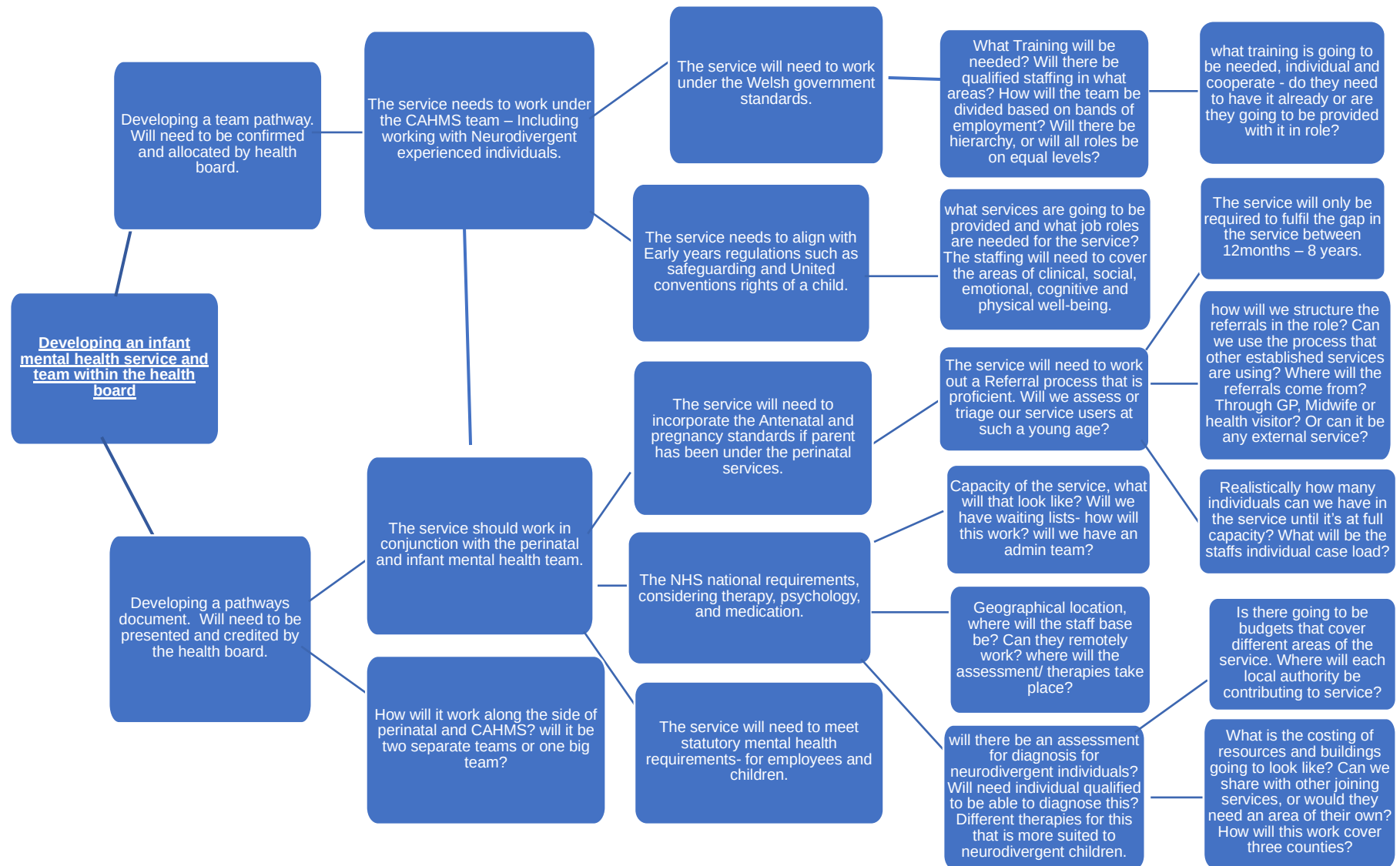


Section 1

OBJECTIVES What do I want to be able to do or do better?	SUCCESS CRITERIA How will I recognise success? How will I review and measure my improvement?	ACTIONS What methods will I use to achieve my learning objectives	IMPLEMENTATION How will I practise and apply what I learn? Timescale?
I want to be able to present better when taking groups or one-to-one training sessions to get my content across when teaching or delivering a service.	I will feel confident. I can measure by undertaking regular time to complete practise sessions and from feedback forms. I will know all the content that I am delivering to individuals. The individuals that I am teaching will understand me better and will be able to learn more.	I will ask someone to observe me and point out my key flaws when presenting, I will then work on these flaws. I will watch others that produce high quality presenting to take tips and I will practise taking my time. These types of measures are effectively used for presenting (Plant, Barac and Sarens, 2019).	I will use the approach of being patient and doing things using a step-by-step guide to remember how to keep calm and to take my time with presenting. I will also practise regularly in front of family and work colleagues. I will improve by knowing my content.
At present I struggle with the accuracy of work documents or university assignments that need to be published to employers, organisations, and clients.	I will know when my manager stops pointing out mistakes. I will know as I will not find any of my own mistakes in punctuation and grammar, including sentence structure.	I will practise spelling, using correct grammar and punctuation. Having a system in place to be able to check my work thoroughly such as proof reading on the laptop then printing and proofreading again before submitting. This type of reputation is reliable way to ensure accuracy in practice (Cottrell, 2019).	I will spend more time looking over my documents carefully. I will use spell checker to help with sentence structure as I may not always see the fault. I will also highlight my mistakes to then reflect on my errors, to know what to look out for next time. I could also practise asking for help from someone in the office to be able to check the document.

