Position Paper of
The IMP Task Force
on
Vicarious Trauma in the Workplace

SUPPORTING
PRACTITIONER
EFFECTIVENESS
WITH YOUNG CHILDREN
IN HIGH-RISK FAMILIES

March 2004
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**Executive Summary**

**Background**

In February 2003, the Infant Mental Health Promotion Project (IMP) held a “think tank” with 60 invited management-level representatives from sectors that provide care to infants and their families. The purpose was to address the serious issue of vicarious trauma when working with young children in high-risk families (i.e. developing symptoms of trauma from repeated exposure to the suffering of others), and to propose strategies for creating the necessary support for working in this challenging field. To implement the recommendations, IMP formed a Task Force on Vicarious Trauma in the Workplace. The goals were to develop a position paper and recommendations for organizational best practices to support effectiveness of intervention with young children in high-risk families.

**Challenges for practitioners**

Repeated exposure to the trauma, suffering and unjust circumstances of others can lead practitioners to develop symptoms such as fears for their own safety and that of their loved ones. Practitioners may begin to question their competence and to feel helpless to relieve the suffering of others particularly when they have received inadequate training for the interventions and assessments needed. In addition, they are burdened with high caseloads, overwhelming paperwork, and responsibility for high-risk families who can be difficult to engage, slow to show positive changes, have frequent crises, and may resist suggestions. Increased public expectations of professionals coupled with a lack of adequate supports in the workplace create anxiety regarding harm to a child as a result of maltreatment or family violence. As well, practitioners have concerns about losing their jobs and careers in the current work climate of restrictive policy and cutbacks.

**High-risk families**

The Task Force reviewed literature on factors that place young children at low, moderate and high risk. Risk factors included genetic or biological conditions of the child, parental psychiatric conditions, parental addiction to drugs or alcohol, environmental challenges such as extreme poverty, family violence, child abuse and neglect, and parental inability to provide adequate care for their children. The more risk factors and the fewer protective variables in a given situation, the greater the risk to the child. Repeated stress of working with high-risk families experiencing such complex circumstances, the many crises that may occur and concerns about harm to a child can have a serious impact on practitioners.

**Effectiveness of interventions**

Conclusions about the effectiveness of interventions in the literature included:

- In-depth assessment is needed so as to focus on the most problematic areas.
- Families need assistance with concrete needs, crisis and supportive services, and help to overcome the effects of unresolved loss and trauma.
- A therapeutic parent-intervenor relationship with sensitivity to family structure, cultural, racial and ethnic differences is key.
- Home visiting may be essential to reach the most high-risk families.
- Long-term, high-intensity, family-centred interventions based on a variety of theoretical approaches may achieve the best outcomes.
- Interventions need to be staged and to address the hierarchy of needs of a family and the emotional well-being of both parents and young children.

**Supports needed for work with high-risk families**

Government guidelines and funding and agency policies for assessment and intervention must take into account current research on effective practices and ensure a supportive structure for innovative approaches that meet the needs of high-risk families. This includes guidelines for assessment, intervention, professional roles and boundaries, confidentiality, safety, team support and crisis response. Opportunities for reflection on casework must be made available through individual supervision with experienced professionals, team support and consultation with experts. Both frontline and supervisory staff need specialized training for the difficult work and ongoing continuing education as new information becomes available. Collaboration with other agencies is necessary as no one agency or professional can provide the multiple interventions needed to meet the needs of complex families.

The IMP Task Force developed a document entitled *Organizational Policies & Practices To Support High Quality Services in the Field of Infant Mental Health* in order to raise awareness of the challenges faced in this field and the responsibilities of organizations to provide appropriate supports that help retain experienced practitioners so that families receive continuity of care. A copy of this document is in Appendix 4.

**Recommendations**

It is therefore recommended that:

1. Government at federal, provincial and municipal levels, and service organizations, managers and practitioners acknowledge:
   a) the complex needs of high-risk families with young children and the amount and kinds of resources and supports required to ensure the best possible outcomes for children
   b) the serious negative impact this work has on practitioners
   c) the supports needed by practitioners to provide effective services.

2. Organizations develop clear policies and strive towards practices that support the principles outlined in *Organizational Policies & Practices To Support High Quality Services in the Field of Infant Mental Health*.

3. Government at federal, provincial and municipal levels provide realistic service guidelines and allocate appropriate funding to ensure organizational support that enables practitioners to provide effective services for high-risk families with young children.
INTRODUCTION AND PURPOSE

The Infant Mental Health Promotion Project (IMP) is a coalition of professional representatives from service agencies dedicated to promoting optimal outcomes for infants (prenatal to 36 months) in collaboration with families and other caregivers.

IMP’s mission is to develop and support best practices for enhancing infant mental health through education, dissemination of information, networking, and advocacy.

IMP’s values and beliefs include that:

- The first few years of life have a unique and formative impact on development, relationships and functioning throughout life.
- Service providers require a specific knowledge and skill base to provide care in the area of infant mental health (see Appendix 3).
- Many adverse outcomes can be prevented when parents and other caregivers are provided with support that enables them to be optimally responsive to their infants and young children.

Scope of Position Paper

This position paper addresses the issue of vicarious trauma when providing intervention for high-risk families and the supports needed to prevent or alleviate negative effects on individual practitioners and the service delivery system. The paper defines high risk and reviews literature on the features of high-risk families that create risks for young children living in them. It also summarizes the characteristics of effective interventions and the challenges of providing services to high-risk families. Finally, the paper makes recommendations for policies and practices needed to support practitioner effectiveness and staff retention.

The Serious Issue of Vicarious Trauma

Infant mental health practitioners are frequently confronted with serious family situations that leave them feeling helpless, hopeless and unsuccessful. In addition, the traumatic experiences of these families can trigger trauma in workers. Concerns about ability to ensure the well-being of both infant and parent, about being involved in legal issues, and about their own personal safety, can lead to practitioner anxiety, anger, withdrawal and/or burnout. This is known as vicarious or secondary trauma.

The ultimate result is that some highly trained practitioners withdraw from this kind of work or remain but become ineffective. Staff turnover and withdrawal increase stress for the remaining workers and are costly to the service delivery system. Thus vicarious trauma has a negative impact on the effectiveness of practice with high-risk families who have young children.

IMP’s Vicarious Trauma Think Tank

To develop solutions to these challenging workplace issues, IMP held a think tank in February 2003 with 60 invited management-level representatives from sectors that provide care to infants and their families (Wolpert, 2003). The goals of the think tank were to:

- Learn more about the stresses of work with high-risk infants, young children and their families
- Discuss innovative ways to support staff, management and organizations
- Discuss strategies for getting the issue of workplace stress on the political agenda and creating a climate that recognizes what is needed to support work in this field
- Plan next steps for action.

