IAPT PERINATAL COMPETENCY FRAMEWORK

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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 fit together. The competency framework includes only perinatally specific 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 find the competency framework useful.

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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, formulation and engagement
- Intervention skills
- Metacompetences

The report then describes and comments on the type of competences found in each domain and organises these into a 'map' which shows how all the competences fit together and inter-relate. Finally it addresses issues that are relevant to the implementation of the competence framework and considers some of the organisational issues around its application.

The report assumes that core and generic therapeutic competences establish the structure for both low- and high-intensity interventions and form the context and structure for the implementation of specific evidence-based therapies. For example, Psychological Wellbeing Practitioners (PWPs) and High Intensity (HI) therapists will both need to consider how having a baby affects a parent's cognitions, behavioural repertoire, and interpersonal relationships. We have specified where competences may be unique to high-intensity. These are primarily where there are specific skills and approaches that pertain to work with approaches (e.g. couple therapy) or disorders (e.g. post-traumatic stress disorder) undertaken by high-intensity therapists only.

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

SEE TABLE ON FOLLOWING PAGE ▶

	Condition[a]	IAPT recommended treatments	Source	Perinatal-Specific Treatment	Perinatal Adaptations
STEP 2: Low Intensity Interventions	Depression	Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme	NICE guidelines: CG90, CG91, CG123	Loughnan et al. 2019 Milgrom et al. 2016 Milgrom et al. 2011a Milgrom et al. 2005 (effective group intervention) O'Mahen et al. 2013 O'Mahen et al. 2014 Trevillion et al. 2020 See note [a]	
	Generalised Anxiety Disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123	Loughnan et al. 2019	Loughnan et al. 2018
	Panic Disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123		Arch Dimidjian, & Chessick, 2012 adaptations for exposure
	Obsessive-Compulsive Disorder	Guided self-help based on CBT	NICE guidelines: CG31, CG123		Challacombe et al. 2017.
STEP 3: High-Intensity Interventions	Depression For those who have not responded to a Step 2 intervention or who have moderate to severe Depression	CBT (individual or group) or IPT Behavioural activation Couple therapy[b] Counselling for depression Brief psychodynamic therapy Note: psychological interventions can be provided in combination with antidepressant medication.	NICE guidelines: CG90, CG91, CG123	Burns et al. (2013) Grote et al. 2009 (IPT: cultural groups) O'Hara et al. (2019) (IPT) O'Mahen et al. 2013[b] Milgrom et al. 2011[b] Stein et al. 2018 Stuart & O'hara (1995)	
	Depression Moderate to severe	CBT (individual) or IPT, each with medication	NICE guidelines: CG90, CG91, CG123	As in row above	
	Depression Prevention of relapse	CBT or mindfulness-based cognitive therapy[c]	NICE guidelines: CG90, CG91, CG123	As in row above	
	Generalised Anxiety Disorder	CBT, applied relaxation	NICE guidelines: CG113, CG123	O'Mahen et al (2020[a])	
	Panic Disorder	CBT	NICE guidelines: CG113, CG123		Arch Dimidjian, & Chessick, 2012 adaptations for exposure
	Post-Traumatic Stress Disorder	Trauma-focused CBT, eye movement desensitisation and reprocessing[d]	NICE guidelines: CG26, CG123		
	Tokophobia				Saisto, et al. 2001. Streibich et al. 2018
	Social Anxiety Disorder	CBT specific for social anxiety disorder[e]	NICE Guidelines CG192, CG159		Arch Dimidjian, & Chessick, 2012 adaptations for exposure
	Obsessive-Compulsive Disorder	CBT (including exposure and response prevention)	NICE Guidelines CG31, CG123		Challacombe et al. 2017

[a] See: https://perinatal-treatment.com to access perinatal-specific 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 (see O'Mahen et al. 2013a), self-help only should not be used.

[b] If the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy. IAPT recognises two forms of couple therapy and supports training courses in each. One closely follows the behavioural couple therapy model. The other is a broader approach with a systemic focus.

[c] CBT during treatment in the acute episode and/or the addition of mindfulness-based cognitive therapy when the episode is largely resolved. Mindfulness is not recommended as a primary treatment for an acute depressive episode.

[d] If no improvement, an alternative form of trauma-focused psychological treatment or augmentation of trauma- focused psychological treatment with a course of pharmacological treatment.

[e] Based on the Clark and Wells model or the Heimberg model.

Reasons for onward referral (rationale in brackets): ***Note that IAPT may still be able to do pieces of work with these individuals in collaboration with perinatal and maternal mental health services.***

- In thinking about a referral to specialist perinatal mental health services: consider the extent to which the severity of the mental health problem impacts on functioning, the complexity of the individual's social circumstances and the need for extensive liaison work across multiple professionals. Chronic or premorbid conditions including multiple trauma or history of abuse, particularly childhood sexual abuse may also indicate a need for input from specialist perinatal services.
- Current symptoms of bipolar disorder, psychosis (including post-partum psychosis). A history of bipolar disorder or psychosis (including post-partum psychosis) even where this is not the current presenting problem. *(There is a high risk of relapse in the perinatal period, which requires careful planning and monitoring.)*
- Severe and complex presentations of birth trauma, fear of childbirth and other problems requiring extensive liaison with maternity and obstetric services. *(Treatment may be more time intensive and benefit from close and frequent involvement with multiple health care professionals. Clients with severe and complex presentations may over utilise health care in an attempt to seek reassurance. This may require coordinated input amongst all involved professionals (e.g. presenting daily at maternity triage around concerns for baby's movements).)*
- Thoughts of harm to the infant; delusional or persecutory beliefs about the infant. *(Expert assessment is required in order to differentiate intrusive thoughts in the context of OCD from those in depressive disorders or an acute psychotic episode. Risk may be high, and safeguarding is a primary concern. However, in the context of OCD, the likelihood of acting on these thoughts is extremely low, and it can be detrimental to treatment to refer to social care.)*
- Complex perinatal loss and bereavement (e.g. multiple miscarriages, stillbirth): However, IAPT may be suitable for those who have depression or anxiety diagnoses where loss or bereavement is the core cause. A discussion with perinatal services may be appropriate to decide on the best treatment options, including Maternal Mental Health Services (previously referred to as Maternity Outreach clinics) in the NHS Long Term Plan and the third sector where appropriate (e.g. client who experienced a neonatal death may benefit from bereavement counselling to process the loss). *(These clients may not meet diagnostic criteria for a mental health problem, therefore not meeting the inclusion criteria for IAPT.)*

- 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 specifically to high intensity clinicians and are identified as such.

