Chapter 2

Early Childhood Intervention

2.1 Introduction

To deal with a concept as comprehensive as early childhood intervention, it is necessary to make a selection of relevant information for the purposes and extent of this chapter. Firstly, the concept of *early childhood intervention* will be defined and then three of the major aspects that emerge from the definition will be described. These are *teamwork, family-centred childhood intervention* and *ecological context*. Further selections under each of the above-mentioned aspects, will be indicated in the text.

In terms of the broad lay out of the content, general information on each aspect will initially be given and then the application in terms of occupational therapy will follow. Application of the content to the South African milieu will also be dealt with throughout the text. Where applicable, evolution of practices will be indicated or the traditional will be compared with the contemporary.

2.2 Defining Early Childhood Intervention

The field of early childhood intervention is a complex and multifaceted one. It ultimately includes not only a variety of underlying assumptions, but also some very specific focus areas.

Shonkoff and Meisels[1] give the following underlying set of beliefs or assumptions that form the cornerstones upon which the idea of early childhood intervention is based. These assumptions are:

- that all living organisms are designed to adapt to their environment. The behaviour and developmental potential of the child (organism) is neither predetermined at birth by fixed genetic factors nor immutably limited by a strict critical period beyond which change is impossible.
- that it is only within a broad ecological context that the development of the young child is to be fully appreciated and understood. This assumption takes as its starting point a core understanding of the family as a dynamic system. From here it extends outwards to include the complex, interactive influences of the child's immediate community as well as the broader social, economic, and political environment in which he or she lives. All aspects of early childhood intervention take the above contextualisation as their starting points.
- that the nature of the field is such that it necessitates the introduction of an interdisciplinary approach to the problem. The range of developmental opportunities and challenges confronting the child and the consequent range of services and supports necessary to meet all the child's needs require the expertise of various professional disciplines.

Taking the above set of assumptions as starting point, Shonkoff and Meisels[1] give the following contemporary and comprehensive general definition of the field of early childhood intervention:

> "Early childhood intervention consists of multidisciplinary services provided to children from birth to 5 years of age to promote child health and well being, enhance emerging competencies, minimise developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning. These goals are accomplished by providing individualised developmental, educational, and therapeutic services for children in conjunction with mutually planned support for their families".

Farel provides a more concise definition, namely: "Early intervention means identifying and providing services to children who are at risk of having a handicap or who have other special needs that might impede their development".[10]

Grisworld states that early intervention addresses "...developmental, educational, and social needs of children, up to the age of 3, who have a disability or developmental delay... Services are family-centered, focusing on the needs of the family unit, not just the child's... In a family-centered model, family members are considered to be equal members of the team and participate in all aspects of planning the child's care..." .[11]

From the reading of the basic underlying assumptions and the resultant definitions of the field, three important concepts emerge that will be addressed further, namely:

- Teamwork
- The family
- Ecological context

2.3 Teamwork

2.3.1 The Importance of Teamwork

Early intervention can only be successful if it is placed within the context of a team approach in the health profession. Spencer and Coye[12] explicitly state that "...exemplary early services are necessarily performed by teams, since only teams can co-ordinate the many specialised efforts needed to address the complex issues of each situation". At the heart of this belief is the fact that all aspects of a child's development are interrelated and that service delivery therefore necessitates the input of all the team members. Individual roles may vary, depending on the unique needs of each child and family.

2.3.2 Types of Teamwork

Baloueff[13] describes three types of approaches that may be used, depending on the setting and availability of team members. These are the multi-, inter-, and transdisciplinary approaches. To these approaches Briggs[9] adds a fourth approach, namely the unidisciplinary approach. Although not necessarily a team approach, its usefulness will nevertheless be discussed.

- **The Unidisciplinary Approach**

  In this approach one professional or professional discipline is involved in service delivery. Should this approach be the preferred one in circumstances where the other approaches are available, it should be seen as an ineffective way of providing early childhood intervention. It would seem to assume that a professional or discipline could meet all the needs of the child or family.

  There could, however, be instances where a specific need and intervention are all that is required. In such cases this approach would be sufficient. Unavailability of multiprofessional teams in some rural areas may also necessitate the use of this approach as one professional may be all that is routinely available.

- **The Multi-disciplinary Approach**

  The multi-disciplinary team is described as a parallel approach as every professional works alongside to the others with limited interaction and exchange of information, opinions and expertise.[9] Even if there is consultation between professionals, there is still a lack of co-ordinated service delivery.[13]

- **The Interdisciplinary Approach**

  In this approach exchanges of information occur readily and programme planning is done to ensure an integrated service plan. Collaboration takes place and interpretation of the child's evaluation, diagnosis, goal setting and treatment is a shared responsibility. Professionals, however, still tend to practice within their own areas of

expertise. Some crossing of disciplinary boundaries may occur and two professionals may provide co-treatment. Briggs points out that in interdisciplinary teams, there is typically a strong appreciation of the contribution of the other team members and the family. She also points out, however, that ".... most professionals do not fully understand the exact nature of each other's professional practice".[9]

Fragmentation of services does still occur and cohesion is not fully established by the team members.

