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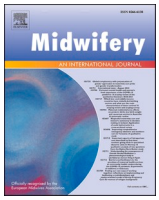

Review Article

Best practice recommendations for the integration of trauma-informed approaches in maternal mental health care within the context of perinatal trauma and loss: A systematic review of current guidance

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ABSTRACT

Purpose: The National Health Service (NHS) in England plans to increase accessibility to evidence-based, trauma-informed psychological care for women in the perinatal period. Therefore, this systematic review aimed to 1) synthesise current guidance from clinical guidelines, policy documents, and care standards on trauma-informed approaches to care in maternal mental health settings within the context of pregnancy-related trauma and 2) to offer recommendations informing the implementation and evaluation of this type of care.

Methods: Nine electronic databases were searched and screened. Data were extracted and analysed using narrative synthesis. Included records were quality-assessed.

Results: After screening 1095 identified records, 11 records were included. The findings were synthesised into eight recommendations: 1) *screening for trauma,* 2) *access to care,* 3) *clear and sensitive communication,* 4) *consistency and continuity of care,* 5) *offering individualised care whilst recognising diversity,* 6) *collaboration between women, families, and services,* 7) *care provider training to enhance skills and knowledge,* and 8) *supervision and peer support for care providers.*

Conclusions: The findings of this review are highly relevant given the current development, delivery, and evaluation of specific maternal mental health services, particularly in the United Kingdom, but also with the increase in perinatal mental health provision more globally.

Introduction

Mental health difficulties, which affect between 10–20 % of women during pregnancy and the first year following birth, are associated with considerable maternal, neonatal, infant and child morbidity and mortality rates (Howard and Khalifeh, 2020). Maternal suicide persists as the leading cause of direct mortality between six weeks and the first year following birth, accounting for almost 40 % of direct deaths during this period (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE-UK], 2023); this highlights the need for high quality trauma-informed perinatal mental health care. In many high-income countries, such as the United Kingdom (UK) and Australia, there have been significant investments to improve perinatal mental health care, underpinned by relevant clinical guidance (for a review, see O'Brien et al., 2023).

The National Health Service (NHS) in the UK recognises perinatal mental health difficulties as occurring in pregnancy up until 12 months after childbirth, which has been extended to 24 months more recently (NHS Health Education England, 2022). In the UK, the NHS Long-Term Plan (NHS England, 2019) was developed to achieve this goal of improved service provision for mothers of infants, which included the implementation of Maternal Mental Health Services (MMHS) alongside existing perinatal mental health services which assess and/or treat women with a range of mental health conditions (such as postnatal depression, anxiety, etc.). This implementation of MMHS is a key joint ambition between perinatal mental health and maternity services, with

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MMHS providing multidisciplinary integrated care and support to women and birthing people experiencing moderate to complex mental health difficulties arising from trauma or loss related to pregnancy or childbirth (e.g., tokophobia, post-traumatic stress following childbirth, miscarriage, stillbirth, neonatal death, pregnancy termination, and loss of custody), whose needs are not currently met in other services (e.g., NHS Talking Therapies).

MMHS have two overarching aims: 1) to offer timely access to specialist assessment and evidence-based treatment, with a focus on psychological interventions in line with National Institute for Health and Care Excellence (NICE) guidance (National Collaborating Centre for Mental Health, 2018) and 2) to implement a holistic, personalised and trauma-informed approach to women's mental health care (Easter et al., 2022; Law et al., 2021).

Trauma-informed care a) prioritises the psychological wellbeing of both service users (e.g., women and/or mothers/and or birthing people) and care providers, b) recognises the prevalence and impact of trauma, and c) focuses on care provider skill to respond compassionately and prevent (re)traumatisation (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). It is important to highlight that trauma-informed care refers to a more holistic approach adopted by the service and as such this type of care differs from trauma-focused therapeutic interventions (such as Trauma-Focused Cognitive Behavioural Therapy and/or Eye Movement Desensitisation and Reprocessing). These specific and structured interventions focus on one or more traumatic event(s) and/or aim at a reduction in traumatic stress symptoms (Lewis et al., 2020).

International evidence highlights the benefits of trauma-informed care for the health outcomes of women, their families, and healthcare professionals and the need for the integration of such an approach in maternity and mental health services for women in the perinatal period (Hall et al., 2021; Sperlich et al., 2017), which has been operationalised in the UK via implementation of MMHS. Furthermore, NHS England recently commissioned an organisation to produce a best practice guide to trauma-informed care in maternity and perinatal mental health services (Law et al., 2021). In line with the increasing international recognition of the importance of trauma-informed care within this setting, numerous other recommendation documents and best practice guidelines have been developed. However, despite aiming to provide perinatal mental health care for 66,000 women with moderate to severe perinatal mental health difficulties by 2023/24, as outlined in the NHS England Long-Term Plan (2019), there is no existing literature which synthesises the recommendations for trauma-informed care in relevant settings to ensure optimal care can be offered to women who have experienced trauma or loss resulting from pregnancy or childbirth. As it is critical to synthesise recommendations to ensure treatment approaches and interventions do not cause iatrogenic (trauma relating to health care) harm in both service users and care providers, the current review aimed to identify, appraise, and synthesise current guidance (from clinical guidelines, policy documents, care standards and practice recommendations) on trauma-informed approaches to care in maternal mental health settings focusing on trauma resulting from pregnancy or childbirth. Furthermore, this review also aimed to support the implementation of trauma-informed care for those working with women with pregnancy or childbirth related loss or trauma (i.e., perinatal trauma) in maternity and mental health settings by offering recommendations.

