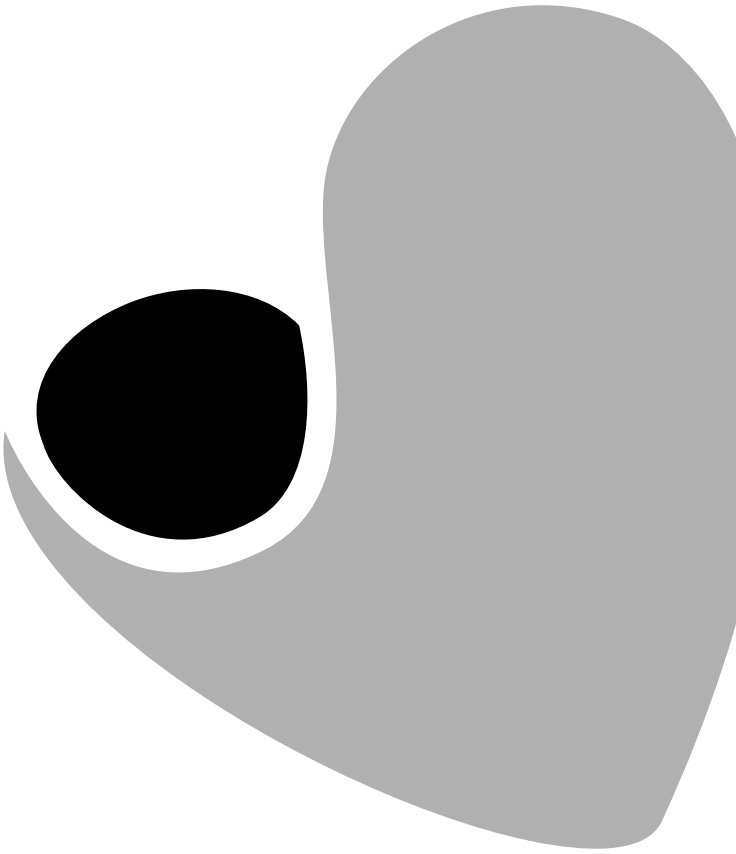
# Welcome to the Competency Framework for delivering psychological therapies in the perinatal period in IAPT services.

## A BRIEF DESCRIPTION OF THE COMPETENCES FRAMEWORK FOR PSYCHOLOGICAL APPROACHES AND INTERVENTIONS IN THE PERINATAL PERIOD

The framework describes the various activities which need to be brought together in order to carry out clinical work in the context of perinatal work within IAPT.

The framework locates competences across six “domains”, each of which represents a broad area of practice. This helps users to see how the various activities associated with work in this area t together. The competency framework includes only perinatally speci c competences, existing competency frameworks should be used to inform general practice.

Although its primary audience will be clinicians, clinical managers and commissioners of primary care mental health services (particularly IAPT), service users will also nd the competency framework useful.



# ACKNOWLEDGEMENTS

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# A COMPETENCE FRAMEWORK FOR IAPT PSYCHOLOGICAL APPROACHES AND INTERVENTIONS IN THE PERINATAL PERIOD

## EXECUTIVE SUMMARY

The report describes a method for identifying competences for all IAPT staff working with clients in the perinatal period. It organises the competences into domains.

The domains are:

- Core underpinning competences for working in the perinatal period
- Core knowledge of the perinatal period and perinatal mental health
- Generic therapeutic competences required for managing clinical sessions and any form of psychological intervention in the perinatal period
- Competences in relation to assessment,
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# HOW TO USE THIS DOCUMENT

This report describes the model underpinning the competence framework, and indicates the various areas of activity that, taken together, represent good psychological clinical practice. It describes how the framework was developed and how it may be used. The framework is available from the UCL Competence Framework Site. (https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks).

