ASSESSMENT SERVICES AT A

UNIVERSITY EDUCATION CLINIC

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RESEARCH REPORT SUBMITTED TO THE FACULTY OF EDUCATION, UNIVERSITY OF WITWATERSRAND, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

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S U M M A R Y

This study was undertaken at the Education Clinic of the University of the Witwatersrand. The study was aimed at examining the attitudes of client families and students towards the effectiveness of the implementation of a new model of psychoeducational assessment called the Initial Assessment and Consultation (IAC).

In accordance with the aims, a study of the literature was undertaken on Child Guidance and Education Clinics both overseas and in South Africa, on psychoeducational decision-making, and on outcome studies related to the IAC. Since the IAC model was relatively recently instituted at the Fernald Centre in the U.S.A., and at the Witwatersrand University Education Clinic, difficulty was experienced in finding literature on outcome studies.

The research study was exploratory and both quantitative and descriptive in nature. The methodology included the administration of questionnaires to forty client-families who had been consulted at the Clinic and to twenty student-consultants of the Division of Specialised Education.

Results indicated that generally the client families were satisfied with the IAC model and with the help rendered by clinic staff. The majority of students also responded positively to the IAC as a method of assessment and intervention for children with learning and scholastic problems.

D E C L A R A T I O N

I declare that this research report is my own, unaided work. It is being submitted for the Degree of Master of Education (School Counselling) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other university.

Z. DA GOR.

1st October, 1983.

A C K N O W L E D G E M E N T S

I would like to express my sincere appreciation to:

My supervisor, Dr. Mervyn Skuy, Head of the Division of Specialized Education and Education Clinic of the University of the Witwatersrand, whose interest, knowledge and valuable guidance proved to be an inspiration at all times.

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My grandmother, Mrs. Hawa Sader, for her support and cheerful tolerance of my pre-occupation with this study.

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TABLE OF CONTENTS

L I S T O F T A B L E S

L I S T O F F I G U R E S

"It is probably unwise to spend much time in attempts to separate off sharply certain qualities of man, as his intelligence, from such emotional and vocational qualities as his interest in mental activity, carefulness, determination to respond effectively, persistence in his efforts to do so; or from his amount of knowledge; or from his moral or aesthetic tastes."

E.L. THORNDIKE

(1) INTRODUCTION

Belkin (1981) describes assessment broadly as "collecting information about an individual's behaviour, aptitudes, abilities, general mental functioning, personality or related areas usually through the use of tests." Sattler (1982) states that assessment cannot take place all at once. He believes that children change as a result of development, life experiences and treatment. The aims of psychological evaluation are to assess the person's performance and capabilities, to decide on the nature of services required, to help implement specific program plans and to evaluate change.

Assessment is often seen as an activity separate from intervention even though assessment and treatment are inextricably intertwined. Assessment involves a careful delineation of strengths and weaknesses, a description of personality and temperament and appropriate recommendations. Once treatment has started, the hypotheses suggested in the assessment can be tested out. As a result, the original appraisal is modified and other issues which may require investigation are delineated (Sattler, 1982). Therefore, short- and long-term follow-ups are important parts of the psychological assessment process. Adelman and Taylor (1979) suggest that in practice assessment is usually the first intervention; it highlights the existence of problems and leads to decision-making regarding treatment.

According to Adelman and Taylor (1979) professional assessment activity in recent years has mainly emphasized screening, diagnosis and prescriptions. These activities have relied on tests, background history, and interviews and reviews of existing records. They suggest that overreliance on test findings often result in invalid data being used in diagnostic classifications and treatment.

Current methods of assessment also tend to overemphasize pathology and person variables resulting in practices which are primarily problem focussed. (Adelman and Taylor 1980; Sattler, 1982). Such models suggest that the client is "ill" or disordered and assumes that a

person behaves inappropriately or inadequately because of certain deficits or defects. Thus it is clear that the medical model approach to assessment is often utilised. In fact even theorists who postulate exclusively psychological or environmental causes for abnormal behaviour continue to use the labels of classification that have emerged from a medical perspective. Rapaport, Gill and Schafer (1968) state that clinical psychologists and psychiatrists have become dissatisfied with the whole enterprise of diagnosis, whether carried out by means of tests or otherwise, partly because real people rarely fit the diagnostic entities very well and partly because it tells relatively little about a person to know only that he fits into a particular diagnostic category. According to May (1979) other researchers such as Fairweather, Sanders, Mcgee and Cressler have also criticised formal diagnostic labels for the above and other reasons. As a result of the criticism levelled against traditional assessment procedures, Adelman developed an alternate approach to psycho-educational assessment based on an interactional model of learning and behaviour (which emphasizes the interplay between the person and the environment). Adelman and Taylor refer to this model as the Initial Assessment and Consultation (IAC) discussed later under Fernald Centre, page 5). Like Adelman, Ysseldeyke (1983) believes that there should be a shift in emphasis on assessment from a pathology orientation to an intervention-planning orientation. Ysseldyke feels that the way in which referrals are made has a direct influence on assessment and decision making practices. He states that referrals are often stated as solutions to problems that have already been identified. He suggests that the focus of assessment should be on pre-referral interventions and that a more appropriate initial emphasis could be on the implementation of behavioural/instructional interventions. This emphasis would further reduce the need for psychometric evaluation and improve instruction for children in the classroom. Just because a student is referred, does not mean that he has problems which require psychoeducational testing. It may indicate a situation requiring teacher consultation for academic or behavioural problems. These steps will help screen appropriate referrals to be considered for a more thorough assessment. This view corroborates the views of Adelman and Taylor on the IAC.

While many assessment procedures have been labelled "psychoeducational" they vary from each other in significant ways. There is wide diversity among practitioners in determining what is relevant information in assessing a child with learning problems. For instance, some practitioners place heavy emphasis on the affective life of the child when referring to psychological and educational assessments, while others have referred to motivational and emotional factors as being unimportant in the assessment of learning disabilities; Brooks (1979).

Brooks (1979) suggests that some specialists in the field write of psychological and educational assessments but do not mention the child's emotional life and its bearing on the evaluation of the child's learning style, often equating psychological and educational assessments with an ability training model. It therefore becomes apparent that assessment for learning disabilities should draw from the fields of both mental health and education. This is done by utilizing a combined psychological and educational assessment approach called psychoeducational assessment. When research and knowledge from both the above fields are pooled, as in some assessment practices, comprehensive diagnostic and treatment programmes become possible.

The psychoeducational assessment services provided at university-based child study clinics are briefly exemplified below.

Kaufman (1980) states that the Centre for Reading and Learning at De Paul university in Chicago, Illinois is a multifunctional clinic that provides diagnostic and treatment plans which include parent education and counselling and ongoing remediation for children likely to benefit from regular tutoring in this setting. The day programme accepts adults and De Paul University undergraduates for services that focus on improving skills in reading and learning. Evening and Saturday programmes are set aside for children and adults with reading and learning problems. Psychoeducational evaluations follow a logical sequence. The child's ability to learn is determined through intelligence and achievement testing. Informal assessments are also carried out when appropriate. Additional information is gathered as necessary to tap the correlates of developmental and academic skill

deficits. Clinicians avoid overtesting clients as much as they guard against insufficient data collection. Psychoeducational diagnoses involve astute detective work This involves collecting, analysing and synthesizing information about an individual's aptitude, abilities, behaviour, personality and general mental functioning. Differential psychoeducational diagnoses are confirmed at case conferences which are held weekly. Diagnoses are aimed at planning remedial programmes for children's weaknesses with corresponding exploitation of their strengths. Detailed recommendation also feature on each report.

The Child Development Clinic at James Madison University in Virginia is a regional clinic that offers assessments, remedial and counselling services to a wide variety of handicapped youth. Like the Centre for Reading and Learning the clinic applies an inter-disciplinary model with emphasis on teamwork and respect for each individual discipline involved with a case. Students conduct the psychoeducational assessments under the scrutiny of the trainers who may observe students from one way mirrors. These observations are followed by informal teaching critique sessions that students find valuable for developing their skills. The evaluation process involves a visit to the school if the child is of school going age. As children react differently in a strange setting the school visit provides valuable information with regard to behaviour and academic performance. Families are requested to attend the initial interview on the days of the formal evaluation and for a follow-up family conference. The aim of the evaluation is to provide school personnel and parents with as clear an understanding as possible of the child's problem and to arrange for appropriate treatment. The framework for the services of the clinic is that of a child-study frame of reference, (Vance, Roberson and Hanson, 1980).

According to Chandler and Siegel (1980) the psychoeducational clinic at the University of Pittsburgh was established as a community service to assist parents in understanding and helping their children with learning and behavioural problems. The clinic employs a decisionmaking model for the clinical assessment of children. This approach involves the use of an analytic deductive process of reasoning and provides a framework for the systematic analysis of the problem. The

