Submission No 249

INQUIRY INTO BIRTH TRAUMA

Organisation: Gidget Foundation Australia

Date Received: 15 August 2023

SUBMISSION: NSW Select Committee on Birth Trauma

Prepared by: Gidget Foundation Australia

15 August 2023

In Australia, perinatal depression and anxiety affects one in five mothers and one in ten fathers, impacting around 100,000 expecting and new parents each year.

Almost 50% of new parents will experience adjustment disorders, and distressingly, maternal suicide is one of the leading causes of death amongst expectant and new mothers.

With one in three parents describing their birth experience as traumatic, we know that birth trauma can significantly influence a parent's sense of wellbeing. An experience of birth trauma also increases a parent's risk of developing perinatal depression and anxiety, posttraumatic stress disorder or other mental illness.

In this submission Gidget Foundation Australia highlights:

- The importance of education and training in the delivery of trauma informed care for all health care workers delivering maternity services.
- The importance of developing policies and procedures which seek to obtain genuine informed consent for both routine and urgent obstetric care.
- The development of continuity of care models which support women physically and psychologically across the entire perinatal period.

Gidget Foundation Australia recognises and honours all people with lived experience of psychological and physical birth trauma, perinatal mental ill-health, and loved ones who provide care and support.

Lived experience is at the heart of everything we do, and we acknowledge these experiences with compassion and respect. We are truly grateful for all those who choose to share their stories and we acknowledge those who carry these stories quietly. We are committed to supporting the Australian and NSW parents and their communities who are providing the foundations for mental wellbeing for their children.

Gidget Foundation Australia implores the NSW Select Committee on Birth Trauma to honour the individuals, and the families impacted by birth trauma, through the development of a pathway to genuine change.

ABOUT GIDGET FOUNDATION AUSTRALIA

Gidget Foundation Australia is a not-for-profit organisation that exists to support the emotional wellbeing of expectant and new parents, promoting awareness, driving advocacy, education and service delivery to prevent and treat perinatal mental health issues through early detection and early intervention.

To meet the increasing demands for specialist perinatal mental health services Gidget Foundation Australia has developed a comprehensive suite of services to assist all new and expectant parents to access care in the right place, at the right time, and at a level best suited to their support needs.

These services include individual psychological consultations (with no out-of-pocket expenses) via the **Gidget House®** and **Start Talking** programs. The **Gidget House®** model provides specialist face to face psychological interventions for clients diagnosed with, or at risk of developing postnatal depression and anxiety. The **Start Talking** program provides these specialist psychological supports via telehealth.

Clients accessing the service via a mental health care plan and GP referral are eligible for up to 10 bulk-billed psychological treatment sessions per calendar year under the Medicare Better Access Initiative. Clients are also eligible to access the **Gidget Perinatal Support Centre** 24/7 perinatal support through our partnership with Sonder) during their period of care.

Other programs developed and delivered by the Foundation are **Gidget Village®** group treatment programs, **Gidget Virtual Village®** online virtual support groups and **Gidget Emotional Wellbeing Screening Program** early intervention screening delivered in person by a Gidget Midwife.

As the leading national provider of perinatal mental health services, Gidget Foundation Australia is committed to supporting, expanding and nurturing the workforce. We currently contract and support 120+ perinatal specialist mental health clinicians to deliver psychological services to our growing client base across Australia. Our workforce includes clinical psychologists, registered psychologists, mental health accredited social workers, mental health nurses and occupational therapists.

The Gidget Foundation Australia workforce continues to expand as more join through our innovative workforce development initiative, the *Perinatal and Infant Mental Health Training and Development Institute* supported by Sydney North PHN through the Australian Government's PHN's Program, NSW Health and the Commonwealth Government.

ABOUT OUR NAMESAKE Gidget

Gidget was the nickname of a vibrant young mother who tragically took her own life while experiencing postnatal depression, a diagnosis that she kept close to her heart. Together, her loving family and friends created Gidget Foundation Australia determined that what happened to *Gidget* would not happen to others.