The perinatal period is taken as the time from conception through pregnancy, childbirth and the first 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 defined.

The competence framework is focused primarily on clinical work and excludes service management and development skills. Audit and research skills are not specified in depth, though the ability to make use of measures (and to monitor outcomes) is identified 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 identified, to advise on process, and to input to and review perinatal competences.

In addition to review by the ERG, competence lists for specific areas of clinical activity and for specific interventions were reviewed by individuals identified 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 efficacy of therapies, focussing on those competences for which there is either good research evidence or strong expert professional consensus about their probable efficacy. 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 field 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 efficacy 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 first 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 specific 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 specific 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 field with a number of trials in progress, and as further evidence emerges this will need to be reflected 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 specific 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 field 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 perinatal context are comorbid, reflect multiple problems or relate to a particular task (rather than a physical or mental health diagnosis), such as promoting adjustment or concordance/adherence with a treatment regimen. This presents a dilemma: organising the framework in relation to diagnosis is one way of keeping it close to the evidence, but this risks making it appear less relevant to clinicians (in the sense that it may be less obvious how to apply it to individuals in the perinatal period). Unfortunately this dilemma has no obvious solution, and despite active debates about the merits of alternative structures the clustering of problems within this framework is essentially diagnostic.

C. Importance of, and evidence for, core, generic therapeutic and assessment skills: There is a clear professional consensus that psychological interventions rest on a set of 'underpinning' skills (core and generic therapeutic competences), as well as a set of assessment skills. Denoting the former as 'underpinning' skills should not be taken to indicate that they are simple or easy to deploy. Further underpinning competences (such as ability to work with issues of confidentiality, consent and capacity) are a major component of many intervention packages. However, there is often little direct evidence of the benefit of these skills from randomised control trials or from other types of study, possibly reflecting researchers' understandable reluctance systematically to manipulate clinician behaviour in this area, and also because researchers may assume that the inclusion of these elements in an intervention does not need to be explored further. However, although evidence on the causal contribution of underpinning and assessment skills is lacking, correlational studies have established the importance of several of the areas included in the framework (notably the importance of the therapeutic relationship to outcome) (e.g. Horvath, Del Re, Flückiger & Symonds,2011; Shirk, Carver & Brown, 2011). Within the assessment field, evidence of the accuracy of the diagnostic process has been gathered through measuring the reliability and validity of standardised tests, scales and interview schedules (both of which are usually accompanied by detailed guidance for their delivery, equivalent to a therapy manual). Nonetheless, in the main the inclusion of specific "underpinning" skills usually rests on expert professional opinion and consensus rather than evidence.

D. Lack of 'manualisation' in basic areas of practice: Reinforcing the sense that many 'underpinning' and assessment skills are seen as critical to clinical practice and treatment delivery, most treatment manuals make general reference to their application, but rarely detail the specific skills involved. As a consequence, the writing team needed to draw on a mix of resources to generate lists of relevant skills, sourcing service user studies, relevant published materials, textbooks, and drawing on their own clinical experience where gaps in the lists remained. As such, this is a process led by professional experience rather than RCT evidence, making the process of peer review (described above) especially critical.

These issues all have a bearing on the capacity of the framework to stay as close to the evidence base as possible, and in practice, research has had to be supplemented by expert professional consensus and practice standards (e.g. NICE, 2018), congruent with models of evidence-based practice (e.g. Roth & Fonagy, 2005) and with the methodology adopted by NICE for clinical guideline development (NICE (2009).