- **The Transdisciplinary Approach**

Briggs[9] states that certain key components must be present before a team can be considered to be transdisciplinary in nature. It is firstly necessary that more than one discipline be involved and that boundaries be flexible and interchangeable in order that an exchange of information, knowledge and skills can take place. Secondly, the team members' interaction must be characterised by collaboration, problem solving and decision making. All members of the team are involved in the planning and monitoring of a case, but not necessarily in service delivery. Thirdly, the family is regarded as an integral part of the team. The parents are thus involved in the assessment, planning, implementation and evaluation of the treatment, and they have the ultimate authority and decision-making power. Lastly, a co-ordinator who is responsible for the implementation of the treatment program, is appointed from the team for each case.

In the transdisciplinary approach, all team members are committed to teaching, learning and working across disciplinary boundaries. The intention of the transdisciplinary process is for individual members to add to their own experience by incorporating the information and skills, offered by other team members, into their own discipline repertoire. The transdisciplinary approach was, however, not intended to promote the development of a team in which each discipline member has the same skills or in which one discipline can be exchanged for another.

2.3.4 Members of the Team

The size of the team and the variety of specialists seem to be limited only by the needs of the community and the availability of funds and manpower. Spencer and Coye[12] describe the traditional team as consisting of physicians, educators, psychologists, nurses, social workers, speech therapists, occupational therapists and physiotherapists. It is felt that other specialists may be necessary to provide a more effective service. Baer, Blyler, Cloud and McCamman for instance, feel that the inclusion of dieticians and nutritionists are of paramount importance in the early childhood intervention team.[10] Where many of these specialists were traditionally confined to tertiary care centres or public health clinics, they need to become part of all community based early intervention teams. It is here that they can fulfil the much-needed function of providing preventative nutritional services to the children most vulnerable to nutritional defects. This argument would then also hold true for any other specialisation that might contribute to a more effective early childhood intervention team.

Another important category of worker in the community-based early intervention team is the so-called lay helpers or paraprofessionals. They are often part of the communities that they help to serve. They add a specific dimension to the early intervention team that is eloquently described by Specht, Hawkins and McGee: "I'm from the community I serve, I know most of the people, they know me. I know their problems because they are mine also, and I understand the poor people because I am one, and a part of them".[1] Apart from the obvious benefits to the community described above, these workers also increase the available manpower at a cost-effective rate. This could also serve to uplift the community by providing employment to some of its members.

The inclusion of the family as part of the whole process of early childhood intervention must be seen as one of the most important innovations in service provision and is advocated by most authorities in the field. In the past the family often felt alienated and resistant because they were not part of the whole process, or were only included at a later stage, thereby lacking insight into the rationale of the programme and what was expected from them. The importance of the family in the team and the professional-parent relationship will be discussed in more detail in 2.4 of this chapter.

2.3.5 Models of Teamwork

Rather than describing the different members of the early intervention team, McConkey[3] differentiates between the different models of teamwork for specific circumstances. He distinguishes between early intervention in developed and developing countries. In developed countries the services are mostly provided by teams consisting of professionals who see the child at clinics or day care centres. To prevent fragmentation and duplication of services, the team should have a case manager for each family to ensure that a coherent service is provided. Transdisciplinary training should enable the key workers to obtain the necessary skills and techniques from members not involved in the case, in order for them to provide an integrated service to the family.

In developing countries, however, the most popular and sustainable staffing model for community-based early intervention consists of project co-ordinators with a team of field workers. (*Field workers* correlates with *paraprofessionals / lay workers* discussed in 2.3.4) The project co-ordinators may be drawn from a range of professionals involved in early intervention. Their main role would be the training of the field workers, rather than direct service delivery. In this way larger numbers of families may be reached than with a team consisting mainly of professionals, situated in certain fixed venues.

In South Africa, which can be defined as a developed and developing country both the above models may be relevant, depending on where the intervention is taking place.

2.3.6 The Role of Occupational Therapy in Teamwork

2.3.6.1 Definition of Occupational Therapy

A definition of occupational therapy is given at this point to differentiate the domain of this profession from that of other team members. For this purpose the official definition, formulated by the American Occupational Therapy Association (AOTA) in 1972, is used.[13]

"Occupational therapy is the art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, diminish or correct pathology and to promote and maintain health. Its fundamental concern is the capacity, throughout the life span, to perform with satisfaction to self and others those tasks and roles essential to productive living and to the mastery of self and the environment".

The definition emphasises the therapeutic use of tasks, which is derived from self-care, school/work and play/leisure activities. It also indicates the importance of independent functioning of the individual, to the best of his ability, throughout life. The role of the occupational therapist is, through use of scientific knowledge and skills, to direct an individual or a group's participation in activities. Productivity and task satisfaction are important end products of activity participation.