Gidget left the world too early, though she has left a remarkable legacy. In the words of *Gidget's* Mum, Sue Cotton, "Gidget Foundation Australia came into being because of *Gidget*, but it's not about my little girl anymore. Gidget Foundation Australia is all about the other 'Gidgets' and guys out there suffering. Let's all do whatever we can to get them to start talking."

Gidget Foundation Australia (GFA) would like to make submissions in relation to the following points of inquiry:

(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

(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) exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:

(i) people in regional, rural and remote New South Wales
(ii) First Nations people
(iii) people from culturally and linguistically diverse (CALD) backgrounds
(iv) LGBTQIA+ people
(v) young parents

(e) the role and importance of "informed choice" in maternity care, and

(i) any legislative, policy or other reforms likely to prevent birth trauma

(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.

There is no single criterion which defines a traumatic birth.

Birth trauma emerges from an interaction between the individual, their care journey, and the complexities of their birthing experience. This makes the provision of trauma informed care critical for every birthing parent, given the role of negative care provider interaction in the development of PTSD (Simpson & Catling, 2016).

The provision of trauma informed care is critical to helping women feel safe, heard, and supported during labour birth and postpartum care. Delivery of trauma informed care requires both organisational and practitioner support in establishing policies, procedures and models of care which are client-centred, compassionate, and respectful.

Trauma-informed care requires acknowledgement of the importance of individual agency in decision-making at all stages during the maternity journey. It also acknowledges the importance of obtaining genuine informed consent and engaging in collaborative decision making across all points of care, including emergency care.

Trauma informed care requires collection of a detailed medical and psychosocial history of the birthing parent and awareness of the non-birthing parent's experiences. This will ensure supporting health practitioners can contextualise a woman's and couple's birthing experience, understanding risk and mitigation factors for trauma after-effects.

Feeling heard, understood, and respected can reduce both the negative impact of a traumatic birth experience, and the risk of developing PNDA, PTSD or OCD as a result of birth trauma.

Cost driven models of care which value expediency over agency can create barriers to understanding, recognising and responding to trauma. A lack of access to a primary care provider, and poor communication between over-stretched and understaffed health professionals can reduce antenatal identification of risk factors and postnatal investigation of symptoms.

In many maternity services, limited access to specialist training means healthcare workers including obstetricians and gynaecologists, midwives, nurses, lactation consultants, paediatricians, etc. are unable to adequately identify predisposing and precipitating factors, or identify early signs and symptoms of birth trauma.

They are also less likely to be able to respond confidently and empathically, or provide appropriate advocacy for women in their care, particularly during difficult births and obstetric emergencies. The inadequate availability of workforce skills in the delivery of trauma informed care can also be exacerbated by high staff turnover and system-wide workforce shortages.

Recommendation: Upskilling the workforce to ensure all maternity care providers have the necessary knowledge, skills and training to deliver trauma informed care is critical to reducing the impact and prevalence of birth trauma.

A lack of follow-up care arising from early discharge due to bed capacity can also rob parents of the opportunity to process their birth experiences. This process results in reduced opportunities for

interactions with a variety of healthcare professionals in the hospital setting and could hinder timely referral for physical and psychological symptoms emerging in the days following delivery.

Financial limitations and extensive wait times when accessing wrap-around care post discharge, including postnatal physiotherapy and perinatal mental health support, are also barriers to holistic trauma-informed care. Metro-centric resourcing of maternity care also limits access to specialist services for parents in rural and regional communities.

Recommendation: Development of models of care which focus on universal antenatal and postnatal screening, access to a primary care provider, and improved access to wrap around maternity service provision for all communities is essential for the provision of timely recognition and response to trauma.

A medical mindset which is preoccupied with physical safety, often at the expense of cultural safety and emotional wellbeing, can also fail to deliver trauma-informed care.

The use of invasive procedures, induction of labour, caesarean delivery and poor pain management have all been associated with increased risk of developing post-traumatic stress disorder (Ertan et al, 2021).

