ASSESSING CHILDREN AT THE ORPHANAGE AND HOSPITAL FOR HANDICAPPED CHILDREN IN SASCA, ROMANIA

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I. INTRODUCTION[1]

In May of 1992, an American research team from the University of Iowa School of Social Work traveled to the Orphanage and Hospital for Handicapped Children in Sasca, Romania. This team was directed by Dr. Victor Groze and included four research assistants.

The assessment tool used was the AAMD Adaptive Behavior Scale. The Adaptive Behavior Scale is a behavior rating scale for mentally retarded, emotionally maladjusted, and developmentally disabled individuals who reside in institutional settings. It is also appropriate to use it for other handicapping conditions as well. The AAMD Adaptive Behavior Scale measures the adaptive behavior of an individual. Adaptive behavior is understood as the level of ability of an individual to cope with the natural and social demands of his or her environment.

The AAMD Adaptive Behavior Scale consists of two parts. The first part measures a person's skills and habits in ten areas of behavior associated with personal independence in daily living. These ten areas of behavior include:

(1) Independent Functioning: This includes behaviors associated with eating, toilet use, cleanliness, appearance, care of clothing, and dressing and undressing.

(2) Physical Development: This includes sensory development and motor development.

(3) Economic Activity: This includes money handling and budgeting.

(4) Language Development: This includes expression, comprehension and social language development.

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[1] Special thanks to Mark Haines Simeon for his assistance in preparing this report.

(5) Numbers and Time: This includes basic mathematical skills.

(6) Domestic Activity: This includes cleaning, kitchen duties, and other domestic activities.

(7) Vocational Activity: This includes job skills, level of performance and work habits.

(8) Self-Direction: This includes initiative, perseverance, and leisure time.

(9) Responsibility: This includes dependability and responsibility.

(10) Socialization: This includes interaction with others, participation and social maturity.

The second part of the AAMD Adaptive Behavior Scale measures maladaptive behavior related to personality and behavior disorders. This section of the assessment consists of 14 areas of behavior: (1) Violent and Destructive Behavior, (2) Antisocial Behavior, (3) Rebellious Behavior, (4) Untrustworthy Behavior, (5) Withdrawal, (6) Stereotyped Behavior and Odd Mannerisms, (7) Inappropriate Interpersonal Manners, (8) Unacceptable Vocal Habits, (9) Unacceptable or Eccentric Habits, (10) Self-Abusive Behavior, (11) Hyperactive Tendencies, (12) Sexually Aberrant Behavior, (13) Psychological Disturbances, and (14) Use of Medications.

The AAMD Adaptive Behavior Scale continues to be studied and updated through longitudinal research. It has been used in the evaluation and assessment of mentally handicapped children and adults residing in institutions for the mentally handicapped in the United States.

The AAMD Adaptive Behavior Scale for the institution at Sasca has implications for four areas. These areas include:

(1) Program Planning and Design: An assessment of the children identifies specific needs. Then, each child is accurately placed in specific programs designed to meet their needs.

(2) Resource Allocation: Accurate identification of program needs of children uses limited resources (staff, equipment, and small budgets). Resources get directed with the greatest effectiveness.

(3) Administrative Control: Ongoing assessment of children can identify the needs for program change. This information is helpful in making administrative decisions to maintain efficient and effective programming.

(4) Program Evaluation: Ongoing assessment of children can measure the overall program effectiveness. Are the programs working?

II. RESULTS

The team assessed 79 children, ranging from 5 to 21 years of age. Reported here are the results from 77 children ranging from 5 to 19 years of age. This group of children was comprised of 52% females and 48% males.

The scoring of the assessments was completed according to age groups. These age groups include: 5 ; 6-7; 8-9; 10-12; 13-15; 16-18; and 19. The summary sheets (found in the Appendix) provide a profile of each age group in comparison to mentally retarded persons in U.S. institutions. The mean score of each age group was contrasted with percentiles of the comparison group. For example, the Independent Functioning score of the age group for 5 year olds is "5". This score equals or exceeds 0% of the comparison group. This means that 100% of comparison children scored higher on independent functioning than this child.

The results for Part I are reviewed according to age groups. Only the extremes in scores are highlighted. In the area of personal independence and daily living skills, only scores below the 10th percentile were reported. This means that in these areas, 90% or more of other children in this age group scored higher in U.S. institutions (with higher meaning greater skill in this area).

The 5 year old group scored low in the areas of independent functioning, self-direction and socialization. For these categories 100% of the comparison group scored higher. In the area of physical development for the 5 year old group, 90% of the comparison group scored higher.