Methods

Design

The current systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021), in liaison with an expert by

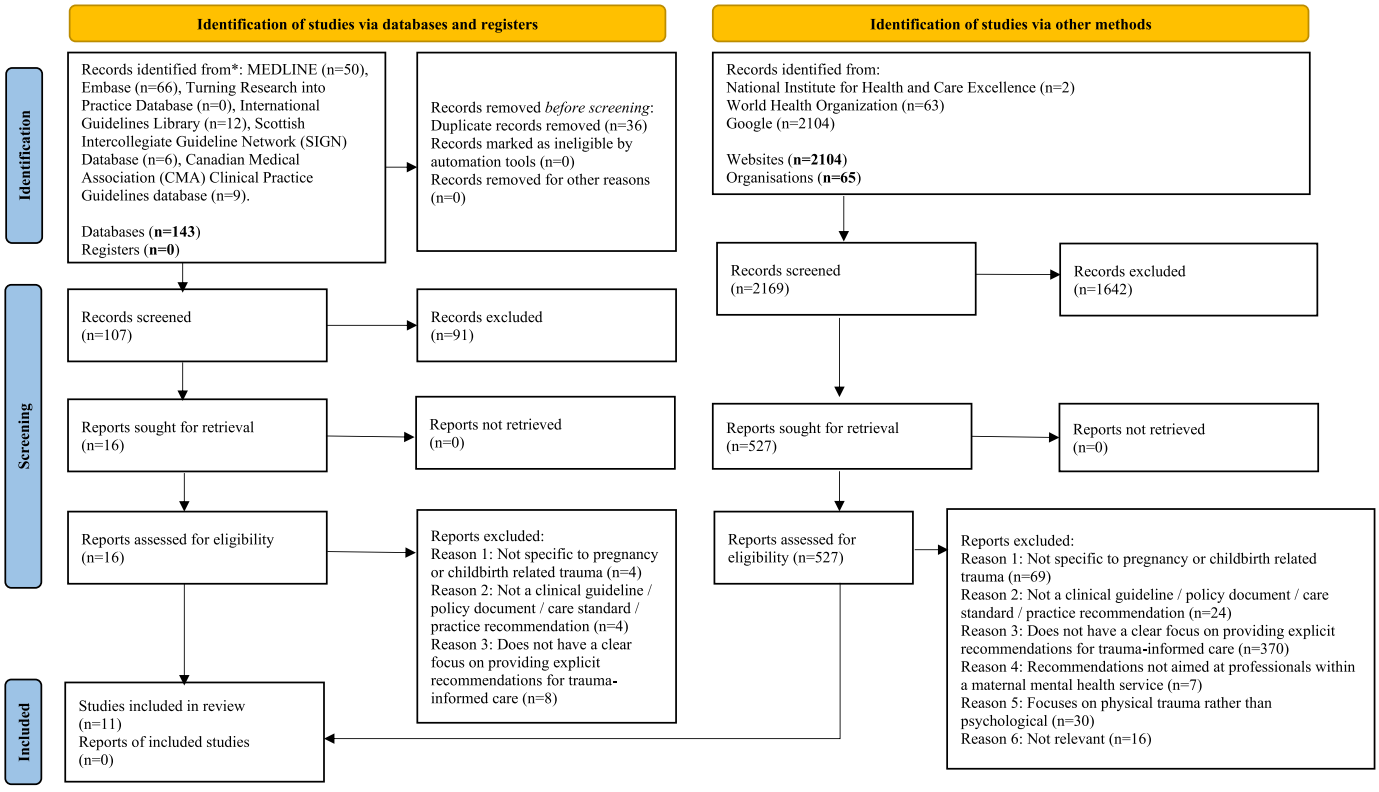

Fig. 1. PRISMA diagram of the search strategy.

experience (TQ) ,[1] maternal mental health care professionals, and with the support of a university librarian.

Search strategy

To identify clinical guidelines, policy documents, care standards and practice recommendations, we conducted a systematic search of the literature in nine electronic databases and websites: MEDLINE, EMBASE, Turning Research into Practice Database, International Guidelines Library, Scottish Intercollegiate Guideline Network (SIGN) Database, Canadian Medical Association (CMA) Clinical Practice Guidelines database, National Institute for Health and Care Excellence, World Health Organization, and Google. One of the authors (HER) and a university librarian developed a combined search strategy of free text terms and exploded Medical Subject Heading (MeSH) terms for the topics of guidelines and perinatal period (see Appendix 1 for the search strategy for all nine electronic databases and websites). The search was performed in May 2022 and updated in February 2023 to capture any new records due to the rapid progression of literature in this field.

Eligibility criteria

The eligibility criteria were developed using the PICOS (Population, Intervention, Comparison, Outcome, Study design) framework (Amir-Behghadami & Janati, 2020). Included clinical guidelines, policy documents, care standards and practice recommendations were required to provide recommendations for the use of a trauma-informed approach within maternity and mental health services for women who experienced pregnancy or childbirth related trauma or loss. For the current review, the perinatal period was considered to include pregnancy up to 24 months after childbirth (NHS England, 2019). Included records had to focus on trauma resulting from pregnancy or childbirth, explicitly state best practice recommendations for trauma-informed care, be available in English and be published in the year 2000 or onwards (due to advances in perinatal research and clinical practice over the last 20 years). All included records had to detail guidelines or recommendations, rather than describe the application of these in practice. There were no limits on country of publication and only the latest version of the record was included. A full representation of the process of searching can be viewed in the PRISMA flow diagram.

Study selection and data extraction

Database search results were imported into a Microsoft Excel spreadsheet. One researcher (ZS) screened all identified records to assess eligibility and removed duplicates, another (HER) independently reviewed 20 % of the titles and abstracts of retrieved records against the inclusion criteria and screened all the excluded abstracts. Full text articles were screened by two independent reviewers (DMS and ZS). Disagreements were discussed and resolved via consensus with a third reviewer (MB). The search was updated in February 2023, when all identified records were screened by one researcher (ZS) and a second researcher (MB) independently screened all included text records. Data were extracted using a structured and piloted data extraction form.