In order to further clarify the unique role of the occupational therapist in the early intervention team, the definition of occupational therapy in early intervention as formulated by the AOTA in 1986, is added.[14]

"Occupational therapy personnel use purposeful activity in the development or restoration of function to help the child and family develop resources to meet personal needs and demands of the environment. The child's occupations of movement, play, eating, interaction with others, dressing, bathing and the like are the purposeful activities used in early childhood intervention to promote normal development and adaptive coping behaviours. Treatment stems from a

scientifically based neurophysiological framework. Services are provided to help parents in their roles as providers and primary care givers. Treatment may be provided in conjunction with other disciplines and professionals.... Occupational therapy in early intervention promotes independent function and adaptive interaction with the environment through the use of age appropriate, purposeful activity".

In both the afore mentioned definitions the scientific base of occupational therapy, use of activities in treatment and independent functioning of the individual in performance areas are emphasised. The definition on occupational therapy in early intervention, however, adds the importance of teamwork and especially the inclusion of the family in the intervention process. This is deemed to be of paramount importance as was will be further highlighted in 2.4.

2.3.6.2 Scope of Occupational Therapy in Early Childhood Intervention

The scope of occupational therapy in early intervention has been clearly indicated in the United States of America with the adoption of the Public Law "The Education of the Handicapped Acts Amendments" in 1986.[15] This has brought about a significant shift from service delivery previously provided to infants and toddlers, mostly in hospital settings and special schools, to a comprehensive system directed at meeting the needs of children and their families in the community. Within this broad scope, the occupational therapist plays a pivotal role in the professional team involved in early intervention, where the "...role of occupational therapy is to facilitate the independent functioning of infants and toddlers and their families".[16]

Directed by the policies in the Public Law, the occupational therapists in the U.S.A. took the lead in broadening and formulating the scope of occupational therapy in early intervention. Central to this process, the needs of the family were constantly considered. In a Position Paper that was published in 1988, the following was stated: "AOTA supports a family-focussed approach to early intervention and preschool services. When families' needs are successfully addressed, children make more progress".[17]
Within this frame of reference, and based on the Public Law, the following parameters for occupational therapy in early intervention were stipulated:[15]

- **General Parameters**
  - Developmental needs of the child, and family needs related to enhancing the child's development, should be addressed.
  - Service provision should be in accordance with other service providers, parents and the appropriate community.
  - Location of services should be, to the extent appropriate, provided in the type of setting in which children without handicaps would participate.
  - Training of parents and others regarding the provision of services should be done.
  - Assessments and setting of goals for treatment and outcome should be integrated in teamwork.

- **Parameters According to the Definition of Occupational Therapy**
  - Identification, assessment and treatment of performance areas and components should be designed to improve the child's functional ability to perform tasks in home, school and community settings.
  - Adaptation to tasks and environments should be performed to facilitate development and promote the acquisition of functional skills.
  - Prevention or minimisation of the impact of delay in development or impairment.

- **Population for Early Intervention**
  - Infants and toddlers from birth through age two who need early intervention because they:
  - experience developmental delays as measured by the appropriate diagnostic instruments.
  - have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

- **Family-Centred Services**
  - The family should be an interactive process between the professional and the family members.
  - An individualised family service plan should be created.
  - Case management should be conducted to co-ordinate the services of team members and other agencies in the provision of needed services.

Although these parameters can be regarded as universal for occupational therapy in early intervention, specific national circumstances need to be taken into consideration in the application of these strategies. The political, cultural and economic factors of a specific country will have an effect on the application of service provision. In South Africa, many under two year old children who are in need of early intervention do not receive sufficient remedial help at this early age. The age for early intervention was thus extended to six years for the purposes of the proposed M ECI. The training and skills of occupational therapists in a specific country would also affect the application of early intervention strategies. It is important for the purposes of the current study to investigate the differences and circumstances which prevail in South Africa and which could influence occupational therapists in adhering to the scope as presented by the AOTA. A closer look at the circumstances in this country is taken in 2.5 of this chapter.

2.4 Family-Centred Early Childhood Intervention

2.4.1 Service Delivery Models

Contemporary literature on early intervention abounds with information on the importance and implementation of family-centred services. A leading author such as Blackman finds it amazing that while the family has been the cornerstone of society for centuries, and everybody has been part of a family themselves, the role of the family needed be rediscovered by professionals. He poses the question: "With such universal expertise, why has the recent emphasis on family-centred care seem so novel and required such a reordering of how we behave professionally?"[18]

The fact of the matter is that professionals have used service delivery models in the past, which have excluded the parents from direct involvement in the programme for their child. Baird and McConachie describe some of the traditional models in use:[3]

- **The Expert Model**

In this model the professional is seen as having all the expert skills to design and carry out the programme. A predetermined assessment method is used and the professionals determine the child and family's level of functioning. That leaves the family out of the process, with the result that the parents are deskilled and left powerless to make decisions that may affect their child. This model correlates with the *medical model* that is described by Bazyk.[19]

- **The Transplant Model**

The professional designs the programme and provide recommendations and strategies that they believe will be beneficial to the family. The model assumes that the professional is a good teacher and that the parents are capable of following the instructions. Dependency on the professional's skills still prevails and decision-making and interventions are not required from the family. Family differences are often not taken into account in the prescribed programme

- **The Partnership Model**

Parents become part of the goal-setting process and the needs of the child and family within their wider social context is taken into account in the programme. The parents' confidence is developed in dealing with service systems and they feel more empowered to take responsibility.