The event included presentations on research related to secondary trauma and approaches to supporting frontline workers. As well, small groups defined the issues experienced in their work, proposed creative strategies to support staff (See Appendix 1) and made recommendations for action. Recommendations included:

- Develop organizational competencies for managing secondary trauma in the workplace and ensuring appropriate practitioner support and safety
- Develop a position paper to inform government and the public about the seriousness of vicarious trauma and to encourage action to address the issue
- Create awareness of vicarious trauma and its impact on workers in all systems, and develop appropriate training.

The Task Force on Vicarious Trauma in the Workplace

In order to implement these recommendations, IMP formed a Task Force on Vicarious Trauma in the Workplace1 with the following goals:

1. To review evidence regarding effective interventions with young children in high-risk families.
2. To review literature on the impact of vicarious trauma when working with young children in high-risk families.
3. To develop a position paper and recommendations regarding organizational best practices for supporting practitioner effectiveness.
4. To develop and implement a dissemination strategy.

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1. For Task Force members see page 20.
Vicarious Trauma

It is now recognized that practitioners who are repeatedly exposed to the trauma and suffering of others can develop symptoms of trauma themselves. This reaction is known as vicarious or secondary trauma. When we listen to the story of another’s pain and suffering, it is normal to be shocked and saddened, and to feel vulnerable. Hearing frequent descriptions of violent events and the cruel realities of the lives of many high-risk families, and being a helpless bystander to tragedy can have serious effects on practitioners (Figley, 1995; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). As well, empathy, which is essential to the process of treatment, places the worker at greater risk of secondary trauma (Figley, 1995) since the trauma of others can cause previously unresolved personal traumas to resurface and be re-experienced.

As a result, workers can experience symptoms similar to those of their clients, for example intrusive memories, nightmares, severe anxiety, irritability and emotional numbing (Regehr, 2003), and they may have difficulty listening to clients’ accounts of events. With repeated exposure, workers can incorporate an accumulation of traumatic material into their own view of self and the world (McCann & Pearlman, 1990) and develop increased fears for their own safety and that of their loved ones. The intensity of work with clients in crisis situations of urgency and emotional reactivity can cause workers to begin to question their competence and to feel helpless to relieve the suffering of others.

In a recent study of traumatic stress arousal symptoms in firefighters, paramedics and child protection workers, child protection workers, particularly managers, showed the highest number of symptoms and degree of traumatic stress (Regehr, 2003). There are many possible reasons for this, including the use of empathy by child protection workers to engage families and bring about change and their lack of specific training or support for dealing with traumatic stress. Emergency workers, on the other hand, may encounter horrific events, but are not required to deal with the anger, grief and despair of their clients on an ongoing basis.

Early interventionists are often idealistic about the effectiveness of their work. Having to come to terms with unjust circumstances in families can quickly make them chronically pessimistic about making a difference (Kauffman, 2002).

Workload, Job Responsibility and Policies

Significant workplace factors related to the development of vicarious trauma are high caseloads and responsibility for the welfare of others (Regehr, 2003). Practitioners with caseloads of almost exclusively high-risk families can experience a sense of failure that builds when positive changes are slow and crises are frequent. As well, if parents are difficult to engage and resistant to suggestions and interventions, a sense of powerlessness can result.

An issue of great concern and anxiety to workers is that a child on their caseload might be seriously injured or even die as a result of child abuse or family violence. Fortunately, such situations are rare. However, dramatic media scrutiny of the inquiry process makes practitioners more cautious in their attempts to help others (Regehr et al., 2003; Regehr et al., 2002). Concerns about job and career loss can produce significant anxiety.

Reduced funding and legislative changes have shifted working environments in sectors such as hospitals, child welfare and community-based health and mental health services. Workloads and pressures for services have increased while opportunities for adequate training, support and supervision have decreased. Policies and procedures in a number of early intervention agencies do not allow workers to provide the variety, length or type of services needed by high-risk families. Workplace strain depletes coping mechanisms and makes workers more vulnerable to vicarious trauma. Increased public expectations of accountability for professionals coupled with the lack of adequate supports in the work environment places practitioners at further risk.

WHICH FAMILIES ARE HIGH-RISK?

High-risk families are those in which several conditions place a child at risk for compromised development. These risk factors may be categorized as follows (Landy, in press):

1. Genetic or biological conditions of the child such as low birth weight, extreme prematurity, repeated hospitalizations or illness.
2. Psychiatric disorder, addiction, or significant developmental disability of a parent.
3. Sociological or environmental challenges, such as extreme poverty that compromise a parent’s ability to provide a safe and secure environment for the child.
4. Parental inability to be adequately nurturing and responsive to a child due to unresolved loss and trauma. This may include neglect, the use of harsh or angry interactions and/or abusive discipline.
There is a complex interplay between risk factors and protective factors or mechanisms that protect a child against the consequences of risk and improve and enhance child functioning under conditions which would otherwise result in compromised development (Coie et al., 1993; Rutter, 1990). Some examples of protective factors are having a supportive family network or community, having someone available to support a child during a mother’s mental illness, promoting a parent’s self esteem, and/or creating opportunities for parents to improve their life skills and parenting skills.

It has been difficult to determine the relative importance of different risk factors and the relative contribution of proximal and distal variables and biological and environmental factors to child outcome. Proximal variable are those closest to the child (e.g., negative mother-child interaction and relationship, high criticism of the child, maternal depression or other mental illness, parental alcoholism, harsh and punitive discipline). Distal variables are those that affect the child indirectly through their influence on parent-child interactions (e.g., minimal parental education, low socioeconomic status, overcrowding, single parent status) (Landy, 2002). The most important factors that have been found to differentiate low risk, moderate risk, and high-risk families are presented in Table 1.

