KIDS STRENGTHS
KIDS in the CONTEXT of MENTAL DISORDERS

Education and Culture DG
Lifelong Learning Programme
Leonardo da Vinci

# Professional Competence Profile

## Regarding competences working with children in the context of mentally vulnerable parents

Health Professionals
Social Workers
Early Intervention Professionals
Kindergarten Teachers
Special/Therapeutical Educators
Teachers
Psychologists

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# Contents

# 1. Preliminary remarks

This report describes **diverse professional competence** profiles regarding professional challenges working with children of mentally vulnerable parents.

## 1.1 Epidemiological data

3-11% of children, current Australian data indicate up to 25% vulnerable children (Mayberry et al. 2005)

> The number of children living in the context of parents with mental disorders is increasing (Schmid/Lisofsky 2000) due to diverse socio-economic factors. Also due to higher prevalence of psychiatric disorders in general population (Müller-Schloher 2004)

## 1.2 Available professional support for our group

There is an observable tendency that professionals in field of mental health are „forgetting" children (in the context of mentally vulnerable parents) or systematically underestimate perceived distress (Bauer et al. 1998, Küchenhoff 2001). It has to be highlighted that 30% of female adult in-patients take care of children (Lenz 2005).

## 1.3 Mental vulnerability and perceived stress by children

A mental (psychiatric) illness of a parent can be **always** seen as a major threat towards the development or coping strategies of a child (Pretis & Dimova 2004). The impact depends of

- age of the child (the younger the higher)
- The intensity of symptoms
- The onset of the disorder (the earlier during the development, the higher the impact on the child)
- The gender of the parent (mothers show higher negative impact)

## 1.4 Documented adverse impacts on children

The impact on children can be assessed as highly individual and – to a high extend – have to take into account protective factors or resilience processes. Symptoms of children mostly are very unspecific.

- Higher own vulnerability (Mattejat/Lisofsky 2001)
- Behavioural problems (depending on age) (Küchenhoff 2001)
- Developmental delays school problems (Kaplan et al. 1999)
- Higher emotional instability (Deneke&Lüders 2003)

### 1.5 Reported experience from adults having lived in the context of parent mental vulnerability

-Disorientation, feeling to be left alone or "forgotten" (Wagenblass 2001)
- Feeling of guilt (Dunn o.J., Williams 1998)
-Living with fear, insecurity
-Parentification: taking age-inadequate responsibility for him/herself and others (Wagenblass 2001)
- Only 25% of children (6-10a) are informed about a disorder

## 2. Draft Definition of "mental vulnerability" within the KIDS STRENGHTS project

In our understanding we include in our term "mental vulnerability" any kind of clinical (ICD 10 or DSM IV-TR) relevant diagnosis or suspected diagnosis of at least 1 parents or carer for a child under 18 years, including substance abuse etc.

## 3. Towards professional competence profiles

To describe the specific requirements of diverse sectorial groups working with children in the context of mentally vulnerable parents we should focus our attention on 3 main issues:

a) contextual factors (in which contexts do we usually work with children and/or vulnerable parents): What are the contextual/setting factors which are facilitating or also hindering our work?
b) Role-understanding and primary tasks associated with this role of the professional (which might be correlated with the context)
c) Necessary competences to perform the tasks (within the role-understanding) in concrete contexts. These necessary competence can be seen under 3 aspects
   - which knowledge do I need as a professional to work with children in the context of mentally vulnerable parents (this includes my collaboration with the parents)
   - which skills do I need
   - which wider personal abilities (personal, social and/or methodological) do I need.

# 4. Concrete professional competence profiles

## 4.0 Theoretical background

The professional competence profile is based on a learning outcome model:
http://www.eucen.org/EQFpro/GeneralDocs/FilesFeb09/GLOSSARY.pdf

(1) **'learning outcomes'** means statements of what a learner knows, understands and is able to do on completion of a learning process, which are defined in terms of knowledge, skills and competence;

(2) **'knowledge'** means the outcome of the assimilation of information through learning. Knowledge is the body of facts, principles, theories and practices that is related to a field of work or study. In the context of the European Qualifications Framework, knowledge is described as theoretical and/or factual;

(3) '**skills**' means the ability to apply knowledge and use know-how to complete tasks and solve problems. In the context of the European Qualifications Framework, skills are described as cognitive (involving the use of logical, intuitive and creative thinking) or practical (involving manual dexterity and the use of methods, materials, tools and instruments);

(4) '**competence'** means the proven ability to use knowledge, skills and personal, social and/or methodological abilities, in work or study situations and in professional and personal development. In the context of the European Qualifications Framework, competence is described in terms of responsibility and autonomy.

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## 4.1.Context(s) in which the professionals are usually working

### *4.1.1 HEALTHCARE PROFESSIONALS (Nurses, Medical Doctors, Professionals in Clinical Settings)*

Healthcare professionals (MDs, nurses, health visitors…) face children in different age groups in several public health services. Early childhood professionals face toddler aged children in the kindergartens, pre-school and school aged children and adolescents are faced by school nurses. These services are provided for all children as basic healthcare services and in the first place children with vulnerability are faced in this context.