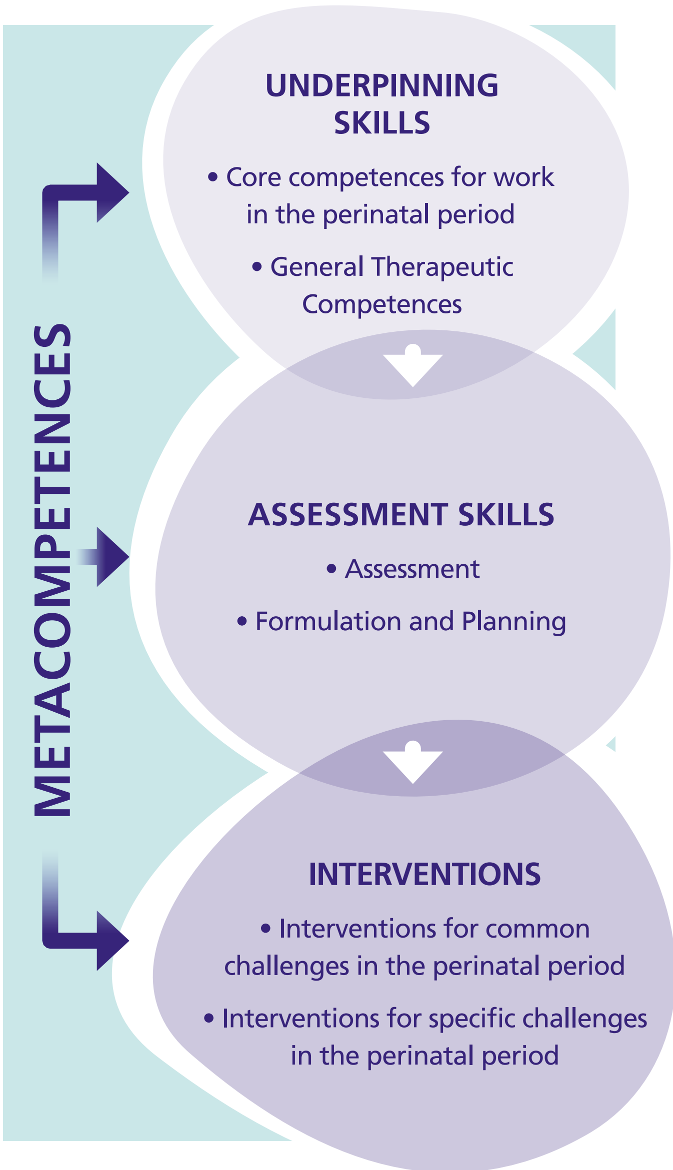
THE COMPETENCE MODEL FOR PERINATAL PSYCHOLOGICAL INTERVENTIONS IN IAPT SETTINGS

ORGANISING THE COMPETENCE LISTS

Competence lists need to be of practical use. They should therefore be understandable and structured in a way that validly reflects practice. The figure below shows the way in which competences have been organised into six domains. The model is intended to ensure that:

- Perinatal provision is standardised across IAPT services across regions to avoid variability in access to provision and improve the sharing of best practice.
- IAPT workers have a suitable knowledge base for working with this client group and know how to implement and modify interventions provided in the perinatal period.
- IAPT workers can meet both the content and service delivery needs of this population.
- IAPT workers can quickly identify when problems in the perinatal period need onward referral for specialist intervention (e.g. in secondary care).
- Interventions are in line with the available evidence base and can be updated as new evidence becomes available.
- IAPT workers receive appropriate training to enable them to work safely and effectively with perinatal clients.
- Efficient and cost-effective training delivery programs through minimisation of unnecessary repetition with existing training in core IAPT programmes.

Please note that these competences should be used in conjunction with the Generic CBT competences and specialist competences where appropriate. IAPT workers should use the appropriate knowledge and experience to deliver NICE-concordant care that centres around the five Perinatal Mental Health Care Pathways. As addressed in the key definitions, the competences in this framework refer to working with both mothers, fathers and partners.



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 specified 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 specific psychological interventions or specific 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 difficulties that require treatment". Others apply only when more specific 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 specific 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 identified 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 significant changes to the format may impact on effectiveness. This is a difficult 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 fidelity 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 specific mental health interventions, it may be particularly important to attend to issues of fidelity 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.

APPLYING THE COMPETENCE FRAMEWORK

This section sets out the various uses to which the framework can be put and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed.

Commissioning: The framework can contribute to the effective use of health care resources by enabling commissioners to specify both the appropriate levels and the range of competences that need to be demonstrated by workers in a perinatal context in order to meet identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of services: The framework represents a set of competences that (wherever possible) are evidence-based and aims to describe best practice, the activities that individuals and teams should follow to deliver psychologically informed care and psychological interventions.

Although further work is required on their utility and associated methods of measurement – they should enable:

- the identification of the key competences required by a practitioner to deliver psychological approaches and interventions across perinatal contexts.
- the identification of the range of competences that a service or team would need to meet the needs of the populations with whom they work.
- the likely training and supervision competences of those managing and delivering the service.

Because the framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice regarding the implementation of approaches and therapies (as set out in NICE or SIGN guidance, along with other national and local policy documents) with the interventions actually delivered. Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of research trials on which claims for the efficacy of specific interventions rest. In this way, it could help to ensure that evidence-based interventions (and evidence informed approaches) are likely to be provided in a competent and effective manner.

Clinical governance: Effective monitoring of the quality of services provided is essential if service users are to be assured optimum benefit. Monitoring the quality and outcomes of perinatal interventions is a key clinical governance activity; the framework will allow providers to ensure that interventions are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of clinician's performance. The introduction of the competence framework into clinical governance can be achieved through local implementation plans for NICE/ SIGN guidance and their monitoring through the local audits procedures as well as by the monitoring systems of organisations such as the Healthcare Commission.

Supervision: Used in conjunction with the competence framework for supervision (www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm and https://www.uea.ac.uk/documents/746480/2855738/IAPT_Supervision_Guidance_2011.pdf), the perinatal competency framework potentially provides a useful tool to improve the quality of supervision for psychological interventions, and psychologically informed approaches, by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners; the framework will support both these through:

- providing a structure by which to identify the key components of effective practice for specified disorders (either in clinical skills supervision for PWPs or clinical supervision for High Intensity clinicians).
- allowing for the identification and remediation of sub-optimal performance.

The framework can achieve this through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Training: Effective training is vital to ensuring increased access to well-delivered psychological informed approaches and psychological therapies. The framework can support this by:

- providing a clear set of competences which can guide and refine the structure and curriculum of training programmes.
- providing a system for the evaluation of the outcome of training programmes.

Research: The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of clinician and clinician competence, the further exploration of the relationship between process and outcome and the evaluation of training programmes and supervision systems.

CONCLUDING COMMENTS

This report describes a model which identifies the activities which characterise effective assessments and interventions in a perinatal context within IAPT and locates them in a "map" of competences. The work has been guided by two overarching principles. Firstly, it follows a Levels-of-evidence approach which prioritises treatment approaches from the evidence-base (including trial evidence, critical empirical studies on perinatal barriers and preferences for treatment, and factors affecting treatment adherence) and where empirical data is not available, expert professional consensus, meaning that an approach or intervention carried out in line with the competences described in the model should be close to best practice, and therefore likely to result in better outcomes for service users. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way in which clinical care and interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cook-book. Delivering effective interventions involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians need to operate using clinical judgment in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way which clarifies the activities associated with a skilled and effective practitioner should prove useful for IAPT clinicians working with clients in the perinatal period. The more stringent test is whether it results in more effective clinical care, psychological interventions and better outcomes for clients of these services.

