A good practice guide to support implementation of trauma-informed care in the perinatal period

Trauma-informed care in the perinatal period

This resource has been produced by The Centre for Early Child Development (Blackpool, UK) with support from the University of Birmingham (UK) and the University at Buffalo (US).

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Equalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvement's values.

Throughout the development of this guide, we have:

- given regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it
- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities
- used the term 'women' throughout this guide to reference those using maternity and/or perinatal mental health services during pregnancy, birth and the perinatal period. However authors acknowledge that not all people who use maternity and perinatal mental health services are cis women, including trans men and non-binary people, and it is important that trauma informed care for maternity and perinatal mental health is inclusive of all birthing people.
- used the terms 'fathers' and 'partners' to reference the significant others of those using maternity and/or perinatal mental health services during pregnancy, birth and the perinatal period

Accessibility

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net

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Acknowledgements

This guide presents a combination of primary research (voices of over 50 parents with lived experience of trauma and over 470 staff, some of whom have also experienced trauma) and review of a broad range of evidence and information on what works well.

This guide was commissioned by NHS England and NHS Improvement in 2019. It has been developed by Clare Law and Dr Lauren Wolfenden at the Centre For Early Child Development (CECD), with support from Assistant Professor Mickey Sperlich at the University at Buffalo (USA) and Professor Julie Taylor at the University of Birmingham (UK). We would also like to acknowledge the expert advice, oversight and support from Professor Julia Seng at the University of Michigan and the support and guidance from Ellen McGale (Perinatal Mental Health Programme) and Lisa Ramsey (Service User Voice Policy Manager from the Maternity Transformation Programme) at NHS England and NHS Improvement.

Development of this guide would not have been possible without the contributions from survivors of previous psychological trauma who took part in our workshops around England, shared personal stories and recommendations for change within services and ultimately championed this work. This guide was also created in partnership with a large Expert Reference Group drawn from a range of disciplines and professions across health, social care, policy and a range of community groups. A full list of those who contributed is available in the appendices.

Introduction

Who is this guide for?

This guide is universal and applies to all staff (clinical and non-clinical) working with perinatal women in maternity and mental health services, although it may be more pertinent to certain roles. All staff can play a part in ensuring women and their families feel safe and secure in the care setting. This includes - but is not limited to - midwives, obstetricians, sonographers, anaesthetists, psychiatrists, psychologists, nursery nurses, mental health nurses and maternity support workers. The principles in this guide equally apply to non-registered staff, those in supportive or administrative roles and those who provide direct professional or clinical care, advice and support.

This guide does not intend to supersede or replace regulatory or practice requirements already in place for a professional group or role, but aims to be additionally supportive.

The guide is also for parents to help them understand what good trauma-informed practice might look like.

It is also recognised that the guide will aid the workforce to strengthen trauma informed practices and policies as part of a recovery response to COVID-19, and also enable them to more effectively support and engage with service users at an understandably more difficult and stressful time.

Aims of the guide

This guide aims to help staff and services understand the impact of psychological trauma on women in the perinatal period and respond in a sensitive and compassionate way. It aims to support staff to ensure they 'do no harm' through care delivery that, without thought or intention, could retraumatise individuals. This includes examples of how to:

- recognise and understand the impact of psychological trauma and how experiences may present during the perinatal period
- respond to disclosures and tailor care to needs of women and families so that services do not retraumatise individuals
- best support staff working in maternity and mental health services, acknowledging the effects of vicarious trauma and that staff may have their own experiences of trauma, which could impact on their capacity to deliver trauma-informed care

We propose four principles of trauma-informed care for the perinatal period:

(see page 13 for further information)

Implementing these principles provides an opportunity to improve experiences of care for women and families, reduce harm and protect staff. This can be achieved through the development of trusting, respectful and collaborative person-practitioner relationships. This good practice guide supports the delivery of high-quality care for women and families as outlined in the NHS Long Term Plan, Better Births, and the Maternity Transformation Programme.

The content of this guide may be triggering for some people to read. It is important to ensure you are in a safe place when reading this guide and you take time to be kind to yourself.

Chapter 1:

WHAT IS PSYCHOLOGICAL TRAUMA AND WHO MIGHT BE AFFECTED?

> *"Trauma is not universal; it is different for every person. Please can staff see us as individuals"*

Mother with experience of birth trauma

Chapter 1: What is psychological trauma and who might be affected?

Psychological trauma has been defined as "*an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individuals functioning and mental, physical, social, emotional or spiritual wellbeing*" [1].

The following points may help staff understand psychological trauma and who might be affected:

- anyone can be affected by psychological trauma at any time in their life
- the term psychological trauma refers to the impact on an individual rather than the event itself. This will vary from person to person
- this impact is often hidden and may never be disclosed
- people may experience a single traumatic event or a series of traumatic experiences over time
- some groups of people are at greater risk of experiencing trauma, including:
    - migrant populations
    - refugees and those seeking asylum
    - Black, Asian and Minority Ethnic Groups (BAME)
    - trafficked individuals
    - prison populations
    - homeless populations or those living in poverty or insecure housing
    - those living with physical or psychological issues (including those with visual or hearing impairments) and substance use problems

It is important for all staff to:

- understand what the impact of trauma could be for the individual, whether they disclose a trauma history or not
- ensure they deliver trauma-informed care that is respectful and responds to care decisions
- consider how care interaction can affect an individual's future engagement with the healthcare system

It is also important to review policies and practices to minimise barriers to care, particularly where people may feel judged by services [2].

Box 1:

Events and experiences associated with psychological trauma and the perinatal period

Birth trauma

Sometimes during childbirth things do not go to plan and there may be unexpected interventions or outcomes this can be frightening or traumatic for mother or partner. This could include near death of mother or baby, emergency procedures, significant bleeding or physical injury, lack of support or communication throughout the experience, for example - what is experienced as traumatic is personal and staff should not make assumptions based on their perception of the health outcomes or care delivered. The Make Birth Better website provides parents and professionals with resources and information on birth trauma and further support available.

Previous perinatal loss

Loss of a baby during pregnancy, birth, or soon after may include miscarriage, ectopic and molar pregnancies, termination, stillbirth, neonatal death or removal of a baby due to parental risk, surrogacy or adoption. **Loss is traumatic and can have a physical and psychological impact for women and their partners and can impact emotions and responses regarding future pregnancies.** For many, pregnancy loss or when a child has been removed can create feelings of grief, helplessness, self-blaming, fear and anxiety, and can lead to symptoms of PTSD [3].

Box 1 Cont'd:

Adverse Childhood Experiences (ACEs)

Experiencing certain traumas or adversity in childhood (physical, sexual, emotional abuse and neglect, a family member with substance abuse issues or untreated serious mental illness or is in prison, loss or separation from primary care givers) has been associated with poorer cognitive development, physical and mental health. These experiences have been related to experiencing intense and overwhelming emotions and engagement in mechanisms for coping that can be perceived as risky or unhelpful, such as smoking, substance and alcohol misuse, excessive exercising, self-harming or overeating [4, 5]. The effects of trauma are often cumulative and those experiencing multiple ACEs have some of the poorest health outcomes in our population.

Early childhood trauma, and absent or inconsistent primary caregivers, may limit a child's experience of developing sustained close bonds with affectionate and attentive caregivers, which can can lead individuals to struggle with relationships, friendships and connections in adulthood due to possible 'attachment trauma' (i.e. trauma as a consequence from and invalidating developmental experience with disrupted parent-infant bonding, such as from abuse, neglect, separation or loss). Such experiences of attachment and childhood trauma have been associated with diagnoses of complex PTSD, PTSD with dissociative subtype and Borderline Personality Disorder (BPD) [6,7]. It is increasingly acknowledged that the behaviours associated with 'labels' of 'personality disorder' may represent patterns of learned behaviour that developed as a consequence of prior experiences, as such, many find the use of these diagnoses unhelpful.

Sexual abuse and assault

Sexual abuse and assault are serious crimes, yet the majority of incidents go unreported, with many not disclosing until decades after the event. The impact is, therefore, often hidden but can have a profound impact on individuals psychological and physical wellbeing, no matter what age. Childhood sexual abuse has been associated with an increased risk of depression, anxiety, and PTSD [8].

Intimate partner violence (IPV)

During the perinatal period, relationships between partners can adapt or change in positive or negative ways. During pregnancy, IPV can increase and women who experience IPV are up to 3 times more likely to experience postpartum depression [9]. Those who have experienced childhood trauma are more at risk for subsequent traumas, such as IPV [10]. This may include physical and/or sexual violence, stalking, or psychological abuse by a current or former partner or spouse.

Responses to trauma in the perinatal period

During pregnancy and the perinatal period, women may revisit past experiences of trauma. These experiences can generate a range of responses and women would benefit from staff understanding and being attuned to these. Some women disclose previous abuse or trauma for the first time in maternity services [11,12].