Although parents are becoming more involved to varying degrees in the above models, they still complain about confusing and conflicting advice that they get from multiple professionals. This is the result of a lack of communication between the various team members and needs to be addressed urgently, as parents are still left feeling helpless and confused about what the best decisions would be concerning the best services for their child. Briggs[9] highlights this problem in a reference to a family where the parents received excellent advice from the different professionals but, because of a lack of communication in the team, were in the end still left with the question, "So now what do we do?"[9]

The answer seems to be the incorporation of the family into the team. This approach demands a new way of service delivery and an adaptation from previous practices. Leviton, Mueller and Kauffman suggest that converting "...traditional service systems to a model based on family-centred care will necessitate changes in the roles of professionals, as well as in the practices of agencies working with families."[18] As was the case with developing a transdisciplinary team approach, this does not happen easily or automatically. A team will have to make a concerted effort and follow the necessary steps, including training, to achieve a truly family-centred approach.

According to Levinton et al.,[18] a true family-centred approach would entail all the following characteristics with regard to assessment, planning and service delivery:

- **Assessment**

The relationship between professionals and the family begin by jointly providing information to assist parents in making informed decisions about which services they would like to receive. Family-needs assessments can be used to assist in the phase. Assessments are not predetermined but are chosen for each family, with the parents fully involved in the process.

- **Planning**

The professionals and parents jointly explore a variety of options for achieving goals. The professionals give information but refrain from making specific recommendations, allowing the parents to formulate the goals and strategies that they feel will be most beneficial to their needs.

- **Service delivery**

Professionals act on the goals and strategies that the parents have decided on. Professionals may provide a range of services including training, therapy, advocacy, support, information and co-ordination, depending on the request of the family. These

may change during the service delivery process in accordance with the parents' needs and decisions.

When all the characteristics of a family-centred approach are considered, it is the contention of the researcher that few early intervention teams in South Africa adhere to all of these. It would necessitate specific intervention institutions and teams representing a complete spectrum of professionals to develop a family-centred approach that would incorporate all the requirements. Not many such settings are found in this country. As will be seen in the next section, the efficacy of a family-centred approach has been proved such that it is desirable to strive towards such a situation.

2.4.2 Effectiveness of Family-Centred Early Childhood Intervention

As the theory on family participation was being translated into practice, various research initiatives were launched to determine the effectiveness of family-centred programmes. In a 1987 study Shonkoff and Hauser-Cram[20] found that not only was parent participation effective, but that the extent and type of involvement has emerged as a strong predictor of child-outcome. Gwalnick's[21] review of the efficacy research on family involvement in early intervention, indicated that the one factor that best differentiated the more successful interventions was the extent to which the interventions were aimed at supporting and enhancing the roles of families as competent caregivers of their children.

These and other similar research findings emphasise the advantage of the family-centred approach where the family is empowered and given a sense of competence, over the traditional approaches where the family was left with a sense of helplessness and dependency.

2.4.3 Occupational Therapy in Family-Centred Early Childhood Intervention

Bazyk[19] states that the occupational therapist's traditional positioning within the medical model (called *expert model* by Baird and McConachie[3]) resulted in limited parent participation. The occupational therapist was regarded as a professional with the knowledge and expertise to plan, set goals for treatment, make decisions and bring about change in the child. As was the case in the medical model, the parents were passive recipients and became dependent on the therapist. They doubted their own abilities to help their child's development and their feelings of helplessness often elicited resentment towards the intervention programme, the therapist, or both. Neither of these resulted in effective intervention for the child.

Bazyk regards the enactment of the Public Law in the U.S.A. as providing the impetus for change in the attitude towards the inclusion of parents in the treatment strategy, as it "…. provided a legal mandate for parents to be included as an integral part of the child's educational programme and defined their participatory rights".[19] In addition to the legal advances, a shift also occurred wherein professionals started to listen to the needs of parents regarding the management of their children. Bazyk feels that occupational therapists have evolved over the past two decades and have largely incorporated the idea that the focus should shift from the traditional therapist centred to a more therapist-parent centred approach to treatment. In the latter approach parents and professionals need to collaborate as equals, as was described in the partnership model in 2.4.1.