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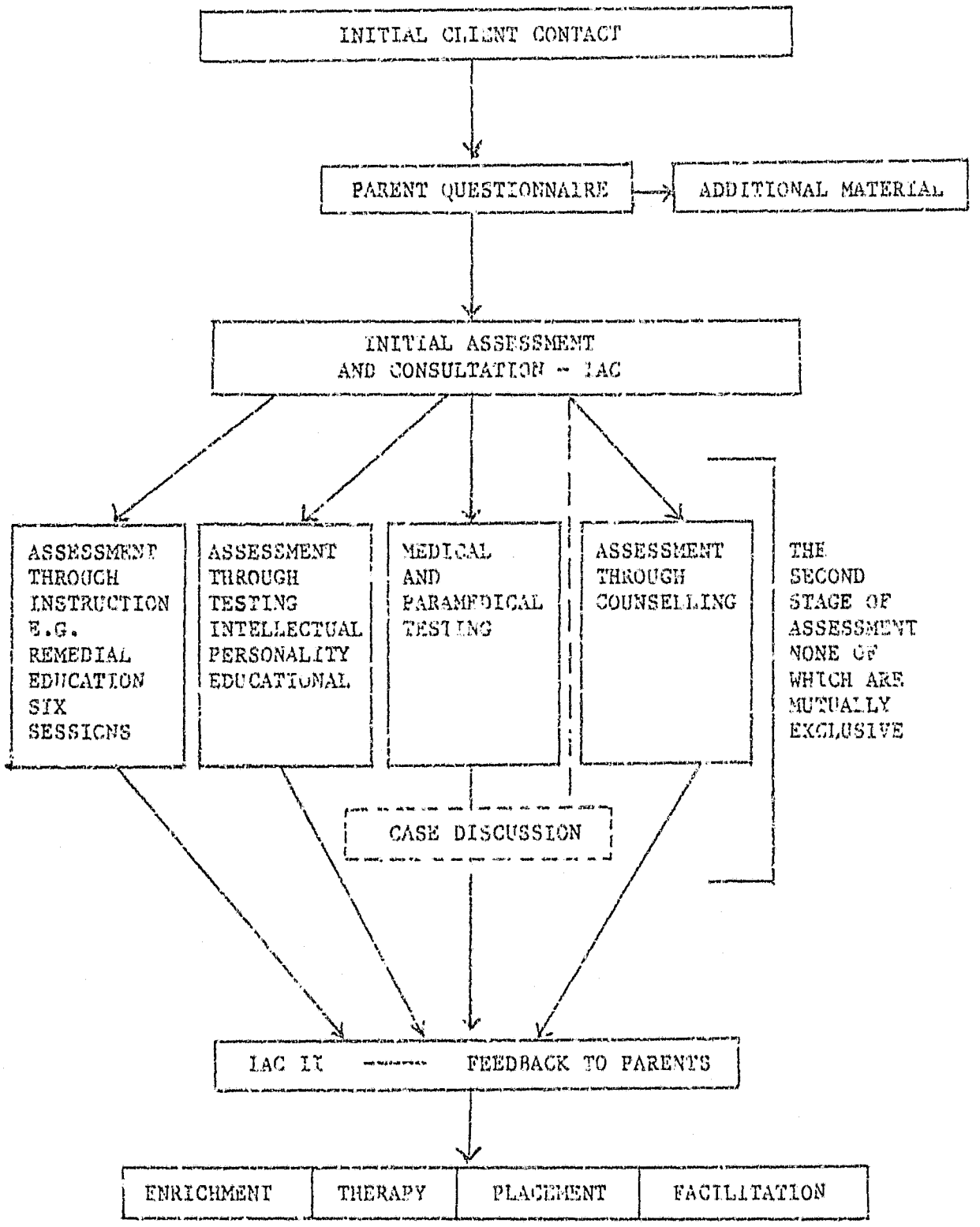
evaluation process begins when parents are asked to complete a behaviour scale and a survey of life events developed to yield information on the sources of stress in the child's life. Thereafter an intake interview is conducted with the parents while the child is seen for psychoeducational assessment. Before the parents leave the clinic they are given an appointment for a posttest conference where the results of the evaluation are discussed and recommendations for intervention formulated.

An alternative method for providing psychoeducational assessments is described by Chandler, (1980). A model child evaluation centre was established in a regular public school. Teachers referred children for formal psychological evaluation because of learning and behavioural problems in the classroom. It was assumed that if consulting services were available at a school on a daily basis, early intervention would be possible, which might reduce the need for formal psychological evaluations. The centre offered psychoeducational assessments, behavioural observations and analysis, in-service training opportunities and informal consultation. The staff were encouraged to work closely with teachers on developing recommendations and keeping frequent contact with them after the initial work had been done. When teachers referred cases, they were reviewed by the clinic co-ordinator and psychologist after which they were assigned to staff members who were responsible for further investigation and development of the referral. This project encouraged teachers to call on staff members as consultants in dealing with behaviour and learning problems which reduced the need for formal psychological evaluations.

The Fernald Centre at the University of California - Los Angeles places heavy emphasis on applied research. As part of their experimental and training programmes Fernald offers a variety of service programmes. However, the only programme discussed here is the Initial Assessment and Consultation (IAC), which is a service designed to aid clients in making decisions regarding the general nature of the services they need to pursue and resolve their problems. The initial contact is usually by telephone. The IAC represents a shared problem-solving model and facilitates active participation by parents and students in identifying

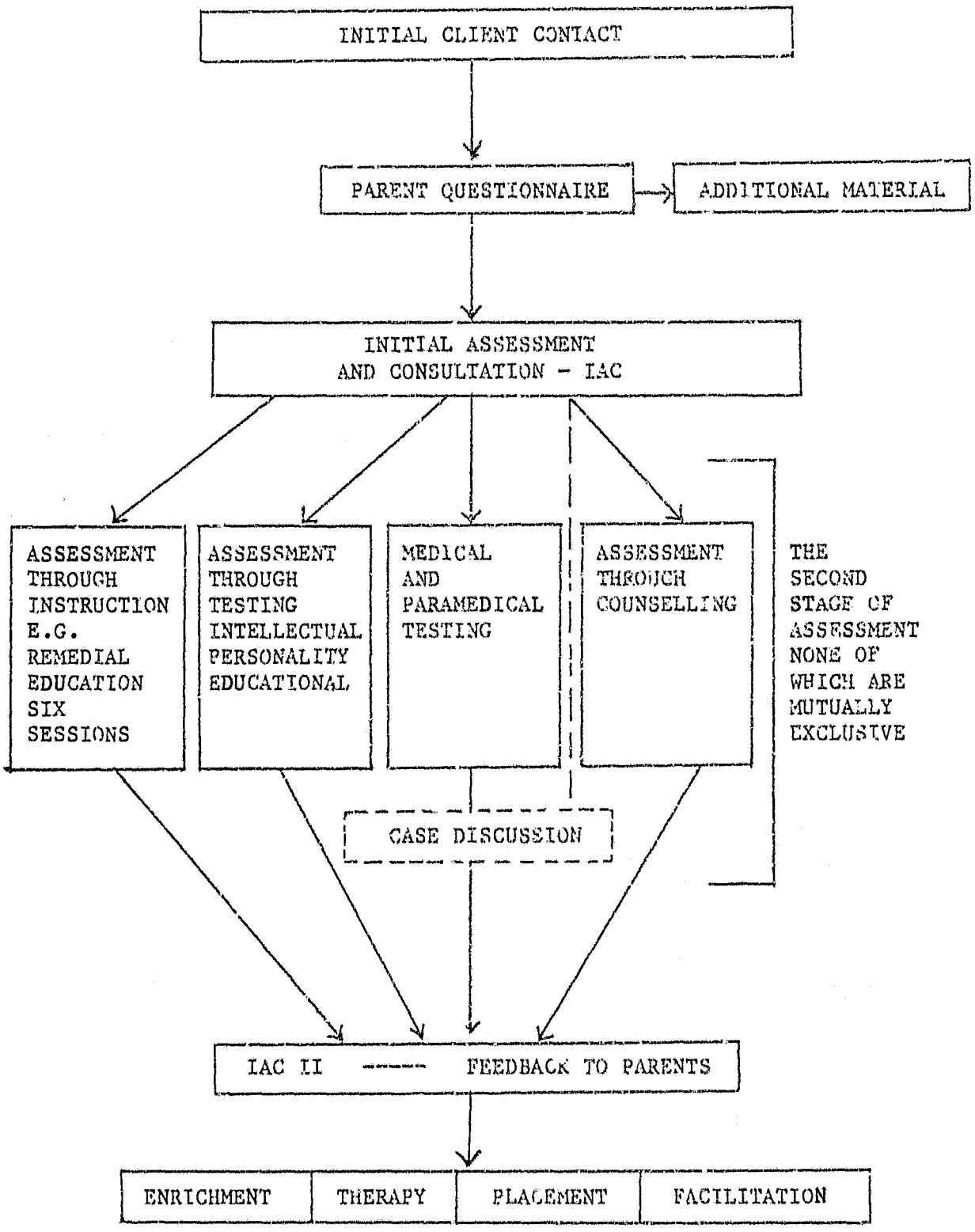
satisfactory alternatives. This process may range from one to several meetings and may include specific testing, a short period of instruction or short term counselling to provide data to help clients make appropriate decisions. After the clients have identified the general nature of services needed, consultants help follow through on decisions. A follow-up call after a month not only provides information to evaluate the service but helps to identify clients who were not able to make contact with an appropriate service and to offer them further support. Taylor and Adelman (1980). The above procedure is diagrammatically represented below.

FIGURE 1



SOMETIMES 1 + 2 + 3 = MAKING SOME DECISIONS

FIGURE 1



SOMETIMES 1 + 2 + 3 = MAKING SOME DECISIONS

The clinics exemplified merely serve as examples of prevalent clinical approaches to school problems in the United States of America. However, the Fernald approach does more than this and is central to the study.

Generally, in South Africa there seems to be a lack of research on psychoeducational and Child Guidance Clinics. The universities that have such clinics include the Universities of Cape Town, Durban-Westville, Western Cape, Pretoria, Stellenbosch, Witwatersrand and Randse Afrikaanse Universiteit. The clinics run at these seven universities can be distinguished as Child Guidance or Education Clinics. The Child Guidance Clinics offer services for a wider spectrum of problems than the Education Clinics and the breadth of their services is reflected by the range of professionals and students-in-training who deal with the problems. The major difference between Child Guidance and Education Clinics seem to be their point of departure. Child Guidance Clinics seem to begin their investigation of problems by means of psychodiagnostic assessment methods whereas Education Clinics tend to focus on psychoeducational assessments. These points of departure then suggest that Education Clinics have a narrower assessment and treatment focus because their services are provided on mainly school related issues. Clinical services at Child Guidance Clinics are available for the diagnosis and treatment of psychological disorders such as developmental, personality, behavioural and learning problems. In terms of this distinction the University clinics of Cape Town, Randse Afrikaanse, Durban-Westville and Western Cape are Child Guidance Clinics whereas the Universities of Pretoria and Witwatersrand have Education Clinics.

All the abovementioned clinics except Witwatersrand and Stellenbosch, function as independent inter-faculty uni's. Teaching, training, research and clinical services to various communities are common to all seven universities previously mentioned.

