Submission No 241

INQUIRY INTO BIRTH TRAUMA

Organisation: Perinatal Anxiety & Depression Australia (PANDA)

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Submission to the NSW Upper House Select Committee: Inquiry into Birth Trauma

Submitted by Perinatal Anxiety & Depression Australia

15th August 2023

I see you. I completely understand that you might be feeling lost in darkness right now, and I also know how irritating it can be to constantly be told 'It will get better', but you need to know that it's actually true. It WILL get better. Maybe not today, but if you seek the help you deserve, I promise you will get through this.
Please, please don't feel ashamed, this is not in your control, but seeking help - that IS in your control, and you can do it. Reach out.
You are never, ever alone. Hold on.

– PANDA Community Member

Abstract:

PANDA's vision is a world where perinatal mental health and wellbeing are understood, supported, and valued. We commend the NSW Upper House Select Committee for their initiative in launching an inquiry into birth trauma in New South Wales. PANDA operates Australia's only National Perinatal Mental Health Helpline for individuals and their families, carers/support people, and healthcare providers. We support parents and families during the perinatal period – pregnancy, birth, and the first year of parenthood.

Our specialised services provide free access to clinical counselling and peer support, service navigation and coordination, and information to support perinatal mental health and wellbeing. The foundation of our perinatal mental health and wellbeing approach is evidence-informed mental healthcare practice, and the expertise of people with a lived experience of perinatal mental health challenges. PANDA also provides secondary consultation and training to healthcare providers.

Through the voices of people with lived expertise, we inform governments, service providers, employers, and the wider community on effective ways to support people experiencing perinatal mental health and wellbeing challenges. For more information, visit https://panda.org.au/about/about-panda.

This submission draws on evidence generated by PANDA's funded support services from 2020 to 2023, and the lived expertise and reflections of PANDA Community Champions who have experienced and recovered from birth trauma. Our submission addresses the following:

a) The experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence").
b) Causes and factors contributing to birth trauma including:
the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth.
c) The physical, emotional, psychological, and economic impacts of birth trauma, including both short and long-term impacts on patients and their families and health workers.
d) The role and importance of "informed choice" in maternity care.

Contents

1 (a). The experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")

Almost 300,000 women give birth in Australia every year, and almost a third of those babies are born in NSW (Centre for Epidemiology and Evidence, 2021). The NSW dataset includes stillbirths and neonatal deaths. Australian and international research suggests that up to 1 in 3 women identify their birth experience as traumatic (Heyne et al, 2022; Watson et al., 2021). Psychological birth trauma is estimated to affect between 10% to 44% of women (Pidd et al., 2023).

Over the last three years, approximately one in every five callers to the PANDA Helpline has discussed birth trauma with our telephone clinicians and peer practitioners.

Callers from NSW account for 10.4% of all birth trauma-related clinical and peer support calls to the PANDA National Helpline, from July 2020 to July 2023.

Birth trauma is deeply personal and subjective. It encompasses a broad spectrum of experiences, including physical injury or threat to the life of a mother and infant, and distress arising from experiences that endanger psychological safety (Heyne et al., 2022; Tsakmakis, Akter & Bohren, 2023).

Impacts of birth trauma include but are not limited to chronic illness, mental ill-health (including suicidal ideation and behaviour, relationship and attachment difficulties, and disruption of future fertility plans (Biggs et al., 2023; Inglis, Sharman & Reed 2016; Keedle, Keedle & Dahlen, 2022; Ponti et al., 2020).

Although childbirth-related psychological trauma is associated with obstetric complications, some women experience physical trauma and injury during a complicated birth but do not experience psychological trauma. Likewise, some women may have an uncomplicated, ‘normal’ delivery but experience childbirth-related psychological distress (Pidd et al., 2023).

Experts and consumer groups recently developed a new woman-centred definition of birth trauma:

> *A traumatic childbirth experience refers to a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/ or long-term negative impacts on a woman's health and wellbeing (Leinweber et al., 2022).*

Yet it’s crucial we also acknowledge that birth trauma has the potential to affect everyone involved in the birthing experience, including infants, fathers and non-birthing partners, and health care providers.