Together with the increased awareness of the significance of parental participation in treatment, clinicians like Henderson, Lawlor and Pehoski expressed concern regarding the occupational therapist's lack of knowledge concerning parenting and the family.[22] They feel that therapists were competent clinicians who were familiar with the effect of disability on the child's development, but lacked knowledge of the effect of disability on the parent-child relationship and the family.

Bazyk[19] stipulated six guidelines for occupational therapists in developing family-centred programmes:

- **The Parent as Decision-maker.**

The therapist must use her knowledge of intervention strategies to enable the parent to acquire the knowledge and skills needed to care for their children with special needs. The parents must be put in control of the process while the therapist remains the service provider. The role of the therapist shifts to being consultant and providing support, while the parents are being empowered to build resilience, develop an internal locus of control and take responsibility for their child's development and well being.

- **Support of Parental Role Development Versus Role of the Parent as Therapist.**

The therapist must acknowledge all the other roles that parents must assume and not expect them to become a therapist. In this regard Case-Smith points out that the, "...aim is to help parents build a repertoire of skills for successful interaction with and greater enjoyment of their children".[16] Parents need to enjoy their children.

- **Collaborative Home Treatment Programmes**

The process of parent training, which traditionally implied a one-way interaction of teaching the parent, should change to parent-professional collaboration. Whereas the therapist has the expert knowledge on intervention strategies, e.g. to improve dressing, positioning, play, etc., it is the parent who has an intimate knowledge of the child's preferences and routines as well as the overall circumstances at home. With this in mind, collaboration means ".... a two-way sharing of this information to successfully identify the best intervention activities for the child and the family".[19]

- **Differences in Collaboration with Families**.

Due to each family's unique composition and needs, collaboration will differ in degree and type. The therapist should take the preferences and needs of parents into consideration when the intervention programme is compiled, in order to avoid frustration if the parents do not meet the therapist's expectation. This will, to a large extent, avoid

labelling parents as being non-compliant should they not always comply with the demands of the programme. When the therapist assumes that the parents will take responsibility and control for their child's progress, she should also respect their choice in the amount of time they spend on intervention strategies at home. To avoid later frustration it is therefore imperative to involve them from the onset in all aspects of the programme, including its management.

- **Options for Parents**

When parents are involved in intervention strategies, they often come up with unique and creative ways of solving their child's problems. This should be encouraged as it enhances the parents' sense of control and confidence, not only in their ability to take care of their child, but also in their contribution to the formal treatment programme.

Diversity in teaching methods and communication styles are very important if the above goals are to be achieved. Parents, who do not understand what the therapist is suggesting, are often left with a greater sense of helplessness and even guilt feelings. Taking the parents' preferences into account, the therapist has various techniques at her disposal to convey the needed information. Modelling, verbal explanations or drawings are all ways in which she can impart the necessary information.

- **Consideration of the Child's Needs.**

It is ultimately the child's special needs and interests that should be at the heart of the intervention process. The child must be viewed as part of the family in a specific community, and must be prepared to assume his life roles to the best of his abilities.

Occupational roles expand as the child grows older and the better he is prepared for these, the more will he be able to assume control and responsibility for his own life. To enhance this process, the child's strengths should be emphasised and his own decision-making skills developed. It is imperative to foster a sense of confidence and assertiveness in the child.

Other authors who have contributed to the process of bringing the family-centred approach closer to home for occupational therapy are Schaaf and Mulrooney. They linked the family-centred approach to a more familiar one in occupational therapy, namely Gary Kielhofner's Model of Human Occupation. They state that Kielhofner's model "...provides therapists with a systematic approach to understanding and working with the values, needs and skills of the family and child within their many environments".[23]

In Kielhofner's model, the environment and the manner in which the individual is influenced by the pattern of interaction with the physical and social surround, is emphasised. The environment in which a family lives and functions should be taken into account, as both the individual's characteristics and the environment influence choices and behaviour. Schaaf and Gitlin[14] support this viewpoint and emphasise that not only should programmes be family specific to be meaningful and effective, but they should capture the cultural diversity and the specific environmental concerns of each family.

Due to the holistic viewpoint of the client and his surroundings, which has always been a cornerstone of occupational therapy, the researcher is of the opinion that the occupational therapist at an advantage to implement the afore-mentioned guidelines during intervention in order to obtain a family-centred approach. In the next section on the ecological context, concepts such as human diversity, economic, political and other environmental issues will be discussed.

2.5 The Ecological Context

As was emphasised in Kielhofner's Model of Human Occupation[23], the ecological context in which early intervention services are to be delivered, is important due to the major influence the physical and social milieu has on human development. Garbarino and Ganzel define ecology as "...the study of relationships between organisms and environments...(and)...how the individual and habitat shape the development of each other".[1]

It is beyond the scope of this study to do justice to the complex and multifaceted nature of the individual and the environment, and the intricate and varied interaction between the two. A brief description will therefore be given of the various factors that influence the individual and the environment, in order to give an overview of the important factors that need to be considered. National policy and community involvement in South Africa will also be discussed in more detail, as any proposed training curriculum for early childhood intervention can only be effective if these aspects are considered and included in such programmes.

