CONNECTED AND SAFE

Trauma Informed Practice toolkit for professionals working in Midwifery and Public Health Nursing

Changing childhoods.
Changing lives.

June 2024

Trauma Informed Partnership
Leicester, Leicestershire and Rutland

PEOPLE PROMOTE PROTECT PROVIDE PARTNERSHIP

Delivering good health and prevention services
Public Health in Leicestershire

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ACKNOWLEDGMENTS

Leicestershire Public Health commissioned Barnardo's to develop this toolkit for professionals working in Midwifery and Public Health Nursing services.

Leicestershire County Council is committed to working collaboratively across organisations and with communities to develop a trauma-informed system that simultaneously aims to prevent childhood trauma and mitigate its harmful impacts across the life course.

We want to acknowledge all the participants of the Focus Groups who dedicated their time to taking part in the group conversations and helping us review this guidance.
Thank you to: Jasmine Jelfs (Midwife); Chloe Ross (Health Visitor); Stacey Bryan (Health Visitor); Paula Weston (School Nurse); Gill Haines (Clinical Team Lead) and a few others.

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We would also like to acknowledge our colleagues at the Maternal Mental Health Team, who helped us develop the section on Birth Trauma.

We have met many people committed to Trauma Informed Practice, and keen to embed its principles within Midwifery and Public Health Nursing. We hope that some conversations will continue, and more people will join them.

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Trauma Informed Practitioner,
Barnardo's

HOW TO USE THIS TOOLKIT

This toolkit can be used by professionals working in health and social care with a particular focus on Midwifery and Public Health Nursing.

This toolkit does not intend to replace any existing regulatory or practice requirements. This toolkit can be used as a tool for reflective practice or individual progression. At the end of each section, we encourage you to reflect on, or write down, one thing that you already know or are already doing and one thing you will consider or do differently.

This toolkit includes definitions of adversity and trauma and looks at trauma within the perinatal period. Trauma is something that can happen to all of us. While reading this toolkit, if you find yourself feeling unsettled, uncomfortable, dysregulated, or as if you are back in the past when a difficult moment in your life happened, please be kind to yourself. Maybe put the toolkit down and chat with a colleague or friend, someone you trust. It is important that we are not left alone with our pain.

We have put together some grounding techniques that you might find helpful. We hope you find something to help you return to the present moment and feel safe and regulated. At the end of this guide, you will find a list of different services you can access if you need further support.

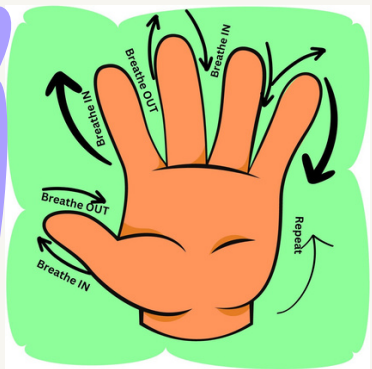
Look around and name
5 Things you can **see**
4 Things you can **feel**
3 Things you can **hear**
2 Things you can **smell**
1 Deep **breath**

Go for a **walk** outside and try to find a blue flower or a butterfly

Trace your pointer finger around your hand breathing **in** on the way **up** and **out on the way** down**, try to go slowly and do it as many times as you need**

Connect with others:
Smile or chat to a colleague;
talk to a friend;
reflect in supervision

Butterfly Hug
Cross your arm over your chest and put each hand on your upper arm and shoulder. Gently tap each arms, one side then the other. Eyes open or closed. Try to slow and lengthen your breath.



GLOSSARY

Allostatic Load – It refers to the cumulative physiological wear and tear caused by toxic stress and life events.

Attachment Trauma – Can occur when a child does not experience consistency in physical and emotional support from caregivers, or other nurturing experiences.

Burnout – Is a state of emotional, mental, and physical exhaustion caused by excessive or prolonged exposure to stress.

Community Trauma – Where the impact of an event or series of events has been felt across a community.

Compassion Fatigue – Often experienced in the context of caring professions, compassion fatigue can arise due to repeated exposure to suffering. It can lead to reduced empathy and feelings of desensitisation, numbness, and detachment.

Co-regulation - A process where individuals learn to recognise their emotions and regulate their arousal levels through interaction with nurturing and supportive caregivers. It involves providing a warm and calming presence, verbal acknowledgment of distress, modelling of behaviours that self soothe and the creation of an emotionally and physically safe environment.

Cultural Sensitivity – It involves recognising, accepting, and welcoming cultural differences. Refraining from judgment, culturally sensitive workers adopt a position of humility, acknowledging the limitations of their own knowledge and continually committing to learn from and understand diverse perspectives. This practice can result in a deeper understanding of cultural nuances and enhanced cross-cultural relationships and communication.

Developmental Trauma – Developmental trauma can occur when a child experience early exposure to repeated traumas (including in utero). Often experienced within the context of significant caregiving relationships, these experiences can lead to high activation of the stress response system. As a result, developmental trauma can impact all aspects of development, which may leave lasting effects across the life course.

Dissociation - A state where you may feel disconnected from yourself and your surroundings, often as a coping mechanism during times of stress or trauma. It can manifest in numerous ways, from everyday experiences (like getting absorbed in a book) to more prolonged and profound experiences.

GLOSSARY

Emotional Safety - The profound sense of being accepted for one's authentic self and emotions. It involves feeling secure in expressing true feelings and needs without fear of judgement or harms. It is a fundamental human need and a crucial foundation for healthy relationships.

Empathy – The ability to take the perspective of another person or recognise their perspective as their truth while staying out of judgment. Empathy is connecting with people, so they do not feel alone with their struggle.

Intergenerational Trauma – When adaptive coping strategies developed following experiences of trauma, are passed down through generations.

Intersectionality - The recognition that various forms of discrimination, such as racism, sexism, and classism, intersect and overlap, especially impacting marginalised individuals or groups. It emphasises that everyone experiences unique forms of discrimination and the interconnected nature of social categorisations, creating overlapping systems of oppression.

Moral injury - The psychological distress resulting from actions or witnessing events that conflict with a person's moral or ethical beliefs, leading to emotional suffering and inner turmoil.

Neuroception – It refers to the neural circuits that allow our bodies to register whether an environment is safe or dangerous. This occurs outside of conscious thought.

Person centred approach - Places the person at the core of the service emphasising their identity as a person first. This approach involves collaboration across sectors to identify and understand the person's needs. Prioritising psychological and physical safety by offering choice, transparency, collaboration, and autonomy in the support provided.

Professionals – For the purpose of this document, the term professional is used to refer to those working within Midwifery and Public Health Nursing services. This is not just limited to midwives and health visitors, but everyone else who supports children and families within these services.

Re-traumatisation - When a trigger takes us right back to that moment when the trauma happened. This can be a physical or psychological experience that leaves a person feeling unsafe.

GLOSSARY

Secondary Trauma - Refers to the emotional and psychological stress experienced by people indirectly exposed to the trauma of others, often associated with helping professions or support roles.

Shame sensitive practice – Adopting approaches that consider and respect a person's feelings of shame, emphasising empathy, understanding, and fostering a supportive environment to address and alleviate shame-based experiences.

Supervision - Involves overseeing and guiding individuals or processes, typically within a professional or educational context, to enhance wellbeing, skills, ensure effective performance and development, and adherence to standards. Clinical supervision is where a psychological process of reflection is facilitated by a clinical specialist.

Systems - Refer to organised and interconnected structures, processes or institutions that work together to achieve a common purpose, for example referral pathways, multiagency safeguarding boards and communities of practice.

Trauma - Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

Vicarious Trauma - Occurs when an individual is indirectly exposed to another person's trauma, often through hearing or witnessing first hand accounts. This can lead to adverse emotional and cognitive changes, impacting the individual's mental health.

1. INTRODUCTION

Studies of trauma, and particularly the impact of experiencing trauma in childhood, have grown over the last 20-30 years. Dr Felitti and colleagues (1) were the first ones to raise awareness of the high prevalence of trauma and the link between adverse experiences in childhood and health outcomes later in life. They developed the **ACEs** (Adverse Childhood Experiences) research model, which has since been replicated in other countries worldwide (3). Even though this research model has its limitations, it was the first step in supporting the idea that trauma and adversity are prevalent in our communities and can have a profound impact on someone's life. The ACEs studies that followed (3) showed us that trauma and adversity are public health issues that can be linked to the structures, systems, and services available in our communities.

The **ACEs study** completed in England estimates that 48% of people have experienced at least one form of adversity during childhood (4). Please keep in mind that the ACEs model has a narrow view of what experiences can be considered adverse. So, this number will probably be much higher if we include other experiences of adversity. We will discuss this later in this toolkit. There is also an acknowledgment that accessing some services can lead to traumatic experiences or re-traumatisation (a trigger that takes us right back to that moment when the trauma happened).

The first 1001 days of a child's life are very important in supporting healthy development (physical and emotional development). We know that our experiences in childhood will shape our nervous system and how we see our internal and external world.

"**There is global evidence that the earliest years of life are a period of uniquely rapid growth, when babies' brains and their understanding of the world are shaped, and the foundations for lifelong health and wellbeing are laid"** (5)

For professionals working in Midwifery and Public Health Nursing, this could be the first opportunity to support the development of children's emotional and physical development and prevent adversity. This is also a second opportunity for parents to break the cycles of intergenerational trauma and start to heal from their own experiences of trauma.

Pregnancy and parenting can be very important and beautiful moments but also a very vulnerable time in life. There are many opportunities for traumatisation and re-traumatisation. For example, re-traumatisation that can happen as part of medical procedures, or parents revisiting their childhood trauma.

We also know that trauma does not just happen to the children and adults we are supporting through our work. Trauma and adversity can happen to all of us, to our colleagues and managers. Professionals working in Midwifery and Public Health Nursing services are often exposed to trauma. For example, disclosures of abuse or death of a child that you hear and see during the day. You are also working in increasingly stressful, underfunded, and stretched services. This can lead to vicarious trauma or a sense of moral distress.

Trauma informed practice is not just about the work that professionals do on the frontline. It is an approach that also looks at systems, policies, and procedures within an organisation to ensure that professionals feel safe, nurtured, supported, and regulated throughout the day.

We recognise that trauma and adversity are prevalent within society, and the best way to mitigate its impact is by focusing on prevention and providing opportunities for everyone to experience safe connections with others. Trauma starts to heal in relationships.