I want to be able to have more self-control when others are speaking and to not talk over them – to get my point or opinion across. Also, to not speak fast and stutter. This is something that has been pointed out to be in work.	When individuals recognise that I am waiting and can give me feedback. Individuals can understand my language better and I will be able to finish a sentence without repeating a word or starting the sentence again.	I will make sure to listen instead of adding. I will practise being slower when I talk, including taking my time. I will remind myself that everyone has a chance to speak once the individual has finished. I will use conditioning model of reptation to enable the best outcome when thinking critically (Cottrell, 2019).	I will practise counting to ten and make sure that I wait until the persons done speaking.
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Section 2



Section 3

Discussion and analytical points have been conveyed during this concept map to explore the idea of implementing the infant mental health side of the service in line with Erikson's Psychosocial Developmental Theory. Continuing, that at the moment it is widely directed at the parents and the perinatal side (White and Killam, 2017). The concept of this idea is to fulfil an area where the service has identified a gap in mental health care. As Welsh Government (2023) purposes the Child and Adolescent Mental Health Services only take children on from the age of five and onwards. Including, that the perinatal team only treat mum and baby from birth to a year old postpartum. Lee (2017) suggests that enabling such a service to be put into practice, the requirement of developing a pathway is the fundamental of this concept to ensuring that the service is structured, researched, investigated and that the process is quality assured.

(Rasche and Pfannstiel, 2016) validates that approaching a new service requires planning which consists of assessing a plan or pathway, reviewing what is available already, to analyse any issues associated with it, and to research for effective alternatives. NHS digital (2023) mentioned that within the Hywel Dda University Health Board a pathway guide and team pathway of roles is a standard procedure before undertaking the setup of a service in a department. NHS England (2018) argues that when developing an idea of a service it must work under the relevant departments, for the concept this includes working under the CAMHS team and in conjunction with the perinatal team. Furthermore, working with neurodivergent experienced individuals or teams. As of yet there are no specialised roles that work with neurodivergent specific individuals within the perinatal teams or CAMHS team. Children and family health NHS (2022) presents that from experience practitioners have reported that treatment is often not changed if the child or adult has a neurodivergent condition. This is an adding concept which can be developed once the service is fully up and running.