The 6-7 year old group scored low in the categories of independent functioning, numbers & time, and domestic activity. In these areas, 100% of the comparison group of children in U.S. institutions scored higher. In physical development, 95% of the comparison group scored higher. And in the categories of self-direction and socialization, 92% of the comparison group scored higher.

The 8-9 year old group scored low in three categories. In independent functioning, 96% of children in the comparison group scored higher. In the categories of self-direction and socialization, 95% of the comparison group scored higher.

The 10-12 year old group scored low in three categories. In socialization, 98% of the children in the comparison group scored higher. In the categories of independent functioning and self-direction, 95% of the comparison group scored higher.

In the 13-15 year old group there were no categories with scores in the 10th percentile. In this group, the lowest score was found in the category of independent

functioning. In this category, the scores for the Sasca children in this age group was equal to 18% of the comparison group. This means that 82% of the comparison group scored higher.

The 16-18 year old group scored low in 4 categories. In the category of socialization, 95% of the comparison group scored higher. In the areas of independent functioning & self-direction, 94% of the comparison group scored higher. And in the category of physical development, 91% of the children in the comparison group scored higher.

For the age group of 19 years, there were 5 areas with low scores. In the categories of socialization and self-direction, 100% of the comparison group scored higher. In the areas of independent functioning and physical development, 99% of the comparison group scored higher. And in language development, 98% of the comparison group scored higher than this age group in Sasca.

These results suggest that, as a group, children score extremely low in the areas of independent functioning, physical development, language development, numbers & time, domestic activity, self-direction, and socialization.

The results for Part II are also reviewed according to age groups. It is noted that only the extremes in scores are highlighted. Only scores equal to or greater than the 90th percentile were reported. It is important to remember that the higher the score, the more behavior problems are evident.

For the 5 year old age group, Part II scores revealed only one category with an extreme score: unacceptable or eccentric habits. Sasca scores were equal to 92% of the comparison group, with only 8% of the population of the comparison group scoring higher.

The 6-7 year old age group had extreme scores in the category of stereotyped behavior and odd mannerisms. In this area, Sasca scores were equal to 90% of the comparison group, with only 10% of the comparison group scoring higher.

The 8-9 year old age group had no scores equal to or above the 90th percentile, when compared to the comparison group.

The 10-12 year old age group had extreme scores in three areas. In self-abusive behavior and stereotyped behavior and odd mannerisms, Sasca scores equaled 90% of the comparison group, with only 10% of the comparison group scoring higher. In the area of withdrawal, Sasca scores were equal to 92% of the comparison group, with only 8% of the comparison group scoring higher.

The 13-15 year old age group scores for Part II indicate only one area with a severe score. In the area of unacceptable or eccentric habits, Sasca children scores equaled 92% of the comparison group, with only 8% scoring higher.

For the 16-18 year old age group, one category was measured to have an extreme score. In the area of unacceptable or eccentric habits, Sasca scores were equal to 90% of the comparison group, with only 10% of the comparison group scoring higher.

Finally, in the 19 year old age group, withdrawal was the only serious score. In this area, Sasca scores were equal to 100% of the comparison population.

In general team members observed that the population of children could be divided between higher and lower functioning abilities. It was observed that the children on the first floor (except for one) were mobile and had no obvious physical disability. They all scored in the top 98% or 65% in physical development. Those with lesser scores were due to minor

physical limitations. The children on the second floor of the Institution have more serious medical, mental, and physical handicaps.

III. IMPLICATIONS

Implications are developed from the assessment of the children and general observations of team members.

Several implications can be made from the assessment of these children. First, it is clear that there are higher functioning children and lower functioning children. This is clear by the differences between the children on the first floor and those children on the second floor. This implies the need for different programs for each group of children. The needs of the higher functioning children are different than the needs of lower functioning children. For example, higher functioning children will have a greater probability of success in a placement outside the institution. Lower functioning children may require life-long institutional care. Long term planning needs to occur for both types of children.

The behaviors observed by team members, and measured by the AAMD Adaptive Behavior Scale, indicate these children have many needs. However, further testing is needed to clarify the needs of each child. For example, high scores of certain behaviors can be misunderstood as evidence of the low functioning level of a child. If a child exhibits high levels of self-abusive behavior or withdrawal, this does not mean that the child could not benefit from new programs. Self-abusive behavior or withdrawal could result from a lack of stimulation, underdeveloped speaking skills, or perhaps the result of abuse or neglect. A high functioning child could exhibit many maladaptive behaviors.