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<th>LOW RISK</th>
<th>MODERATE RISK</th>
<th>HIGH RISK</th>
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<tr>
<td>• Less than 4 risk factors</td>
<td>• Between 4 and 8 risk factors</td>
<td>• More than 8 risk factors</td>
</tr>
<tr>
<td>• Several protective factors</td>
<td>• Few protective factors</td>
<td>• Protective factors rare</td>
</tr>
<tr>
<td>• Child responsive &amp; content</td>
<td>• Child sometimes responsive &amp; content</td>
<td>• Child is often unresponsive, withdrawn and unhappy</td>
</tr>
<tr>
<td>• Child seems to expect to be cared for</td>
<td>• Child sometimes seems to expect to be cared for</td>
<td>• Child seems to distrust parent, withdraw or act out for attention</td>
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<td>• Parent(s) have good emotion regulation</td>
<td>• Parent(s) have difficulty with emotion regulation</td>
<td>• Parent(s) often lose control of emotions, and seem very depressed or anxious</td>
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<tr>
<td>• Can be self reflective</td>
<td>• Some self reflectivity except in certain areas</td>
<td>• Lacks capacity for self reflectivity</td>
</tr>
<tr>
<td>• A strong sense of self efficacy</td>
<td>• Some sense of self efficacy in certain situation</td>
<td>• Low sense of self efficacy</td>
</tr>
<tr>
<td>• Realistic self confidence about parenting</td>
<td>• Anxious and judges self to be a bad parent</td>
<td>• Very low or unrealistic high confidence about parenting</td>
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<tr>
<td>• Has positive attributions of the child</td>
<td>• Attributions of child distorted</td>
<td>• Attributions of child distorted &amp; very negative/hostile</td>
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<tr>
<td>• Good capacity for empathy</td>
<td>• Only empathetic towards the child in certain situations</td>
<td>• No empathy for the child when s/he is upset and sad</td>
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<tr>
<td>• Average to above average intelligence</td>
<td>• May have some cognitive limitations</td>
<td>• Significant cognitive limitations, concrete thinking</td>
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<tr>
<td>• Cultural beliefs and practices protective of child</td>
<td>• Some distortions about child because of cultural beliefs but these are not destructive</td>
<td>• Cultural beliefs about the child could lead to harm</td>
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<td>• Parent willing to use services &amp; try suggestions. Open to an intervenor</td>
<td>• Somewhat ambivalent about using services and the intervenor</td>
<td>• Rejecting of services and suspicious of the intervenor</td>
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<td>• Interaction is warm, sensitive, and responsive</td>
<td>• Interaction is sometimes sensitive and responsive but can be rejecting</td>
<td>• Interaction is insensitive, ignores child’s cues and is hostile</td>
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<tr>
<td>• Positive history of being parented or has resolved any trauma or loss</td>
<td>• At time issues from past history impede ability to respond to child</td>
<td>• Unresolved loss and trauma significantly impede ability to respond to child</td>
</tr>
<tr>
<td>• Good problem-solving and ability to plan and organize</td>
<td>• Some problem solving possible but can be impulsive</td>
<td>• Very impulsive, does not think things through and thus may place child and self at risk</td>
</tr>
<tr>
<td>• Family interactions seem to be warm and caring, have ways to deal with conflict</td>
<td>• Family interactions are questionable but manageable</td>
<td>• Very conflictual family relationships and no ways to deal with problems</td>
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* Adapted from Landy (in press)
CHALLENGING CHARACTERISTICS AND BEHAVIOURS OF HIGH-RISK FAMILIES

Parents in high-risk families show several characteristics and behaviours that interfere with their ability to care for children. In addition to creating risks for their children, these characteristics make establishing therapeutic relationships and providing effective interventions challenging. Some of these parental characteristics and behaviours are outlined below.

1. Psychological characteristics of parents that interfere with their ability to be effective parents and make intervention challenging include (Landy, in press):
   - Inability to consider their own mental state and that of others, and therefore lack of empathy, sensitivity and responsiveness for their child.
   - Inability to regulate emotions in themselves and therefore in their child.
   - Negative attributions (i.e. beliefs or views) of the child (e.g. “that baby is crying just to make me mad”).
   - Poor sense of competence and inability to plan and problem solve.

2. Unresolved loss and trauma. Unprocessed memories of trauma or loss that are disassociated and stored as sensory and emotional fragments of the experience are easily triggered by situations reminiscent of the original trauma and re-lived in vivid flashbacks or nightmares that interfere with parenting (Briere & Conte, 1993; Herman & Shatzow, 1987; van der Kolk & van der Hart, 1991). As well, a number of physiological (e.g. chronic hyper-reactivity to stress, increased susceptibility to infection) and psychological consequences of unresolved loss and trauma (e.g. difficulty regulating emotions, loss of trust, withdrawal, detachment, hypervigilance, anger, fear) can negatively impact parent-child interactions. Some atypical behaviours of traumatized parents are associated with a disorganized pattern of early attachment which is known to be a potent risk for later psychopathology (Goldberg, 2000). These behaviours include frightened and frightening behaviour, inability to meet the emotional needs of their children, and sexualized and self-referential behaviour (Bronfman, Parsons & Lyons-Ruth, 2000). All of these characteristics also make intervention challenging.

3. Psychiatric conditions that interfere with a parent’s ability to be responsive to a child and place children at risk include:
   - Schizophrenia (Seifer & Dickstein, 2000). Reasons for this vulnerability include increased genetic vulnerability, environmental strain caused by the illness (e.g., lack of employment, loss of income, hospitalizations), and parent-child interactions that tend to lack sensitivity, synchrony or mutuality, and fail to meet the emotional needs of children.
   - Maternal depression (Cohn & Campbell, 1992; Lyons-Ruth, Connell, Grunebaum & Botein, 1990). Because they have low feelings of self efficacy, depressed mothers are likely to be less responsive to their young children and to alternate between being helpless and hostile or critical, thus creating disorganization in the child (Cutrona & Troutman, 1986; DeMulder & Radke-Yarrow, 1991; Teti, Gelfand, Messinger & Isabella, 1995). As a result, their young children have difficulties with self-regulation and mirror their mothers’ anxiety and depressive symptoms, for example lethargy, sadness, and extreme distress on separation (Jameson et al., 1997).

4. Use of drugs or alcohol exposes children to effects of the substance in utero and to later chaotic environmental conditions and difficulties in parent-child interactions (Freir, 1994; Weston, Ivins, Zuckerman, Jones & Lopez, 1989). Many of these mothers have histories of trauma, loss, abuse, and parental substance abuse (Brooks, Zuckerman, Bamforth, Cole & Kaplan-Sanoff, 1994). They may have become addicted to overcome low self-esteem and their own difficulties with affect control and self regulation make it difficult to meet their infant’s regulatory needs (Brooks et al., 1994) particularly when their infants show withdrawal symptoms such as irritability, difficulty settling, and feeding and sleeping problems.

