Submission No 880

INQUIRY INTO BIRTH TRAUMA

Organisation: Better Births Illawarra

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Better Births Illawarra is a volunteer run, not for profit community organisation representing the needs and rights of families and advocating for best possible outcomes for babies born in the Illawarra. Our aim is to improve access to evidence-based maternity care in the public system, working with the to elevate the voice of local parents and counteract the alarmingly high rates of perinatal trauma in our community. More information about us can be found here: About Us — Better Births Illawarra

Since we formed in 2016, we have received more feedback than we are able to simply summarise in an online submission. It has been broad ranging and extensive and varied. Much like the needs of women and people during pregnancy, birth and post-partum. We have attempted to summarise what we'd see as some of the key factors relating to birth trauma and in relation to the terms of reference.

We welcome and commend the Select committee for investigating this important issue. We remain concerned that the response rate for submissions will be low and not reflect the true impact of birth trauma. Because in its nature this is a difficult thing to re-live and for many women something they simply do not want to discuss again or worse still haven't heard the process is underway.

Midwifery Group Practice – the situation

Our organisation formed in 2016 with the specific objective to call for an expansion of the Midwifery Group practice. International evidence has demonstrated that continuity of care by a known midwife is associated with many positive outcomes, including:

- Greater birth satisfaction for women
- Safer birth outcomes for babies
- High level of job satisfaction for midwives
- Better breastfeeding outcomes
- Reduced likelihood of birth interventions such as the use of narcotic pain relief, epidural, episiotomy, inductions and caesarean sections
- Shorter postnatal hospital stays
- Reduced likelihood of postnatal depression and better access to support if necessary
- Prevention of pre-term birth

It is our firmly held view based on years of advocacy, evidenced based research and sitting with our community, that increasing access to MGP is a key change required to reducing birth trauma rates in NSW.

We have attached a report compiled by BBI in 2016 called "BBI call for expansion of MGP" where we have outlined evidenced based research on improved outcomes via MGP and the summary of a survey we conducted with our community in 2016 on the benefits they experienced accessing this model of care.

Our call for an expansion to the program is in line with the Towards Normal Birth policy guidelines. The "Documents for Release under GIPA" (2016) prepared by the outlines their progress in the midwifery led continuity of care target (13-15% in 2016). There has been no increase at all in this time, and we suspect, has further eroded due to the staff turnover in MGP

Midwifery Group Practice – from a trauma perspective

Based on feedback we have received from woman in our community there are layers of trauma associated with their model of care from a lack of choice perspective.

1. There is trauma associated with missing out on accessing this care (i.e., they apply and miss out)
2. There is trauma associated with being "risked out" of this model of care
3. There is trauma associated with not feeling like they have an option
4. There is trauma associated with accessing a different model of care, experiencing birth trauma and realising that MGP existed and might have led to a different outcome had they been able to access it or had an awareness of it.

We have also received feedback on other dimensions relating to this:

- A lack of transparency on "eligibility" for MGP
- only being for "low risk" pregnancies therefore high-risk pregnancies are accessing fragmented care, going against the grain of the evidenced based research.
- Poor communication throughout the entire process in terms of not getting a place, or being risked out

The impact to women and their families is starting their pregnancy with anxiety, stress and worry. And feeling powerless with no options.

After 7 years of advocacy, we have identified a long list of barriers associated with expansion of the MGP, including (but not limited too):

- No budget (despite the M@NGO trial findings re: cost benefits of MGP over all other models of care)
- Staff shortages (despite any targeted MGP recruitment leading to higher numbers of applications)
- Staff burnout in MGP (this is a proven thing if the health service has inadequate organisational structures and support for MGP midwives, which we believe to be a challenge across most NSW hospitals)
- No space to run clinics. Apparently, this kind of service design takes up more room.
- Inconsistency in how different MGP members deliver the service, so a more consistent service would need to be designed before an expansion was possible.