The impact of previous care experiences and stigma associated with trauma-related disclosure can also impact subsequent care, requiring health practitioners to have an understanding of both objective and subjective history when assessing holistic care needs during the perinatal period.

Recommendation: Improved education and training around communication and the importance of obtaining genuine informed consent during labour, along with a more balanced approach to weighting physical and psychological wellbeing when assessing and responding to obstetric risk is urgently needed.

(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.

Short and long term emotional and psychological impact on patients and families

The birth of a new baby is a life changing event which can bring both excitement and relief. However, for some parents, the birth experience can be both unexpected and distressing, impacting both birthing and non-birthing parents. How parents perceive the birth of their baby is an incredibly individual experience which often takes some time to process. This view may also shift over time as parents recall different elements of both the birth, and their obstetric care experience.

Parents may feel confused when messages from their treating health practitioner do not align with their own emotional experience of the birth. They may struggle to understand why they feel so distressed or traumatised, when they 'should' be feeling happy or relieved.

Even parents who might describe their labour as 'normal' can struggle to understand why they feel so confused, upset, anxious or distressed by their experience, and this can be exacerbated by any invalidating messaging from health professionals, support networks, and even other parents.

Some parents will recognise the physical and psychological effects of trauma immediately after the birth, while other parents may not identify their injuries or experience as traumatic for weeks, or

even months. For some, the trauma will arise directly from the birth, while for others the focus will be on the quality of their care. A lack of awareness can also contribute to challenges in identifying birth trauma, with many parents unsure of what to expect, physically and emotionally. This may leave parents feeling confused and uncertain about why their ability to cope is so variable from one day to the next.

Recommendation: Preventative parent education during antenatal classes needs to ensure parents are equipped to recognise and respond to both physical and psychological birth trauma symptoms experienced by themselves, or their partner.

Existing mental health issues and previous negative life experiences can also contribute to birth trauma; with a prior history of personal trauma, violence or abuse increasing the risk for both birthing and non-birthing parents. A previously traumatic birth, past perinatal loss and a lack of emotional support can also increase the risk of birth trauma. Parents and health care workers need better education and training to help them understand the risks, and the support options available.

Birth trauma can significantly impact parents and their infants, and even the wider family, Negative emotions can significantly affect parent-infant attachment, family relationships, and feelings of self-worth as a parent and partner, so seeking help is very important for both birthing and non-birthing parents.

Having an opportunity to explore complex emotions and make sense of distressing thoughts and feelings is an important step in birth trauma recovery and should begin with supportive discussions on the maternity unit. The World Health organisation recommends follow-up care at between two and three days, and again between seven and 14 days (WHO 2022).

Recommendation: Screening of birthing partners for physical symptoms, and both birthing and non-birthing partners for psychological symptoms at the six-week GP check should also be routine.

Careful management of physical trauma and newborn health is also important to reduce disruption to early attachment, and further trauma. Separation of mother and baby can reduce bonding opportunities, impede breastfeeding and exacerbate anxiety and distress. Where possible, mothers and babies should remain together at all times, and where not possible, regular communication should be provided, along with supported access visits to optimise bonding and limit further traumatisation.

Parents who have experienced loss also need thoughtful management during postnatal care. Access to timely psychological support, along with a quiet, private space to grieve and process loss is essential.

Recommendation: Women who have experienced recent loss should not be subjected to recovering in a shared space occupied by mothers and babies, and their postnatal care should address both their physical and psychological needs.

Acute trauma symptoms, including nightmares, flashbacks, intrusive thoughts, panic attacks and fear of significant harm can lead to isolation, loneliness and significant pressure on the parent/ child dyad, and the parental relationship.

Parents who have experienced untreated birth trauma often present for psychological therapy in preparation for subsequent births, reflecting the enduring impact of unaddressed trauma. This

presentation may include non-birthing parents, who have been traumatised by witnessing their partner's labour and delivery.