5. Family violence has a serious impact on children both when they witness domestic violence and when they suffer physical, sexual, and emotional abuse and neglect from a parent. Indirect effects of spousal abuse occur through the mother’s lack of emotional availability, harsh discipline from either or both parents, and being blamed for the fights. Infants of mothers who experience a partner violence are more likely to have a disorganized attachment (Zeanah, Danis, Hirshberg, Benoit, Miller & Heller, 1999). Many of these children develop aggressive behavior and other conduct problems (Bell, 1995), depression and anxiety, lower social competence and self-esteem, and lower social academic performance (Graham-Bermann & Levendosky, 1998; Sudermann & Jaffe, 1999), as well as symptoms of Post Traumatic Stress Disorder (Osofsky, 1995).
6. **Effects of parental abuse and neglect** include affect regulation difficulties (Cummings et al., 1994; Shields, Cicchetti & Ryan, 1994) hyperactivity, distractibility and a high level of anger (Erickson, Egeland & Pianta, 1989). Eventually some of these children become aggressive themselves (Cummings, Hennessy, Rabideau & Cicchetti, 1994). Some are more hypervigilant, anxious, withdrawn or depressed (Rieder & Cicchetti, 1989) whereas those who are sexually abused also show more sexuality problems (Wolfe, Gentile & Wolfe, 1989). Children exposed to various forms of neglect and/or abuse frequently have insecure disorganized attachments (Carlson, Cicchetti, Barnett & Braungold, 1989; Cicchetti & Toth, 1995), more difficulty recognizing the emotions of others (Camras, Grow & Ribordy, 1983), lower scores on measures of self-esteem (Egeland, Sroufe & Erickson, 1983), and elevated levels of psychopathology (Cicchetti & Toth, 1995). Child maltreatment has been linked to childhood depression, conduct disorder and delinquency, antisocial personality disorder, substance abuse, suicidal and self-injurious behaviour, anxiety, and dissociation (Luntz & Widom, 1994; Malinosky-Rummell & Hansen, 1993).

7. **Teenage parenting** can also place infants at risk. Infants of teenage parents are more likely to be avoidantly attached and to meet criteria for disorganized attachment to their mother (Hann, Castino, Jarosinski & Britton, 1991; Spieker, 1989). Like all mothers, teenage parents have a wide range of parenting ability. However, as a group they are less sensitive, responsive, and emotionally positive with their infants and young children (Landy, Montgomery, Schubert, Cleland & Clark, 1983; Osofsky & Eberhart-Wright, 1992; Zeana, Keener, Anders & Vieira-Baker, 1987). Teenage parents also misread their infants’ cues (Lester, 1992) and have less realistic expectations for young children, underestimating abilities in some areas and overestimating in others (Osofsky, Hann & Peebles, 1993; Fodi, Grolnick, Bridges & Berko, 1990). Toddlerhood is challenging for teenage mothers who experience their child’s increasing independence as rejection (Crockenberg, 1987). Thus infants of teenage mothers are less likely to experience empathetic responsiveness and nurturing when upset and distressed (Hann, Osofsky, Barnard & Leonard, 1994). The repeated stress of working with high-risk families experiencing any of the above complex circumstances and the many crises and risks to young children that may occur can have a serious impact on practitioners. Therefore, a variety of strategies are needed to support those who work in early intervention programs with such families.

**EFFECTIVENESS OF INTERVENTIONS WITH HIGH-RISK FAMILIES**

It is difficult to determine how successful early intervention is in enhancing the outcomes of infants and young children because intervention programs are diverse and complex as are the populations served. As pointed out by Guralnick (1999), we need a “second generation” of research to inform us about what works, with whom, and at what stage of a child’s development. Also we must be more precise about “what” works. When an intervention is successful, we need to know how it can be replicated with integrity in other similar situations.

At the current time, some general conclusions can be made about the efficacy of interventions (Gomby et al., 1995; Karoly et al., 1998; Landy, 2001; Landy, in press). A few of these are highlighted below:

- Beginning earlier in a child’s life, either during pregnancy or at birth, is more likely to be successful than intervention that begins after a child is one or two years of age. Early plasticity of the brain allows opportunity to optimize brain structure and biochemistry. Interventions provided early can avoid negative interactional patterns between parent and child and prevent negative parental attributions of a child becoming firmly entrenched.
- When children already have developmental delays or other disorders, or have been abused or neglected, or are at extreme psychosocial risk, child outcomes are best enhanced by interventions that include working directly with a child, probably because of the greater intensity that direct child treatment can provide. Such interventions include educational centre-based childcare or specialized individual treatments adapted to the child’s specific problem areas and needs.
  - Since interventions are most successful when focused on areas in which there are most difficulties, the first stage should be an assessment of risk and protective factors and family needs in order to choose the most suitable approaches. Ongoing monitoring and assessment are also necessary to determine adjustments needed, for example when change occurs, some risks or difficulties are overcome, and/or new patterns of need arise.
- High-risk families need a range of services including assistance with concrete needs, crisis intervention, supportive services, short-term interventions, and long-term interventions that help overcome the effects of unresolved loss and trauma.
- As well as being sensitive to the individual needs of children and parents, interventions must be attuned to differences in family structure, roles and patterns of relating including cultural, racial and ethnic differences.
- Home visiting may be essential for the most high-risk families who otherwise are unlikely to access programs. It may also be necessary to develop creative strategies to keep parents involved so as to reduce drop-outs. Home visitors from the same cultural background as families and who are able to speak the language of parents may be essential for immigrant families.

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*Position Paper on Vicarious Trauma in the Workplace*

March 2004

The Infant Mental Health Promotion Project
• In general, when parents in high-risk families have a history of trauma or loss, interventions need to be of high intensity and over a long period of time, and the development of a therapeutic parent-intervenor relationship is key. However, brief focused interventions within the framework of ongoing availability of service providers are effective in changing specific aspects of functioning or providing parents with understanding and strategies to alter parent-child interactions and attachment.
• Families at highest risk may need a mental health approach that is less didactic and follows the parent’s lead, taking into account parental goals. This approach makes the parent an active participant and avoids parental perception of powerlessness in a hierarchical relationship. Providing a sense of partnership between parents and intervenor needs to be a focus of the intervention. This is particularly important when parents have experienced loss and trauma.

Interventions need to be based on a variety of theoretical approaches and to be staged to address the hierarchy of needs of a family and the emotional well-being of both parents and young children. The challenge for practitioners is first to engage high-risk families and establish a trusting therapeutic relationship. For many children, it is critical to stabilize the family situation by enhancing the family’s support systems. In extreme cases such as parental mental illness, violence in the family, or drug and alcohol use that significantly impair parenting or place a child at risk for abuse or neglect, reporting to child welfare and removal of the child may be necessary at least until the situation can be stabilized.