Methodological quality assessment

The quality of the included records was assessed using the Appraisal of Guidelines, Research and Evaluation Version 2 (AGREE II) instrument because its framework (Brouwers et al., 2010) has been used to assess the quality of guidelines (e.g., see O'Brien, Gregg & Wittkowski, 2023). Three reviewers (ZS, MB and DMS) independently rated the quality of all included records. The instrument uses a 7-point Likert scale of agreement from 1 (strongly disagree/information not present) to 7 (strongly agree). Records were assessed across six domains: *scope and purpose, stakeholder involvement, rigour of development, clarity of presentation, applicability*, and *editorial independence*. Domain scores were calculated by totalling the scores of each item by each reviewer and scaling the total as a percentage of the maximum possible score, as per the AGREE II User Manual (Brouwers et al., 2010). The overall quality of each record was rated by considering the overall domain scores and it was then stated whether the guideline would be recommended for use. Percentage scores of the quality of included guidelines were tabulated. A decision was made a-priori to retain any records despite their potentially poor-quality assessment to prevent bias.

Synthesis

A narrative synthesis (Popay et al., 2006) was undertaken by two authors (DMS and MB). Firstly, the definition of trauma and trauma-informed care as given in the included resources were extracted and scrutinised. Secondly, best practice guidelines and recommendations from identified records to support the implementation of trauma-informed care for women with pregnancy and/or childbirth related trauma and/or loss were synthesised so that the relevant data addressed the aim of this review (Levac et al., 2010). For completeness and accuracy, the inclusion of specific recommendations was discussed with the review team who agreed with the findings.

Results

The PRISMA flow chart (see Fig. 1) illustrates the search process and outcome. The systematic search strategy identified an initial 1095 records from the nine databases. Thirty-one duplicates were removed, and the remaining 1064 titles and abstracts were screened for eligibility. Three hundred and fifty-two full texts were assessed and after only publications meeting all inclusion criteria were retained, a total of nine records were included. An updated search conducted in February 2023 identified an additional 1217 records. Five duplicates were removed, leaving 1212 titles and abstracts which were screened for eligibility. Of the 191 full text records assessed, an additional two records met the inclusion criteria, resulting in a total of 11 records included in this review.

Description of included records

Included records were published or most recently updated between 2017 and 2023. One record stated no publication date. All records were published in high-income countries: UK (n=7), Ireland (n=1), Canada (n=1), Australia (n=1) and the USA (n=1).

Quality assessment outcome

The quality assessment of the 11 included guidelines is detailed in Table 1. There was an overarching strength in reporting of guideline objectives and purposes, with most records scoring highly in the *Scope and Purpose* domain on the AGREE II measure. Additionally, most records scored highly in the *Clarity of Presentation* domain, with recommendations clearly presented without ambiguity. However, there were considerable weaknesses in the reporting of *Rigor of Development* domain across guidelines, with a common failure a) to demonstrate how evidence was selected, b) to conduct external reviews prior to publication, and c) to state a procedure for updating guidance.

Section 1: Definition of trauma and trauma-informed care

Due to the variation in definitions of trauma and trauma-informed

[1] Here an expert by experience is defined as an individual with personal experience of using or caring for a person who uses the relevant services (Care Quality Commission, 2022).

Table 1
AGREE II1 quality assessment scores of the 11 included records presented in alphabetical order.

	Organisation, Author, and Year	Domain 1: Scope and Purpose	Domain 2: Stakeholder Involvement	Domain 3: Rigor of Development	Domain 4: Clarity of Presentation	Domain 5: Applicability	Domain 6: Editorial Independence	Overall Guideline Assessment[2]	Overall Guideline Assessment (Recommendations)
1	American College of Obstetricians and Gynecologists' Committee, McNicholas et al. (2021)	81%	31%	1%	100%	54%	100%	4	YES
2	Health Service Executive, Higgins et al. (2017)	100%	50%	0%	100%	100%	100%	4	YES
3	Make Birth Better, Ingman et al. (2020)	97%	83%	38%	100%	38%	100%	5	YES
4	McPin Foundation, Mahony and Thompson (2023)	94%	86%	56%	78%	58%	25%	5	YES
5	NHS Education for Scotland, Currer et al. (2022)	97%	17%	0%	67%	13%	46%	3	YES
6	NHS Shetland, Robertson et al. (2021)	100%	67%	2%	100%	63%	0%	5	YES
7	NHS Wales Perinatal Mental Health Network, unknown (no date)*	100%	92%	31%	100%	100%	50%	5	YES
8	Saskatchewan Prevention Institute, Bayly (2022)	89%	0%	46%	100%	67%	0%	5	YES
9	The ACT Government, Brockway et al. (2022)	50%	56%	33%	36%	48%	17%	3	YES
10	The Centre for Early Child Development, Law et al. (2021)	100%	89%	0%	97%	88%	100%	5	YES
11	The University of Liverpool, Anders et al. (2021)	97%	100%	82%	100%	100%	50%	7	YES

Excellent (>80%)	Good (60 – 79%)	Average (40 – 59%)	Fair (20 – 39%)	Poor (< 20%)

[1]AGREE II Instrument Criteria (Brouwers et al., 2010): Values are the sum of individual scores of criteria within each of the six independent domains scaled as a percentage of the highest possible score. [2]Overall Assessment Guideline rated from 1 (lowest possible quality) to 7 (highest possible quality).
*Despite the absence of a clear publication date, we are confident in justifying its inclusion, as there are details of workshops informing the document conducted in 2019.

care within the literature, definitions of each were extracted (see Appendix 2 for further details). Four records did not provide a definition for trauma (Brockway et al., 2022; Higgins et al., 2017; Mahony & Thompson, 2023; Robertson et al., 2021). Those records that provided a definition, defined trauma in terms of three aspects: the event, the subjective experience of it, and its lasting effects (Ingman et al., 2020). Six records provided a more general definition of psychological trauma (Bayly, 2022; Currer et al., 2022; Law et al., 2021; McNicholas et al., 2021; NHS Wales, n.d.; The University of Liverpool, 2021), three records did not provide a definition of trauma-informed care (Brockway et al., 2022; Ingman et al., 2020; Robertson et al., 2021). Four records referred to the definition provided by (SAMHSA, 2014), in which being trauma-informed is seen as a system-level approach, implemented through policies, procedures and practices that recognise and respond to trauma (Bayly, 2022; Law et al., 2021; Mahony & Thompson, 2023; McNicholas et al., 2021). Other definitions of trauma-informed care emphasised the importance of recognising signs and responding to the impact of trauma to ensure women feel in control of their care (Currer et al., 2022; Higgins et al., 2017; NHS Wales, n.d.; The University of Liverpool, 2021). The differences in definitions of trauma and trauma-informed care across various guidelines signify a lack of consensus and a potential disparity in how healthcare professionals and services understand and approach trauma.