2. WHAT IS TRAUMA?

Definition of Trauma

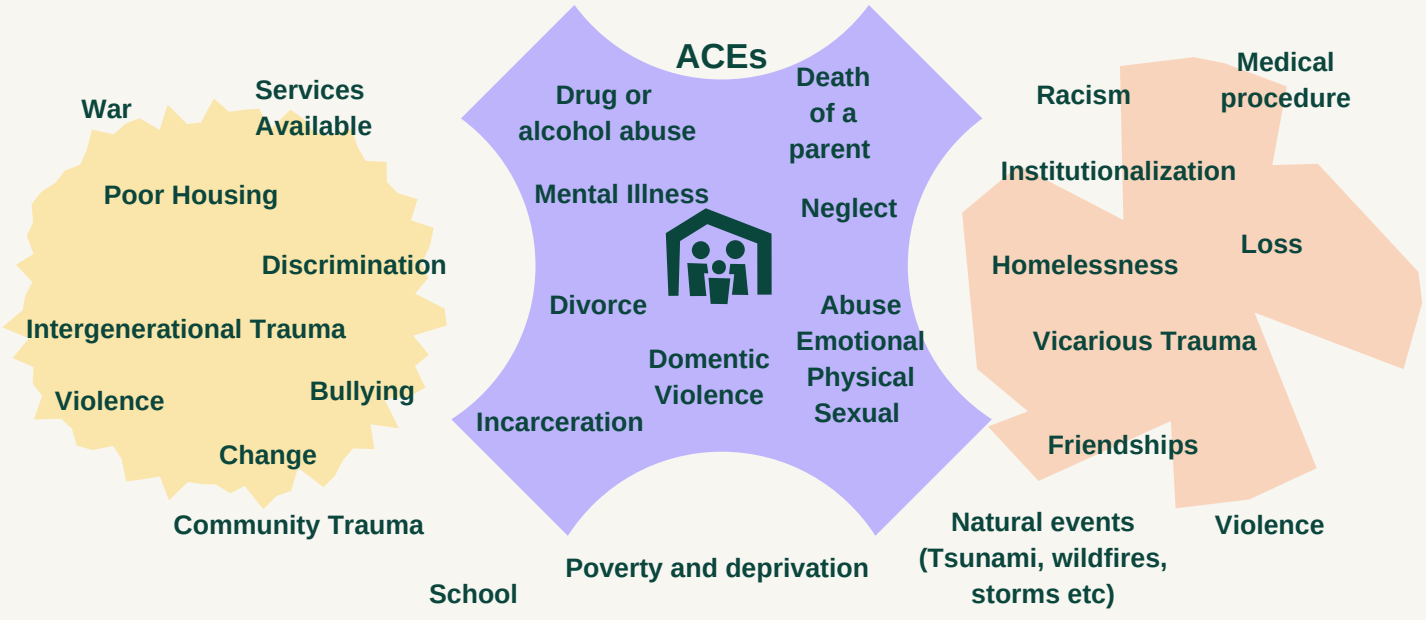
The word trauma comes from the ancient Greek word that meant piercing, wounding, or damage. Trauma can have an impact on our physical and emotional health.

“Trauma results from 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 individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (8).

Various factors determine what an event is or what can lead someone to experience it as harmful or life-threatening. It is very important that we validate individual experiences and support individuals in expressing how certain events or environments have made them feel. Trauma can also happen when we are left alone with our pain.

There are many ways to categorise or define what could be felt or experienced as trauma and adversity. It could be a single event or a complexity of different events, environments that are experienced over long periods of time and are difficult to escape from.
Felitti and colleagues (1) created a list of ten events that they considered adverse.
However, adversity and trauma are much more than ten ACEs.

Trauma and adversity happen in context and in relationships



Trauma and Adversity are often experienced in a context, not as isolated events. Please see below some types of trauma. This is not an exhaustive list, but some types of trauma that you are more likely to encounter in your work.

 **Attachment Trauma**: can occur when a child does not experience consistency in physical and emotional support from a caregiver or other nurturing relationships.

 **Developmental trauma:** when a child experiences early exposure to repeated traumas (including in utero) throughout their childhood. This is often experienced in the context of attachment trauma.

 **Birth trauma:** any physical or emotional distress that can be experienced during or after childbirth.

 **Cultural/identity and insidious trauma** include systemic injustices, structural inequalities, racism, and prejudice.

 **Intergenerational trauma:** adaptive coping patterns developed by parents as a result of trauma are passed through generations.

 **Collective trauma:** the impact of an event or series of events has been felt across collective demographics, such as communities, schools, or organisations.
Change and loss: experiences of loss and change can lead to someone feeling overwhelmed.

 **Secondary or vicarious trauma**: a change in the way we feel and see the world caused by exposure to others' experiences of trauma and adversity.

In most definitions of trauma, we find the words overwhelm and change. Trauma is an event (or series of events) that overwhelms our internal and external resources, making us feel that we cannot cope with that situation. How trauma impacts an individual or community and how they start to recover and heal will depend on a variety of factors:

Event

Exposure to a stressful event or series of events. Also linked to the absence of something happening. For example, when children's needs are not consistently met

Effect

The effect can be experienced immediately or have a delayed onset. Impact can have long or short-term effects.

Experience

How the person experiences the event. Could be influenced by age and stage of development; identity; support network; historical or cultural context.

Environment

Environmental context in which the event takes place.
Physical space
Emotional significance of the space.

What can Trauma look like?

Trauma responses can vary, but it is crucial that we are curious about behaviour and that we see behaviour as a form of communication.

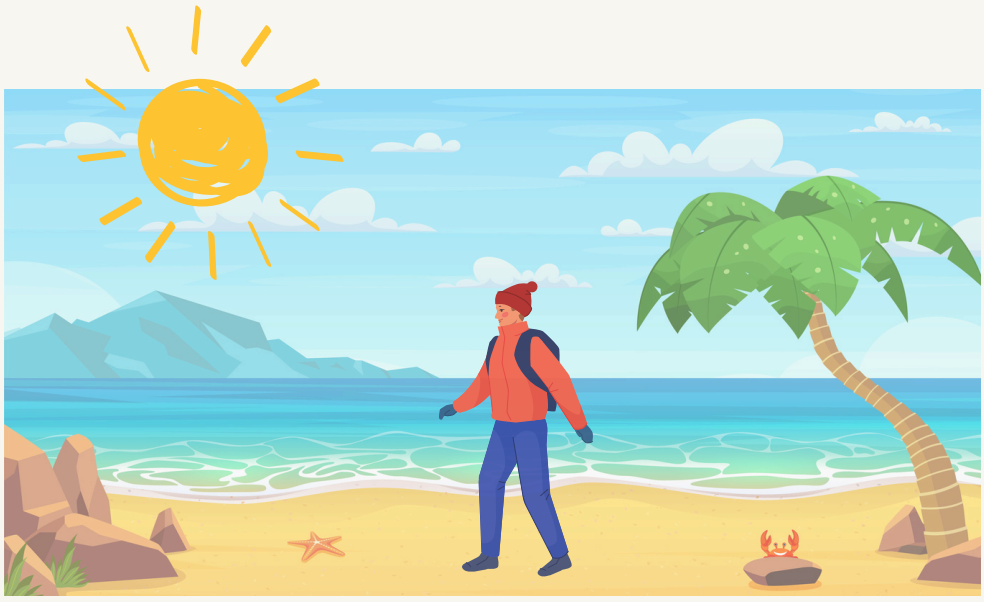
We communicate in many ways: through written or spoken words, sign language, or how we behave. Our body language and behaviour carry many unspoken words, many feelings that cannot be expressed, or needs that have not been met.

We need to engage our **professional curiosity** to help us explore the meaning of behaviour, especially behaviour that we find challenging. For example, if someone does not attend an appointment, could we wonder about the barriers to that person's attendance? Could it be that they do not feel safe coming into an office? At the last meeting, did we say something that might have made them feel unsafe? Did they not have money for transport? Is the person feeling shame linked to their experiences?

Engaging our professional curiosity makes us more likely to respond with compassion. We must understand that we are always trying the best we can with the resources (internal and external) available at that point in time.

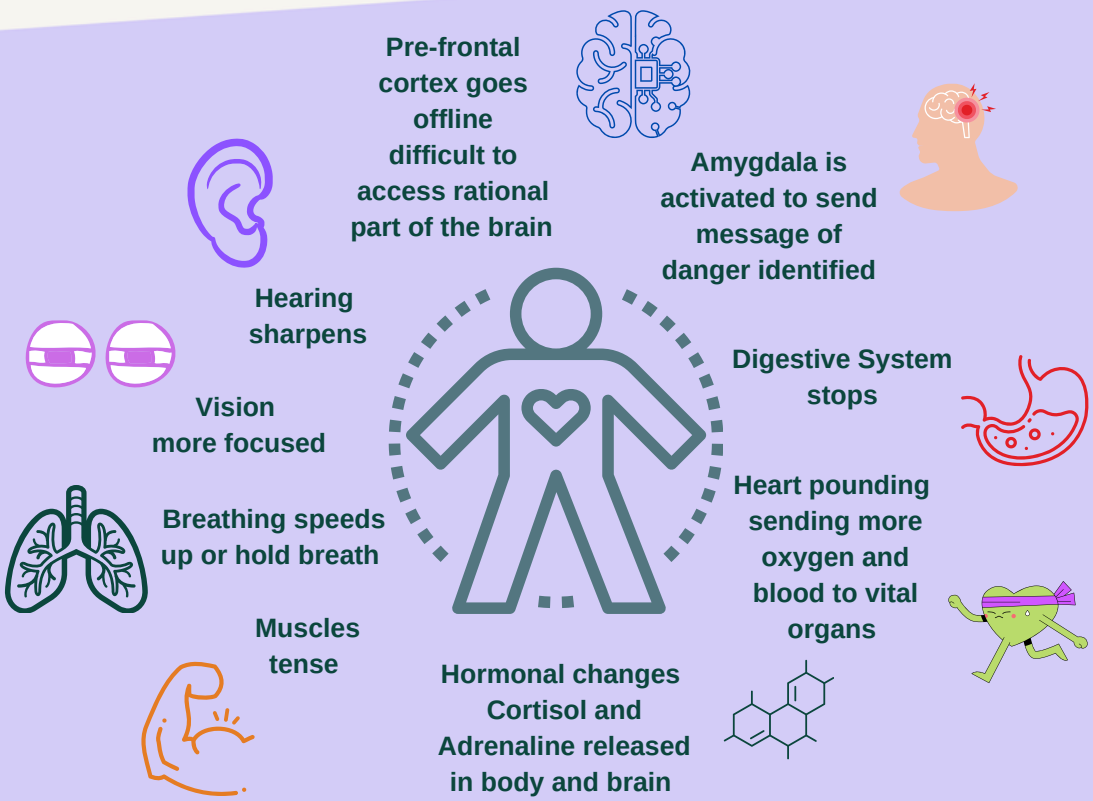
When we experience trauma, we feel overwhelmed, and our bodies and minds need to respond to this threat and develop strategies to survive.