Please note that this perinatal IAPT competency framework draws on the Perinatal Competency Framework developed by Health Education England (HEE) for all staff working to support parents and families across the perinatal care pathway. This IAPT-speci c perinatal framework complements the HEE perinatal multidisciplinary competence framework. It draws from the HEE perinatal competences that are relevant for low intensity (PWP) and high intensity practitioners, with further detail for competences related to speci c evidence-based perinatal interventions offered within IAPT (https://www.hee.nhs.uk/our-work/mental-health/perinatal-mental-health/competency-framework-perinatal-mental-health). The document recognises that some “foundational” competences may be relevant for a range of health professionals working with individuals during the perinatal period. This framework only references those competences in terms of the work that IAPT clinicians would undertake (even if other professionals should also have them).

This document has been compiled with reference to other IAPT competences (Roth & Pilling, 2007) and should be used in conjunction with them, in particular the Cognitive and Behavioural Therapy Framework. There is an expectation that core therapeutic competences will be met through core PWP/High Intensity therapy training. This document focuses on additional competences, speci c to the perinatal period and should be used in conjunction with the HEE perinatal competence framework, particularly the perinatal assessment and therapy competences.

Problems that can be effectively and appropriately treated within IAPT:

The chart below speci es evidence for treatments used in IAPT, by condition. Column 4 shows NICE (2014) Antenatal and Postnatal Guideline (CG192) recommended treatments, with references to perinatal-speci c evidence-based treatments. Column 5 shows how to make perinatal adaptations to existing evidence-based treatments. [a]

SEE TABLE ON FOLLOWING PAGE X

| | Condition [a] | IAPT recommended treatments | Source | Perinatal-Speci c Treatment | Perinatal Adaptations |
|---|---|---|---|---|---|
| STEP 2: Low Intensity Interventions | Depression | | | | |
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[a] See: https://perinatal-treatment.com to access perinatal-speci c guided self-help treatments for depression. In IAPT, these should always be used in conjunction with support from a PWP. Given the very high rates of attrition without support

- Parents who have a child/children previously removed from their care. (In these cases there is close co-working with social care and early planning during pregnancy for the care of the child after the birth. Legal reports may be required. A parenting assessment may be necessary.)
- Attachment issues. (Working with the parent-infant relationship is a specialist area drawing upon knowledge of parent-infant interaction, developmental theory, attachment theory and systemic theory, which goes beyond the scope of IAPT training.)

# SCOPE OF THE COMPETENCE FRAMEWORK

The framework is intended to apply to all IAPT clinicians (low and high intensity) working with clients presenting in the perinatal period. There are some areas where competences relate speci cally to high intensity clinicians and are identi ed as such.

The perinatal period is taken as the time from conception through pregnancy, childbirth and the rst 12 months postnatally. The NHS Long Term Plan commits to extending the provision of care provided by specialist perinatal mental health services to 24 months postnatally by 2023/24. This guide may therefore be applied up to 24 months postnatally. This document refers throughout to “parent,” and this includes both mothers, fathers and partners. Clinicians should consider the impact of pregnancy and the postnatal period on both parents and adapt interventions accordingly. The competences aim to be inclusive of all parents and recognises the range of ways in which “family” may be de ned.

The competence framework is focused primarily on clinical work and excludes service management and development skills. Audit and research skills are not speci ed in depth, though the ability to make use of measures (and to monitor outcomes) is identi ed as a core clinical skill, as is the ability to make informed use of the evidence base relating to therapeutic models.

Supervision clearly plays a critical role in supporting the development of competences, and the ability to make use of supervision is included in the framework. Competences associated with the delivery of supervision are detailed in a separate framework, available on the CORE website (https://www.ucl.ac.uk/clinical-psychology/competency-maps/pd-map.html).

# THE DEVELOPMENT OF THE COMPETENCE FRAMEWORK

Oversight and peer-review:

The work described in this project was overseen by an Expert Reference Group (ERG) comprising experts in working within the perinatal period across the UK, selected for their expertise in research, training and service delivery (the ERG membership is detailed in the Acknowledgements). The ERG were consulted regularly throughout the project to ensure that key texts, policy documents, and service user documentation were identi ed, to advise on process, and to input to and review perinatal competences.