Section 2: Synthesised recommendations

Recommendations for trauma-informed care were extracted from the 11 guidelines and synthesised into eight key recommendations, which are presented in Table 2 and illustrated in Fig. 2. Time was a cross-cutting theme across the eight recommendations. It was recognised that time was vital for the provision of effective care for service users, and essential for staff to engage in reflective supervision which contributed to how they delivered their care.

Recommendation 1: Screening for trauma

Screening for trauma in service users was identified across records as an important aspect for integrating a trauma-informed approach into maternity settings. Screening featured in two ways, namely use in care and in education. Use in care included standardised tools or asking a single question about past or current trauma to open a conversation with the healthcare provider. It is important for care providers to be aware that not all individuals will choose to disclose their trauma, and care providers should be aware of nonverbal indicators of distress and modify care to avoid re-traumatisation. It is also important to remember that trauma is ubiquitous and to apply the principles of a trauma-informed approach to all clients or service users, not just those who have been identified as trauma survivors through screening (Bayly, 2022). Records highlighted the need to educate individuals about the health effects of trauma and the reasons for using screening questions and tools to reduce

Table 2
Synthesised recommendations synthesised across records.

Recommendation		Description of synthesised best practice	Reports
Time	**1: Screening for trauma**	Standardised screening tools and questions can be used to support identification of trauma and open conversation with the healthcare provider. Education around best practice screening (including being aware of nonverbal indicators of distress and avoiding re-traumatisation), and reasons for screening to reduce fear and anxiety around disclosure.	1,3,8,10,11
	2: Access to care	Accessible, timely and understandable information about different care options is needed to provide access to specialist, evidence-based, trauma-informed care for both women, families, and care providers.	2,3,7,8,9,10,11
	3: Clear and sensitive communication	Clear and sensitive communication between care providers and families, involving the woman's partner or family where appropriate, and effective systems of communication between services.	2,7,8,9,10,11
	4: Consistency and continuity of care	Continuity and consistency of high-quality care for women and their families that encourages individuals with experience of trauma to be involved in the co-production of services.	7,8,10,11
	5: Offering individualised care and recognising diversity	Individualised and tailored care that recognises and responds to diversity, cultural, historical and gender issues, fostering a sense of safety, trust, and understanding.	1,7,8,9,10,11
	6: Collaboration between women, families, and services	Collaborative care that centres the woman as an active participant in decision-making, actively involves support networks with the woman's consent, and integrates the input of all care providers in the woman's care and other services that may be necessary.	1,2,5,7,8,10,11
	7: Care provider training to enhance skills and knowledge	Continuous training and education for care providers in a trauma-informed approach, which is integrated into standard induction processes at all organisational levels with a flexible approach incorporating a variety of formats and including input from those with lived experience.	1,3,4,5,6,8,10,11
	8: Supervision and peer support for care providers' wellbeing	Time for reflective supervision and empathetic peer support for care providers to address the potential for experiencing secondary trauma and providing protected time to access appropriate supervision and opportunities for informal debriefings, learning, reflection and building peer support networks.	1,3,5,7,8,10,11

[1]American College of Obstetricians and Gynecologists' Committee, McNicholas et al. (2021).
[2]Health Service Executive, Higgins et al. (2017).
[3]Make Birth Better, Ingman et al. (2020).
[4]McPin Foundation, Mahony and Thompson (2023).
[5]NHS Education for Scotland, Currer et al. (2022).
[6]NHS Shetland, Robertson et al. (2021).
[7]NHS Wales, unknown (no date)
[8]Saskatchewan Prevention Institute, Bayly (2022).
[9]The ACT Government, Brockway et al. (2022).
[10]The Centre for Early Child Development, Law et al. (2021).
[11]The University of Liverpool, Anders et al. (2021)

fear and anxiety around disclosure (Higgins et al., 2017; McNicholas et al., 2021). Consideration should also be given to what modalities of education would be best to deliver this information. Lastly, records highlighted that screening should only be conducted if providers are able to provide appropriate follow-up discussion, offer appropriate care options, and/or refer to other trauma specific services.

Recommendation 2: Access to care

Improving access to specialist, evidence-based, trauma-informed care which includes women, partners, families, and care providers in the long-term must be accessible and timely (Ingman et al., 2020; The University of Liverpool, 2021). Opportunities for conversation, care, and debriefing should be offered to all in the postnatal period with care providers involved in care (Brockway et al., 2022). Information about different care pathways needs to be accessible and understandable to all, which includes information about relevant services that the whole family can access, including third sector, peer support and community organisations. Having a postnatal debrief could offer this information and important signposting could take place. Finally, the access to these services for women must be timely and respond to their needs when identified.

Recommendation 3: Clear and sensitive communication

Emphasis was placed on the consideration of both verbal and written communication. Clear, honest, attentive, non-judgemental communication that is sensitive to trauma and avoids use of medical jargon should be used between care providers and families (Law et al., 2021; The University of Liverpool, 2021). Woman's partner and/or families should be involved where appropriate, in communication between care providers and families (The University of Liverpool, 2021). Information should be up to date, consistent, clear and opportunities provided for the woman or her partner/family to ask questions with repeated opportunities to communicate with familiar care providers (The University of Liverpool, 2021). Ensuring clear communication around care pathways, available support, and decision-making with families, will assist women to feel in control of their care and empowered in their choices and behaviours (Law et al., 2021). The importance of communication when addressing physical contact between professionals, service users, and their families, where appropriate, was also highlighted. When physical contact may be necessary, care providers should ask the person before any contact is made, explain what they are about to do and ask the person if they are ready, aiming to avoid a rushed, insensitive, service-centred approach and ensure a thoughtful, sensitive, woman-focussed approach. In situations of unexpected medical intervention, care providers need to use clear and accessible communication (Higgins et al., 2017). Lastly, the importance of effective systems of communication between services was highlighted, which can assist care providers exchange patient information in an accurate and timely way through close working relationships and collaboration (The University of Liverpool, 2021).