Generic competences for all IAPT Staff	Competencies that apply to Low intensity & High Intensity Therapists	Competencies that apply to Low Intensity and High Intensity therapists with specific competencies indicated only for HI	Competencies that apply only to High Intensity Therapists

CORE PROFESSIONAL COMPETENCES FOR WORK IN THE PERINATAL PERIOD

Professional skills and values

- Ability to work with difference and diversity

GENERIC THERAPEUTIC COMPETENCES

- Knowledge of pregnancy, childbirth and the postnatal period
- Knowledge of mental health during the perinatal period
- Knowledge of psychotropic medication in the perinatal period.
- Knowledge of models of intervention and their employment in practice
- Ability to understand and respond to the emotional content of session
- Ability to make use of measures (including monitoring of outcomes)
- Ability to make use of supervision and training

ASSESSMENT, FORMULATION, ENGAGEMENT AND PLANNING

Assessment

- Ability to undertake a comprehensive perinatal specific biopsychosocial assessment
- Ability to undertake risk assessment and management including safeguarding

Formulation

- Ability to use the formulation to plan treatment, incorporating the baby and the perinatal context

Engagement and communication

- Ability to collaboratively engage clients with the treatment model with an awareness of barriers to engagement
- Ability to co-ordinate across different agencies and/or individuals

SPECIFIC INTERVENTIONS

Interventions for common challenges in the perinatal context

- Ability to adapt evidence-based interventions to work in the perinatal period
- Ability to support clients in preparing for the psychological aspects of the birth experience
- Ability to support clients in preparing for ongoing parenting challenges
- Ability to consider the infant in working with clients in the perinatal period
- Ability to consider the partner when working with clients in the perinatal period
- Ability to consider perinatal issues in endings and relapse prevention
- Ability to deliver group-based interventions

Interventions for specific challenges in the perinatal context

- Adapting treatment of depression and anxiety during the perinatal period
- Adapting treatment of PTSD, tokophobia and OCD during the perinatal period

METACOMPETENCES

Metacompetences for work with parents in the perinatal period

- Working with families and the system around them
- Working with the evidence base in the perinatal period
- Capacity to implement interventions in a flexible but coherent manner
- Working with the infant
- Safe Practice and Supervision

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 mental health disorders in the context of the parent and partner's diversity (i.e. race, culture, religion, socioeconomic situation, gender, sexuality and/or other 'protected characteristics').

An ability to draw on knowledge of the incidence and prevalence of perinatal mental health presentations across different cultures/ethnicities/ social backgrounds.

An ability to draw on knowledge of diversity and cultural awareness of mental health disorders in the perinatal period when discussing problems with the parent and their family. For example ideas about:

- How symptoms and problems are understood and accounted for (e.g., voice hearing being understood as a religious experience).
- Ways of talking about and managing mental health problems and risk.

An ability to draw on knowledge of diversity and culture and how this may impact in pregnancy and postnatal care, for example, culturally-specific issues such as:

- Conventions about caring for women in pregnancy/ postnatally (e.g. accepted levels of activity in pregnancy; periods of confinement in the postnatal period).
- Who cares for the infant (e.g. involvement of the mother in law in caring for newborn).
- How the infant is cared for (e.g., levels of infant stimulation, infant contact, co-sleeping that are considered appropriate).
- Notions of parenting and what it means to be a parent.
- Double stigma (i.e. struggling with perinatal mental health stigma and ethnicity/religious/ gender/sexual diversity stigma)
- Attitudes towards contraception.

An ability to draw on knowledge of additional stressors experienced by minority groups and the impact this may have on their mental health, and on their ability to seek support.

An ability to draw on knowledge of the challenges unique to LGBTQI+ families, for example:

- The risk of making heteronormative assumptions about families (i.e. assuming birth parent has a male partner/ birth parent identifies as female/ birth parent is genetically connected to baby)
- Ensuring use of appropriate wording such as 'parent' rather than 'mother'/ 'father' when talking with patients and/or their partners about challenges unique to their family structure
- The potential lack of support for LGBTQI+ families from their extended family.

DOMAIN TWO: CORE KNOWLEDGE AND CLINICAL COMPETENCES

KNOWLEDGE OF THE PERINATAL PERIOD: PREGNANCY, CHILDBIRTH AND THE POSTNATAL PERIOD

Knowledge across the perinatal period

An ability to draw on knowledge that pregnancy, childbirth and having a new baby are times of significant psychological, social and practical adjustment, and the impact of these changes on day-to-day life and relationships, for example:

- Changes to daily routine/activities that often take place in the perinatal period (e.g. stopping work for maternity leave, changes to maternal sleep patterns during pregnancy and with a young infant, and the changes in lifestyle associated with putting the infant's needs first).
- The effects the transition to parenthood may have on personal identity and beliefs about oneself and one's family, and its effect on close relationships, particularly with partners and extended family.
- The effects of lifestyle factors such as diet, exercise, smoking, alcohol and substance use/misuse on the parent and the baby during pregnancy and the postnatal period.

An ability to draw on knowledge of the most common physical features and possible complications of pregnancy, childbirth and the postnatal period (e.g. nausea or hyperemesis, fatigue, pelvic pain) and their impact on activity level and mental health.

An ability to draw on knowledge of the effects on mental health of infertility, IVF, miscarriage, stillbirth, neonatal death, premature delivery, (perceived) traumatic delivery, and termination of pregnancy.

An ability to draw on knowledge of factors that contribute to parenting resilience (tolerating uncertainty related to pregnancy and infant needs, parental emotion regulation, social support).

An ability to draw on knowledge about the distinction between unplanned and unwanted pregnancies (e.g., not assuming an unplanned pregnancy is an unwanted pregnancy).

- An ability to draw on knowledge about the impact that unwanted pregnancies can have on mental health, family relations, and the parent-infant relationship.

