests for trainers to also focus on teaching healthy interaction and boundaries. Johnson (2009) states that children, whose boundaries have been violated due to abuse or neglect, may not know what healthy boundaries are, and therefore must learn them. Healthy boundaries should be encouraged by the development of healthy rules in the home regarding privacy and healthy physical contact in the home (Johnson, 2009). She suggests encouraging the development of healthy rules in the home regarding the following:

a) The private space that people can have around their bodies when they want it.

b) The private space people like to have for personal things they do not want to share.

c) People’s rights to privacy in the bathroom, for dressing, and for sleeping alone in bed.

d) Private parts are private.

e) Private thoughts.

f) Children’s right to have information about them being shared only with people who need to know.

g) People keeping their promises.

h) People not getting out of control when drinking, fighting, gambling, or yelling.

i) Healthy sexual expression.

As could be seen in table 13, children with sexual disorders need guidance on specific issues like appropriate ways of getting attention of love, appropriate touching, etc. Johnson (2009, p. 11) also suggests to “encourage the development of healthy physical contact in the home, such as comforting and soothing touch and touch that takes care of someone’s needs. Examples of healthy touch are combing or cutting one’s hair, shaking hands, giving a pat on the back, sitting next to someone while reading a book etc.”
This research study established that it would be conducive to the overall behaviour of a child when he/she is knowledgeable about certain aspects pertaining to their behaviour, emotions and/or mental health problem – sexual disorders.

The researcher and participants of focus groups are of the opinion that general life skills and values training might also be conducive to the overall improvement of these children’s behaviour. Gill and Johnson (1993) justly state that caregivers play an important part in instilling values about sexuality in their children.

Therefore Miller (2001) states that in the midst of the hustle and bustle of daily life, caregivers need to look for opportunities to intentionally talk to children about their values. That means caregivers have to give some thought ahead of time to what they believe in and then seek out those teachable moments. The researcher therefore refers back to the quality time that should be spent with children.

5.7.1.5. Educational needs:

There is no mention of children with sexual disorders experiencing problems with regards to educational performance. The researcher feels that the only manner in which the disorder can interfere with a child’s school functioning is if he/she cannot concentrate on school work, because of thoughts regarding sexual desires.

Johnson’s (2009) concern with regards to school is exposure to sexual behaviour towards peers at school, and not the actual academics and cognitive functioning of the child. She states that should caregivers think that a child may target other children at school, they should talk to the child’s teacher so that special precautions can be taken to keep other children safe. Therefore the researcher suggests for caregivers and/or social workers to talk to teachers regarding relevant concerns. The social worker and/or caregivers should be in contact with each other as soon as an incident occurs.
5.7.1.6. Medicinal needs:

Focus group participants did not have any comment on pharmacotherapy for children with sexual disorders. Corcoran and Walsh (2006) however state that significant advances in psychotropic medications have been made during the past 20 years to assist in lowering libido and decreasing the incidence of deviant sexual thoughts and actions. The SSRI’s all have the common effect of decreasing libido for instance.

A class of medications known as antiandrogen agents is sometimes used to treat paedophilia and the other paraphilias. These drugs have had only modest success, however, in part because of their adverse effects (nausea, diarrhoea, anaemia etc.) (Corcoran & Walsh, 2006).

The researcher could not find any research on medication for children with sexual disorders, and therefore feels that it is currently not being utilised.

5.7.2. Ecosystemic guidelines:

5.7.2.1. Micro level:

It became clear that children with inappropriate sexual behaviour have a need for attention, acceptance and love. It seems as if children, who were sexually abused, felt that their needs were provided for when these caregivers inappropriately touched and/or sexually abused them. Therefore they might attempt to re-experience this feeling. In attempting to do this, they abuse other children in their direct environment. Therefore their peers might be in danger of being abused, and child care workers in child and youth care centres should have rigid supervision over children who present with this behaviour.

Since children with sexual behaviour problems are confused about sex and sexuality, a stable and consistent home environment with healthy emotional, physical, and sexual boundaries needs to be established. The researcher is of the opinion that such consistent environments can be established when the correct
disciplinary techniques are implemented, and all role-players receive appropriate training as discussed above.

Johnson (2009) states that because young children learn by what they experience, the emotional and sexual health of the caregivers and the quality of the environment they provide are the most important element in the resolution of sexual behaviour problem children. It is important for caregivers to be objective. Parents or caregivers must provide a sense of safety for children who molest by carefully monitoring their problematic sexual behaviours, ensuring that other children are not victimised (Gil & Johnson, 1993). The younger the children who molest, the more dependent they are on the family for supervision, limit-setting and guidance. Peers play a greater role as children enter a child-care programme or a school setting (Gil & Johnson, 1993).

As stated earlier, different therapeutic interventions can be implemented to attempt to address inappropriate sexual behaviour. In summary, Johnson (2009), states that the key to modifying children's problematic sexual behaviour is to provide a healthy emotional, physical, and sexual environment with caring, consistent and supportive caregivers.

5.7.2.2. Meso level:

The researcher is of the opinion that on a meso level, social workers should provide basic, general services as mentioned earlier in this chapter. They should also have good communication with the child’s teachers and therapists, to establish progress of the child. Wickham and West (2009) state that in a residential facility, the social worker usually undertakes planned work with the carers to help them cope with the child’s removal from the family and the effects of abuse. Additionally the social worker might undertake specific tasks with the child such as life story work, preparing for court, making arrangements for the child’s future, getting medical treatment, and often acts as a link between the therapist and the family (Wickham & West, 2002).

Wickham and West (2002) feel that when a child is placed outside the home, the context of therapy broadens. The therapist may be involved with social workers,
natural parents, and, in some cases, institutional settings. It is advisable to explore and define the roles of carers and professionals to avoid misunderstandings and crossed boundaries.

Collaboration and coordination of services become part of the therapeutic process. The therapist will for instance also elicit the current carers’ perceptions and concerns. Together they explore the appropriateness and feasibility of therapeutic work. It is helpful if the therapist is informed about changes in the child’s life and behaviour, and carers often want feedback about major areas of therapy, plus suggestions about how the child can best be helped at home and school.

Except for a social worker and therapist, Johnson (2009) feels that caregivers will need the assistance of a mental health provider as well. A mental health provider can provide the knowledge and support to the caregivers to help them provide a healing environment for the child. The researcher is of the opinion that this can be the psychiatrist that sees the child.

Per summary on this section Gil and Johnson (1993) state that experience indicates that treatment providers need a firm grounding in victim and offender dynamics. Treatment for sexualised children who have been sexually abused can be addressed either in individual or group therapy. Special attention must be paid to the meaning of the sexualised behaviour (e.g. reducing tension, coping with post-traumatic stress symptoms, feelings of helplessness, etc.).

5.7.2.3. Exo level:

The researcher again notes that a lack of resources exist to practically implement legislation with regards to children with mental health problems in child and youth care centres. This level was not discussed by the focus group participants when talking about sexual problems and/or disorders.
5.7.2.4. Macro level:

There was not much discussion on the question of whether children with sexual disorders should remain in a mainstream home or be transferred to a specialised programme. Focus group participants were of the opinion that in general children should be transferred to specialised care when they pose a danger to other people in their direct environment. It seems that if a child that has been diagnosed with a sexual disorder (not just present with symptoms that minimise when traumatic experiences are addressed), should be transferred to a specialised care programme. They may not hurt others by physically hitting or abusing them, but by sexually abusing them. This can cause a lot of trauma and problems in other children.

The researcher is however of opinion that children who have been exposed to sexual behaviours, abuse and/or exploitation before they were removed and taken to a child and youth care centre, should not be admitted into a facility where children reside that have not been exposed to this kind of abuse as well. One focus group participant justly stated that a child who was sexually abused, will sexually abuse his/her peers. A specialised home (not necessarily concerned with mental health though), should therefore exist for these children as well.

Resources to be made available for children with inappropriate sexual behaviour can therefore be summarised as follows:
Figure 10: Summary of interventions necessary for a child with sexual problems and/or disorders
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5.8. Human development, assessment and individual treatment plans:

The importance of individual treatment plans were already raised in Chapter 2. Participants of focus groups stressed that each child in a child and youth care centre should receive treatment based on individualised plans. The researcher is of the opinion that individualised treatment plans can only be developed, when the development of children has been taken into account.
In Chapter 2 developmental stages and developmental areas were looked at briefly. Characteristics of mental health disorders were identified in terms of developmental stages. The development of children did not feature in the focus group feedback at all, but the researcher is of the opinion that the importance of this in the development of an individual treatment plan cannot be ignored completely. Unavoidably children develop, and as they develop the symptoms of their disorders, probable treatment approaches, will differ.

Therefore the researcher suggests for child and youth care centres to keep the developmental stage of each child in mind when evaluating, planning for, and implementing treatment. Effective ecosystemic care that promotes coping and adaptation to a child with a mental health problem in a child and youth care centre can only be provided when these aspects have been taken into account.

Mash and Wolfe (2002) refer to the considerations of human development that involve children and mental health problems, as developmental psychopathology. They state that it is an approach describing and studying disorders of childhood and adolescence in a manner that emphasises the importance of developmental processes and tasks. This approach uses abnormal development to inform normal development and vice versa. It proves a useful framework for organising the study of abnormal child psychology around milestones and sequences in physical, cognitive, social-emotional, and educational development.

Consequently the researcher suggests for caregivers to be trained not only on mental health issues, but also on the following developmental areas (already identified in Chapter 2), of children:

i. Physical development: It is the area of human development concerned primarily with changes such as growth, motor skill development, and basic aspects of perception (Seifert, Hoffnung and Hoffnung, 2000). The researcher is of the opinion that none of the mental health disorders discussed above will present physical developmental delays in a child. Therefore the caregiver will not be able to identify mental health problems by looking at this developmental area only.
ii. *Psycho-social development:* The area of human development concerned primarily with personality, social knowledge and skills and emotions (Seifert, Hoffnung and Hoffnung, 2000). This was regarded as the most important developmental area in Chapter 2, and the researcher is of the opinion that most characteristics of mental health disorders as discussed above, will fall under this section.

iii. Other areas that can possibly identify when a child needs specialised attention, is *cognitive development.* Cognitive development is the area of human development concerned with cognition and involves all psychological processes by which individuals learn and think about their environment (Seifert, Hoffnung and Hoffnung, 2000).

Upon admission, these and other aspects are addressed by utilising an ecosystemic assessment designed by the researcher. This assessment was developed, based on the Wildwood Case Management Unit (Summers, 2009). It was made applicable to the situation of children with mental health problems in a child and youth care centre in South Africa. It is presented under the following section of this chapter.

Kirst-Ashman and Hull (2002) demonstrate the integral part this practice has in social work practice. They state that assessment is the second step in the planned change process. It involves acquiring an understanding of a problem, what causes it, and what can be changed to minimise or resolve it. The researcher is of the opinion that the ecosystemic assessment form serves as a link between the initial assessment of a child upon admission, and other relevant assessments to be completed after. Additional assessments can be suggested to see what the cause of a problem is, and what can be done to minimise or resolve it. The programme developed from this research study, suggests to service users what path to follow in establishing what mental health problem (if any), a child presents with.

After implementation of more literature studies, and feedback from focus group participants, the researcher added some suggestions to the initially developed assessment procedure and programme (in Chapter 2). Suggestions added centres around new information discussed above regarding the five most usual mental health problems/disorders diagnosed in children that reside in residential facilities. The fully
developed and suggested programme to follow for children with mental health problems in child and youth care centres will be discussed hereunder.