Freud (2022) advises of the change that the Welsh Government has been engaging settings to pay attention to children's well-being, emotional state and mental health. The service will need to incorporate the All-Wales Antenatal Care Criteria (2021) to meet the standards in the antenatal area of the service if the parent has been under the perinatal services. The service needs to align with

Early years regulations such as Children act (2004), Working together to safeguard children (2023) and the United Nations Convention on the Rights of a Child (UNICEF, 2019). Moreover, this includes the NHS national requirements, such as Admissions Guidance (2019) considering therapy, psychology, and medication. The service will need to meet statutory mental health requirements for children which comes under the mental health act (2007). As there will be individual roles, the professionals will also be working under their own regulations such as a psychologist working under the British psychological society (2023) or the Nursing and Midwife Council (2024).

(Zeanah, 2018) suggest that there are priority areas when looking at a service that treat children such as clinical, social, emotional, cognitive, physical and well-being. (Diem-Wille, 2018) indicated that this will be used to prepare outcomes for children In line with Freud's Psychosexual Developmental Theory. Furthermore, this is done during his clinical practice where he studied individuals suffering with mental health, Freud theory came to the conclusion that children experiencing their childhood and discovering their unconscious desires leads to behaviour that is influenced.

Cardiff and Vale university health board (2023) advocates that due to the nature of the service there will be mandatory cooperate training which is essential for any individual who joins the organisation. Furthermore, it highlights the importance that all employees have the same understanding and follow the organisational values. National services Scotland (2021) suggest that within a team for mental health with infants there should be specialised roles such as a clinical lead, nursery nurse, occupational therapist, child psychologist, paediatric nurse, mental health nurse, paediatric doctor, specialist health visitor, child therapist, play therapist. (Dogra et al., 2017) supports the above point and demonstrates the reason for the variation in roles is to be effective with the child's care, needs, safeguarding and child protection. (Hardy and Murphy, 2020) argues that families and their children will need to have access to a range of different specialists during a child's life. Adding that It's a high priority that practitioners work together to gain a full idea of a child's background and have a holistic approach to their tailored support.

O'Connell, Pote and Shafran (2021) discuss the variation of roles and how they will be put into bands based upon the responsibility of their role and qualifications. For example, a therapy practitioner would be a band four and a psychologist would be a band eight. However, in line with the Diversity act (2010) all roles will be equal. NHS (2022) present that as CAHMS and the perinatal team are conjoining and can share resources and referrals can be made, the ideal scenario would be for the service to be its own team however, still working close within the department and other services. Moreover, Within the perinatal team they initially do not provide 24-hour care however, they have a crisis team which can provide critical treatment in case of an emergency. Montreuil, et al. (2018) analyses that a crisis team is an essential part of a mental health service as often we cannot predict when crisis point can happen. Additionally, this could be a possible long-term goal for the service due to the early stages of the service being set up (Hywell Dda University health board, 2023).

As (Cohen and Waite-Stupiansky, 2017) highlights John Bowlby's theory and in line with research from the perinatal team, interventions with infancy can be a difficult area to approach when moving to therapy. CCQI (2019) demonstrates the regulationa for Inpatient Perinatal Mental Health Services is required in all services where therapies need to be delivered in groups and one to one. Including having the offer to be able to complete this online or within their home. This must be considered when deciding what roles will undertake therapies.

Riedinger, Pinquart and Teubert (2017) Research shows that these types of therapies are the most suitable for children that will be in the service. Attachment disorder, Cognitive behavioural therapy (CBT), Child-cantered play therapy (CCPT), this is play-based intervention. Continuing with Parent-child interaction therapy (PCIT), Dialectical behaviour therapy (DBT), which teaches children skills to cope with emotions, stress, and relationships. Family therapy, which involves the whole family in addressing the child's issues and improving communication. Zyromski, et al. (2018) argues that there should be an area of educational approach when completing therapy such as Maria Montessori theory and Theory Jerome Bruner, who advocated for discovery learning and scaffolding.

NHS Wales (2023) demonstrates the standard way to assess the needs of a child or adult is throughout a triage assessment where they are asked questions and are answered, this is often around experience, personal history, and current situation, the idea of Vygotsky's Sociocultural Theory should also be used to assess when considering early years. This method will need to be tailored to how a practitioner would assess a child, for example using play and assessing behaviour.