The second context for the health professionals to face the vulnerable children, are the services offering specific examination, support and treatment for the children. The problems of one child within the family could predict increased difficulties on their siblings. Therefore it is essential to map out the situation of all children in the family. The services providing support and treatment are for example family counselling, child psychiatric outpatient clinics and child psychiatric units, as well somatic treatment units for children.

| Area | Favourable factors | Hindering Factors |
|---|---|---|
| Healthcare Professionals | • There is research based knowledge promoting psychosocial well-being of the children preventing the current and subsequent difficulties of the children, when parent is getting treatment.<br>• There are specific relevant tools that are based on the knowledge of prevention and promotion. Nowadays there is practical experience to systematically support the children of patients in adult healthcare units. | • Traditionally health professionals tend to work only with adult patients or adult members of the families. It is rather uncommon to work systematically in a child centred way in clinical practise in most of health care organisations. |

### *4.1.2 SOCIAL WORKERS*

There are different areas where professional social workers get in contact with families or children with mentally vulnerable parents. This happens in the fields of:

a. Psycho-social Counselling
b. Clinical social work in a psychiatric clinic
c. Child and Youth welfare

Ad a) Psycho-social Counselling:

Social Workers in this area counsel adults who are mentally vulnerable. Those parents might get support in financial, jurisdiction, medical, personal or family related issues. Usually the client has a regular appointment where the progress of the guidance is discussed. Support can also take place outside the office, e.g. as a visit to the hospital or a home visit.

Ad b) Clinical social work

In a psychiatric clinic, social workers take care for the clients who are in a psycho-social crises and stay in an open or closed ward. Professionals also might try to get in contact with relatives and arrange the setting after the inpatient stay.

Ad c) Child – and Youth welfare

Social workers act in child- and youth welfare or child protection situations where (usually) a child under 18 is neglected or there are serious doubts that the parents might not look after the

child because of e.g. alcohol or substance abuse or a mental vulnerability. Child welfare can offer a wide range of support.

| Area | Favourable factors | Hindering Factors |
|---|---|---|
| a) Psycho-social Counselling | **periodic appointments**: the social worker has a good overview of the situation of the client | social workers **focuse on the client's needs and problems**, and might neglect children in this context. |
| b) Clinical social work | the **medical help** plus the **organisational support** to keep life running outside | mostly the **patient is not asked about the situation of children** (e.g. at home)<br>for small children in most clinics **a joined hospitalisation of mother/father and child is not foreseen** (up to the age of 3 years). |
| c) Youth welfare | this sector mostly **acts in case of an emergency** (e.g. when there are serious problems in the family that cannot be handled by other institutions or the family itself) | children sometimes are taken into **foster care or residential care** without considering other types of support.<br>families also might be afraid to ask for help at early stages, because they might be **afraid to loose their children** |

To conclude, from children's view the two first mentioned areas, Psycho-social Counselling and Clinical social work act more in the preventive setting, whereas the Child and Youth welfare system comes into action when there is already a problem with neglecting or a significant incident has happened.

### *4.1.3 EARLY INTERVENTIONISTS*

The early intervention professionals work with families and children with special needs or at risk, from birth to age of three or six (depending on national settings). Services are usually organized in local teams (interdisciplinary teams), including cooperation with the family. Small children in the context of mentally vulnerable parents usually do not represent the primary target group of early childhood intervention systems as ECI traditionally (only) works in the context of disability or risk to be disabled. Children in the context of mental vulnerability might not always meet this (intake) criteria.

ECI works within basic principles for recommended practices (e.g. proximity, family-centredness … (www.european-agency.org): support is usually provided by interdisciplinary teams, with family centred principles and the development of an Individualized Family

Services Plan (IFSP). The usual contexts where professionals work is the natural surrounding of the child, its home, child care facilities, early childhood settings (private or public preschools), and nannies. Early childhood interventionists might be one of the first professionals who are directly working with and in vulnerable families, highlighting the preventive importance of these services at early stages of mental vulnerability.

| Area | Favourable factors | Hindering Factors |
|---|---|---|
| Early Childhood Intervention | most services require health, education and social services to **work together** in Early Intervention<br><br>most of the work is done within **home visits**, which allow proximity with families, the possibility to work within natural contexts of the child and within the normal routines of children and families | **lack of contact between parents and professionals** or other professionals e.g. due to very rigid time schedules of professionals working in these services and also the culture of parent involvement is still a difficult aspect<br><br>Despite of good general rate of coverage in EU there is still an **observable difference between urban and rural areas**.<br>Children in the contest of mental vulnerability often do not qualify for services. |

### *4.1.4 KINDERGARTEN TEACHERS*

Kindergarten (following http://en.wikipedia.org/wiki/Kindergarten) is a form of education for young children which serves as a transition from home to the commencement of more formal schooling. Children are taught to develop basic skills through creative play and social interaction. In most countries kindergarten is part of the preschool system of early childhood education. Children usually attend kindergarten any time between the ages of two and seven years, depending on the local custom.

Children attend kindergarten to learn to communicate, play, and interact with others. Preschool/kindergarten teachers provide various materials and activities to motivate children to be an active citizen and explore his or her world actively, to learn to interact with peers, to learn language, ethical principles, as well as that of music, art, and social behaviors. For children who previously have spent most of their time at home, kindergarten may serve the purpose of helping them to feel also secure in an educational setting (without parents being present). Children usually might be exposed to their first idea of peer-contacts and friendship while they play and interact with other children on a regular basis. Kindergarten may also allow mothers, fathers, or other caregivers to go back to part-time or full-time employment. Within the context of mental vulnerable parents kindergarten might represent a first step

towards new experience of a child and "reality-checks" with other adults outside the family system.