An ability to draw on knowledge that advice about pregnancy and caring for babies is often conflicting and parents may need support in making decisions that work best for their family (e.g. health visitor, midwife and GP all giving conflicting advice around infant sleep).

Knowledge in relation to pregnancy

An ability to draw on basic awareness about key aspects of pregnancy, and how these factors can impact on mental health functioning for example:

- the stages of pregnancy (e.g., common symptoms mothers may experience, such as "morning" sickness and fatigue and how these relate to ability to accomplish valued activities)
- likelihood of miscarriage at each stage (e.g., miscarriage is more likely to happen in the first 12 weeks of pregnancy)
- physical changes in the mother (e.g., how weight gain, bodily pains, etc. can affect self-image)
- regularly administered screening tests (e.g., how tests or scans may contribute to pregnancy-related uncertainty and anxiety)
- foetal movement patterns throughout pregnancy (e.g., how parent should always check with medical professional, but awareness that movements may be felt less reliably at the end of pregnancy because baby is too large to move as much inside mother)

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, reflux, sleep).

An ability to draw on knowledge of key developmental milestones of the first 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 benefits of breast and bottle feeding, including how difficulties breastfeeding can impact on maternal mental health.

An ability to draw on knowledge of how mastitis, tongue tie, and reflux 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 first 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 significant 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 defined 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 specific 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 specific 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-benefit 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 THREE: GENERIC THERAPEUTIC COMPETENCES

The competency framework includes only perinatally specific competences, existing competency frameworks should be used to inform general practice.

KNOWLEDGE OF MODELS OF INTERVENTION AND THEIR EMPLOYMENT IN PRACTICE

Ability to use information from psychological assessment to inform and adapt psychological therapies for use in the perinatal period (i.e., standard CBT interventions for anxiety and depression) https://www.ucl.ac.uk/pals/sites/pals/files/all_problem-specific_competences.pdf.

ABILITY TO UNDERSTAND AND RESPOND TO THE EMOTIONAL CONTENT OF SESSIONS

An ability to use knowledge of the clinical complexity of managing both parent and infant's emotional needs simultaneously (for example when baby is smiling while mum is crying).

An ability to reflect on one's own attitudes towards pregnancy, children and parenting and how this could impact on clinical practice.

- Ability to reflect on changes in one's own emotions triggered by any issues raised.
- Ability to use appropriate strategies to manage any emotional and psychological impacts of the work (e.g. supervision, self-care).

ABILITY TO MAKE USE OF MEASURES (INCLUDING MONITORING OF OUTCOMES) AND TO ADAPT MEASURES TO PERINATAL CONTEXT (I.E., SOMATIC SYMPTOMS)

An ability to use and interpret relevant perinatal-specific measures. These are measures that could be issued in addition to the IAPT minimum data set and core measures. These measures include:

- Mother-infant responsiveness inventory (MIRI): This is a self-report measure that looks at the extent to which a mother is responding sensitively to her infant and may indicate problems in the relationship that require onward referral to CAHMS or the perinatal mental health team.
- Mothers' Object Relations Scales Short-form (MORS-SF): The MORS-SF looks at how the mother is feeling about her relationship with her infant. As well as providing information that may support an onward referral it may also highlight unhelpful cognitions that can be addressed in treatment in IAPT.
- Pregnancy Related Anxiety Questionnaire (PRAQ): The PRAQ identifies anxieties that are significant to pregnancy. It may be useful to help identify targets for treatment and to measure the effectiveness of the intervention.
- Edinburgh Postnatal Depression Screen (EPDS): The EPDS should only be used if a woman has significant somatic symptoms and has difficulty in discriminating when they are due to pregnancy or postnatal physical symptoms, or due to mood.

ABILITY TO MAKE USE OF SUPERVISION AND TRAINING

Ability to use supervision to maintain a perspective that holds in mind (and integrates thinking about) the parent, infant, parent-infant relationship and the needs of, and relationship with, the partner.

Ability to reflect appropriately on one's own emotional response to perinatal clients and seek supervision, especially where this conflicts with a capacity to maintain a neutral therapeutic stance (e.g. when an issue raises personal and/or ethical concerns when a woman is considering termination due to an intense fear of childbirth).

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 influenced 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).

ABILITY TO UNDERTAKE RISK ASSESSMENT AND MANAGEMENT INCLUDING SAFEGUARDING

This section should be used in conjunction with the Self-harm and Suicide Prevention Competence Framework (https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self). Competences below address perinatally specific adaptations to undertaking risk assessment and the management of risk.

An ability to carry out a risk assessment in conjunction with the parent and, if they agree, their partner, family or carer.

An ability to perform an initial assessment for parents who experience suicidal thoughts in pregnancy or the postnatal period.

An awareness that mental health disorders are the leading cause of maternal death within the first postnatal year.

An ability to draw on knowledge that mental health status and suicidal intent can change very quickly in the perinatal period.

An ability to draw on knowledge that feelings of entrapment can be particularly acute in the perinatal period and may trigger mental health issues.

An ability to draw on knowledge of 'red flags' for severe maternal health problems that require urgent psychiatric assessment, for example:

- new thoughts or acts of violent self-harm.
- recent significant change in mental state or emergence of new symptoms.
- new and persistent expressions of parental incompetency or estrangement from the infant.

An ability to escalate concerns about a parent's mental health to an appropriate health care professional or specialist perinatal team.

An ability to rapidly refer for an emergency assessment, where there is a concern that a client may be experiencing a psychotic episode.

An ability to draw on knowledge that admission to a mother and baby unit should always be considered where there is high risk, for example if a woman has any of the following:

- rapidly changing mental state.
- suicidal intent (particularly of a violent nature).
- significant level of hopelessness.
- significant estrangement from the infant.
- evidence of psychosis.

An ability to discriminate between actual risk and the parent's perception of risk, particularly in relation to perinatal OCD and excessive guilt and repetitive thinking in depression (i.e., where parents feel there is a high risk that they will harm their infant, but in reality there is unlikely to be a role for social services).