Recommendation 4: Consistency and continuity of care

Continuity and consistency of high-quality care were recognised as key to the delivery of trauma-informed care and discussed in relation to its impact and ways to improve delivery. It offers women, their families, and care providers the opportunity to build trusting relationships with each other in the perinatal period (NHS Wales, n.d). Those care providers are then better placed to notice longer term changes in mental health that may benefit from intervention (The University of Liverpool, 2021). Continuity of care, and particularly carer, can promote feelings of safety and security, reduce anxiety and stress, increase attendance, improve safety and clinical outcomes (The University of Liverpool, 2021). Importantly, continuity of carer may assist in reducing

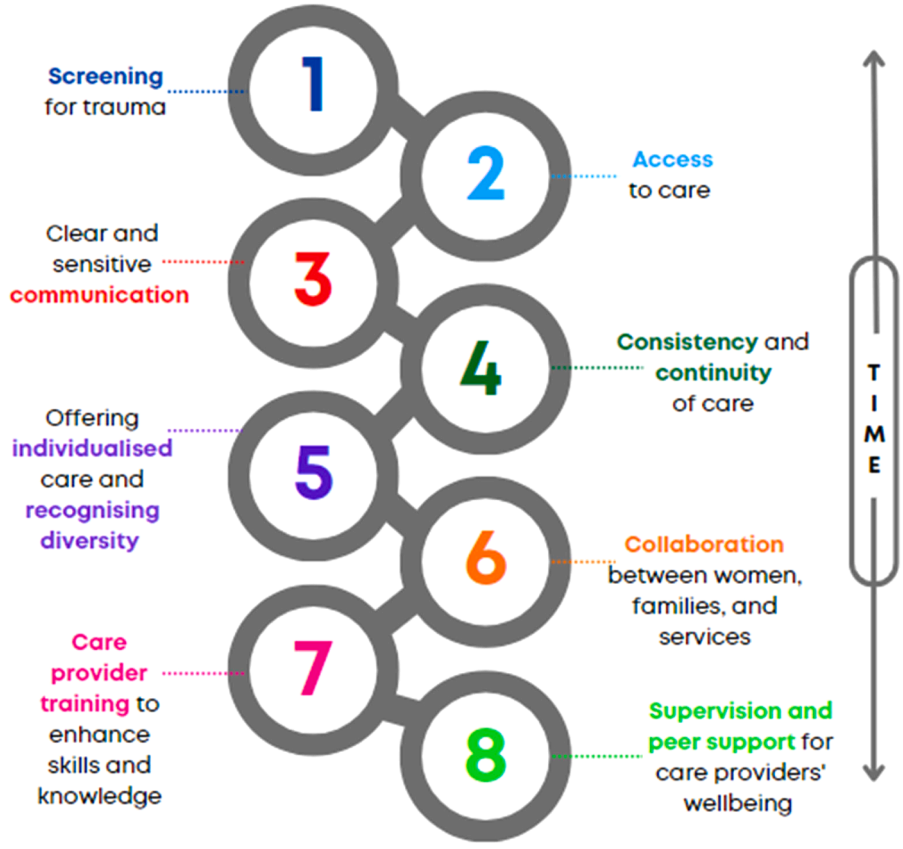

Fig. 2. Model of recommendations.

re-traumatisation by minimising the need to retell experiences of trauma at follow up appointments (Law et al., 2021). Furthermore, it was highlighted that documenting information about a woman's mental health history, mental wellbeing and her plan of care, as well as decisions reached in collaboration with her and her significant other(s), are important for communication and continuity of care (Higgins et al., 2017). Lastly, it was emphasised that individuals with experience of trauma are integral to co-produced services to improve delivery, this approach includes how services are commissioned and designed; how care providers gain the appropriate skills, knowledge and abilities to support people effectively (Law et al., 2021).

Recommendation 5: Offering individualised care and recognising diversity

The importance of offering individualised care, tailored to individual needs and preferences, that recognises diversity and how cultural, historical and gender issues may impact on individuals and families' lives was highlighted (Law et al., 2021; The University of Liverpool, 2021). It is important for care providers to remain curious about what sort of care would be acceptable and appropriate for women, which in turn should foster a sense of safety, trust and understanding for women (Law et al., 2021). In addition, Law et al. (2021) outlined that to develop cultural sensitivity, care providers should critically reflect on their own beliefs, biases or stereotypes that they might hold, even if unintentionally.

Recommendation 6: Collaboration between women, families, and services

The importance of collaboration was highlighted across records. Collaboration included ensuring women are active participants in decision making around their care and that a woman's family or other support network are encouraged to be involved in her care, with the woman's consent (Higgins et al., 2017). Care plans should be developed in collaboration and consultation with the woman and current and relevant past and present care providers to facilitate the sharing of key information between all (Higgins et al., 2017). It is also important that clear explanations and multiple opportunities are offered to women to ask questions to support empowered collaborations, as well as efforts to minimise power differences through shared decision making between care providers and women and their families. Furthermore, collaborative working between professions and across services was highlighted as key to achieving the best outcomes for women (Robertson et al., 2021).

Recommendation 7: Care provider training to enhance skills and knowledge

Records documented the importance of care provider training for the

integration of trauma-informed care into maternity settings. It was highlighted that training should be part of the routine induction of care providers and their ongoing professional development, as well as the need for training to occur at all hierarchical levels of an organisation, and opportunities for education and training should be flexible (Bayly, 2022; Currer et al., 2022; Law et al., 2021). This training needs to ensure that care providers have the skills and knowledge to take an active trauma-informed approach to care from service design down to delivery. Bayly (2022) noted that training within a trauma-informed approach should address secondary trauma and supports to mitigate it. Ideally, training should be co-produced with experts by experience (The University of Liverpool, 2021).