Those **survival strategies** can be helpful in an unsafe environment but will not be so helpful in safe situations. It is like wearing our winter clothes in the summer. A warm coat, gloves, and boots are essential to survive in cold weather but not so helpful in hot weather.



What happens when we feel unsafe?

When we feel unsafe, our body and brain focus on survival. This leads to changes in the way our body functions to **prioritise survival.** We know that adrenaline and cortisol are released to help us gain more energy. So, what other changes happen in our bodies when we feel unsafe?



What we might do:

Fight:
shouting, punching, hitting someone, pushing or shoving, throwing something across the room, or swearing.

Freeze: the body wants to move but cannot; cannot say a word; not being able to attend an appointment; no eye contact; shrugging shoulders.

Flight: the person who leaves the room, runs away, or walks away.

Friend: the best way to survive is to agree with everything that I am being asked to do, to nod and say 'yes' to everything.

Flop: when your body collapses on the floor and it gets ready to shut down. It might look like dissociation like we are somewhere else in our minds.

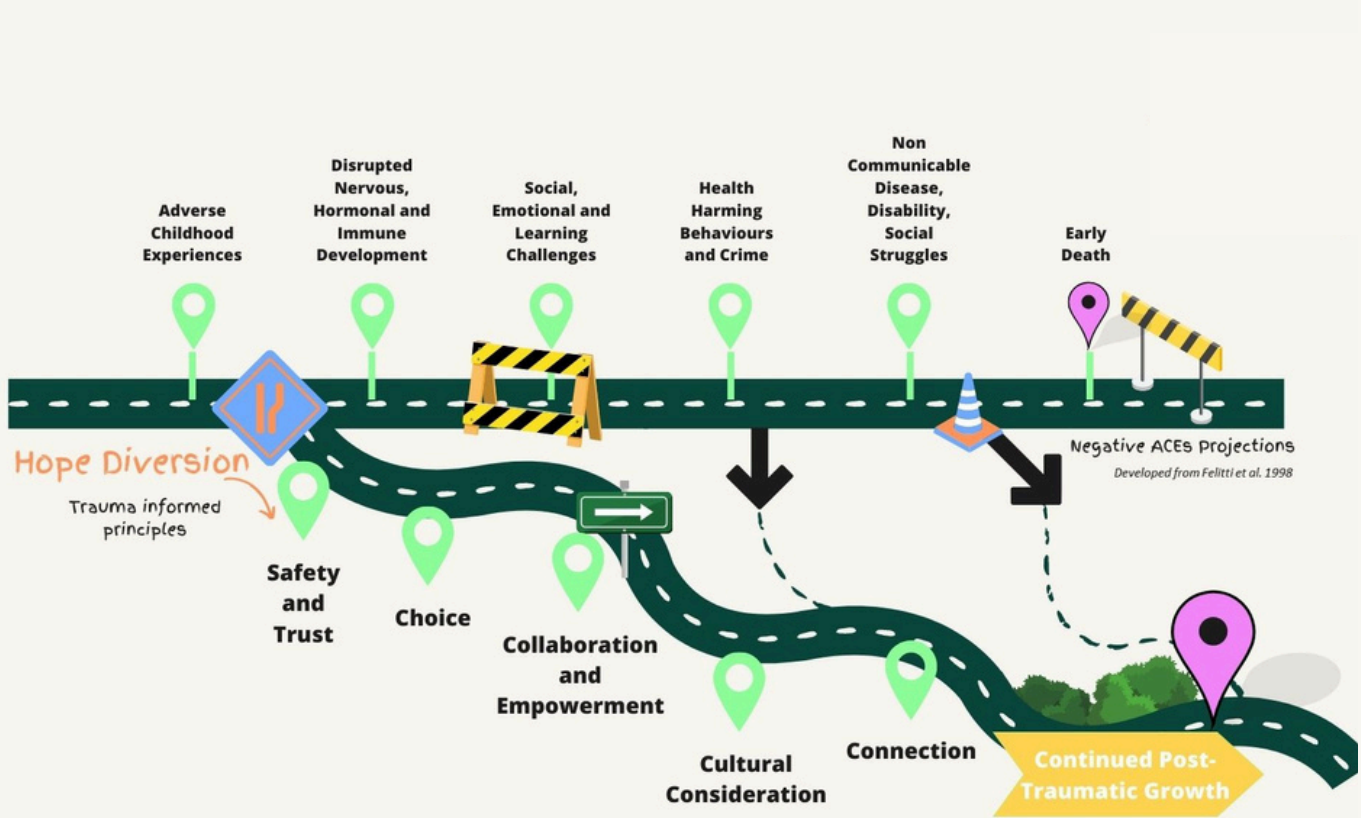
We might see one of these responses or a combination of different responses. It is important to remember that when our body is in 'survival mode', we struggle to access the pre-frontal cortex, the part of our brain that reasons and thinks logically.

The potential impact of Trauma on the body

When this happens repeatedly, and our body and brain are regularly flooded with adrenaline and cortisol, it changes how our brain is wired and structured, and can physically impact our vital organs. **Trauma wires the brain for danger**. Even in safe situations, you don't feel safe. A smile and a soft tone of voice might feel like a threat (16; 34).

Allostatic load is the term used to describe the impact of frequent activation of stress hormones on our body and mind. We also need to consider the impact that toxic stress can have on the developing nervous system of an unborn baby. The baby will hear the mother's rapid heartbeat, the adrenaline and cortisol will be passed on through the placenta (18). This can impact the very fragile structure of the brain and nervous system.

Hope and Recovery



Hope is a key value for Barnardo's and those working within health and social care. We work in these sectors because we want to help, and we believe that the world of those we support can feel safer, and with the right support, people can succeed.
We know that trauma is not destiny. Many people who have experienced trauma have been able to recover, heal, and reconnect with themselves and the world around them. This often happens when individuals are supported by the community, family, or services around them (16; 33).

As professionals we need to hold on to this idea with confidence. We are not suggesting that the risks and challenges should be ignored. These need to be considered, discussed, and reflected upon. We need to reflect with curiosity and compassion to assist in finding creative ways to support the children and adults (including our colleagues) who have been impacted by trauma and adversity.

"I know it sounds like common sense, but when you're just doing like bam bam bam, checking if the child's safe, checking if they're healthy. But it's sometimes good to just take a step back and give that opportunity to go into the past, to help see if that can help with the future"
Health Visitor

3. What is Trauma informed practice?

Trauma informed practice is a way of seeing/being in the world that acknowledges that many people we interact with every day have experienced trauma and adversity. It aims to create an environment that feels safe, where people are encouraged to collaborate and feel empowered. This does not just apply to the children and families that we support but also to our colleagues and to ourselves.

It is a way of working that understands that behaviour that might challenge us (aggression, not talking, not attending appointments) needs to be understood by **'holding trauma in mind'** as a possible explanation and by being creative in finding solutions to address those challenges.

Pregnancy and parenthood can be a very vulnerable stage in someone's life. According to the Birth Trauma Association, 4-5% of women and birthing people who give birth develop Post-Traumatic Stress Disorder (approximately 30,000 a year) (9). The Crime Survey for England and Wales estimated that 2.1 million people aged 16 years and over (1.4 million women and 751,000 men) experienced domestic abuse in the year ending March 2023 (10).

In 2014, SAMHSA (Substance Abuse Mental Health Service Administration) published a guidance document to develop a working concept of trauma and a trauma informed approach. SAMHSA developed a framework that can be used for all services (8). SAMSHA says that in a trauma-informed approach, everyone in an organisation:

Realises that trauma and adversity are prevalent within our communities and societies. Furthermore, we also understand that there are paths to recovery.

Recognises the signs of trauma; understands how this is affecting you now in the present; and looks at behaviour as a form of communication, including thinking about ways that professionals respond to certain situations or organisations are operating.

Responds by utilizing the principles of a trauma-informed approach in all areas of service delivery. We understand that the work we do can traumatise or re-traumatise those engaging with our service, either directly or indirectly. Based on this understanding, we change our practice, for example, considering the layout of the building, the language we use, pathways, etc.

Resist traumatisation by considering our service delivery through the eyes of those accessing it and consider what strategies we can use to minimise the potential for re-traumatisation.

Trauma Informed Practice is not a "one size fits all approach" but an ongoing journey of **Reflection** on our values, principles and how we work by showing compassion to ourselves and others.

The principles of Trauma Informed Practice

These guiding principles should be considered in everyday practice. We will explore what these principles can look like for Midwifery and Public Health nursing, later in this toolkit.

Safety

This can look different for individuals, but it is essential to consider what a safe environment can look and feel like for professionals and the families you are supporting. We are considering physical and emotional safety.

Trust

Trusting another person is key to helping us feel safe and explore the world around us, knowing we have someone we can turn to if things do not go according to plan.

Connection

Providing children and adults with the opportunity to experience safe relationships is vital to supporting people's feelings of empowerment, safety, and trust in others.

Choice

Trauma and adversity are never a choice. Providing opportunities where children and adults can make choices is crucial to support the development of trust and a sense of safety.

Cultural Consideration

We develop physically and emotionally in interaction with the culture and environment around us, and this influences our views of ourselves and the world.

Collaboration

It is important that we understand the importance of collaborating with others, whether that is the children and families we are supporting; our colleagues, or other professionals working in different sectors.

Empowerment

Trauma can leave us feeling powerless. To support children and adults to heal from trauma it is important that they have a voice and choices in the direction of their lives. We all have our own individual skills and strengths, and it is essential to build on those.


Context
Collaboration
Trust
Choice
Trauma Informed Practice
Safety
Empowerment
Connection

4. Trauma in the Perinatal Period

Perinatal Trauma

Perinatal trauma refers to stressful or traumatic experiences that a person may go through during and after pregnancy. It may significantly impact both the birthing person and the developing baby. It may have lasting effects on a child's physical and emotional development.

Pregnancy and postpartum can be vulnerable times in a person's life, regardless of their childhood experiences. It is a time when the body changes, and there is a sense of loss of control. Also, it is a time when parents might reflect and look back on their own childhood experiences and think about the future.