In addition to review by the ERG, competence lists for speci c areas of clinical activity and for speci c interventions were reviewed by individuals identi ed as having particular research or clinical expertise in the area.

Adopting an evidence-based approach to framework development:

A guiding principle for the development of previous frameworks (Roth and Pilling 2008) has been a commitment to staying close to the evidence-base for the ef cacy of therapies, focussing on those competences for which there is either good research evidence or strong expert professional consensus about their probable ef cacy. We applied this principle to this framework, but note several important issues in relation to the evidence-base for working in the perinatal period (all of which need to be taken into account):

A. Number of published research trials: Compared to the  eld of adult mental health, there are fewer large randomised controlled trials contrasting one active intervention to another, or to a control condition. Such trials are critical for making causal inferences about the ef cacy of an intervention, and although the evidence base on smaller trials or other research designs is relevant, the conclusions that can be drawn from them are less robust. We therefore followed the "levels of evidence" approach used by NICE guidelines. We  rst followed NICE, SIGN and "Matrix" guideline recommended treatments and updated this with more recent trial evidence where this was available. Where these guidelines did not provide speci c recommendations for diagnoses, we followed guideline methodology and prioritised randomised trials, then pre-post designs. Where data was lacking, we have consulted relevant guidance in non-perinatal areas, conjoined with evidence from correlational designs and qualitative research on perinatal speci c clinician, client and contextual aspects that impact on treatment engagement, adherence and outcomes, and expert input. It is important to acknowledge that this is a rapidly developing  eld with a number of trials in progress, and as further evidence emerges this will need to be re ected in revisions of the framework.

B. Organisation of evidence base in relation to diagnosis: There is a developing body of evidence for CBT and Interpersonal Psychotherapy (IPT) in perinatal depression, but less for the other disorders. In the absence of any speci c perinatal period research evidence, the relevant NICE guideline for the disorder should be followed (e.g. panic disorder should be treated with CBT regardless of whether it presents in the perinatal period or not). We have considered the existing evidence base and the existing empirical evidence base on perinatal adaptations and made appropriate recommendations, but that these may change as evidence changes. Thus, clinicians should keep abreast of evidence in working with parents in the perinatal period. As is the case across the  eld of psychotherapy research, the evidence-base for work in the perinatal period tends to be organised in relation to diagnosis. However, it is well-recognised that many presentations in the

# IMPLEMENTING THE COMPETENCE FRAMEWORK

A number of issues are relevant to the practical application of the competence framework.

### Do all clinicians need to be able to do everything speci ed in the competence list?

As described above, not all clinicians are expected to carry out all the competences in all the domains of the framework. However, all members of a clinical team would be expected to be able to demonstrate “underpinning” skills (core and generic psychologically informed competences - shaded green on the map), and all clinicians would be expected to be able to assess clients and use assessment information to develop appropriate treatment plans. Whether or not an individual clinician will demonstrate competence in other areas of the map will depend on their having had the appropriate training and supervision to work within the perinatal period.

How the metacompetences apply is more complex: some apply to all psychologically informed care, while others relate to the implementation of speci c psychological interventions or speci c procedures, and so only apply when these are being carried out. For example, metacompetences that apply to all workers are “An ability to make a judgement about when mental health problems, past or current, require support from a Specialist Perinatal Mental Health Team”, or “An ability to judge the differences between normal emotional changes in the perinatal period and dif culties that require treatment”. Others apply only when more speci c interventions are being carried out (for example, “An ability to judge when safe and appropriate to do exposure-based treatment with perinatal women.”). As such, whether or not a metacompetence applies depends on the work a particular clinician is conducting.

### COMPETENCES RELATING TO SPECIFIC PSYCHOLOGICAL THERAPIES

The impact of treatment formats on clinical effectiveness for psychological therapies: Some of the competence lists in this report focus on setting out what a clinician should do when delivering speci c psychological therapies, but most of them do not comment on the way in which an assessment or intervention is organised and delivered (for example, the duration of each session of a psychological treatment, how sessions are spaced (e.g. daily, weekly or fortnightly) or the usual number of sessions). However, these formats are often identi ed in clinical guidelines, and in manuals and research protocols, with the schedule constructed so as to match to clinical need and the rationale for the intervention.