> *“When we first arrived at hospital, one of the staff said to me, ‘You’d better not faint on me like the other dads!’ That’s such a challenging thing to say to men. You can rephrase it as ‘If you feel unwell, sit on the floor.’ You’re in a heightened state during the birth, and so intensely aware of what people are saying to you. Language is so key. These medical professionals did a wonderful job, they were great – but my core memory of my baby’s birth was feeling excluded and frustrated.”*
> *– PANDA Community Member*

Birth trauma is associated with a range of mental health challenges for women, including perinatal anxiety, depression, suicidal ideation, post-traumatic stress disorder (PTSD), obsessive-

compulsive disorder (OCD) (Biggs et al., 2023; Asadzadeh et el., 2020; Thiel & Dekel, 2020). Traumatic birth experiences may also increase the risk of paternal perinatal depression and anxiety, acute stress disorder (ASD) and PTSD (Daniels, Arden-Close & Mayers, 2020; Elmir & Schmied, 2022).

Although 'obstetric violence' is not currently recognised in Australian legislation, it is enshrined in law in some South American countries like Venezuela, where the term originated (Tsakmakis et al., 2023). In Venezuelan law, obstetric violence is defined as:

> "…*the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women." (D'Gregorio, 2010)*

Obstetric violence during pregnancy, birth and the postnatal period can also include:

- Verbal, physical, psychological abuse and discrimination.
- Inappropriate or inadequate clinical treatment.
- Violations of rights to privacy and autonomy.
- Coerced consent for procedures and interventions.

Recent obstetric violence research suggests the development of childbirth-related PTSD may be linked to verbal and psychological obstetric abuse, coerced consent, and healthcare providers not respecting women's birth plans. (Borges, 2017; Keedle et al., 2022; Martinez-Vázquez et al., 2021). Of these risk factors, verbal abuse was the most strongly associated with a subsequent diagnosis of PTSD. However, partner support and early breastfeeding support were protective factors against the development of trauma (Martinez-Vázquez et al., 2021).

> *"I called the PANDA Helpline with my first baby when she was 6 months of age. Having someone listen, validate, and normalise my experience was so cathartic. Exploring my traumatic birth and understanding the impact that it had had on my early parenting journey was very enlightening - I hadn't connected the two previously."*
>
> *- PANDA Community Member*

Respectful, individualised, trauma-informed maternity and birth care can help to reduce the prevalence and impact of birth trauma and obstetric violence in all forms (Keedle et al, 2022). To achieve this, we require healthcare systems that champion evidence- and trauma-informed models of care (Govender, Topp, & Tunçalp, 2022; Huo et al., 2023; Tsakmakis et al., 2023).

1. (b) Causes and factors contributing to birth trauma including: (iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

> *"Initially, I found that people in the medical field dismissed how I was feeling during the first days and weeks after (my baby) was born. I was trying to explain that I wasn't okay, that I wasn't coping - but all that was mentioned were 'the baby blues'.*
>
> *My obstetrician was incredibly supportive when I was able to speak to her about what was going on. She took my concerns seriously and sprang into action. I will be forever grateful to her. The support I received in the Mother Baby Unit was beyond anything I could have hoped for. The nurses and midwives held space for me as I cried for days, they gently*

encouraged me, they talked me through some of the most difficult moments of my life and they made sure I rested - they were absolute angels during the six weeks (my baby) and I were in their care.

After finding the right support, the extreme anxiety and depression slowly began to lift. It didn't disappear completely, but I was no longer lost in the thickest fog of doom I had ever experienced. I was able to look after my baby and myself and continue to take steps to help me recover, including medication, therapy and ensuring I rested whenever I could."

– PANDA Community Member

Government-funded, free-to-access perinatal mental health care supports like the PANDA National Helpline, and birth trauma recovery services like the Australian Birth Trauma Association's Peer2Peer Support program should be available to all expecting and new parents nationwide. Both of these services offer parents the opportunity to debrief their birth experience and explore ways to manage the ongoing impacts of birth trauma, including referral to specialist community-based birth trauma support services.

Caller demand on the PANDA National Helpline consistently outstrips service capacity, with Helpline staff able to pick up 20-30% of 'live calls' on any given day. All other callers are directed to leave a message, resulting in unanswered calls or Helpline 'callbacks' at times that do not always suit the person in need.

