Submission No 334

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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I worked as a mental health nurse in Sydney for several years before completing the Graduate Diploma in Midwifery in 2018 as an already registered nurse.

While mental health services still have a long way to go, trauma informed care was taught, discussed and strived for in the public mental health services I worked in, and I felt there was a general understanding amongst mental health clinicians about the effects of trauma, and the importance of the client-clinician relationship being trustworthy, transparent and empowering for clients.

I did my midwifery training at a small, busy hospital in one of Sydney's most diverse and socioeconomically disadvantaged areas.and was completely alarmed when I looked at the maternity service through the lens of trauma informed care. Firstly, all clinicians were so incredibly busy it was very challenging to establish rapport, or get to know the women/birthing people under our care, and to have time to clearly provide information and support in ways they understood. For example, booking appointments were less than 90 minutes long. We often used interpreters, and people were often coming from overseas with a different understanding of healthcare and faced many barriers to accessing standard maternity care like ultrasounds and blood work, which meant appointments were often wasted trying to get an interpreter, or calling around to find pathology results. We were not allocated enough time or resources to establish trauma-informed care during the antenatal period. Women saw different midwives almost every appointment, and by the time women were presenting to the birth unit to give birth, they often had very little understanding about labour, or their options during the birthing process. I felt we failed the population we were caring for by giving them such short appointments (20 minutes for a regular antenatal appointment) and poor continuity of care, and were not well resourced enough to provide information and support in ways that were relevant to the population we serviced.

It was very rare to work on the birth unit with only having to care for one woman at a time, even as a very junior member of staff. We were so rushed, and women were frequently presenting with little understanding of their options and their rights while giving birth. I felt I rarely had time to support women in labour, and there was a very strong focus on task-oriented care, which was largely centered on monitoring and intervening for risk. It was awful, so stressful, and so different to the kind of midwifery I was learning about at university. Being so busy and risk-oriented led to some practices that were completely opposed to trauma-informed care. I frequently saw clinicians walk into women's rooms and perform vaginal examinations without introducing themselves, explaining what was happening, or gaining consent. Coercion was regularly used to gain 'consent' and there was rarely time to establish relationships with families to trustfully explain processes, risks and options. I think clinical practice was so fear-based and driven by clinicians' own anxieties, the care provided was far from trauma-informed and often prioritised the needs of the clinician, rather than those of families. Even women who were presenting with known psychosocial vulnerabilities, including histories of sexual abuse or violence, were not provided with specialised care plans or support for clinicians to provide them with trauma-informed care.

During emergency situations, it was rare to have available staff to support the woman and her family to understand what was going on. I so often felt in flight or fight myself, I can't imagine what that would have felt like for the people seeking care there. The postnatal ward was also very challenging, we often had up to 10 women and 10 babies to care for, it was very difficult to provide the most basic of care.

I think a major barrier to providing trauma-informed care was the fear-based culture of practice, being extremely time-poor and rushed as a clinician, and very limited understanding and general reflection within the service about how they could be more trauma-informed.

I loved being a midwife but hated working as one, and left midwifery practice after less than two years because I couldn't continue working in a field where the day-to-day work was so stressful, and opposed to the values and philosophy of midwifery.