It can be inferred from the literature and personal interviews that the Education Clinics mentioned do not utilise the same approaches to psychoeducational assessments as Child Guidance clinics. Child Guidance Clinics seem to follow a diagnostic classification system.

There do seem to be similarities between Child Guidance and Education Clinics in the implementation of certain principles. For instance most clinics request the whole family to come for the first interview even though this may not be stated explicitly in the paradigm followed. The Pretoria University Education Clinic follows an "orthopedagogical approach" which is concerned with the contribution of education to the child's psychic life. The Witwatersrand University Clinic takes an interactional approach, based on the Fernald model, which is elucidated in section three (page 16).

Table II below is a description of the clinic services and functions, the number of clients assisted and the philosophies followed by some of the University Clinics in South Africa.

TABLE 1

COMPARATIVE DESCRIPTION OF UNIVERSITY CLINICS IN SOUTH AFRICA

UNIVERSITY	TYPE OF CLINIC	NO. OF CLIENTS SEEN	COMMUNITY SERVED	PROBLEMS DEALT WITH	SERVICES OFFERED	FUNCTIONS SERVED	PHILOSOPHY FOLLOWED
Cape Town	Child Guidance	1981 (251)	Coloured White African Malay Indian	Psychological Behavioural Developmental Learning	Psychotherapy. Advisory Interviews Parent Counselling Remediation Medical Examination	1. Teaching 2. Practical training of students at degree and diploma levels. These include Clinical Psychology, Social work, Remedial teachers 3. Research 4. Community services	Diagnostic Classification System
Durban-Westville	Child Guidance	1981-1982 (153)	African Coloured Indian	Psychological Behavioural Developmental Scholastic and	Counselling or Psychotherapy Home Visits Remediation	1. Teaching 2. Practical teaching of students at degree and diploma levels. These include Remedial and Special Education; Teachers Counselling; Clinical and Educational Psychologists; Therapists; Speech Therapists; and Optometrists. 3. Research 4. Community services.	Not Specified
Western Cape	Child and Adult	1981 (179)	Coloured	Psychological Vocational Learning and Scholastic	Counselling or Psychotherapy - Children and Adults. Family and Marital Therapy Remediation Teacher interviews Speech Therapy Medical	1. Teaching Practical training of students at degree and diploma levels. These include Counselling Psychologists, Remedial Teachers and Child Guidance Specialists. 3. Research 4. Community services	Not Specified
Pretoria	Education Clinic	1981 (600)	White	Psychological Developmental Scholastic and Learning	Remediation Play Therapy Social Work Services Vocational Guidance Consulting Psychologist and Psychiatrist	1. Teaching 2. Practical training of students at degree and diploma levels. These include B.Ed (Orhtopedagogics) B.Ed ((School Guidance) Teacher Training M.Ed (Planned:1984) 3. Research 4. Clinical activities e.g. Testing, interviewing, etc.	"Orthopedagogical Model" i.e. Education has to contribute to the child's psychic life
Randse Afrikaanse	Child and Adult Guidance	1981 (722)	White	Psychological Developmental Behavioural Learning Vocational Speech disorders	Psychotherapy - Child, Adult and Family. Counselling and Vocational Guidance. Speech Therapy and Optometry - part time Voluntary Paediatric services	1. Teaching 2. Practical training of students at degree and diploma levels. These include: Counselling and Educational Psychologists; B.Ed (Orthopedagogics); 4th year social work student practicals. 3. Research 4. Community services 5. Planned M.Ed (Psychology) 1984.	No one specific approach utilised
Witwatersrand	Education Clinic	1982 (85)	White Coloured Indian African	Scholastic and learning Vocational Psychological	Psychoeducational assessments Remediation Counselling - Individual and Family. Big Buddy programme Behaviour modification. Home programme.	1. Teaching 2. Practical training of students at degree and diploma levels. These include M.Ed (School Counselling) and internships. B.Ed (Remedial Education) HDE (Guidance). 3. Research 4. Community services	Fernald approach i.e. International model
Stellenbosch	Child and Parent Guidance	1982-1983 (200-400)	White Coloured	Psychological Developmental Vocational Learning	Psychoeducational Assessments Speech Therapy Play Therapy Medical Vocational Family Counselling	1. Teaching 2. Practical training of students at degree and diploma levels. These include M.Ed. Educational Psychology, B.Ed, B. Prim. Ed (School Guidance) Special Diploma, Clinical Remedial teaching 3. Research 4. Community services	Not Specified

(2) BRIEF DESCRIPTION OF THE UNIVERSITY OF THE WITWATERSRAND EDUCATION CLINIC

The Education Clinic of the University of the Witwatersrand was originally established in 1974. Prior to this period, clinical programmes were already operating on an informal basis within the education department. The clinic was established on an inter-disciplinary basis for training, research and intervention with children who had scholastic and or emotional and behavioural problems (Progress report, 1977).

It was only at the beginning of 1982 that the clinic began to function on a permanent basis. This happened as a result of the formal establishment of the Division of Specialised Education and the introduction of an annual intake of remedial and counselling students. Previously remedial programmes had operated biennially. (Annual Report of the Education Clinic, 1982).

During the period January to November 1982 the clinic fulfilled several roles:

It provided a multiracial community service for children experiencing learning and behaviour problems. This service included the provision of assessment, consultation, remedial therapy and counselling which were carried out by the students after an initial demonstration period, under the supervision of clinic staff.

It also provided the counselling, remedial and guidance students opportunities for practical training and experience and also afforded opportunities for research.

Clinic Personnel

The personnel involved in the work of the education clinic consisted of the head of the department, two lecturers and two clinical tutors who

served as supervisors. Students themselves carried out most of the actual direct services.

Sixty-one students were enrolled in the Division of Specialised Education for different courses. Of these the first year remedial students and the Higher Diploma in Education-guidance students were involved in the clinic in an informal programme called the Big Buddy programme. The second year remedial students and the Med in school counselling students were allocated the tasks of psychoeducational assessment, consultation, remedial therapy and counselling. (Annual Report of the Education clinic, 1982).

Client Population

Within the service programmes offered in 1982, the centre served a total of one hundred and nine children. Eighty-five of these children were referred for assessment and possibly other interventions in the clinic, a further twenty-four were referred specifically to the Division's Big Buddy programme, while nine other children were referred to the Division's Big Buddy programme after being assessed by the clinic. The types of presenting problems seen are discussed later (page 15).

The following breakdown is based on the premise that the child was the referred client although the centre maintains the basic approach of focussing on the family and other community resources.

Sex Differences

Of the total number of children receiving services 56 or 66% were males and 29 or 34% were females. Approximately twice as many boys as girls were thus seen in 1982.

Age

The large majority of children (83%) who received services were from the primary school; and the largest single group was from the senior primary school (between std. 2 and std 5) i.e. 51,8%. Neither adolescents older than eighteen years or adults with learning difficulties were catered for.

Social Class

Reliable figures on socio-economic status were not available. Income levels of parents or guardians are not specified on the initial questionnaire. It was then decided to rate the social class of the family instead according to the father's profession which is illustrated in the following table.

TABLE 2 - SOCIAL CLASS OF CLIENT FAMILIES

Class I	Cabinet ministers; principals-university; millionaires; managing directors or chairman of boards	3
Class II	Professionals; salaried executives; owners of large firms; operators of moderate-size enterprises; students of universities and colleges; prosperous farmers and land owners	26
Class III	Small businessmen; small farmers; clerical workers; white collar workers; semi-professionals	27
Class IV	Skilled workers; qualified tradesman; apprentices	22
Class V	Semi-skilled workers	5
Class VI	Unskilled workers; permanently unemployed	2
		N = 85

The above table indicates that the majority of client families seen at the education clinic were fairly equally distributed between classes II, III and IV. The minority of families seen at the clinic fell into classes I, V and VI.

Race Groups

The majority of clients catered for were White: 55 (65%). A small number of children who received services were Coloured 21 (25%), Indian 5 (5%) and Black 4 (5%). Difficulties in catering to the cultural and language groups represented by the Black population prevented a larger

number of Blacks being seen. An expansion of the programme involving Black children is being considered. However this would depend on the number of Black students that are attracted in the Division (Annual Report, 1982). The report also makes the recommendation that elementary courses in remedial education and basic school counselling should be offered for teachers and teacher-trainees who do not have matriculation exemption.

Source of Referrals to the Education Clinic

Parents, relatives and friends were the major source of referrals in the community 34 (40%), while schools 23 (27%), doctors 25 (29%) and other professionals also represented a substantial source of referral.

The centre also had a short waiting list of children who needed to be assessed. The number of children who can be seen by the clinic in any one year is determined by the number of students available to carry out supervised clinical activities.

Nature of the Presenting Problems

The largest category of problems seen relate to a generally poor school performance with or without associated problems. The latter referred to both specific learning disabilities and also emotional problems. Of the eighty five children seen, 44 (51,8%) were referred for remedial therapy. Half of this number (26% of the total clinic intake) were given remedial therapy at the Education Clinic itself. Apart from the forty four referred for direct remedial therapy, a further 8 (8,4%) of the client population received home or school remedial or behaviour modification programmes drawn up by the Bed students in the division.

Counselling/Psychotherapy was recommended in 38 (44,7%) of the cases. Of these approximately half were seen in the Education clinic largely in family counselling. In several cases, clients received multiple interventions in the clinic (e.g. remedial therapy plus counselling).

(3) THE CLINIC'S APPROACH TO ASSESSMENT

A new approach to the assessment of children was adopted within the Education Clinic for the first time in 1982. It is called the Fernald Approach and is based on a method successfully used in the University of California, Los Angeles Learning Centre. This approach has been adapted and introduced by Dr. Skuy, head of the Division of Specialised Education and its Education Clinic after experience in the approach in the United States, as well as after conducting a pilot study for one year in 1981 in South Africa.