The last point was raised to us in 2018 which led to the UTS undertaking a report called

. This report, withheld by the , but shared a summary presentation recommended:

1. Recruit a dedicated midwifery manager who understands midwifery led continuity of care (NOT COMPLETE)
2. Change the name for MGP to Midwifery Caseload Practice to reflect a high level of continuity of care (NOT COMPLETE)
3. Increase women's access by advertising on the hospital's website and in the community (PARTIALLY COMPLETE)
4. Attract and support midwifery caseload workforce by placing students with the model, employing graduates to the model, transitioning midwives from other areas of the practice into the model (NOT COMPLETE)
5. Increase access to publicly funded homebirth by adjusting the accreditation process and providing mentor support (NOT COMPLETE)
6. Provide flexible ways of working (NOT COMPLETE)

7. Increase access and acceptability for women by providing antenatal care in the women's home or expand community settings (NOT COMPLETE)
8. Promote collaboration through providing a named OB to work in partnership with midwives (COMPLETE)

Our extensive experience over seven years of lobbying for this expansion, with limited change, highlights the deeply engrained cultural barriers to expanding MGP. We urge the Select committee to consider how services can be cost effectively re-designed to enable the change our community wants to see and in turn significantly reduce birth trauma.
To recap:

1. MGP is a model of care that will deliver better outcomes for mothers, babies and reduce trauma
2. There is a very strong demand for this model of care
3. There are deeply engrained barriers and failings in service delivery to meet community expectations
4. The effects of this are deleterious to families, community, and society more broadly.
5. Recommendations need to address these cultural failings to see changes within a lifetime.

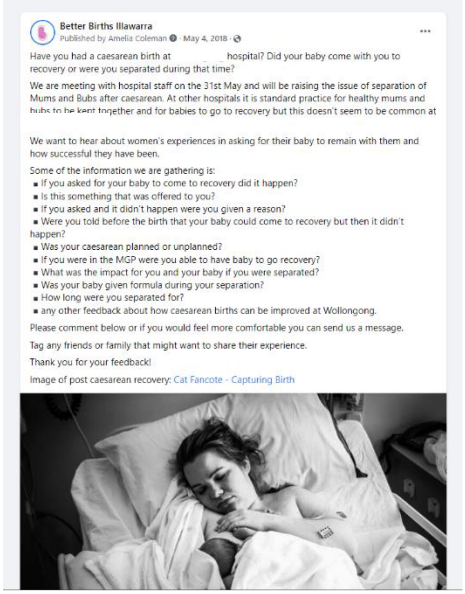
Separation of mothers and babies after caesarean section

Since our formation in 2016 we began to receive anecdotal feedback that mothers and babies were being separated after caesarean section and in circumstances where there wasn't a medical emergency with either. Typically, after the surgery, we were told by women that they were wheeled to recovery and their partner to the maternity ward to wait with the baby.

This separation has led to significant and long-lasting impacts.

The Facebook screen shot below is from May 2018. This had a reach of over 20,000 people with over 500 unique comments (responses), in addition many more responded via DM and email. We summarised via a report called, "Better Birth Caesarean Summary" which outlines in detail the responses and analysis we undertook. We have shared this report to help inform the understanding of the impact of this separation.

Despite extensive lobbying, a change to policy, recruitment of a part time dedicated Caesarean section midwife, this separation is STILL OCCURING leading to extremely traumatic experiences which could be prevented if the mother and baby were kept together.



"I begged and cried and yelled to have my baby brought to me after my c section and was both ignored and refused. It was horrible and terrifying laying in recovery being ignored when all I wanted was my baby. After 3hrs they let me see her as they took me back to the ward. I am still angry. I had issues bonding with her and breastfeeding was difficult." ***(Quote received April 2018 – deidentified for privacy)***

Staff (midwife) shortages

It will not be news to the Select Committee that there is a global shortage of midwives. There has never been a more important time to ensure our health services and maternity wards are designed efficiently.

We have received extensive feedback over the years around trauma associated with staff shortages. It's generally been our experience that midwives want to deliver high quality care. However, when they are stretched, understaffed, not supported this is simply not always possible.

There are layers of problems associated with closing the staff shortage situation. What we want to emphasise are the long-lasting impacts of poor-quality care, being neglected or not cared for appropriately during pregnancy, birth and post-partum.

During the pregnancy missed appointments are very risky and we have had woman contact us to say that they are simply not seeing midwives for appointments as they're fully booked. This poses a risk to their babies' health and their health if there is no early detection of issues. This is also leading to anxiety and stress during pregnancy.

During birth we are told of stories where women are being left alone during birth and not being adequately supported during labour. The impacts of this can range from feeling fear and stalling labour – leading to interventions that lead to trauma. And women not feeling supported at an extremely vulnerable time.

Post-partum women are not being visited at home or missing follow up services, not being referred to other support services.

We know that staff shortages in public health will continue to be a prolific challenge for Governments however, we believe that not addressing this in maternity will lead to significant increased public health costs in other ways if not adequately addressed.