"The biggest challenge for me was the fact it was Christmas time after both my older sons were born. Everything was closed. I wanted help, I asked for help, and I was told 'Sorry, we don't reopen until mid-January'. I really struggled with feeling so powerless at this time.

The second problem was attending some GPs and them not really considering that I had postnatal depression, as well as their lack of understanding about providing medications/breastfeeding concerns. They did not explain how the medications worked, or that they had side effects. I was told to stop breastfeeding by one doctor if I wanted to take medication. This made me feel even worse about seeking help!

None of the GPs I attended referred me to services such as PANDA, and I had to ask for a referral for the perinatal mental health outreach program from my doctor through my own research - it was not known about."

– PANDA Community Member, NSW

A potential barrier to accessing trauma-informed perinatal mental health care is a lack of awareness in the community about birth trauma aftercare and recovery support options. When PANDA clinicians and peer practitioners ask our callers, 'How was your birth experience?', many callers share that PANDA is the first service to ask how they're feeling about their birth – often many weeks or months after physical and/or psychological birth injury initially occurred.

Our Helpline callers also advise that they weren't aware that they could request a birth debrief – or they may call PANDA after a distressing experience debriefing their birth with healthcare providers who focused solely on the rationale for obstetric interventions. Callers to PANDA express disappointment and grief if their questions and feedback about the emotional and psychological impacts of distressing birth experiences were either dismissed, minimised or ignored.

Increased awareness and education about birth trauma and its impacts, and referral pathways for birth trauma aftercare and recovery support are urgently needed. Further funding should be committed for specialised services to provide accessible person-centred aftercare via trusted

providers such as the PANDA Helpline and/or ABTA.

1. (c) The physical, emotional, psychological, and economic impacts of birth trauma, including both short and long-term impacts on patients and their families and health workers

A traumatic birth experience can have immediate and longer-term adverse impacts on physical and emotional wellbeing, mental and sexual/reproductive health, family dynamics and relationships with the self, baby and others. Women and their partners may experience acute postnatal distress, adjustment issues, self-harm and suicidal ideation, and post-traumatic stress symptoms following a traumatic birth experience (Biggs et al., 2023; Bright, Doody, & Tuohy, 2022; Dikmen-Yildiz, Ayers & Phillips, 2018; Leinweber et al., 2022; Pidd et al., 2023; Uddin et al., 2022).

Beck's (2015) Middle Range Theory of Childbirth suggests birth trauma consists of five main attributes:

1. Deprived of caring
2. Stripped of their dignity
3. Terrifying loss of control
4. Neglected communication, and
5. Buried and forgotten.

There are numerous risk factors for birth trauma throughout the perinatal period. Of the five factors listed above, women most often attribute a traumatic birth experience to loss of control, communication issues and lack of emotional and practical support from their informal support people and healthcare providers (Beck, 2015; Hollander et al., 2017; Keedle, Bell et al., 2022).

Antenatal birth trauma risk factors include fear of childbirth, antenatal depression, health complications during pregnancy, and a history of PTSD.
Birth-related trauma risk factors include an unexpected mode of delivery (unplanned caesarian section or assisted vaginal delivery), negative subjective birth experiences, dissociation and lack of support.
Postnatal risk factors include postnatal depression, stress, and limited coping skills.

Women in Hollander's (2017) study reported that if they'd had better communication and support from their caregivers, or they had the opportunity to ask for, or refuse, interventions, they believed their trauma may have been reduced – or prevented. They also reported caregivers could have provided better postnatal support if they had thoroughly evaluated the birth experience and referred for trauma treatment.

> *"Birth trauma is not limited to the birth itself. This trauma has been carried with me every single day for 4.5 years. I was deemed 'not as serious a case' because I was induced, and I was not provided options to continue labour at home. I was not sufficiently educated prior to birth. We need education for expecting mothers about postnatal depression, postnatal anxiety, and postnatal psychosis.*
>
> *I haemorrhaged, required surgery, and I had midwives jumping and pushing on my stomach to evacuate the placenta. My placenta abrupted and I 'retained product'. The team lied to me and said I didn't. If I had been treated with time, care and advocacy for ME from an independent peer, I would have had surgery, not people touching me aggressively. I would have received blood transfusions that would have helped me immensely in my*

recovery. Someone there to say 'No that's not right, you need consent, you need to provide care'.