The main features of the approach include the application of shared problem-solving and decision making processes, a de-emphasis of psychometric testing and focus on the strengths as well as weaknesses of the child, which shows concern for the total person. Unlike a clinical interview the Fernald Approach utilises a concrete structure in the initial interview with specific subheadings, so that the clients concerns/problems are written out (See Appendix A for format of IAC). It is considered that this approach is a more appropriate one in the field of learning disabilities. It was taught to staff and students and was successfully implemented in 1982.

The procedure is as follows: When someone telephones, the secretaries carry out a brief telephone intake and arrange to send out a questionnaire. The questionnaire itself is based on the Fernald Approach in that it emphasises current rather than previous/historical difficulties and concerns. It also immediately involves parents and child as active participants in the process by requesting their perceptions of the problem. The questionnaire also requests basic demographic data such as age, sex, school, etc. and other relevant information on medical examination, developmental history and the child's strengths and interests (See Appendix B for sample questionnaire.)

Once the questionnaire is returned the case is activated. The head of the clinic allocates the case to a supervisor and a student who then arranges an Initial Assessment and Consultation (IAC) with the family.

The decisions emanating from the IAC may involve intervention provided at the clinic or may require referral elsewhere.

The clinic itself provides remedial therapy, remedial programming (students prepare structured programmes for teachers and parents to follow) and counselling as well as the Big Buddy programme (in which children experiencing socialisation difficulties are befriended by students).

Psychological and educational testing usually forms part of the initial assessment and consultation but serves only as one source of data collection, i.e. it provides one aspect of understanding for making the decisions. Other aspects of the assessment includes visits to and discussions with teachers and sometimes principals as well as the determination of the perceptions of the family members and the consultant.

After the sources of evidence have been gathered a second or follow-up IAC is arranged with the family. On the basis of all the data collected alternatives for intervention and or action are generated jointly by the consultant and the family. The next steps to be taken are also discussed. The consultant then writes a report which is sent to the parents and any other person to whom the parents want it sent. (See Appendix C for report format.)

Aspects of assessment other than the psychoeducational - for example medical or speech evaluations - were referred to the Transvaal Memorial Institute for Child Health. The Education Clinic played a major role in the operation and development of the Institute of Child Health during 1982, and also availed itself of the facilities and personnel in other university departments attached to the Institute of Child Health (ICH). Approximately one third of the eighty five children assessed in the Education Clinic received medical examinations from Dr. Cartwright, consultant paediatrician at the ICH. A number of cases were also seen by occupational therapists and speech therapists working within the ICH team. Several highly successful multidisciplinary team conferences were also held to discuss plans and treatment of difficult cases. When

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available, the results of the assessments were incorporated into the decision making process.

Although the IAC model of psychoeducational assessment was put into practice at the Fernald Centre some years ago, there appears to be little published research about its effectiveness. Adelman and Taylor (1979) have however pointed out that initial data suggests that the IAC is effective and that it avoids many problems (e.g. ethical and practical) that other approaches produce. They state that the problems produced by the IAC are relatively few and mostly soluble. As this approach has been implemented for the first time in South Africa studies on the effectiveness of the adapted model need to be conducted to determine its usefulness for client families in this country.

It appears that the applicability of the IAC to all population groups has to be tested out. It does seem that this model may not necessarily be applicable to all population groups because of the implicit assumption that clients are openly able to express and share their concerns in the presence of other family members as well as the consultant. In view of the fact that the norms in certain sub-cultures differ from the type of norms that are appropriate in Western cultures, the applicability of the IAC to different South African sub-cultures is questionable and therefore requires investigation.

The concept of problem solving suggests that there are particular phases of problem solving. These include the clients' understanding of the problem, choice behaviours involving generating and evaluating alternatives and decisions as well as motivation and developmental capability. Adelman and Taylor (1979) state that there is no evidence that this is how most people problem-solve but there seems to be a tendency for people not to problem solve in the sequence outlined above. Whether they are able to do so and whether this would be more effective remains unanswered empirically.

There are two ways in which IAC decisions can be made. The first involves the consultant, whose decisions are made through recommendations. The consultant's decisions are made through his

perception of the problem which then shapes the decisions regarding intervention. The second involves the client whose decision making is facilitated by the consultant. This requires that the client becomes actively involved in making decisions and experiencing feelings of self control and competence with reference to his change processes.

The above emphasis on the problem-solving and decision making approach differs from traditional assessment models in which the responsibility for problem solving and decision making rests primarily with the "expert". It is therefore important to assess clients' feelings about being involved as active participants in their own problem solving and decision making processes.

Furthermore, since staff and students at the Education Clinic have been involved in implementing the IAC practically, it is important to identify their attitudes to the IAC in order to determine its effectiveness in a teaching and service situation.

(4) PILOT STUDY

4.1 Rationale

There is a lack of research on the effectiveness of psychoeducational assessment models used at South African clinics. On the one hand, the implementation of a new model is an innovative action and on the other hand it is a risky venture. As research on the effectiveness of the IAC does not seem to have been published such a study seems to be warranted to investigate its perceived value among client families in South Africa.

The present study examines the attitudes of the consumers i.e. client families in a particular clinic as a first step or pilot study in determining the effectiveness of the IAC. The attitudes of staff and students towards the IAC approach need to be elicited. Staff and students have been involved in the practical implementation of this model and their perceptions and reports of their experiences in applying the IAC would help to determine its effectiveness from a teaching point of view.

4.2 Aims of the Study

(1) To determine the perceptions of student consultants in relation to the IAC.
(2) To determine the effectiveness of the IAC by means of client family perceptions and reports.
(3) To investigate the implementation of the IAC as a viable psychoeducational assessment model for clients in South Africa.

4.3 Subjects

The subjects were:

(1) Twenty student assessors who were registered in the Division of Specialised Education either for the Diploma in Remedial Education (final year), the Bed in Remedial Education (final year) or the Med in school counselling.

(2) Forty families who received some form of help from the Education Clinic. They had all been seen in the first six months of 1982 and were each surveyed six months after they had received help at the clinic. The forty families represent 90% of the population seen in the first six months of the year. They also represent 47% of the total clinic population for 1982.

The client families were predominantly from the White population group but also included families from the Indian, Coloured and African populations. The socio-economic levels of these families ranged from unskilled workers to businessmen, professionals and directors of companies.

4.4 Measures

Two questionnaires were compiled, one for the students and the other for the client families.

The student questionnaire consisted of ten questions which were close ended i.e. respondents had to select answers from a limited number of responses. Some of the closed questions requested additional information by requesting open-ended comments e.g. "Please elaborate if necessary". Examples of some of the questions on the student questionnaire include: "Do you feel positive about using the IAC", "Do you feel you were able to help your clients resolve their concerns" and "Would you have preferred to use another assessment model to the one you have used". Responses had to be rated on a four point scale, which are indicative of different degrees of positive and negative scores e.g.

+2	+1	-1	-2
Yes!	Yes	No	Not at all

As is indicated above, yes! is the most positive response, yes is positive, no is negative while not at all is the most negative response. No names appeared on the questionnaire and to encourage frankness and honesty, students were verbally assured of the anonymity of the study (See Appendix D for student questionnaire).

The family questionnaire consisted of twenty seven questions which were sub-divided into three sections. Section A comprised questions relating to family perceptions of the assessment services; for example "Were you satisfied with the report you received". Questions in section B related to remedial help, for example "Do you feel your son/daughter benefited from the remedial help he/she received". Section C tapped perceptions of family counselling e.g. "Do you feel that family counselling was an important aspect of the help offered". These questions were also close-ended. However, additional comments were also requested as was the case with the student questionnaire. Names appeared on this questionnaire in order to allow for follow-up of any problems related to the service. Responses on this questionnaire as in the case of the student questionnaire had to be rated on a four point scale. (See Appendix E for client questionnaire).

In both questionnaires a four point scale was used in order to determine the different degrees of positive and negative responses.

Closed questions were mainly used on both questionnaires so as to facilitate data processing and introduce some objectivity in analysing and interpreting the data.

+2	+1	-1	-2
Yes!	Yes	No	Not at all

As is indicated above, yes! is the most positive response, yes is positive, no is negative while not at all is the most negative response. No names appeared on the questionnaire and to encourage frankness and honesty, students were verbally assured of the anonymity of the study (See Appendix D for student questionnaire).

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In both questionnaires a four point scale was used in order to determine the different degrees of positive and negative responses.

Closed questions were mainly used on both questionnaires so as to facilitate data processing and introduce some objectivity in analysing and interpreting the data.

4.4 Procedure

The writer administered the questionnaire to students at a group gathering and collected most of them at the same session. The other students questionnaires were returned to the Division of Specialised Education a few days later.

Questionnaires, together with self-addressed envelopes were posted to families. After a period of three weeks the writer carried out home visits to collect the questionnaires which had not been returned by the families.

(5) RESULTS

The results of this study are presented in three main sections. The first section is a presentation of client (family) results. The second section represents student results, while the third section provides a comparison of client and student responses to common items from both questionnaires.

Section 5.1 has been divided into the following eight sub-sections:

1.1 Decision Making (consisting of questions 7,8,9,10,11)
1.2 Active Participation in the IAC (consisting of questions 1,2,12,15)
1.3 Attitudes towards Consultants (consisting of questions 3,4,6)
1.4 Inter-racial contact (consisting of question 18)
1.5 Attitudes towards Services (consisting of questions 5,13,14,16,19).
1.6 Remedial help (consisting of questions 1,2,3,4 of Section B).
1.7 Family Counselling (consisting of questions 1,2,3,4 of Section C and q.15)
1.8 Open-ended comments.

The above sub-sections were devised by grouping questions from the client (family) questionnaire. The questions that comprise each category are indicated next to each category.

Section 5.2 has been divided into five sub-sections. These sub-sections were devised in the same way as the client (family) questionnaire.

2.1 Student attitudes to the IAC (consisting of questions 1,2,3,4,6,7).
2.2 Attitudes towards students' own effectiveness (consisting of questions 5,9)
2.3 Help offered to clients of other ethnic groups (consisting of question 10).