Often practitioners do not have adequate training in the variety of interventions needed and the assessments necessary to decide on appropriate interventions. As a result, they struggle with feelings of incompetence and hopelessness and they require a variety of supports to prevent vicarious trauma and enable them to remain effective in their work.

**SUPPORTS NEEDED FOR EFFECTIVE INTERVENTIONS WITH HIGH-RISK FAMILIES**

**Appropriate Government Guidelines and Organizational Policies**

Government guidelines and funding and agency policies need to take into account current research on effective practices and ensure that a structure is in place to support innovative approaches and interventions to meet the needs of high-risk families (Landy, in press). For example, policies that allow only brief interventions are not appropriate.

Guidelines are necessary for referrals, assessments, intervention decisions and outcomes for evaluation (e.g., characteristics of child, parent, and parent-child relationship). As well, protocols are needed for recording service and assessments.

Policies are essential for maintaining reasonable caseloads and appropriate role definitions and boundaries. Policies about boundaries with families assist in establishing therapeutic relationships that are supportive and open but maintain professional roles and functions. These policies should include guidance on issues such as giving and accepting gifts, attending events (e.g., christenings, funerals), lending money, and sharing of personal information (e.g., strategies that worked with their own children but not personal details other than training and experience).

Policies are also needed about confidentiality, safety, acceptable team behaviour, crisis responses and managing critical incidents (Howe & Milstein, 2003). Health benefits and disability coverage should allow time off to recover from serious work-related events or burnout and to help workers maintain a balance between work and family time. It is important to note that a worker’s personal supports and outside interests can serve as a buffer against secondary trauma (Regehr & Cadell, 1999).

**Reflective Supervision**

Supervision that is reflective is one way that has been found to help overcome some of the symptoms of vicarious trauma that may result from this work and avoid burnout (Bernstein, 2002; Fenichel, 1992; Landy, 2003; Parlakian, 2001, 2002).

The four main components of reflective supervision are:

• It is available regularly, preferably on a weekly or at least biweekly basis, and as far as possible without interruptions such as phone calls.
• It is a collaborative and supportive relationship between supervisor and supervisee that encourages open discussion of difficult feelings, disappointments and frustrations, that acknowledges success when a parent and child make valuable gains, and that respects each person’s expertise.
• It has a sound theoretical basis that is accepted and understood within the agency and offers a common understanding of what is occurring in the treatment. Such theory can make what may seem on the surface like random, disconnected or incoherent behavior into something that is understandable and more coherent. Theoretical understanding is needed in several areas (see Appendix 3).
• It is reflective and allows practitioners to step back to consider their cases and work situations and to learn from their personal reactions that may be clouding their judgement. This may mean learning to set limits or boundaries without feeling guilty, not giving up on a family too soon, balancing the needs of a child with that of a parent, and developing new ways of working.

Supervision is also needed to review management and evaluation functions such as the type and number of cases, agency recording requirements, policies and procedures, and annual performance evaluations. Optimally, reflective supervision is provided individually by someone other than the supervisor responsible for these management and evaluation functions. When time constraints and budget do not allow individual supervision, peer or group supervision with a variety of disciplines can be helpful as well as bi-weekly or monthly clinical consultations from outside experts (e.g. Levkoe, 2002; Manio-Dimagio, 2002; Moher, 2002).

Training

Specialized ongoing training is needed to work effectively with high-risk families. It is common for practitioners to feel a lack of skills and knowledge when working with a particular parent or family. New understanding and ideas for intervention strategies can build morale and enhance interventions. Team discussions of complex cases can provide excellent training as well as a sense of support. It is important that all staff members receive information and training related to relevant legislation such as child abuse and neglect reporting protocols and how to proceed if abuse is suspected. Opportunities are also needed to attend outside training such as workshops offered by IMP (for examples see Appendix 2) and the Certificate in Infant Mental Health that IMP offers in collaboration with York University (Moran, 2003).

Consultation, Collaboration and Service Coordination

Service providers in this field come from a variety of professional disciplines, including nursing, social work, medicine, psychology, early childhood education, occupational therapy, speech and language pathology. Paraprofessionals or lay home visitors trained on-the-job also provide support to families and interventions with parents and children. The competencies needed by practitioners from all backgrounds to work in the field were specified by IMP in 2002, in Competencies for Practice in the Field of Infant Mental Health (see Appendix 3). This document acknowledged that the level of knowledge and skills would differ by discipline and area of practice, and that no individual service provider is expected to have all the competencies. Instead the document recommended that all practitioners have access to consultation and collaboration through individual supervision, other team members or experts from other agencies in the system in order to meet the variety of needs of high-risk families and children.

No one can do this work alone. Teams blending professionals and paraprofessionals are needed to work with high-risk families and hiring criteria need to consider personal aspects such as self-reflectivity, capacity for empathy, and ability to work both independently and as part of a team (see Appendix 3). Integrating teams of professionals and paraprofessionals who have passion for this work, ensuring training and supervision for all, and consultation from experts allows for the provision of the variety of the intervention strategies needed by high-risk families.

Because it is often not possible for one program to provide all of the services required by high-risk families, a coordinated system is needed with established arrangements for interagency cooperation. In Ontario, guidelines have been specified for service coordination (Office of Integrated Services for Children, 2000). These guidelines make it necessary for every high-risk family to have a designated service coordinator responsible for planning and coordinating services in collaboration with the family and other service partners. Although this has potential to be a valuable contribution to care, the process will be challenging because of the variety and number of components that may be involved (e.g., child protection, infant and child mental health, health care, infant development, child care). Bringing different disciplines and agencies with different philosophies, goals and vested interests together is time consuming. There may also be interagency rivalry and attempts to pass the most high-risk families on to others. However, the benefits include increased continuity, consistency and coordination of service, reduced duplication of services and more efficient use of limited resources (Bain, 2003-04).

Maintaining a Positive and Realistic Perspective

Progress with high-risk families can be limited. To maintain a realistic but hopeful view of the possibilities for change, it is important to establish small, obtainable goals and to recognize the achievement of small gains. Qualitative feedback from families on helpful therapists’ attitudes and caring (Norcross & Arkowitz, 1992) can be encouraging. Sometimes, progress in children is seen without progress in their parents (e.g., cognitive growth, socioemotional development, reduction difficult behaviours). In some cases the best that can be accomplished may be to assure the safety of the child and family. This achievement too needs to be recognized.