We also need to consider how medical examinations or the many questions someone is asked during pre and post-natal appointments can be difficult and feel intrusive or re-traumatising.

In this section, we will talk about intergenerational trauma, epigenetics, and birth trauma. However, it is also essential to acknowledge all the other factors that might contribute to vulnerability within families (this is not an exhaustive list):

Fertility journey: miscarriage, stillbirth

Migrant

Unplanned Pregnancy

Learning difficulties

Loneliness

Previous medical injury/ illness

Socioeconomic factors: Poverty, unemployment

Medical Complications

Cultural context

Drugs or Alcohol Use

Domestic Abuse

Previous experience of trauma

Financial concerns:
housing conditions;
changes in income
debt
increased costs with childcare

No support network

Racism and discrimination

Asylum Seeker/ Refugee

Grief and Loss: previous loss of a baby or child; child in foster care or adopted

Sexual abuse

Mental Health Concerns

Shame

Previously in foster care or adopted

Disability

Shame in pregnancy and parenting

Shame is central to the human experience and can influence how we view ourselves and others. Shame is often described as a negative emotion arising from our self-judgment and concern for how others see us. "***We feel shame when we are seen by another or others to be flawed in some crucial way, or when some part of our core self is perceived to be inadequate, inappropriate or immoral***" (12).

Shame is something that needs to be considered as a **barrier** for some people to **access and engage** with services. Women and birthing people living with social complexities are vulnerable and often hesitant to engage with services because of fears of social care involvement. (13) This could also be linked to feelings of being judged as a "bad" parent or other factors that might lead to overwhelming feelings of shame.

Jenny Cunningham is a midwife currently working on research that looks at the experiences of women and birthing people who are of higher weights during pregnancy. Most of the studies that she has reviewed so far show that there are many moments when shame is experienced, such as being asked to stand on a scale or experiencing bullying behaviour during maternity care (22).

Shame is an **overwhelming** feeling that can lead us to behave in ways that might seem dishonest or disinterested—for example, not seeking medical care, not disclosing a pregnancy, not attending antenatal appointments, or not asking for support when struggling with a new baby.

Shame for professionals

Shame can also be a feeling that professionals experience in their day-to-day work. Some processes and procedures that follow "when care doesn't go to plan" (14) can leave professionals feeling overwhelmed and experience shame. Some of the language used during these reviews can also lead to feelings of shame.

Professionals might also experience shame when they feel overwhelmed when working in a very stressful system. Shame to ask for help or say they are finding things difficult because everyone around us seems to **"just get on with it"**.

Intergenerational Trauma

Intergenerational trauma happens when psychological or social stress experienced by a parent can modify the development of the children in the next generation.

Vivian Rakoff was the first to publish an article on intergenerational trauma, but many other studies have been conducted since then. For example, children of holocaust survivors have been studied on different occasions. (15)

Dr Gabor Maté often talks about his experiences as a Holocaust Survivor, what this meant for his emotional health, and the impact it had on his children (16).

Other examples are studies on **children of famine survivors in Holland in 1944**. This year, Germany blocked all food supplies to Holland, leading the country into famine. By the time the Netherlands was liberated a year later, 20,000 people had died of starvation. Some studies followed children of famine survivors who were pregnant at the time. When they became adults, they had higher rates of obesity, diabetes, and schizophrenia and died at younger ages. Some studies showed that their children and grandchildren were also at higher risk of having diabetes and cardiovascular diseases. (17)

Intergenerational trauma may impact **pregnancy** in various ways, affecting both parents and the child. It may impact mental health, stress responses, maternal health, prenatal attachment, birth outcomes, and parenting styles.

We also need to consider **transgenerational patterns**, cultural factors, and resilience. A study found that the children of mothers who had ACEs were at an increased risk of behavioural problems and depressive symptoms. (18)

It is important to understand parents' childhood experiences and how those might influence or impact their capacity to care for the child and their emotional and physical health.

"Pregnancy is the first time to get it right for the baby. And the second time to get it right for the parents."
Penny Mansfield

Epigenetics

Epigenetics is a new field developing to explore how environmental factors may change the expression of our genes. It suggests that specific vulnerabilities can be passed on to the offspring and how they can be ‘switched on/off’ depending on environmental interactions. What happens to us is what makes a difference (35).
Our genes are essential to our health, as so our behaviours and environment. For example, what you eat and drink, or how much exercise you do, the pollution of the environment etc.

Epigenetic changes are reversible and can change how our body reads a DNA sequence. This is an area that is developing as scientists make more discoveries.

It is also necessary to understand that a woman's and a birthing person’s environment and behaviour during pregnancy can change a baby’s epigenetics. This is not new, as we have already discussed how high levels of cortisol and adrenaline can impact the developing nervous system and brain structure.

Birth Trauma

The day a baby is born is usually celebrated as "**one of the happiest days of parents' lives.**" The events of this day are often repeated throughout a parent's life and passed on to their children and grandchildren. Every year, on the child's birthday, the parent might remember and recount the details. Every time a friend or family member is pregnant, parents will retell the story. However, for some parents, **this can be a challenging** experience or even **traumatising.**

Make Birth Better survey (41) shows that around **25%** of women or birthing people find some aspects of their **birth traumatic**, and 1 in 5 women or birthing people suffer postnatal post-traumatic stress disorder.

Birth trauma refers to ***"a physical and/or psychological reaction to one single event, or a mixture of experiences through conception, pregnancy, during labour or after the birth"*** (42).

Birth trauma (as any other form of trauma) happens within a context. Therefore, experiences from the past might also be an influencing factor. For example, a previous traumatic experience or depression. The following **factors** can also be linked the experience of birth feeling traumatic:

Lack of informed consent

Medical emergency (not being told what is happening during an emergency)

Feeling out of control, silenced or alone

Quick or long labour with sleep deprivation

Perception of pain and pain management

Physical birth injury

Burnt out care givers

Systemic racism

Interpersonal factors

Previous loss or removal of a baby or child

Other people can also be impacted by birth trauma, such as **partner**, **baby** or other members of the **family or birth companions**. Other **professionals** that are involved in supporting the family. Some midwives who attended the training and were part of the focus groups shared how being unable to provide the care as expected or being part of a difficult event impacted them personally.

Symptoms to look out for:

Talking about the event as if they were not there or not remembering parts of labour. This could be a flashback, nightmares, or intrusive memories.

Avoiding anything that reminds of the trauma. For example, refusing to walk past the hospital where you gave birth or avoiding meeting others with new babies. Another example, could be not attending appointments or dismissing injuries.

Hypervigilant: being constantly on alert, irritable and jumpy. Overly worrying about something terrible happening to the baby.

Feeling low and unhappy: the person may talk about feeling guilty or blaming themselves for the traumatic birth.

What can help?

Relationships

Support Network

Listening to understand

Validate experiences

Empathy

Open Communication

Informed consent

Understanding what is happening and why things happen in a certain way

Collaboration

Being involved in every part of the journey

Individualised care

Talking about potential triggers

Understanding personal journeys

The impact of working with Trauma (and/or in traumatic environments)

Maternity care is an **emotionally charged** and inherently **stressful environment** (20). You are supporting families at some of the most **vulnerable stages** of their lives. Doing a job that requires you to **connect emotionally** with others (**empathy**) can sometimes involve a level of **vulnerability** for professionals.

Various research documents and a recent survey within midwifery (7) show that England **needs more than 2,500 midwives**. Most services are understaffed, and there is a high rate of Midwives leaving the profession. This report also shows that the **complexity of maternity care has increased** in recent years. One of the changes is the average age of women and birthing people giving birth, which can bring added medical challenges.

Research also shows that **71% of health visitors reported increased work-related stress** levels in the last 12 months (6). In 2019, Action for Children reported a **62% cut in funding for Children's Centres**, with the most significant effect in deprived areas. Children's centres provide invaluable support for families where parents can access emotional support for themselves or support for their children.

All the Public Health nurses we spoke to in the focus group and training sessions discussed the added challenges of children's centres closing or reducing their services available for families.

"It is quite a lot that we are actually dealing with day to day. Any situation we go into, you could uncover trauma, and I hadn't really thought of my job in that way"
Health visitor

Despite some of these difficult working conditions, it is important to acknowledge and celebrate the amazing work that continues to happen while also addressing the challenges and how these may impact professionals' emotional and physical well-being.

What trauma for professionals can look like?

We recommend that you to be kind and compassionate with yourself as you read through this next section. If you notice any signs and symptoms of trauma on a colleague, please reach out and offer a smile and a space to share. We are all trying the best we can with the resources (internal and external) we have available at any given point in time.

Secondary or Vicarious Trauma

Indirect trauma that can occur when you witness, listen to, or experience a traumatic event at work (20).

- Feeling Disconnected
- Exhaustion
- Isolation
- Feeling overwhelmed
- Altered World view
- Altered Character and Believes
- Feeling powerless
- Difficulties sleeping
- Concerned with how fragile life is

Compassion Fatigue

When you run out of empathy

- "I have seen worse"
- Eroding empathy for us and others
- Feel disconnected
- Signs in personal or professional life
- Becoming cynical
- Feeling hopeless

Moral Injury

Working in a system that does not align with your moral principles and values. This can be the result of a lack of power, structural limitations, training, time, insufficient staff.

- Deep feelings of powerlessness and shame
- Feels like your 'spirit has been broken'
- Working in a way that does not align with your values

What can help?

A culture of well-being is vital in ensuring that staff feel safe and supported. Well-being is not just an individual's responsibility; it must be embedded into the organisational culture. When talking to Midwives, Public Health Nurses (and many others working in health social care), support from colleagues was often mentioned as a protective factor. Knowing they had a team leader and colleagues with whom they could share or 'offload' was crucial for helping them manage the complexities of their roles.

It's about creating a **safe working environment** where it is acceptable to say, "*Today I am really tired*" or "*I am finding today difficult because*". A place where it is **acceptable and encouraged to take breaks**. Just because we say that "*today was really difficult*" does not mean we are not coming back tomorrow or are not 'strong' or 'resilient' enough. It is about feeling heard, validated, and supported.

A midwife who attended the focus group shared the phrase below:

"If we can share it, we can bear it."

It is also about finding small moments during the day when we can close our eyes for two minutes and imagine being somewhere else; or take a few deep breaths and check in with how our bodies are feeling. We must find short moments in the day to regulate our nervous system. It is about finding small "Spa moments" rather than waiting for "Spa Days".

5. Creating a Trauma Informed Culture

Trauma informed practice is a framework, a way of thinking, and not a “one size fits all approach”. In this next section, we will consider the fundamental values and principles or things we must consider when aiming to embed trauma informed practice into our everyday practice and culture within an organisation.