I left the hospital 12 hours after a 550ml blood loss, with retained placenta. I had been judged and criticised by midwives the entire time. I ended up back in ED 48 hours later with the rest of my placenta in a bag the size of a dinner plate. Left in an emergency bed, crying, wanting to die and then discharged with antibiotics in a taxi home. Where is the ethical care?

This affected my attachment to my baby, my sleep, my mind. Every aspect of my life changed because of the trauma I sustained. I had a second baby privately, and the two experiences were worlds apart. Why should continuity of care and support be only available to those who can pay? I desperately want a third baby, but we cannot afford private hospital fees, let alone GP fees in this current climate. I would never ever have another baby through the public system. It has failed me. If we can implement change, wouldn't this reduce the statistics of readmission to hospital after birth and reduce suicide attempts and thoughts, reduce the risk of harm to the baby?

We need peer support from individuals who have experienced this. We need in-home care and birth debriefing out of the hospital setting."

- PANDA Community Member

Physical birth trauma and mental health

Physical injuries and surgical interventions during birth like genital tract and perineal trauma, assisted vaginal delivery, caesarian section, shoulder dystocia, acute haemorrhage and emergency peripartum hysterectomy can have profound impacts on a woman or birthing person's mental health, self-identity, sexual function and/or relationships (Kallianidis et al., 2023; Petročnik & Polona Mivšek, 2023; Skinner, Barnett, & Dietz, 2018).

Postpartum complications like pelvic organ prolapse, anal and urinary incontinence are also strongly associated with medium to long-term mental and physical ill-health, poor mother-infant bonding, relationship difficulties and sexual dysfunction (Bodunde et al., 2023; Dakic et al., 2021; Mirskaya, Lindgren, & Carlsson, 2019; Ponti et al., 2023).

Birth trauma and post-traumatic stress disorder (PTSD)

"I have done several sessions of Eye Movement Desensitization and Reprocessing (EMDR) with my psychologist which have really helped me to overcome the trauma of my labour and first few months of my baby's life."
– PANDA Community Member

A recent meta-analysis of childbirth-related trauma in both parents found that mothers have a pooled prevalence rate of 4.7% for post-traumatic stress disorder (PTSD), and 12.3% for symptoms of post-traumatic stress. For fathers, the pooled prevalence rate for PTSD was 1.2%, and 1.3% for post-traumatic stress symptoms (Heyne et al., 2022).

PTSD is characterised by 'actual or perceived threat of death or serious injury, or a threat to the integrity of self or others', as per the criteria for PTSD diagnosis in the DSM-V (APA, 2013). Common childbirth-related symptoms include 're-experiencing' the birth, and avoidance – this may include the women's own body and in particular genitals as the site of trauma reminders. Some women may avoid sexual intimacy with their partner, and routine healthcare check-ups.

There may be changes in mood and thinking, with feelings of horror, disgust, shame, guilt and fear. 'Hyperarousal' is the other criteria for PTSD diagnosis, which may manifest as extreme attentiveness to the infant, or irritability with loved ones (Kranenburg, Lambregtse-van den Berg, & Stramrood, 2023).

Severe PTSD and postnatal depression symptoms may also adversely impact parent-infant attachment and bonding, infant health and early childhood development (Beck, 2015; Cook, Ayers & Horsch, 2018; Ponti et al., 2020; Van Sieleghem et al., 2022).

We note that childbirth-related PTSD is not a diagnosis currently recognised in either the DSM-V or the ICD-11. However, research suggests that childbirth-related PTSD may be a unique sub-type of post-traumatic stress disorder (Horesh, Garthus-Niegel & Horsch, 2021; Kranenburg et al., 2023).