Other factors can complicate the accurate assessment of the children. For example, at Sasca the adults and children are housed in separate buildings. However, it was observed that the adults and children mix freely, resulting in several adults sexually abusing the children. This kind of abuse can create and reinforce many maladaptive behaviors in children.

Sasca has benefited greatly from the work and resources of international relief agencies. The institution has upgraded its heating system, in addition to receiving a wide range of other resources. However, there are two areas of concern. The first area of concern is that international relief agencies eventually end their work. When international agencies leave, the programs end and the resources stop. There is no long term planning to avoid losing the progress that has been made by training appropriate staff or increasing resource allocation to the facility.

The second area of concern relates to the early departure of international agencies. Many international agencies struggle with the disappearance and loss of their supplies and resources intended for the benefit of children. Such experiences of theft and disappearance of supplies tends to undermine the motivation of international relief organizations. Future efforts in providing assistance and aid could become compromised if the problem of theft is not remedied.

IV. RECOMMENDATIONS

This study reveals the importance of ongoing assessment of children. Such assessment could define specific needs of individual children, particularly in defining new

programs.

Program development is the primary recommendation of this study. Higher functioning children would benefit from educational programs, including speech therapy. It is believed that the majority of children on the first floor would benefit from some type of formal educational program and vocational skill training program. Particularly important would be language development, with sign language instruction for those with hearing or speech impairment. It is assumed that such programs would directly impact the independent functioning, language development, domestic activity, self-direction responsibility, and socialization scores of these children.

Program development for lower functioning children is also needed. Depending upon individual need, this could include play therapy and physical therapy. In addition, a structured environment to encourage and train lower functioning children (i.e., in toilet training, simple chores/duties, laundry, & general cleaning) would provide long-term benefits to children and caretakers. Children with limited abilities also benefit from structured time in which their major senses (touch, smell, taste, vision, hearing) are stimulated.

As an example of program change, a daily routine of domestic activities would reinforce a sense of purpose within the child, instilling self-direction, self-discipline, responsibility and identity. Scheduled times in which assigned chores for the higher functioning children could occur, with appropriate expectations in personal care. These children could learn how to care for their personal belongings, to fold clothes, to make their beds, to participate in laundry and clean their rooms.

Another recommendation is the intentional separation of adult residents and children.

This separation would reduce chaos and some of the sexual abuse occurring.

Long-term planning for high and low functioning children needs to occur. Higher functioning children could benefit from being placed in Romanian families, or placed for national or international adoption. We recognize that this recommendation would be difficult to implement. However, with the leadership of the Ministry of the Handicapped, national and international adoption and foster programs would provide excellent alternatives for some of these children.

Options for the long term care of lower functioning children could include training for independent functioning and encouraging a greater level of participation in their own care.

A final recommendation relates to the role of international agencies. It is important that in the future, international relief organizations address the survival of their programs once aid is withdrawn or completed. One solution is to encourage international agencies to educate Romanian staff. This transfer of skill and knowledge would increase the potential for long-term program survival.

V. FINAL COMMENTS

The assessment of the children at Sasca provides important information at many levels. The benefits of assessment were discussed earlier in the area of program development. This assessment could also be used administratively as for administrative control and program evaluation.

Institutional care of children raises other issues. Specifically, are institutions a positive means of meeting the needs of children orphaned or abandoned by families?

Clearly, alternatives to institutional care must be developed. While this report makes specific program recommendations for institutional change, this report does not assume that institutions are the best means of caring for children. Many of the minor physical disabilities and behavior difficulties have been exacerbated by institutional care. While institutions serve a function in providing care for some children, ultimately it is not in the best interests of the child. Regardless of the best intentions of any institution, the benefits of family home care cannot be replicated.

Therefore, as Romania continues to progress in its social, economic and political spheres, it is important to develop national policies and programs that will eventually eliminate the institutional care of children.