An ability to support parents concerned about the involvement of social services and their concern (whether real or imagined) that they will be separated from their babies.

KNOWLEDGE OF DOMESTIC VIOLENCE

An ability to draw on knowledge of the increased incidence and impact of domestic violence in the perinatal period.

An ability to draw on knowledge of the importance of asking routinely about domestic violence and an awareness of how to safely respond to disclosures of abuse.

An ability to draw on knowledge of common reasons for non-disclosure of domestic violence (e.g. fear of social services involvement, shame, fear of retribution).

An ability to draw on knowledge of the risks to the infant or foetus associated with domestic violence.

An ability to draw on knowledge of how opportunities for coercive control may intensify in the perinatal period (e.g. when a woman is on maternity leave and has decreased financial means).

An awareness of when pregnancy and having a baby may put a woman at increased risk of honour-based violence (e.g. when a partner is not approved of by family).

An ability to draw on knowledge of services available for those who disclose domestic violence and how to refer them (or help them to self-refer).

FORMULATION

An ability to draw on evidence-based models to create a client-specific 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 benefits 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).
- identifies the goals of the intervention and includes, where appropriate, the infant and other relevant family members.
- identifies 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 difficulties, or changing infant schedules).

- An awareness of an increased need for outreach and flexibility 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 benefit (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 technicians, paediatricians).

- An ability to draw on knowledge of, and liaise with, key mental health contacts within the perinatal health context (i.e., specialist midwife/health visitor).
- An ability to encourage appropriate referrals from perinatal healthcare (i.e., presenting information on treatments available to health visiting teams; presenting group outcomes).
- An ability to co-work with other perinatal healthcare workers (e.g. co-leading groups with them).

An ability to draw on knowledge of the range of services available for women in the perinatal period. This includes an awareness of services that clinicians may be able to work alongside, as well as those appropriate for an onward referral. Services may include (note that local provision may vary and this list is not exhaustive):

SEE TABLE ON FOLLOWING PAGE ▶

ROLE	POSSIBLE SUPPORT AVAILABLE
MIDWIFE	Requesting access to notes from a previous birth to support trauma work; Liaising to consider management of mental health needs during labour (e.g. strategies to be included in the client's birth plan to support the management of their mental health needs); Information resource if knowledge of client's specific needs is relevant for treatment (e.g. Client is terrified of stillbirth and clinician feels client's estimation of likelihood of this is exaggerated, midwife may be able to provide accurate information); Tour of delivery suite following trauma work in relation to a previous birth. Note that most hospitals have specialist midwives who provide support in relation to mental health.
HEALTH VISITOR	Provide additional support in relation to feeding, sleep, or health concerns. Some health visitors may also be able to provide support in relation to the mother-infant relationship (e.g. may be trained in the Solihull approach).
GP	Review medication; monitor mental health following discharge (e.g. if you are working with a woman in pregnancy, it may be helpful to suggest GP reviews her mental health in the postnatal period)
CHILDREN'S CENTRES	May offer support with breastfeeding such as drop in clinics; Baby groups to address social isolation; Some children's centres run parenting courses; May provide antenatal support groups; Early years workers located in children's centres may be able to offer support in helping parents engage in local services (e.g. they may be able to accompany clients to the mother-infant groups). Some children's centres may also be able to provide childcare support to attend therapy or for respite.
SPECIALIST PERINATAL COMMUNITY TEAMS	Accept referrals for women presenting with more severe and complex mental health needs. Provide support in ascertaining whether a referral is appropriate. Pre-conception support in regard to medication. All Perinatal teams have a Clinical Psychologist who may be available to consult with in regard to challenging clinical issues that arise in working with clients in the perinatal period.
LOCAL MOTHER-BABY ACTIVITIES	It is helpful to be aware of opportunities in the community for clients to engage with other parents, this is particularly relevant for behavioural activation work. Activities may include: baby massage, drop in groups, antenatal and postnatal yoga classes, gyms that offer creche support, baby cinema.
ANTENATAL CLASSES	Hospitals usually offer antenatal classes as part of their antenatal care. These support clients to plan for their birth, feeding options and postnatal care. There will also be National Childbirth Trust (NCT) classes and other local antenatal classes available (note that these are generally self-funded). As well as helping to plan for the birth and the postnatal period, these classes provide an opportunity to develop friendships with families expecting babies at the same time).
CHARITIES/ THIRD SECTOR	Local charities and third sector organisations may provide practical support, respite, peer support, drop-in play sessions and mental health support (e.g. Homestart, Cocoon, Bluebells, Acacia).
BEREAVEMENT SERVICES	The Stillbirth and Neonatal Death Charity, SANDS (www.sands.org.uk) and other organisations provide resources, information and links to local support groups.
ONLINE RESOURCES	Websites such as Netmums, Best Beginnings, SANDS, Tommy's may provide resources for clients and forums that may help to normalise their experience. They may also link to local support groups and services. Online self-help evidence informed treatments are compiled on this site: www.perinatal-treatment.com

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-specific cognitions, behaviours, and beliefs about pregnancy, childbirth, and parenting.

- An ability to address communication difficulties 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 difficult 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 difficulties).

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 difficulties, 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
- instrumental deliveries (e.g. forceps)
- emergency and planned caesarean sections

An ability to draw on knowledge of the impact of anxiety on the labour process.

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 benefit from support in communicating their emotional needs to their midwife).

PREPARING CLIENTS FOR THE CHALLENGES OF PARENTING

An ability to prepare clients for parenthood by:

- Discussing the change in priorities and the challenges they face.
- Discussing the ways in which caring for a baby can affect relationship functioning.
- Encouraging resilience by building social support structures and using them effectively.
- Addressing lifestyle factors (e.g. exercise, eating, sleep).