### *4.1.5 SPECIAL EDUCATORS*

The special educator is qualified to educate children with disabilities and/or impairments. He/she works systematically with the parents of the child in cases of educational problems (e.g. learning disabilities, attention disorder etc.) or challenging behavior. The most important task of the special educator is his/her ability to communicate with the parent regarding the needs of the child, e.g. the parent's attitude towards the child, their communication with the child, the child's daily routine, or hobbies and help with learning. The most common contexts, when special educator meets a child and its parent with mental disorder are the following:

| **Contexts** | **Responsibilities of special educators** |
|---|---|
| a) Diagnostics | • e.g. preschool diagnosis<br>• diagnosing preparedness for school attendance |
| b) Counseling | • empowering parent or the child solve educational problems |
| c) Prevention | • creation of inclusive settings regarding education<br>• consultations with parents or other stakeholder<br>• early identification of the child's special needs |
| d) Education | • education within the school system and also after school |
| e) Special-education intervention | • direct child centered work |
| f) Re-education and rehabilitation | • systematic approach to compensate e.g. learning difficulties |
| g) Informal events | • random meetings with parents and social events |

Cooperation with the parents is determined by the willingness of the parent and his/her motivation to participate in solving the child's needs and communication skills of the professionals. The cooperation with the parents increases the effects of special-education intervention, however sometimes cooperation might only be possible with the healthy parent.

### *4.1.6 THERAPEUTIC EDUCATORS*

Therapeutic educators work with children with problems in development, behaviour and health. In their praxis they often meet also with mentally vulnerable parents in various contexts. Several therapeutic educators work at the departments and institutions for adults with psychiatric diagnosis. Children of these parents have not been included in the care of the professionals so far. Therapeutic educators have systemized workplaces also in the

educational and social sector. They also work in nongovernmental, charity and educational organizations.

| Area | Favourable factors | Hindering Factors |
|---|---|---|
| a) Hospitals, psychiatric clinics, psychiatric departments | • close cooperation of therapeutic educator with psychiatrists,<br>• opportunity to detect children as early as possible<br>• opportunity to form healthier models of coping in a protective environment | • lack of therapeutic educators at the clinics (economic reasons)<br>• problems in creating feeling of security in hospital environment<br>• limited opportunities to work with the family (difficulty to transfer the learned from the hospital environment into everyday life) |
| b) Private offices of therapeutic educators where children are referred to | • close cooperation with family and professionals<br>• holistic diagnostics<br>• work in an prepared environment d<br>• focusing on the sources of coping, development of potentials of the child through successful experiences,<br>• better opportunity to adjust the intervention to the problems of the child and its family,<br>• voluntary search for help, an interest to change, | • possible financial demands<br>• difficulties in orientation in the possibilities of help, long process of going from one professional to the other. |
| c) Inclusion of the Child | • more professionals are concentrated at one workplace | • some parents may expect that professionals will solve everything,<br>• focused on developmental problems of disabled or at risk children, mentally vulnerable parents might be forgotten. |
| d) Children in protective care | • discovery of the child in a crisis situation | • traumatic experience, often means the loss of family background,<br>• alternative environments often lack information about the causes of behavioural problems of the child. |
| e) Children in care (children's homes, foster care, etc.) | • children also experience healthier family models,<br>• chance for children and a better start into life | • high concentration of children with difficult life experience<br>• minimal cooperation with parents,<br>• family background is missing, deficits in relationships. |
| f) Special schools | • parents know child's special needs | • serious barriers in |

| | | |
|---|---|---|
| | • personal and material facilities | communication between the child and parent,<br>• social stigmatisation. |
| g) Extracurricular activities, clubs | • have a preventive aspect,<br>• offer a chance to learn in a healthy peer group | • problems in the family are discovered often only by chance,<br>• there is not always space for providing help,<br>• parents may not be interested in their solutions, or they can even remove the child from the programmes. |
| h) Schools | • healthy peer environment,<br>• opportunity to identify problems of the child when a change in his/her behaviour is noticed,<br>• possibility to intervene without taking the child out of his/her natural environment | • a lot of other different types of challenges that the child meets and needs to deal with – e.g. relationships, etc.<br>• problems in the family are often discovered by chance, teacher and parents may not be interested in solving them. |
| i) Centres for people with substance abuse or other | • willingness of the relatives to change the status,<br>• opportunity to work in a group with a similar problem, | • behavioural patterns are influenced by the effects of addictions. |
| j) Family therapy | • chance to improve the situation of every family member,<br>• high motivation to cooperate,<br>• space to reveal family taboos | • rigid models of upbringing, unwillingness to cooperate on change. |

### *4.1.7 TEACHERS*

A school is an institution designed to allow and encourage students to learn in a school setting, under the supervision of teachers. Most countries have systems of formal education, which is commonly compulsory (http://en.wikipedia.org/wiki/School#Components_of_most_schools).

In education, teachers create conditions which stimulate student to "learn" (within a broader sense). The objective is typically accomplished through either an informal or formal approach to learning, including a course of study and lesson plan that teaches skills, knowledge and/or thinking skills. When deciding what teaching method to use teachers consider students' background knowledge, environment, and their learning goals as well as standardized curricula as determined by the relevant authority. The teacher may interact with students of different ages, from infants to adults, students with different abilities and students with learning disabilities. Teaching using pedogogy also involve assessing the educational

levels of the students on particular skills. Understanding the pedogogy of the students in a classroom involves using differentiated instruction, as well as, supervision to meet the needs of all students in the classroom.

Perhaps the most significant difference between primary school and secondary school teaching is the relationship between teachers and children. This relationship tends to be closer in the primary school where they act as form tutor, specialist teacher and (sometimes) surrogate parent during the course of the day.

Regarding mental vulnerability teachers in terms of a possible trustworthy person for the child might play a key role in communication and support for the child.