Support for Self Care

Often professionals who care for others find it difficult to acknowledge their own need to balance personal lifestyles and deal with stress. Organizations need to create a climate that encourages staff well-being in four areas: mental energy (e.g. learning something new, pursuing a hobby), spiritual energy (e.g. pleasure in nature, organized religion), emotional energy (e.g. connecting with family and friends) and physical energy (e.g. nutrition, exercise, and rest). Discussion and fun exercises about these strategies at a retreat or team meeting can facilitate meaningful interpersonal encounters and positive attitudinal changes (Peters, 2003).
COMPETENCIES FOR ORGANIZATIONAL SUPPORT

Based on the research outlined above and opinions expressed at the “think tank” (see Appendix 1), IMP developed a document Organizational Policies & Practices To Support High Quality Services in the Field of Infant Mental Health (see Appendix 4). A third draft of this document was circulated for feedback and evaluation to participants at IMP’s Vicarious Trauma “Think Tank” and to members of IMP committees and revised accordingly. A final draft was refined and approved by the IMP Executive and Steering Committees.

RECOMMENDATIONS

Taking into account findings from current research, opinions of participants at the IMP’s 2003 Vicarious Trauma “Think Tank,” and feedback received on the draft Organizational Policies & Practices To Support High Quality Services in the Field of Infant Mental Health, it is recommended that:

1. Government at federal, provincial and municipal levels, and service organizations, managers and practitioners acknowledge:
   
   a) The complex needs of high-risk families with young children and the amount and kinds of resources and supports required to ensure the best possible outcomes for children
   b) The serious negative impact that this work can have on practitioners
   c) The supports needed by practitioners in order to provide effective services.

2. Organizations develop clear policies and strive towards practices that support the principles outlined in Organizational Policies & Practices To Support High Quality Services in the Field of Infant Mental Health (see Appendix 4).

3. Government at federal, provincial and municipal levels provide realistic service guidelines & allocate appropriate funding to ensure an adequate level of organizational support that enables practitioners to provide effective services for high-risk families with young children.
References


Landy S (Spring 2003). Reflective supervision. IMPrint 36, 6-7.


ISSUES DEFINED & SOLUTIONS PROPOSED AT IMP’S VICARIOUS TRAUMA THINK TANK

Issues

Participants at IMP’s February 2003 “Think Tank” identified several stressors for frontline practitioners serving high-risk families (Wolpert, 2003) including:

- Increased workload demands including high caseloads, more complicated cases, overwhelming documentation requirements, and the time and energy involved in collaboration and service coordination.

- The emotional burden of listening repeatedly to difficult family stories and trying to engage and establish trust with many burdened clients affecting personal life and reawakening personal trauma histories.

- Concerns about personal safety being alone in the home with families, and the risk of liability and lawsuits in situations that place a child or parent at risk for harm.

- Increased expectations and accountability in the workplace, fear of failure, and job insecurity due to budget cuts or inadequate funding.

- Inadequate training and support for the difficult work.

Stressors for managers included:

- Being “sandwiched” by pressure from administration above and from staff who they are responsible for below.

- Making decisions without support, and enforcing policies they may not believe in.

- The drain of increased liability and accountability, high waiting lists, demands to justify funding, never-ending statistical reports and grant proposals, time constraints, personality conflicts and media involvement.

- Necessary administrative tasks interfering with needed supervision for large numbers of staff.

- Repeated training of new staff members due to high turnover.

As well, participants highlighted that organizations are challenged by systemic pressures including large mergers without adequate infrastructure, and poor funding not allowing for necessary supervision nor salary increases for workers who face increasing caseloads and often see little or no change in many high-risk clients.

Solutions

Several approaches were recommended by Think Tank participants to support staff and prevent burnout. Some of these solutions had been used successfully by agencies represented.

- Creating an atmosphere of appreciation and support that recognizes accomplishments, encourages a balance for mental, physical, spiritual and emotional well-being, and ensures training to understand and respond meaningfully to the reality of secondary trauma when working with high-risk families.

- Proactive management that provides support and information during organizational change and encourages ownership and investment.

- Flexible work arrangements that provide opportunities to accommodate individual strengths and vary the type of work (e.g. service delivery, research, education, community meetings), and allow work hours that accommodate personal situations.

- Team building that ensures formal debriefing in stressful situations, the regular exchange of ideas, case presentations, and clinical consultation from different disciplines. Time away from the office for team building and visioning was suggested as a promising strategy.

- Funding commitment to meet specialized training needs for the challenging work with high-risk families and for advancing personal careers.

- Appropriate supervisor-staff ratios that allow regularly scheduled reflective supervision to ensure the nurturing and case support needed for this work, and that this clinical supervision be distinct from administration supervision.

- Ensuring safe working environments.

APPENDIX 1

2. See page 4.
# EXAMPLES OF IMP WORKSHOPS

**May 2004**  
**FEEDING DISORDERS IN INFANTS AND YOUNG CHILDREN: Diagnosis and Treatment**  
Irene Chatooor  
Director, Infant and Toddler Mental Health Center  
Children’s National Medical Center, Washington

**September 2003**  
**CAREGIVER BEHAVIOURS ASSOCIATED WITH DISORGANIZED ATTACHMENT: Clinical assessment and applications**  
Diane Benoit, Infant Psychiatrist, The Hospital for Sick Children

**April 2004**  
**EMOTION REGULATION: The Development & Treatment of Mental Health Problems in Infants and Young Children**  
Susan Bradley, Professor of Psychiatry, University of Toronto  
Psychiatrist, The Hospital for Sick Children, Co-Chair, IMP

**June 2003**  
**A COGNITIVE APPROACH TO CHILD ABUSE PREVENTION**  
Daphne Bugental, PhD  
Professor, Developmental & Social Psychology  
University of California

**November 2003**  
**NEGLECT OF YOUNG CHILDREN: Impact & Intervention**  
Michelle Shouldice, Paediatrician & Jennifer Coolbear, Psychologist, SCAN, The Hospital for Sick Children  
Jane Long, Manager of Legal Services & Nancy Andrews, Assistant Branch Director, Children’s Aid Society of Toronto  
Sarah Landy, Developmental Psychologist, Hincksdellcrest Institute

**May 2003**  
**PARENTING WITH A PSYCHOTIC DISORDER: Promoting Optimal Outcomes for Both Parents & Infants**  
Keynote presenter: Laura J. Miller, Chief, Women’s Services Division, Department of Psychiatry, University of Illinois, Chicago College of Medicine  
Other presenters: Robert Zipursky, Clinical Director, Schizophrenia & Continuing Care Program, CAMH, Adrienne Einarson, Assistant Director, Motherisk, HSC & Jean Wittenberg, Head, Infant Psychiatry, HSC
COMPETENCIES
FOR PRACTICE IN THE FIELD OF INFANT MENTAL HEALTH

Infant mental health practice refers to the promotion of optimal development and well being in infants (prenatal to age 3) and their families, the prevention of difficulties, and intervention when infants are at-risk or have identified problems.