MAKING ADAPTATIONS TO THERAPY TO INCLUDE THE INFANT

Practical Adaptations

An awareness of the benefits and challenges of having the infant in the room (on the parent, the infant and the process of work in the room), for example:

- benefits, such as being able to directly observe the parent-infant interaction, being able to provide immediate feedback to parents about positive interactions, and for involving the infant in behavioural experiments
- challenges, such as parental concerns about the impact of their distress on the infant, or the potential for the infant to distract from the process in the room.

An ability to help parents make an informed decision about when or whether the infant is present during psychological treatment.

An ability to manage parent's concerns about putting infant in crèche during treatment, if that is the option available and chosen by mum.

Adaptations to the Therapy Content

An ability to work with behaviours and cognitions arising from the parent-infant interaction (e.g. 'I'm not good at comforting my baby'; 'I can't cope.' 'The baby doesn't like me.').

An ability to help the parent to adapt to the impact of their infant's changing development and the challenges this may bring (e.g. separation anxiety, baby walking, weaning).

An ability to consider how the parent's values and goals may need to be adapted to incorporate the infant (e.g. previous values of spontaneity or independence may need to be adapted to the infant's need for routine).

Ability to incorporate infant and other children into homework where appropriate (e.g., not accomplishing routine activities like going to grocery store because of infant, helping client to address barriers so can go to store with infant).

High Intensity Only:

An ability to work with parents who are avoiding bonding with their infant due to overestimating the likelihood of something going wrong (e.g. Previous miscarriages resulting in actively trying not to connect to the foetus).

HIGH INTENSITY ONLY: MAKING ADAPTATIONS TO THERAPY TO INCLUDE THE PARTNER

An ability to involve the partner in therapy where appropriate and feasible.

An ability to explore the partner's reaction to the pregnancy/adjustment to having a child.

An ability to identify and address unhelpful behaviours on the part of the partner and support both parents in addressing these (e.g. a partner who is helping to maintain a mother's anxiety about parenting because they never allow her to be left alone with the baby).

An ability to identify and work with problematic changes in the balance of tasks between a couple that occur after the birth of a baby.

An ability to work with similarities and differences in parenting roles and style between a couple.

An ability to discuss how the impact of one parents' mental health problems on the infant's development and wellbeing could be buffered by input and support from other caregivers.

An ability to consider the protective nature of having a partner/supportive other available for the infant if parent is struggling with her/his mental health and including this strength in treatment planning. This should involve including the partner in sessions where appropriate and feasible.

ENDINGS AND RELAPSE PREVENTION

An ability to help clients discuss their feelings and thoughts about endings, and help them:

- to manage any anxieties about coping with the baby alone.
- to maintain their ability to engage in self-care in the face of the demands of parenting.

An ability to draw on knowledge that relapse prevention should include discussion of potential challenges as the infant develops (e.g. increased independence, tantrums, challenging of boundaries).

An ability to think about the implications of future pregnancies and ensure that the client is aware of appropriate services should they be required.

ABILITY TO DELIVER GROUP-BASED INTERVENTIONS

An ability to weigh up the pros and cons of group-based treatment for clients in the perinatal period, for example:

- Pros: the benefits of interaction with parents and normalising of difficulties, a break from childcare.
- Cons: where client's pregnancy, childbirth, or parenting experiences are traumatic/outside the norm of other group members' experiences.

An ability to consider the impact of either providing childcare for the group or incorporating babies into a group.

- An ability to manage parental anxiety about leaving infants in a crèche.
- An ability to help parents to attend to group discussions if they are anxious about their infant.

An ability to make use of in vivo anxieties about babies when they are present in the group (e.g. where anxiety about the infant becoming ill results in the parent discouraging them from exploring the environment during the group).

An ability to work with local service providers to think about appropriate settings for a perinatal group (e.g. children's centres, libraries).

An ability to draw on the experience of group members to help normalise challenges in the perinatal period.

An ability to identify whether and how parents are comparing themselves to others and the impact this has on group dynamics.

An ability to hold in mind time constraints on parents' ability to regularly attend groups (e.g. multiple medical appointments, changing schedules of babies).

An ability to consider flexible ways to support engagement and adherence given perinatally specific practical barriers (e.g. such as infant illness, nap schedules).

An ability to acknowledge and manage the "illness identities" of parents with first episode versus recurrent mental health problems (e.g. people experiencing difficulties for the first time struggling to relate to group members with longstanding difficulties).

INTERVENTIONS FOR SPECIFIC CHALLENGES IN THE PERINATAL CONTEXT

ADAPTING TREATMENT OF DEPRESSION AND ANXIETY DURING THE PERINATAL PERIOD

Ability to draw on knowledge about how the transition to parenthood can impact on mental health, for example:

- Reduced opportunities for positive reinforcement in valued domains (e.g. work, interpersonal relationships).
- Increased perceived pressure to perform in areas in which clients may feel deskilled (e.g. caring for the infant, or forming new parent relationships).
- Struggling to maintain self-care in the face of the demands of childcare and beliefs about "self-sacrifice".

An ability to address maintaining factors for anxiety and/or depression (as identified by the formulation) such as: addressing communication problems, sleep difficulties, taking excessive responsibility, challenges to accessing social support, high and rigid standards of everyday behaviour leading to parenting perfectionism.

Cognitive Adaptations to treatment

An ability to work with negative beliefs about parenthood (e.g. I should provide perfect baby care, I should feel overwhelming love towards my baby, I should not need to ask for help).

An ability to draw on knowledge of how the uncertainty associated with GAD can manifest itself in the perinatal period (e.g.. in worries about the viability of foetus, foetal movements, delivery, well-being of infant).

- An ability to work with tolerance of uncertainty about specific perinatal topics.
- An ability to address excessive reassurance seeking from the internet, health providers and family members in relation to perinatal issues.

Behavioural Adaptations to treatment

An ability to draw on knowledge of physiological changes in pregnancy (e.g. increased heart rate and decreased blood pressure) when considering panic disorder treatment.