Porrás-Javier, et al. (2018) describes the process for referrals that is used within the perinatal service and CAHMS, this is where a GP will refer or as an individual you can refer yourself, the suggestion would be that we could use a mixed approach of both referral pathway so that it is developed to how children are triaged by practitioners this should also be in line with Piaget, who proposed a theory of cognitive development which should be assessed during the triage. González-García, et al. (2017) proposes that the service should have access and be able to refer to external organisations. Also, adding that this would be the most beneficial for children in this age category. Hansen, et al. (2021) argues that when assessing children, they have the right to be assessed for neurodivergent if there are traits or they feel that this is something they have previously experienced. The perinatal service has recently had two of their staff attend training to be able to assess and diagnose neurodivergent conditions. This has been decided based on evidence of how often this can affect individuals that are referred to the service. However, CAHMS have not got an individual specific to assessing or diagnosing neurodivergent conditions. Hanlon, et al. (2022) highlights how important it could be for assessing children as it could open different therapies that are more suited to neurodivergent.

Waid and Kelly (2020) believe that the involvement in family during clinical care is crucial to better outcomes in line with Bronfenbrenner's ecological systems theory however, Doody, et al. (2017) points out that sometimes during the care of mental health family involvement should be minimal depending on the needs of the child at the time. However, Stadnick, Haine-Schlagel and Martinez (2016) argues that the age category for this service may be difficult due to the young nature where consent and confidentiality may be a challenge to obtain from the child. Additionally, there may be many challenges with children that are in foster care that could arise.

Section 4

Currently within my practice a situation came to my attention regarding dads in our service. As it is perinatal and Infant mental health services my role is to treat new or to be parents for their mental health, including some therapies with the child and baby up to one year old. I mostly treated mum and baby, however, in recent practice I have had the pleasure of treating a dad. I questioned to why we don't have many dads in our service. The service manager explained the criteria for the service where dads can only be treated if the mum is undergoing intervention or therapies with us. This is something that shocked me, reflecting I wouldn't assume that this was the case within the service. Further development came from this situation, where I was treating both mum and dad however, social situations arose where they had separated and lived at different address. Requirements from the service, were to hand over one of the individuals to a separate practitioner to conduct further support until I completed therapy with mum. During this time, myself and the separate practitioner were not allowed to share information or cross over in anyway. This made me realise that the dad would be the one that would not get treated until mum finished therapy or passed onto another service such as the community mental health team.

Henderson, Potts and Robinson (2020) claims that mental health is an aspect of overall well-being, often individuals do not address the stigma surrounding it. In the United Kingdom, men's mental health is seen to have a lot of stigma attached to it, which can prevent men from seeking support when they need it most. According to the Mental Health Foundation (2023) in the United Kingdom 75% of deaths that are recorded are suicide by men. Paula da Silva Ramos, et al (2023) highlights that societal gender roles can influence how men express emotion, such as 'men do not cry'. McKenzie, et al. (2022) argues that the stigma can lead men to shut down and to hide their emotions to show that they are manly or strong.

Nejaime (2017) suggest that it is crucial to treat both parents equally during pregnancy and childbirth. However, Sherman and Hooker (2018) highlights that within services there can be differences in the treatment of mums and dads. Lawrence Hill (2017) explains that

for instance, the mother of the baby is automatically granted parental responsibility as soon as she gives birth to a child, whereas the legality for men can be more complicated. Furthermore, a dad can be granted parental responsibility if he is the mum's husband or is named on the birth certificate, sometimes this may not always be the case (Lawrence Hill, 2017).