Recommendation: Access to skilled psychological care prior to, and during pregnancy is critical for addressing unresolved trauma and limiting re-traumatisation.

Short and long term emotional and psychological impact on health workers

A traumatic birth can also impact healthcare workers, who may witness or participate in distressing, events during labour and delivery.

Midwives and other health care providers report feelings of shock, fear, guilt, shame and failure following exposure to a traumatic birth experience. They also report a loss of confidence in professional practice, an increased desire to leave the profession, and a fear of legal consequences (Aydın R, Aktaş S, 2021).

Symptoms of post-traumatic stress (PTS) experienced by healthcare professionals can adversely affect decision-making and the quality of care they provide. PTS can also contribute to burnout, and a significant decrease in job satisfaction, increased sick leave, reduced productivity, and low levels of workplace engagement can also occur.

Female health care providers in particular can feel anxious about their own birthing experiences following exposure to birth trauma in their work role. This can influence personal decision making around planned and unplanned pregnancy, and maternity care.

Recommendation: Health care professionals should be offered psychological support and professional mentoring following exposure to a traumatic birth experience.

d) exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:

i. **People in regional, rural and remote New South Wales** continue to experience a disparity in birth choices, availability of specialist care and access to services. Many are expected to travel significant distances to access care, and are required to leave families for an extended period of time to be close to maternity services as their due date arrives. Lengthy separation from other children and social supports can also occur postnatally if there are physical complications for mother or baby.

Recommendation: Any changes to recommendations should consider these additional barriers and work to improve equity of services. This should take into consideration both pre and postnatal care.

ii. **First Nations people** The perinatal period can be challenging for Aboriginal and Torres Strait Islander women due to the medicalised model of pre- and post-natal care. Past and ongoing impacts of transgenerational trauma, grief, loss, alienation from kinship, and other factors predispose Aboriginal and Torres Strait Islander parents to greater complexity and risk of trauma during this vulnerable period.

    Responding to medical issues arising due to birth trauma may mean being moved away from Country which can increase distress for the parent, kin and community. A lack of culturally informed and sensitive services may also create barriers in accessing support in dealing with both psychological and physical birth trauma.

Recommendation: Development of culturally informed models of pre and postnatal physical and psychological care delivered within local communities is required to reduce the frequency and severity of birth trauma for First Nations parents.

iii. **People from culturally and linguistically diverse (CALD) backgrounds** Despite approximately 29% of the resident Australian population being born overseas and almost half of Australians have a parent born overseas 48.2% (Australian Bureau of Statistics, 2021), healthcare systems continue to disadvantage CALD communities. Parents from CALD communities may experience difficulty in identifying and asking for support in relation to birth trauma due to differing concepts of health and illness, and cultural expectations.

Intergenerational trauma and the need to access culturally appropriate, gender-safe care provided by female staff can also exacerbate challenges. Language barriers and a lack of understanding around cultural context may also prevent wider support systems from being present, leading to further isolation and lack of informed choice.

Parents from CALD communities may also experience discrimination linked to race or ethnicity. Limited training for healthcare staff around cultural humility can result in reduced rates of psychological screening and a poor understanding of how screening can be effectively utilised in CALD communities. Lack of timely access to interpreters also creates challenges for health care providers and consumers where there are language/ cultural barriers.

Recommendation: Improved training for healthcare workers around delivery of culturally safe care, along with increased access to appropriately trained interpreters is needed to reduce trauma rates among CALD parents.

iv. **LGBTQIA+ communities** LGBTQIA+ expectant and new parents still face discrimination on a macro and micro level in relation to conception, pregnancy, birth, and parenting. Within the medical system, information and resources often contain non-inclusive language and focus on support processes geared towards heterosexual couples. This may be a barrier to seeking support in dealing with the aftereffects of both physical and/or psychological birth trauma.