When implemented in routine services, treatment formats often deviate from the schedules used in research trials. This can be for a range of reasons, but it is reasonable to ask whether making signi cant changes to the format may impact on effectiveness. This is a dif cult question to answer because on the whole there is little research evidence on which to draw. However, where research has been conducted it suggests that better outcomes are achieved when clinicians show greater  delity to the procedures set out in the manuals. As such, there is much that could be neglected if clinicians deliver bespoke programmes that include some, but not all, areas set out in a manual. This suggests that when clinicians vary a ‘standard’ treatment procedure they should have a clear rationale for doing so, and that where procedures are varied there should be careful monitoring and benchmarking of clinical outcomes in order to detect whether this has a neutral or an adverse impact.

Given the limited but growing body of evidence for perinatal speci c mental health interventions, it may be particularly important to attend to issues of  delity when adapting existing evidence-based interventions to the perinatal period. Therefore special attention should be paid to training and supervision in the provision of therapeutic interventions in the perinatal period.

# DOMAIN ONE: CORE PROFESSIONAL COMPETENCES

## PROFESSIONAL SKILLS AND VALUES

### Ability to work with difference and diversity

As well as the perinatal competences listed below, the IAPT Black Asian and Minority Ethnic Service User Positive Practice guide and audit tool should be used in conjunction with this framework (https://babcp.com/Therapists/BAME-Positive-Practice-Guide-PDF). The HEE competences for perinatal mental health provide additional competences relevant to working with difference.

### Basic stance

An ability to consider mental wellbeing and

DOMAIN TWO:

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### Knowledge in relation to the postnatal period

An ability to draw on knowledge of the most common features and challenges in the postnatal period (e.g., labour resulting in perineal tears, infant crying, re ux, sleep).

An ability to draw on knowledge of key developmental milestones of the  rst year (e.g. smiling, weaning, crawling, development of language, infant feeding and sleep patterns).

An ability to draw on knowledge of the current evidence base about the costs and bene ts of breast and bottle feeding, including how dif culties breastfeeding can impact on maternal mental health.

An ability to draw on knowledge of how mastitis, tongue tie, and re ux can affect breast and bottle feeding.

- An ability to draw on knowledge of feeding (breast, bottle, mixed) options and their impact on maternal functioning and mental health.

An ability to draw on basic knowledge of infant sleep including:

- Patterns during the  rst postnatal year, including how an infant sleeps in the context of developmental growth “spurts.”
- Current guidance on safe sleeping conditions and awareness that the evidence base is rapidly changing in this area.
- Different approaches to infant sleep and their evidence base (for example, controlled crying, or attachment-parenting).

in order to help inform decisions about when to seek professional input (e.g., health visitor) and how to help the client manage the impact of infant sleep patterns on their mood and functioning.

### KNOWLEDGE OF MENTAL HEALTH DURING THE PERINATAL PERIOD

An ability to draw on knowledge of perinatal mental health conditions and their prevalence rates in order to:

- distinguish between normal and clinically signi cant levels of anxiety and low mood during pregnancy and the postnatal period.
- be aware that women with bipolar I disorder are at particular risk for postpartum psychosis, but that it can occur in women with no previous psychiatric history.
- identify which presentations require urgent assessment for specialist perinatal mental health services or secondary care (e.g. postnatal psychosis, severe anxiety, severe depression, thoughts of harm to self, others or the infant).
- distinguish between primary and secondary tokophobia and the recommended treatments for each. Note that primary tokophobia is de ned as a fear of childbirth in those who have no previous experience of pregnancy, whereas secondary tokophobia occurs after a traumatic obstetric event in a previous pregnancy.
- identify comorbidity (e.g. of birth trauma and postnatal depression).

An ability to draw on knowledge of perinatal factors that can impact on parental mental health, such as:

- Whether the pregnancy was planned or unplanned, wanted or unwanted, and whether the parents are supported or unsupported in their decisions around pregnancy.
- Previous losses and traumas, which may impact on the relationship between mother, partner and infant.