5.9. Summary of recommended programme:

A definite course (illustrated hereunder through an outline of a programme model), to follow for the recommended programme (containing ecosystemic guidelines), was established. The illustration hereunder differs from Figure 5 in Chapter 2, in that it has a more in-depth and focused approach with regards to suggested guidelines to be followed for specific mental health problems and/or disorders. The summary and contents of the programme is presented and explained in the manner in which the researcher suggests for it to be implemented in the field of social work in child and youth care centres. It also contains documents the researcher suggests to be utilised during implementation of the programme model. In order for the practitioner to fully comprehend how this programme is to be implemented, a case study is included.

The researcher reminds the practitioner that this programme and/or documents may or cannot be implemented without the permission and/or training of the researcher.
Figure 11: Summary of suggested programme to be implemented (Effective ecosystemic orientated care to children with mental health problems in child and youth care centres)

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The above programme model was designed by the researcher, based on the data collected from literature and focus groups. As discussed earlier, it starts with the implementation of an ecosystemic assessment. The researcher suggests for this assessment to be conducted with each child being admitted into a child and youth care centre. The researcher was of the opinion that child and youth care centres do not have any standardised forms to be utilised when wanting to establish what a child’s needs are, upon admission into such a residential facility. She was further of the opinion that, consequently, the child and youth care centre is usually in the dark with regards to providing for the child’s needs (irrelevant of whether the child has a mental health problem or not).

Therefore the researcher developed an assessment form (ecosystemic assessment) to be utilised during this first step of the suggested programme model illustrated above. The researcher developed this assessment based on the Wildwood Case Management Unit (Summers, 2009). It was made applicable to the situation of children with mental health problems in a child and youth care centre in South Africa.

The following case study practically illustrates the manner in which the researcher suggests for social workers to implement the ecosystemic assessment and remainder of the steps contained in the suggested programme model illustrated above:

Jamie is an 8 year old boy. A day ago Jamie was removed from the care of his biological parents. The school he attends reported a case of alleged child neglect and abuse to a social worker (Ms. Ackerman), at the local Child Welfare offices. It is alleged that Jamie’s biological father abuses his biological mother, and sometimes him, physically. Reports further show that Jamie’s father feeds him alcohol, and neighbours complain about drug abuse. The reunification social worker (Ms. Ackerman) is investigating the allegations and the circumstances of the biological parents.

The social worker of the child and youth care centre (acting as the case manager (Ms. Sithole)’s, task is to render social work services to Jamie, and to ensure that his physical, educational, and psychosocial needs are provided for. Before his needs can be provided for though, the social worker has to identify what Jamie’s needs are. On the same day as Jamie’s arrival at the child and youth care centre, Ms. Sithole sits down with firstly Ms. Ackerman (reunification worker), and secondly Jamie. If it is possible to have the biological parents present and participating, the opportunity is utilised. Jamie’s mother was able to provide valuable information on his behavioural characteristics.
Ms. Sithole retrieves as much as possible information from the reunification social worker and/or parents. She completes the ecosystemic assessment, and retrieves all documentation needed. The most important information to be retrieved from reunification social workers are: identifying particulars and previous care positions of the child, presenting problems, education, medical history, and mental and social aspects.

Ms. Sithole can however not get all the information from Ms. Ackerman, and speaks to Jamie himself about his views, behaviour, and interests. She explains the reasons why he will be residing in the child and youth care centre (temporarily until further notice), and attempts to calm him, as he is still troubled about the removal. Jamie was however able to participate during implementation of the remaining of the ecosystemic assessment, and important information (his view on his previous care positions, family history and structure, social and recreational aspects, and mental health status) was retrieved.

After retrieving all the above information, the child and youth care centre’s social worker (Ms. Sithole), summarises her views and evaluations of the initial interview with Ms. Ackerman, the parents, and Jamie. During summarisation she notices that Jamie seems to experience problems in his school, relationship and other areas of life. Ms. Ackerman and the biological mother for instance indicated that Jamie presents with the following behavioural characteristics: aggression, hurting himself, lying and stealing, and bullying of others. Jamie shows no remorse when he hurt someone. Jamie’s mother states that he does not want to listen when spoken to, and that he achieves poorly at school.

Ms. Sithole is aware that the above behavioural characteristics may present themselves because of the alleged traumatic experiences Jamie has had, but is concerned that he might have some mental health problems as well. Therefore Ms. Sithole, in her summary of the ecosystemic assessment, suggests for Jamie to firstly be observed by the child care workers in the home he resides in.

After a minimum of four weeks, the child care workers complete a form designed to isolate certain behavioural characteristics observed. (This form concludes the summary of the programme). This completed form is handed back to the intake social worker – Ms. Sithole. Ms. Sithole read through it, and noticed that the child care worker’s observations state that Jamie often and/or always presents with the following behavioural characteristics: aggression, anger, argumentativeness, lying, stealing, non-compliance, bullying, threatening (usually intimidates others with knives). Jamie shows a lack of remorse for such behaviour. The child care worker also indicates that it appears as if Jamie has suicide tendencies. She noticed him scratching himself until he bleeds. Once he verbally expressed that he wanted to hang himself from a tree. The child care worker states that she struggles to complete homework with Jamie, and it appears as if he has some cognitive delays.

The information collected from the child care worker, is captured on the ecosystemic assessment form. The child care worker assessment form is attached to the ecosystemic form.

Another letter that is attached to the ecosystemic assessment form is from the general health practitioner (GP). The social worker suggested for Jamie to undergo this examination, mainly because of the alleged physical abuse. The GP did note some old scars and bruises that might have been caused by physical abuse. The GP does however not believe that Jamie’s behaviour is caused by anything physical.
Because of Jamie’s poor academic performance, Ms. Sithole also requested for Jamie to undergo an educational assessment. The educational psychologist who completed the assessment, indicated in her report that Jamie has some cognitive delays, largely because of a lack of stimulation. She suggested for Jamie to be transferred to specialised schooling, as he is already repeating Grade 1, and would not be able to be transferred to Grade 2 yet either. She also noted a concern for Jamie’s behaviour. This report is also attached to the ecosystemic assessment form.

The social worker suggested for Jamie to undergo a full assessment with a psychiatrist or psychologist to establish his current mental health status. After Jamie was observed and assessed by a psychiatrist at a local psychiatric hospital, it was indicated that he is diagnosed with oppositional defiance and conduct disorder, and at times appear to be depressed. The psychiatrists suggested for Jamie to receive trauma and pharmacotherapy. These recommendations are captured on the ecosystemic assessment form, and the report attached.

The social worker from the child and youth care centre then combines all the above reports and recommendations from multi-disciplinary role-players. Based on this integration of information, and Jamie’s behavioural characteristics observed in the facility, Ms. Sithole then develops an individual development plan.

Ms. Sithole came to the conclusion that Jamie has oppositional defiance and conduct disorder, and depression. Therefore she indicated on the ecosystemic assessment form which guidelines she suggests to be followed to provide for Jamie’s physical, educational and psychosocial needs.

Today Jamie is 9 years old. He is still residing in the child and youth care centre, as his parents’ circumstances did not improve yet. In the past six months all role-players on all ecosystemic levels were involved in providing for Jamie’s needs. Amongst others, he receives: individual acceptance, love, patience, attention, and some quality time from child care workers mainly. He underwent trauma counselling and was taught some skills on how to deal with his anger by appropriate and qualified therapists. A strict, authoritative disciplinary method is enforced, but in a positive reinforcement environment. Jamie benefited from learning more about his mental health status. He was also taught life, problem and social skills in a group setting. Jamie takes his prescribed medicine daily, and attends a home school programme.

The ecosystemic assessment is repeated every six months, to ensure that Jamie’s needs are provided for, and to notice changes in his mental health status. Some of Jamie’s behavioural characteristics improved, and he is not as aggressive as before. He also does not threaten other children any longer. Ms. Sithole is however of the opinion that the current status quo should be continued for the following six months, until the next assessment is completed.

The ecosystemic assessment form designed by the researcher follows.
Ecosystemic assessment
(Step 1 of recommended programme)

Date: ____________________________________________
Intake worker (C & Y C C): ____________________________________________
Information source & relationship to child: ____________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

1. Identifying information

Child name & surname: ____________________________________________
Gender: ____________________________________________
Date of birth: ____________________________________________
I.D. number: ____________________________________________
Primary language: ____________________________________________
*Child’s birth certificate required.

2. Previous care position

Child removed from: Child & youth care centre or Family (circle & describe)
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

*Applicable legislative documentation required from the Children’s Court, the Department of Social Development and/or South African Police Services.

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Reason for current transfer:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

3. Description of presenting problem

Why was the child initially removed from his/her family/primary caregivers?
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Status of Children’s court and/or criminal court proceedings
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

*Opening and finalisation of Children’s Court Proceedings and/or most recent background reports required.

4. Family history and structure

Summarise the family of origin’s history and structure, with attention to contact (type and frequency) that the child has with each member still involved.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

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5. Education

Is the child currently attending school? (Circle) Yes or No

If yes, what school and grade? Indicate if the child attends remedial/special schooling.

*Most recent school report and IQ test required.

6. Social/Recreational

Religion: __________________________________________________

Interests: __________________________________________________

Hobbies: __________________________________________________

Sports: __________________________________________________

7. Medical history

General practitioner: ________________________________________

Contact number: __________________________________________

Most recent illness: _________________________________________

Immunisations: (up to date or not) ______________________________

Previous operations: _________________________________________

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8. Mental health history

Does the child present with mental health problems? (Circle)  
Yes or No

If yes, what mental health problems, and has the child ever been assessed and/or diagnosed for/with a mental health disorder? Explain.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Complete if the child has received mental health/psychiatric services (including hospitalisation) before:

<table>
<thead>
<tr>
<th>Where</th>
<th>When</th>
<th>Termination date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

*All previous evaluations, assessments, diagnoses and psychiatrist reports required.*
9. Social and mental health status examination

Mark behavioural characteristics experienced previously and/or currently:

<table>
<thead>
<tr>
<th>Conduct and oppositional defiance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Destructive</td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
</tr>
<tr>
<td>Aggressive</td>
<td></td>
</tr>
<tr>
<td>Non-compliant</td>
<td></td>
</tr>
<tr>
<td>Violate rules</td>
<td></td>
</tr>
<tr>
<td>Criminal activities</td>
<td></td>
</tr>
<tr>
<td>Lying</td>
<td></td>
</tr>
<tr>
<td>Stealing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADHD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Readily distractible</td>
<td></td>
</tr>
<tr>
<td>Not following through instructions</td>
<td></td>
</tr>
<tr>
<td>Impulsive</td>
<td></td>
</tr>
<tr>
<td>Inattention</td>
<td></td>
</tr>
<tr>
<td>Restless</td>
<td></td>
</tr>
<tr>
<td>Sleep disturbances</td>
<td></td>
</tr>
<tr>
<td>Fidgetiness</td>
<td></td>
</tr>
<tr>
<td>Learning difficulties</td>
<td></td>
</tr>
<tr>
<td>Difficulty with relationships</td>
<td></td>
</tr>
<tr>
<td>Aggression</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td></td>
</tr>
<tr>
<td>Social withdrawal</td>
<td></td>
</tr>
<tr>
<td>Eating problems</td>
<td></td>
</tr>
<tr>
<td>Suicide tendency</td>
<td></td>
</tr>
<tr>
<td>Self harming behaviour</td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
</tr>
<tr>
<td>Emotional problems</td>
<td></td>
</tr>
<tr>
<td>Loss of interest and/or pleasure</td>
<td></td>
</tr>
<tr>
<td>Poor academic performance</td>
<td></td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td></td>
</tr>
<tr>
<td>Low self-esteem</td>
<td></td>
</tr>
<tr>
<td>Fatigue or loss of energy</td>
<td></td>
</tr>
<tr>
<td><strong>Schizophrenia</strong></td>
<td>Altered contact with reality</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>Outbursts of anger</td>
</tr>
<tr>
<td></td>
<td>Social withdrawal</td>
</tr>
<tr>
<td></td>
<td>Loss of interest in school</td>
</tr>
<tr>
<td></td>
<td>Somatic passivity experiences</td>
</tr>
<tr>
<td></td>
<td>Phobias hindering functioning</td>
</tr>
<tr>
<td></td>
<td>Poor hygiene</td>
</tr>
<tr>
<td></td>
<td>Depressive and euphoric moods</td>
</tr>
<tr>
<td></td>
<td>Disorganised speech and behaviour</td>
</tr>
</tbody>
</table>