Parents-to-be often reflect on their own childhood experiences and consider how they themselves were parented. This may be particularly challenging for those who have experienced attachment trauma (trauma caused by poor or disrupted parent-infant bonding, resulting from abuse, neglect, separation or loss) as they consider good models of parenting and what their relationship with their own baby might be like.

Box 2

Responses to psychological trauma

Responses may be:

- physical (e.g. disturbances in sleep, eating, hypervigilance/startling easily)
- emotional (e.g. panic attacks, irritability, depression)
- cognitive (e.g. difficulty in making decisions, challenges concentrating)

Re-experiencing a trauma may involve:

- intrusive thoughts
- flashbacks or nightmares
- sudden floods of emotions or images related to the traumatic event

Individuals may try to avoid re-experiencing trauma through avoidance of events that share similarities with the trauma, detachment or dissociation.

Recognising and understanding the behaviour and symptoms relating to trauma and responding sensitively, and without judgement, is key to being trauma informed.

For some, the physicality of pregnancy and birth itself may be a cause of worry or anxiety. History of previous birth trauma, sexual violence or abuse has been associated with presentation of tokophobia (severe fear of childbirth) and requests for caesarean section [12]. Some women feel a loss of control as their body changes. Some aspects of childbirth can cause triggers or flashbacks to past trauma, particularly sexual abuse or IPV. These may include close proximity of a relative stranger and feeling exposed during procedures or examinations by healthcare staff, being told to not move, the sight of blood or the smell of medical settings [13-16].

It is acknowledged that individuals with a history of trauma may present later to maternity care (34+ weeks), and be at greater risk of miscarriage, pre-term birth or longer birth duration [12,17-19].

Some women with a history of trauma may experience escalating levels of anxiety and flashbacks as pregnancy progresses. This can result in 'fight or flight' responses, such as – fighting, surrendering or retreating, in an effort to take control of their experience. They may also experience dissociation (which may include depersonalisation, 'out of body' experiences and loss of memory or awareness of time) during labour. [13,14,16,19,20].

Pregnancy and childbirth can trigger a relapse of pre-existing mental health difficulties or symptoms related to past trauma. For example, early childhood trauma is associated with increased PTSD symptoms during pregnancy [21].

Fathers and partners may also have experienced trauma, which may impact on their mental health and wellbeing during the perinatal period. This can include anxiety and fear around parenting and their needs should also be considered.

Chapter 2:

WHAT IS TRAUMA-INFORMED CARE?

"Trauma-informed care means that somebody understands the impact of my experiences on me... How and why I feel, act and think is impacted by it. Staff can make sure I feel safe and secure."

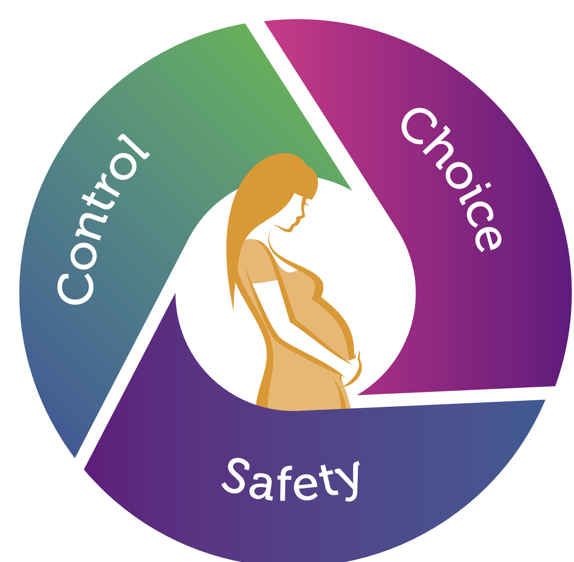
Mother with experience of childhood trauma and birth trauma

Chapter 2: What is trauma-informed care?

"*A program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist retraumatisation*." [1].

Principles of trauma-informed care for use across service sectors have previously been described. These broadly include attention to: 1) safety, 2) trustworthiness and transparency, 3) peer support and mutual self help, 4) empowerment, voice and choice, 5) collaboration & mutuality, and 5) attention to cultural, historical, and gender issues [1, 12].

Trauma-informed care aims to promote feelings of psychological safety, choice, and control. Every contact with a woman and her partner matters. It is important that staff put the woman at the centre of her care – this can be done by ensuring all individuals feel seen, heard and cared for.

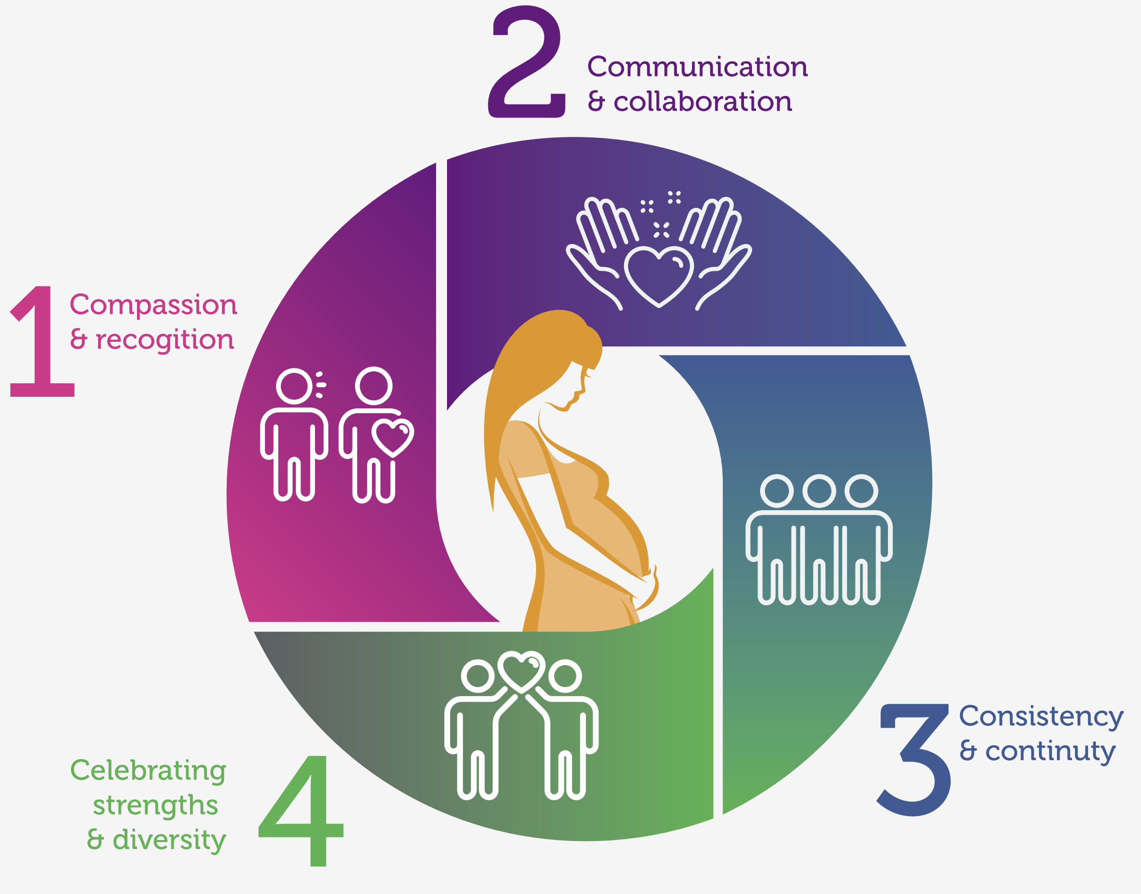


There are many misconceptions about trauma-informed care, for example that it is purely conceptual, already widely implemented or a form of treatment in itself. This may prohibit implementation. Trauma-informed approaches do not claim that all individuals have experienced trauma or that everyone with a mental health difficulty has a history of trauma. However, they do acknowledge that trauma is widespread and could cause mental health difficulties to develop. All individuals benefit from the delivery of universal, compassionate care.

Principles of trauma-informed care in the perinatal period

Keeping the aforementioned broader principles of trauma-informed care in mind, further to engagement with women, families, and staff, we describe four principles of trauma-informed care of relevance to the perinatal period:

At the end of this document practice examples are provided with suggestions for implementing each of the five trauma-informed principles in the perinatal period. These include the: care environment, decision-making, moving between care, personalised care and considering needs of partners/families.



Principle 1: Compassion and recognition

"My life has been filled with trauma since being 3 years old. There was sexual, physical and emotional abuse through my childhood. At 11 years old I started my journey of substance misuse to try and escape and forget. I was 15 and put in a children's home; I had to leave at 16 and was put in a hostel. I was groomed, kidnapped and abused further and was now pregnant.