#### *4.1.8 PSYCHOLOGISTS*

Psychologists tend to work in diverse settings (early childhood, school, labour market, clinical setting). However, in the context of mentally vulnerable parents and children, clinical settings and counselling situation would be the most prevalent ones. Parents might seek psychological support or diagnostic assessment because they are worried about the development or the behaviour of their child. On the other hand psychologists, due to their institutional background, might come into contact with children in the context of mentally vulnerable parents in diverse settings: in the kindergarten, the school system or community based psychosocial services..

| Area | Favourable factors | Hindering Factors |
|---|---|---|
| Psychological services | • Mostly psychologists rely on the specific professional training regarding risk and resilience factors in children and families | • Psychology for many parents is still directly connected with "mental illness" and most of the parents when they seek for support of psychologists might stress that they are not mentally ill. |

## 4.2.Roles and tasks

#### *4.2.1 HEALTHCARE PROFESSIONALS (Nurses, Medical Doctors, Professionals in Clinical Settings)*

Mental disorders and substance abuse of parents increase the risk for mental vulnerability and other difficulties of their children. Therefore, the most common context where health professionals work with vulnerable children are adult healthcare units or adult psychiatric units. In these units where parents are treated, a focus towards "forgotten children" is possible

by taking into account the needs of the children. In addition also parental serious physical illness can be a source for childrens` vulnerability. In many cases, there is a correlation between parental serious physical and mental illness and levels of functioning in the family.

### *4.2.2 SOCIAL WORKERS*

In most EU27 countries there are no special roles and tasks of social workers regarding children of mentally vulnerable parents in psycho-social counselling yet.

Of course, when a parent or a youngster would come to e.g. a community centre to ask for help they would support them. The task would be to ask the client if he or she has any children and how the situation is at home, whether there are any problems or if any help is needed. Furthermore the adult could take the child once to the counselling centre so that the social worker can evaluate the situation. It might not be supportive to work with the child in the same institution (e.g. psychiatric hospital), as this can lead to an early stigma to the child. It is better to advise the child in some kind of children group, which can be similar to the existing peer support groups (e.g. "Rainbows groups" in Austria: www.rainbows.at).

b. Clinical social work in a psychiatric clinic

Clinical social workers meet their clients when they are in mental health crises. Till now there are also no selected roles or tasks regarding the children. There are two major aspects, which could be considered: Firstly, within the assessment the social workers should ask if there are any children in the family and who takes care for them during the stay of the mother or father. If the client needs any help the social worker should arrange what is needed to set up a save environment for the child. Secondly if the mental situation of the parent is not to acute - it should be possible that the parent can take the child into the clinic. Especially – when the child is a baby it needs the bounding of the mother and a separation can lead to a endangered relationship and distress when the child is older. Therefore – e.g. for postnatal depression it could be suggested that psychiatric clinics have mother-child rooms (e.g. http://www.waidhofen-thaya.lknoe.at/ambulanzen/ambulanz-des-waldviertler-zentrums-fuer-seelische-gesundheit.html).

c. Child- Youth welfare/child protection system

These governmental institutions mostly have to care for child protection by law as soon as they get to know about any harm of children. Other institutions should involve child welfare in earlier stages, however sometimes other professionals are afraid that the child is taken away

from the parents and subsequently this will cause another crisis. Preventive types of supports, like social pedagogic family support etc., could be offered.

To conclude, all three branches should cooperate and tell each other the main tasks and roles, because in some interviews professionals mentioned that there is a lack of cooperation and sharing of information. An improved cooperation could lead to institutional help acting more preventive.

### *4.2.3 EARLY INTERVENTIONISTS*

The role and tasks of early intervention professionals are performed within a model of team work with different professionals (Health, Education and Social services).
The different phases of support provided by the teams are:
- after referral the team has an initial contact with the families
- then an assessment of child development as well as the assessment of family's needs and priorities is done
- after this process in most systems Individual Family Support Plans are elaborated together with the family
- the next phase is the implementation of the IFSP and monitoring of the plan.

So the roles and tasks of ECI professionals are

- providing support (informational, emotional, instrumental, health, parent education, material, etc.) to families through the network of formal and informal support of the families,
- coordinating different services that families receive,
- collaborating among different disciplines and families,
- consulting and
- evaluating the implementation and outcomes of services in vulnerable families.

The professionals can also play roles of advocacy helping families and children acknowledge their rights and responsibilities and helping them achieving those rights. And in some cases activate Child Protection Services.

Particularly when working with families with mental vulnerabilities, the main outcome for the early intervention is to improve the child-parent interaction, creating learning opportunities and improving family well being.

### *4.2.4 KINDERGARTEN TEACHERS*

Roles and tasks of kindergarten teachers related to developing and strengthening mentally vulnerable children include that they obtain relevant information on the family background of the child, of its possible vulnerability to reveal or exclude the fact of being at risk and follow closely the physical, mental and social development of the child.

Kindergarten teachers design, implement and evaluate individualized education plans for the vulnerable child and in addition strengthen the child's resiliency in order to avoid or decrease the child's sense of shame and stress in connection with its parents. Furthermore they follow the child's cognitive development closely and actively help the child in its moral development e.g. by forming moral concepts and functions of conscience. Another role of kindergarten teachers in this context is to develop the basic skills of social competence, verbal and nonverbal communicational skills, emphatic and helping skills, cooperative and conflict management skills and the skills for cooping with stress. They actively stimulate the development of frustration-tolerance, the formation of daily routine activities and skills for respecting rules of living in community. The kindergarten provides opportunities for playful, movement activities in order to ease the child's stress level and satisfy the child's needs for emotional and social security, attachment. Furthermore the child's attachment relations with persons are enriched.