Recommendation: Ensuring health care providers are trained and knowledgeable in working with this population, along with improved access to appropriate information and resources is required to reduce barriers to care.

v. **Young parents** Adolescent parents are more likely to report mental health difficulties and a history of previous trauma, which may lead to increased vulnerability to birth trauma. For young people, depression, lack of partner support, poor pain management and infant complications contributed to either a negative perception of birth, or acute stress (Anderson & Connolly, 2018). Risk factors are further heightened for adolescents in culturally or linguistically diverse communities, and those with limited psychosocial and financial support.

Recommendation: Young parents need to be identified early through tailored screening and linked in with services to minimise potentially adverse impacts on both parent and baby.

vi. Those with **historical vulnerabilities** such as a history of childhood or sexual abuse can experience a recurrence of past trauma due to the invasive nature of labour and medical care. Early intervention is key in assisting recovery from birth trauma and this is helped by screening for vulnerability factors antenatally.

Recommendation: Ideally early intervention should be paced and can include guiding identified women, birthing parents and their partners to additional material on birth trauma, raising awareness of symptoms, referrals into support organisations, and shared care planning around labour and birth.

vii. Individuals with **intellectual disability** experience marginalisation and may struggle to have their individual needs and informed consent adequately factored into maternity care procedures. Using a person-centred model of health care provision not only reduces marginalisation of this population, but also supports informed decision-making, which can be more challenging for parents with intellectual disabilities. Women with intellectual disabilities are more likely to experience pregnancy and birth-related complications and need to be supported at a level appropriate with both their physical and psychological needs. Providing information in accessible formats is also key and should be addressed through public policy and communication design.

viii. Individuals with a **physical disability** also need better access to person-centred maternity care. Women with physically disabling conditions need expert support around birthing options, anaesthesia, and aftercare. They also need access to equipment and facilities designed to optimise autonomy, agency and self-reliance (Pavlidou and Sarantaki, 2021). This heightens the vulnerability of this community and care should be taken to ensure that recommendations consider the needs of those with physical disability.

(e) the role and importance of "informed choice" in maternity care

Informed choice should sit at the centre of all maternity care. Women should be provided with a range of options aligned to their physical, psychological, emotional and cultural needs, and care should be provided objectively and impartially, without judgement.

Where possible, continuity of care should be central to all maternity care programs, with evidence increasingly supporting the positive outcomes for both mother and infant, linked to this model (Fox et al, 2023).

The relational trust and communication built during a sustained healthcare relationship has been associated with greater empathy among care providers, and more positive experiences for women, even for those with high-risk presentations.

Recommendation: In delivering on informed choice, healthcare workers should seek to collaboratively address how women are consulted around their care, including both routine care and escalation of care during emergency situations. Such consultation should look at all aspects of care, including pain relief, interventions and support partners. It should also encompass aftercare, including supported choices around feeding, discharge and follow-up care in the community.

(i) any legislative, policy or other reforms likely to prevent birth trauma

Definitions of informed consent for obstetric procedures should include a responsibility on health care workers to provide objective information around the risks and benefits of available options. Health policy should also expressly articulate the presumption that a birthing parent is entitled to make choices around their care, even when there are risks associated with that decision.

Recommendations: Policies which favour early discharge over informed consent should be actioned only when there is no clinical justification for an extended stay with regard to both physical and psychological care.

Trauma informed care should be included in the teaching curriculums of all obstetric and maternity care training programs.

Parents who have experienced birth trauma require access to regular care over an extended period of time. Consideration should be given to the funding of models of care which can top up access beyond the 10 sessions currently available through Medicare.

GIDGET FOUNDATION AUSTRALIA STEPPED CARE MODEL

At Gidget Foundation Australia we offer a stepped model of care to facilitate flexible access to a range of healthcare supports and resources, from low intensity self-help supports, through to high intensity clinician led interventions. This stepped-care model allows clients to engage in care which is person-centered, needs driven and evidence informed for at risk, and mild through to moderate clinical presentations.

A blend of face-to face, telehealth and online resources allows Gidget Foundation Australia to support new and expectant parents across Australia, facilitating access by reducing both the individual and systemic barriers to care, including cost, availability and accessibility. It also allows clients to be stepped up or down in their care, based on changing clinical circumstances and support requirements.