PANDA recommends routine screening for acute postnatal distress and birth-related trauma, to ensure early intervention and treatment of childbirth-related PTSD. The City Birth Trauma Scale (City BiTS) is the first diagnostic tool for childbirth-related PTSD based on the DSM-5 criteria for PTSD. It has recently been validated for use with an Australian cohort of mothers (Fameli et al., 2023). There is also a Partner version of the City BiTS which has been validated internationally for use with fathers and birth partners (Webb et al., 2021). The National Perinatal Mental Health Guideline recommends diagnostic screening and referral for women and their partners if symptoms of post-traumatic stress persist longer than three months (Highet et al., 2023).

> *"I had a beautiful, healthy baby boy, a loving husband, a safe home - I should have been on top of the world! I told myself these things every single day, and it made me feel so much worse. I had no idea what was going on in my brain and why I was feeling so horrendously sad. It made no sense to me at all, and it didn't get any better as the days passed.*
> *I was so tired, so beyond depressed and terrified, that I started thinking it would all be easier if I didn't exist anymore. I am so grateful that I sought help before things could get worse.*
>
> *I was admitted to the Mother Baby Unit when (my baby) was three and a half weeks old. I was diagnosed with severe postnatal depression and anxiety by my psychiatrist, and also developed agoraphobia along with PTSD due to the physical and emotional trauma of my labour."*
>
> *– PANDA Community Member*

Birthing again after birth trauma

> *"The birth was very traumatic and overwhelming compared to my first birth 12 years earlier. I also had one of the midwives at the hospital tell me I would never have another child again, which I found very insulting and made me upset at the time. I reached out to my midwives and obstetrician about how I felt - they showed me so much empathy and respect."*
>
> *– PANDA Community Member*

Some families' experiences of birth trauma are so distressing that they may choose not to have another child. For other parents, subsequent pregnancies provide an opportunity to advocate for their birth rights, participate in shared decision-making, including support for vaginal birth after caesarian section (Hamilton, McLaughlin & Mollart, 2023; Pidd et al., 2023; Keedle et al., 2022).

Unfortunately, it is also common for parents with a history of birth trauma to experience psychological distress during subsequent pregnancies, including significant fear of childbirth

(Hamilton, McLaughlin & Mollart, 2023). Other mental health challenges include severe antenatal anxiety and panic attacks, depression, disrupted sleep, and suicidal ideation and behaviours (Biggs et al., 2023; Bright et al., 2022; Pidd et al., 2023).

Callers to the PANDA Helpline share feelings of intense fear and anticipatory anxiety about experiencing pregnancy- and birth-related trauma a second, third or fourth time. Callers who live in regional, rural and remote areas also express disappointment that they don't have access to alternative birthing options in their area, and may dread the prospect of returning to the local hospital where they previously experienced psychological and/or physical birthing injuries.

> *"My first son was born in an incredibly fast and intense labour. He got stuck during the birthing process, and as I pushed him out, I suffered a fourth-degree tear which required urgent surgery. A feeling of anxiety overwhelmed me within hours. I had pictured in my head that I would spend some time with him as soon as he was born. Due to my injury, I was immediately taken away from him to surgery, and didn't come back until about six hours later.*
>
> *I remember lying in recovery, feeling sick, and in pain, and like I had already failed at being a mother because I wasn't with my baby. As the weeks went on, I struggled to sleep, I lost my appetite, and I felt overwhelming dread for the majority of my days.*
>
> *With my second son, I had an elective caesarean section, in a different hospital. I thought I was coping well for the first few days, but right before I was discharged, I started to become anxious, and developed insomnia. I struggled with PTSD from the experience with my first child, and felt myself quickly disappearing down the same road. I knew as soon as I arrived home that I was going to need help."*
>
> *– PANDA Community Member, NSW*

Research suggests antenatal stress levels can have an adverse impact on long-term maternal and infant health and wellbeing outcomes (Pidd et al., 2023; Van den Bergh, 2020). Psychological interventions that effectively reduce levels of antenatal anxiety and stress, coupled with individualised and person-centred care in subsequent pregnancies may mediate the impacts of previous traumatic birth experiences and optimise birth outcomes for parents and infants (Matvienko-Sikar, Redsell, & Flannery, 2023; Moore et al., 2023; Pidd et al., 2023; Sun et al., 2023).