Recommendation 8: Supervision and peer support for care providers wellbeing

The potential for care providers to experience trauma and adversity themselves was acknowledged across records, which recommended that trauma-informed care incorporate the provision of reflective supervision and empathic peer support for all care providers. Recognising secondary trauma and the potential for re-traumatisation of care providers who are working with those experiencing current trauma or who have a trauma history should be essential to their supervision and support (Bayly, 2022). Law et al. (2021) highlighted that supervisors should understand the real risk and impact of vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout and work with care providers to recognise early signs and develop support strategies. Peer support workers within services also require adequate support to fulfil their roles as they may not have supervision structures in place (Law et al., 2021). Services should consider providing protected time for care providers to regularly access appropriate supervision that does not reinforce or deepen trauma by doing the following: a) normalising reactions that any care providers across service sectors might have in reaction to trauma, including vicarious trauma, secondary traumatic stress, compassion fatigue and burnout, b) holding informal debriefings among peers following particularly challenging cases, situations or events, and c) enabling time and space to learn and reflect together and build a network of peer support (Law et al., 2021).

Discussion

Loss or trauma in relation to pregnancy or childbirth experiences can have significant impacts on women and their families, affecting their emotional, psychological, and physical health. There is a drive in policy and practice for perinatal health services to provide trauma-informed care as seen in the roll-out of MMHS in the UK. Our review led to the identification of 11 guidelines whose recommendations were distilled into eight distinct but connected recommendations (see Fig. 2). Integral to all eight recommendations was the importance of time, which was recognised as vital for the provision of effective care for service users, and essential for staff to engage in reflective supervision which contributed to how they delivered their care. Increased evidence surrounding the potential short- and long-term benefits of trauma-informed care would strengthen motivations for organisations to invest, and healthcare providers to train in implementing a trauma-informed approach.

The eight recommendations presented here are already partly reflected in the priority areas within maternity settings in the UK, and outlined in key policy documents (e.g., NHS England, 2016). For example, in relation to recommendation 4, models of midwifery continuity of care are already recommended in international guidance and at the heart of maternity policy in the UK and Australia, when there are recommendations to scale up continuity models on the basis of improving high quality and safe maternity care (Australian Government Department of Health, 2019; Fernandez Turienzo et al., 2020; Homer, 2016; NHS England, 2016). In several countries, including the UK, midwives provide care for women during pregnancy and as such are gatekeepers to further care such as mental health support. Likewise, continuity of carer has been suggested as important when discussing existing trauma with women in pregnancy due to familiarity and comfort with the person (Cull et al., 2023). Finally, it has been suggested that when continuity of care is aligned with a trauma-informed approach, it further supports and empowers vulnerable women during their maternity care (Godkin, 2020).

A recent integrative review of trauma-informed care education provided for midwives and midwifery students, emphasised that trauma-informed care education is the foundational intervention when implementing such approaches, and that this education should be provided to all care providers employed within the maternity service (Long et al., 2022). However, in their review, Long et al. (2022) also stressed that perinatal care providers currently received limited or no access to trauma-informed care training and that there was a dearth of literature on trauma-informed care education for care providers in this setting. Despite such education being a recommendation in the current review (see recommendation 8), and in line with previous literature (Long et al., 2022), we acknowledge that further consideration and research are required to implement and evaluate the impact of trauma-informed care education including the identification of appropriate content and strategies for effective delivery to produce sustainable change and long-term improvements in care quality.

Strengths and limitations

A key strength of the study was our approach to identification of records, which included guidance and guidelines containing explicit recommendations. This approach was selected due to the common practice of MMHS utilising clinical practice guidelines and recommendations to design care provisions; clinical practice guidelines are often relied on to inform the delivery of high-quality care (e.g., see O'Brien et al., 2023). This approach will allow for services to incorporate synthesised and appraised recommendations into service design and will also aid service evaluation. Another major strength of this study was that our team comprised individuals with lived experience who informed the generation of the recommendations.

We recognise that potentially relevant records might have been missed, written in languages other than English, or indexed in databases other than those chosen by us. It is important to acknowledge that all identified records were conducted in high income countries. Although several records discussed the importance and use of trauma and trauma-informed care within maternity settings (e.g., see Royal College of Psychiatrists, 2021; Western Australian Department of Health, 2015), they were excluded because no explicit recommendations were reported. We also acknowledge that using the quality tool, the team perceived one element (rigour of development) of the included evidence

to be low quality. A similar experience was found in a recent review in which low scores were also assigned to rigour of development due to missing information (O'Brien et al., 2023). In agreement with O'Brien et al. (2023), we feel these processes were likely to have been completed but not captured in the published report. The AGREE-II tool takes an academic approach and measures methodological quality (Brouwers et al., 2010), whereas the reports were aimed at audiences interested in implementing the findings rather than the methodological processes.

Implications

The present study has several significant implications for policy, service delivery, and health outcomes of women and birthing people, and their families. They are particularly relevant in light of the increasing emphasis on and understanding of the importance of trauma-informed services and ongoing issues relating to the inconsistent way 'trauma-informed' is understood and operationalised in maternity services. Overall, the recommendations are of particular value for care professionals and organisations working with women who have experienced perinatal trauma or loss, as well as aiding women and their families in understanding what good trauma-informed care might include. Adopting the provided recommendations offers an opportunity to improve experiences of care for women and families, reduce harm, and improve working for care providers. In view of the growing emphasis on improving support and care for women during the perinatal period, the findings of this review provide a foundation for the development and delivery of mental health services during this critical time. Furthermore, the review can be used as a framework to evaluate services that adopt a trauma-informed approach to care for women who have experienced perinatal trauma or loss. Overall, the implementation of these eight recommendations will likely require service commissioners requesting service providers to carefully consider and earnestly attempt to put these recommendations into practice. Embedding these recommendations into existing MMHS may also necessitate extra funding, possibly for employment of psychologists to aid in supervising and training staff, as well as for recruiting additional personnel to ensure sufficient time for engaging in these activities. We would also like to note that the concept of co-production was only thoroughly addressed in a single document (Law et al., 2021). However, co-production has been central to many reports in maternity settings, particularly in the UK (e.g., see the NHS Better Births report, 2016). Importantly, co-production can assist with the implementation of several of our identified recommendations including a) the improvement in accessibility (recommendation 2), b) the development of effective communication strategies (recommendation 3), c) the identification of barriers to care (recommendation 6), and d) the tailoring of services to community diversity (recommendation 5).