An ability to draw on knowledge of how an absent partner, or lack of support from the family, may affect the parent and infant’s mental health and their relationship.

An ability to draw on knowledge that the demands of pregnancy and caring for a new baby may increase risks for relapse in those with pre-existing mental health problems.

- An ability to help parents manage the uncertainty and possible anxiety that may result from this.

An ability to draw on knowledge that severe and chronic perinatal mental health problems may have an impact on the woman's health, pregnancy, and the foetus.

- An ability to communicate sensitively with parents about this possible risk.

An ability to draw on knowledge of:

- pregnancy speci c worries and their impact on birth outcomes (gestational weight and gestational age).
- protective factors where there is a mental health problem, including the positive impact of a supportive family member.
- potential impact of perinatal mental health disorder on parenting, and that this may be an important factor related to infant outcomes.

An ability to draw on knowledge to recognise where the parent-infant relationship may be problematic and how to refer to appropriate services for assessment and speci c support.

## KNOWLEDGE IN RELATION TO PSYCHOTROPIC MEDICATION IN THE PERINATAL PERIOD

An ability to draw on awareness about the use of medication in the perinatal period, for example:

- there is an altered cost-bene t ratio of some medications during pregnancy and whilst breastfeeding.
- the possible risks of abruptly stopping medications.
- that benzodiazepines should not be taken in pregnancy.

and questions about these issues should be referred to a perinatal pharmacist, nurse prescriber, or psychiatrist.

# DOMAIN FOUR: ASSESSMENT, FORMULATION, ENGAGEMENT AND PLANNING

## ASSESSMENT SKILLS

### ABILITY TO UNDERTAKE A COMPREHENSIVE BIOPSYCHOSOCIAL ASSESSMENT

An ability to draw on knowledge of the broad domains usually included in an assessment during the perinatal period, for example:

- An ability to gather information about the client's pregnancy, previous pregnancies, support available and preparation for the baby.
- An ability to draw on knowledge about the distinction between unplanned and unwanted pregnancies (e.g. an unplanned pregnancy can be wanted).
- An ability to gather information about the client's experience of childbirth, their infant's development, their relationship with the baby and their adjustment to parenthood.

An ability to draw on knowledge of how presenting problems and their maintaining factors are in uenced by pregnancy, childbirth and the transition to parenthood, for example:

- Presenting Problems, such as: anhedonia in infant interactions; Intrusive thoughts related to the infant (e.g. thoughts of possible harm coming to infant) and related compulsive behaviour; Trauma symptoms related to the birth.
- Maintaining Factors, such as the parents' level of functioning (e.g. coping strategies, activities of daily living, engagement in pleasurable activities, ability to care for infant).

An ability to respond to and discuss the parents' concerns about the impact of mental health issues on their infant's well-being (e.g., whether infant is at risk for social/emotional problems).

An ability to draw on knowledge of risk factors for perinatal mental illness when assessing women of childbearing age (e.g. Bipolar I).

An ability to identify the extent to which the parents' perception of their capacity to nurture their infant is (or is not) congruent with their actual sensitivity and responsiveness (e.g., anxious parents who may worry that they are not doing enough but who appear to be responding to infant's needs, contrasted to parents who express bonding problems and who do indeed appear to struggle to respond to infant's needs).

An ability to compassionately enquire about infant death and/or other traumas relating to childbirth during assessment.

An ability to refer for specialist interventions where assessment indicates this is appropriate (e.g. child and infant assessment; bereavement support).

