BIRTH REFLECTION SERVICES IN THE NORTH EAST OF ENGLAND

Local Maternity Systems Prevention Team

April 2020

LMS
Darlington, Tees, Hambleton and Richmondshire and Whitby
Northumberland, Tyne and Wear and Durham
Local Maternity Systems

Birth Reflection Services in the North East

This report outlines the various birth reflections services offered in the North East of England. It then describes the model used in Northumbria Healthcare NHS Foundation Trust as an example of good practice, before making key recommendations for services.

Contents

Background …………………………………………………………………………………………………… p1
Outline of regional services ………………………………………………………………………………… p2
Northumbria Healthcare NHS Foundation Trust Model ………………………………………………… p4
Recommendations …………………………………………………………………………………………… p5
Acknowledgements …………………………………………………………………………………………. p7
Bibliography and Reference List …………………………………………………………………………. p7
Appendix 1: Definitions ……………………………………………………………………………………. p8
Appendix 2: Diagnostic Criteria for Post-Traumatic Stress Disorder (PTSD) ………………………… p9
Appendix 3: Northumbria Health Care Trust Birth Reflections Service Pathway Referrals Card p11
Appendix 4: Northumbria Health Care Trust Referral Pathway for Health Psychology and Mental Health Services for Obstetrics and Gynaecology ……………………………………………………… p11

Background

The Northern Maternity Engagement Group requested a report on birth "debrief" services that are offered across the region. Many women have contacted their local Maternity Voices Partnerships to enquire about such services and there has been confusion due to differing names and approaches between Foundation Trusts.

Service evaluations have shown that women appreciate the opportunity to discuss their pregnancy and childbirth experience (Rowan et al, 2007) and many trusts offer a postnatal service to do this. Nationally, these sessions have a range of names including Afterthoughts, Debrief and Reflections services. Current NICE Guidance (CG37, 2015) does not recommend formal debriefing of the birth process. A Cochrane Review undertaken by Bastos and colleagues (2015) showed that there is no real evidence that a debriefing service reduces psychological trauma in women following childbirth. It is important to note that there is no agreed upon definition in the literature for postnatal debrief; the studies reviewed were deemed to be of low quality and included very different interventions; and the review concluded that more rigorous studies are required. However, giving women the opportunity to discuss their birth experiences could help identify those who have symptoms of trauma early and facilitate appropriate referral to psychological services.

Traumatic births are defined by NICE (CG192, 2020) as those that are physically traumatic or those that are experienced as traumatic. Importantly, symptoms of trauma may not reflect the obstetric complexity of the birth (Fraser and Kearney, 2017). The literature estimates that 1-6% of women experience Post-Traumatic Stress Disorder (PTSD) post-childbirth, with a further 22-40% experiencing symptoms of PTSD without reaching the threshold for diagnosis (Fraser and Kearney, 2017). This emphasises the scale of the issue and the need for a clear approach for detection and management.

Regional Services

Trusts Reviewed:

- County Durham & Darlington NHS Foundation Trust (CDDFT)
- Gateshead Health NHS Foundation Trust (Gateshead)
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust (Newcastle)
- North Tees and Hartlepool Hospitals NHS Foundation Trust (North Tees)
- Northumbria Healthcare NHS Foundation Trust (Northumbria)
- South Tees Hospitals NHS Foundation Trust (South Tees)
- South Tyneside and Sunderland NHS Foundation Trust (STSFT)

All seven trusts in the North East offer some form of postnatal discussion service, although the service is not formalised in South Tees or STSFT. The service in North Tees is new from February 2020 and the service in Gateshead has undergone a complete change in the last few months. South Tyneside and Sunderland Foundation Trust are currently in the early stages of developing a formal midwifery-led service. Maternity services in each of the seven trusts were contacted by email and their responses inform the descriptions below.

Name of Service

The service is called Birth Reflections in Newcastle, Gateshead and Northumbria. The name Reflections is used in North Tees, while The Listening Service is used in CDDFT, although this is undergoing review. South Tees offer an informal service with individual obstetricians and a Talking About Birth service for pregnant women who have had a previously difficult or traumatic birth experience. South Tyneside and Sunderland Foundation Trust also offer women the opportunity to discuss delivery with either the Head of Midwifery or one of the Obstetricians, but they do not currently provide a midwifery-led service.