| **Sexual behaviour**                      | Dissociation                | ___ |
|                                          | Lack of boundaries           | ___ |
|                                          | Disobedient                 | ___ |
|                                          | Impulsive                   | ___ |
|                                          | Promiscuous                 | ___ |
|                                          | Attention seeking           | ___ |
|                                          | Persistent, compulsive, obsessive | ___ |
|                                          | Violation of other's boundaries | ___ |
|                                          | Seeking pleasure            | ___ |
|                                          | Manipulating into sexual relations | ___ |

| **Anxiety**                               | Panic attacks               | ___ |
|                                          | Social avoidance             | ___ |
|                                          | Persistent worry             | ___ |
|                                          | Uncomfortable leaving        | ___ |
|                                          | Somatic complaints           | ___ |

| **Suicidal**                              | Vague death wish            | ___ |
|                                          | Thoughts without plan        | ___ |
|                                          | Thoughts with plan           | ___ |
|                                          | Attempts                     | ___ |

| **Speech:**                               | Normal                       | ___ |
|                                          | Impoverished                 | ___ |
|                                          | Overly talkative             | ___ |
|                                          | Under talkative              | ___ |
|                                          | Pressured                    | ___ |
|                                          | Clear/coherent               | ___ |

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### Memory:
- Adequate [___]
- Impaired [___]

### Intelligence:
- Above average [___]
- Average [___]
- Below average [___]

### Motivation:
- Good [___]
- Fair [___]
- Poor [___]

### Other behavioural characteristics observed:
- [_________________________________________________________________________________]
- [_________________________________________________________________________________]
- [_________________________________________________________________________________]
- [_________________________________________________________________________________]

### 10. Summary

#### Impact of problems:
- Health [___]
- School [___]
- Relationships [___]
- Other [___]

#### Impressions and recommendations:
- Child does not present with a mental health problem. *(Discuss)*

- [_________________________________________________________________________________]
- [_________________________________________________________________________________]
- [_________________________________________________________________________________]
- [_________________________________________________________________________________]

- Child presents with a mental health problem. *(Discuss)*

- [_________________________________________________________________________________]
- [_________________________________________________________________________________]
- [_________________________________________________________________________________]
- [_________________________________________________________________________________]
Indicate whether the child should complete one or more of the following assessments:

(Step 2 of recommended programme)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Tick if yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child care worker’s assessment</td>
<td></td>
</tr>
<tr>
<td>Physical examination by primary health practitioner</td>
<td></td>
</tr>
<tr>
<td>Educational assessment by professional</td>
<td></td>
</tr>
<tr>
<td>Psychiatric and/or psychological assessment</td>
<td></td>
</tr>
</tbody>
</table>

Indicate what the results were of assessments completed

Child care worker assessment:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Physical examination:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Educational assessment:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Psychiatric or psychological assessment:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

*Attach reports from all assessments completed.
11. Evaluations and development of individual development plan
(Step 3 of recommended programme)

___ Child does not present with a mental health problem, and mainstream programme can be followed. (Discuss)

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

___ Child presents with a mental health problem, and a specialised programme (includes individual development plan), should be followed. (Discuss)

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________
Please note:

- It is suggested for the ecosystemic assessment to be completed on a six monthly bases. In this manner any changes in the child’s mental health status, development and/or functioning can be noted, and be paid the needed attention. All documents should be kept on the child’s file, in order for the social worker to compare results of previous assessments.

- If the social worker concluded that the child does not present with a mental health problem and/or disorder by the end of the ecosystemic assessment and additional assessments, the mainstream programme of the relevant child and youth care centre should be followed.

- If the social worker concluded that a child presents with a mental health problem and/or disorder by the end of the ecosystemic assessment and additional assessments, an indication must be made of which services would be utilised in caring ecosystemically for that child. Suggested guidelines to follow for children diagnosed with specific mental health disorders and/or problems, are presented in table form on the following five pages.

- The social worker should firstly indicate which behavioural characteristics the child presents with. The child care worker is the primary source to establish what behavioural characteristics the child presents with the most, and therefore the information provided by them is essential. As seen in the programme model, the completion of an assessment form, by child care workers, is suggested as an additional assessment. This assessment form is attached hereunder. The assessment form was developed by the researcher, based on the information collected regarding the behavioural characteristics a child usually presents with when he/she has a mental health problem and/or disorder.

- The social worker (with the help of the child care worker), should indicate which services would be utilised in caring for this child ecosystemically, and providing for his/her needs.

- If the disorder the child is diagnosed with is not included in the suggested guidelines, the social worker is responsible to liaise with the appropriate professionals in ensuring what services the child is in need of, and that these needs are provided for.
### 3.1. Oppositional defiance & conduct disorders

**Behavioural characteristics observed** *(After admission, when additional assessments were completed)*:

- Destructive behaviour (e.g. arson)
- Loosing temper, being angry and argumentative
- Self-harm and harm to others
- Lying and/or stealing
- Serious violation of rules
- Non-compliance
- Bullying, threatening and intimidating
- Lack of remorse
- Absconding
- Easily annoyed and purposefully annoy others
- Criminal activities and/or juvenile delinquency

---

**Table 14: Suggested guidelines to follow if child has been diagnosed and/or presents with oppositional defiance and conduct disorders:**

<table>
<thead>
<tr>
<th>Need</th>
<th>Guidelines</th>
<th>Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>• Acceptance: <em>Unconditional</em> – It is the child’s behaviour that is unacceptable, not the child</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Love: <em>Unconditional</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patience &amp; tolerance: <em>From the caregiver towards the child and his/her behaviour</em></td>
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<tr>
<td></td>
<td>• Attachment &amp; belonging: <em>Between child and caregivers (including biological parents)</em></td>
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<tr>
<td></td>
<td>• Individual attention: <em>Need a low staff:child ratio to ensure quality time spent</em></td>
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<tr>
<td></td>
<td>• Quality time</td>
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</tr>
<tr>
<td><strong>Therapeutic</strong></td>
<td>• Trauma counselling: <em>To deal with negative childhood experiences</em></td>
<td></td>
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<tr>
<td></td>
<td>• CBT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Anger management</td>
<td></td>
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<tr>
<td></td>
<td>• Breathing, relaxation and grounding techniques: <em>Also to assist with anger</em></td>
<td></td>
</tr>
<tr>
<td><strong>Disciplinary</strong></td>
<td>• Structured &amp; routine environment: <em>To assist with predictability</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rules &amp; consequences: <em>For inappropriate behaviour</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strong authority figure: <em>To implement discipline</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Positive reinforcement: <em>To encourage good behaviour</em></td>
<td></td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>• Psycho-education: <em>On conduct &amp; oppositional defiance disorders</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• General life skills &amp; values: <em>Especially with regards to empathy</em></td>
<td></td>
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<tr>
<td></td>
<td>• Social skills training: <em>To assist in interpersonal difficulties</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Problem solving skills: <em>To handle problems effectively on his/her own</em></td>
<td></td>
</tr>
<tr>
<td><strong>Medicinal</strong></td>
<td>• Neuroleptics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lithium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Anticonvulsants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stimulants</td>
<td></td>
</tr>
<tr>
<td><strong>Educational</strong></td>
<td>• Individual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Specialised: <em>To assist with especially reading problems and learning difficulties</em></td>
<td></td>
</tr>
</tbody>
</table>

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3.2. Attention deficit disorders

Behavioural characteristics observed (After admission, when additional assessments were completed):
- Readily distractible
- Short attention span
- Not completing tasks
- Fails to respond to disciplinary methods
- Lack of inner and/or impulse control
- Cannot stop talking, sit still or fidget
- Cannot cope in a mainstream school
- Aggression
- Difficulty with peer relations and developing friendships

Table 15: Suggested guidelines to follow if child has been diagnosed and/or presents with attention deficit disorders:

<table>
<thead>
<tr>
<th>Need:</th>
<th>Guidelines:</th>
<th>Implement:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>• Attention &amp; love: <em>Show unconditional love by providing the child with individual attention</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patience &amp; tolerance: <em>To help child with tasks and tolerance with characteristics of disorder</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Acceptance: <em>Of the child</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Guidance: <em>In terms of appropriate behaviour</em></td>
<td></td>
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<tr>
<td></td>
<td>• Supporter &amp; friend</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participation in activities: <em>To get the child involved in a sport and or/hobby that he/she enjoys and perform in</em></td>
<td></td>
</tr>
<tr>
<td><strong>Therapeutic</strong></td>
<td>• Trauma therapy: <em>To deal with negative childhood experiences</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Play &amp; art Therapy: <em>Manner in which to conduct the above</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Operant conditioning &amp; CBT: <em>For teaching appropriate behaviour</em></td>
<td></td>
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<tr>
<td></td>
<td>• Occupational therapy: <em>For developmental delays and academic difficulties</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strengths perspective</td>
<td></td>
</tr>
<tr>
<td><strong>Disciplinary</strong></td>
<td>• Pre-arranged discipline plan: <em>Child should be aware of rules</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Communication: <em>To communicate the contents of above plan</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Structure &amp; routine: <em>For predictability</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Positive reinforcement: <em>To encourage good behaviour</em></td>
<td></td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>• Psycho-education: <em>On ADHD</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social skills training: <em>To assist in interpersonal difficulties</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Life skills &amp; values: <em>To assist with appropriate manners of handling life situations</em></td>
<td></td>
</tr>
<tr>
<td><strong>Medicinal</strong></td>
<td>• Stimulants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Antidepressants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Alpha-2 adrenergic agonists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Amphetamines</td>
<td></td>
</tr>
<tr>
<td><strong>Educational</strong></td>
<td>• Individual &amp; specialised: <em>To assist with attention deficit and hyperactivity problems</em></td>
<td></td>
</tr>
</tbody>
</table>
### 3.3. Depression

**Behavioural characteristics observed** *(After admission, when additional assessments were completed):*

- Social withdrawal
- Eating problems
- Suicide acts
- Self-harming and self-destructive behaviour
- Substance abuse
- Emotional problems
- Aggression
- Defiance and conduct problems
- Loss of interest and/or pleasure
- Poor academic performance
- Sleep disturbances
- Low self-esteem
- Fatigue or loss of energy