With my last child, I arrived at hospital alone for my third caesarean. I was discharged after 2 days, to be on my own with my new baby. Staff asked me no questions to understand why I was alone.

I lost my son to the local authority soon after this traumatic birth. I was diagnosed with postnatal depression with four of the children and with the fifth I was diagnosed with OCD, PTSD, emotional unstable personality disorder and depression. I was put on a lot of medication and my weight went up by five stone. I don't think I had postnatal depression.

I think I was misdiagnosed because the questionnaires aren't designed for trauma patients. I can see that I have never had this, as I know now it was the symptoms of PTSD and trauma.

I was getting a lot of flashbacks from my past throughout the pregnancy and labour and no-one asked me if I needed anything doing differently."

Mother with experience of trauma and poor mental health

It is important that all staff working with women in the perinatal period recognise the prevalence of trauma and understand how this may impact on individuals. It may be helpful to reflect, in peer groups, supervision or reflective practice, on the challenges these women face. For example, balancing positive emotions linked to pregnancy and birth with the negative memories of previous traumatic events. Women may present a range of behaviours as they manage these conflicting emotions.

Women might experience a range of emotions which they may or may not wish to share with their partner, family or those involved in their care. Staff working with perinatal women can support all individuals, whether they choose to disclose or not, by showing compassion and acknowledging that a history of trauma may be impacting on the person's experience of pregnancy, birth and parenthood. The act of 'acknowledging' or 'validating' someone's painful experiences can be healing and may help to foster positive therapeutic relationships.

LARA-VP Manual – supporting enquiries about domestic violence and abuse

King's College London (2019) Linking Abuse and Recovery through Advocacy for Victims and Perpetrators (LARA-VP) manual

Trying to understand how the person is feeling and reflecting what you hear back can really help them feel seen and understood. For example, by saying 'it sounds like you are really worried, that makes sense to me'. Staff may benefit from additional training or support on how to sensitively conduct routine enquiries so they feel confident and competent to respond compassionately and with appropriate follow up information.

If staff assume that everyone could have a history of trauma or maltreatment, this will help them recognise its potential impact and show kindness and compassion. Following disclosures of abuse or assault (sexual, physical, emotional or any other) it is important that staff:

- demonstrate belief in the individual
- assess their immediate safety
- follow appropriate safeguarding and incident reporting procedures, in accordance with national policy and local multiagency safeguarding processes, if required

This ensures women consistently feel supported at every stage of their care following a disclosure of abuse or assault.

It is important that organisations acknowledge the support needed for staff to deliver a trauma-informed approach. Staff may be traumatised by hearing disclosures or witnessing traumatic events as part of their role. Staff may also have had their own personal traumatic experiences. This can make listening to disclosures even more difficult. Services are to recognise and understand the impact this can have on staff and provide information on the support available to staff so they know how to access it if needed.

Please refer to the "Practical tips" at the end of this document for some example practice tips to further support implementation of this principle.

Case Study:

Responding to disclosures of previous or current trauma

In the Tees Esk and Wear Valleys NHS Foundation Trust, Angela Kennedy and the team have developed a clinical link pathway to facilitate services becoming more trauma-informed in the way they deliver care. Their trauma-informed care project aims to improve service users' experiences and outcomes. This includes supporting staff to contextualise trauma and have open and genuine conversations about trauma and the symptoms experienced.

The 8 "A's" can facilitate a supportive response to disclosure or signs that a woman might be experiencing post-traumatic symptoms:

ASK	Ask about the abuse history, how it affects them generally and what they need from you. Follow up on this at subsequent appointments.
ACKNOWLEDGE	Acknowledge the long-term effects of trauma, that they are not alone and that you and/or others can help.
ASSESS	Assess continually for risk of associated problems critical to perinatal outcomes, e.g. substance use, current abuse, high-risk sexual practices, disordered eating, self-harm, perinatal mood and attachment disorders and lack of infant safety.
ASSUME	Assume, in the absence of disclosure but in the presence of PTSD reactions, that the client could be a survivor. Respond therapeutically but without forcing the issue.
AVOID	Avoid triggering PTSD reactions by learning triggers and increasing awareness of aspects of care that are generally triggering, e.g. pelvic exams, being touched without permission, feeling out of control.
ARRANGE	Arrange the care they need, such as more frequent and extensive contacts, and be ready to arrange connections to additional community based or targeted programmes.
ADVOCATE	Advocate for appropriate programmes to meet the individual's trauma-related needs and consider engaging mental health professionals.
ASCERTAIN	Ascertain by follow-up and evaluation of practice whether trauma-related outcomes are being met in line with perinatal goals.

Adapted from Seng et al., 2002 [22]

In addition to the steps above, it is essential that organisational safeguarding policies and processes are followed where there may be current risk to a baby, child or dependent adult.

Principle 2: Communication and collaboration

"Being told to 'stop being silly' and 'calm down' is completely useless and makes us feel worse. Staff need to employ effective techniques with more sensitivity and kindness"

Mother with experience of trauma

Engaging in positive relationships with families is a fundamental component of any type of care, with effective communication at the very heart of developing attuned relationships. Positive relationships are built on trust, respect and collaboration. This will help individuals understand their options and make informed decisions about their care. It is important to take steps to ensure communication and collaboration work equally well for all individuals, such as those with learning disabilities or for whom English is not their first language. Consider how you communicate verbally and in writing. Be attentive, non-judgemental, use language that is sensitive to trauma and avoid use of jargon.

"Everything happened so fast. I didn't have time to process it and ask questions. I felt really broken afterwards and I felt like no-one had the time to listen to me. I wonder if someone had just sat down and explained things, how things may have been better. It could have been while they happened or even afterwards. It would have made a big difference to the first few months of motherhood."

Mother with experience of previous birth trauma

It is important women feel empowered to collaborate with healthcare professionals and make informed choices about their care. To do this, women need to understand their rights, the choices available to them and the risks and benefits of all options. Often the impact of trauma can be experienced through a sense of powerlessness. When traumatic incidents occur, they often involve the survivor being in a situation they are unable to control and where they come to harm. Other experiences of not being in control can therefore trigger the traumatic event and cause further pain and distress for the survivor. It is important that healthcare professionals acknowledge they are in a position of power with regard to the people they treat, reflect on this and think about how they could minimise the impact on the individual.

For example, ensuring a person understands the pathway of their care, the support available and the decisions they can make, will help them feel in control of their care. For trauma survivors, it is particularly important the person feels in control of physical contact with healthcare professionals. Staff should ask the person before they lay hands on them, explain what they are about to do and ask the person if they are ready and okay, aiming to avoid a rushed, insensitive, service-centred approach and ensure a thoughtful, sensitive, woman-focussed approach.

Birthrights

Birthrights provide information and advice relevant to women, doctors and midwives on rights and consent in maternity care. This includes:

- consent and/right to decline interventions and examinations, including where risks and benefits of interventions change.
- consent in emergency situations, including pre-authorising consent in the event of loss or/lack of capacity

Studies indicate that traumatic birth experiences could be reduced or minimised through better communication between healthcare professionals and women/partners. This includes providing clear explanations of interventions and the likelihood of possible outcomes. Poor communication can contribute to women feeling a loss of control and removed from decision-making about their bodies. There are clear benefits to staff discussing all care options available to women and partners in advance. For example, it can help them understand their care and birth preferences and allow them to develop advance decisions in case of a care emergency or the loss of capacity.

Services and providers should also consider how best to collaborate with individuals with different experiences of trauma to co-design the service so that it sensitively and appropriately meets their needs (see page 33).

Please refer to the “Practical tips” at the end of this document for some example practice tips to further support implementation of this principle.

Principle 3: Consistency and continuity

"The different departments treating me didn't acknowledge my mental health difficulties and none of them contacted each other about my needs."

Mother with experience of trauma and poor mental health

Consistently compassionate and attuned interactions with ALL staff can promote feelings of safety and security, which is critical for the recovery of those who have experienced trauma. All staff can play a role in this, including non-clinical roles. For example, reception staff may be the first point of contact and can assist by making individuals feel comfortable and welcome. Providers and commissioners would benefit from considering how to support all professions involved in the care of women and experience of and experience of services in the perinatal period (such as midwives, obstetricians, health visitors and mental health professionals) to consistently recognise and respond to trauma experiences.

It is important that staff working with women in the perinatal period are aware of how to refer or signpost to other relevant health and social care services that an individual may need or want. This may include where to access trauma-focused interventions that aim to support individuals to understand and process traumatic memories. Key links to other services may include: Sexual Abuse and Assault Referral Centres; Improving Access to Psychological Therapies (IAPT); specialist perinatal mental health services; Maternal Mental Health Services; domestic violence services; and social, practical and peer support through the third sector (see box). Commissioners and providers may wish to consider how to facilitate those with experience of trauma to access onward services so that they consistently feel supported through each stage of their care. For example, through the provision of peer support, which could be provided by collaborative relationships with third sector organisations.

