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Moving Beyond Recommendations: Considerations for Effective Change in Relation to Birth Trauma

Kyla Vaillancourt, Susan Ayers, Julie Jomeen

Increasing awareness that parents and staff can be affected by traumatic childbirth, and might subsequently develop post-traumatic stress disorder (PTSD) saw the 2024 publication of two inaugural Government Inquiries into birth trauma (BT). In Australia the New South Wales (NSW) Legislative Council Select Committee on BT was catalysed by evidence that 28 per cent of Australian women experienced BT, over one-in-ten obstetric violence and a complaint lodged by the Maternity Consumer Network (NSW Select Committee, 2024). The United Kingdom (UK) All-Party Parliamentary Group on BT was initiated by an MP after her own experiences of BT, underpinned by serial inquiries into failings of maternity services (APPG Birth Trauma, 2024).

The Australian and UK inquiry reports make 43 and 12 recommendations respectively (NSW Select Committee, 2024; APPG Birth Trauma 2024), developed from thousands of evidence submissions from parents, health practitioners and experts, identifying a crucial need to prevent and respond to BT.

Though the scope and focus of these inquiries differs; one state in Australia (NSW) and national in the UK, they share key recommendations; including the need for trauma-informed care (TIC) and understanding of BT to be a mandatory training requirement, and maternity workforce changes to promote continuity of care and TIC. Improving antenatal education so parents are fully informed about birth options. Furthermore, the importance of improved postpartum care and screening for PTSD symptoms, the need for an evidence-based model of birth “debriefs”, and access to physiotherapy for pelvic health injuries. Other crosscutting features include, poor communication between staff and parents, particularly about risks and informed consent and each report makes recommendations of training, policy change and service redesign. In terms of mental health support, both reports identify gaps in access to suitable psychological therapy for parents, birthing partners, and staff who experience BT. Inclusive services to meet the needs of diverse communities are also a key feature. Finally, gaps in the evidence base are consistently acknowledged on how to prevent, screen and respond to BT.

The two reports also vary, particularly in recommended changes to postpartum care. In the UK, implementation of the obstetric anal sphincter injury (OASI) care bundle is recommended; in the NSW report the SAFE START model of psychosocial assessment and depression screening for perinatal women, although SAFE START's limitations to identifying BT is acknowledged. The UK report also recognises the screening gap recommending research to develop a brief, standardised screening tool.

Recommendations are nuanced in relation to local and national contexts. For example, the NSW recommendations have a greater focus on marginalised groups, reflecting the Australian demographics, including First Nations women, as well as proposed changes to legislation for informed consent. In the UK, recommendations to provide specialist maternity care for younger parents, and a commitment to address racial disparities in maternity care are recommended linked to maternal and perinatal mortality surveillance reports.

The recommendations provide an incentive and benchmark for maternity services and healthcare providers to develop and assess services and outcomes. The need to prevent and treat BT through appropriate support is clear. How to implement changes effectively is complex and challenging. We outline three considerations in respect to the recommendations:

1. The importance of **evidence-based change and intervention** is enshrined in modern healthcare. However, there remain areas of prevention and treatment that require further research to understand how to enhance outcomes for women, families and staff. Absence of clear evidence, leaves services implementing approaches that are not – or weakly - evidence based in order to do something. Gaps where evidence is needed include effective screening for BT and PTSD; how to reduce inequalities in birth experiences/outcomes; the efficacy and application of postnatal 'debriefing', OASI/Safe Start implementation, and what works to prevent BT.

In the absence of investment, services need to respond in justifiable ways, acknowledging the evidence gaps, and ensuring that changes are done within adequate governance and evaluation.

2. Both inquiries focus on treatment and prevention of BT, but the balance of recommendations are towards the pressing need for support and treatment of BT. However, this should not overshadow a **focus on the prevention of traumatic birth**. What changes will make the most difference in terms of preventing BT? Prevention will most effectively reduce the disease burden, related costs (to women,

healthcare services and society), and is scalable. Recommendations from these inquiries include the importance of TIC and improving the culture within maternity to retain staff equipped and supported to promote compassionate care, which centres on respect and dignity and reduces inequalities. TIC is highly relevant but has been poorly defined, and hence implemented differentially by organisations. Truly TIC requires more than training; but shift in service design/delivery, with trauma-informed principles guiding policies, procedures, budgets, leadership, staff well-being, and clinical care. Examples of comprehensive TIC approaches include Scotland's [National Trauma Transformation Programme \(2023\)](#). Noteworthy is the effectiveness of TIC in preventing BT has not yet been evaluated.

3. Recommendations from these inquiries could drive meaningful change but consideration is needed of **how changes are implemented**, by whom and with what resources. Implementation is not easy or straightforward, particularly complex psychosocial and behavioural interventions. This challenge is further amplified when implementing changes within maternity services that are often over-burdened, under-resourced, and suffering from high staff turnover and poor staff morale (WHO, 2019). Arguably, recommendations, if implemented poorly, can increase staff burden which is counterproductive to creating truly trauma-informed organisations that can deliver on the recommendations.

Implementation science provides systematic approaches to implementing and sustaining evidence-based practice and may help to guide changes in response to these recommendations. We propose that frameworks that consider the human and social factors associated with healthcare implementation are most appropriate to maternity (Khalil & Kynoch, 2021).

In conclusion, these inquiries and recommendations form a significant milestone in tackling BT, serving as powerful reminders of the suffering BT can cause. Recommendations must be resourced, enacted with integrity, considering the evidence base to make meaningful change. Research funding should be prioritised to avoid the situation where the evidence-base needs to 'catch-up' to policy and practice.

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