2.5.1 Factors Related to the Ecological Context

Masagatani[13] divides the environment into two categories, namely the human and non-human environments. As is the case with the description of many complex constructs, these classifications are neither mutually exclusive, nor does the total of sub-categories express the final potential of the categories. It remains a useful way, however, to categorise the multiple and dynamic processes involved in the ecological context and assists in easier identification and explanation.

- **Human environment**

The human environment consists of the individual and of groups. The individual has a specific biophysical status comprised of characteristics such as age, gender, genetic and ethnical background. These constitute the individual's unique identity. The individual is also endowed with a sensory-motor, cognitive and psychological make-up that allows him to interact with the environment. The experiences and opportunities that are encountered in its lifetime influence the way in which the individual's potential develops, or is restricted.

Because humans are interactively and socially inclined, the formation of groups occurs as a logical consequence thereof and each individual will belong to a myriad of groups in its lifetime. The family forms the primary group to which the individual belongs and is instrumental in its acquisition of language, religious and cultural values and psychological development. Socio-political realities necessitate that the family extends into larger groups that will eventually

comprise the community in which the individual must function. The individual thus becomes part of a social environment.

- **Non-human environment**

The non-human environment is comprised of physical conditions, things and ideas.[13] Demographic boundaries, housing, availability of work and schools, food, furniture, toys, etc. are all part of the physical world in which the individual and groups must make a living. There is a reciprocal influence between these various components, like economic status and the availability of the necessities for optimum development. Political ideation and the way in which it is administered, has a profound overall influence on the non-human and thus the human environment.

In an ideal world all these factors would work together in a harmonious way to create a environment that is conducive to health and development. In a society where "...humans can relate to human and non-human environments in a self-directed, purposeful, satisfying and meaningful way... they achieve and maintain a state of health".[13]

In South Africa with its current conflict, crime and poverty, health and development is seriously compromised. Prevalent factors such as the high percentage of the population afflicted with AIDS, the large number of homeless or abused children and the disintegration of families through divorce or crime related deaths, add additional stress to all members of society. It has a detrimental effect on the socio-economic status of a large portion of the population, which renders them helpless and dependent on others for help. This has serious implications for the health and well-being of the child.[24]

Any venture that attempts to make a significant difference through early childhood intervention, will have to take these circumstances into account. National policy on the child and community involvement needs to be discussed further with regards their relevance to the ecological context in South Africa.

2.5.2 National Policy on the Child

2.5.2.1 Strategies, Programmes and Services.

Since the general election in South Africa in 1994, national reconstruction of government services was undertaken. With regards the welfare of the child, the ratification of the Convention on the Rights of the Child (CRC) in June 1995,"...committed South Africa to implement a first call for children, whereby the needs of children are considered paramount throughout the government's policies, developmental strategies, programmes and services".[25]

The government subsequently sought to bring legislation, policy and practice in line with the requirements of the CRC. This is reflected in the Bill of Rights of the Constitution in 1996, which deals specifically with the rights of children.[26] Among others, these include the right to parental or appropriate alternative care, the right to basic nutrition, shelter, basic health care and social services, and the right to be protected from maltreatment, neglect, abuse or degradation. In addition to the rights of the child, the government has also adopted a set of principles for protection of children. These principles correlate to an extent with the policies in the Public Law, which was adopted in the USA in 1986 (refer to 2.3.6.2). These principles are:[26]

- **Diversity**
  Services to children, their families and communities should respond to the diversity of their cultural background and of the circumstances in which the child, family and community find themselves.
- **Accountability**
  Everyone who intervenes with children and their families should be held accountable for the delivery of an appropriate and quality service.

- **Empowerment**

  The resourcefulness of each child and his/her family should be promoted by providing opportunities to use and build their own capacity and support networks and to act on their choices and sense of responsibility.

- **Participation**

  Children and their families should be actively involved in all the stages of the intervention process.

- **Family-centred**

  Support and capacity building should be provided through regular developmental assessment and programs, which strengthen the families' development over time.

- **Services**

  Children and their families should have access to a range of differentiated services and/or programmes appropriate to their individual development and therapeutic needs.

- **Integration**

  Services to children and their families should be holistic, inter-sectoral and delivered by an appropriate multi-disciplinary team wherever possible

- **Continuity of Care**

  The changing social, emotional, physical, cognitive and cultural needs of children and their families should be recognised and addressed throughout the intervention process.

- **Effective and Efficient**

  Service provision to children and their families should be rendered in the most effective and efficient way possible

- **Child Centred**

  Positive developmental experiences, support and capacity building should be ensured through regular developmental assessment and programmes that strengthen the child's development over time.

- **Rights of Children**

  The rights of children as established in the CRC, African Children's Charter and The Constitution shall be protected.