These are the key elements we are going to consider:

Language

Context – Cultural sensitivity

Collaboration and empowerment

Safety

Co-regulation

As we go through each section, we encourage you to consider what you are already doing (**celebrate successes**) and what you will take away (**consider; continue to reflect on**).

Remember that trauma informed practice is not an ‘end destination’ or a ‘badge’ but a **continual journey of learning and reflection**. We are not expecting perfection (if such a thing exists) and acknowledge that systems, policies, and existing cultures create many barriers. We aim for kind, respectful, and compassionate care for children and their families and yourselves as professionals.

Language

The language we use can be very powerful in showing how we see and think about ourselves, others, and the world around us.
The **feeling** created by language can stay in our memories for a long time. Words can create feelings of blame and shame or create feelings of trust and motivation.
Some language used in different health and social care settings **can problematise the individual**, forgetting that our environment, culture, and the structures of our systems and organisations **influence individual behaviour**.
Language can also be a **powerful tool to support** children and adults we encounter in our work (23). We need to consider not just the words we say but also **how we say** them, the tone of voice, and our body language.
Midwives and Public Health Nurses work with families from many cultural backgrounds. For some families, English might not be their first language, or they might not have had opportunities to develop the "**language of feelings"** (emotional literacy). Some might need more time to reflect and process information. Some might prefer **written words**; others might find it difficult to read the many leaflets or website links that professionals often refer them to.
For those whom English is **not their first language** but can speak English, they may have worries about not understanding what is being said, confusing words, or not wanting to ask a question for fear of not being understood.
Some of the tools health visitors use to screen for mental health, such as the Edinburgh Postnatal Depression scale, cannot be **translated** into specific languages. So, **professionals must adapt** and look for other ways to express themselves, ask questions, and use their **professional curiosity** to observe what people may try to communicate through behaviour.
Language can also be very **powerful in labelling people**, and we need to consider the labels we give to people and the power dynamics within this (23).
The organisation **Make Birth Better** refers to The Birth Trauma Association Survey completed in 2020 (24), which showed that "***poor communication contributed to 9 in 10 cases of birth trauma".***
This organisation has launched the '**Every Word Counts Campaign**' to share some examples of how the language used by professionals around birth can have a shaming and traumatic impact on women and birthing people.

Please see below some examples from *Birth: does the language we use matter?* (25)

Examples of poor language	Suggested alternative language
Labour Ward	Birthing Suite
My Woman (for the person giving birth)	Use name or say “the person I am caring for”
Good girl (during birth)	You’re doing really well
I’ll go and consent her	I’ll go and ask if they are happy with that and ask them to sign a consent form/ discuss informed consent
Patient refused	Patient declined
Failed induction	Unsuccessful induction
Poor maternal effort	Not finding it easy
Poor obstetric history/ high risk	Medically Complex
Painful contraction	Strong contractions

Other suggestions for change in language:

Examples of poor language	Suggested changes
Attention seeking/ clingy	Attention needing/connection seeking
Did not attend	Could not attend
Not engaging	Not feeling safe yet/ not able to connect yet
‘Don’t worry, that’s normal’	Tell me more /I can see how this has been difficult for you
What is wrong with you	What has happened to you
Won’t do	Can’t do it yet
Aggressive	Fight mode/ feeling unsafe
Disrespectful	Not feeling heard/validated
Incident	When care didn’t go according to plan

Whenever you write or talk about a child or adult, hold them in mind. Remember that they might have access to their notes. Remember that **language reflects the way we see human behaviour.**

It is also important to **not use acronyms, jargon, abbreviations** when talking to/ or about the families we are supporting, our colleagues, or ourselves.

Some examples of language that feel more sensitive are suggestions, as we acknowledge that some language can be triggering for one person while being acceptable for another. It is essential that we listen to the language used by families and ask what they would prefer or words that might be difficult for them to hear. **Individualising language** should be the aim, and it requires us not only to ask but also to observe behaviour and notice any changes in body language.

The words we use carry a lot of power that can help connect with a family or lead to disconnection.

Take a moment to reflect:

Context: Cultural sensitivity

We are social beings that survive, grow, and exist within a cultural context, in relationships with different people, systems, and organisations that impact the way we define ourselves, our identity, and what is important to us. It is also important to consider how the environment/context interacts with our physical characteristics.
Many physical, environmental, and social factors influence our uniqueness.
Some women or birthing people may have a disability that can potentially impact pregnancy and care of the baby. For example, some women or birthing people with a learning disability may not connect with maternity care due to a lack of confidence or fear of judgment and social services involvement. Some might need adjustments to the physical environment to access services or access to interpreters.
Reasonable adjustments should be made due to a woman or birthing person's disability to ensure they can fully access maternal care. The adjustments should be personalised (28). These can include:

It is essential to understand the additional vulnerabilities some groups have, for example, transgender, black, and minority groups, physical and mental illness or disability, and neurodiversity (amongst others).
There is **limited research on the experiences of transgender women** during pregnancy (37). However, it is crucial to have open conversations about the use of preferred language and any adjustments that might be needed to ensure people can access and fully engage in their maternal care.
We also need to consider the **care provided post-birth** and how to support families best to ensure their needs are met. For example, we know in England that children's medical records are only linked to the medical records of their biological mothers. One health visitor shared the challenges this creates, for example for same sex male couples.

There might be limitations on what professionals can do regarding systems, procedures, and policies, but it is key that you continue to raise concerns and advocate for the needs of those accessing your services.

The **Women and Equalities Committee** published a report (29) in 2023 that showed that in the UK, **maternal mortality for Black women is almost four times higher** than for White women. Disparities also exist for women of Asian and mixed ethnicities. These disparities have been documented in other parts of the world and have been consistent for over two decades.

The **reasons for these disparities** are complex and are not fully understood, but some reasons have been explored:

Pre-existing conditions and co-morbidities

Socioeconomic factors

Maternity care

The **Women and Equalities Committee suggests** the following try to improve health outcomes for women and birthing people:

Continuity of care

Having a consistent midwife, health visitor, or other professionals who may be involved in the care provided during and after pregnancy. This is mentioned in different research documents, recommendations from different reports, and research as something that would improve the care provided to children and families. When we talked to midwives and public health nurses, they felt this was important. They felt continuity of service would support the development of safe relationships that are so important in supporting families to heal from experiences of trauma and avoid re-traumatisation.

Equity and equality guidance

This document was published in 2021 and was welcomed. However, it is essential that more than publishing guidance, staff have access to training and time to reflect on their own unconscious bias, their values, and views of the world and how these impact their day-to-day practice.

We understand the challenges and barriers to implementing these recommendations. It is important that practitioners continue to aim to provide personalized care and understand that trauma and adversity happen in a context. Also, it is important that we maintain our professional curiosity, and reflect on our values

Cultural humility is a constant process of learning, inquiring, and identifying gaps in our knowledge with compassion and without shame. It is about creating opportunities to **engage and acknowledge the social structures**, biases, and prejudice that have helped shape reality as people experience it. It also recognises intersectionality. **Intersectionality** recognises that individuals have overlapping social identities that impact their experiences, which must be considered collectively. It explains how interlocking forms of discrimination can create new inequalities and how these can impact health. It recognises that each person's **health experiences** (or other services) are **impacted by multiple intersecting factors** such as race, gender, socioeconomic status, and sexual orientation, amongst others.

NSPCC (31) also suggests using **genograms** to support health visitors in developing a better understanding of the family history, relationships and identifying needs from childhood. Genograms are a visual tool that shows a family tree developed with the person to highlight who is in the family and open conversation about relationships, protective factors, vulnerabilities, and wider support networks. If families are supported by social care, they probably already have one. You can create a genogram using paper and a pencil or be as creative as possible by using pictures, drawings, or other images.

"***This is part of getting to know people, understanding what is important to them***"
Clinical Team Lead

" ***Taking more time to explore someone's interests. For example, a mother that was a bit isolated, mentioned she liked knitting, so I tried to find some local knitting groups.***"
Healthy Child Programme Practitioner

Take a moment to reflect:

What am I already doing?

What am I going to reflect on? Anything I could do differently?

Collaborating to Empower

When a person experiences trauma, they may feel alone and powerless. On the journey of helping someone to heal and avoid re-traumatisation, we need to share power and encourage people to find the "power within".
Please see below some ways we can work collaboratively with families and support the development of feelings of empowerment.

Introductions: Say hello, your name, and your role. Explain your role and responsibilities in clear, simple language. Provide clear information about what will be discussed during the visit. If you are going to discuss any sensitive topics, allow time, give a warning, and explain the reason for this conversation.

Start with a chat and "check-in" before launching into your agenda. One health visitor shared that on visits after birth, she always starts by asking how the mother is rather than asking about the baby.

Body language: Remember that we also communicate through our body language, tone of voice, posture, and where we sit when we visit a family home. Some of the Health visitors we spoke to shared that they prefer to sit on the floor or are careful with their facial expressions.

Agree an action plan: Talk with the children and adults you are supporting and find a way forward. Allow time and space for suggestions, reviews, and reflection on what has worked in the past or what they feel could be a realistic option. Also, allow space to explore options that might seem less realistic: "If we had a magic wand, what would we do?"

Families accessing our services **already bring their own strengths and skills**. It is our job to help them reflect on which skills might help in this situation. Most health visitors we spoke to mentioned how some parents were left feeling confused, worried about their children, and sometimes just needed some encouragement and reassurance that they were "doing a good job."

Provide clear information: ensuring people understand what we are trying to say using clear and simple language. Reflect it back, ask open ended questions and ensure you are not using acronyms or jargon. If the person does not take your suggestion on board, ensure that they have understood or are ready to take on this step.

Offer choice whenever possible. Trauma is never a choice; therefore, people will need to be allowed choices. It is also important to keep in mind that sometimes, when we are feeling overwhelmed or have never been given this option before, we will need time to process, think, and reflect. Allow time to revisit decisions or choices made.

Asking permission before you touch: some of the services you provide involve intimate care for the woman or birthing person or for the baby. Ensure you explain processes and procedures and the reasons for these.

Be open and honest: This could be about what resources are available and realistic waiting lists for support.

Support needs to be culturally competent and informed by understanding diverse cultural practices, needs, and choices.

Collaboration with the families you are supporting should always be encouraged so we can empower them to feel in control and able to make informed decisions.

"I think it is about making them feel in control because if they feel in control, they are more likely to work with you and engage with you."
School Nurse

Take a moment to reflect:

What am I already doing?