<table>
<thead>
<tr>
<th>Need</th>
<th>Guidelines</th>
<th>Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>• Love: <em>To show the child that he/she is worth something</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Attention: <em>Quality time – child should be able to confide in caregiver</em></td>
<td></td>
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<tr>
<td></td>
<td>• Motivation: <em>To continue with life and the everyday expectancies thereof</em></td>
<td></td>
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<tr>
<td></td>
<td>• Close supervision: <em>Especially for children with suicide tendencies</em></td>
<td></td>
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<tr>
<td></td>
<td>• Secure attachment: <em>Would assist in effectiveness of above</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reassurance and build-up of self-worth</td>
<td></td>
</tr>
<tr>
<td><strong>Therapeutic</strong></td>
<td>• Trauma counselling: <em>To deal with negative childhood experiences</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CBT: <em>To change negative cognitive thinking patterns</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assessment of motivation: <em>Child has to be motivated before real change can take place</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strengths based approach: <em>Especially because these children have such low self-esteem and pessimistic views</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gestalt approach: <em>For child to have an awareness of self, and be able to establish when he/she is depressed and how to manage the feelings that come with it</em></td>
<td></td>
</tr>
<tr>
<td><strong>Disciplinary</strong></td>
<td>• Positive reinforcement: <em>To encourage good behaviour and to not focus on negatives</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Boundaries and consequences: <em>For difficult or problem behaviour</em></td>
<td></td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>• Psycho-education: <em>On depression</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social skills training: <em>To assist with social withdrawal and problems with social interactions</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Problem solving skills: <em>For this child to be able to deal with life’s problems, and solve them</em></td>
<td></td>
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<tr>
<td></td>
<td>• Life skills &amp; values: <em>To teach appropriate manners of handling different situations</em></td>
<td></td>
</tr>
<tr>
<td><strong>Medicinal</strong></td>
<td>• Serotonin</td>
<td></td>
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<tr>
<td></td>
<td>• Norepinephrine</td>
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<tr>
<td></td>
<td>• Dopamine</td>
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<tr>
<td></td>
<td>• Typical antidepressants</td>
<td></td>
</tr>
<tr>
<td><strong>Educational</strong></td>
<td>• Motivation to attend school and achieve academically</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Positive and supportive school environment</td>
<td></td>
</tr>
</tbody>
</table>
### 3.4. Schizophrenia

**Behavioural characteristics observed** *(After admission, when additional assessments were completed):*

- Altered contact with reality
- Outbursts of anger
- Social withdrawal
- Loss of interest in school
- Somatic passivity experiences
- Phobias hinder functioning
- Poor hygiene
- Depressive and euphoric mood changes
- Disorganised speech and behaviour

<table>
<thead>
<tr>
<th>Table 17: Suggested guidelines to follow if child has been diagnosed and/or presents with schizophrenia:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Need</strong></td>
</tr>
<tr>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td><strong>Therapeutic</strong></td>
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<tr>
<td><strong>Disciplinary</strong></td>
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<tr>
<td><strong>Training</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Medicinal</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Educational</strong></td>
</tr>
</tbody>
</table>
3.5. Sexual disorders and/or behaviour

**Behavioural characteristics to be on the lookout for** *(After admission, when additional assessments were completed)*:

- Dissociation
- Lack of boundaries
- Disobedient
- Impulsive
- Promiscuous
- Attention seeking
- Persistent, compulsive or obsessive behaviour
- Violation of other’s boundaries
- Seeking pleasure
- Manipulate others into sexual relations

They are always to be looked out for.

| Table 18: Suggested guidelines to follow if child has been diagnosed and/or presents with sexual disorders and/or behaviour: |
|---|---|---|
| **Need** | **Guidelines** | **Implement** |
| **Individual** | - Attention & love: *If the child receives this from his/her caregivers, he/she will maybe not seek it from others in inappropriate manners*<br>- Acceptance: *Irrespective of behavioural problems*<br>- Attachment: *May help the child to feel loved, and therefore the child may choose to not resolve to others to feel loved*<br>- Patience & tolerance: *In the process of teaching healthy boundaries*<br>- Healthy boundaries: *In terms of sexuality and appropriate behaviour* |  |
| **Therapeutic** | - Trauma counselling: *Extremely important in resolving probable sexual abuse*<br>- Clinical assessments: *To assess where the behaviour emanates from to help in treatment thereof*<br>- Play & art therapy: *Can be utilised to conduct trauma counselling and clinical assessments*<br>- Group therapy: *Can assist the child in realising that he/she is not the only one who went through the abuse; also relevant to training aspects* |  |
| **Disciplinary** | - Strong boundaries & consequences: *Mostly aimed at inappropriate sexual behaviour*<br>- Strengths perspective: *To build the child up* |  |
| **Training** | - Education on sexual disorders and/or behavioural problems<br>- Healthy boundaries<br>- Guidance on sexuality<br>- Values & social skills: *To assist in appropriate behaviour and interactions towards others* |  |
| **Medicinal** | - Psychotropic medication<br>- Antiandrogen agents |  |
| **Educational** | - Communication with teacher regarding supervision and reporting of incidences |  |
Child care worker assessment – Developed by Y Allers

(The child care worker should complete this assessment after a minimum of four weeks of observation of child)

Indicate how often a child presents with a behavioural characteristic by drawing a cross (x). The aim of this assessment is to see with what behavioural characteristics a child presents. Positive characteristics can be utilised during strengths based interventions, and with implementation of positive reinforcement.

Name of child: ____________________________________
Name of child care worker: ____________________________________

<table>
<thead>
<tr>
<th>Behavioural characteristics</th>
<th>1</th>
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<tr>
<td>1. Angriness</td>
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<td>2. Aggressiveness</td>
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<td>3. Destructiveness</td>
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<td>4. Non-compliance</td>
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<td>5. Violation of rules</td>
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<td>6. Lying</td>
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<td>7. Stealing</td>
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<td>8. Short attention span</td>
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<td>9. Not following through with tasks</td>
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<td>10. Restlessness</td>
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<td>11. Sleep disturbances</td>
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<td>12. Fidgetiness</td>
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<td>13. Learning difficulties</td>
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<td>14. Difficulty with relationships</td>
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<td>15. Sadness</td>
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<td>16. Social withdrawal</td>
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<td>17. Eating problems</td>
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<td>18. Suicidal</td>
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<td>19. Self-harming behaviour</td>
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<td>20. Loss of interest and/or pleasure</td>
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<td>21. Low self-esteem</td>
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<td>22. Fatigue or loss of energy</td>
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<td>23. Altered contact with reality</td>
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<td>24. Phobias hindering functioning</td>
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<td>25. Poor hygiene</td>
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<td>26. Disorganised speech and behaviour</td>
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<td>27. Dissociation</td>
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<td>28. Lack of boundaries</td>
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<td>29. Impulsiveness</td>
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<td>30. Promiscuous</td>
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<td>31. Attention seeking behaviour</td>
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<td>32. Violation of other’s boundaries</td>
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<td>33. Engaging in sexual relations</td>
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<td>34. Panic</td>
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<td>35. Persistent worry</td>
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<td>36. Cooperativeness</td>
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<td>37. Sharing</td>
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<td>38. Pro-social</td>
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<td>39. Motivated</td>
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<tr>
<td>40. Achieves</td>
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Indicate if there is anything additional regarding the child that you want to bring under the attention of the social worker:

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5.10. Conclusion:

In conclusion to the above discussed aspects, the SOS Children’s Villages International (2009), state that decisions regarding children in alternative care, should have due regard for the importance of ensuring children a stable home, and of meeting their basic need for safe and continuous attachment to their caregivers. Attention must be paid to promoting and safeguarding all other rights of special pertinence to the situation of children without parental care, including, but not limited to, access to education, health and other basic services.

To reach the above, the researcher first had to establish what the needs are of children with mental health problems and/or disorders, in child and youth care centres. Only when the needs were known and confirmed by participants of focus groups, the researcher was able to search for manners (in other words services), to provide for the identified needs. Opinions of key role-players of child and youth care centres and additional literature had to be studied to provide such information.

Focus group participants felt that children (irrespective of their mental health status or diagnoses), have basic needs. The participants also identified guidelines that they think can assist in providing for these basic needs. The participants were however of opinion (as discussed in Chapter 2 as well), that every child is unique, and that his/her individual needs should be addressed on a micro level. Not only caregivers and peers are involved in the micro level, but interacting micro systems influence the child and his/her behaviour as well.

Therefore the researcher, with the help of literature and the participants of focus groups, identified role-players that should be involved in the general care of children with mental health problems in child and youth care centres. Social workers render social work services to the child from the moment that the child is admitted into the child and youth care centre. Social workers are responsible to initiate and coordinate all services rendered to the child, ensuring that the child’s physical, cognitive, and psychosocial needs are provided for. Social workers also attend to the necessary case management. Teachers play a significant part in these children’s lives, and the way they manage a child with a mental health problem/disorder, can “make or break”
the child. As seen, therapy is an integral part of the treatment process, and therefore different therapists are involved in conducting different therapeutic interventions with the individual child. The need for other role-players such as psychiatrists and psychologists was confirmed.

In correlation with Chapter 2, focus group participants did not have any problem with the existence of legislation to provide for the needs of children with mental health problems in child and youth care centres. They however confirmed that the actual services are lacking, and that the children’s needs are not provided for.

On a macro level, participants of focus groups were at times in two minds on whether a child with a mental health problem/disorder should be transferred to specialised care, or if they can remain in a mainstream child and youth care centre. Generally the researcher observed that participants were of the opinion that children who are not a danger to others in the mainstream home, can remain there. It however seems as though they would prefer for a child who has a negative impact on others in the micro environment, to be transferred to a specialised home.

As mentioned throughout this research study, the goal of this research study was however to provide a programme with ecosystemic guidelines to mainstream and specialised residential facilities. The researcher is of the opinion that the proposed programme may be successfully implemented in both, as it has a general focus on social work practices, and suggests for staff to make use of specialised services in the community. Specialised services (mental health services), are for instance suggested for the identified mental health disorders.

Five mental health disorders that usually present in children with mental health problems and/or disorders were identified by focus group participants as follows: conduct and oppositional defiance disorder, ADHD, depression, schizophrenia, and inappropriate sexual behaviour or disorders.

The researcher suggests for a social worker to, upon admission, complete an ecosystemic assessment to establish the functioning of a child on a physical, cognitive and psychosocial level. Additional assessments might be necessary to
confirm concerns regarding a child’s mental health. Based on the integration of all assessments and conclusions from the social worker regarding a child’s mental health status, an individual development plan is developed. This plan should provide for the physical, educational and psychosocial needs of the individual child.

The following chapter concludes the findings of this research study, which attempted to provide a management programme to mainstream and specialised child and youth care centres on how to care optimally for children with mental health disorders.
Chapter 6
Conclusions and recommendations

6.1. Introduction:

This research study focused on a child with mental health problems and/or disorders in child and youth care centres in Gauteng. This poem titled “The Misunderstood Child” by Winters (2007), serves as a summary of a child with a mental health problem:

I am the child that looks healthy and fine.
I was born with ten fingers and toes.
But something is different, somewhere in my mind.
And what it is nobody knows.

I am the child that struggles at school,
though they say that I'm perfectly smart.
They tell me I'm lazy – can learn if I try –
But I don't seem to know where to start.

I am the child that won't wear the clothes
which hurt me or bother my feet.
I dread sudden noises, can't handle most smells
And tastes – there are few foods I will eat.

I am the child that can't catch the ball
and runs with an awkward gait.
I am the one chosen last on the team
and I cringe as I stand there and wait.

I am the child with whom no one will play –
The one that gets bullied and teased.
I try to fit in and I want to be liked,
but nothing I do seems to please.

I am the child that tantrums and freaks
Over things that seem petty and trite.
You'll never know how I panic inside,
when I'm lost in my anger and fright.

I am the child that fidgets and squirms
though I'm told to sit still and be good.
Do you think that I choose to be out of control?
Don't you know that I would if I could?

I am the child with the broken heart
though I act like I didn't really care.
Perhaps there's a reason God made me this way –
Some message he sent me to share.

For I am the child that needs to be loved
and accepted and valued too.
I am the child that is misunderstood;
I am different—but look just like you.
The goal of this study was to provide a management programme to mainstream and specialised child and youth care centres, on how to care optimally for children. The researcher conducted a literature study in Chapter 2 to partly attain this goal. The literature study stated, amongst others, that this research study views children systemically in terms of their environment – a child and youth care centre. Systems that were applicable in this study were micro, meso, exo and macro level systems.