Consider sharing information and best practice between staff and services across the pathway, for example, between maternity services and specialist PMH services. This will ensure that care is coordinated and consistent in line with service user needs and and choices.

THIRD SECTOR GROUPS

There are many organisations that offer support to women and families in the perinatal period who have experience of prior or pregnancy related trauma. Some examples are included below. Providers/commissioners will want to also consider third sector groups relevant to their local population:

Birth Companions: Supports perinatal women who are in prison or experiencing immigration issues, homelessness, financial difficulties, mental ill-health, involvement with social services or a history of domestic violence or sexual abuse.

Birth Trauma Association: Supports women who suffer birth trauma.

Make Birth Better: Provides resources for parents and healthcare professionals to support those with experience of birth trauma.

The Survivors Trust: Provides support for anyone who has experienced sexual abuse or violence, including an online resource for women who have experienced childhood sexual abuse (CSA) to prepare for pregnancy, birth and parenthood.

Tommy's: Provides support before, during and after pregnancy, including after loss. The website has information on pregnancy planning for those with serious mental illness or experience of previous loss or trauma.

Women's Aid: Supports those experiencing domestic violence and abuse through forums, text and other resources.

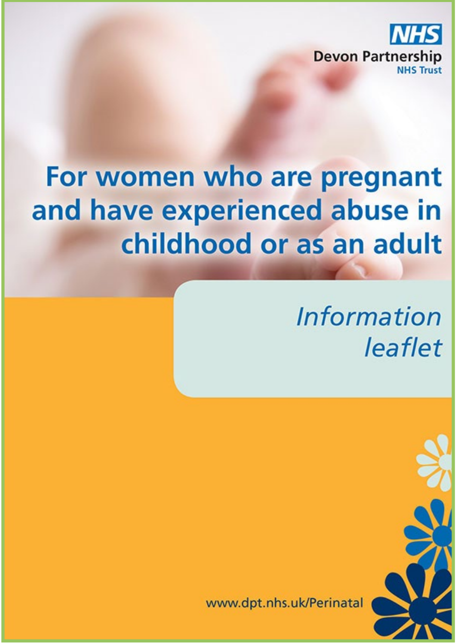
Case Study:

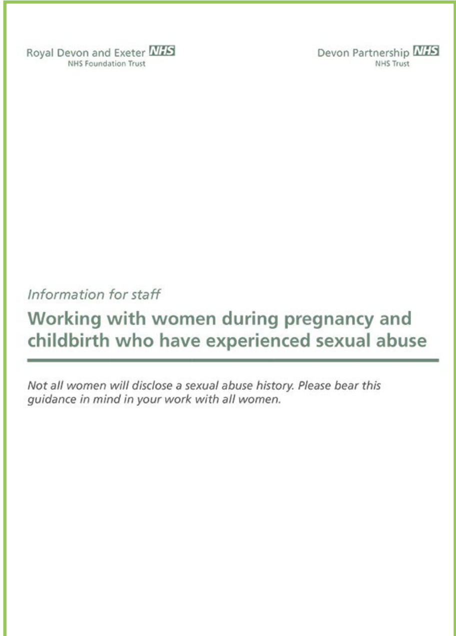
Developing pathways of consistent support for women with trauma history

Devon Partnership NHS Trust's perinatal mental health pathway provides community-based mental health support for women during the perinatal period in children's centres and antenatal clinics. They have worked to strengthen working relationships between teams, which helps women be seen for both their physical and mental health.

They have developed the Sexual Abuse Care Pathway for Women in Pregnancy. This offers routine enquiry to all women about past or current abuse at their first booking with the community midwife. If there is a disclosure, staff complete the 'Prediction and Detection tool' and, with consent, they refer to the Perinatal Mental Health Team where the mother is triaged and offered an 'opt in' letter. From there, a range of referrals can take place, depending on the level of need. For example, women can be placed on the PMH care pathway or referred to the Obstetric Clinic where they can discuss delivery choices and options.

Additionally, they have developed two information leaflets. One supports expectant women who have experienced abuse in childhood, as a teenager or adult. The other is for staff working with women during pregnancy and childbirth who have experienced sexual abuse. Such tools can encourage meaningful conversation.





In Better Births and the NHS Long Term Plan, the NHS set out the ambition to increase access to continuity of carer by 2021. This means individuals are to receive care from the same midwife or small team of 4-8 midwives, with a linked obstetrician, during pregnancy, birth and the early postnatal period. Evidence suggests that women who receive midwife-led continuity of carer experience less intervention and are more satisfied with their care compared with those who receive other models of care [2]. Women report that they are more likely to disclose prior trauma to healthcare professionals who have consistently been involved in their care. Furthermore, those healthcare professionals are better placed to notice changes in mental health that arise in the perinatal period that may warrant or benefit from intervention. It is thought that continuity of carer may assist in reducing retraumatisation by minimising the need to retell experiences of trauma at follow up appointments.

Applying the principles of trauma-informed care for fathers and partners is crucial to ensuring that care feels safe and dependable to all.

> *"Staff didn't let me be involved…I felt ignored by all staff and unimportant and completely useless and like a secondary concern from day one…No-one even tried to include me".*

Partner present at birth

Case Study:

Continuity of carer for women with mental health difficulties. Magnolia Midwives, North Middlesex Hospital

The team of eight midwives, led by a perinatal mental health consultant midwife, facilitate provision of antenatal and postnatal continuity, from booking through to 28 days postnatally. They provide full continuity of carer (ie antenatal, during labour and birth and postnatally) for women with pre-existing moderate to severe or complex mental health issues, including those with fear of birth or experience of birth trauma. This includes:

- providing antenatal care and education that supports and empowers women to make informed choices about their care
- offering flexibility in the time and place of appointments to suit women' needs, ensuring each mother has time to discuss her needs at booking and at every appointment - this approach establishes a professional relationship of trust and mutual respect
- meetings with the consultant midwife to co-create collaborative, individualised labour and birth plans, ensuring the maternal choice is respected and heard
- attending joint weekly perinatal mental health multi-disciplinary team (MDT) clinics
- developing perinatal mental health pathways to facilitate comprehensive advice, support and referral routes for healthcare professionals.

This approach has increased attendance and improved communication and care for women with perinatal mental health needs.

The midwives have also developed postnatal support networks for women following discharge from maternity services. These help women, particularly those with mental health needs or experiences of trauma, who face social isolation. The midwives have established strong links with organisations in the local area, hosting weekly mindfulness sessions, arts and crafts in a local café and setting up social media groups to create ongoing peer support for women.

The emotional demands on midwives hearing mother's stories, often of abuse, rape, domestic violence, suicide attempts, torture and trafficking, can be overwhelming and could result in burnout. MDT working, and weekly clinical supervision ensures shared responsibility for these women and provides the midwives with professional support, enabling them to resolve complex issues as a team.

Please refer to the "Practical tips" at the end of this document for some example practice tips to further support implementation of this principle.

Principle 4: Recognising diversity and facilitating recovery

Following a very traumatic first birth experience with complications both during the birth and for months afterwards, I accessed support to cope with the PTSD I experienced. I then became pregnant a second time and as the birth approached I knew I needed some additional support, help and guidance so I contacted a local doula. Due to coronavirus, we had a series of 90 minute video call sessions which was just what I needed. The sessions gave me the confidence and knowledge to get through all the steps I needed to take in the remaining weeks of my pregnancy and birth and early moments/hours/days to feel OK. With my second birth experience, I achieved an extremely different birthing experience to last time. It cannot be compared to my first birth as I don't feel it is right to compare, but this birth has given me a huge sense of achievement, pride, and joy. It was hard going at times and there were moments where I don't quite know how I got through it, but I did.... I did it! The team I had looking after me were amazing, so caring and so kind and understanding. The experience was odd, but very loving - I couldn't have asked for better.

Mother with experience of previous birth trauma

Trauma-informed care involves recognising that individuals are shaped by their experiences and everyone will be unique in their understanding of and responses to trauma in their lives. Remaining curious, attuned and attentive to an individual's verbal and non-verbal cues, checking in and checking understanding to each individual so that care is responsive to their needs is key to supporting recovery. For example, working to understand what is and is not helpful will help them feel empowered and in control of their care.

It is important to recognise diversity and how cultural, historical and gender issues may impact on people's lives. BAME groups have poorer outcomes and experiences of maternity and mental health care. More can be done to recognise people's needs. Remaining curious and asking people about what is right for them will foster a sense of safety, trust and understanding. This can help identify those with vulnerabilities earlier on in their pregnancy journey and reduce barriers to access and fears of service attendance. It is helpful for commissioners and providers to engage with local community groups to understand cultural barriers that may prevent access to care and treatment. Together they can develop solutions to combat these barriers. To develop cultural sensitivity, staff should critically reflect on their beliefs and any conscious or unconscious biases or stereotypes they might unintentionally hold. Challenging one's own assumptions of people and their behaviours is central to a trauma-informed approach.