What am I going to reflect on? Anything I could do differently?

Collaboration with our colleagues

Midwives and Public Health Nurses talked to us about the challenges in communication between both services. **Continuity of service** is often referred to as the "gold standard," not just for those who have experienced trauma but for everyone. This is also a way to utilise time and resources more effectively.
Some Health Visitors talked about sometimes not being able to have a **"full picture"** of what was happening in a family and only seeing families once. Sometimes, the frustration of "feeling" something is "not quite right" for families but knowing they do not have the time to see them again. For trauma survivors, this also means having to **build different relationships**, sometimes repeating their story or assuming that professionals know or understand.
We also need to consider **other services** that support families.

Seng and Taylor (26) discuss the importance of **observing the "mother-infant dyad** in the earliest days through eyes that know the woman's vulnerabilities enough to spot difficulties and reinforce success.
All the professionals we spoke to have shared how beneficial they have found when allowed to share and reflect on information about families with other professionals. **Our colleagues can offer a different view or perspective,** new ideas on how to approach a situation or **new resources** that might be helpful.
We also need to keep in mind that our **colleagues might also be impacted by trauma** in their personal and professional lives, and with these, we might notice some trauma responses. These could include not answering emails, not taking phone calls, and not sharing information.
As mentioned before, we understand that maternity services are stretched, underfunded, and understaffed, which creates some barriers to collaboration with colleagues. However, we should always aim for this. We should try to create opportunities or engage in existing opportunities to share information, resources, and ideas.

Take a moment to reflect:

Safety

Physical and emotional safety are essential for survival and thriving. We feel safe when we are connected to others and when we feel consistently heard and validated.
We are all constantly scanning the environment for cues of safety or danger. This is called "**Neuroception**" and explains why a baby might coo or stop crying when hearing a familiar voice but cries when he sees or hears a stranger.
We know that **trauma can have an impact on how people perceive safety and danger**. We might see a mocking laugh in a friendly smile or hear a threat in a raised voice.
A **safe and secure base is critical to supporting children and adults** (including professionals) in exploring the world and connecting emotionally.
We might not be able to provide a physically and psychologically safe environment for everyone as this can be very subjective to the individual. However, there are some things we can do that will help and support this. Some of these suggestions were provided by professionals who attended the focus groups:

Be a **detective** and notice a change in behaviour or a response that feels disproportionate to the situation and respond to this with compassion.

Listen to understand or to validate people's experiences (hold the space)

Ask: "How will I know when you are not feeling safe/ or when we need to stop?"**.**

Physical environments with neutral colours; posters on the walls have supportive messages.

Encouraging women and birthing people to **bring familiar objects** from home when they enter the birthing centre.

Agree on a plan of action with small and realistic actions.

Meet in a **private space**, especially when doing intimate examinations

Open **conversations**: validate feelings and emotions.

Be **open, honest, and straightforward** when communicating with families and understand that you might need to explain things again or differently.

Give a **warning** when having conversations that might be difficult or when medical procedures need to happen.

Be mindful of your **body language**: do not stand over people; where do you sit when visiting a family.

Co-regulation (being 'anchored' when others become dysregulated)

It is equally important that professionals feel safe in their work environment. Sometimes, this might be difficult to achieve due to having no choice or control over the space where you work, such as when doing home visits or using office spaces or children's centres. However, there are things that you can do or consider within your team to support the development of a sense of safety.

Having someone to talk to when care doesn't go according to plan or when we feel overwhelmed. Having the opportunity to "offload" or share with a colleague can support reflection.

Senior colleagues (managers, team leaders) are also responsible for creating an environment where reflection and conversations happen in a safe space.

Encourage and protect time for breaks

Check-in and Check-out processes

Develop a culture of well-being (being ok to not be ok) in your team. We all contribute to the culture of a team.

Create space in supervision for reflection and use this space.

Encourage face-to-face connections for those working remotely. Even when it feels difficult, try to engage in face-to-face meetings or other opportunities for connection.

Many professionals who have attended our training sessions or focus groups told us about the invaluable support their colleagues provide. Some talked about the benefits of hybrid working but also about the challenges this has created as they miss the opportunity to chat with colleagues and learn from others.

"Sometimes we don't realise we are holding on to difficult things for a few days; whilst before we would just go back to the office and share with colleagues".
Public Health Nurse

Take a moment to reflect:

What am I already doing?

What am I going to reflect on? Anything I could do differently?

Connection and Co-Regulation

Emotional regulation starts with co-regulation with a primary caregiver. Babies have limited abilities to regulate themselves at the beginning of life. When they are upset or have a need, they rely on others to help restore the balance and meet their needs. The experience of **receiving external support** serves as a **scaffold for children** to develop their ability to deal with emotional distress.
Co-regulation is nurturing a connection with another individual that supports regulation using strategies, tools, and calming techniques to self-soothe or respond in times of stress. In the focus groups, we also talked about **safety for parents**, and it was felt that there is a better focus on parents' mental health. Professionals shared talking to parents about finding small things they can do during the day that might help them feel more regulated.

In the same way, parents or caregivers act as "**neurobiological regulators**" (26) for children, **professionals can offer co-regulation** for children and adults who have experienced trauma and are finding it difficult to regulate their feelings and emotions. Professionals act as **role models in a relationship** with the people they support by using the same relational strategies parents will ideally enact with their baby. Seng and Taylor (26) describe this as providing a **secure attachment** (one where our needs are consistently met, and there are opportunities to repair when care does not go according to plan), providing a **holding environment** where it is safe to respond to a significant challenge; and expecting to need to work with the people we support "***to regulate fear, anxiety, intense emotions provoked by pregnancy, birth and parenting"*** (26).

"When you are there, you're the person they're talking to. But then, when you go, they're still left with all this trauma and hurt. So, I encourage mothers to think about even just an hour or two where they can watch a programme or have a nice bath and ask a partner or a friend to look after the baby".
Health Visitor

It is essential to **first regulate our own nervous system**. There are behaviours and words that might trigger our own survival responses, so we need to do some self-reflection and find out how we usually feel and respond when we feel unsafe. What are our potential triggers? What do we need to stay regulated through our day at work? Develop our own coping strategies and regulate our bodies and minds.

Human behaviour can be very contagious, and when people around us behave in a certain way, it can directly affect us. For example, if someone starts yawning, suddenly, everyone in the room is yawning and feeling tired.

We also need to create a **well-being culture in the workplace** to support staff in staying regulated and feeling safe throughout the day. Our managers and colleagues also provide co-regulation for us.

"Sometimes just slowing down how we respond, listening, not jumping to problem solving"
Health visitor

"You just have to listen. And that is ok to do that. Sometimes you are the only person they can talk to."
Health Visitor

Take a moment to reflect:

What am I already doing?

What am I going to reflect on? Anything I could do differently?

Recommendations

This toolkit was written considering current research on trauma and its impact. We were able to listen to the views of some professionals working within Midwifery and Public Health nursing that reflected some of the themes presented in different surveys and research documents. However, we understand that this might not reflect your professional experience. Not all suggestions will apply to your practice.

We encourage professionals to continue learning about trauma and stay informed about the best evidence on trauma, impact, and recovery.
We are not encouraging professionals to do therapeutic work with children and adults, but we encourage them to work therapeutically while keeping in mind the principles discussed in this toolkit.

Trauma informed practice is not an ‘end destination’ but an **ongoing journey of learning and reflection**. Further work needs to continue to support professional development and embed the principles of safety, collaboration, and empowerment into everyday practice and organisational culture.

Support

If you have been impacted by anything we discussed on this toolkit, please reach out to someone. Talk to a friend, a colleague or a manager.

Please see below a list of organisations that can offer support to professionals working across Leicester, Leicestershire and Rutland:

For midwives – contact your PMA (Professional Midwifery Advocate)

Discuss any issues/reflections during **supervision**

Amica - Welcome (amica-counselling.uk)

Vita Health Group - https://www.vitahealthgroup.co.uk/

If it is urgent call **Samaritans a**ny time day or night for free on 116 123; email on jo@samaritans.org or visit their website where they have useful information https://www.samaritans.org/how-we-can-help/contact-samaritan/

Contact your **GP or NHS Mental Health Central Access Point** on 0800 800 3302

Mind - https://www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/helplines-listening-services/

Quetzal - childhood sexual abuse (Women) https://quetzal.org.uk/

First Steps – Childhood Sexual Abuse (men) https://firststepleicester.org.uk/

Victim First –Living without abuse https://lwa.org.uk/

Juniper Lodge – Sexual assault and Rape https://juniperlodge.org.uk/

Ebb – Family support for those affected by imprisonment For more information visit The Ebb Leicester's Facebook page or email ebbleicester@gmail.com.

LGBT Centre https://www.leicesterlgbtcentre.org/

Crisis Cafes - https://www.leicspart.nhs.uk/wp-content/uploads/2023/08/V4-AUGUST-2023-Neighbourhood-Mental-Health-Cafe-Booklet.pdf

The Bridge – wellbeing support for those affected by homelessness https://www.thebridge-eastmidlands.org.uk/

Joy - https://services.thejoyapp.com/ For information on different services available in your local area

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ERS EVIDENCE REQUEST SERVICE

Evidence Summary

Trauma-informed Perinatal Care

Gaps in the Evidence Base

There is a significant lack of evidence on trauma-informed approaches in healthcare in general. It was not possible to find examples of trauma-informed perinatal care models that have been evaluated and therefore there is no clear evidence of best practice.

There is much acknowledgement that staff delivering trauma-informed perinatal care need to receive their own support and supervision, but there is little evidence to demonstrate what works to support staff in practice and from their perspectives.

Key Findings

Trauma-informed practice aims to reduce the negative impact of trauma experiences and support mental and physical health outcomes. Three key elements of trauma-informed practice are to:

- Realise that trauma can affect individuals, groups and communities
- Recognise the signs, symptoms and widespread impact of trauma
- Prevent retraumatisation

The six key principles of trauma-informed care are safety, trust, choice, collaboration, empowerment and cultural consideration.

Recommendations for implementing trauma-informed perinatal care begin with creating organisational change, including providing all staff with trauma-informed and cultural competency training and making trauma-informed practice a core and consistent part of service delivery.

Adaptations can also be made to everyday clinical practice in order to promote patients' sense of safety, trust, control and sense of empowerment in perinatal care.

Though trauma-informed approaches are increasingly recommended in policy and practice, there remains a lack of clarity and consistency in their implementation in the UK. There is also very little evidence of the effectiveness of trauma-informed practice in the UK.