# FORMULATION

An ability to draw on evidence-based models to create a client-speci c conceptualisation that:

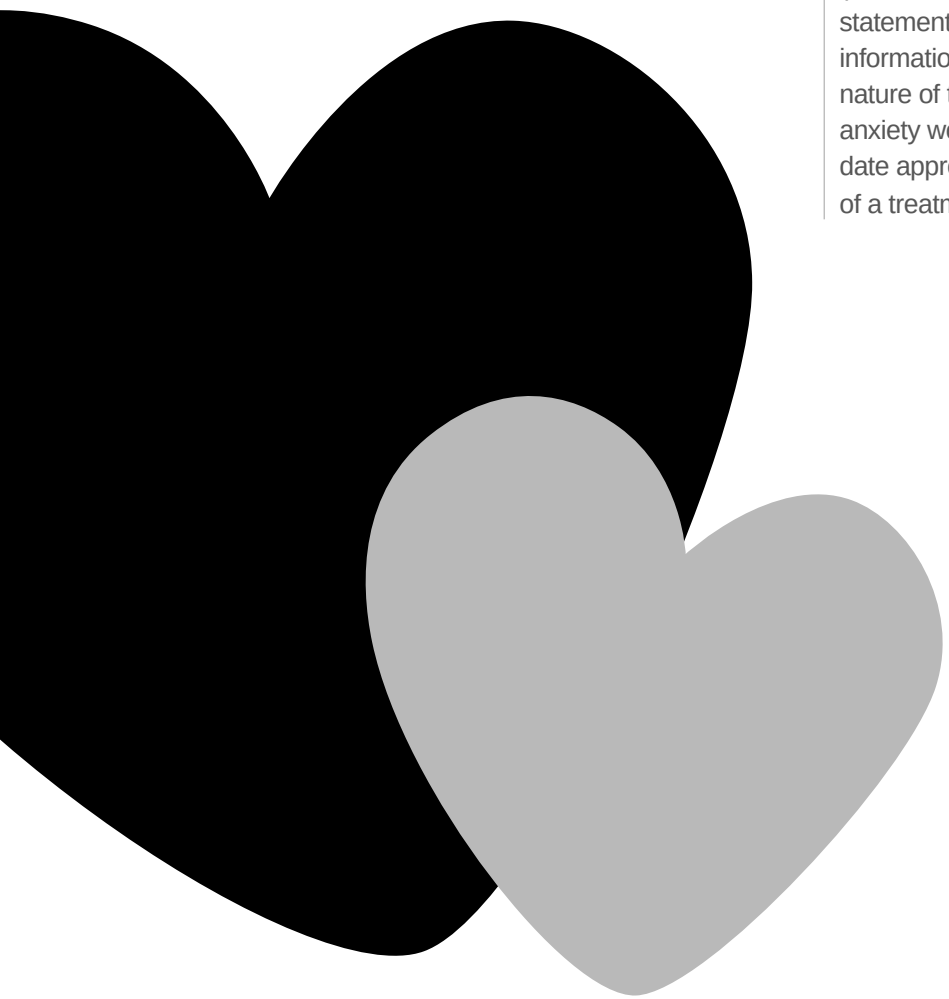
- accounts for the onset and maintenance of symptoms and problems in relation to the experience of the pregnancy, the infant(s), and other children.
- draws on knowledge of how pregnancy and a new baby can fundamentally alter a client's ability to draw on personal and external resources (e.g. access to social support, coping strategies, changing roles).

## USING THE FORMULATION TO PLAN TREATMENT

An ability to collaboratively develop a treatment plan that:

- considers the perinatal context (e.g. thinking about how the expected date of delivery may impact on treatment options; how maternity leave may be challenging for a client who bene ts from the structure, recognition and feedback that their career may offer; recognition of the need for consistent interaction with health professionals which may be challenging for those with fears around medical interventions).
- identi es the goals of the intervention and includes, where appropriate, the infant and other relevant family members.
- identi es likely obstacles to implementation, including pregnancy or infant related obstacles.

An ability to revise and update the formulation (and hence the treatment plan/problem statement) in the light of newly emerging clinical information (particularly given the dynamic nature of the perinatal period, e.g. an increase in anxiety would be expected as a client's delivery date approaches, and is not necessarily indicative of a treatment's ineffectiveness).