Conclusion

The current review identified eight recommendations for trauma-informed approaches within maternal mental health-care settings in the context of pregnancy or childbirth-related loss or trauma. Findings have significant implications for policy, service delivery, and women's health outcomes, providing a foundation for the development, refinement, or implementation of perinatal mental health services. Additionally, the recommendations are valuable for assessing services that adopt a trauma-informed approach and as potential service standards.

Ethics approval and consent to participate

No ethical approval or consent was required for this rapid review.

Consent for publication

Not applicable

Availability of data and materials

Not applicable

CRediT authorship contribution statement

Madeleine Benton: Data curation, Formal analysis, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing. **Anja Wittkowski:** Conceptualization, Data curation, Funding acquisition, Investigation, Methodology, Supervision, Writing – review & editing. **Dawn Edge:** Conceptualization, Funding acquisition, Supervision, Writing – review & editing. **Holly E. Reid:** Data curation, Methodology, Writing – review & editing, Investigation. **Terri Quigley:** Writing – review & editing. **Zoyah Sheikh:** Data curation, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Debbie M. Smith:** Conceptualization, Funding acquisition, Project administration, Investigation, Methodology, Data curation, Formal analysis, Supervision, Writing – original draft, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix

Database	Adapted Search Strategy
Medline	1 exp GUIDELINE 2 (guideline* OR standard* OR best practice* OR recommendation* OR pathway* OR policy guidance).ti,ab. 3 1 OR 2 4 exp PERINATAL CARE 5 exp PREGNANCY 6 (maternal mental health OR maternity OR postpartum mental health OR postnatal mental health OR peripartum mental health OR antenatal mental health OR antepartum mental health).ti,ab. 7 4 OR 5 OR 6 8 (trauma informed OR TIC OR trauma based).ti,ab. 9 3 AND 7 AND 8
Embase	1 exp PRACTICE GUIDELINE 2 (guideline* OR standard* OR best practice* OR recommendation* OR pathway* OR policy guidance).ti,ab. 3 1 OR 2 4 exp PERINATAL CARE 5 exp PREGNANCY 6 (maternal mental health OR maternity OR postpartum mental health OR postnatal mental health OR peripartum mental health OR antenatal mental health OR antepartum mental health).ti,ab. 7 4 OR 5 OR 6 8 (trauma informed OR TIC OR trauma based).ti,ab. 9 3 AND 7 AND 8
Turning Research Into Practice Database	(pregnancy) OR (perinatal care) OR (maternal mental health OR maternity OR postpartum mental health OR postnatal mental health OR peripartum mental health OR antenatal mental health OR antepartum mental health).ti,ab. AND (standard guideline* OR standard* OR best practice* OR recommendation* OR pathway* OR policy guidance).ti,ab.") OR (guideline) AND (trauma informed OR tic OR trauma based).ti,ab.
International Guidelines Library	Used the following terms individually: 'perinatal care', 'maternal mental health', 'postpartum mental health', 'postnatal mental health', 'peripartum mental health', 'antenatal mental health', 'antepartum mental health', 'TIC', 'trauma informed', 'trauma based', 'pregnancy mental health', 'maternity mental health'
Canadian Medical Association (CMA) Clinical Practice Guidelines database	(exp GUIDELINE) OR (guideline* OR standard* OR best practice* OR recommendation* OR pathway* OR "policy guidance") AND ((exp "PERINATAL CARE") OR (exp PREGNANCY) OR ("maternal mental health" OR maternity OR "postpartum mental health" OR "postnatal mental health" OR "peripartum mental health" OR "antenatal mental health" OR "antepartum mental health")) AND ("trauma informed" OR TIC OR "trauma based") Used the following terms individually: 'perinatal care', 'maternal mental health', 'postpartum mental health', 'postnatal mental health', 'peripartum mental health', 'antenatal mental health', 'antepartum mental health', 'TIC', 'trauma informed', 'trauma based', 'pregnancy mental health', 'maternity mental health'
National Institute for Health and Care Excellence (NICE)	Used the following terms individually: 'perinatal care', 'maternal mental health', 'postpartum mental health', 'postnatal mental health', 'peripartum mental health', 'antenatal mental health', 'antepartum mental health', 'TIC', 'trauma informed', 'trauma based', 'pregnancy mental health', 'maternity mental health'
World Health Organization (WHO)	Predefined categories selected: "Pregnancy", "Mental health", "Mental disorders", "Maternal health"
Scottish Intercollegiate Guidelines Network (SIGN)	Included results in the topics: "Mental health and behavioural conditions", "gynaecology, pregnancy and birth"
Google	The following combinations of the search terms were used: (E.g., 'Perinatal care trauma informed guideline')

		Perinatal Care	Pregnancy	Maternal Mental Health	Maternity	Postpartum Mental Health	Postnatal Mental Health	Peripartum Mental Health	Antenatal Mental Health	Antepartum Mental Health
Trauma Informed	Guideline									
	Standard									
	Best Practice									
	Recommendation									
	Pathway									
	Policy Guidance									
TIC	Guideline									
	Standard									
	Best Practice									
	Recommendation									
	Pathway									
	Policy Guidance									
Trauma Based	Guideline									
	Standard									
	Best Practice									
	Recommendation									
	Pathway									
	Policy Guidance									