- **Restorative Justice**

  The approach to children in conflict with the law should focus on restoring societal harmony. A child older than seven years is criminally responsible and should be held accountable for his or her actions and where possible make amends to the victim.

- **Appropriateness**

  All services to children and their families should be the most appropriate for the individual, the family and the community.

- **Family Preservation**

  All services should prioritise the goal to have children remain within the family and/or community context wherever possible. When a child is placed in alternative care, services should aim to retain and support communication and relationships between the child and his/her family (unless proven to not be in the child's best interests), and maximise the time which the child spends in the care of his/her family.

- **Permanency Planning**

  Every child in alternative care should be provided within the shortest time possible with the opportunity to build and maintain lifetime relationships within a family and/or community context.

In April 1996, the cabinet also approved the National Programme of Action for Children (NPA) as the instrument by which South Africa's commitments to children are being carried out. It serves to integrate all the policies and plans developed by government departments and non-government organisations (NGO's) with regard to children.[26]

One of the important strategies that have been developed to address the needs of young children in South Africa, is the Early Childhood Development (ECD) program. This is spearheaded by the

Departement of Education and its aims are to provide a comprehensive programme covering the development of all children from birth to nine years of age.[27]

Education and health are addressed in the White Paper on An Integrated National Disability Strategy in 1997.[28] The health policy needs to be addressed here as it has important implications for early childhood intervention. As far as health care is concerned, it is declared in the White Paper that prevention is one of the cornerstones of the disability policy. It is, however, stated that certain problem areas that cause failure to prevent disabilities are encountered. Government strategies for the prevention of disabilities are often not successful, mainly because of a lack of co-ordination between government departments. Existing prevention policies are also not effectively linked to identification and early intervention. Where disabilities are already identified, services should include general medical and nursing assistance on an in-patient, out-patient or community home-care basis. Specialised health professional assistance should also be available. The White Paper states that the Disabled People's Organisations' involvement in the facilitation of public educational programmes, early identification and referral is of paramount importance. NGO's would play an important role in this process.[28]

To supplement the CRC, The African Children's Charter (ACC) was ratified in January 2000. The ACC was inspired specifically by the unique factors affecting the African child, such as poverty, exploitation, armed conflict and natural disasters. As circumstances seem to worsen for the child in this country, the ACC is seen as an important instrument to advance the implementation of the CRC in communities.[26]

2.5.2.2 Problems Facing Early Childhood Intervention Strategies

In spite of well-intended ideations and strategies on a national level, the circumstances surrounding the majority of children in South Africa is still deplorable.

In a publication of the NPA in 2000[24], the following problems are highlighted: "It is estimated that 5% to 12% of South Africans are moderately to severely disabled. More than 80% of black children with disabilities live in extreme poverty, and have poor access to appropriate health care

facilities, or early childhood development opportunities. The HIV/AIDS pandemic is having a devastating impact on South Africa. The epidemic is growing rapidly, with over 1,500 new infections daily. It is estimated that 21% of HIV/AIDS sufferers are younger than 20 years old. This situation places great stress on families, households and children".[24]

A strong concern for the growing severity of child abuse, neglect and exploitation is expressed in the Draft Strategy on Child Protection in South Africa. "While these problems appear to be spiralling, our countries protection system is in disarray".[26] The increasing violence and crime that the country is exposed to, only increase the stress placed on the families and children.

While the above-mentioned circumstances worsen, the available professional help for children in need is being compromised by a decrease in the number of occupational therapists working in the public sector posts over the past few years. If the Gauteng Province could be taken as an example, there has been a steady increase in the vacancy of posts since 1995. For 24 hospitals in the Gauteng Province, the vacancy rate in 1995 was 15,7% and it has steadily increased to 32.9% in 2001. Statistics on 10 institutions which provide community services indicate an even greater vacancy rate with a current 42.3% vacant posts in 2001.Lack of available funds to fill the posts seems to be one of the problems leading to the vacancy of posts.[29] While the government seems to be economising on posts, the problems surrounding the child in need are mounting.

2.5.3 Community Involvement

The importance of considering the child in his community has been emphasised throughout this chapter. Shonkoff and Meisels[1] based their second assumption for early intervention on the influence of the environment on the child and the family (refer to 2.2). Kielhofner's Model of Human Occupation[30] further emphasises the role of the physical and social surround on the functioning of the individual in the community. The ecological context and the variety of factors that influence the child and the family in their specific community, should always be regarded in intervention.

Although the significance of the environment on an individual's functioning is widely recognised and the term *community* is often used in the literature, a specific definition of the concept is seldom given. The meaning is either regarded to be universally known, or it is too evasive to be easily defined. Establishing a clarification of the term is important for communication purposes in this study, as the term is often associated in South Africa with only one group of society, namely the underdeveloped, poor, previously disadvantaged and rural population.

Turning to the dictionary definition a variety of uses is found. It can refer to all the people living in a specific locality, joint ownership, fellowship of interests, people organised into a unity, or people sharing a common race, religion, pursuits, etc.[31] As is seen from this definition everybody belongs to one or more community(ies) as part of their daily living. Through the primary family group, the members belong to different communities such as the neighbourhood, workplace, school, country, etc.