Darwin, et al. (2017) advocates that practitioners should note that dad's mental health is a priority just as much as the mother, as dads can play a significant role in a supporting maternal and child health. Baldwin (2018) claims that when dads are involved during pregnancy and the perinatal period. Continuing, that mums are 1.5 times more open to receiving prenatal care in the early stages of pregnancy, in this case it would have a positive implication for mum, dad and baby. Hambidge, et al. (2021) presents that a dad being emotionally available and in a stable mental state when a child is an infant, this enabled dads to support new mums in breastfeeding. Counting that dads can also support mums with sleep and the safe sleep guidelines, which can be cindered to reduce infant deaths and suicide in new mums.

In conclusion with Sizikova and Kudryavtsev (2023) and the discussion on lev Vygotsky learning theory it is essential to recognise that both parents should have the same number of opportunities in relation to their mental health. As it is evidenced that both are essential to having healthy relationships including supporting the growth and development of children (Sizikova and Kudryavtsev, 2023)

After reflection upon our service and investigations, myself as a practitioner discovered that we do not tailor any of our services to dads and the terminology used can be considered discriminatory, for example for therapies or posters the language used is 'mum and baby'. According to the Royal College of Midwives (2023), as a team they have been promoting the position on inclusion during pregnancy, childbirth and the postpartum stage, including taking measure to ensure their language they use reflects this. Moreover, as practitioners they have implemented many methods for the use of inclusive language, such as being neutral and removing all references to sex and gender, and sex-specific language with an organisational acknowledgment of the diversity of gender identity

with parents. (Royal College of Midwives, 2023). This is something as a service we could take upon us to make a change to the barrier that dads feel of inequity within our service.

Hanley and Williams (2019) suggest that the perinatal service uses the process of treatment based on the fact that dad can only be treated if mum is being treated, in relation to capacity of the service, prioritising perinatal mental health and trying not to be stretched out as a service. Das and Hodkinson (2019) present that pressured services can result in the patient receiving an experience of bad quality care. Gough, and Novikova (2020) proposed that dads and men in general do struggle to come to terms with their mental health and it can be a long process for them, as frequently dads will not refer themselves into our service. From experience as a practitioner within the service, the mum will refer to the needs of the dad and make suggestions on his behalf. This situation can also be a difficult area for a practitioner as we explain that the dad is welcome to be assessed but men often show fear to this process of talking. This is where Rominov, et al. (2017) argues that dads often do not engage in services, which can be a waste of resources if there is another individual such as a mum, desperate for support and wanting to engage with the service. Harvey, et al. (2022) highlights that the separation of practitioners can be demanding, maintaining that it can be challenging to treat both individuals mum and dad if in the same household or if they have split up and have environment issues with social services.

According to The Children Act (1989) In the UK, parental responsibility is seen as the legal responsibilities and rights that a parent has in relation to their child. The human right act (1998) states that all individuals have a right to seek medical or health care. Park and Banchevsky (2019) argues that for this reason dads should have as much opportunity and right to be treated within the service as mums do. Bramante (2022) underpins this argument and agrees that perinatal is suggested as a parent-based service where both parents are considered whether it be mum or dad. Additionally, that discrimination should not occur based on gender and equal opportunities should be provided.

Lim, et al. (2023) argues that dads can be forgotten in the system as traditionally the mum carries baby for around nine months, which suggests that mum and baby are seen as more of a priority when triaging or therapy is considered. NHS trust (2024) claims that this is why the service of the community mental health team is available however, Hodgson, et al. (2021) argues that this should not be the case, as it is not fair treatment for dads to attend another service when the term of the service is perinatal which confers to parents, including if the mental health struggles are tailer to becoming a parent or new dad.

As a practitioner reflecting, I evaluated what would happen if we had a situation where mum had passed away during birth, and there was a situation with only dad present. How would we approach this situation. My emotion toward this issue made me become very passionate towards the topic and challenge myself to discover how I could make a change to this or what could I add to our service. NHS Trust (2023) points out that the Dadpad was created within the NHS, which is something that we currently do not have within the perinatal service. Furthermore, the Dadpad enables dads with the knowledge and skills to support their needs and their partner, which will help babies get the quality start in life. DadPad (2024) claims that using a resource like this has benefits, such as supporting dads to work on anxiety and mental health by getting involved, learning how to enable a healthy attachment with the baby and forming a good family relationship by talking.