Therefore, before summaries, conclusions and recommendations are discussed and made regarding the methodology and limitations of the study, the researcher firstly provide conclusions regarding the way in which practitioners should view ecosystemic levels of child functioning, in order for them to know how to view the child on these levels. Suggestions regarding future development of mental health in the field of social work conclude this chapter.

6.2. Conclusions regarding ecosystemic levels of child functioning:

6.2.1. Micro level systems:

The first sub-system implicated on this level, is identified as the individual child with a mental health disorder. Mental health disorders were defined as disorders that interfere with daily functioning, such as education and employment (Dumaine, 2003). The causation of such disorders was mentioned briefly. The researcher feels that children in child and youth care centres usually present with functional disorders.

After all studies were completed, it was established that children in child and youth care centres usually present with; conduct and oppositional defiance disorders, ADHD, depression, schizophrenia, and sexual behavioural problems and/or disorders. Although this study has a social work and not mental health approach, the researcher examined literature and information retrieved from key role-players, about each of these disorders, so that its management could be determined. The goal of the study is ultimately to put guidelines in place that can assist in providing for the children’s needs, and consequently managing their behaviour.
On this ecosystemic level, it was also established that children’s individual childhood experiences (which were presumably predominantly negative), have an impact on their normal development. Therefore theories about how children develop were mentioned briefly, in terms of different developmental areas and stages. It was established that children present with different characteristics of a mental health problem at different developmental stages. The researcher is however of the opinion that general guidelines provided will assist in managing the behaviour and providing for the needs of a child across different developmental stages. During holistic assessments and specialised treatment from multi-disciplinary professionals, development is however an important consideration.

Besides the child with a mental health problem being part of the micro level, caregivers (biological parents and child care workers), and peers (other children who reside in the residential facility), also form part of it.

It was established that even though a child has been removed from his/her biological parents, and even though they might have hurt him/her, they remain his/her parents. The researcher and participants of focus groups felt that if the parents’ involvement is not disadvantageous to the overall wellbeing of the child, it should be encouraged. Friesen, Kruzich, Robinson, Jivanjee, Pullmann and Bowles (2005), state that studies proved on-going contact with caregivers is related to positive behaviour of children in care.

As the biological parents of the child are however not involved in the direct, everyday live of the child, the researcher focused on the significant role that child care workers play. The study established that child care workers are responsible to provide for the child’s basic, individual needs. These needs are regarded as the most important for a developing child. Two main needs that were identified are unconditional love, and acceptance. The need for quality time should not be forgotten. In providing for these needs, the child care worker should build up a good attachment with the child. This will assist in the ease of implementation of specific disciplinary techniques that have to be implemented by the child care workers. It is extremely important for the child care worker to be knowledgeable about the different disorders that the children who are in his/her care, present with. This includes
knowledge on the child’s individual, therapeutic, disciplinary, training, medicinal and educational needs, and how to provide for these needs.

Peers also form part of this micro level system, and it was established that the impact the child with a mental health problem may have on his/her peers, is immense. Therefore the participants of focus groups were of the opinion that children with mental health problems should be transferred to specialised programmes and facilities, and that they cannot reside in a mainstream child and youth care centre with peers that have not been diagnosed with mental health problems.

It was established that there are also other role-players that are supposed to form part of a child with a mental health problems’ life. These role-players are not involved in the direct environment of the child, and form part of the next system level.

6.2.2. Meso systems level:

Kail and Cavanaugh (2007) defined meso systems as connected micro systems. Different role-players are involved in the treatment of each mental health disorder, but in general the following role-players are suggested:

- **Social worker:** As seen these role-players work closely with the child care workers in their daily tasks. A social worker is the person who has first contact with a child, and conducts the ecosystemic assessment. They are also the important links between a child and the services needed to provide for their diverse needs. Social workers are responsible to, in conjunction with the reunification social worker, complete the necessary case management of a child who was removed from his/her primary caregivers. Social workers can (although this study showed that there are time constraints involved), also conduct certain therapies and training with these children and their caregivers.

- **Teachers:** It was supported that teachers can have a positive or negative effect on children’s mental health status. Therefore the way that they work and interact with the children, is extremely important. Teachers should also be knowledgeable on the disorders that children present with, in order for them to develop specialised working plans. It was established that most of the children
with mental health problems cannot function in a mainstream school, and are in need of individualised and specialised schooling.

- **Therapists:** This study highlighted the importance of therapy for children who present with mental health problems. The previous chapter identified specific therapeutic interventions to be conducted with children who present with specific mental health disorders. It is important to note that the therapist should be trained to conduct certain therapies with the child. Social workers can for instance not implement psychotherapy or prescribe psychiatric medication. A psychiatrist and/or psychologist are necessary to do this.

- **Other role-players:** The researcher noted that children with mental health problems sometimes need additional services like speech therapy. Therefore speech and occupational therapists might form part of these role-players. Other role-players are not excluded.

The importance of cohesiveness between these role-players was highlighted in the preceding chapters.

### 6.2.3. Exo systems level:

This systems level focused on settings the child does not experience first-hand, but that still have an influence on his/her functioning. Government policy was discussed briefly. The researcher was of the opinion, and participants from focus groups confirmed, that legislation to provide for the needs of a child with mental health problems is in place. Legislative documents that were studied are:

- **The Constitution (1996):** This provides for the most basic physiological needs of children to be met. The researcher agrees that a child’s need for food and shelter should be met without any exceptions.

- **The White Paper of Social Welfare, 1997 & Children’s Act 38 of 2005:** Social welfare policies state that children are entitled to specialised services to be rendered to them in the form of a programme.

- **Mental Health Act 17 of 2002:** It stated that a child with a mental health problem has the right to be treated humanely and with dignity.
It was however established that the supposed services mentioned in these guidelines, do not exist. Neither the researcher, nor the participants of focus groups, is for instance aware of any specialised programmes for children with mental health problems. As mentioned throughout the study, it might be because of a lack of funding and/or human resources.

6.2.4. Macro systems level:

The researcher identified this level as the child and youth care centre as a whole. All the above systems fall into this one. Therefore this system level was utilised as the grounds from where the researcher provided information on whether a child with a specific disorder should remain in the mainstream home, or if he/she should be transferred to a specialised home. The researcher however came to the conclusion that the proposed programme can be implemented in a mainstream and specialised residential facility.

Figure 4 in Chapter 2 provided a summary of interventions necessary on the macro level. This summary was combined with the initial programme (Figure 5) and the data collected from the empirical research study (focus groups and one-on-one interview). Additional literature (as per guidance of focus group participants), was presented in Chapter 5, which enabled the researcher to enrich and add to the existing programme.

This enriched programme consists of suggested ecosystemic guidelines that can assist the child in improved coping and adaptation in a child and youth care centre, by providing for his/her needs. The researcher believes that improved coping and adaptation can lead to an improved person-environment-fit. This in turn, can optimise the child’s mental health. Therefore the researcher recommends for key role-players of child and youth care centres to follow the suggested programme presented in Chapter 5.
6.3. Summary of methodology and limitations of study:

In Chapter 3 the researcher planned for the implementation of the empirical part of this research study. Plans were to conduct qualitative research methods only. The first method (literature study) was discussed, and the results thereof summarised in the preceding section of this chapter. The researcher was able to retrieve an adequate amount of information from relevant literature for the basis of an ecosystemic programme, and the development of an interview schedule for the empirical part of the study.

The researcher was however of the opinion that some information and data still lacked, as the topic of children with mental health problems in child and youth care centres appeared to be under researched. After the conducting of a pilot study, information that lacked was retrieved from key role-players who work with children with mental health problems in child and youth care centres.

An extensive sampling process was conducted, and some social workers and child care workers, who work with children with mental health problems, represented their child and youth care centre at focus groups that were hosted by the researcher. As discussed in Chapter 3, the researcher planned to conduct three focus groups with the representatives from child and youth care centres that indicated they work with children with mental health problems.

Unfortunately not all the respondents attended the focus groups as planned. The researcher is of the opinion that this limitation appeared due to the high work loads of both social workers and child care workers. At the third focus group that was run in Pretoria, only one social worker was present, and the researcher implemented the developed interview schedule on a one-on-one basis with this social worker. The researcher was of the opinion that the information this respondent provided, was of value and applicable to the study, and therefore information retrieved from this one-on-one interview, was also analysed and utilised in the research report. The researcher was further of the opinion that valuable and applicable information was also retrieved from the pilot study group, and therefore data retrieved from them were also analysed and utilised in the research report.
Overall the researcher learnt that valuable information can be gathered by conducting qualitative research with key role-players. Although the absence of some expected participants is a limitation to the study, the researcher believes that the implementation of focus groups was the best method for obtaining the needed information.

Data were analysed according to recognised analysis methodology. Abridged transcripts were developed from video recordings taken during implementation of the groups, and certain categories and themes arose from these transcripts. These categories and themes were integrated with data collected during the literature study, and as a lot of new information came forth, a complete literature control was conducted in Chapter 5. As seen in the mentioned chapter, integration of the data retrieved from the various resources, assisted the researcher in attaining the set goal for this study.

6.4. Conclusions and recommendations:

This study was motivated by an identified gap in service delivery. Close observation of children with mental health disorders in a residential care setting in South Africa, led the researcher to become acutely aware of the challenges associated with providing for these children’s needs. An apparent lack of knowledge caused child care workers, biological parents, social workers and other staff to appear not to have the necessary skills and resources to deal appropriately with children with mental health problems.

The researcher conducted a literature study, and implemented focus groups with key role-players from child and youth care centres in an attempt to attain more knowledge regarding the said problem. During the practical implementation of these qualitative research methods, some challenges arose with the attendance of focus group discussions.

Despite these challenges, the researcher is of the opinion that this study did explore and reach a full understanding of the characteristics and needs of a child with a mental health problem. Therefore the objectives that were set in Chapter 1 were met.
In reaching the set objectives, the goal of this study, which was to provide a management programme to mainstream and specialised child and youth care centres, on how to care optimally for children with mental health problems, was also attained. This management programme was summarised in the previous chapter. The researcher is of the opinion that the ecosystemic guidelines pertaining in this programme can be utilised in an attempt to improve the coping, adaptation, and, more than that, mental health of individual children with mental health problems in child and youth care centres.

The researcher however stresses that the developed programme and conclusions will not benefit any role-players and/or systems involved, when it remains in this document only. Therefore the researcher recommends for an apposite manual to be developed, which is based on the suggested programme. She suggests for this manual to consist of, amongst more detailed interventions, the specific steps to be undertaken when a child is admitted into a child and youth care centre.

The researcher however recommends for such a manual to not just be handed to child and youth care centres. She suggests to, after development of a manual, guide staff (social workers and child care workers primarily), of child and youth care centres, on the practical implementation of the recommended steps. As mentioned throughout this study, the researcher regards it as extremely important that all role-players should have appropriate and sufficient education on mental health and mental health problems. The researcher feels that this profound knowledge cannot be transferred when role-players read through a document independently.

The researcher further recommends for this type of training to not only be implemented in child and youth care centres in Gauteng, but also in all specialised and mainstream residential facilities across South Africa. Therefore all children in child and youth care centres across the country will have the opportunity to develop optimal physical, educational, and psychosocial functioning.

The researcher feels that even though this study and the proposed programme focus on children with mental health disorders, it will not be only them who benefit from it. The researcher is of the opinion that children who does not present with mental
health problems, would also benefit from the programme on a preventative level. With the ecosystemic assessment that is suggested to be administered, the slightest problem (negative behavioural characteristics; not necessarily mental health problems), would be observed as soon as possible, and addressed accordingly. The researcher feels that there would be no room for error in preventing negative behaviour to increase, and for the child to consequently develop a mental health problem later in his/her life. In order for this to happen, the researcher suggests for all role-players on all system levels to be involved in the implementation of sustaining individual development plans.