Increasing inductions of labour

We are very concerned with the increasing rates of inductions of labour as outlined in the recent Mother and Babies Report 2021. Although the statistics align with state

averages, we question if they are medically necessary or if they're coming around due to poor evidence being referenced like the "Arrive Trial" or for convenience of scheduling due to staff shortages. Year on year the induction rates have increased. Women have reported to us that they've felt coerced into having an induction or that they didn't realise they even have the choice to say no.
Communication around induction needs significant improvement. Recommended as hospital policy or routine care, and often underpinned by reasoning including but not limited to, estimated due dates, babies size estimates, maternal age, gestational diabetes, VBAC, IVF pregnancies etc.
We have not found a health service that will hand out evidence-based resources that women can review, and then ask questions, to make an informed decisions on the risks, benefits and consequences of having or not having an induction.

The Cascade of Intervention is widely acknowledged and understood. It starts with induction and progresses through medical pain relief and into instrumental birth, episiotomies, and caesarean sections. These highly invasive medical procedures are arguably more likely to result in women experiencing trauma because of the associated physical and mental impacts.

National Safety and Quality health service standards – partnering with consumers

Arguably a preventative strategy for trauma is an environment where health services have included consumers in the design, delivery and evaluation of quality health care. As a consumer advocacy organisation, we are very underwhelmed with how this standard is enabling co-design, collaboration and communication. It has not enabled fast, responsive change when it comes to trauma and the numbers of traumatised families is testament to this.

Our experience is that woman don't trust the service and the process is cumbersome for them. Once they're home with their baby and traumatised they're trying to "get on with it" or "forget it" or "avoid ever thinking about it". A complaints process needs to address these very real issues and barriers to even receive live feedback, so that a service might make changes and respond to how they're delivering care.

Secondly, when consumer advocacy groups like ours do exist and want to be part of informing positive changes; the power imbalances need to be addressed within health organisations. Consumer voices need to be heard, valued and respected.

Currently there is no value of our time, no remuneration despite representing consumers in Executive level forums. It is simply not good enough and this is another barrier that gets in the way of preventing trauma.

Trauma support

There's a window whilst women are within the system of care to capture their feedback but there's a lack of safety, support and process to do this meaningfully.

We believe that staff need to be more informed around identifying when woman have experienced trauma and ensuring that they're offered support services, debriefed via a trauma informed care provider and referred to other services immediately.

Policy mechanisms to date have failed

The rates of trauma in NSW have occurred under the last decades policy frameworks. Something is failing here. We implore the Select committee to please consider proven policy approaches that have led to sustainable and long-term positive improvements and outcomes for our community.

We look forward to the recommendations to come from this review and are hopeful of positive changes that will reduce the rates of birth trauma in NSW.

Giselle Coromandel on behalf of Better Births Ilawarra

To understand the importance of keeping mothers and babies together we first need to acknowledge the importance of what is happening in the immediate post-partum period. When mother and baby finally meet they are biologically hardwired to want to touch and remain together. We know from research how vital immediate and uninterrupted skin to skin contact is. For the mother, it promotes the release of oxytocin which encourages bonding and helps uterine contractions to deliver the placenta. It also encourages prolactin production which facilitates milk production. For babies uninterrupted skin to skin stabilizes their temperature, heart rate and breathing. Immediate and continuous skin to skin is in line with current best practices for maternity health care. RANZCOG policy recommends that healthy term infants be placed on their mothers bare skin and covered with a warm blanket and that this practice facilitates breastfeeding and bonding.

Having that golden hour of contact with your baby is the ultimate reward after nine months of waiting. When women and babies miss out on this time the impacts can be significant and long lasting.

Currently birth unit staff are excellent in ensuring uninterrupted skin to skin for at least an hour after birth for vaginal births. It is well understood about the importance of this time and newborn checks (unless medically necessary) are not done until at least an hour after birth. Given that Hospitals caesarean rate sits close to 30% it is incredible that that this large group of women are not being provided with the same evidence-based care.

We had been provided with feedback from local women about being routinely separated from their healthy baby after a caesarean and that this separation had negative consequences. We were unsure how important this topic would be for women so decided to do a Facebook post asking whether women had been allowed to have their baby accompany them to recovery and if not what the impact of that had been. We expected a response like other facebook posts BBI had done of about a dozen responses.