When kindergarten teachers collaborate with mentally vulnerable parents, they need to be aware of the vulnerability of the parent, accept him/her empathically and secure total discretion. Their role is to understand and accept that families are the first and most important settings for socialisation and that they are to help their functioning with all their means. In this context they help parents in their care for their children, give advice in education and care, meaning that they provide possible role models for parent how to form adult-child relationships and how to provide daily care. Additionally teachers in kindergartens could provide information on resources, services available for families.

Regarding the group of children it is not only the function of the kindergarten teacher to provide role models regarding acceptance, tolerance and social skills but also to develop these social skills together with the children and create and adapt supportive environments that facilitate the development of these skills. Besides following the development of vulnerable children, kindergarten teachers acknowledge the needs and demands of other members of the group and manage conflict situations.

When collaborating with helping services kindergarten teachers take the responsibility for a child at risk and are responsible to communicate with adequate professionals within and outside the institute. The roles and functions of kindergarten teachers in connection with the community of parents and educational professionals is primarily to respect ethical rules of their profession, provide confidentiality, and create atmosphere that enhances trust. Furthermore they should avoid stigmatisation and discrimination connected to vulnerability and foster (re)socialisation processes of the parent by organising joint programmes.

### *4.2.5 SPECIAL EDUCATORS*

The roles of the special educator are primarily to complete their task of establishing contact and cooperation with the parent after they have performed screening and diagnosis of the child. These includes in a first step that they initiate meetings with the parents and create an atmosphere of trust and cooperation during consultations. It is their responsibility to exchange solutions for practice with the parents and to sensibilize them regarding any needs of the child.

In cooperation with other stakeholders special educators provide professional advice to institutions or parents to help to solve any problems of the child. They prepare the child with special-educational needs e.g. for entry into school and help with the selection of an optimal "training" method. Furthermore special educators perform rehabilitative activities. A basic task of the special educator, is of course, to follow ethical principles when working with a child with a disability or impairment.

### *4.2.6 THERAPEUTIC EDUCATORS*

One main function of therapeutical educators includes prevention, meaning the necessity to create a healthy education environment. In addition it is the responsibility of the therapeutical educator to support the child in terms of emotional support, support in everyday situations, support of clients' competencies, support towards development of personality and integrity of the child and to accompany the child in difficult situations.

In this context they use art, music, occupational, play, drama, psychomotoric or family therapy etc. In different words, it is the role of the therapeutic to help in orientation (perception, cognitive processes, communication), in developing competencies to manage tasks of a particular age and in finding values. They also help the child/family in terms of stress reduction, processing emotions, building new attitudes, accepting changes and coping

with new situations, etc. All work with families also takes place on the level of learning and personality forming. Counselling processes are realised on the level of providing information and supporting competencies of the client to solve his/her problem.

### *4.2.7 TEACHERS*

Generally, teachers in all types of schools have mainly the role of an educator, who teaches a class of children during a fixed period of time regarding his/her formal teaching subject. Although some teachers might regard this as their only responsibility, a perspective to identify and support vulnerable children should be added. Therefore there are also other roles apart from the pure "teacher/instructor" role, e.g. "attachment person", "friend" and "leader".

In pre-schools and primary schools the teacher can also have the role of an "attachment person" for the small child. Teachers then have to deal with all behaviours of the student starting with coming to the kindergarten in the morning and going home in the afternoon or evening. Especially the little child in pre-school needs a person representing a secure base. Generally schools education has two dimensions: first formal training of learners in classes and the second in-formal training of broader needs such as being an individual, how to live or act as a citizen in society.

In secondary schools and high school, there are teachers of different branches. Regarding children in the context of mentally vulnerable parents the teacher also can take a role as a "trustful healthy adult attachment person", to whom I can talk, what is going on at home. However – based on traditional training structures - a tendency is observable that teachers are overwhelmed by multiple some role requirements.

### *4.2.8 PSYCHOLOGISTS*

The diversity of settings in which psychologists might work is also reflected within the diversity of roles and tasks. In the context of mentally vulnerable parents psychologists will mainly provide diagnostics (e.g. in terms of developmental diagnostics for the children), counselling or parent guidance and intervention in terms of treatment. Mostly the diagnostic setting is a clear defined area with well-established tools (screening tests, questionnaires, behavioural observation etc). The product of a diagnostic process is a description of a status quo, mostly related to concepts of statistical normality. However, it has to be highlighted that every diagnostic process mainly represents a dialogue between the person performing the

diagnostic process and the diagnosed person. However this dialogue sometimes due to severe mental impairment (e.g. florid symptoms of paranoia) could be endangered. In this context observation of attachment, of possible developmental risks and resilience factors in the context of mentally vulnerable parents are important. The diagnostic perspective then has to be the child and his or her protective factors or risks.

Counselling focuses on the support of the family, mainly reinforcing and empowering self-help factors in the family system. Compared to diagnostic processes, counselling processes depend to a high extent on the ability and motivation of the parents to reflect ones own situation (e.g. in terms of mental health).
Beside diagnostics and counselling psychologists also perform treatment processes. It seems evident that the treatment methods regarding children due to possible motivational factors and possible lack of insight or compliance have to follow different way than e.g. psychological treatment of adults. Treatment will be based on play activities, however mostly the active cooperation of parents is required; sometimes primarily by a health adult attachment person (partner, grandparents…)

## 4.3 Necessary Competences of the professionals

It has to be highlighted, that the described professional competences refer only to the work with children in the context of mentally vulnerable parents. Other necessary competences of the diverse professional groups are not included (as the are part of general job profiles of the diverse professional sectors

### *4.3.1 Knowledge expressed by all professional groups*

There is a consensus that all professional need to have a certain level of specific vulnerability-related knowledge. This includes child centred areas such as child development, children's ways to understand and react on parental illness in different age groups, the impact of mental vulnerabilities of the parents on children or the question what is most helpful or dangerous for children and youngsters.