Commissioners and providers should consider how they can best meet the needs of individuals, such as those whose immigration status is uncertain, who have English as a second language, have a learning disability or are accompanied by a carer. Consider how this may present challenges for that individual to disclose or discuss trauma or talk about how their care would be best tailored to meet their needs.

With the right support, built on kindness, compassion and empathy, pregnancy and birth can present opportunities that may contribute to the healing process. Women can achieve this by identifying triggers and feelings associated with previous trauma and engaging in positive relationships with staff that support adaptation to the labour and birth experience. This approach can enable 'post-traumatic growth', which is the positive change achieved by responding to or making sense of previous trauma. This enables individuals to feel stronger, empowered and in control of their experiences.

Please refer to the "Practical tips" at the end of this document for some example practice tips to further support implementation of this principle.

Chapter 3:

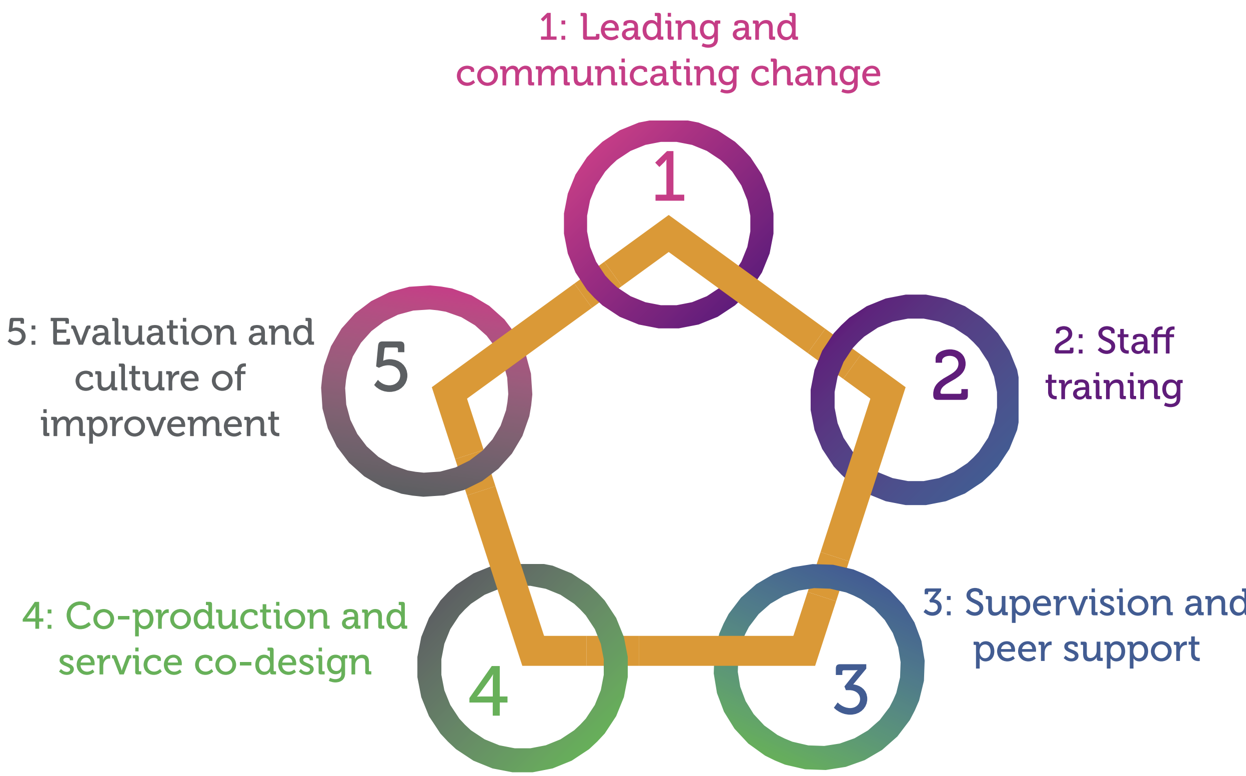
BECOMING A TRAUMA-INFORMED SYSTEM

Chapter 3: Becoming a trauma-informed system

Creating a trauma-informed healthcare system will require a change in culture and practice at multiple levels. This includes support and understanding from Sustainability and transformation partnerships/integrated care systems, local maternity systems, networks, commissioners and providers.

To support implementation, it is helpful to reflect on how principles of trauma-informed care can have many positive outcomes for service users, staff and and healthcare systems. For example, adopting the principles of trauma-informed care outlined in this document may lead to more women and their partners feeling that their emotional wellbeing was supported earlier and more consistently. It is hoped this could contribute to fewer women experiencing their birth as traumatic and reduced escalation or exacerbation of mental ill health.

Here we describe five activities that organisations should consider to facilitate effective implementation of the previously described principles and become a truly trauma-informed organisation.



"As staff, we need to be provided with protected time to access support for ourselves..."

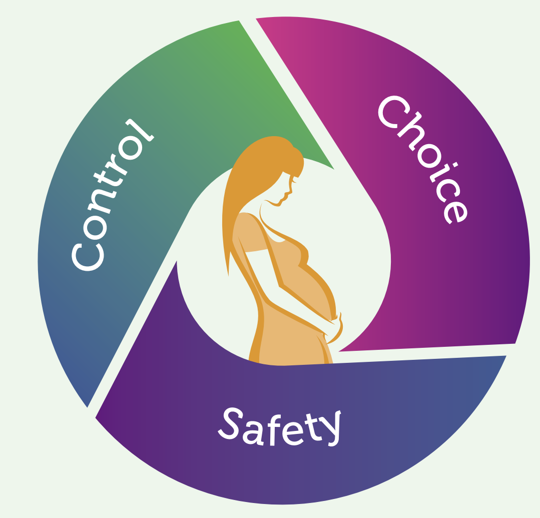
Midwife

1. Leading and communicating change

Leadership and management involvement is vital for supporting staff to embed these trauma-informed principles.

Leaders can make delivering trauma-informed care a priority by:

- making commitments to become an organisation which is aware of the impact trauma can have on service users and staff
- integrating trauma-informed care into the organisation's culture, policies and practices
- communicating clearly the change that they want to see and why
- appointing trauma champions within each service to ensure the approach remains high on the agenda and is prioritised at every level
- employing experts by experience to review policies and procedures, training materials and communications strategies
- healthcare services working with perinatal women can support staff by:
    - providing training on how to deliver trauma-informed care (such as on how to enquire and respond to disclosures)
    - facilitating peer supervision (The A-EQUIP model for midwives and maternity teams in England provides opportunity for restorative clinical supervision, provided by trained PMAs (professional midwifery advocates)
    - supporting time for staff support and reflective practice



Leaders, including commissioners, providers and staff in networks and local maternity systems, could present clear ways in which trauma currently impacts their population or service. They could show how implementation of a trauma-informed approach could improve outcomes for women and families and benefit staff. Trauma-informed approaches could be embedded in strategic plans, local care pathways, service specifications, or commissioning arrangements.

"It's the little things that sometimes make the biggest difference."

Mother with experience of trauma

2. Staff training

Reports of care experiences from women and partners gathered through this work indicate varying levels of staff competence and confidence in understanding and responding to trauma. Some staff, particularly those in physical care settings, may not have received consistent training to help them recognise and understand trauma in themselves and others, and may benefit from training on how to best deliver trauma-informed care [17]. This guide aims to provide a framework for staff and commissioners to be more responsive to trauma. Additional support for provision of staff learning programmes may form part of commissioning or service plans.