The goal of infant mental health services is to ensure optimal child outcomes in terms of a sense of security and self-esteem, and the ability to form satisfying relationships, to engage with the world, to learn, to cope and problem solve, and to continue positive development throughout life.

Infant mental health services strive to promote stable and supportive families and communities. Collaboration with families is central to the work.

Service providers in the field of infant mental health come from a diverse range of professional backgrounds, including medicine, nursing, social work, psychology, early childhood education, occupational therapy, physiotherapy, speech and language pathology and others. In addition, an increasing number of lay home visitors trained on-the-job offer support and intervention in the field. Service is provided to infants both in the homes of families and in a variety of settings under the auspices of many organizations, for example, public health, hospitals, child welfare, infant development programs, childcare, community and family resource centres.

Regardless of background and training, broad-based theoretical knowledge and a variety of skills are essential for infant mental health practice. The level of knowledge and skill in each specific item would be different for different disciplines and different areas of practice.

This document outlines the knowledge and skills needed to provide competent care specific to each infant and family. The document was developed by the Infant Mental Health Promotion Project in order to broaden and refine understanding of the cross-disciplinary competencies required to provide quality care for infants and their families, and to offer guidelines for the training needed by infant mental health practitioners.

It is recognized that no individual practitioner is likely to have all of these competencies. However, all practitioners should have access to consultation and collaboration with a supervisor, members of a team, and other professionals in the system of services in order to meet the wide variety of needs presented by infants and families.

KNOWLEDGE REQUIRED_____________________________ Section 1

Practitioners in the field of infant mental health must demonstrate understanding of:

The Child

___ Normal infant and toddler development
___ Common behavioural problems, syndromes and disorders of early childhood (e.g. sleeping and feeding difficulties, developmental delays, autistic spectrum disorders)
___ Effects of prematurity, illness, hospitalization, and special needs on infants and families

Influences on Child Development

___ Risk and protective factors (e.g. sociodemographic factors, infant characteristics and health, parental health and knowledge, family functioning, community and social supports)
___ Influences of community, social and family supports on parent-child interaction and infant well being
___ Socio-cultural differences in child rearing and parenting expectations
___ Different patterns of parent-infant interaction and attachment and their impact on child outcomes
___ Impact of past experience of being parented on parents' expectations of their infant and their relationship with their child
___ Effects of parental health, mental health and substance use on parent-child interaction
___ Physical, psychological and social adaptations of pregnancy, and the transition to parenthood

Intervention

___ Basic principles of a variety of individual and group approaches to prevention, intervention and parenting education
___ Basic principles of different theories that inform practice, including developmental, psychodynamic, social support, cognitive behavioural, trauma, family and group dynamics, communication, and ecological and systems theory.
___ Awareness of research on the effectiveness of approaches
___ Resources available to families in the local community
___ Legislation relating to child protection and reporting, confidentiality and consent

Discipline Specific

___ Principles and research relating to work with infants and families in the discipline originally trained (e.g., nursing, psychology)
**SKILLS REQUIRED**  
**Section 2**  

### Service Delivery  
2.1

Practitioners in the field of infant mental health must demonstrate ability to:

<table>
<thead>
<tr>
<th><strong>Relate to Families</strong></th>
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<tbody>
<tr>
<td>Establish a therapeutic relationship with families</td>
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<tr>
<td>Be with families and listen actively</td>
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<tr>
<td>Understand the experiences of both infants and parents</td>
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<tr>
<td>Be sensitive to the learning styles of each infant and parent</td>
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**Intervene**

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<tr>
<td>Observe, make decisions on approaches needed by each family, and set priorities</td>
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<tr>
<td>Provide developmental information and anticipatory guidance</td>
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<tr>
<td>Suggest and demonstrate ways to nurture a child’s development</td>
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<tr>
<td>Intervene regarding the safety of an infant and family</td>
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<tr>
<td>Use a variety of techniques to facilitate positive parent-infant interaction and enhance parents’ capacity to be responsive and sensitive to their baby</td>
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<tr>
<td>Use a variety of techniques to reduce negative parent-infant interaction</td>
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<tr>
<td>Help parents understand their child’s point of view</td>
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<tr>
<td>Recognize and develop the strengths of families and extended families</td>
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<tr>
<td>Adapt intervention to the diverse needs of infants and families and their socio-cultural differences</td>
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<tr>
<td>Help parents understand and cope with unresolved issues from their past that might be interfering with their ability to parent</td>
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<tr>
<td>Plan, develop and implement group parent education programs</td>
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<tr>
<td>Maintain their own personal safety</td>
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<tr>
<td>Manage crises</td>
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<tr>
<th><strong>Collaborate</strong></th>
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<tr>
<td>Establish working relationships with other community agencies and collaborate on behalf of children and families</td>
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<tr>
<td>Consult with other service providers and agencies and make referrals as needed</td>
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<tr>
<td>Facilitate linkages to community resources</td>
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**Discipline Specific**

- Effectively use and share with others techniques of the discipline in which originally trained (e.g. nursing, psychology, occupational therapy)

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### Assessment & Formulation  
2.2

Practitioners in the field of infant mental health must demonstrate ability to:

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<tbody>
<tr>
<td>Recognize infants who are not developing normally</td>
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<td>Identify factors that might place infants at risk and those that protect infants</td>
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<tr>
<td>Recognize signs and symptoms of child abuse and neglect, and when a situation requires immediate action</td>
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<tr>
<td>Observe and analyze parent-child interactions</td>
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<tr>
<td>Recognize contributions of both infants and parents</td>
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<tr>
<td>Recognize signs and symptoms of parental issues that interfere with their ability to care for their child e.g. depression, unresolved trauma, substance use, family violence and other mental health issues</td>
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<td>Recognize child characteristics and temperament that might make the child difficult to care for</td>
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<tr>
<td>Use non-standardized and standardized screening tools</td>
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<tr>
<td>Integrate information and formulate plans together with family</td>
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<tr>
<td>Monitor progress and reformulate plans as needed with the family</td>
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<tr>
<td>Recognize when referral to other professionals and services is needed</td>
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**Discipline Specific**