Furthermore relevant basic knowledge about psychiatric disorders is needed including diagnostic criteria (ICD 10 or DSM IV-TR (e.g. What different kinds of disorders exist?, What are the symptoms? What is the best medication?) or other health related issues (somatic development of children, diseases etc.).

Furthermore all sectors need: basic knowledge on legal and administrative issues like children's rights, country-specific child protection systems and educational systems, concrete support methods and didactics as well as basic principles of counselling and advising and communication peculiarities of people with in the field of mental vulnerability

In order to provide proper support all professionals should possess basic knowledge regarding resilience research, resilience factors and cooperation from other sectors (e.g. health, social, educational…). Nevertheless each professional group might need specific knowledge within the area of their profession (see below)

### *4.3.2 Specific Knowledge needs expressed by the diverse professional groups*

4.3.2.1 HEALTHCARE PROFESSIONALS (Nurses, Medical Doctors, Other Professionals in Clinical Settings)

| **Area of Knowledge** | **Examples** |
|---|---|
| a) information about risks as a basis for child centered work | The parental mental vulnerability e.g. may lead on the onset of child's own illness. This knowledge is essential reason for the preventive child centred work. |
| b) knowledge about children's protective factors which formulates the professionals' clinical work | Professionals working in adult healthcare also need information regarding psychosocial well-being of the children. Although They have to be able to recognize the most common concerns of children and to know how to ask and receive help from the services for children. For example professionals need to know whom to contact if the child is withdrawal and not willing to go to the school |

4.3.2.2 SOCIAL WORKERS

| **Area of knowledge** | **Specific knowledge within this area** |
|---|---|
| a) specific legal issues | • Child/Youth welfare law<br>• social assistance law<br>• guidelines within the health system<br>• where you can get benefits.<br>• Employment law |
| b) specific organizational issues | • Methods in assessment<br>• Intake and evaluation and setting up a support plan including the different instruments to measure the important factors like the network of a client or family as well as the available resources and how to activate the resources. |
| c) The method Case Management from the perspective of children | • a lot of the target group families are multi-problem families and case management is a good method to gain an overview as well as to lead and bring together the helping processes |
| d) Basics of social work | • Participation<br>• concepts of human autonomy |

| | |
|---|---|
| | • a successful life despite disagreements |
| c) Project work and business administration | • Because a lot of institutions start as a project and social workers should know how to plan and successfully lead a project |

4.3.2.3 EARLY INTERVENTIONISTS

| Area of knowledge | Specific knowledge within this area |
|---|---|
| family theory | • ecology theory, and family systems theory, including the challenges of families in the context of mental vulnerability |
| Coping mechanisms of children with distress | • parent-child interactions and its impact on child development or attachment, the strengths, values and individuality of family functions and empowerment principles on working with families |
| Intervention methods to promote resilience | • Knowledge about family intervention and child centred methods |
| Transdisciplinary team work in the field of mental health | • Knowledge about effective communication and collaboration, social support networks and its influence on development and evidenced based practices within this specific area. |

4.3.2.4 KINDERGARTEN TEACHERS

| Area of knowledge | Specific knowledge within this area |
|---|---|
| Regional socio-cultural aspects and the states of mental vulnerability | • Knowledge related to environmental circumstances in which families live. Knowledge about specific impact of mental vulnerability on the (kindergarten) age group |
| Intervention methods | • Methods with which the above mentioned harm can be decreased in the framework of institutional education, like activities that strengthen resilience, release stress, art activities, individualized education methods |

4.3.2.5 SPECIAL EDUCATORS

| Area of knowledge | Specific knowledge within this area |
|---|---|
| screening methods | • acquiring ways to understand, plan and evaluate education processes and how to cope with problematic situations |
| Knowledge about support of the children in the educational system | • Knowledge about support processes for children in the educational process, consulting service, or with communication with parents |
| Basic intervention techniques | • being aware of methods of basal psychotherapy and know selected psychotherapeutic techniques (active listening, role playing, working in self-supporting groups) |

4.3.2.6 THERAPEUTIC EDUCATORS

| Area of knowledge | Specific knowledge within this area |
|---|---|
| Mental vulnerability | • knowledge about concepts of psychiatric disorders and their link to education, the upbringing styles in family, knowledge about resilience and risks (especially in parents with mental disorders) |
| Therapeutical concepts | • resources, options and use of therapeutic concepts (family therapy, art therapy, music therapy, occupational therapy, play therapy, drama therapy, psychomotoric therapy |
| Psycho diagnostics | • basics of psycho diagnostics (e.g. process diagnostics, problem oriented diagnostics)<br>• methods and principles of therapeutic education (e.g. including crisis intervention |

4.3.2.7 TEACHERS

| Area of Knowledge | Specific Knowledge of Teachers |
|---|---|
| Knowledge about the bio-psycho-social development of learners in the school setting | This aspect includes knowledge about coping processes of young people with taboos, stigma (of having a parent with mental vulnerability) and<br>Knowledge about techniques of "behaviour modification. |
| Knowledge of cooperation models with families in school | Knowledge how to assess the needs of a family, how to initiate changes in a family system |