To facilitate development of a workforce that feels confident and competent at delivering trauma-informed care, services could consider:

- how to ensure the content will enable the needs of those accessing a service to be met, as well as those providing care within it, which can be achieved through co-production of training module content and format (see page 33)
- including training as a part of routine induction and ongoing development, and enabling managers to see details of attendance and participation
- making training suitable for staff at all levels
- enabling staff and managers to express their own training/learning gaps and needs
- developing a sustainability plan for training

The content of training may include:

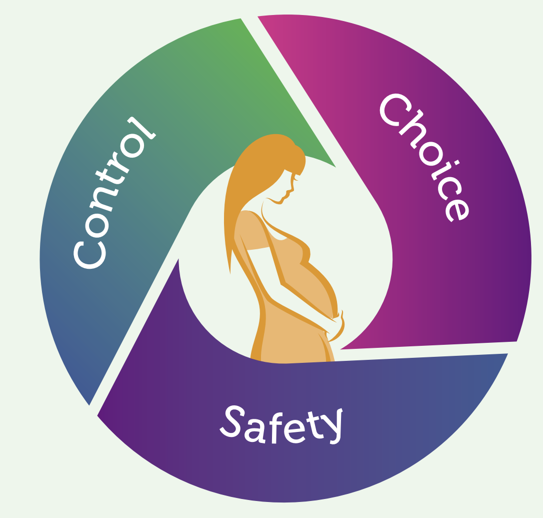
- how to greet people in a welcoming manner to help foster feelings of safety and acceptance
- how to conduct routine enquiries about abuse
- how to initiate and maintain positive person-practitioner relationships that empower individuals to make informed decisions about their care
- the range of trauma-focused interventions that are available and how to access these
- follow-up activities to assess whether information has been understood and to gather feedback on whether an educational approach or content could be improved

Clinical, non-clinical, frontline and strategic staff would benefit from receiving training on how to communicate with sensitivity. This should acknowledge that an individual's reaction to a situation or environment could relate to their feelings of safety or security and previous experiences [1, 23].

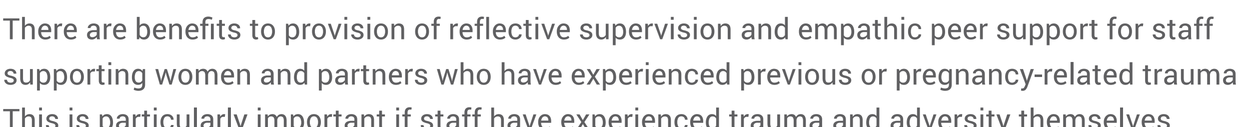
Educators in the field of improving trauma-informed care should be especially aware of their need to ensure all attendees are safe and supported. Training on psychological trauma could cause some staff to be reminded of their own life experiences. It is important that organisations remain aware of this, delivering training in a compassionate and empathetic way. It is vital during this type of learning experience to:

- discuss responses to trauma in a non-judgemental way
- offer plenty of comfort breaks between sessions
- remind staff to be kind to themselves and each other
- provide information on how to access support if desired or needed, for example, this could include workplace counselling or employee assistance programmes
- pay specific reference to these issues in the development of workforce 'Wellbeing Action Plans'

Encourage staff to share good practice examples and celebrate where things have really worked. Also reflect on where things could have been done better. Doing this routinely in team meetings, supervision and mandatory training days can ensure that women and partners receive consistency between services and staff.



A multi-modal training offer could be useful. This could include online, face-to-face and simulation training of how to respond to disclosures sensitively, together with written resources that can be accessed at any time. Learning should be appropriate for the role, service or team and allow opportunities for practice and reflection. This will ensure the learning is embedded within routine care delivery, particularly when the learning was originally accessed virtually.



> "We need more working together between teams... but we need time to spend with the individual to understand their needs."
>
> Psychologist

3. Supervision and peer support

There are benefits to provision of reflective supervision and empathic peer support for staff supporting women and partners who have experienced previous or pregnancy-related trauma. This is particularly important if staff have experienced trauma and adversity themselves.

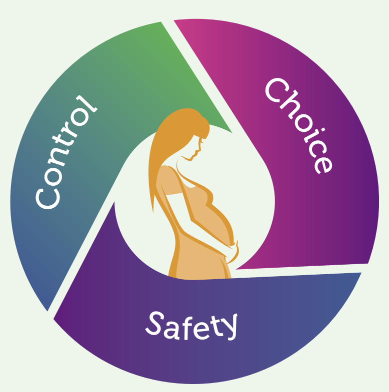
Clinicians may experience vicarious trauma following distressing events where an individual's life was at risk or lost. It is also possible for staff to experience secondary traumatic stress just through listening to details of the trauma that the women and the families they are caring for have experienced, or witnessing their distress at re-experiencing traumatic symptoms in the course of care. Over time, the weight of carrying the burdens of others can lead to compassion fatigue and eventual burnout. This is not a failing on the part of staff, but a logical progression when support is not adequate or readily available. It is important that all feel supported in the workplace, regardless of their role.

Supervisors are to understand the real risk and impact of vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout and work with staff to recognise early signs and develop support strategies. In particular, it is important to ensure that peer support workers or peer navigators receive adequate support to fulfil their roles as they may not currently have supervision structures in place.

To support all staff, including students and trainees, to feel supported to deliver trauma-informed care, services should consider:

- providing protected time to regularly access to appropriate supervision that does not reinforce or deepen traumatic feelings
- normalizing reactions that any staff across service sectors might have in reaction to trauma, including vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout
- holding informal debriefings among peers following particularly challenging cases, situations or events
- enabling time and space to learn and reflect together and build a network of peer support.

A strengths-based approach to supervision and team meetings may be particularly beneficial. A good practice example of supportive supervision structures is the deployment of the Professional Midwifery Advocate (PMA). In England, the PMA provides a safe space for midwives and maternity staff to receive clinical restorative supervision.



Prioritise dedicated time for listening and responding to staff needs, appropriate supervision and peer support. Such activities facilitate staff to manage the impact of working with individuals with prior and pregnancy-related trauma.

Burnout
The cumulative psychological strain of working with a range of stressors. You can feel physical and emotional exhaustion.

The cumulative effects from working with people who have experienced trauma and is due to empathetic engagement.

Compassion stress
The stress of helping or wanting to help people who have experienced trauma. This can be a natural outcome for anyone.

Secondary traumatic stress
This can be the clinical or sub-clinical signs and symptoms of professionals experiences of PTSD or similar difficulties.

4. Co-production of services

To ensure services are truly trauma-informed, it is critical that individuals with experience of trauma are an integral part of co-producing services.

This includes:

- how services are commissioned and designed
- how staff gain the appropriate skills, knowledge and abilities to support people effectively.

Maternity Voices Partnerships (MVPs) are established or being established across every provider as part of the Better Births maternity transformation programme.

When inviting someone with lived experience of trauma to be involved in an event or co-production exercise:

- **Be clear what you are asking of them in advance - no one should need to retell a traumatic experience. The focus of engagement should be on aspects of care delivery that they think should change.**
- **Be clear on what your support offer is to them:**
  - **suggest a call in advance with information on the ask and an opportunity to ask questions**
  - **advise they are welcome to bring a partner/family member, a third sector group, or someone involved in their care - anyone they trust**
  - **a named contact available on the day**
  - **follow up call after to debrief**

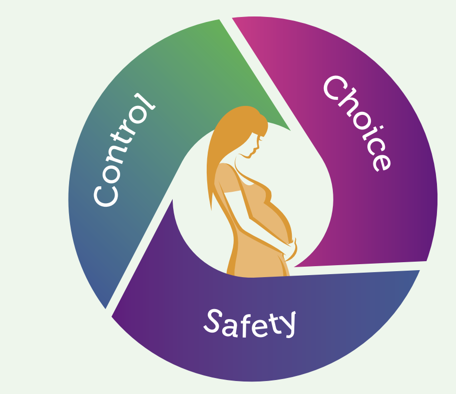
These local NHS working groups bring together women and their families, staff and commissioners to co-review and co-produce local services. You can find out about your local MVP via National Maternity Voices. It is important that service users involved MVPs and co-production is representative of local communities. This will ensure that any changes implemented are accessible and meaningful for the very people they are designed to support. One example of MVPs undertaking co-production in terms of the experience of accessing a maternity setting is using the 15 Steps for Maternity toolkit, which invites women and their families to assess the 'feel' of a maternity setting, and one aspect is how safe the setting 'feels'.

Commissioners and providers can involve experts by experience in working groups to:

- agree priorities and practicalities for service development
- meaningfully co-produce products, such as staff training on delivering trauma-informed care and information materials on trauma and its impact
- participate in staff training and evaluation of service delivery
- hold systems to account to drive change forward.

It is important that the contributions of experts by experience are acknowledged and valued, and funding considered in line with policies for engagement. The NHS England and NHS Improvement policies around resourcing user involvement can be found here.

Models of collaboration or commissioning of VCSE and community organisations that are already established or embedded within local communities are likely to be extremely valuable in facilitating connections with relevant lived experience representatives that may otherwise be 'seldom heard'. In addition, such VCSE and community groups may be able to offer support to those keen to engage, such as through joint attendance at events – such peer support may provide confidence and reassurance to lived experience representatives to feel psychologically safe attending and contributing. Maternity Voices Partnerships provide examples of engaging meaningfully with service users, public and staff about their experiences or services with a view to making changes to service delivery and design. Find out how to do co-production via NHS England and NHS Improvement.