> *"With the experience of falling pregnant again with my third, I learned from my first two experiences that I needed to prepare myself - have support set up before the birth, go on medication, and make all health professionals aware of my history so that they could give me the best support."*
>
> *– PANDA Community Member, NSW*

Birth experience and relational trauma: Attachment and bonding

> *"My son was placed on my chest, and I expected to feel a rush of positive emotion; 'overwhelming love' as it had so often been described to me. I felt nothing but fear. This fear intensified over the following days. I would stare at (my baby) as he slept, trying to summon any positive feeling. I couldn't sleep, although I was beyond exhausted. I couldn't eat. I could barely breathe. I tried to explain how I was feeling, but I just couldn't find the words. We arrived home and nothing changed. I felt sick constantly, I dreaded breastfeeding, I dreaded everything to do with my precious baby. I convinced myself that I was the worst mother in the world, he deserved so much better – I didn't want to be a Mum at all anymore."*

– PANDA Community Member

Women with childbirth-related trauma who experience bonding issues may report feeling that they have 'failed' as a mother (Ponti et al., 2020; Tsakmakis et al., 2023). Failure to birth the way they wanted to, failing to fall head over heels in love with their newborn at first sight. There is a significant association between childbirth-related trauma and impaired or disrupted parent-infant bonding (Bahari et al., 2022; Beck, 2015; Galbally et al., 2022).

PANDA advocates that the World Health Organisation's 2022 Recommendations on Maternal and Newborn Care defines best practice dyadic care of parents and newborns, as can be achieved in the NSW healthcare setting:

> *"A positive postnatal experience is defined as one in which women, newborns, partners, parents, caregivers and families receive information, reassurance and support in a consistent manner from motivated health workers; where a resourced and flexible health system recognizes the needs of women and babies, and respects their cultural context… At least three postnatal care contacts (should) occur during the first six weeks after birth. This includes the provision of effective clinical practices, relevant and timely information, and psychosocial and emotional support… An effective referral system, including communication between facility- and community-based care providers… are also essential components of this postnatal care model".*

Birth trauma and dads

> *"All three of my children's births were traumatic for my wife and I. My anxieties and fears of failure overwhelmed me after the births of my first two children, and I was diagnosed with postnatal depression." – PANDA Community Member*

Just as we advocate for women-centred and trauma-informed maternity care, so too do we hope to draw the Select Committee's attention to the critical but often overlooked matter of birth trauma's impact on paternal mental health and wellbeing.

> *"When bub was born, it was two and a half hours before I even touched him. I still feel traumatised by that. I was watching this student midwife holding my bub up and going 'Ohhh, aren't you beautiful?' She got to cuddle and play with my kid before I did, and she didn't even think to include me.*
>
> *As a nurse, I knew what was happening wasn't all clinical, but my only focus during the birth was making sure my partner and baby were okay. I still wonder how long it would have taken for them to include me if I didn't say something. I was patient, but I was also scared. I'm a nurse, but I know nothing about birth.*
>
> *Until babies can communicate it's that skin contact that connects you. More than anything else, I wish I could go back and have those first moments of skin-to-skin contact with my baby."*
>
> *- PANDA Community Member*
>
> *"Both my husband and I went through postnatal depression with our first child. I struggled to cope as a mother, and my husband struggled to support me, as he didn't know what to do, and felt like a failure."*
>
> *– PANDA Community Member, NSW*

Even if a 'positive' outcome, for example an uncomplicated birth is achieved for the mother and infant, men can still experience birth as traumatic (Etheridge & Slade, 2017). Paternal birth trauma experiences are frequently associated with feeling excluded during the birth - helpless and powerless, and inadequately prepared to witness birth events like threats to the life of their partner and/or infant, emergency caesarian section, postpartum haemorrhage or their infant's Neonatal Intensive Care Unit (NICU) admission (Beck & Vo, 2020; Elmir & Schmied, 2022; Kothari, Bruxner, Dalhunty et al., 2022).

Feelings of grief, anger, worthlessness, and violation of their normative masculine role as their family's 'protector' can contribute to men experiencing mental health challenges like perinatal depression and/or anxiety, and post-traumatic stress (Kothari, Bruxner, Callaway et al., 2022; McNab, Martin & Norris, 2022; Tsakmakis et al., 2023; Vallin, Nestander & Wells, 2019).