If delivered well and with adequate staff resource, trauma screening at the early stages of maternity care can prove an effective way to provide targeted perinatal support to women with experience of trauma.

It is not possible to identify specific interventions or practices that are helpful and effective for all women, or work within all organisations. Services must adapt to their own setting and service users.

Inequalities in perinatal care are often experienced by marginalised women, which can create distress. Greater consideration should be given to these women's needs and how to make trauma-informed perinatal care more equitable.

Summary of available evidence

Trauma-informed approaches have become increasingly recommended in policy and practice as a means for reducing the negative impact of trauma experiences and supporting mental and physical health outcomes
.1 There are two strands of trauma-informed care: universal precautions, which are applied to all patient interactions, and trauma-specific services or approaches which are tailored to individuals with identified history of trauma.
2 Universal precautions are the most commonly covered in literature.
The most cited definition and framework for trauma-informed practice continues to be the internationally recognised work by US Substance Abuse and Mental Health Services Administration (SAMHSA). Based on the SAMHSA framework, the UK Office for Health Improvement & Disparities has published a working definition of trauma-informed practice for practitioners working in the health and social care sector in the UK. Based on the SAMHSA framework, this identifies three key aspects of trauma-informed practice:

- Realise that trauma can affect individuals, groups and communities
- Recognise the signs, symptoms and widespread impact of trauma
- Prevent retraumatisation

In addition it outlines the six key principles of trauma-informed practice as 1) safety, 2) trust, 3) choice, 4) collaboration, 5) empowerment and 6) cultural consideration.
Guidance generally advocates for first using these aspects and definitions to create change in organisational culture, and then a change in clinical practices.
However it is acknowledged that within health and social care in the UK there is a lack of consensus and clarity around how trauma-informed practice is defined and how it should be implemented in practice.3
This is particularly the case in England, with Scotland and
Wales having more centralised, national approaches to the implementation of trauma-informed practice (see Scotland's National Trauma Training Programme and Trauma-Informed Wales). In addition, there is very little evidence of the effectiveness and acceptability of trauma-informed approaches in healthcare settings, especially in the UK, therefore a lack of available evidence on best practice (4).

Recommendations for trauma-informed perinatal care

Much of the literature provides similar recommendations for implementing trauma-informed perinatal care, which follows the six key principles of trauma-informed practice to increase patients' sense of safety, trust, control and sense of empowerment.
Recommendations include adaptations to clinical practice and direct contact with patients, as well as wider structural and cultural changes. Recommendations for effective trauma-informed perinatal care include:

- Recognise that medical examinations can be distressing or retraumatising for those with trauma experience. Accommodations can be made in verbal communication (e.g. full explanation of procedure beforehand, giving warning before each step, initial touching of another body part), nonverbal communication (e.g. making eye contact and be at eye-level), and environmental factors (e.g. being in a safe space and limiting the number of people in the room, inviting a patient to bring a support person, use soft lights)5 6.

Perinatal women want a “humanised care model”7 within a medical system that can feel dehumanising. Staff should be attentive, supportive and respectful.8

- Work in collaboration with women about their care, and offer women genuine choice in the type of support and services they receive9. Perinatal women express the importance for practitioners to listen to, acknowledge and validate their experiences10. A physically and emotionally safe environment is important for trauma discussion11.
- Trauma-informed care should take a holistic approach to mothers’ needs and include mental health support as a core component.12 Staff should have access to adequate referral pathways to provide routes to additional support.
- Where relevant, partners should be included in appointments and receive information about changes to expect and look out for during the perinatal period13. Follow-up support should be provided to women who experience loss of a child, or have a child removed from their care14 15.
- Where possible, women with lived experience should be involved in co-producing services. Women using services should be given the chance to be involved in decisions about service design and delivery and opportunities to provide regular feedback16. Provide all staff with training and resources in trauma-informed approaches and cultural competency, which are also realistic about workforce capacity and challenges.17 Make this central to services in order to promote organisational change. May use organisational ‘champions’ to promote cultural change.18 Recognise the impact of vicarious trauma or potential past trauma of professionals working in perinatal care. Adequate support for staff wellbeing is essential to combat staff burnout and emotional fatigue.

Reflective supervision, debriefing, self-care resources, access to therapeutic services and building a culture of trust are recommended for supporting staff19 20 (see more about clinical supervision in mental health in an evidence summary here). Recognise the longer-term impact that the COVID-19 pandemic may have had on perinatal women and staff (particularly in terms of negative mental health and staff burnout) and build this into trauma-informed approaches21. More widely, it is recommended that trauma-informed services are implemented in a unified, centralised approach across the UK. With adequate funding and resource to properly deliver and evaluate trauma-informed care22.

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- Recognise the impact of vicarious trauma or potential past trauma of professionals working in perinatal care. Adequate support for staff wellbeing is essential to combat staff burnout and emotional fatigue. Reflective supervision, debriefing, self-care resources, access to therapeutic services and building a culture of trust are recommended for supporting staff19 20 (see more about clinical supervision in mental health in an evidence summary here).
- Recognise the longer-term impact that the COVID-19 pandemic may have had on perinatal women and staff (particularly in terms of negative mental health and staff burnout) and build this into trauma-informed approaches21.

More widely, it is recommended that trauma-informed services are implemented in a unified, centralised approach across the UK. With adequate funding and resource to properly deliver and evaluate trauma-informed care22.

Trauma screening practices

As part of recognising how trauma may have long-term impacts on mothers and babies, universal screening for past trauma at the early stages of maternity care has become increasingly common, though not rolled out consistently in the UK. In a 2023 review, Cull et al explored the views of women and maternity care providers on routine discussions of previous trauma in the perinatal period. For many patients and professionals, trauma discussion was perceived as acceptable and worthwhile; it helped to identify particular needs and provide more targeted support in perinatal care.23 However, the review highlights several considerations if trauma discussion is to prove a positive process and not deter women from services:

he focus of trauma discussions should not be eliciting specific details of past trauma, but rather ascertaining what resources, support, and/or adjustments to the care plan would be helpful.

Some felt that the screening was intrusive. It is important that women are forewarned of the discussion, including any limits to confidentiality and that disclosure of past trauma is entirely voluntary.

Questionnaires were deemed inappropriate for trauma screening, as were closed or direct questions from professionals.
It is vital that women have had time to build a trusting relationship over multiple encounters with a professional before trauma disclosure. Some women will choose not to disclose trauma. Women may be concerned about judgement as a mother, confidentiality or having a child removed from their care. Information about trauma should be provided to all women to give them the means to access independent support.

- If trauma screenings are used, it is essential that staff have adequate time and resources to properly respond and provide appropriate support or referrals, something which is often lacking.
- Trauma discussions are emotionally challenging for professionals, and reflective supervision is recommended in order to support them.
- In a trauma-informed care framework, implementation of routine screening for

previous trauma should be considered within the context of much broader changes to services, including staff training, continuity of care, emotional support for staff, and service evaluation.24

Equity in trauma-informed perinatal care

A challenge in adopting a trauma-informed approach is the impossibility of identifying specific interventions or practices that are helpful and effective for all women, or work within all organisations25 26. Instead literature on trauma-informed practice tends to recommend broader approaches and values for practitioners to adapt to their own setting27. Yet it is essential to acknowledge within these approaches that individuals will experience trauma in different ways, and also that their needs from services will differ, and services must also adapt to each service user to provide equitable care. Moreover, trauma-informed care means perinatal services not only responding to distress and past trauma experience, but crucially acknowledging their own role in contributing to further distress, something which can be heightened for women from marginalised backgrounds.28 Two examples of where some women's needs have been overlooked in perinatal care and considerations for how to make trauma-informed care more equitable are below:

Birth Companions

Birth Companions have published a 2023 Birth Charter with specific focus on supporting women involved with children's social care in the perinatal period. It highlights that these women often have increased health vulnerabilities and are more likely to have past experience of trauma, as well as potential to experience trauma in the perinatal period (e.g. having a child removed from their care). Yet, services are often not designed with these women in mind, nor are they present in policy and research. The Birth Charter therefore outlines principles to inform policy and best practice to ensure fair treatment and better outcomes for all mothers and babies. In relation to trauma-informed practice, it advocates for the following actions:

- All those working with women have training in trauma-informed care so that:
    - The impact of women's past and ongoing trauma and abuse is recognised and responded to
    - The risk of re-traumatising women is mitigated as far as possible.

• Where necessary, timely referrals are made to specialist trauma-responsive therapeutic services.

- Experience of racism in all its forms is acknowledged as a form of trauma.
- Challenging behaviour and/ or a lack of engagement are viewed through the lens of possible past trauma, and creative solutions to address these are considered.

Professionals and women agree how best to record women's experiences of trauma, and minimise the need to reiterate them. For example a statement or 'history' could be written together.

- Professionals working with women are supported to access reflective supervision and therapeutic services themselves.29

Inequalities in perinatal mental health pathways

Darwin et al (2022) highlight the inequalities in identifying and managing perinatal mental health difficulties for women from more marginalised backgrounds. Those mostly likely to experience inequality in accessing perinatal mental health support are women who do not speak English, ethnic minority women who do speak English, women experiencing socio-economic deprivation, and those with learning difficulties. They note that barriers for these women include a lack of appropriate language provision (e.g. interpreters), a lack of clarity and consistency in referral pathways, digital exclusion, increased stigma around mental health, a lack of representation in service staff, distrust of services and unwanted involvement with services. Many of these barriers cause further distress to patients and deepen unequal access to perinatal care.