4.3.2.8 PSYCHOLOGISTS

| Area of knowledge | Specific knowledge within this area |
|---|---|
| Counseling | • knowledge regarding the impact of mental illness on the child or family system |
| Knowledge about intergenerational transmission | • generational transmission of mental vulnerability within family systems |
| Diagnostics | • Knowledge about family centred diagnostic systems, including strengths and resilience factors |
| Child development | • Specific knowledge about resilience factors, developmental milestones and developmental processes |

### *4.3.3 Skills described by all professional groups*

The second column of the learning outcome model are skills. Although many skills which experts of different professional groups need to acquire are highly specific, some skills should be available in every professional field of children from vulnerable families like:

- to set up a trustful relationship with the family

- to provide emotional security and create a climate of acceptance and confidence
- to solve problems solving skills and
- to listen effectively and gain information sensitively
- to co-operate with maximum discretion when working together with mentally vulnerable parents
- to apply basic ethical principles
- to identify the child's and family's needs
- to provide a feeling of security and
- to keep boundaries
- to be able to understand non-verbal signals of the parent's behaviour
- to be able to detect the child's possible vulnerability (including resilience processes)
- to be able to communicate with children, their parents and other educational professionals without prejudices and stereotypes.
- to cooperate with social care services, taking into account professional and ethical principles,
- to focus on own psycho-hygienic rules (e.g. using supervision)
- to give feedback, which the client(s) are able to understand.
- to respect decisions of the family, unless the child's welfare is not in danger

### *4.3.4 Specific skills described by the diverse professional groups*

4.3.4.1 HEALTH CARE PROFESSIONALS (Nurses, Medical Doctors, Professionals in Clinical Settings)

Health professionals need skills to work in a child centred way, to include aspects of family dynamics and abilities/coping strategies of the child and proper training regarding available tools (e.g. Let's Talk about the Children).

Furthermore they need to become aware of two kinds of "expertises".

a) They need to understand that the family itself has a lot of expertise. This includes the shared experience and way of thinking within the family. Therefore the family members need to be heard and understood with their point of views.

b) The second expertise focuses on the professionals in terms of information e.g. about the illness, treatment, protective factors of children etc. Professional supporting children in the context of mentally vulnerable parents should have skill to combine these two expertises. The needs of the family members are the basis for the use of the professionals' common knowledge. It might be a professional challenge to put your self as a professional into the child's position, but also to see the position of the parent – and keep a professional distance.

4.3.4.2 SOCIAL WORKERS

**Cognitive skills:**

If the client is a child, social workers should have the skill to act in a decent way a child can follow and understand. For instance there are some children books that explain the

circumstances when a parent is mentally vulnerable. Additionally the ability to work with groups of children is also necessary. Furthermore skills pertaining to crises intervention and communication methods are useful. Flexibility is necessary to design individual assistance plans.

**Practical skills:**

The practical skill area includes the ability to use methods, which were described above under section "knowledge". They should be installed and used in a realistic way and appropriate to the clients needs. Especially when professionals work with children it is essential to be creative and work with a variety of methods and materials like toys, books, arts and crafts materials etc. Moreover social workers should handle situations where they hear different opinions within the family. It is useful to have the ability to reflect these different statements and act in the best way for the clients needs.

#### 4.3.4.3 EARLY INTERVENTIONISTS

Early interventionists should also be able to identify informational and educational needs of family and children. Adult educational practices could be applied: to work with families; to meet as well as identify family and children's needs, to apply collaboration strategies to help families to access services and support. In the work with children early interventionists should have the ability to identify community resources and help family access them (build the support network map, especially cooperating with mental health services), and use assessment instruments to identify developmental needs and priorities for children and/or the families. Additionally they should be able to develop together with families IFSP goals that are coherent with family needs, life style and cultural values and provide appropriate follow-up while monitoring and evaluating the IFSP process.

#### 4.3.4.4 KINDERGARTEN TEACHERS

Kindergarten teachers should also be able to design and implement developmental and educational plans related to children of mentally vulnerable parents. They have the competence to help the child's integration into the community and acceptance by his/her group mates and apply pedagogical and methodological knowledge to develop the child's competences and skills with respect to the child's needs. It should also be the responsibility of kindergarten teachers to provide opportunities for the child to canalise and cope with tension, to help the child to form ones self-concept, support self-strength, to form moral concepts, and to strengthen functions of conscience.

In addition it is a specific skill of kindergarten teachers to foster the child's verbal and non-verbal communication skills, emphatic and helping skills, cooperation and conflict management skills, healthy coping mechanisms and frustration-tolerance and to enhance consolidation of daily routine activities, and respect for the rules of living in community. When working with children of mentally vulnerable parents kindergarten pedagogues should be able to create and adapt supportive environments (private and community spaces, tools, toys etc) to provide optimal condition for the child's development, to develop tolerance, empathy and acceptance without prejudice among the kids and to enhance development of the child's cooperation and conflict-management skills.

In terms of group dynamics kindergarten teachers help to create a feeling of "belonging" to someone in the kindergarten and act as a role model for the children in applying social skills. Furthermore, regarding the work with parents kindergarten teachers support mentally vulnerable parent's integration into parents' community and give advice to mentally vulnerable parents on educational and daily care issues.

#### 4.3.4.5 SPECIAL EDUCATORS

When working with vulnerable families a special educator is able to plan necessary steps to achieve the objective, the ability to formulate advice and recommendations in a manner that is acceptable for the parent (e.g. based on simple and clear communication with the parent). The educators applies know-how to adequately react when the parent might loose emotional control and e.g. calms down an e.g. aggressive parent. It is very important that special educators in this context possess the competence to praise positive changes in the client's or parent's behaviour and give positive feedback, to allow the parent to comment on the problem of the child in a manner he deems necessary.