There are many further changes I want to consider such as introducing a new area to the service which could include having a process of a centred approach to dads, this could include having a male practitioner, and male only therapies. (Conrad and White, 2018) highlights that having a male practitioner within the service can provide a range of benefits for dads. In line with the National Institute for Health and Care Excellence (2021) professionals should be ensuring that dad has support to attend appointments, offering them a space to talk during scans and overall caring for dad throughout the process as well as mum. This is where a male practitioner can be more relatable and beneficial to our service.

Additionally, Father hood institute (2023) highlights that the service provides resources to support the needs of dads, including the Becoming Dad guide, which aims to help men make sense of what's happening, how to take care of themselves and how to build confidence. This is something that I have come across that could be delivered within my practice for dads, this can be done in group therapy or one to one. Including providing couples therapy, which (Glick et al., 2015) suggest is a valid form of improvements towards a dad's mental health and mums at the same time and can have overall benefits for the baby or child.

Section 5

I Currently work for the health board organisation of Hywel Dda, my role sits within the perinatal and infant mental health service. The term of my job description is a psychological therapy assistant practitioner. My role incorporates medical treatment, interventions, and therapy. The service is a team of twenty-two individual which consists of specialised professionals in each area that would be needed during pregnancy. Such as health visitor, nurse, occupation therapist, psychologist, social worker, support worker, midwife and nursery nurse. The sector is treating mental health conditions such as, anxiety depress, obsessive compulsive disorder, attachment disorder, boding issues, Bipolar, schizophrenia, trauma, borderline personality disorder, health anxiety and many others. The service is available from finding out about the pregnancy to one-year post-partum. My responsibility as a practitioner consists of physiological assessment, creating therapies under supervision, delivering all therapies on a one-to-one basis, birth reflections, participating in education for new parents, group-based work, supporting mum, dad and baby with whatever they need during that time.

Azad, et al. (2020) highlights that often it is seen where sectors such as health and social care are dominated sectors by females. Rubery (2017) claims that traditionally women have been seen in a nurturing and caring profession, which are qualities often associated with job roles such as a nurse or midwife. Cundiff and Vescio (2016) study demonstrated the serotyping in roles of what

sectors female should be in and where males belong. However, Rouse, et al. (2020) argues that individuals must note that the gender balance in healthcare is changing, and more men are entering the field. Furthermore, it's often promoted that it's about breaking stereotypes and embracing diversity. Froehlich, et al. (2020) empowers that having a service that is balanced by gender representation can bring a variety of different perspectives, experiences, and ideas to the table. It promotes a more inclusive and comprehensive approach to healthcare.

As a practitioner I evaluated my experience considering the positives such as having more women within the practice can increased productivity and growth due to the emotional maturity. Kunze and Miller (2017) highlights that women enjoy a complete environment with other women, which can lead to higher achieving outcomes for the organisation. Kalaitzi, et al. (2019) agrees that having more women in leadership roles can be beneficial for the whole health care board, as women have the natural ability to think ahead with a long-term strategic plan and are successful in community building.

Whilst researching this top Samulowitz, et al. (2018) article I came across a section where they discussed women dominated service and how this can become a barrier for some individuals. Counting that this type of environment can become intimidating and a demotivating practice to work in. Central to this analysis I also evaluated the negatives, as a practitioner, during this time I have noticed the importance of approaching this topic with sensitivity and to avoid generalisations. (Marques, 2021) highlights there may be some challenges or disadvantages associated with gender-dominated services, the result of this can be focusing on individual abilities and qualifications rather than making assumptions based on gender. As a practitioner my perspective through this reflective process is to promote the goal of creating an inclusive and supportive environment where professionals can thrive and provide the best care for service users despite the gender of the professional.