An ability to adapt coping skills to the stage of pregnancy or postnatal stage (e.g., lowering activity levels towards the end of pregnancy and the beginning of the postnatal period).

An ability to ascertain the function of a behaviour, considering that it may be less functional that it initially appears (e.g. a client with depression who spends infant's naptimes cleaning to a very high standard instead of resting/napping as needed).

An ability to understand the reasons individuals may be avoiding adaptive behaviours in the perinatal period (e.g. avoiding playgroups for fear of being judged as a bad parent, avoidance of new situations because of social anxiety, avoidance in regard to exposing the infant to germs).

An ability to address key partner behaviours that lead to dissatisfaction and conflict.

An ability to use grading and communication strategies to reduce social avoidance and improve social relationships (e.g., fear of talking to other parents).

An ability to find ways to incorporate the infant into reinforcing activities (e.g., encouraging a parent who previously enjoyed running, but has now stopped, to run with the pram).

ADAPTING TREATMENT OF PTSD, TOKOPHOBIA AND OCD DURING THE PERINATAL PERIOD.

An ability to differentiate between symptoms of trauma, OCD, and normal hypervigilance common in new parents.

High Intensity Only

An ability to draw on knowledge of the benefits of exposure related treatments across the perinatal period and the limitations imposed on those approaches through pregnancy (e.g. you would not have a heavily pregnant woman spin around while standing as part of treatment for panic).

Ability to safely and compassionately incorporate the infant into in vivo exposure when the infant is itself the object of avoidance.

An ability to conduct relevant behavioural experiments (e.g. exposure to making up baby's bottles without excessively cleaning them).

An ability to draw on knowledge about perinatal specific domains of concern in OCD (e.g. fear of harm to infant, increased sense of responsibility, concerns around social care input in relation to the content of intrusive thoughts).

An ability to distinguish between obsessions and psychosis.

An ability to understand the impact of various presentations of OCD on particular phases of parenting/infant development and set current and future treatment goals accordingly.

An ability to draw on knowledge about perinatal specific domains of concern in PTSD (e.g. traumatic experience of birth, miscarriage, or infant death or illness; triggers including the infant, the hospital, healthcare professionals, vaginal discharge and menstruation, intimacy with partner, fear around future pregnancies; possible physical consequences of childbirth such as incontinence, serious vaginal tears, painful intercourse, pelvic pain).

An ability to understand the impact that PTSD in relation to birth may have on a client's mood, ensuring that treatment planning addresses the trauma directly (e.g. trauma symptoms following birth may lead to behaviours that negatively impact on mood, such as avoidance of other parents in case they talk about birth stories, difficulty connecting with baby due to flashbacks, guilt in relation to not enjoying the postnatal experience. As recommended when treating PTSD:

- usually treat the PTSD first because the depression will often improve with successful PTSD treatment.
- treat the depression first if it is severe enough to make psychological treatment of the PTSD difficult, or there is a risk of the person harming themselves or others.

An ability to understand when it is important to gather medical information from other healthcare professionals in the treatment of PTSD (e.g accessing maternity notes of previous birth; liaising with midwife to arrange for the client to re-visit the delivery suite).

An ability to draw on knowledge of the perinatal period when using trauma-focused CBT or EMDR, such as considering the impact of the trauma on the parent's identity and their functioning as a parent (e.g. feeling helpless in their ability to protect their child or partner, difficulties bonding with baby), and considering the nature of the birth experience that may reinforce previously held beliefs (e.g. loss of control through pain, not being heard or listened to; invasive examinations that they did not feel they consented to).

- An ability to use this knowledge to explore trauma hotspots, the meaning of the trauma, and supporting the parent to discriminate the differences between then and now.

An ability to determine when a specific piece of work for tokophobia may be appropriate (i.e., mild primary tokophobia, secondary tokophobia that is mild to moderate) and when to refer to specialist perinatal mental health teams or Maternal Mental Health Services (severe, complex tokophobia, when the woman wants a c-section because of tokophobia, third trimester of pregnancy, when treatment of tokophobia requires significant co-planning with perinatal health providers, such as birth planning). See section 'Knowledge of Mental Health during the Perinatal Period' for a definition of tokophobia.

An ability to adapt evidence-based treatments to treat mild primary tokophobia or simple mild-to moderate secondary tokophobia.

An ability to gain a clear understanding of the specific 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 specific form of post-traumatic stress disorder (PTSD), where the woman also is fearful of the possibility (real or in the future) of childbirth.

An ability to draw on knowledge to support a client with tokophobia to prepare for the upcoming delivery (e.g. helping them to think about birth options that may give them more of a sense of control, helping them to communicate their needs to health professionals so that they feel heard and listened to, working with both parents to think about managing their emotional needs during labour).

An ability to draw on knowledge of the importance of close working relationships between psychological therapies and maternity about mental health, obstetric needs and care planning when treating tokophobia.

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 difficulties 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 difficulties 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 flexible and responsive to the issues clients raise, but which also ensures that all relevant components of the intervention are included.

WORKING WITH THE INFANT

An ability to integrate thinking about the infant into parental mental health.

- An ability to make a judgement on when challenges in the parent-infant relationship require specialist support.

SAFE PRACTICE AND SUPERVISION

An ability to judge when safe and appropriate to do exposure-based treatment with perinatal women.

- An ability to draw on knowledge of the impact of treatment of panic disorder, specifically: balance, dizziness and blood pressure.
- An ability to draw on knowledge around foetal exposure to temporarily raised levels of cortisol to help inform treatment decisions.

An ability to make a judgement about when mental health problems, past or current, require support from a Specialist Perinatal Mental Health Team.

An ability for clinicians to recognise the limits of their competence, and to judge when they should seek advice and/or supervision from more experienced colleagues and medical professionals.

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 reflect 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.

Where there is evidence that social and cultural difference is likely to impact on the accessibility/acceptability of an intervention, an ability to make appropriate adjustments to the intervention and/or the manner in which it is delivered, with the aim of maximising its potential benefit.

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