The researcher stipulated some very important tasks that specific role-players should implement during ecosystemic interventions. On a micro level, child care workers and biological parents are regarded as the most important and influential role-players. These role-players care for the child and share most of the day with him/her. The researcher is of the opinion that the developed programme will benefit child care workers and biological parents, in that they will be empowered in managing children and their needs. The researcher feels that if the child is managed in the correct manner, it affects the individual child, as he/she is content with the manner in which his/her caregivers are providing for his/her needs.

The researcher however noted that support for child care workers and biological parents are pivotal, and because of this, and other reasons, social workers are regarded equally important role-players. The researcher feels that this research study will ease the work of social workers in child and youth care centres across South Africa. The researcher, being a social worker herself, notices a set of sequenced steps to follow; from the admission of the child, to identifying his/her needs, to developing an individual development plan. Therefore the social worker not only has knowledge on managing the child and his/her needs, but also on how to help other staff of child and youth care centres on how to do this.

In the packaged ecosystemic intervention provided in Chapter 5, the social worker is also provided with a list of suggested professionals, and other role-players, that are required to provide for the child’s needs. The social worker is provided with clear steps in networking with these professionals. The researcher feels that professionals
like general health practitioners, teachers, and therapists, would also benefit from the developed programme. When the social worker that networks with the professional, has knowledge on concerning topics, and can identify the child’s behavioural characteristics, the work of the other professional would be so much easier to complete adequately in due course.

The researcher further noticed that adequate interventions with children of a child and youth care centre can have precipitations on more top levels of the different systems as well. If the staff of a child and youth care centre for instance have knowledge on how to adequately care for a child with a mental health problem, the researcher feels that they would be content in their work. Therefore, on a meso level, top management of a child and youth care centre might notice improvement in the work quality of staff.

On an exo level, when the suggested programme is utilised, the policies (especially the Children’s Act 38 of 2005), discussed will in fact be practically implemented, especially if all government departments unite in further research and development of this topic. On a macro level, this would consequently contribute to the overall social development of child and youth care centres across South Africa.

Consequently the researcher is of the opinion that the research goal was met on an inclusive level (micro, meso, exo and macro ecosystemic levels). This was done through the implementation of data collection from a variety of sources – primarily literature and key role-players. Ultimately a management programme is provided to practitioners in the field of mental health social work – more specifically to mainstream and specialised child and youth care centres. This management programme provides ecosystemic guidelines on how to optimally care for a child with a mental health problem.
Reference list:


Appendix A

Referral list for mental health services

UNIVERSITY OF JOHANNESBURG
General information:

- Mental Health Agencies in Gauteng – for assistance with mental illness and mental handicap:
  - SA Federation for Mental Health National Office:
    267 Long Avenue, Ferndale, Randburg, 2194
    011 326 0625

- Mental Health Societies
  - Daveyton: 011 614 9890
  - Eldorado Park: 011 945 1291
  - Johannesburg: 011 624 2344
  - Reiger Park: 011 910 4071
  - Soweto: 011 984 4038

Accommodation for people with mental disorders:

- Abri Foundation – Observatory
  021 448 3886
- Comcare Trust – Observatory
  021 448 0760
- Garden Cottage – Heideveld
  021 633 3743
- Hope House – Pinelands
  021 689 3507
- Kimber House – Observatory
  021 448 7949
- Kingdom Ministries – Brackenfell
  021 981 9850
- Selous House – Claremont
  021 683 4003
- St Anthony’s Home, Mowbray
  021 685 5415
- Kungwini Child and Youth Care Centre
  012 809 0020

Counselling services:

Refer to the “MHIC Mental Health Resource Guide” (021 938 9229) for therapists in private practice.

- Life Line 24-hour Crisis Line
  0861 322 3er22
  National office:
  011 715 2000
• Traumaclinic Nationwide Trauma Counselling 24 Hours
  084 944 9444

Professional bodies:

• The Society for Psychiatrists of South Africa
  011 717 2026
• The Psychology Society of South Africa
  011 486 3322
• SA Association for Social Workers in Private Practice
  011 887 1968

Psychiatric hospitals and care and rehabilitation centres:

• Life Care Randfontein Care Centre
  011 693 3615
• Sterkfontein Hospital
  011 956 6324
• TARA Hospital
  011 535 3000
• Weskoppies Hospital
  012 319 9500
• Witpoort Sanatorium
  011 813 2155

Support groups for mentally ill people:

• Polar Bears (Bipolar support group)
  082 551 4592
• Overeaters Anonymous
  011 640 2901
• Welcome Club Daily social support groups for mental health consumers
  011 706 1910

Child care (General information):

• SA National Council for Child and Family Welfare
  011 339 5741
Appendix B
Schedule of questions for focus groups
Initial schedule of questions for focus groups

1. What are your names, work title and at which residential facility are you employed?
2. As you all were made aware during the sampling process, social workers and child care workers that work with children with mental health problems were invited to join the focus groups. What do you regard as a mental health problem in a child?
3. What is the number of children you have worked with recently (past 12 months) that presented with a mental health problem?
4. What was the most common mental health problems observed?
5. Based on the three most common mental health problems that according to you, children in residential facilities present with; what is in your opinion, the characteristics of these disorders?
6. Based on the characteristics identified by you, what according to you are the care needs emanating from this?
7. What effective ecosystemic guidelines in your opinion, can be put in place on a micro level (individual child with mental health problem and people in his/her direct environment) to ensure that children with mental health problems’ needs are provided for in a residential facility?
8. What effective ecosystemic guidelines in your opinion, can be put in place on a meso level (interacting micro systems) to ensure that children with mental health problems’ needs are provided for in a residential facility?
9. What effective ecosystemic guidelines in your opinion, can be put in place on an exo level (legislation) to ensure that children with mental health problems’ needs are provided for in a residential facility?
10. What effective ecosystemic guidelines in your opinion, can be put in place on a macro level (child and youth care centre) to ensure that children with mental health problems’ needs are provided for in a residential facility?
11. Should you have a choice between caring for a child with a mental health problem in your mainstream facility would you, or would you prefer to send the child to a specialised home? Discuss.

12. State in one sentence what are, according to you, the critical areas of concern regarding children with mental health problems in child and youth care centres?

13. Have we missed anything?
Final schedule of questions for focus groups

1. What are your names, work title and at which residential facility are you employed?
2. As you all were made aware during the sampling process, social workers and child care workers that work with children with mental health problems were invited to join the focus groups. What do you regard as a mental health problem in a child?
3. What kind of mental health problems were observed?
4. Based on the three most common mental health problems that according to you, children in residential facilities present with; what is in your opinion, the characteristics of these disorders?
5. Based on the characteristics identified by you, what according to you, are the care needs emanating from this?
6. What guidelines in your opinion, can be put in place on a micro level (individual child with mental health problem and people in his/her direct environment) to ensure that these children’s needs are provided for in a residential facility?
7. What guidelines in your opinion, can be put in place on a meso level (interacting micro systems) to ensure that these children’s needs are provided for in a residential facility?
8. What guidelines in your opinion, can be put in place on an exo level (legislation) to ensure that these children’s needs are provided for in a residential facility?
9. What guidelines in your opinion, can be put in place on a macro level (child and youth care centre) to ensure that these children’s needs are provided for in a residential facility?
10. Should you have a choice between caring for a child with a mental health problem in your mainstream facility would you, or would you prefer to send the child to a specialised home? Discuss.
11. State in one sentence what are, according to you, the critical areas of concern regarding children with mental health problems in child and youth care centres?
12. Have we missed anything?
Appendix C:
List of residential facilities in Gauteng
Colour coding utilised:

Group that partook in pilot study on 30 May 2011
Interest shown in beginning, but didn’t confirm attendance for a group
Confirmed attendance of Group 1 – West Rand, 9 June 2011, 9:30
Confirmed attendance of Group 2 – West Rand, 9 June 2011, 12:30
Confirmed attendance of Group 3 – Pretoria, 10 June 2011, 10:00