Informing Women of Service

Women are informed of the service postpartum or on discharge from the postnatal ward in CDDFT, Gateshead, Newcastle and Northumbria. This is the plan for North Tees who are still developing their service. Newcastle and Northumbria also provide information about the service antenatally. Clear descriptions of the service are available on the trust websites for CDDFT, Newcastle and Northumbria. All services are yet to be added onto the LMS Pregnancy and Birth Choices WebApp.

Referral Process

Women are encouraged to self-refer to the services in CDDFT, Gateshead, Newcastle and Northumbria. This will be available in North Tees once a dedicated email address and phone number are organised. Community Midwives, Health Visitors and GPs can also signpost and refer women into the services. Timing of referral was not specifically asked but Northumbria see women from 12 weeks to 12 months postpartum and there is no time limit for services in CDDFT. Newcastle and Northumbria prioritise women who are currently pregnant if gestation indicates, and South Tees' Talking About Birth service is for pregnant women with a previously traumatic birth experience.

Location of Service

Sessions happen in hospitals in South Tees, STSFT, North Tees and Gateshead. CDDFT offer the option of conducting the session in the hospital or the woman's home. Newcastle use a parent education room which is adjacent to the Birthing Centre. They also offer to conduct sessions by telephone if women live out of area. Northumbria offer their service in Children's Centres, away from the hospital environment. North Tees plan to offer sessions in hospital, Children's Centres and women's homes. Gateshead service provide monthly clinic that runs alongside the Perinatal Mental Health clinic so that those skill sets can be utilised if necessary.

Team Involved

North Tees service is overseen by three midwives and each session is jointly conducted by two midwives based on the delivery suite. Two senior midwives conduct each session jointly in Northumbria. Two or three midwives per community midwifery team offer the service in CDDFT. Individual sessions are conducted by one midwife. The service in Newcastle is run by one senior midwife and 20 midwives in the team conduct sessions. Of note, the survey sent to units did not specifically ask about training received by midwives undertaking these sessions.

What happens during the session?

The sessions in CDDFT, Gateshead, Newcastle, Northumbria and North Tees are woman-led and are based on individual wishes and expectations. They all emphasise that it is not a counselling service and that the services aim to offer an opportunity to explain why events occurred as they did. Often, the pregnancy from booking appointment to birth is discussed. The midwives can refer to the woman's clinical notes during the session or read through these in advance. Questions and concerns are addressed and discussed. Newcastle's service also uses props (eg dolls, forceps and pelvis) to aid explanations of physiology and their sessions can take up to two hours. CDDFT and North Tees refer on to other specialties, such as maternity-specific counselling services, or signpost to woman's GP if required. North Tees offer more than one session if needed. If a more medical opinion or advice is required, the Gateshead service has the involvement of a named Obstetrician for support. In Northumbria, the birth reflection clinics are a 1.5 hour contact and conclude with a review of any additional needs across the birth reflection pathway where women can be signposted to an embedded psychology service and/or a medical consultation if indicated. Birthing partners or significant others are welcome to the formal sessions. Of note, the survey did not specifically ask about referral procedures for women who display trauma symptoms.

Waiting lists

There is currently no waiting list in Gateshead, North Tees and Northumbria. There is a three-month waiting list in Newcastle.

Evaluation of Services

The service in North Tees ask women to fill in a service evaluation at end of session. Newcastle ask for anonymous evaluation which is posted in after the session. In Northumbria, women can choose to fill the evaluation in after the session or post it. Newcastle audit various aspects of their service including waiting times. Midwives conducting sessions in CDDFT provide monthly reports. Gateshead also have a strong emphasis on evaluation, and their service was developed with input from the local Maternity Voices Partnership and previous service users.