It is fair to say that we were quite overwhelmed with the outpouring of women wanting to share their experiences from Hospital. Within 24 hours we had received over 100 responses of caesarean experience and by the end of the week it reached 200. A great number of women tagged friends and family in the post and in total there were 525 comments on the post and 53 shares, indicating a high community interest and engagement with the issue. Women who were not BBI participants or maternity rights advocates were motivated to reach out and share their experiences. We know that the feedback is not consistent with thorough research methodology and is a self-selecting group, nonetheless the responses are from Hospital consumers and still valuable.

In the post we asked several questions such as, was your caesarean planned or unplanned, did you ask for your baby to accompany you to recovery, if you were in the MGP were you able to have your baby come to recovery, how long were you separated for, did the separation impact bonding or breastfeeding. Not all respondent answered every question however we were able to summarise the feedback into some key numbers:

- We received 200 responses in total and some women shared separate birth experiences, so the total births described was over 215.
- Of the 215 births detailed - 189 were separated from their healthy baby while in recovery
- 35 women had their baby come to recovery
- 43 women **explicitly** asked for their baby to remain with them and were told no, most of the time they were not given any reason for this, but 16 women were told it was due to understaffing
- Of the women who shared how long they were separated for, the average time was between 2-5 hours, with 10 women being kept in recovery despite being well for over 5 hours! The length of time was a significant factor in how deeply upset women felt about being separated from their baby.
- Women in the MGP were more likely to have their baby come to recovery
- 166 women reported experiences of trauma, anxiety, dissatisfaction during the period of separation
- 34 women reported breastfeeding issues
- 29 women reported issues bonding with their baby
- Disturbingly 41 women reported experiencing long term negative emotional effects, severe psychological trauma, diagnosed PTSD, or PND and they felt the separation was a significant factor

It is clear from the feedback that the majority of women who undergo caesarean section at hospital are separated from their baby and that even for planned caesareans during business hours with a healthy mother and baby e.g breech birth, babies are not routinely taken to recovery.

It is impossible to read out all the responses, but we will share one with you as it is a representation of how deep the pain of separation is felt:

"I begged and cried and yelled to have my baby brought to me after my c section and was both ignored and refused. It was horrible and terrifying laying in recovery being ignored when all I wanted was my baby. After 3hrs they let me see her as they took me back to the ward. I'm still angry. I had issues bonding with her and breastfeeding was difficult."

Some of the common language used by women to describe their separation included

“devasting”, “horrible” “heart breaking” “scared” “sad” “frustrated” “anxious” and that they “begged to see my baby”.

This contrasts with women whose babies **did** accompany them to recovery describing their baby’s birth experience as “amazing” and overall positive. Interestingly some women had experienced both (ie. Caeserean with and without separation) and there is a vast difference in how they described each birth. It would appear that having babies accompany their mothers to recovery is a small thing to the hospital but it has a great impact on how women feel about their baby’s birth and their entry to motherhood.

Aside from the emotional impact, some other key themes were identified.

- Disconnect in communication between recovery unit and maternity unit. Many women described asking for updates about the status of their baby and were ignored or not provided with answers. They were also not given updates about when they would be taken to maternity unit, this uncertainly creates feelings of powerlessness and anxiety.
- Being told that the reason their baby couldn’t stay in recovery was because their baby needed to be cared for a midwife (recovery unit nurses are not trained for neonate care), however their partners were left alone for many hours with the baby in maternity with no one checking on them.
- Once women were finally taken to the maternity unit and reunited with the partner and baby, if it was outside of visiting hours their partner was told they had to leave immediately. This seemed to compound the trauma of separation as now they were missing out on family bonding time.
- Mothers missing out on being present for newborn checks.

We acknowledge that staffing has been an ongoing issue for the hospital and that it is likely to be a significant factor, however it is unfair that women in their most vulnerable moment are being asked to bear the burden of this staff shortage.

We are also concerned that this is another example of entrenched habits and that even as staffing levels continue to improve, that the practice of keeping mums and baby’s together after caesarean will not be a priority. It will take not just a change in staffing but a culture change as well for it to be routine.

From the themes identified Better Births Illawarra are asking the following on behalf of local consumers:

- A commitment to create policies and practices will reflect current recommendations that healthy mothers and babies remain together in recovery.
- A Midwife, EN or student midwife be rostered on the recovery ward every day.
- Expansion of the MGP as this has been shown to increase the likelihood of having baby’s remain with mothers in recovery.

In the event where separation is unavoidable

- Partner be allowed to stay longer on the maternity ward and improved communication between recovery and maternity unit.
- Newborn checks be delayed until the mother is present.
- Given that the length of separation correlates to the degree of trauma, mother and baby being reunited as soon as possible.