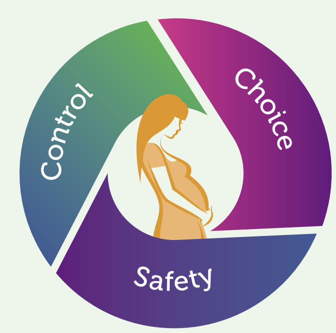


It can be helpful for providers and commissioners to consider how the pathway of services is experienced by those with prior and pregnancy-related trauma. Staff could 'walk through' a survivor's experience of getting an appointment, parking, following signage, signing in at reception, sitting in the waiting area and finding the bathroom.

5. Evaluation and culture of improvement

Services and commissioners should consider what data they can collect and monitor to evaluate whether the care provided is truly trauma-informed and is improving experiences and outcomes for women and families. This could include, but is not limited to:

- monitoring changes in service user experiences of care following staff training to implement trauma-informed principles of care
- monitoring rates of disclosures, including prior or current physical, sexual or emotional abuse, to indicate whether individuals feel safe to disclose should they wish to
- evaluating the implementation of trauma-informed approaches by staff.

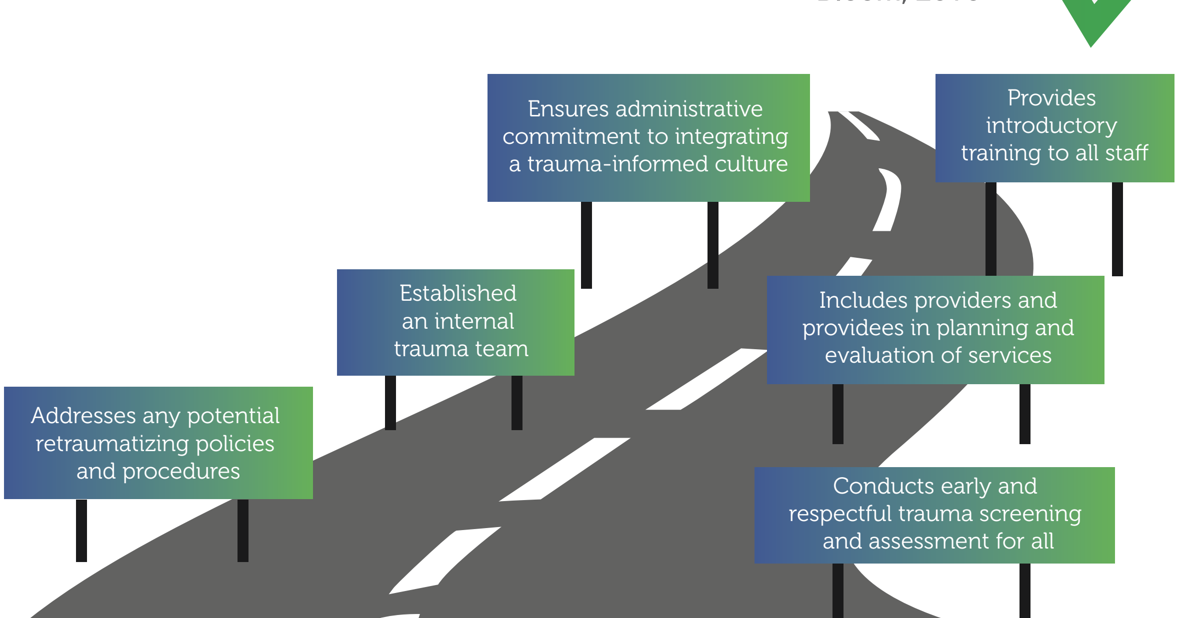


Commissioners and providers could consider how to learn from implementing trauma-informed principles. This will enable them to continue improving service design and delivery. Engaging with lived experience and third sector groups as part of the evaluation process would help with this.

The Road to Trauma-Informed Care

Trauma-Informed Care calls for a change in organizational culture, where an emphasis is placed on understanding, respecting and appropriately responding to the effects of trauma at all levels.

Bloom, 2010



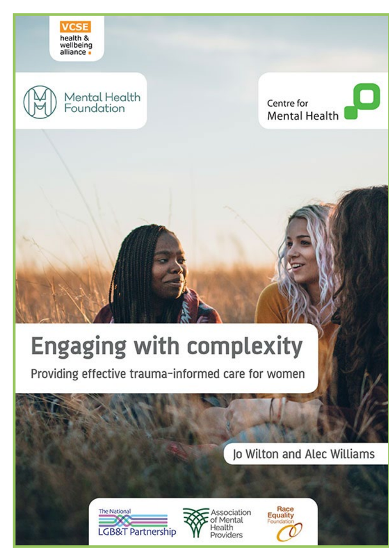
Graphic adapted from Graphic by the Institute on Trauma and Trauma-Informed Care (2015)

Fallot & Harris 2001

Relevant resources

There are a growing number of resources that provide information about trauma-informed care and the impact of trauma. These may be useful for staff training and sharing with families.

Engaging with Complexity. Providing Effective Trauma-Informed Care for Women Centre for Mental Health and Mental Health Foundation (2019). Information for public sector providers and commissioners on providing effective trauma-informed care for women.



A sense of safety. Trauma-Informed approaches for women Agenda Alliance for Women and Girls at Risk and Centre for Mental Health (2020). Considers barriers to implementing trauma-informed approaches across the health and care context.

A Case for TIC: A Complex Adaptive Systems Enquiry for Trauma Informed Care Thirkle, Kennedy & Sice (2018).

Trauma-Informed Organizational Change Manual Institute on Trauma and Trauma-Informed Care (2019).

Trauma-informed Care and Practice Organisational Toolkit. The Mental Health Coordinating Council (MHCC), Australia (2018).

The Alberta Family Wellness Initiative Brain Story Certificate Free, accredited online trauma training.

Women's Mental Health Taskforce Department of Health and Social Care and Agenda Alliance for Women and Girls at Risk (2018). Priorities for improving women's mental health and experiences of services, including principles of trauma-informed care.

Strategic Direction for Sexual Assault and Abuse Services NHS England (2018). Outlines six priorities for the health and care system for improving the response and support available to those who experience recent or historic sexual abuse and assault.

Restraint in Mental Health Services What the Guidance Says Mind (2015). Outlines how to prevent retraumatisation through care by limiting use of restrictive practices in mental health services. Staff may use restrictive practices 'to prevent, restrict or subdue a person's movement' to prevent harm to the individual or others and/or give treatment. The experience can be retraumatising for individuals, for example by returning memories of being physically restrained, and is thought to hinder recovery. A trauma-informed approach identifies and understands the triggers of distressed behaviour and avoids the use of restrictive practices in mental health services.

Conclusion

This guide provides a framework for staff on how to implement trauma-informed care in the perinatal period, focusing on a distilled set of four principles: compassion and recognition; communication and collaboration; consistency and continuity; and recognising diversity and facilitating recovery.

This is supplemented by five considerations for healthcare systems designed to embed safe and supportive delivery of trauma-informed care: leading and communicating change; staff training; supervision and peer support; co-production and service co-design; and evaluation and culture of improvement.

Trauma-informed and culturally responsive care can be of great benefit to the many women, fathers and partners in the perinatal period who have experienced trauma and adversity. A new pregnancy brings opportunities for growth and change and offering trauma-informed services allows staff to be in a position to truly change lives.

Trauma-informed care is also important for staff. Many are trauma survivors who could be at greater risk of further trauma, stress and feeling burnt out. They deserve to be treated compassionately by leadership teams and peers, and provided with opportunities for self development. They need supportive relationships through supervision and peer support. They should have an integral role where collaborations with parents, leaders and other staff can help direct the systems in which they work towards enhancing care to be trauma-informed and culturally-responsive.

Full list of acknowledgements

We would like to thank each and every parent who took part in our workshops around England for their time sharing personal stories and recommendations for change within services and for being champions of the work. This work could not have happened without your input.

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We would like to give a special thank you to 'Birth Companions' and the 'Freedom Project' for their time and effort engaging women with our workshops and for supporting them to attend and have a voice. You made such a difference.

A number of NHS staff with a range of roles shared their valuable insights. Thank you for sharing so much with us, your knowledge and experience will allow us to move forward with this work. We would like to acknowledge the 458 staff members who took part in our survey; we were absolutely blown away by your responses. Thank you to the staff who took part in our workshops and chose to receive a special thank you – Dr Catherine Green, Sarah Stephen-Smith, Kerrie Roberts, Salena Holmes, Rebecca Hatcher, Denise Marshall, Marie Smith, Dr Miriam Inder, Melanie Farman, Kate Chivers, Lynne Mackinnon, Dr Kyla Vaillancourt, Schelley Lowe, Dee McGregor, Salena Holmes, James Boyes, Zoe Tate, Leanne Haley–Holt, Sarah Buck, Dr Rina Gupta, Sara Szydlowski, Georgia Dray and Helen Hicks.