2.4 Attitudes towards the use of alternative assessment methods (question 8)

2.5 Open-ended comments.

Section 5.3 provides a comparison of similar items from both the client (family) and student questionnaires by counting the number of positive "yes ++" and "yes +" as well as negative "no-" and "not at all --" responses. In addition the writer considered the highly positive yes!++" and positive "yes +" responses together.

Modal responses to each item on both questionnaires have been computed and are presented.

Section 5.1 - Client Family Results

5.1.1 Decision Making

26 (86,7%) of the total number of thirty clients felt that they played a part in making decisions about the action to take regarding their concerns - (Item 7).

All 30 (100%) of the clients felt that the decisions arising out of the assessments were reasonably sound and useful (item 8).

28 (93,3%) of the total number of thirty clients carried out the decisions that were taken jointly (item 9).

25 (83,3%) of the total number of thirty clients felt that the decisions taken at the clinic appeared to be producing positive results for them (item 10).

20 (67%) of the total number of thirty clients felt that they would not have preferred the consultants to have played a larger role in decision making.

The results on decision making are also presented in Table 3.

TABLE 3 - DECISION MAKING N = 30 %

ACTIVE PARTICIPATION	26	86,7
DECISIONS - SOUND AND USEFUL	30	100
DECISIONS TAKEN JOINTLY	28	93,3
DECISIONS PRODUCING POSITIVE RESULTS	25	83,3
CONSULTANT-NOT-PLAY LARGER ROLE	20	67

5.1.2 Active Participation in the IAC

30 (100%) of the clients showed a positive attitude to active participation.

28 (93,3%) of the total number of thirty clients felt that their attitude to the problem changed after seeking help - (Item 2).

29 (97%) of the total number of thirty clients felt that their sons/daughters enjoyed their participation in the assessment - (Item 12)

In 20 (67%) of the total number of thirty clients both parents attended the assessment interview. These results are presented in Table 5.

TABLE 4 - ACTIVE PARTICIPATION N = 30 %

POSITIVE ATTITUDE TO IAC	30	100
ATTITUDE CHANGE TO PROBLEM	28	93,3
PARENT VIEW: CHILD ENJOYED ASSESSMENT	29	97
BOTH PARENTS ATTENDED INTERVIEW	20	67

5.1.3 Attitudes towards Consultants

30 (100%) of the clients felt that the consultants understood

and demonstrated a genuine interest in the concerns they expressed.

30 (100%) of the clients felt that the consultants tried their best to help them.

20 (67%) of the total number of thirty clients felt that the consultants discussion with the teacher/principal was a vital aspect of assessment. These results are presented in Table 6.

TABLE 5 - ATTITUDE TOWARDS CONSULTANT N = 30 %

UNDERSTOOD AND SHARED CONCERNS	30	100
TRIED BEST TO HELP	30	100
DISCUSSION-TEACHER-VITAL ASPECT OF ASSESSMENT	20	67

5.1.4 Inter-racial contact of clients

12 (40%) of the total number of thirty clients were helped by a consultant of a race group other than their own.

5.1.5 Attitudes towards Services

29 (96,6%) of the total number of thirty clients did not feel that too much testing was done.

All thirty clients indicated that their children gained from the assessment.

28 (93,3%) of the total number of clients did not feel that the assessment took too long.

27 (90%) of the total number of clients felt that they were given sufficient feedback/information regarding their concerns.

28 (93,3%) of the total number of thirty clients indicated satisfaction with the report they received. These results are presented in Table 7 below.

TABLE 6 - ATTITUDE TOWARDS SERVICES N = 30 %

TESTING NOT EXCESSIVE	29	96,6
PARENTS: CHILD GAINED ASSESSMENT	30	100
ASSESSMENT DID NOT TAKE LONG	28	93,3
GIVEN SUFFICIENT FEEDBACK	27	90
SATISFIED WITH REPORT	28	93,3

5.1.6 Remedial Help

12 children received remedial help therefore N = 12.

12 (100%) of the clients i.e. parents, were of the opinion that their children benefited from the remedial help they received.

12 (100%) of the children who received help felt that they had benefited.

11 (92%) of the children who received remedial help showed improvement in their school work.

5 (42%) of the parents felt that remedial teaching had alleviated many of their school related concerns. The results on remedial help are illustrated below in Table 8.

TABLE 7 - REMEDIAL HELP N = 12 %

BENEFIT OF REMEDIAL HELP - PARENTS VIEW	12	100
BENEFIT OF REMEDIAL HELP - CHILD'S VIEW	12	100
IMPROVEMENT THROUGH REMEDIATION	11	92
ALLEVIATION OF CONCERNS - REMEDIAL TEACHING	5	4[illegible]

5.1.7 Family Counselling

Only nine families out of thirty received family counselling therefore N = 9.

8 (89,2%) out of nine families indicated that family counselling was an important aspect of the help offered.

7 (78,2%) of the clients were of the opinion that they gained a better understanding of their concerns through family counselling.

5 (55,5%) of the clients held the view that family counselling was relevant to the original problem for which they sought help.

7 (78,2%) of the clients indicated that they benefited from their participation in family counselling. Views on family counselling are illustrated in Table 9 below.

TABLE 8 - FAMILY COUNSELLING N = 9 %

FAMILY COUNSELLING - IMPORTANT ASPECT OF HELP OFFERED	8	89,2
GAINED BETTER UNDERSTANDING THROUGH FAMILY COUNSELLING	7	78,2
FAMILY COUNSELLING - RELEVANT TO ORIGINAL PROBLEM	5	55,5
BENEFIT RECEIVED FROM FAMILY COUNSELLING	7	78,2

5.1.8 Open Ended Questions

Responses to significant open-ended questions by client families:

In answer to the question "Please list the things you liked about the service" some of the responses noted are:

"Parental involvement ..." "Accuracy of test findings ..." "Consultants described as 'kind' 'caring' 'amicable' 'patient' 'committed' 'genuine'" "Cases handled professionally ..." "Finally someone could help us ..." "Excellent service, keep it up" "Personal caring of remedial teacher" "The fact that the service is available ..." "Confidence my child gained".

In response to the question "Please list the things you didn't like" the following responses were obtained

"Not enough supervision over remedial consultants" "Too much time had to be taken off from work" "Did not know with whom to communicate about my son's report" "Waited too long for report" "Disliked being observed by students from behind the one-way mirror ..." "Education clinic not widely known" "Too many interruptions in the interview from supervisor (Family Counselling)".

In response to the request "Suggestions for improvement or change" the following responses were obtained

"Specified fees to be paid instead of donation" "Clinic should be run in other areas" "Difficult to get to clinic" "Let people know" - services "Closer co-operation between the education department and the university to make things easier" "Satisfied with services" "Maintain your standard ..."

Section 5.2 - Student Results

5.2.1 Student Attitudes to the IAC

20 (100%) of the students felt positive about using the IAC.

18 (90%) of the students felt that the structure offered by the IAC was useful.

4 (20%) of the students felt that clients experienced difficulty in being active participants in their own problem solving and decision making processes.

20 (100%) of the students indicated that it was advantageous to examine the strengths of the clients along with their weaknesses.

16 (80%) of the students felt that they had brought about positive changes in their clients' perception/s of their problem/s as a result of the IAC.

12 (65%) of the students felt that their clients were sufficiently motivated to carry out the decisions that they jointly made. Student attitudes to the IAC are presented in Table 10 below.

TABLE 9 - STUDENT ATTITUDES TO IAC N = 20 %

FELT POSITIVE ABOUT USING IAC	20	100
STRUCTURE OF IAC HELPFUL	18	90
CLIENT DIFFICULTY IN BEING ACTIVE PARTICIPANTS	4	20
ADVANTAGEOUS TO EXAMINE STRENGTHS AND WEAKNESSES	20	100
BROUGHT POSITIVE CHANGE-CLIENT'S PERCEPTION PROBLEM	16	80
CLIENT SUFFICIENTLY MOTIVATED TO CARRY OUT DECISIONS	12	65

5.2.2 Attitudes towards students' own effectiveness

16 (80%) of the students held the view that they were able to help their clients resolve their concerns.

20 (100%) of the students described themselves as being effective helpers. These results are illustrated in Table 11.

TABLE 10 - ATTITUDES - STUDENT'S OWN EFFECTIVENESS N = 20 %

HELPED CLIENTS RESOLVE CONCERNS	16	80
EFFECTIVE HELPERS	20	100

5.2.3 Help offered to clients of other ethnic groups

11 (55%) of the students worked with clients of ethnic groups other than their own.

5.2.4 Attitudes towards the use of an alternative assessment method

7 (35%) of the students felt that they would have preferred to use another assessment model to the one they had used (IAC).

5.2.5 Open Ended Questions

Responses to significant open ended questions by students:
In response to the question "Please list the things you liked about the service" the following responses were obtained:
"Presen ation of case-conferences worthwhile" "Multidisciplinary team approach" "Positive about the emphasis of the IAC approach" "Pleased about involvement of school and family system" "Reports are comprehensive and easy to understand" "Services carried out professionally" "Pleased that such a service is available"

In response to the question "Please list the things you didn't like" the following answers were noted

"Case conferences were not well organised" "Lack of structure regarding administration of referrals to the other specialists" "Fernald approach does not adequately focus on the client's feelings" "No place for alternatives in this report" "Too much delay in sending out reports" "Supervision not always consistent ..." "Since the services rendered were free of charge, clients often missed family therapy sessions".

In response to the request for "Suggestions for improvement or change" the following were stated:

"Reliable system for arranging appointments with other specialists" "Alternative assessment model should be tested out for different cultural groups" "Another typist should be employed" "Generally a good service" "Clients should be charged a consultation fee which is in keeping with their earnings".

Section 5.3 - Comparison of Similar Items

5.3.1 Attitudes to IAC

All of the thirty client families (100%) felt positive about the IAC.

12 (40%) of the client families felt very positive about it, while 18 (60%) of the client families felt positively about it.

All of the twenty students (100%) felt positive about using the IAC.

11 (55%) of the students felt very positive about using the IAC while 9 (45%) of the students felt positively about it. The attitudes of client families and students are depicted in Table 12.