<table>
<thead>
<tr>
<th>Nr</th>
<th>Name</th>
<th>Address</th>
<th>E-mail</th>
<th>Interest</th>
<th>Confirmation</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abraham Kriel Campus Childcare</td>
<td>Langlaagte</td>
<td><a href="mailto:yb@abrahamkriel.org">yb@abrahamkriel.org</a></td>
<td>Yes</td>
<td>Yes (WR 12:30)</td>
<td>Present</td>
</tr>
<tr>
<td>2</td>
<td>Acres of love</td>
<td>Bryanston</td>
<td><a href="mailto:janine@acrosolove.org">janine@acrosolove.org</a></td>
<td>Yes</td>
<td>Yes (WR 9:30)</td>
<td>Present</td>
</tr>
<tr>
<td>3</td>
<td>Amazing Grace Children’s Home</td>
<td>Eikenhof</td>
<td><a href="mailto:eikenhof@agch.org.za">eikenhof@agch.org.za</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Armstrong Berning Centre</td>
<td>Arcadia</td>
<td><a href="mailto:armstrong@savf.co.za">armstrong@savf.co.za</a></td>
<td>Yes</td>
<td>Yes (P 10:00)</td>
<td>Absent</td>
</tr>
<tr>
<td>5</td>
<td>Aryan Benevolent Home</td>
<td>Lenasia</td>
<td><a href="mailto:rl@abh.co.za">rl@abh.co.za</a></td>
<td>No (Babies)</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>6</td>
<td>Berg-en-Dal Crisis Centre</td>
<td>Queenswood</td>
<td><a href="mailto:babies@cmrn.co.za">babies@cmrn.co.za</a></td>
<td>No (Pregnant women)</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>7</td>
<td>Bethany Children’s Home</td>
<td>Klipspruit</td>
<td>[no e-mail]</td>
<td>Yes</td>
<td>Yes (WR 12:30)</td>
<td>Present</td>
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<tr>
<td>8</td>
<td>Bethany House Trust</td>
<td>Krugersdorp</td>
<td><a href="mailto:michelle@childincrisis.org.za">michelle@childincrisis.org.za</a></td>
<td>Yes (Pilot)</td>
<td>Yes</td>
<td>Present</td>
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<tr>
<td>9</td>
<td>Bethesda Outreach Children’s Village</td>
<td>Hammanskraal</td>
<td><a href="mailto:bethesda-temda@boi.org">bethesda-temda@boi.org</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>10</td>
<td>Boys Town Kagiso</td>
<td>Randfontein</td>
<td>[no e-mail]</td>
<td>No (Not admit)</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>11</td>
<td>Boys Town Magaliesburg</td>
<td>Magaliesburg</td>
<td>[no e-mail]</td>
<td>No (Not admit)</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>12</td>
<td>Botshabelo Babie’s Home</td>
<td>Midrand</td>
<td><a href="mailto:elke@botshabelo.co.za">elke@botshabelo.co.za</a></td>
<td>Yes</td>
<td>Yes (WR 9:30)</td>
<td>Absent</td>
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<tr>
<td>13</td>
<td>Bramley Children’s Home</td>
<td>Pretoria</td>
<td><a href="mailto:bramley@childwelfare.co.za">bramley@childwelfare.co.za</a></td>
<td>Yes</td>
<td>Yes (P 10:00)</td>
<td>Absent</td>
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<tr>
<td>14</td>
<td>Carl Sithole Centre</td>
<td>Soweto</td>
<td><a href="mailto:carlssithole@lantic.net">carlssithole@lantic.net</a></td>
<td>Yes</td>
<td>Yes (WR 12:30)</td>
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<tr>
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<td>Name</td>
<td>Address</td>
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<td>Interest</td>
<td>Confirmation</td>
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<td>15</td>
<td>Catherine Robson Children’s Home</td>
<td>Vereeniging</td>
<td><a href="mailto:catherinerobson@absamail.co.za">catherinerobson@absamail.co.za</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>16</td>
<td>Chance Children’s Home</td>
<td>Springs</td>
<td><a href="mailto:kidsforkeeps@polka.co.za">kidsforkeeps@polka.co.za</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>17</td>
<td>Collands Aids Hospice for babies</td>
<td>Turffontein</td>
<td><a href="mailto:kathy@collands.org">kathy@collands.org</a></td>
<td>Yes</td>
<td>Yes</td>
<td>Absent</td>
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<tr>
<td>18</td>
<td>Crescent Haven Children’s Home</td>
<td>Lenasia</td>
<td><a href="mailto:crescent@mweb.co.za">crescent@mweb.co.za</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>19</td>
<td>Door of hope</td>
<td>Johannesburg</td>
<td><a href="mailto:adoptionprep@netactive.co.za">adoptionprep@netactive.co.za</a></td>
<td>Yes</td>
<td>Yes</td>
<td>Present</td>
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<tr>
<td>20</td>
<td>Ekhaya Lothando Children’s Home</td>
<td>Tembisa</td>
<td><a href="mailto:ikhayal@telkomsa.net">ikhayal@telkomsa.net</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>21</td>
<td>Emdeni Campus Childcare</td>
<td>Emdeni</td>
<td><a href="mailto:aj@abrahamkriel.org.za">aj@abrahamkriel.org.za</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>22</td>
<td>Epworth Children’s Home</td>
<td>Lambton</td>
<td><a href="mailto:robyn@epworthvillage.org.za">robyn@epworthvillage.org.za</a></td>
<td>None</td>
<td>N/A</td>
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<tr>
<td>23</td>
<td>Ethembeni Home</td>
<td>Doornfontein</td>
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<tr>
<td>24</td>
<td>Fatima House</td>
<td>Pretoria North</td>
<td><a href="mailto:fatimahouse@absamail.co.za">fatimahouse@absamail.co.za</a></td>
<td>None</td>
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<tr>
<td>25</td>
<td>Firlands Children’s Home</td>
<td>Linden</td>
<td><a href="mailto:admin@firlandsch.co.za">admin@firlandsch.co.za</a></td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>26</td>
<td>Guild Cottage</td>
<td>Johannesburg</td>
<td><a href="mailto:Guildcot2@mweb.co.za">Guildcot2@mweb.co.za</a></td>
<td>None</td>
<td>N/A</td>
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<tr>
<td>27</td>
<td>House Lerato</td>
<td>Pretoria</td>
<td>(no e-mail)</td>
<td>None</td>
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<tr>
<td>28</td>
<td>Ikholwa Community Service</td>
<td>Roodepoort</td>
<td><a href="mailto:maud@ikholwa.com">maud@ikholwa.com</a></td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>29</td>
<td>I’Themba Children’s Home</td>
<td>Four Ways</td>
<td><a href="mailto:info@heartsoftime.org.za">info@heartsoftime.org.za</a></td>
<td>None</td>
<td>N/A</td>
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<tr>
<td>30</td>
<td>Jakaranda Children’s Home</td>
<td>East Lynne</td>
<td><a href="mailto:charlene@jafricanchildren.co.za">charlene@jafricanchildren.co.za</a></td>
<td>None</td>
<td>N/A</td>
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<tr>
<td>31</td>
<td>Johannesburg Children’s Home</td>
<td>Observatory</td>
<td><a href="mailto:director@ich.org.za">director@ich.org.za</a></td>
<td>Yes</td>
<td>Yes</td>
<td>Present</td>
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<tr>
<td>32</td>
<td>John Wesley Child Care Centre</td>
<td>Kempton Park</td>
<td><a href="mailto:jwh@kpmc.org.za">jwh@kpmc.org.za</a></td>
<td>None</td>
<td>N/A</td>
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<td>33</td>
<td>Ki-deo</td>
<td>Lyttleton Manor</td>
<td><a href="mailto:charmaine@netdial.co.za">charmaine@netdial.co.za</a></td>
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<td>Kotulong Community Centre</td>
<td>Meyerton</td>
<td><a href="mailto:centremanager@kotulong.org">centremanager@kotulong.org</a></td>
<td>None</td>
<td>N/A</td>
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<tr>
<td>35</td>
<td>Leamogetswe Safety House</td>
<td>Atteridgeville</td>
<td><a href="mailto:leamogetswesh@yahoo.com">leamogetswesh@yahoo.com</a></td>
<td>Yes</td>
<td>Yes</td>
<td>Absent</td>
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<tr>
<td>36</td>
<td>Legae La Rona Children’s Home</td>
<td>Soshanguve</td>
<td>(no e-mail)</td>
<td>No</td>
<td>N/A</td>
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<td>37</td>
<td>Lerato Children’s Home</td>
<td>Meyerton</td>
<td><a href="mailto:leratohome@telkomsa.net">leratohome@telkomsa.net</a></td>
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<td>Nr</td>
<td>Name</td>
<td>Address</td>
<td>E-mail</td>
<td>Interest</td>
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<td>38</td>
<td>Louis Botha Children's Home</td>
<td>Pretoria</td>
<td><a href="mailto:ivanleeuwen@louisbothachildren.co.za">ivanleeuwen@louisbothachildren.co.za</a></td>
<td>Yes</td>
<td>Yes (P 10:00)</td>
<td>Present</td>
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<tr>
<td>39</td>
<td>Makeba Rehabilitation Centre</td>
<td>Midrand</td>
<td><a href="mailto:kwazik@yahoo.com">kwazik@yahoo.com</a></td>
<td>None</td>
<td>N/A</td>
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<td>Mamelodi Village</td>
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<td>41</td>
<td>Maria Kloppers Campus Childcare</td>
<td>Observatary</td>
<td>(no e-mail)</td>
<td>No</td>
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<td>Mohau Child Care Centre (Diana – Princess of Whales)</td>
<td>Atteridgeville</td>
<td><a href="mailto:mohau.centre@mwebbiz.co.za">mohau.centre@mwebbiz.co.za</a></td>
<td>None</td>
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<td>43</td>
<td>Nazareth House</td>
<td>Yeoville</td>
<td><a href="mailto:socialworker@nazarethhousejohnesburg.org">socialworker@nazarethhousejohnesburg.org</a></td>
<td>None</td>
<td>N/A</td>
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<td>44</td>
<td>New Jerusalem Children's Home</td>
<td>Midrand</td>
<td><a href="mailto:phinam1@live.com">phinam1@live.com</a></td>
<td>Yes</td>
<td>Yes (WR 12:30)</td>
<td>Absent</td>
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<tr>
<td>45</td>
<td>Oasis Children's Home</td>
<td>Randburg</td>
<td><a href="mailto:lucrezia@oasishaven.org">lucrezia@oasishaven.org</a></td>
<td>None</td>
<td>N/A</td>
<td>N/A</td>
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<td>46</td>
<td>Orlando Children's Home</td>
<td>Orlando East</td>
<td><a href="mailto:othandweni@jhbchildwelfare.org.za">othandweni@jhbchildwelfare.org.za</a></td>
<td>None</td>
<td>N/A</td>
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<td>47</td>
<td>Othandweni Children's Home</td>
<td>Mofolo South</td>
<td><a href="mailto:othandweni@jhbchildwelfare.org.za">othandweni@jhbchildwelfare.org.za</a></td>
<td>None</td>
<td>N/A</td>
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<td>Polokong Children's Village</td>
<td>Evaton</td>
<td><a href="mailto:polokong@telkomsa.net">polokong@telkomsa.net</a></td>
<td>Yes</td>
<td>Yes (WR 9:30)</td>
<td>Present</td>
</tr>
<tr>
<td>49</td>
<td>President Kruger Children's Home</td>
<td>Villieria</td>
<td><a href="mailto:beaulah.dupreez@gmail.com">beaulah.dupreez@gmail.com</a></td>
<td>None</td>
<td>N/A</td>
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<td>50</td>
<td>Princess Alice Adoption Home</td>
<td>Westcliff</td>
<td><a href="mailto:princess_alice@mweb.co.za">princess_alice@mweb.co.za</a></td>
<td>None</td>
<td>N/A</td>
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<td>51</td>
<td>Rhema Hands of Compassion</td>
<td>Joubert Park</td>
<td><a href="mailto:rhemacy@tiscali.co.za">rhemacy@tiscali.co.za</a></td>
<td>None</td>
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<td>Rhema Paradise Children's Home</td>
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<td>carolfrhema.co.za</td>
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<td>Mayfair</td>
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<td>SOS Children's Home</td>
<td>Ennerdale</td>
<td><a href="mailto:ennedale@mail.ngo.za">ennedale@mail.ngo.za</a></td>
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<td>55</td>
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<td>Mamelodi East</td>
<td><a href="mailto:pinky@sosmamelodi.org.za">pinky@sosmamelodi.org.za</a></td>
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<td>56</td>
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<td>Roodepoort</td>
<td><a href="mailto:shospice@metroweb.co.za">shospice@metroweb.co.za</a></td>
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<td><a href="mailto:adminlifecampus@coach.org.za">adminlifecampus@coach.org.za</a></td>
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<td>58</td>
<td>St Joseph's Children's Home</td>
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<td>St Francis Rainbow Baby Cottage</td>
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<td>Confirmation</td>
<td>Attendance</td>
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<td>Strathyre Girl’s Home</td>
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<td><a href="mailto:socialworker@strathyregirlshome.co.za">socialworker@strathyregirlshome.co.za</a></td>
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<td>The Love of Christ Ministries</td>
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<td><a href="mailto:viv@tlc.org.za">viv@tlc.org.za</a></td>
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<td><a href="mailto:sandra@coach.org.za">sandra@coach.org.za</a> <a href="mailto:sasam@coach.org.za">sasam@coach.org.za</a></td>
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<td><a href="mailto:Tshwane@mweb.co.za">Tshwane@mweb.co.za</a></td>
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<td>Uitkoms Tehuis</td>
<td>Observatory</td>
<td><a href="mailto:uitkoms.manager@absamail.co.za">uitkoms.manager@absamail.co.za</a></td>
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<td>Villa of Hope Children’s Home</td>
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<td><a href="mailto:eunice@villahope.org.za">eunice@villahope.org.za</a></td>
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<td>UMephi</td>
<td>Pretoria</td>
<td><a href="mailto:elsavdw@netdial.co.za">elsavdw@netdial.co.za</a></td>
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<td>Midrand</td>
<td><a href="mailto:info@yenzani.org">info@yenzani.org</a> <a href="mailto:sane@yenzani.org">sane@yenzani.org</a></td>
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**List of psychiatric residential facilities in Gauteng**

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<td>TARA Hospital</td>
<td>Johannesburg</td>
<td><a href="mailto:faiza.khota@gauteng.gov.za">faiza.khota@gauteng.gov.za</a></td>
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<td><a href="mailto:fikile.nkosi@gauteng.gov.za">fikile.nkosi@gauteng.gov.za</a> <a href="mailto:grace.raswisi@gauteng.gov.za">grace.raswisi@gauteng.gov.za</a></td>
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Appendix D

Letters (e-mails) sent to residential facilities in Gauteng
Good day

I am Yolande Allers, a registered social worker and researcher employed at the Bethany House Trust Child and Youth Care Centre in Krugersdorp.

Close observation of children with mental health problems in a residential care setting in South Africa, led the undersigned to become acutely aware of the challenges associated with providing for these children's needs, and consequently managing their behaviour. A gap in service delivery was identified when specific programmes addressing the care needs of children with mental health problems in child and youth care centres, couldn't be found.