# ENGAGEMENT AND COMMUNICATION

## ABILITY TO COLLABORATIVELY ENGAGE CLIENTS IN TREATMENT

An ability to draw on knowledge of barriers to regular treatment attendance (for example: maternal health problems during pregnancy (e.g., bed rest, pre-eclampsia, hyperemesis), premature delivery, delivery, infant illness, transport dif culties, or changing infant schedules).

- An awareness of an increased need for outreach and exibility in regard to cancellations and the timing of interventions.
- An ability to adapt the delivery of psychological therapy throughout the course of treatment according to the needs of the perinatal period (for example, meeting in the parental home, maintaining contact via phone or email/online apps).

An ability to draw on knowledge of barriers to treatment engagement, including:

- “double stigma” of experiencing depression/ anxiety and not enjoying parenthood in the way that they and others would have expected (often contributing to feelings of guilt and shame).
- sleep deprivation in the perinatal period which can affect planning, attention, and control, and thus may affect therapeutic engagement.
- fears that the infant will be taken away by social services.

An ability to draw on knowledge about the bene t (and therefore the importance of) treating women before they give birth.

## ABILITY TO COORDINATE ACROSS DIFFERENT AGENCIES AND/OR INDIVIDUALS

An ability to help other professionals (from both clinical and non-clinical backgrounds) understand how the perinatal period impacts parental and infant mental health.

An ability to draw on knowledge of the range and remit of local services available for parents in the perinatal period, and how to refer to them.

- An ability to provide information about available services to parents.

An ability to draw on knowledge of the different settings for psychological therapies in the perinatal period and ability to step-up/down treatment appropriately based on perinatal needs.

## LIAISING EFFECTIVELY WITH OTHER HEALTHCARE WORKERS

An ability to draw on knowledge of the roles and remit of healthcare workers usually involved with clients during the perinatal period (e.g. nurses, midwives, health visitors, obstetricians, scanning technlity to scapaedelyians, s

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# DOMAIN FIVE: INTERVENTION SKILLS

## INTERVENTIONS FOR COMMON CHALLENGES IN THE PERINATAL PERIOD

### ABILITY TO ADAPT EVIDENCE BASED INTERVENTIONS

An ability to adapt evidence-based psychological interventions in the perinatal period (e.g. CBT, interpersonal psychotherapy (IPT), eye movement desensitisation and reprocessing, behavioural activation, couple therapy for depression, brief psychodynamic therapy, mindfulness based cognitive therapy, and counselling for depression).

An ability to focus on perinatally-speci c cognitions, behaviours, and beliefs about pregnancy, childbirth, and parenting.

- An ability to address communication dif culties in the perinatal period (e.g. discrepancies within a couple regarding expectations of parenthood).

An ability to help parents manage the difference between their perinatal expectations and reality (e.g. of pregnancy, childbirth, or caring for an infant).

An ability to vary the frequency of sessions in relation to perinatal stage (e.g., initially weekly, twice weekly immediately before birth, taking a planned break in treatment after birth where appropriate).

An ability to adapt the timing/sequencing of psychological interventions in relation to the perinatal period (e.g. it may be dif cult for a parent to do exposure treatment in the weeks immediately preceding childbirth or it may be challenging to complete homework in the perinatal period (e.g. because of infant illness, or sleep dif culties).

An ability to draw on knowledge of the available evidence-based interventions and support groups to support parents struggling with common challenges in the early postnatal period (e.g. interventions to cope with infant crying and infant sleep dif culties, Cry-sis website).

An ability to refer parents to appropriate support when the sexual relationship is impacted (e.g., following a traumatic childbirth).

High Intensity Only:

An ability to help couples focus on managing changes in roles and routines in the transition to parenthood.

An ability to help parents make sense of their own experiences of being parented in the context of becoming a parent themselves.

### PREPARING CLIENTS FOR THE PSYCHOLOGICAL ASPECTS OF THE BIRTH EXPERIENCE

An ability to draw on knowledge of common birth experiences, for example:

- vaginal delivery, including common pain management techniques
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High-Intensity Only

An ability to support women to consider their psychological and support needs during delivery and to consider how to communicate this to their midwife during birth planning (e.g. a client's anxiety may not be apparent to other professionals due to their safety behaviours such as asking a lot of questions or avoiding conversations. The client may bene t from support in communicating their emotional needs to their midwife).