TABLE 11

ATTITUDES IAC	OVERALL POSITIVE	VERY POSITIVE	MODERATELY POSITIVE	NEGATIVE	VERY NEGATIVE	N
CLIENT FAMILIES	30(100%)	12(40%)	18(60%)			30
STUDENTS	20(100%)	11(55%)	9(45%)			20

5.3.2 Change in the Perception of the Problem

28 (93,3%) of the thirty client families indicated changes in their perceptions of the problems. 10 (33,3%) of the total number of thirty client families felt that there was very positive change in their perceptions of the problems while 18 (60%) of the client families felt less strongly so.

17 (85%) of the twenty students were of the opinion that there was a change in the clients perception of the problems. 6 (30%) of the twenty students felt that there was a strong change in the perception of the problem while 11 (55%) felt less strongly so. These results are indicated in Table 13.

TABLE 12

CHANGE IN PERCEPTION OF PROBLEM	OVERALL POSITIVE	VERY POSITIVE	MODERATELY POSITIVE	NEGATIVE	VERY NEGATIVE	N
CLIENT FAMILIES	28(93,3%)	10(33,3%)	18(60%)	2(6,66%)		30
STUDENTS	17(85%)	6(30%)	11(55%)	2(10%)		20

5.3.3 Help offered by Students to Client Families

All thirty client families felt positively about the help received from students.

17(57%) of the thirty families felt very positively about the help received from the students while 13 (43,3%) felt moderately positive about it.

All of the twenty students felt that the help they offered was effective.

5 (25%) of the twenty students felt that the help they offered was very effective while 15 (75%) of the students felt that it was moderately effective. These results are also depicted in Table 14.

TABLE 13

HELP OFFERED	OVERALL POSITIVE	VERY POSITIVE	MODERATELY POSITIVE	NEGATIVE	VERY NEGATIVE	N
CLIENT FAMILIES	30(100%)	17(57%)	13(43,3%)			30
STUDENTS	20(100%)	5(25%)	15(75%)			20

5.3.4 Activation of Decisions

28 (93,3%) of the thirty client families were actively involved in decision making.

6 (20%) of the thirty families felt that they were very actively involved in decision-making while 22 (73,3%) felt less actively involved.

15 (70%) of the twenty students were active facilitators of client decision making.

5 (25%) of the twenty students felt that they were very active in decision making, while 9 (45%) of the twenty students felt less actively involved. These results are depicted in Table 15 below.

TABLE 14

ACTIVATION OF DECISIONS	OVERALL POSITIVE	VERY POSITIVE	MODERATELY POSITIVE	NEGATIVE	VERY NEGATIVE	N
CLIENT FAMILIES	28(93,3%)	6(20%)	22(73,3%)	2(6,7%)		30
STUDENTS	15(70%)	5(25%)	9(45%)	6(30%)		20

(6) DISCUSSION

6.1 Interpretation of Findings

(a) Client Families

Results indicate that client families endorsed the joint decision making process between the consultants and themselves as being highly positive. This suggests that parents were adequately involved in decision making and that they were interested and motivated to be involved as shared problem-solvers. Table 4 (page 26). All the client families perceived the decisions emanating from the IAC to be very worthwhile, possibly suggesting that the decisions taken were both appropriate and realistic. Since ten out of thirty client families would have preferred the consultants to have played a larger role in decision making it appears that clients still sometimes see the consultant as the "expert". In this regard Adelman and Taylor (1979) state that the role of the consultant is not to give advice about the choices clients should make. While offering expertise and facilitation (e.g. clarifying issues) the consultant helps the client make decisions through the understanding of their problems and choosing the best alternatives, but avoiding overreliance on "expert" advice.

The results highlight that all thirty client families perceived active participation and shared problem-solving to be a very positive aspect of the assessment model, indicating that the clients did not passively accept the predilections of the consultant. Table 5 (Page 26). The majority of families also perceived a change in attitude towards the problem after having sought help. It appears that one child did not enjoy his participation in the assessment, apparently because the test session was too long drawn out and tiring. In most cases, both parents attended the interview, while in ten families mothers

usually accompanied their children. Thus it could be speculated that some fathers are less actively involved in their families or that fathers preferred not to take time off from work, especially in cases where employers may have become unreasonable.

All the client families experienced the consultants as having been interested and helpful with regard to their concerns. Table 6 (Page 27). It is interesting to note that ten out of thirty families did not see the discussion with the teacher as a vital aspect of assessment. This may have resulted from the perception that teachers are not helpful in making suggestions on how to help the child, even though they are more likely to have the greatest amount of educational information about the student.

Table 7 (Page 31) highlights the extremely positive attitudes of families towards the services rendered at the Education Clinic, possibly indicating satisfaction with the services that were rendered. Parents did not feel that too much testing had taken place but they certainly felt that their children had benefited from the assessments. Parents were also pleased that the assessments did not take too long and indicated satisfaction with the reports they received. Parents may have found the reports to be valuable because of their practical values, i.e. they were interested in learning different ways in which to help their children and to explore different services and professions in an attempt to be of assistance to their children.

Both the parents and their children felt that the children had benefited from the remedial help that was provided at the clinic. However only 42% of the children felt that all their concerns were alleviated as a result of remedial help. This raises the issue that learning disabled children may also have concomitant emotional problems. Reimondi,

Lockwood and Brannigan (1981) state that unless both the child's learning and emotional difficulties are addressed, the probability that a child will benefit from a remedial programme will not be greatly increased. In this respect it is interesting to note that many parents did not perceive their children's difficulties to be of an emotional nature. In fact 44% of the families did not see the relevance of family counselling to the original problem. This kind of response could have resulted from the inability of many families to link their children's school problems to conflict in the home. Boike Gesten and Cowen (1978) state that children with family background problems have more trouble in school than those who do not have such histories. This then indicates the need for more extensive and diverse family involvements in educational and intervention programmes in order to improve the child's school experiences.

On the other hand, the resistance of some families to be involved in Family Counselling could suggest that they may not want to share the problem with the child and may have felt intimidated by the equality given to the child in the decision making process. Philage and Kuna (1978). This may well be true for certain cultural groups. It may also explain why student consultants experienced difficulties in getting families of different cultural groups to attend family counselling sessions regularly and not to prematurely terminate treatment.

In general, the open ended family comments suggest that most clients were highly satisfied with the services rendered at the Education Clinic. They were also very impressed with the quality of work rendered by the student consultants. The major dissatisfaction resulted from being observed by students through a one-way mirror. Although their dissatisfaction is understandable, it has to be borne in mind that the University remains a training institution

and that it is difficult to alleviate this type of dissatisfaction. Most families were satisfied with the reports they received - this has been discussed previously - (Family Results).

It appears that the sending of reports from the Clinic and the the receiving of reports by parents was experienced as a problem mainly because of the long delay after the assessment period. In this connection Nolan (1981) points out that no empirical studies state how long agencies should take to evaluate children. However, on the basis of his experience, he believes that six weeks is more than enough time in which to gather data, complete evaluations, give feedback and send out reports to appropriate people.

(b) Student Consultants

Results indicate that all twenty students expressed positive responses towards the use of the IAC; most of them found the structure of the IAC helpful and all of them felt that the emphasis on strengths was advantageous in an assessment procedure. Four out of twenty students felt that families generally experienced difficulty in being active participants in their own problem solving and decision making processes. They also believed that the level of difficulty varied from one family to another.

Approximately 50% of the students felt that clients were not sufficiently motivated to carry out the decisions taken during the IAC, even though all the clients felt that the decisions taken were reasonably sound and useful. This situation may be attributed to the students' perceptions of how motivated clients need to be.

Table 11 (page 32) illustrates that students perceived themselves as being effective helpers. This view is consistent with the families perceptions of the students.

It suggests that the students probably possessed some characteristics required of effective helpers.

Seven of the twenty students felt that they would have preferred to use another assessment model to the one they had used. Some explanations for this were that students would have like exposure to models other than the IAC. Other students felt that the IAC is not suitable for use with people of other cultures since children are not always encouraged to be part of the problem-solving and decision-making processes, with the result that they are usually not active participants in the interview. It was also felt that the IAC approach lacks depth, ignores the clients feelings and was rather rigidly imposed on students to utilise in their psychoeducational assessments.

The students' open-ended comments are generally favourable. They seem to be mainly dissatisfied with the administrative handling of situations. Many students were in favour of the involvement of both school and family systems. Christiansen in Green and Fine (1978) point out that the home and the school are the most important systems for the child and what occurs in one system can greatly affect the other. This indicates the need and relevance of Family Counselling. Tucker and Dyson (1976) state that the processes of family therapy are used with the aims of reversing maladaptive school behaviour of children and facilitating positive interactions between the family and the school. It therefore seems necessary for parents to be able to perceive the link between academic remediation and family counselling in many cases.

(c) Discrepancy between Student and Client Outcomes

There was no overall discrepancy between client family and student attitudes to the IAC. Table 12 (page 34). There was however some discrepancy between client families and

students who felt moderately positive towards the IAC. Table 12 column 3. This sort of discrepancy is not unusual when it is considered that people have their specific likes and dislikes. It is significant that there were no negative or very negative responses in both students' and families' attitudes to the IAC.

Table 13 suggests that there was an overall 11% discrepancy between client family and student views of change in the perception of the problem as a result of the IAC. The discrepancy suggests that Client Families perceived greater change in the perceptions of their problems than the students had expected. It could be speculated that these changes are not necessarily tangible and this is perhaps why client families could have perceived a greater change in perception than the students. It is interesting to note that two students and two families did not feel that there were any positive changes in their perception of the problem as a result of the IAC.

Table 14 shows consistency in client family and student views on the help offered by the students. It was evident that client families felt more positively about the help received than the students actually felt they were able to give. (Table 14 - column 2). This could be an indication of modesty on the part of the students. The 23% discrepancy between client family and student views of how much decision-making there was suggests that students may have underestimated the parents' involvement or parents may have overestimated their involvement in the decision-making process. Table 15 (page 36).