- Use standardized assessment instruments specific to one’s own discipline
- Analyze and interpret assessment findings

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### Personal and Interpersonal  
2.3

Practitioners in the field of infant mental health must demonstrate:

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<tr>
<td>Capacity for empathy</td>
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<td>Capacity for self-reflection and ability to engage in ongoing assessment of strategies and effectiveness</td>
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<tr>
<td>Awareness of the effects of one’s own personal and cultural background on one’s work</td>
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<td>Flexibility and resilience</td>
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<tr>
<td>Ability to communicate effectively both orally and in writing</td>
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<td>Initiative to seek new information or information not familiar with, as needed</td>
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<td>Non-judgmental attitudes and acceptance of difference</td>
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<td>Openness to different approaches and perspectives</td>
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<td>Ability to use supervision effectively</td>
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<td>Persistence in trying to engage hard-to-reach families</td>
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<td>Capacity to work independently and as part of a team</td>
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<tr>
<td>Ability to recognize one’s own limitations and seek help when needed</td>
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<tr>
<td>Ability to recognize and take steps to reduce personal stress and burnout</td>
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ORGANIZATIONAL POLICIES & PRACTICES
TO SUPPORT HIGH QUALITY SERVICES IN THE FIELD
OF INFANT AND YOUNG CHILD MENTAL HEALTH

Working with young children and their families (prenatal through age 6 years) is a specialized area of practice that carries a unique emotional burden. In particular, working with high-risk families who have multiple problems is complex and demanding.

Practitioners who work with young children and their families come from various disciplines and backgrounds and work in a variety of settings (e.g., hospitals, public health, child welfare, child care, children’s mental health centres, family resource centres). These infant mental health practitioners and early intervention specialists are frequently confronted with overwhelming and alarming family situations that can leave them feeling helpless and hopeless. Such experiences can lead to vicarious or secondary trauma. As a result practitioners may “burn out,” become ineffective or even leave the field, thus increasing stress for the families and the remaining workers.

Organizations have a responsibility to ensure that practitioners are able to provide ongoing competent support and intervention to young children and their families. This means preventing or alleviating vicarious trauma in the workplace. Such a responsibility involves creating policies and practices that ensure appropriate training and support for their staff. It is essential that this responsibility is recognized and endorsed by senior management, agency boards and all levels of government.

The Infant Mental Health Promotion Project developed this document in order to:
- raise awareness of the challenges faced by practitioners in this field and the responsibility of organizations to recognize, prevent and overcome vicarious trauma in the workplace,
- offer guidelines regarding organizational policies and practices needed to support practitioners in coping with vicarious trauma in the workplace so that they are able to provide competent care to infants and their families; and
- assist agencies in finding ways to retain experienced staff members in order to provide stability and continuity of care for families.

At the current time, it would be unlikely for any organization to have implemented all of the policies and practices outlined in this document. The challenge is for organizations to mobilize themselves and strive towards making these policies and practices achievable within their individual contexts.

2. See Competencies for Practice in the Field of Infant Mental Health, IMP, December 2002.

INFANT MENTAL HEALTH PROMOTION PROJECT (IMP)
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Organizational Practices continued...

RELATIONSHIPS WITH FAMILIES
Organizations responsible for services to young children and their families must ensure appropriate practitioner-family relationships. This involves:

- Clear recognition and support for the time needed to build therapeutic relationships with families that are responsive, respectful, and family-centred.
- Such trusting relationships open family receptivity to services that help them establish the responsive relationships needed by young children.

ORGANIZATIONAL PRACTICES NEEDED FOR HIGH QUALITY SERVICES

STAFF SUPPORT & SUPERVISION
Organizations responsible for services to young children and their families must provide adequate support to increase staff satisfaction and ability to adapt practices appropriate to each child and family. Such support involves:

Valuing Staff
- Creating an atmosphere of appreciation (e.g., recognition for accomplishments and hard work, incentives)
- Recognizing that self-care is necessary and offering health promotion practices (e.g., time off for family responsibilities, workshops dealing with stress, Employee Assistance Programs)
- Ensuring staff input into the day-to-day organization of their own work arrangements as well as organizational policies and procedures

Reflective Practice
- Providing regularly scheduled reflective supervision appropriate to the needs of individual staff members (i.e., at least bi-weekly for most practitioners)
- Clear separation between supervision for administrative requirements and supervision to nurture and encourage practitioner reflection on work with families (e.g., at separate times or by separate supervisors)
- Creating opportunities for reflective peer support (e.g., regular team meetings, mentoring)
- Identifying primary support persons for challenging situations (e.g., a peer mentor, team leader or supervisor)
- Regular clinical consultation from experts to support work with individual cases

Supporting Staff Members During Organizational Change, Conflict and Case Crises
- Ensuring that all levels of staff are kept informed of proposed changes
- Taking steps to encourage the ownership and investment of all staff in organizational plans
- A process for managing conflict between workers, between a worker and supervisor, and with other agencies
- A defined debriefing and/or peer support process for dealing with traumatic incidents involving work with clients

STAFF TRAINING
Organizations responsible for services to young children and their families must provide or support participation of both frontline practitioners and supervisory staff in specialized initial training and ongoing continuing education to achieve the broad range of knowledge and skills needed in this field. Training is needed in the following areas:

- Child development and parenting practices
- Physical child development and the supports needed by young children with special needs and their families
- Recognition and reporting of child maltreatment
- Parent mental health including unresolved loss and trauma
- A variety of theoretically and clinically sound and evidence-based assessments and intervention approaches designed for work with young children and their families
- Cultural competence when working with families
- Peer support and reflective practice
- Recognition of signs & symptoms and management of vicarious trauma
- Self-care to deal with stress and find a balance for mental, physical, spiritual and emotional well-being in self and clients
- Networking, collaboration and service coordination
- Personal safety

COLLABORATION, COORDINATION & CONSULTATION
Organizations responsible for services to young children and their families must ensure capacity for effective networking and collaboration with a broad range of services. This involves:

- Recognition that no one agency can meet all family needs and that multiple interventions may be needed
- Appropriate training in the process of smooth and effective service coordination
- Ensuring adequate staff time for effective collaboration with other agencies
- An organized system of readily available specialized consultation and assessments regarding infant and young child mental health, adult mental health services for parents, and parenting capacity

March 2004
Infant Mental Health Promotion Project (IMP)

COMMITTEE MEMBERS

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