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A wealth of work went into undertaking a thorough review of the literature that underpinned much of this work and gathering information in workshops with parents and staff. We would like to thank Jane Scott for the numerous drafts and managing our comments so well! Thank you for the hard work and effort that went into the review.

Finally, we would like to acknowledge the work of Marie Sola, the project co-ordinator for all "trauma" work at the Centre for Early Child Development in Blackpool. Thank you for the time and effort you put into organising the workshops. Your input was invaluable.

Planning and implementation tips for principles of trauma-informed care in the perinatal period

DOMAINS	Recognition and compassion	Communication and collaboration	Consistency and continuity	Recognising diversity and facilitating recovery
Care environment	Consider the environment where care is accessed and whether you are facilitating opportunities for disclosures by providing appropriate time and privacy to have conversations about experiences that are of a traumatic nature (this includes considering the presence of partners, carers, interpreters, or other family members in the room)	When inviting someone for an appointment which will involve physical examination, provide communication that explains what the examination may entail, acknowledges some may find appointments of this nature difficult, and offers the choice of female staff, bringing support, and invites the person to contact the team to discuss any issues so they can agree a plan together. During appointments, consider the physical environment of any procedures (e.g. vaginal examinations) and remain curious and responsive to any actions that could be made to support someone feel more comfortable (e.g. change in lighting) Provision of emergency or crisis care can be incredibly anxiety provoking and could be re-triggering for someone who has experienced trauma. It could be useful to have a staff member allocated to communicate with the person and their partner/family to ensure that they understand what is happening and why, and make sure that the environment feels as safe as possible.	All staff throughout the maternity and perinatal pathway can play a role in supporting women and families to feel safe in the care environment. At your each contact, pay attention to the surrounding environment. For example: - Sonographers could talk through the process (e.g., touch, lifting of clothing, application of cold gel on the stomach) prior to beginning the scan. - Midwives/Obstetricians could describe what they are going to do before beginning and ask if that makes sense or if there is anything that they could do differently to make the person feel more comfortable. - Non-clinical staff (e.g., receptionists, catering staff, cleaners and health care assistants) could be offered training to ensure they have the skills to welcome, reassure and provide information to women who may be anxious, fearful or distressed.	Commissioners and providers should consider the steps that are needed to overcome practical challenges, such as language or literacy problems (access to interpreters, different formats/ languages of information/ materials) to ensure all women are supported equally within services. What makes one person feel safe might not be the same for someone else. Remain curious to the role and impact of a range of factors that may impact how each individual experiences and responds to their care environment (religious or spiritual beliefs, mental health understanding or awareness, and different patterns of help-seeking behaviours).

Planning and implementation tips for principles of trauma-informed care in the perinatal period

DOMAINS	Recognition and compassion	Communication and collaboration	Consistency and continuity	Recognising diversity and facilitating recovery
Decision making	Provide all women with accessible information on prior and pregnancy-related trauma and how it might impact them in pregnancy, birth and becoming a parent, including what support is available to them. This could be in the form of an information leaflet, link to a web page or through digital media, such as an app. This could include: - What would be done with any information following a disclosure and why. - How women will be supported to develop a Personalised Care and Support Plan, which prepares for all eventualities of birth (e.g. including an emergency Caesarean birth). - Their right to deny consent to interventions.	Enable the women to feel empowered to be the decision-maker for their care throughout the perinatal period. Find out what matters most to them, offer real choices and provide information at a level they can understand on benefits, risks and alternatives. The **B.R.A.I.N** acronym may be helpful: **Benefits:** what are the benefits of making this decision? **Risks:** what are the risks involved? **Alternatives**: are there any alternatives to consider? **Intuition**: what does the persons gut say to do? **Nothing** – what if we do nothing? Develop advance decision documentation and gather informed consent in the case of loss of capacity.	It is important that throughout pregnancy and birth and each stage of care that mothers feel empowered to be the decision-maker. For example, if a mother is under the care of a specialist mental health team, it is important advanced decisions about their care are discussed and documented where consent is given in the case of loss of capacity. This may include their medication options – it may be helpful to offer women information on their treatment options (medication, psychological therapies) and time to consider their preferences.	Support all individuals to participate equally well in their care and consider what additional support may be needed for particular groups in order to achieve this. If a person has suggested or acknowledged that they require additional emotional support, such as in the form of a second birth partner or doula, it is good to affirm this and encourage the woman to organise this for herself.
Moving between care	At each stage of the pregnancy and birth pathway, it is important staff can recognise possible behavioural responses to trauma and act in a non-judgemental and compassionate way. There should be clear referral pathways for support relating to prior or pregnancy-related trauma and staff should be aware of these, and relevant voluntary or third sector organisations. **Commissioners and providers should consider how they can support development and commission for outcomes of trauma informed pathways.**	Following a disclosure, seek consent to sharing of this information in the service where it is to the benefit of the individuals care, but explain how the information will be used, and copy the individual in to correspondence. For example, if a referral has been made to mental health services for additional support. Ensure this information is only communicated in line with agreements made by the woman.	Providing an opportunity to be supported by the same staff (continuity of carer) throughout their journey supports people to build safe and trusting person-practitioner relationships. This can: - Increase the likelihood of disclosure - Reduce the need for people to re-tell their experiences to multiple clinicians, preventing retraumatisation - Support the identification of changes in mental health. If a woman is under the care of a secondary mental health team, their care should be coordinated between maternity and mental health services.	Consider individual differences in ability or willingness to engage with different parts of the health care system. For example, some groups may experience more barriers to engaging with mental health services than others. Commissioners and providers may want to consider how they can support all individuals to feel able to engage with services. Commissioners and providers could facilitate collaboration with local/third sector organisations relevant to the needs of their population and those with experiences of prior and pregnancy related trauma.

Planning and implementation tips for principles of trauma-informed care in the perinatal period

DOMAINS	Recognition and compassion	Communication and collaboration	Consistency and continuity	Recognising diversity and facilitating recovery
Personalised care	Demonstrate attentive listening and respond respectfully to disclosures; genuinely acknowledge what a person has disclosed and the impact it could have had. Further details of the trauma do not need to be gathered, unless the person chooses to share them. Ensure safeguarding procedures are followed where required. It is important not to be scripted in your conversation, but you could respond something like: *"I am sorry to hear about your experience. Thank you for sharing that with me. We will do our best to ensure that you feel safe and in control and we will support you to make decisions that are right for you*". It is important to adapt your care beyond handling disclosures.	Avoid being scripted in your conversation and be led by the needs of the person. Keep body language open and listen more than you speak. Ways to support empowered collaboration include: - Offer clear explanations and offer multiple opportunities for women to ask questions. - Encourage women to attach a copy of their birth plan, infant feeding plan and postnatal plan to either their digital or handheld maternity notes for easy access during labour and ensure these are read by staff. - When deviation from birth preferences is required, acknowledge this and help women to understand their options, working to incorporate as much as possible from their birth plan in the new situation. For example, if skin-to-skin contact with their baby is important, aim to facilitate this, even in theatre.	Consistent approaches from staff at each stage of care support feelings of trust and safety. At all stages of care in the maternity and perinatal pathway, acknowledge how prior and pregnancy- related trauma may impact on experiences of or responses to pregnancy, childbirth and parenthood. For example, for some who have experienced sexual abuse, they may feel nervous or fearful of touching or feeding their baby, because they may feel anxious about hurting or harming their baby. Allow people the space and time to talk about any challenges they might be facing in that care setting, acknowledging there could be new difficulties or triggers brought by each care scenario.	Personalised care, recognising diversity and facilitating recovery go hand in hand – ensuring care responds to what matters to each individual, and builds on strengths, has shown to improve outcomes. Staff should not make assumptions of what is right for an individual and work with women/ families to build a plan for care that is right for them. The NHS has a duty to ensure services promote equality and diversity, and staff may benefit from training to support cultural competence and recognition/ understanding of unconscious biases.
Considering needs of partners/ families	**Remain aware that partners/family members may have their own experiences of trauma that should be considered** (this could include partners' experiences of a traumatic birth). Inform partners/family members what support is available to them and ask them what they need - acknowledging partners may have their own experience of trauma and may also be affected by events related to the maternity experience.	Clear communication with the partner/family can support them to feel valued and integral; preventing partners from feeling invisible within services by showing such warmth and compassion, asking direct questions, having eye contact and using their name. A positive family or couple's relationship can be hugely important for post-traumatic growth; staff can foster this where appropriate.	Commissioners and providers should consider how to best support partners and the wider family across all services in the perinatal journey. The 'Supporting and involving partners and family members of those accessing specialist community perinatal mental health services' is a helpful resource on how services can consider how best to include all significant others in services.	Recognition of the diversity of family forms is needed. There are increasing numbers of same-sex partner, non-male non-birth parents, and non-female birth parents within services. This diversity should be recognised to ensure greater inclusion and signposting to services where necessary.

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