6.2 Suggestions for the Improvement of the IAC and other Clinic Services

According to Ysseldyke (1983) it appears that team

decision-making (multidisciplinary team conferences) could serve to further enhance active participation by including both parents and teachers at such meetings. At present parents are only actively involved in the IAC and teachers are not always present at team conferences. Both parents and teachers are likely to have the greatest amounts of personal and educational information about the student which can be utilised in decision-making. Ysseldyke is also of the opinion that more time should be spent in team-meetings talking about generating alternative service options and instructional interventions for the student.

A more organised administration system has to be developed to enhance the services rendered by the Clinic. It appears that a reliable system for arranging appointments with other specialists such as the Paediatrician and Occupational therapist has to be organised. The typing of reports by one person caused considerable delay in the sending out of reports. Students could be encouraged to type their own reports if a typewriter was made available to them or alternatively a second typist could be employed. Students seemed to feel that clients often missed family counselling sessions and sometimes they did not take the initiative to cancel the session. The possibility of charging a consultation fee which is in keeping with the clients socio-economic position requires further investigation.

6.3 Limitations of the Study

Some of the limitations of this study are:

(a) There were limitations in the questionnaire. For instance the question content may have been biased and ambiguous and the degree of respondent motivation to the questionnaires may have constituted extraneous variables which were difficult to control.

(b) It was decided to use all clients in the first half of the year to afford follow up in the second half of the year, after a standardised period of time. This limited the sample size.

(c) Difficulty in data collection was related to the generally poor responses from families in returning their questionnaires. In many cases second and third telephonic reminders were made before parents returned their questionnaires. Home visits were time consuming, uneconomical but at times interesting.

6.4 Future Research

(a) As mentioned earlier, further studies need to be conducted using objective change criteria to gauge the effectiveness of the IAC.

(b) Pilot studies need to be conducted at other Education Clinics using the IAC method or an adapted version of the IAC to further determine the feasibility of this model.

(c) The IAC method should be compared with other approaches. This should be done within the framework of a controlled study.

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(c) The IAC method should be compared with other approaches. This should be done within the framework of a controlled study.

(7) CONCLUSION

The high degree of client family satisfaction with the IAC and the services rendered by the Education Clinic, as well as the generally very positive student responses to the use of the IAC, suggests that the IAC can be considered an appropriate method of assessment and consultation in the field of learning disabilities. The results of this study thus favour the continued use of the IAC.

The review of literature does, however, illustrate that the IAC is not widely used overseas or locally. It is utilised at the Fernald Centre at the University of California in Los Angeles, where it originated and an adapted version of the model has been put into practice at the Education Clinic of the University of the Witwatersrand. Some general suggestions for the improvement of the IAC have been discussed. Furthermore, objective research studies on the effectiveness of the IAC model and its applicability for the various population groups in South Africa is indicated.

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ASSESSMENT THROUGH PROBLEM SOLVING

GOALS :

STRENGTHS / INTERESTS :

CONCERNS	UNDERSTANDING	ALTERNATIVES	DECISIONS

Division of Specialised Education
UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

APPENDIX B

Enquiries —
Telephone 716 2241
Date January 27 1982
Our ref MS/sc

EDUCATION CLINIC - 1982

Please complete the enclosed Parent Questionnaire/s and Release Form/s in respect of the child/ren you would like to have assessed at the Education Clinic. There is a waiting list of those to be seen, and the sooner you return the form, the higher your application will be on the list.

Please return the form to:

The Secretary
Division of Specialised Education
University of the Witwatersrand
1 Jan Smuts Avenue 2001

Children will be tested by our second-year remedial students under the supervision of qualified tutors, who in turn will report to the Head of the Division. Written reports after testing will be furnished to parents and to any other relevant person at the request of the parents.

This is a free service offered by the University. However, a donation after your child has been accepted will be most gratefully received, as the Division is still in need of more equipment to enhance its services.

Mervyn Skuy

MERVYN SKUY PhD
Head, Division of Specialised Education

UNIVERSITY OF THE WITWATERSRAND

DIVISION OF SPECIALISED EDUCATION

EDUCATION CLINIC

PARENT QUESTIONNAIRE

The initial consultation is likely to be more effective if you have had time to summarise your perspective of the problem. Therefore, we have developed this questionnaire.

This form is to be filled out by parents or guardians. When possible we would like both parents to work on the answers. If you have differing views, indicate when you differ, and tell us both views.

After you have answered the following questions, please share your responses with your child so that (s)he is aware of what you have said. This will save time during the conference.

We have tried to arrange the questions logically and clearly, but no printed form can fit the variety of individuals filling it out. Feel free to answer in the way that is best for you and do not worry if there are some questions you cannot answer, but where possible, please answer fully.

CHILD . . . . . DATE . . . . .

Child's name . . . . . SEX . . . . . .

Date of birth . . . . . AGE . . . .

Home Language . . . . . .

Address . . . . . .

. . . . . .

Home Telephone No . . . . . .

PARENT/S / GUARDIAN

Father's name . . . . . Mother's name . . . . . .

Occupation . . . . . Occupation . . . . . .

Business address . . . . . Business address . . . . . .

. . . .

. . . .

Business telephone . . . . . Business telephone . . . . . .

Marital Status : Married/Divorced/Separated/Widowed/Both Deceased

PTO

Siblings Number and ages of brothers and sisters . . . . . .

. . . . . .

FAMILY HISTORY: Any significant factors

SCHOOL : Name, Address and Telephone No of School

. . . . . .

. . . . . .

Class : (Grade/Standard) . . . . . .

Class Teacher's Name : . . . . . .

School Principal's Name : . . . . . .

Child's School History : Comments on significant problems or successes at school in the past

REASON FOR SEEKING CONSULTATION AND/OR ASSESSMENT AT THIS TIME:

(Please express as fully as possible how you see the problem/concer
- continue on back of questionnaire if necessary.

please state person and/or organisation who made the referral (e.g. school, doctor, teacher, family friend, or others)

*please state whether your child has had any previous testing (educational or psychological) and if so, by whom and when.

*Please state whether you have sought help before and if so, where and when (e.g. clinical psychologist, remedial teacher, or other)

*Medical Examination

1. Has your child had a recent medical examination?
   (a) by a General Practitioner (name) . . . . . .

   (date) . . . . . .

   Findings . . . . . .

   . . . . . .

   (b) by a Paediatrician (name) . . . .

   (date) . . . . . .

   Findings : Eyes . . . . . .

   Ears . . . . . .

Developmental history: Please state any significant factors in your child's physical and/or emotional development (e.g. walking early or late, speech difficulties or early speech, comments on mother's pregnancy (state whether normal or not) and confinement; bed-wetting, nightmares etc).

Strengths and interests: Please state the particular interests of your child, (e.g. [illegible]; hobbies; clubs; reading; arts and crafts,

Social relationships : Please indicate how your child gets on with adults and peers - friends, family, teachers etc.

Please indicate the age at which the current problem began . . . . .

What in your view are the factors that caused or are causing and/or aggravating the problem?

Is (are) the original cause(s) still contributing to the problem?

Yes . . . . . No . . . . .

Are there any other things currently contributing to the problem?

Yes . . . . . No . . . . .

What has been done about these problems until now?

What do you think should have been done in the past to prevent the problem or to deal with it in the early stages?

How did you come to realise that these corrective steps should have been taken? (e.g. you observed the need, you were told by a teacher, a doctor, a psychologist or other professional) (Specify)

You may have given thought to the kind of help that is needed at this time. If so, what do you think would be the most helpful?

Briefly state what you expect to accomplish through your consultation with us:

Other than parents, whom can we see to help (e.g. teacher) . . . . . .

. . . . . .

Problem is (tick applicable space(s) ( ) Academic ( ) Behavioural

( ) Emotional ( ) Motivational

( ) Other (specify) . . . . . .

. . . . . .

. . . . . .

If Academic, ( ) Reading ( ) Maths ( ) Writing ( ) Spelling

( ) Other (Specify) . . . . . .

. . . . . .

* If you have any reports of previous examinations/assessments/ interventions, you may bring them to the first appointment if you feel they will be of help to us. If you require us to obtain any reports, please complete the attached release form.

Thank you for your kind co-operation.

PERMISSION TO RELEASE AND ACQUIRE RECORDS

I hereby authorise the Division of Specialised Education at the University of the Witwatersrand to gain access to any records required by them and provide records to other appropriate agencies where necessary.

Signed . . . . . .

Relationship to Child . . . . . .

Witness . . . . . .

Date . . . . . .

Please indicate which records you wish us to obtain (e.g. doctor's report).

Name	Address

APPENDIX C

UNIVERSITY OF THE WITWATERSRAND

DIVISION OF SPECIALISED EDUCATION

Outline for

PSYCHO-EDUCATIONAL ASSESSMENT REPORTS

Letterhead

Division of Specialised Education

Psycho-Educational Assessment

Name of Child :

Class :

Date of Birth :

School :

Date of Initial Assessment :

Age at Assessment :

Participants in Assessment

Child :

Parents :

Student Consultants/Testers :

Supervisors :

(Teacher)

Summary of Concerns (Including significant historical factors, but emphasising current problems, needs, and strengths - as perceived by child and by parents)

Summary of Decisions (Child's name)..current situation was discussed and the following decisions were agreed upon, based upon the stated information and rationale :

Decision 1

Rationale :

(where appropriate) Tests Administered

Date

Observations and Results (including a succinct summary of levels of functioning, quality of functioning, and behaviour)

Conclusions of Testing

Decision 2

Rationale :

etc

Next Steps

1.

2.

3. etc

Signed _____

Student Tester B Ed (Rem Ed)

_____

Dr M Skuy (Clin Psych)
Head, Division of Specialised Education

*Most professionals are reluctant to provide the client with specific test scores because such scores have been misused by uninformed persons. Because we believe our clients are entitled to know whatever information we have gathered in arriving at our recommendations, we are including the test results. The information presented here will help you to understand the nature and limitations of such testing.

An achievement test samples abilities related to a specific type of learning, such as reading, math, language skills, spelling, etc.

