From: Alysha-Leigh Fameli
Sent: Thursday, 2 May 2024 11:37 AM
To: Birth Trauma
Subject: CM: Supplementary questions response

Dear Birth Trauma Committee,

Please find the response to the supplementary questions submitted;

1. The AAPI's submission made the observation that "care provider's actions are impacted by under-resourced wards."
a. Can you explain the mental health impacts on care providers who are under-resourced or over-stretched, or who witness birth trauma?
Healthcare providers
b. Are those care providers who have experienced this situation receiving adequate support and resources – and if not, can you provide details of what needs to change?
Healthcare providers are at risk of developing post-traumatic stress disorder (PTSD) when witnessing traumatic births. The first criteria for the development of PTSD *is 'The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):Direct exposure (experiencing themselves), witnessing the trauma…'.*
Repeated exposure to traumatic, stressful birth experiences can lead to clinician burnout, a desire to leave the profession, compassion fatigue and capacity to care for future patients can be impacted (Beck and Gable, 2012, Aydin & Atkis, 2021). PTSD does not occur on every occasion that an individual is exposed to a stressful or traumatic event, however repeated exposure can increase the risk. Symptoms of post-traumatic stress can impact mood, capacity to sleep and relax, beliefs about self (including beliefs about competency at work) and the world, cause nightmares, flashbacks to distressing birth experiences, instrusive memories of birth experiences, hyperarousal (jumpy, easily startled, frightened). All of these symptoms can impact an individuals occupational, social and emotional functioning and the effects can be cumulative (worsening with increased exposure). Employee Assistance Programs may be available, though may not necessarily be tailored to understanding the specific impact of secondary exposure to birth trauma.

It is crucial that midwives and obstetricians have access to;

a) Safe, trauma-informed psychological care as the first responders in traumatic births. These services should be delivered by psychologists with an understanding of birth trauma and the effects. These services should be able to be accessed independent of an individual's workplace (that is, regardless of who pays for the service, the content of all sessions and psychological progress should be completely confidential). It would be useful for this to be accessible during paid work hours, as part of professional development requirements. If it is required that this support is sought outside of work this may impact a clinician's capacity to access this care as our maternity system is already drastically understaffed.
b) Birth-specific trauma-informed practice training. National training that is able to be researched and monitored for effectiveness would be ideal. This training would be best facilitated by a multi-disciplinary team (e.g. midwives, psychologists, physiotherapists, occupational therapists, obstetricians) as birth is often a multidisciplinary affair.

2. You note in your submission that "Some primary health networks provide perinatal programs; however, this is not consistent across local health districts in NSW and places are often limited." Can you tell us about some of the perinatal programs that are working well and what the benefits would be to expanding these programs?
Primary health networks operate independently; therefore, it is difficult to get much data on individual programs. In the Illawarra for instance, there was a specialized perinatal mental health program that was funded under the

Access to Allied Psychological Services (ATAPS) funding. This program originally allowed women to access 12-18 sessions with a psychologist, with flexibility for a second episode of care if needed (an additional 12-18 sessions). This was meant to be an alternative to the Medicare Better Access program for people who had a barrier to accessing sessions under that option (e.g. being on maternity leave with increased financial pressure). This program was flexible, with the ability to do home visits, hospital visits, family-based care and inclusion of infants and children in sessions (the Better Access Program does not cover family therapy) and overall care co-ordination as opposed to just individual therapy which is what is possible under the Better Access Program. This program, as well as several other specialised programs (such as the suicide prevention program) was defunded two years ago, leaving a huge gap in the Illawarra for service availability. A program like this would be incredible if rolled out in each health district. It allows for flexible service delivery, supports clinicians to provide high level care that is based on individual need and not the limitations of the Better Access Scheme and allows the mother-infant relationship to become part of the treatment, thus reducing early risks for infants. This would be particularly useful for families with moderate-higher risk if sessions could be expanded to up to 40 sessions per year dependant on need.

Organisations such as the Gidget Foundation provide wonderful, bulk-billed sessions to mothers in the perinatal period, however these services are limited to;

1) Up to 10 sessions per calendar year under the Better Access scheme
2) Sessions with the mother as the client (family sessions are not funded by Medicare)

This may not always be sufficient to meet the complex needs of a woman following traumatic birth. Expanding these services to up to 20 sessions would be beneficial for families with mild-moderate risk.

Warm regards,
Alysha Fameli

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