Appendix 1. Adapted search strategy for each database
Appendix 2. Extracted definitions of trauma and trauma-informed care across the included records

Organisation, Author(s), Year	Definition of trauma	Definition of trauma-informed care
American College of Obstetricians and Gynecologists' Committee, McNicholas et al. (2021)	"Although there is no single definition of trauma, a useful framework recognizes that "individual 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" (Substance Abuse and Mental Health Services Administration, 2014).	"Trauma-informed care practices seek to create physical and emotional safety for survivors and rebuild their sense of control and empowerment through interactions." (McNicholas et al., 2021, p. 95). "A trauma-informed approach to care had been defined as "a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both practitioners and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010). "The Substance Abuse and Mental Health Services Administration has outlined four assumptions of trauma-informed care. The four "R's" describe the key assumptions of any program, organization, or system that is trauma-informed and include the following: *Realize* the widespread effect of trauma and understand potential paths for recovery; *Recognize* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; *Respond* by fully integrating knowledge about trauma into policies, procedures, and practices; and *Seek* to actively resist re-traumatization" (McNicholas et al., 2021, p. 96).
Health Service Executive, Higgins et al. (2017)	Not provided	"Services that are trauma-informed understand that trauma can affect everyone, and care is provided in a way that prioritises safety, choice, decision-making and control (Markoff et al., 2005, p. 15). "Trauma-informed care promotes a culture where the woman feels comfortable to express her feelings and concerns without judgement, where information is provided in a way that she has a clear understanding about what to expect throughout the perinatal period and where her choices and decisions about her and her baby's health and wellbeing are respected (British Columbia Provincial Mental Health and Substance Use Planning Council, 2013, p. 15)
Make Birth Better, Ingman et al. (2020)	"This is what defines trauma - a traumatic event can leave your view of the world turned on its head, and leave you feeling fundamentally unsafe. […] Birth trauma describes symptoms of trauma which may be related to the birth itself but also circumstances around the birth. What makes birth trauma different from other traumatic events is that it is so often dismissed by those around–us - as the birth of a healthy baby is usually seen as a joyful event. And, unlike other traumatic events, we not only have a reminder of it in our baby, but we may even choose to go through it again. The crucial thing to remember when it comes to birth trauma is that it is entirely subjective' (Beck, 2013).	Not Provided
McPin Foundation, Mahony and Thompson (2023)	Not Provided	"Aims to promote feelings of psychological safety, choice, and control" (Substance Abuse and Mental Health Services Administration, 2014, p. 13) and enables transparency and trust to build between patient and clinician, whilst promoting empowerment.
NHS Education for Scotland, Currer et al. (2022)	"The term trauma can refer to a wide range of traumatic, abusive, or neglectful events or series of events, including ACEs and trauma in adulthood, that are experienced as being emotionally or physically harmful or life threatening. Whether an event(s) is traumatic depends not only on our individual experience of the event, but also how it negatively impacts on our emotional, social, spiritual, and physical wellbeing." (Currer et al., 2022, p. 4)	"Being 'Trauma-Informed' means being able to recognise when someone may be affected by trauma, being person centred through working in partnership with them and responding in a way that supports recovery, does no harm and recognises and supports people's resilience. Being 'Trauma-Informed' is underpinned by the'5 R's: 1. Realising how common the experience of trauma and adversity is; 2. Recognising the different ways that trauma can affect people; 3. Responding by taking account of the ways that people can be affected by trauma to support recovery; 4. Opportunities to Resist re-traumatisation and offer a greater sense of choice and control, empowerment, collaboration and safety with everyone that you have contact with; 5. Recognising the central importance of Relationships." (Currer et al., 2022, p. 5)
NHS Shetland, Robertson et al. (2021)	Not provided	Not provided
NHS Wales, unknown (no date) *	"Psychological trauma has been defined as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing" (Substance Abuse and Mental Health Services Administration, 2014, p. 7)	"Trauma-informed care aims to promote feelings of psychological safety, choice, and control. Every contact with a woman and her partner matters. It is important that practitioners put them at the centre of their care – this can be done by ensuring all women feel seen, heard and cared for." (NHS Wales, n.d, p. 16)
Saskatchewan Prevention Institute, Bayly (2022)	"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 wellbeing" (Substance Abuse and Mental Health Services Administration, 2014, p. 7)	"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (Substance Abuse and Mental Health Services Administration, 2014, p. 9)

(*continued on next page*)

(*continued*)

Organisation, Author(s), Year	Definition of trauma	Definition of trauma-informed care
The ACT Government, Brockway et al. (2022)	Not Provided	Not Provided
The Centre for Early Child Development, Law et al. (2021)	"An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individuals functioning and mental, physical, social, emotional or spiritual wellbeing" (Substance Abuse and Mental Health Services Administration, 2014, p. 7)	"A program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatisation."(Substance Abuse and Mental Health Services Administration, 2014, p. 9)… "Trauma-informed care aims to promote feelings of psychological safety, choice, and control. Every contact with a woman and her partner matters. It is important that staff put the woman at the centre of her care – this can be done by ensuring all individuals feel seen, heard and cared for" (Substance Abuse and Mental Health Services Administration, 2014, p. 13)
The University of Liverpool, Anders et al. (2021)	"Trauma results from an event, or series of events, that an individual feels is harmful or life-threatening and that has long-lasting effects on their mental, physical, social, emotional or spiritual wellbeing" (Substance Abuse and Mental Health Services Administration, 2014, p. 8)	"Psychologically- and trauma-informed care aims to promote feelings of psychological safety, choice and control. Every contact with a woman, partner and family member matters. It is important that staff put the woman at the centre of her care and consider the needs of the family – this can be done by ensuring all individuals feel seen, heard and cared for." (The University of Liverpool, 2021, p. 10)

* Despite the absence of a clear publication date, we are confident in justifying its inclusion, as there are details of workshops informing the document conducted in 2019.

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