Central to my reflection as a practitioner and discovery of my own thoughts and feels regarding the main aspect of my experience, it came to my attention how the female gender has taken a leadership role within history. Rogers, et al. (2021) support this statement

and advocates how we celebrate the female gender for a whole month for the contributions of women to history, culture, and society, which is known as women's story month. This is not specific to the UK however, (Yenilmez and Burak, 2019) argues that it is specialised to the history of the gender and not from what country it was achieved in.

The concept to why this might be is covered in Day (2018) research where the Representation of the People Act (1918) was brought into the United Kingdom, granting voting rights to some women over the age of thirty years old. From this evidence, it has been almost a century since women gained the right to vote in the UK. Despotovic and Joksimovic (2019) explains that traditionally women's lives consisted of staying at home being a mother that attends to the home, children, and partner. Continuing that men were to be the ones that would go out, provide, and work.

As a reflective practitioner I have always been aware that the rights for women to work have been a gradual process, and it can vary across countries and regions. For example, the Sex Disqualification Removal Act (1919) was brought into the United Kingdom, which provided various professions to open up for women. As a practitioner my attention to this subject will stay with me throughout my career as a female, it is influential to know that women dominating services is now possible due to the limitations that the gender has experienced throughout many years.

This has made me feel differently about how I think, and I want this to reflect in my practice, or in the future to help with the fact that even today we can still be gendered one way. As a whole (Haynes, Kilgour and Flynn, 2017) study have shown that the performance of organisations improves with more gender-equal corporate boards or employees. As a practitioner in a women dominated service, I would take a different approach to what I might do differently or develop such as enabling the service to have male based appropriate roles as (Williams, 2023) still supports that having a male's perspective an influence within a service is an advantage. (Agha and Maestro, 2022) advocates the importance of have an inclusive women and male service, where it is not dominated by any one gender.

To approach this in the future I believe that I would make or request for gender natural training, including feedback to my team about the idea of how dominated the service is by women and to discover how they feel about this. (Anderson, Beaman and Platteau, 2018) suggest that there still is not enough training on gender within workplaces, as the culture around gender is constantly evolving and discussion has also come into place where some individuals choose not to identify as one gender.

(Ferguson, 2018) argues that there is training out there however, it is not as promoted as it should be within work practices. I have experienced this myself where an individual has stated gender as female but has opted to be known by different pronouns such as 'they' instead of the traditional 'he' or 'she' that is known to us.

I consider myself as a very inclusive and respectful practitioner however, it is often hard to slip back into what the traditional used pronouns are. In relation to discussion on gender dominated services I found this situation overwhelming. From a service user's perspective, I could understand that I was using discriminatory behaviour unintentionally, which could have made them feel uncomfortable. I reflected upon this and realised that I had made my judgment based upon an assumption, to ensure that this does not happen again during my practice, I have actioned myself to look at the situation and remember that all individuals are different and unique. Whilst thinking of my approach for the future, this made me consider going over the Equality act (2010) and Welsh government (2024) claims that everyone should familiarising themselves with the diversity and inclusion strategy framework (2018).

The use of the Gibbs model has concluded my reflection based upon my experience. This consisted of using the model where you describe, evaluate, analyse, make a conclusion and therefore are able to plan actions. (The University of Edinburgh, 2024). I have chosen this model due to the discussion within my workplace regarding how common it is used within healthcare practice.

As a service we also have a session once a month for an hour where we reflect due to the nature of our job roles, some service users can be challenging, and this can result in having practitioner needing to off load. This process is based upon Gibbs model and is applied on how we share with the group. Aziz, Mahboob and Saleem (2020) suggest how valuable the model is in healthcare as it

promotes a structured approach to learning from experiences. Since working within perinatal services, I have evaluated that reflection is used for continuous professional development and improving our equality as practitioners. Sekarwinahyu, et al. (2019) advocates that it helps foster a culture of learning and accountability within healthcare settings.

I enjoyed using the model of reflection as it is a structured approach that has enhanced my learning and personal development. It provides a clear and systematic framework for reflection. It guides you through different stages, allowing you to thoroughly examine and learn from your experiences. The model encouraged me to be more self-awareness, think in a critical way, and how to develop action plans for improvement.

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