APPENDIX

TABLES OF SCORES BY AGE GROUP FOR AAMD SCALES

Table I : AAMD Scale for 5 Year Old Children (n=1)

Age Group: 5		
Frequency: 1		
Part I	Sasca	Comparison Group
	Scores	Percentile
I. Independent Functioning	5	0%
II. Physical Development	9	10%
III. Economic Activity	0	No Norms Available
IV. Language Development	4	28%
V. Numbers & Time	0	No Norms Available
VI. Domestic Activity	0	No Norms Available
VII. Vocational Activity	0	No Norms Available
VIII. Self-Direction	0	0%
IX Responsibility	0	No Norms Available
X. Socialization	2	0%
Part II		
I. Violent & Destructive Behav.	4	70%
II. Antisocial Behavior	0	55%
III. Rebellious Behavior	0	58%
IV. Untrustworthy Behavior	0	No Norms Available
V. Withdrawal	2	60%
VI. Stereotyped Behavior &	2	78%
Odd Mannerisms		
VII. Inappropriate Interpersonal	0	No Norms Available
Manners		
VIII. Unacceptable Vocal Habits	0	No Norms Available
IX. Unacceptable or Eccentric	10	92%
Habits		
X. Self-Abusive Behavior	4	No Norms Available
XI. Hyperactive Tendencies	0	60%
XII. Sexually Aberrant Behavior	0	No Norms Available
XIII. Psychological Disturbances	6	85%
XIV. Use of Medications	0	55%

Table III : AAMD Scale for 8-9 Year Old Children (n=8)

Age Group: 8-9				
Frequency: 8				
				Comparison Group
Part I		Sasca		Percentile
	Mean	Median	Mode	
I. Independent Functioning	21.25	17	17	4%
II. Physical Development	15.13	18	7	20%
III. Economic Activity	0	0	0	65%
IV. Language Development	6	4.5	0	20%
V. Numbers & Time	0.25	0	0	38%
VI. Domestic Activity	0.625	0	0	35%
VII. Vocational Activity	0	0	0	No Norms Available
VIII. Self-Direction	2.5	0	0	5%
IX Responsibility	0.75	0	0	56%
X. Socialization	4.375	0.5	0	5%
Part II				
I. Violent & Destructive Behav	5.375	2.5	0	60%
II. Antisocial Behavior	3.25	0.5	0	60%
III. Rebellious Behavior	1.875	0	0	58%
IV. Untrustworthy Behavior	1.25	0	0	No Norms Available
V. Withdrawal	4.5	1.5	0	82%
VI. Stereotyped Behavior &	3.125	2.5	2	82%
Odd Mannerisms				
VII. Inappropriate Interpersona	0.5	0	0	No Norms Available
Manners				
VIII. Unacceptable Vocal Habits	1.625	1	0	No Norms Available
IX. Unacceptable or Eccentric	4.875	4.5	2	82%
Habits				
X. Self-Abusive Behavior	1.75	0.5	0	88%
XI. Hyperactive Tendencies	1.5	0	0	72%
XII. Sexually Aberrant Behavio	0.875	0	0	No Norms Available
XIII. Psychological Disturbances	3.25	2	0	62%
XIV. Use of Medications	0	0	0	60%

Table IV : AAMD Scale for 10-12 Year Old Children (n=26)

Age Group: 10-12				
Frequency: 26				
				Comparison Group
Part I		Sasca		Percentile
	Mean	Median	Mode	
I. Independent Functioning	27.731	22	5	5%
II. Physical Development	15.423	16.5	23	15%
III. Economic Activity	0	0	0	50%
IV. Language Development	4.577	2.5	0	12%
V. Numbers & Time	0.231	0	0	28%
VI. Domestic Activity	0.577	0	0	28%
VII. Vocational Activity	0.385	0	0	42%
VIII. Self-Direction	2.654	0	0	5%
IX Responsibility	0.615	0	0	40%
X. Socialization	4.423	2.5	0	2%
Part II				
I. Violent & Destructive Behav	3.577	1.5	1	60%
II. Antisocial Behavior	2	0	0	55%
III. Rebellious Behavior	1.385	0	0	52%
IV. Untrustworthy Behavior	0.5	0	0	No Norms Available
V. Withdrawal	8.038	8	8	92%
VI. Stereotyped Behavior & Odd Mannerisms	5.115	5	0	90%
VII. Inappropriate Interpersona Manners	0.615	0	0	No Norms Available
VIII. Unacceptable Vocal Habits	1.615	1	0	No Norms Available
IX. Unacceptable or Eccentric Habits	6.269	6	0	85%
X. Self-Abusive Behavior	2.154	0	0	90%
XI. Hyperactive Tendencies	0.808	0	0	68%
XII. Sexually Aberrant Behavio	0.154	0	0	No Norms Available
XIII. Psychological Disturbances	3.654	2.5	0	60%
XIV. Use of Medications	0.5	0	0	65%

Table V : AAMD Scale for 13-15 Year Old Children (n=17)

