**The Mentally Handicapped Child in the Smith Mitchell Organisation**

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The management of the mentally handicapped child offers an exciting challenge to many in the clinical field. Yet it is a field beset by enormous conceptual and practical problems. Society's approach to the mentally handicapped has travelled a long road, beginning with the era of extermination during early Greek and Roman civilisations to the present day which sees a renewal of interest and research in various fields, especially in the educational field. Scandinavia leads the field in the provision for the care of the mentally handicapped, in its normalisation and integration of the mentally handicapped into the community. South Africa has a short history compared to other Western countries and mental handicap forms an integral part of psychiatric services in this country.

The mentally handicapped child has many problems, primarily related to his ability to learn. The child shows a lack of the inner motivation to learn, and inherently poor psychic activity which encompasses limited mental activity, curiosity and desire to explore. Additional barriers to the learning process are cognitive deficits, attention disorders, sensory defects, perceptual-motor problems, poor acquisition and retention of memory, poor discriminatory ability and lack of involvement in reality. The child is loath to attempt learning and when he/she does, is largely unable to succeed. In the learning process of a normal child, the experience of mastering something creates the desire to learn more. This process is severely hampered in the mentally handicapped child since the expectation is one of failure.

Zubeck's (Joubert, 1982, p. 14) experiments with the effect of sensory deprivation on a person's motivation may lead one to conclude that the mentally handicapped child who has an abnormal threshold for sensory perception and decreased curiosity and who 'reacts less readily to external stimuli' (Steenkamp & Steenkamp, 1981, p. 14), in fact suffers sensory deprivation. The integration of sensory input is affected with resultant deficits in sensory motor skills, perceptual motor ability and higher cognitive functioning. These insights should provide an important starting point in the management of the mentally handicapped child. It should be borne in mind that such children are multi-factorially disabled and therefore require a multi-professional approach. An holistic approach is of cardinal importance since it enables one to view the mentally handicapped as, above all else, children with needs similar to those of other children.

Introducing and maintaining a dynamic activation programme for large numbers of hospitalised mentally handicapped children is, in many respects, like participating in an obstacle course, with barriers, dead end streets, tunnels and high jumps! There are various problems confronting one - these may be 'people problems' (either patients or staff) and they are also to be found in the very nature of institutionalisation and separation of the sick child from his family, or they may be caused by limited community resources to cater for future placement of the multiply handicapped child.

The Occupational Therapist, faced with the daunting list of problems of the mentally handicapped child, as well as having to cope with a few hundred such children on differing levels of ability may ask: "Where do I begin?" The therapist has the privilege and responsibility of giving direction to the activity programme, of introducing a comprehensive programme dealing with as many of the above problems as possible, as well as having to assist other team members in the task of encouraging the child's participation in activities.

A few years have passed since the Occupational Therapists in the Smith Mitchell Organisation started working, often on a trial and error basis, with mentally handicapped children. As in the case of adult psychiatric patients, the following four step procedure was followed: firstly, evaluation; secondly, programming; thirdly, programme maintenance; and fourthly, programme development.

**EVALUATION**

The children are assessed and grouped, taking staff and other resources into account. The main aim should be the formation of homogeneous groups comprising manageable numbers. A group leader expected to manage 25 profoundly mentally handicapped children all day long soon becomes discouraged; one should therefore attempt to keep the groups (particularly the lower level groups) as small as possible.

An evaluation method based on levels of creativity has been devised and has been found to be not only time-effective but also a reliable guideline for grouping children and adults.

This form is filled in by the Occupational Therapist (assisted by the group leader who has more intimate knowledge of the child) and once this has been done, the groups are formed and relevant programmes drawn up for each. This evaluation method may also be used for screening candidates for a school-related programme.

**OCCUPATIONAL THERAPY REPORT FORM**

Name: Date:

Age: Sex: Group:

Assessed by:

**General Level of Activity Participation:**

**Unconstructive/Pre-constructive Level - Lower Level**

Cannot do tasks or make a product. Does not understand what he must do. Picks up materials or objects and is unable to use them in a constructive manner, e.g., drops the article, chews it, breaks it, etc. Does not make contact with people, usually does not even look at them.