To make perinatal care more trauma-informed and equitable, Darwin et al call for system level change which crucially builds emotional safety for both those receiving and providing perinatal care. This includes tackling distrust in services, for individuals but also at a community level, and the authors call for greater recognition that marginalised communities may be traumatised by services. In addition, the authors argue for the need to improve cultural competency in perinatal services, to make mental health care a core part of perinatal care so that adequate provision is provided, and to utilise partnership working in order to achieve these aims.30

Citation	Evidence type	Summary
SAMHSA (2014) ***SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*** Available here	Paper	This early paper develops a working definition of the concept of trauma and a trauma-informed approach. It is the first to identify six key principles of a trauma-informed approach. This work is internationally recognised and remains the most widely cited piece of work on trauma-informed practice and continues to form the basis of most other literature on, and recommendations for, trauma-informed care.
Office for Health Improvement & Disparities (2022) Guidance: Working definition of trauma informed practice, GOV.UK Available here	Web page	This short guidance page provides a working definition of trauma-informed practice and its key principles for practitioners working in the health and social care sector in the UK. The working definition presented in this document reflects the original work of SAMHSA above.
Birth Companions (2023) ***The Birth Charter for women with involvement from children's social care*** Available here	Report	This Birth Charter sets out how services and systems in England should support all women involved with children's social care from conception to their child's second birthday. These women are more likely to have experience of trauma and increased vulnerabilities, and yet they are often overlooked in policy, research and service development. The Charter provides trauma-informed principles and recommendations to inform and shape policy, commissioning, and professional practice to ensure fair treatment and better outcomes for these mothers and their babies.
Cull J., Thomson G., Downe S., Fine M., Topalidou A. (2023) Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: A qualitative evidence synthesis. PLOS ONE 18(5) Available here	Journal article	This evidence review explores the views of women and maternity care professionals on routine discussion of previous trauma in the perinatal period from a total of 25 papers. It finds that women and clinicians largely felt trauma discussions were valuable and worthwhile, provided there was adequate time and appropriate referral pathways. It raises key considerations to make trauma screening successful, including prewarning patients of trauma discussion, establishing a trusting practitioner-patient relationship, undertaking trauma discussions only when and if women want to, ensuring that staff have adequate time and resource to respond to trauma disclosure, and providing support to staff involved in trauma discussions.
Perera, E. et al. (2023) Women's experiences of trauma, the psychosocial impact and health service needs during the perinatal	Journal article	This Canadian study addresses two main objectives: 1) To explore the psychological symptoms and experiences of perinatal women with histories of interpersonal traumatic experiences (prior to, or during pregnancy); and 2) To understand the psychological and medical service needs and gaps as expressed by perinatal women. It explores the role of traumatic events and the role of social support in perinatal experiences, perinatal experiences during COVID-19, barriers in help-seeking and the specific service and medical needs of women with a history of trauma.

period. ***BMC Pregnancy Childbirth*** 197 (23) Available here		It provides a list of recommendations made by perinatal women with experience of trauma about the kind of care and services they want to receive.
Darwin, Z. et al. (2022) Addressing inequalities in the identification and management of perinatal mental health difficulties: The perspectives of minoritised women, healthcare practitioners and the voluntary sector***, Frontiers in Global Women's Health***, 3 Available here	Journal article	This study aims to understand the key factors that enable and hinder access to perinatal mental health care for women from minoritised groups. It identifies avoidable barriers and facilitators which lead to inequalities in perinatal mental health care for women such as those who do not speak English, ethnic minority women, and those who are socioeconomically deprived. It provides recommendations for trauma-informed perinatal mental health care to become more equitable, which include the need for system level change, building emotional safety, perinatal mental health as part of core business, cultural competency and partnership working.
Ward, LG. (2020) Trauma- Informed Perinatal Healthcare for Survivors of Sexual Violence. ***J Perinat Neonatal Nurs***,34(3), pp.199- 202. (Manuscript version) Available here	Journal article	This short article outlines the principles of trauma-informed care and provides some examples for implementing universal perinatal trauma-informed practices.
Hall S, White A, Ballas J, Saxton SN, Dempsey A, Saxer K. (2021) Education in Trauma-Informed Care in Maternity Settings Can Promote Mental Health During the COVID-19 Pandemic. J Obstet Gynecol Neonatal Nurs.50(3), pp.340-351 Available here	Journal article	This article highlights the adverse effects that the COVID-19 pandemic had on people's mental health globally, including pregnant women and clinicians who provide maternity care. It argues the need for clinicians in maternity settings to be educated about the principles of trauma-informed care to support the mental health of pregnant women, themselves and other professionals during the pandemic, but also noting the longer lasting effects the pandemic is likely to have on perinatal women and professionals.
Emsley, E. et al. (2022) Trauma-informed care in the UK: where are we? A	Journal article	This study aims to investigate trauma-informed approaches to health care in a UK-context. It explores how trauma-informed approaches are represented in health policies in the UK, and how they are understood and implemented by policy makers and professionals. It finds that

qualitative study of health policies and professional perspectives. ***BMC Health Serv Res*** 22, 1164 Available here		there is a lack of consistency in approach, understanding and implementation of trauma- informed care because there is no UK or NHS wide strategy. In addition there is a lack of evidence and evaluation to measure the efficacy of trauma-informed services. It argues for a coordinated, more centralised strategy and provision for trauma-informed healthcare, increased funding for evaluation and professional education about evidence-based trauma-informed care.
Wilton, J & Williams, A (2019) Engaging with complexity: Providing effective trauma-informed care for women, Centre for Mental Health Available here	Resource	This is a resource examining and providing guidance for gender-sensitive trauma-informed approaches for public sector service providers (not specific to health or perinatal care). Working with women with lived experience of trauma, their research identifies four essential aspects that women want in trauma-informed care: Listening, Understanding, Responding and Checking. The resource outlines 'Actions' for how each of these might be implemented in practice. It is a nice example of a simple and user-friendly resource on trauma-informed care.

Appendix 1 – Methodology

Date of literature search

Search: Sources in NSPCC Learning, Current awareness for policy, practice and research (CASPAR) newsletter, 10th July 2023 CASPAR

- Relevant results:
  - Birth Companions (2023) ***The Birth Charter for women with involvement from children's social care***

Search: References in Birth Companions (2023) ***The Birth Charter for women with involvement from children's social care***

- Relevant results:
  - Office for Health Improvement & Disparities (2022) Guidance: Working definition of trauma-informed practice, GOV.UK

Search: EBSCO Discovery Service

- Search terms: trauma-informed perinatal care
- Filtered by: peer reviewed, 2019-2023
- Relevant results:
  - Melissa A. Simon ***et al.*** (2020) 'Refining Trauma-Informed Perinatal Care for Urban Prenatal Care Patients with Multiple Lifetime Traumatic Exposures: A Qualitative Study', ***Journal of Midwifery & Women's Health***, 65, pp. 224–230 (cannot gain access)

Search: References in Melissa A. Simon ***et al.*** (2020) 'Refining Trauma-Informed Perinatal Care for Urban Prenatal Care Patients with Multiple Lifetime Traumatic Exposures: A Qualitative Study', ***Journal of Midwifery & Women's Health***, 65, pp. 224– 230 (cannot gain full access)

- Relevant results:
  - Cull J., Thomson G., Downe S., Fine M., Topalidou A. (2023) Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: A qualitative evidence synthesis. PLOS ONE 18(5)
  - Perera, E. et al. (2023) Women's experiences of trauma, the psychosocial impact and health service needs during the perinatal period. ***BMC Pregnancy Childbirth*** 197 (23)

Search: EBSCO Discovery Service

- Search terms: best practice perinatal care
- Filtered by: peer reviewed, 2020-2023, full text
- No relevant results

Search: EBSCO Discovery Service

- Search terms: best practice and trauma-informed and perinatal care
- Filtered by: peer reviewed, 2020-2023, full text
- No results

Search: EBSCO Discovery Service

- Search terms: trauma and perinatal
- Filtered by: peer reviewed, 2020-2023, full text
- Relevant results:

- Darwin Z. et al. (2022) 'Addressing inequalities in the identification and management of perinatal mental health difficulties: The perspectives of minoritised women, healthcare practitioners and the voluntary sector', Frontiers in Global Women's Health, 3. doi:10.3389/fgwh.2022.1028192.
- Kuzma E, Pardee M, Morgan A. (2020) Implementing Patient-Centered Trauma-Informed Care for the Perinatal Nurse. The Journal of Perinatal & Neonatal Nursing; 34 (4): E23-E31. (cannot gain access)

Search: Google Scholar
- Search terms: trauma informed perinatal care
- Filtered by: Since 2019
- Relevant results:
  - Ward LG. (2020) Trauma-Informed Perinatal Healthcare for Survivors of Sexual Violence. ***J Perinat Neonatal Nurs***,34(3), pp.199-202.
  - Hall S, White A, Ballas J, Saxton SN, Dempsey A, Saxer K. (2021) Education in Trauma-Informed Care in Maternity Settings Can Promote Mental Health During the COVID-19 Pandemic. ***J Obstet Gynecol Neonatal Nurs***, 50(3), pp.340-351.

Search: Google Scholar
- Search terms: clinical supervision for perinatal nurses or midwives or professionals
- Filtered by: Since 2019
- No relevant results

Search: Google Scholar
- Search terms: trauma informed support for perinatal nurses or midwives or professionals
- Filtered by: Since 2019
- No relevant results

Search: Google Scholar
- Search terms: trauma informed perinatal care leicestershire
- Filtered by: 2019
- No relevant results

Search:
- Search terms: trauma informed perinatal care uk
- Filtered by: Since 2019
- Relevant results:
  - Emsley, E. et al. (2022) Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives. ***BMC Health Serv Res*** 22, 1164

Search: References in Emsley, E. et al. (2022) Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives. ***BMC Health Serv Res*** 22, 1164
Relevant results:
  - Wilton, J & Williams, A (2019) Engaging with complexity: Providing effective trauma-informed care for women, Centre for Mental Health

Appendix 2 – References

1 Office for Health Improvement & Disparities (2022) Guidance: Working definition of trauma informed practice, GOV.UK

2 Ward, LG. (2020) Trauma-Informed Perinatal Healthcare for Survivors of Sexual Violence. ***J Perinat Neonatal Nurs***,34(3), pp.199-202. (Manuscript version)

3 Office for Health Improvement & Disparities (2022) Guidance: Working definition of trauma informed practice, GOV.UK

4 Emsley, E. et al. (2022) Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives. ***BMC Health Serv Res*** 22, 1164

5 Ward, LG. (2020) Trauma-Informed Perinatal Healthcare for Survivors of Sexual Violence. ***J Perinat Neonatal Nurs***,34(3), pp.199-202. (Manuscript version)

health service needs during the perinatal period. ***BMC Pregnancy Childbirth*** 197 (23)

9 Wilton, J & Williams, A (2019) Engaging with complexity: Providing effective trauma- informed care for women, Centre for Mental Health, health service needs during the perinatal period. ***BMC Pregnancy Childbirth*** 197 (23)

11 Wilton, J & Williams, A (2019) Engaging with complexity: Providing effective trauma- informed care for women, Centre for Mental Health

health service needs during the perinatal period. ***BMC Pregnancy Childbirth*** 197 (23)

14 Perera, E. et al. (2023) Women's experiences of trauma, the psychosocial impact and health service needs during the perinatal period. ***BMC Pregnancy Childbirth*** 197 (23)

15 Birth Companions (2023) ***The Birth Charter for women with involvement from children's social care***

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THANK YOU!