An ability to gain a clear understanding of the speci c area of the focus of fear in tokophobia presentations to inform formulation and treatment options (e.g. fear of: pain; losing control; not being heard or listened to; death).

- An ability to use this understanding to identify and address behaviours that are maintaining the anxiety (e.g. Fear of pain leading to avoiding any information on stages of labour and pain relief options. Support client to approach the information and make an informed decision of their options).

An ability to draw on knowledge that increasing proximity to the delivery is likely to be associated with increasing anxiety in women with tokophobia.

An ability to draw on knowledge that many of the risk factors for tokophobia are highly sensitive topics (e.g. history of sexual abuse or rape), which women may hesitate to disclose.

An ability to draw on knowledge that secondary tokophobia may occur as a result of a traumatic birth, but also following a miscarriage, termination, stillbirth or neonatal death.

An ability to draw on knowledge that secondary tokophobia relates to a woman's subjective experience of childbirth independently of whether or not there were any obstetric complications (e.g this can include perceived risk of medical events such as maternal or infant death, but also perceived threats to integrity such as feeling violated, out of control or abandoned).

An ability to draw on knowledge that secondary tokophobia is commonly conceptualised and treated as a speci c form of post-traumatic stress disorder (PTSD), where the woman also is fearful of the possibility (real or

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# DOMAIN SIX: METACOMPETENCES

## WORKING WITH FAMILIES AND THE SYSTEM AROUND THEM

An ability to judge the differences between normal emotional changes in the perinatal period and dif culties that require treatment.

An ability to judge when women with a current or past severe mental health problem who are considering pregnancy require a referral to a Perinatal Mental Health service for preconception counselling.

High Intensity Only

An ability to differentiate between high levels of anxiety/obsessions and psychotic presentations.

## WORKING WITH THE EVIDENCE BASE IN THE PERINATAL PERIOD

An ability to make informed use of the current evidence base to guide decision- making about the interventions that are indicated.

Where a parent presents with multiple problems and conditions, an ability to adapt treatment protocols so that they can be applied to the individual case in a manner that is: informed by the case formulation / diagnosis congruent with the treatment principles inherent in the protocol.

An ability to use knowledge about presenting problems in the perinatal period to ensure that treatment is guided by the most appropriate formulation (e.g. a client presenting with a fear of her baby being stillborn could be struggling with OCD, generalised anxiety or secondary tokophobia (PTSD subsequent to childbirth) or mild primary tokophobia).

## CAPACITY TO IMPLEMENT INTERVENTIONS IN A FLEXIBLE BUT COHERENT MANNER

An ability to judge when physical health dif culties are impacting on a parent's ability to engage with assessment or interventions, and to make appropriate adaptations (e.g. bedrest, postnatal complications).

An ability to implement an intervention or a model of therapy in a manner that is exible and responsive to the issues clients raise, but which also ensures that all relevant compod39d3tx48(lity to implee inteclu

## WORKING WITH CLIENTS FROM A RANGE OF BACKGROUNDS

An ability for practitioners to maintain an awareness of their own values about parenting and family customs, and to re ect on the ways that these assumptions impact (positively and negatively) on the families with whom they are working.

Where families discuss parenting practices at variance with the norms and values of the practitioner, an ability to judge when this difference should be respected and when it represents a concern that should be responded to.

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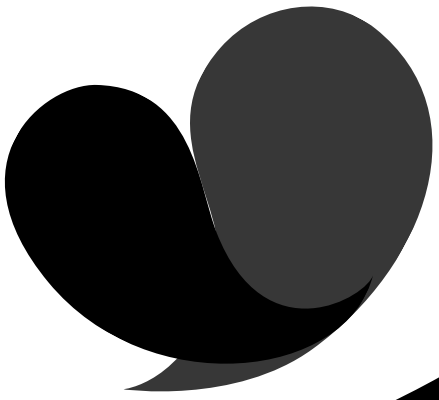

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