Birth trauma impact on the family unit

The impacts of birth trauma are not limited to parents. Traumatic experiences like a newborn's admission to a NICU and/or childbirth-related mental health decline can affect all members of the family, including older children (Dickinson, Vangaveti, & Browne, 2022; Howard & Khalifeh, 2020; Pierce et al., 2020). Inclusive, family-centred perinatal care is crucial for families managing the impacts of birth trauma.

> *"After my second child was born, a psychologist recommended I attend a mother and baby unit. My husband, along with our mothers, helped to juggle the household while I was away. He was incredibly supportive, and even went and had his own therapy to try and support me. It had a big impact on our oldest son, who had just started kindergarten, and didn't understand why his mother and new brother were in a hospital."*
>
> *– PANDA Community Member*

1. (e) The role and importance of "informed choice" in maternity care

> *"Things started to go downhill when I went into labour. The whole experience was really traumatic, and I felt that my wishes and concerns were brushed aside."*
>
> *– PANDA Community Member*

Informed choice in maternity care has foundations in shared decision-making and informed consent (Kloester et al., 2022) Truly informed consent is dynamic, and revisited often as situations rapidly evolve and change during pregnancy, birth, and early parenthood (Buchanan et al., 2023). Shared decision-making should be an ongoing dialogue between the person and their healthcare provider/s, that allows for exploration of the risks and benefits of care decisions from both the consumer and the provider's perspectives (Nicholls et al., 2019; 2022).

All expecting and new parents should have the option of choosing which treatments they consent to, or refuse. In qualitative research about maternity care and informed choice, the major barriers to informed consent and choice are the time-sensitive nature of the birthing context, and women's experiences of exhaustion, pain and distress during labour compromising their capacity for informed consent (Djanogly et el., 2022).

Proactive conversations about care and birthing choices that happen during the antenatal period may reduce the incidence of women and birthing people reporting experiences of pressured or coerced 'choice', and compliant, deferential agreement to procedures and interventions during labour and birth (Van Der Pijl et al., 2023; Watkins et al., 2023). Whilst the wellbeing of mother and infant are paramount during labour and birth, taking a moment to undertake informed consent and

choice via shared decision-making can prevent significant trauma for women, their babies, partners and families (Australian Institute of Health and Welfare, 2023).

Conclusion

We believe that much more can be done to:

1. Reduce the prevalence of birth trauma in NSW.
2. Optimise birth trauma recovery outcomes for parents, their babies and families by increasing equitable access to trauma-informed perinatal health and mental health care, with a priority focus on targeted psychological interventions for parents with a history of trauma who are expecting.
3. Mitigate the impacts of birth trauma and secondary/vicarious trauma for all affected parties (parents, infants, families and healthcare providers) via:
    a. Routine, early postnatal mental health screening using the Edinburgh Postnatal Depression Scale, and Kimberley Mum's Mood Scale as indicated for Aboriginal and Torres Strait Islander parents, and screening for trauma using an evidence-based scale such as the City Birth Trauma Scale.
    b. Government funding for trauma-informed birth debrief, clinical and peer support services, including healthcare provider access to regular clinical supervision and secondary consultation as required.

Recommendations from PANDA

As part of the focus on person-centred perinatal care, PANDA recommends further exploration and investment in the following areas:

1. Targeted screening practices during pregnancy and the postnatal period for all parents, to identify birth trauma as early as possible.
2. Funded specialist birth trauma counselling and debriefing helpline informed by lived experience and clinical evidence, available nationally for all Australians. Service to include secondary consultation and debriefing for healthcare providers. This specialised intervention could be provided by PANDA and ABTA, in a partnership leveraging existing infrastructure.
3. Training all maternity healthcare providers in birth trauma and trauma-informed perinatal care.
4. Health promotion activities to increase awareness and recognition of the prevalence and impact of birth trauma.
5. Resources to highlight the impact of trauma (throughout the parents' life) on their birthing journey, for community and health care providers.

PANDA welcomes all opportunities to further discuss any aspects of this submission with the Select Committee facilitating the Inquiry into Birth Trauma.

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