When community involvement in terms of rehabilitation or service delivery is addressed, specific terminology also needs to be defined. A concept such as *Community-Based Rehabilitation* (CBR) has been defined by the World Health Organisation as "...a systematized approach to helping disabled persons within their own community, making the best use of local resources, and helping the community to become aware of their responsibility in this regard".[32] Even with such a specific definition available, authors such as Chaudhury, Menon-Sen and Zinkin feel that many different interpretations of the term still exist and that the reader is often left to gather the meaning of the term by deduction, according to the content that is presented under the term.[3]

In terms of *community-based service delivery*, Baloueff describes services as such when their "...location and structure vary with the characteristics of that community, such as geographic setting (rural, urban and so on), the needs of the population served, the community resources and the goal of the services".[13] Adoption of a comprehensive description of community-based service delivery such as the above, would help to rectify the possible misconception in South Africa that the term *communities* should only be narrowed down to specific groups or societies.

2.6 Conclusion

The three major concepts in this chapter were derived from the definitions given on early childhood intervention in 2.2. These were teamwork, family-centred intervention and the ecological context.

Regarding teamwork the literature pointed towards the transdisciplinary approach as the most effected method to deal with the complex and multifaceted process of early intervention. It was also evident that it requires a concerted effort from team members to change from more traditional approaches to a transdisciplinary approach. Team building methods should be implemented to reach *shared meaning*, as was described by Briggs.[9] Professionals in the team should be prepared to work across disciplinary boundaries and multiskilling is another challenge that need to be faced by all team members. The transdisciplinary team also incorporates the family into the team and collaboration should be done on a regular basis to involve each member in the intervention process.

Contemporary literature on early childhood intervention focuses sharply on the family. To the astonishment of Blackman[18], it is as if the role of the family had to be re-established, while it should have been the pivotal point in the intervention process all along. Gwalnick's[20] review of the efficacy research on family involvement in early intervention indicated an overall positive result.

Although the importance of active family participation in early intervention is widely acknowledged by occupational therapists, researchers such as Henderson, Lawlor and Pehoski[21] expressed concern regarding therapists' knowledge on family dynamics. Along with the rest of the team, the occupational therapist will also have to make vigorous efforts to learn more about the family and involve the family in all the intervention processes.

The importance of the ecological context was considered and an overview of the national policy on the child was given in order to narrow it down to the South African context. It is the researcher's experience that the term *community* is often used only to indicate a certain part of the population and the term was therefore defined. It became clear that each family belongs to one or

more community(ies) and that all the members of the family should be considered against these different backgrounds.

From Baloueff's[13] description, it is also clear that there are many factors that need to be considered in community-based services. Only the transdisciplinary team, as was indicated in 2.3, can effectively deliver a holistic and multifaceted program that would meet all these requirements. In South Africa, especially in the rural areas, such teams are often not available. Team members that are available are often expected to operate in a transdisciplinary fashion, although they might in actual fact be in a unidisciplinary situation. The occupational therapist, due to her holistic approach to treatment and her diversity of skills, is a valuable member of the team for service delivery under these circumstances.

When the extreme circumstances, described in 2.5.3.2, are further taken into account, it is clear that an attempt at early childhood intervention in communities where these factors are prevalent, is a daunting task. One of the factors mentioned in 2.5.3.2, is the vacancy of posts in the public sector. The occupational therapist has traditionally provided services to infants and toddlers in centre-based locations like hospitals, clinics and special schools as part of an interdisciplinary team. Although this was not necessarily the ideal situation by which to address the problems of all the children in need of early intervention, services were more readily available. Due to the vacancy of posts in the public sector, the large underprivileged section of the population for which legislation and national strategies are intended, are currently even more deprived of specialised services than before.

2.7 Summary

In this chapter a literature review was given on early childhood intervention. Different definitions were considered and from these, the major concepts of teamwork, family-centred intervention and the importance of the ecological context emerged. Each of these concepts was subsequently again reviewed.

Teamwork was discussed with regard to the importance, types and models of teamwork. The different members of the team and the process of team building were also specified. The role of the occupational therapist in the team was discussed in more detail. The definition of occupational therapy demarcated the contribution of the occupational therapist in the team and this was then expanded on in a discussion on the scope of occupational therapy in early childhood intervention.

The importance of a family-centred approach in early childhood intervention was highlighted in the literature review. Different service delivery models and the effectiveness of a family-centred approach in early childhood intervention were discussed. The role of the occupational therapist in a family-centred approach was emphasised and the need for integration of the family during intervention was advocated.

The ecological context was considered and the different factors related to ecology were specified. It is of importance for therapists to take cognisance of the circumstances in South Africa. An overview on the national policy on the child was thus given in this chapter. Issues related to community involvement were also discussed.