Based on the need for guidelines which may assist in addressing the care needs of children with mental health problems in child and youth care centres, the goal of the research study is: To provide a management programme to mainstream and specialized child and youth care centres, on how to care optimally for children with mental health problems. This means that children with mental health problems would be able to cope better with challenging life situations and adaptation in residential facilities. Ultimately their mental health status can improve. This would better the quality of life for all systems involved in child and youth care centres - from the individual child with a mental health problem, to the management of such a facility. Participating organisations will benefit from this research study by receiving updates on the programme to be developed, and implications for facilities in and around Gauteng.

In attaining the above goal, the undersigned call on employees (specifically social workers and child care workers), of child and youth care centres in Gauteng. The undersigned would appreciate your participation and ask you to kindly answer the following questions by replying to this e-mail:

1. At which child and youth care centre are you employed?
2. Do you have children in the child and youth care centre that has a mental health disorder? (For example: depression, attention deficit disorder, anxiety disorders, oppositional defiance disorder etc).
3. Would you be interested to partake in a focus group that will take place during May 2011? (Focus groups will be held in two or three areas around Gauteng. These groups will be held specifically for employees of child and youth care centres that work with children with mental disorders. Groups would focus on your opinions regarding the mentioned topic. Further information regarding the continuing of this study will also be addressed).

The dates and venues for the mentioned focus groups will be confirmed as soon as possible.

Thank you in advance.

Regards,

Yolande Allers
Social Worker
Second letter (e-mail) sent to residential facilities in Gauteng

Good day colleagues

I sincerely thank you for responding to the previous e-mail sent regarding the issue of children with mental health problems in residential care settings in South Africa. You are indeed assisting in accomplishing the goal of the research study, which is to provide a management programme to mainstream and specialized child and youth care centres, on how to care optimally for children with mental health problems. For the persons who missed previous communication, it is attached at the bottom of this e-mail.

As stated in the previous e-mail, focus groups are conducted to retrieve the opinions of social workers and child care workers that work with children with mental health problems. These focus groups will be implemented on:

- 9 June 2011 (West Rand & Johannesburg area)
- 10 June 2011 (East Rand & Pretoria area).

Upon stating that you are interested to join the focus groups, the researcher will confirm attendance on either of the above dates, via e-mail or telephone.

The undersigned again call on all employees (specifically social workers and child care workers) of child and youth care centres in Gauteng to participate in this research study. Should you be of opinion that your organisation would not benefit from the information retrieved, the undersigned respectfully request for you to answer the following questions by replying to this e-mail:

- At which child and youth care centre are you employed?
- What is the reason for your organisation not caring for, or not having any children with mental health problems residing there?

Note again that participating organisations will benefit from this research study by receiving updates on the programme to be developed, and implications for facilities in and around Gauteng.

Thank you in advance.

Kind regards,
Yolande Allers
Social Worker

Previous communication:

I am Yolande Allers, a registered social worker and researcher employed at the Bethany House Trust Child and Youth Care Centre in Krugersdorp.

Close observation of children with mental health problems in a residential care setting in South Africa, led the undersigned to become acutely aware of the challenges associated with providing for these children's needs, and consequently managing their behaviour. A gap in service delivery was identified when specific programmes addressing the care needs of children with mental health problems in child and youth care centres, couldn't be found.
Based on the need for guidelines which may assist in addressing the care needs of children with mental health problems in child and youth care centres, the goal of the research study is: To provide a management programme to mainstream and specialized child and youth care centres, on how to care optimally for children with mental health problems. This means that children with mental health problems would be able to cope better with challenging life situations and adaptation in residential facilities. Ultimately their mental health status can improve. This would better the quality of life for all systems involved in child and youth care centres – from the individual child with a mental health problem, to the management of such a facility. Participating organisations will benefit from this research study by receiving updates on the programme to be developed, and implications for facilities in and around Gauteng.

In attaining the above goal, the undersigned call on employees (specifically social workers and child care workers), of child and youth care centres in Gauteng. The undersigned would appreciate your participation and ask you to kindly answer the following questions by replying to this e-mail:

4. At which child and youth care centre are you employed?

5. Do you have children in the child and youth care centre that has a mental health disorder? (For example: depression, attention deficit disorder, anxiety disorders, oppositional defiance disorder etc).

6. Would you be interested to partake in a focus group that will take place during May 2011? (Focus groups will be held in two or three areas around Gauteng. These groups will be held specifically for employees of child and youth care centres that work with children with mental disorders. Groups would focus on your opinions regarding the mentioned topic. Further information regarding the continuing of this study will also be addressed).

The dates and venues for the mentioned focus groups will be confirmed as soon as possible.

Thank you in advance.

Regards,
Yolande Allers
Social Worker
Invitation (e-mail) sent to residential psychiatric facilities/hospitals in Gauteng

Good day

I am Yolande Allers, a registered social worker and researcher employed at the Bethany House Trust Child and Youth Care Centre in Krugersdorp.

Close observation of children with mental health problems in a residential care setting in South Africa, led the undersigned to become acutely aware of the challenges associated with providing for these children's needs, and consequently managing their behaviour. A gap in service delivery was identified when specific programmes addressing the care needs of children with mental health problems in child and youth care centres, couldn't be found.

Based on the need for guidelines which may assist in addressing the care needs of children with mental health problems in child and youth care centres, the goal of the research study is: To provide a management programme to mainstream and specialized child and youth care centres, on how to care optimally for children with mental health problems. This means that children with mental health problems would be able to cope better with challenging life situations and adaptation in residential facilities. Ultimately their mental health status can improve. This would better the quality of life for all systems involved in child and youth care centres – from the individual child with a mental health problem, to the management of such a facility. Participating organisations will benefit from this research study by receiving updates on the programme to be developed, and implications for facilities in and around Gauteng.

In attaining the above goal, the undersigned called on employees of child and youth care centres in Gauteng. Focus groups will be run with a sample of social workers and child care workers who work with children with mental health problems in child and youth care centres.

The opinions of social workers employed at psychiatric hospitals that work with these children in a residential context (although temporary), would be of great value to this study.

Therefore the undersigned cordially invites you to join the focus groups that would be run on:
- 9 June 2011 (Krugersdorp area) and
- 10 June 2011 (Pretoria area).

Please confirm your availability for attendance.

Thank you in advance.

Regards,
Yolande Allers
Social Worker

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xxxi
Invitation for focus group 1 (e-mail) sent to residential facilities in Gauteng

Dear colleagues

Thank you for your interest in the focus group that will be conducted regarding children with mental health problems in child and youth care centres. Details for the group are as follow:

Date: 9 June 2011
Time: 9:30
Venue: The Bethany House Trust
19 Potgieter Street
Monument
Krugersdorp
R.S.V.P.: 3 June 2011

The purpose of the focus group is to share opinions that social workers and child care workers have regarding managing the care needs of children with mental health problems in child and youth care centres. Your opinions and knowledge would be highly appreciated and considered in the development of a initial programme on how to care optimally for such children in mainstream or specialised facilities.

Tea, coffee and light refreshments will be served.

Please confirm attendance.

Kind regards,
Yolande Allers
Social Worker

=================================================================================================
Invitation for focus group 2 (e-mail) sent to residential facilities in Gauteng

Dear colleagues

Thank you for your interest in the focus group that will be conducted regarding children with mental health problems in child and youth care centres. Details for the group are as follow:

Date: 9 June 2011
Time: 12:30
Venue: The Bethany House Trust
19 Potgieter Street
Monument
Krugersdorp
R.S.V.P.: 3 June 2011

The purpose of the focus group is to share opinions that social workers and child care workers have regarding managing the care needs of children with mental health problems in child and youth care centres. Your opinions and knowledge would be highly appreciated and considered in the development of a initial programme on how to care optimally for such children in mainstream or specialised facilities.

Tea, coffee and light refreshments will be served.

Please confirm attendance.

Kind regards,
Yolande Allers
Social Worker

_________________________________________________________________________________
Invitation for focus group 3 (e-mail) sent to residential facilities in Gauteng

Dear colleagues

Thank you for your interest in the focus group that will be conducted regarding children with mental health problems in child and youth care centres. Details for the group are as follows:

Date: 10 June 2011
Time: 10:00
Venue: Umephi Child and Youth Care Centre
1085 Hertzog Street
Villieria
Pretoria
R.S.V.P.: 3 June 2011

The purpose of the focus group is to share opinions that social workers and child care workers have regarding managing the care needs of children with mental health problems in child and youth care centres. Your opinions and knowledge would be highly appreciated and considered in the development of an initial programme on how to care optimally for such children in mainstream or specialised facilities.

Tea, coffee and light refreshments will be served.

Please confirm attendance.

Kind regards,
Yolande Allers
Social Worker
Good day colleagues

This is the final invitation for you to participate in focus groups that will be hosted by the undersigned regarding children with mental health problems in child and youth care centres. Details for the group are as follow:

Date: 9 June 2011
Time: 9:30
Venue: The Bethany House Trust
19 Potgieter Street
Monument
Krugersdorp
R.S.V.P.: 3 June 2011

or

Date: 9 June 2011
Time: 12:30
Venue: The Bethany House Trust
19 Potgieter Street
Monument
Krugersdorp
R.S.V.P.: 3 June 2011

or

Date: 10 June 2011
Time: 10:00
Venue: Umephi Child and Youth Care Centre
1085 Hertzog Street
Villieria
Pretoria
R.S.V.P.: 3 June 2011

The purpose of the focus group is to share opinions that social workers and child care workers have regarding managing the care needs of children with mental health problems in child and youth care centres. Your opinions and knowledge would be highly appreciated and considered in the development of an initial programme on how to care optimally for such children in mainstream or specialised facilities.

Tea, coffee and light refreshments will be served.

Please confirm attendance.

The undersigned would appreciate a reason for organisations not being interested in participating in this research project.

Kind regards,
Appendix E

Informed Consent Form
Informed Consent Form

Close observation of children with mental health problems in a residential care setting in South Africa, led the researcher (MA student at the University of Johannesburg) to become acutely aware of the challenges associated with providing for these children’s needs, and consequently managing their behaviour. A gap in service delivery was identified when specific programmes addressing the care needs of children with mental health problems in child and youth care centres couldn’t be found.

Based on the need for guidelines which may assist in improving the mental health of the children concerned in child and youth care centres, the goal of this research study was formulated as follows: \emph{To provide a management programme – summarising plans which contain guidelines to be conducted in a specific manner (Odendal, Schoonees, Swanepoel, DuToit & Booysen, 2004) - to mainstream and specialized child and youth care centres, on how to care optimally for children with mental disorders.}

The researcher aims to retrieve information on the opinions of certain key role players who work with children that have mental health problems in child and youth care centres on:

- the characteristics and emanating needs of these children,
- and effective ecosystemic guidelines that may provide for these needs.

Please note that participation in the focus groups are completely voluntary and can be terminated at any time. The biographical information of the participating social workers and child care workers, and the names of children discussed during the group, will not be published in the final research report. The name of the child and youth care centre will be used when referring to the opinions of a specific organisation. A video recording is made during implementation of the group for data collection purposes. These recordings are however kept confidential and private, and would not be published either.

The researcher may provide respondents of focus groups with a written summary of findings upon completion of the research study.

Regards,

Yolande Allers
Social Worker

Please complete your biographical details and sign on the following page:
Hereby I, ___________________________ give consent to partake in the focus groups. I acknowledge that I know what the study entails, and what I am consenting for.

Signature ___________________________ Date ___________________________
Appendix F
Declaration of language editor
Declaration of language editor

Hereby I declare that I have language edited and proofread the thesis Managing children with mental health disorders in child and youth care centres by Yolande Allers for the degree MA in Social Work.
I am a freelance language practitioner after a career as editor-in-chief at a leading publishing house.

Lambert Daniel Jacobs (BA Hons, MA, BD, MDiv)
14 October 2011