There is no test that can completely reflect a person's intelligence or what one has learned. We use test results as an estimate; we recommend that every test finding should be viewed with extreme caution. We know that a wrong answer does not mean that a person does not understand a question; also, a wrong answer does not necessarily mean that a person is incapable of arriving at a correct answer. People know much more than they can produce, especially under test conditions. A person's behavior, especially under test conditions, is controlled by many factors, e.g., motivation, anxiety, expectancy of success, language proficiency, perceptual-motor skills and preferences, relationship to others in the situation such as the tester, etc. We strongly advise you to view the following scores as an approximation. (Parts of the above discussion are adapted from J. Kagan, Understanding Children, New York: Harcourt, Brace, Jovanovich, 1971.)

APPENDIX D

UNIVERSITY OF THE WITWATERSRAND

DIVISION OF SPECIALIZED EDUCATION.

EDUCATION CLINIC.

Dear Student

We need your help. We are not asking for funds - all we ask is a few minutes of your time. You have been involved inpsycho-educational assessments during the course of the year, we are very interested in finding out:-

(a) How much success you have experienced in carrying out these assessments,

(b) And how you feel about using a particular model within which to work...

You can assist us to maintain and improve the services offered at the clinic by co-operating in the evaluation survey. I would therefore be grateful if you would kindly answer the following questions as briefly as you wish and as frankly as you can - and return the completed questionnaire to me asscon as possible by placing it in the Med. pigeonhole in the secretary's office. Thank you for the courtesy of your assistance.

Very sincerely yours

Jubie Langor
(Med. Student)

Mervyn Skuy

Mark the alternative that applies in each case with an X.

1. Do you feel positive about using the IAC?

Yes	Yes	No	Not at all

Please elaborate if necessary .....
.....

2. Did you find the structure offered by the IAC helpful?

Yes	Yes	No	Not at all

Please elaborate if necessary .....
.....

3. In this approach, clients are expected to be active participants in their own problem-solving and decision-making processes. Do you feel that this presenteddifficulties for your clients?

Case 1	Yes	yes	No	Not at all
case 2	Yes	Yes	No	Not at all
Case 3	Yes	Yes	No	Not at all
Case 4	Yes	Yes	No	Not at all
Case 5	Yes	Yes	No	Not at all

4. The Fernald approach emphasises the need to examine the strengths of the clients along with the weaknesses. Do you perceive this as being advantageous in an assessment procedure?

Yes	Yes	No	Not at all

Please elaborate if necessary .....
.....

5. /.....p. 2

Mark the alternative that applies in each case with an X.

1. Do you feel positive about using the IAC?

Yes	Yes	No	Not at all

Please elaborate if necessary .....
.....

2. Did you find the structure offered by the IAC helpful?

Yes	Yes	No	Not at all

Please elaborate if necessary .....
.....

3. In this approach, clients are expected to be active participants in their own problem-solving and decision-making processes. Do you feel that this presenteddifficulties for your clients?

Case 1	Yes	yes	No	Not at all
case 2	Yes	Yes	No	Not at all
Case 3	Yes	Ye	No	Not at all
Case 4	Yes	Yes	No	Not at all
Case 5	Yes	Yes	No	Not at all

4. The Fernald approach emphasizes the need to examine the strengths of the clients along with the weaknesses. Do you perceive this as being advantageous in an assessment procedure?

Yes	Yes	No	Not at all

Please elaborate if necessary .....
.....

5. /.....p. 2

5. Do you feel you were able to help your clients resolve their concerns?

Case 1	Yes	Yes	No	Not at all
Case 2	Yes	Yes	No	Not at all
Case 3	Yes	Yes	No	Not at all
Case 4	Yes	Yes	No	Not at all
Case 5	Yes	Yes	No	Not at all

6. Do you perceive yourself as having brought about any positive change in your client's perception/s of their problem/s as a result of the IAC?

Case 1	Yes	Yes	No	Not at all
Case 2	Yes	Yes	No	Not at all
Case 3	Yes	Yes	No	Not at all
Case 4	Yes	Yes	No	Not at all
Case 5	Yes	Yes	No	Not at all

7. Do you feel that your client's were sufficiently motivated to carry out the decisions that you jointly made?

Case 1	Yes	Yes	No	Not at all
Case 2	Yes	Yes	No	Not at all
Case 3	Yes	Yes	No	Not at all
Case 4	Yes	Yes	No	Not at all
Case 5	Yes	Yes	No	Not at all

8. Would you have preferred to use another assessment model to the one you have used?

Yes	Yes	No	Not at all

9. /..... p. 3

9. Taking all your activities in the clinic into account, would you describe yourself as having been an effective helper this year?

Successful	Moderately successful	Not successful	Ineffective

Please elaborate .....
.....

10. Did you help clients from an ethnic group other than your own?

Yes	No

If so, what did you think about this? (Please elaborate)
.....
.....

Comments:

11. Please list the things you liked about the services offered at the clinic. .....
.....

12. Please indicate the things you didn't like. .....
.....

13. Do you have any suggestions for the improvement or change of our service. .....
.....

Thank - you.

APPENDIX E

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
DIVISION OF SPECIALISED EDUCATION

Enquiries
Telephone (011) 716 2241

Our ref MS/jd
Your ref

Date 8th November 1982

1922-1982

EDUCATION CLINIC

Dear_____

We need your help! So please give us a few minutes of your time.

We are very concerned to find out:-

(i) how pleased you were with our psycho-educational services,

(ii) how much success there has so far been towards the alleviation of the concerns for which you consulted us.

You can assist us to maintain and improve the services offered at this clinic by co-operating in the Evaluation Survey. I would therefore be grateful if you would kindly answer the following questions as frankly as you can and return the completed questionnaire to me in the enclosed stamped, self-addressed envelope as soon as possible. Thank you for the courtesy of your assistance.

Very sincerely yours

Jubie Dangor, BA(Hons.)
Student Counsellor.

Dr M. Skuy, Clinical & Educational Psychologist
Head, Division of Specialised Education.

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
1 Jan Smuts Avenue
Johannesburg
2001 South Africa
(011) 716-1111
Telegrams Univits

Name: _____

Please mark tne alternative that applies in each case with an X.

1. You were expected to play an active part togetner with the staff member (consultant) in discussing and trying to solve your problems and reach decisions. Did you feel positive about tnis approach.

Yes, most definitely	Yes	No	Not at all

2. Do you feel tnat your attitude to tne problem has changed now tnat you have sougnt help.

Yes, most definitely	Yes	No	Not at all

3. Do you feel that the staff member (consultant) understood and shared a genuine interest in the concerns you expressed.

Yes, most definitely	Yes	No	Not at all

4. Do you feel that the staff member (consultant) tried his or her best to help you.

Yes, most definitely	Yes	No	Not at all

5. Do you think there was too much testing.

Yes, most definitely	Yes	No	Not at all

6. Do you think that the staff member's (consultant's) discussion with the teacher/principal was a vital aspect of assessment.

Yes, most definitely	Yes	No	Not at all

7. Do you feel that you played a part in making decisions about the action to take about your concerns.

Yes, most definitely	Yes	No	Not at all

8. / .....p. 2.

8. Do you feel that the decisions arising out of the assessment were reasonably sound and useful.

Yes, most definitely	Yes	No	Not at all

9. Did you carry out the decisions that were taken jointly.

Yes, most definitely	Yes	No	Not at all

10. Do the decisions taken at the clinic appear to be producing positive results for you.

Yes, most definitely	Yes	No	Not at all

11. Would you have preferred the staff member (consultant) to have played a larger role in making decisions?

Yes, most definitely	Yes	No	Not at all

12. Did you son/daughter enjoy his/her participation in the assessment.

Yes, most definitely	Yes	No	Not at all

13. Do you feel you and your son/daughter gained anything from the assessment.

Yes, most definitely	Yes	No	Not at all

14. Do you feel that the assessment took too long?

Yes, most definitely	Yes	No	Not at all

Please elaborate .....

.....

15. If both parents are living, did both of them attend the assessment interview, if not, please state the reason.

Yes	No

.....

.....

16. / ..... p. 3.

16. Regarding your concerns do you think you were given sufficient feedback/information?

Yes, most definitely	Yes	No	Not at all

17. Do you feel that you son/daughter's difficulty/ies are/were of an emotional nature.

Yes, most definitely	Yes	No	Not at all

18. Were you helped by a staff member (consultant) of a race group other than your own.

Yes		No	

If so what did you feel about this? Please elaborate .

.....

.....

19. Were you satisfied with the report you received.

Yes, most definitely	Yes	No	Not at all

SECTION B.

<u>If your son or daughter received remedial help at this clinic complete this section.</u>

1. Do you feel tnat your child has benefited from the remedial help he/she received.

Yes, most definitely	Yes	No	Not at all

2. Does your son/daughter feel that he/she benefited fom the remedial teaching?

Yes, most definitely	Yes	No	Not at all

3 / ..... p. 4.

3. Does your son/daughter show any noticeable improvement in his/her school work after having had remedial help.

Yes, most definitely	Yes	No	Not at all

4. Has remedial teaching alleviated all the concerns about your child's schoolwork you discussed at the first interview.

Yes, most definitely	Yes	No	NOt at all

If not, please elaborate .....

.....

SECTION C.

If your family received one or more session/s of family counselling complete this section.

1. Do you feel that family counselling was an important aspect of the help offered.

Yes, most definitely	Yes	No	Not at all

2. Do you feel that you gained a better understanding of your concerns/problems through family counselling.

Yes, most definitely	Yes	No	Not at all

3. Do you feel family counselling was relevant to the original problem/concern for which you sought help.

Yes, most definitely	Yes	No	Not at all

4. Did you and your family members feel that you benefited from your participation in family counselling.

Yes, most definitely	Yes	No	Not at all

Please elaborate. .....

.....

COMMENTS / ..... P. 5.

COMMENTS

a. Please list the things you liked about the service.

.....

.....

.....

.....

b. Please indicate the things you didn't like.

.....

.....

.....

.....

c. Do you have any suggestions for improvement or change of our service.

.....

.....

.....

.....

THANK - YOU.