Age Group: 13-15				
Frequency: 17				
				Comparison Group
Part I		Sasca		Percentile
	Mean	Median	Mode	
I. Independent Functioning	49.118	54	82	18%
II. Physical Development	20.059	23	24	25%
III. Economic Activity	0.471	0	0	40%
IV. Language Development	12.235	10	23	25%
V. Numbers & Time	2.059	0	0	30%
VI. Domestic Activity	3.824	1	0	40%
VII. Vocational Activity	3.529	0	0	39%
VIII. Self-Direction	9.765	11	14	28%
IX Responsibility	2.118	3	0	52%
X. Socialization	9.882	10	17	48%
Part II				
I. Violent & Destructive Behav	4.765	3	0	68%
II. Antisocial Behavior	5.588	2	0	68%
III. Rebellious Behavior	4.941	1	0	75%
IV. Untrustworthy Behavior	1.647	0	0	66%
V. Withdrawal	3.294	1	0	82%
VI. Stereotyped Behavior &	2.647	1	0	85%
Odd Mannerisms				
VII. Inappropriate Interpersona	0.529	0	0	70%
Manners				
VIII. Unacceptable Vocal Habits	1.235	0	0	75%
IX. Unacceptable or Eccentric	7.118	7	7	92%
Habits				
X. Self-Abusive Behavior	1.118	0	0	85%
XI. Hyperactive Tendencies	1.059	0	0	75%
XII. Sexually Aberrant Behavio	1.529	0	0	80%
XIII. Psychological Disturbances	4.412	2	0	62%
XIV. Use of Medications	0	0	0	50%

Table VI : AAMD Scale for 16-18 Year Old Children (n=14)

Age Group: 16-18				
Frequency: 14				
				Comparison Group
Part I		Sasca		Percentile
	Mean	Median	Mode	
I. Independent Functioning	36.571	32	5	6%
II. Physical Development	15.929	16	23	9%
III. Economic Activity	0.143	0	0	26%
IV. Language Development	9.714	7	0	15%
V. Numbers & Time	1.5	0	0	25%
VI. Domestic Activity	2.786	0	0	28%
VII. Vocational Activity	2.357	0	0	26%
VIII. Self-Direction	5.429	1.5	0	6%
IX Responsibility	1.643	1	0	40%
X. Socialization	7.857	6.5	1	5%
Part II				
I. Violent & Destructive Behav	4.357	2	0	74%
II. Antisocial Behavior	2.643	3	0	48%
III. Rebellious Behavior	1	0	0	52%
IV. Untrustworthy Behavior	0.571	0	0	55%
V. Withdrawal	5.071	2.5	0	86%
VI. Stereotyped Behavior &	3	1.5	0	88%
Odd Mannerisms				
VII. Inappropriate Interpersona	0.214	0	0	65%
Manners				
VIII. Unacceptable Vocal Habits	1.071	1	0	75%
IX. Unacceptable or Eccentric	5.714	2.5	0	90%
Habits				
X. Self-Abusive Behavior	1.214	0	0	85%
XI. Hyperactive Tendencies	0.429	0	0	70%
XII. Sexually Aberrant Behavio	1.357	0	0	75%
XIII. Psychological Disturbances	3.429	1	0	62%
XIV. Use of Medications	0.071	0	0	50%

Table VII : AAMD Scale for 19 Year Old Children (n=1)

Age Group: 19		
Frequency: 1		
	Sasca	Comparison Group
Part I	Scores	Percentile
I. Independent Functioning	5	1%
II. Physical Development	6	1%
III. Economic Activity	0	25%
IV. Language Development	0	2%
V. Numbers & Time	0	15%
VI. Domestic Activity	0	15%
VII. Vocational Activity	0	20%
VIII. Self-Direction	0	0%
IX Responsibility	0	22%
X. Socialization	0	0%
Part II		
I. Violent & Destructive Behav	1	50%
II. Antisocial Behavior	0	35%
III. Rebellious Behavior	0	45%
IV. Untrustworthy Behavior	0	55%
V. Withdrawal	16	100%
VI. Stereotyped Behavior &	1	70%
Odd Mannerisms		
VII. Inappropriate Interpersona	0	70%
Manners		
VIII. Unacceptable Vocal Habits	1	65%
IX. Unacceptable or Eccentric	1	60%
Habits		
X. Self-Abusive Behavior	0	70%
XI. Hyperactive Tendencies	0	70%
XII. Sexually Aberrant Behavio	0	65%
XIII. Psychological Disturbances	0	25%
XIV. Use of Medications	0	50%