**Constructive/Explorative Level - Middle Level**

He is prepared to do some activities and to handle the materials/equipment. He usually uses these incorrectly, makes mistakes, works carelessly or does not finish what he started doing. When he is praised for trying to do the task, he is often pleased and this encourages him. He does appear interested in people and looks at them and tries to communicate verbally or non-verbally.

**Norm Awareness Level - Higher Level**

He has some idea of how to do tasks correctly. He still makes mistakes but usually tries his best to follow instructions or to work neatly. He tries to behave appropriately and to communicate with others.

**Norm Compliance Level - Higher Level**

He knows how to do various tasks and follows instructions well. He is fairly reliable and helpful, usually completes what he started doing, works neatly and can do activities for ± 1 to 2 hours without stopping in-between. He behaves in an appropriate manner and gets on fairly well with other people.

**PROGRAMMING**

Programmes for each group are drawn up bearing in mind that the following should be catered for:

* self-care skills, including feeding, dressing and toileting;
* communication skills, non-verbal and verbal;
* social skills;
* sensory input and sensory integration programmes which form an important part of the programme for those on middle and lower levels, and provide additional sensory input in order to improve sensory integration;
* perceptual-motor skills, covering the gamut of body image, auditory, visual, tactile and haptic perception, fine and gross motor skills;
* academic skills appropriate for those on norm-awareness and norm-compliance levels;
* leisure time and recreational skills, including art, music, hobbies, sport and games;
* domestic usefulness and vocational skills, relevant for those on the 2 higher levels of ability.

Provided these programmes are based on principles applying to each level of creativity, the Occupational Therapist may feel confident that a group's programme is correct and therapeutic for most of the children in that group. This is the most one can realistically hope for when dealing with large numbers of patients with very little opportunity for individual, specialised therapy.

The following activities may be used selectively for lower, middle and higher level groups: 'tender love and care' (cuddle time and communication); independence training (self-care, habit training); sensory stimulation (visual, auditory, tactile, haptic, olfactory); rock 'n roll (sensory integration); music therapy (listening to and making music, awareness of rhythm); developmental play (with toys); sandpit and water play (including swimming); mobility training, obstacle course and playground equipment; Trim Gym (rhythmic exercises); talks and environmental awareness; concept training; art; baking; sewing; gardening; outdoor games; sport activities; beauty parlour; perceptual training; academic training (writing, reading, arithmetic); vocational training (e.g. simple handcrafts); care of pets; daily orientation; tribal dancing; story time; birthday parties; church services/ Sunday school; physiotherapy; TV; evening recreation; horse riding; hospital braai and games; and outings for selected patients.

**MAINTENANCE**

It is vital that this programme be maintained as a daily, ongoing part of the hospital programme. If an activity is not flourishing, this is often because the Occupational Therapist has not obtained a nurse's interest and cooperation, or her orientation to a particular programme or activity is inadequate.

**PROGRAMME DEVELOPMENT**

Future developments are anticipated, such as vocational training programmes for older children who need to be transferred to adult sections of the hospital or who may be eligible for discharge. Consideration should also be given to greater family and community involvement and the possibilities this offers for children who might not require hospitalisation if there was adequate care for them outside the institution.

**CONCLUSION**

Of all the different handicaps from which children may suffer, a mental handicap must surely be the most difficult for the parent to accept and work through (Steenkamp et al., 1981. P. 147). Similarly, those who work with a mentally handicapped person may experience frustration since progress is painfully slow over a very long period. Yet it is in fact the high degree of dependency of these children which often elicits profound compassion from many people. The moment of happiness which the patient experiences and any progress made by him, give tremendous satisfaction to those who work with him, and create an awareness of the special importance of this task.

**REFERENCES**

Joubert, R.W.E. (1982). Preventing sensory deprivation in the long term hospitalized patient. S.A. Journal of Occupational Therapy. 1.

Steenkamp, E., & Steenkamp, W. (1981). The mentally handicapped child. Durban: Butterworths.