GOVERNANCE AT GIDGET FOUNDATION AUSTRALIA

Gidget Foundation Australia is committed to delivering safe, high quality perinatal mental health care to new and expectant parents. Through advocacy, education and research, the Foundation also supports the development of a skilled workforce and a health-informed community.

Gidget Foundation Australia is governed by a passionate and committed Board of Directors, who donate their time, energy and professional expertise to support the Foundation's mission. The Gidget Board has overall responsibility for establishing and monitoring the governance of the organisation to ensure equity, accountability, and transparency in service delivery, while also providing leadership and stewardship across the organisation.

The Board is supported by a number of key committees and working groups which operate in an advisory capacity, informing policy and process, and providing operational oversight of both compliance and performance. An emphasis on membership diversity and lived experience leadership, and participation ensures a culture of consultation and inclusivity underpins delivery of current and emerging models of care.

Safety, quality and clinical care standards are overseen by the **Clinical Governance Committee**, to ensure the maintenance of clinical standards, quality and safety, and that ethics and risk are appropriately monitored and addressed. The Committee's membership and experience is diverse and represents a range of stakeholders including lived experience, psychologists, mental health nurses, general practitioners, obstetrician and gynecologists and pharmacists. The Clinical Governance Committee provides independent advice and expertise to support both Executive and Board decision-making.

Gidget Foundation Australia's First Nations, LGBQTIA+ and Disability Working Groups are also cross representative of external volunteers with lived experience in each area and staff members. These groups inform inclusive practice across both the clinical and corporate functions of the organisation, fostering a culture of safety and belonging for all.

Gidget Foundation Australia clinicians are provided with access to regular individual and group supervision, with clear clinical escalation pathways for ensuring excellence in clinical services delivery. Professional development is also supported through ongoing access to monthly education, training and seminar presentations and bi-annual perinatal focused conference for continuing education.

For more information on Gidget Foundation Australia visit gidgetfoundation.org.au

References

Anderson, C., & Connolly, J. P. (2018). A model to predict birth stress in adolescents within 72 hours of childbirth. *Advances in Nursing Science*, 41, 216–229. doi: 10.1097/ANS.0000000000000000203

Aydın R, and Aktaş S (2021). Midwives' experiences of traumatic births: A systematic review and meta-synthesis. Eur J Midwifery. Jul 26;5:31. doi: 10.18332/ejm/138197. PMID: 34386725; PMCID: PMC8312097.

D'Angelo, A., Ceccanti, M., Fiore, M., et al (2020). Pregnancy in women with physical and intellectual disability: psychiatric implications. *Riv Psichiatr*, 55(6):331-336. doi: 10.1708/3503.34890.

Ertan, D., Hingray, C., Burlacu, E. *et al* (2021). Post-traumatic stress disorder following childbirth. *BMC Psychiatry* **21**, 155. https://doi.org/10.1186/s12888-021-03158-6

Fox,D; Scarf, V; Turkmani, S; Rossiter, C; Coddington, R; Sheehy, A; Catling, C; Cummins, A and Baird, K. (2023). Midwifery continuity of care for women with complex pregnancies in Australia: An integrative review, *Women and Birth*, 36(2). https://doi.org/10.1016/j.wombi.2022.07.001.

Pavlidou, A., and Sarantaki, A., (2021). Experiences of Physically Disabled Women during Childbirth. A Systematic Review of the Latest Literature. *Maedica (Bucur)* 16(4): 685–694. doi: 10.26574/maedica.2020.16.4.685

Simpson, M. and Catling, C. (2016). Understanding psychological traumatic birth experiences: A literature review, Women and Birth, Volume 29(3): 203-207. https://doi.org/10.1016/j.wombi.2015.10.009

WHO (2022) Global Guidelines to Support Women and Newborns in the Postnatal Period. https://www.who.int/publications-detail-redirect/9789240045989