Additionally it is necessary for this professional group to have the abilities to support a parent in order to create a suitable environment for a child, to create an individual program for a child with special educational needs and to create a daily program for a child for constructive use of leisure time at home.

#### 4.3.4.6 THERAPEUTIC EDUCATORS

Therapeutic educators additionally need to perform observations of the child within an open activity (e.g. play), to analyse collected data, identify problems of the child and elaborate a prognosis in order to offer a therapeutic-educational programme and evaluate it. Therapeutic

educators working with children of parents with mental vulnerability also need to perform practical therapeutical interventions (e.g. crisis intervention).

4.3.4.7 TEACHERS

Teachers should be able to observe and be aware of the student's emotional state and identify, whether there is the necessity to intervene or offer support. With a high probability, a child in the context of mental vulnerability might not show signs of distress openly. In such situations a teacher should have the skill to listen carefully and – if necessary- activate network resources (e.g. support teacher, social worker…). The teaching processes also could include aspects of therapeutic intervention (e.g. in terms of behavioural changes).

4.3.4.8 PSYCHOLOGISTS

Clinical psychologists should be able to assess resilience and risk factors of a child within the family system and initiate exchange processes regarding his or her findings. Furthermore they should be able to use available screening and diagnostic tools and initiate resilience processes within vulnerable family systems to prevent further distress or impairment of the child.

### *4.3.5 Wider personal abilities described by all professional groups*

Beside specific knowledge and specific skills the learning outcome model also foresees wider personal competences which contribute to high quality professional actions. In the context of children of mentally vulnerable parents the diverse sectors described following wider (personal) competences:

- respectful attitude towards all family members, including the mental vulnerable person
- sensitivity, availability and empathy,
- flexibility and creativity
- tolerance and patience
- friendliness and open-mindedness
- interest in family processes
- authenticity and advocacy for the child and the family

Especially in the context of vulnerable families it is important for all experts working with and within the families to have an attitude to know that the family members are the experts of their situation and to take responsibility for own decisions and advice, unless they are in acute psychosis.

### *4.3.6 Specific wider personal abilities described by the diverse professional groups*

4.3.6.1 HEALTHCARE PROFESSIONALS (Nurses, Medical Doctors, Professionals in Clinical Settings)

The working relationship within a clinical setting needs to be non-stigmatising and open. Working with the children must be based on mutual trust and confidence to the child and the parent(s). The professional's willingness to learn to listen to the child is important. Child's every day experiences relating to the parental illness and child's own point of views are essential to be heard and to be taken into account.

The next personal competence area is the professionals' will to learn to help parents themselves to satisfy their children needs, answer their questions and/or concerns. In the case when parent cannot respond to the child, the parent must be informed what has been told to the children. Furthermore it is important, that the professionals are able to help family members combine the parent's vulnerability with the children's understanding of the situation. The fourth competence is the professional's capability to create a positive and a supportive working environment. The working relationship should be hopeful and future orientated.

4.3.6.2 SOCIAL WORKERS

There are some specific personal abilities that a social worker in this context should have,

- to work autonomously in being aware of family coalitions and institutional dependence
- to comprehend existing family connections and networks and empower them
- to reflect statements of the client
- to understand with what they are dealing in their daily life and
- to reflect resources which are available for the family and the child.

The social worker should have own experiences to better deal with the certain situations of the clients and possibilities for self-awareness- and mediation, enabling children to learn skills and competencies in their own situation. Also the willingness to act unconventionally, e.g. handcraft with children, is needed.

4.3.6.3 EARLY INTERVENTIONISTS

Professionals in the field of early intervention need to specifically focus onto the whole family-system (including siblings or grand parents), try to reinforce changes and value small steps. Additionally they need the special personal competence to be persistent and to transfer competencies (e.g. as a key worker for the family).

4.3.6.4 KINDERGARTEN TEACHERS

Special wider personal competences for kindergarten teachers are

- high emotional and social intelligence

- good organizing and managing skills and
- neatness and pleasing appearance.

4.3.6.5 SPECIAL EDUCATORS

Wider personal skills which are important for special educators can be seen from two different perspectives:

**a. in relation to the parent:** it is important for special educators to be able to work in a team, to stay (relatively) emotionally detached (from sometimes threatening experience) and reflect prognosis

**b. in relation to himself/herself:** special educators need

- self-reflexivity
- the ability to activate own resources or use external support (e.g. supervision)
- the ability to cope with stressful situations
- self-regulation and self-control
- as well as the skill to respect discipline.

4.3.6.6 THERAPEUTIC EDUCATORS

For the professional field of therapeutic educators the following specific necessary wider personal can be summarized when working with children in the context of mental vulnerability:

- consideration
- the ability to cope with unpredictable situations and reactions
- the ability to create an accepting, non-judgemental environment.

4.3.6.7 TEACHERS

A teacher gives his/her knowledge and shows his/her skills by combining individual competences. Education is a holistic process, therefore teachers should also keep in mind the whole personality of a student in his or her learning environment (school or home). Furthermore they should be open towards to criticism. It might be necessary that teachers are more skilled and experienced in order to achieve these roles: e.g. in terms of sensitivity, social competence, analytically thinking to find solutions to sometimes complex problems.

4.3.6.8 PSYCHOLOGISTS

In terms of wider personal competences psychologists should also be able to communicate their diagnostic findings in an understandable way to parents and keep in mind complex system dynamcis when “treating” children (e.g. regarding possible loyalty conflicts of the child).

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