Northumbria Healthcare NHS Foundation Trust Model

Information about the Birth Reflection Service is given prior to discharge from the postnatal ward and from community midwives. The service is also available antenatally for women who delivered previously in Northumbria. Further information is found on the trust website and the Birth Reflections Service is one of the first services listed on the maternity webpage. There is an online referral system for women who are six weeks or more postpartum. This online referral form asks where the woman found out about the service which helps monitor how information is being shared. It also asks for personal details and a description of what the individual woman hopes to gain through the process. Women can choose to have a discussion with a senior midwife or with a health psychologist on this referral form depending on what is most important to her at that time. This means that the woman's expectations are identified from the offset and all referrals can then be triaged and managed appropriately. Women are replied to within two weeks of self-referring and seen from 12 weeks postnatally, or sooner if indicated.

The Birth Reflections Service is part of a pathway of support, which involves trained senior midwives, Obstetricians, Health Psychology and formal complaints processes (appendix 3). Senior midwives conduct Birth Reflection sessions in pairs in a community setting for a one-off 1.5 hour session. The service is also introducing telephone contact if preferred. Hospital notes are used to help explain any queries or concerns that the woman may have. Women are referred to Obstetric Outpatients for further clinical discussion around obstetrically complex cases or if preconception advice is required.

Women are referred to Health Psychology if markers of trauma (appendix 2) are identified or further psychological support is required or requested. Health Psychology offer evidence-based psychological therapies for psychological health issues relating to the maternity context such as PTSD post-childbirth and tokophobia. CBT-based therapies, as recommended by NICE, are used in Northumbria Trust. Health Psychology can also refer women back to midwives if an obstetric discussion is required. There are strong links with community IAPT services and specialist perinatal mental health teams with clear referral pathways for each service (appendix 4).

The Birth Reflections Pathway is linked with Patient Experience and Patient Satisfaction, including the formal complaints process. This means that any issues, concerns or complaints raised by a woman can be officially recorded and actioned at a higher level.

All maternity and gynaecology staff have undertaken trauma training within the trust, provided by the embedded Health Psychology Service. Perinatal trauma training includes post-traumatic stress disorder, recognition of birth trauma, active listening to birth stories, prevention of PTSD following childbirth and the vicarious impact on staff. The Trust have also shared this perinatal trauma training with South Tees Trust. Training was officially evaluated as part of NHS England's Maternity Challenge in 2018 and was evaluated very highly by staff in both trusts (Fraser, 2018a, 2018b).

Health Psychology is embedded within the Maternity and Gynaecology services. Strategic support is offered by the inclusion of Health Psychology on the Trust's surgical board. Psychological support is also offered to midwives who may have witnessed or been involved in a traumatic birth or major incident at work. Midwives conduct the Birth Reflection Sessions in pairs which offers peer support.

The Birth Reflections Service is evaluated annually, and referral data is to be added to the Maternity Dashboard. This includes user-feedback, auditing of formal complaints and onward referral to the Health Psychology team. Northumbria Trust was one of three winners of the 2018 NHS England

Maternity Experience Challenge fund which funded a project focusing on PTSD following childbirth and perinatal trauma training. The service also won two HSJ Awards in 2018 for Compassionate Patient Care and Innovation in Mental Health (Health Service Journal, 2018).

Recommendations

General Recommendations

1. Women should be offered the opportunity to discuss any concerns or worries about their pregnancy or childbirth experience. There is no consensus in the literature in regard to the ideal timing but it would be reasonable to see women from six weeks postpartum up to two years postnatal or if identified in subsequent pregnancies.

2. There should be a consistent name for these services across the region. Birth Reflections is suggested as regional Maternity Voices Partnerships' feedback shows that this is acceptable to service users and is already the most commonly used name in the North East region.

3. The information provided and the referral process should be standardised across the region. Each Trust should advertise their service on the Regional Pregnancy and Birth Choices webapp and there should be an online description on Trust Websites and on Trust social media to spread awareness.

4. The Birth Reflections Service should be part of pathway including midwifery and obstetric staff, Obstetric Healthy Psychology and Patient Satisfaction and Experience processes.

5. Birth partners should also be offered a birth reflection service as they can suffer from vicarious trauma, in accordance with NICE Clinical Guidance (CG192, 2020).

6. Services should be evaluated and audited. Evaluations should include both user satisfaction and outcome data such as number of women identified as requiring more complex psychological interventions. There is currently little evidence for similar services and so rigorous evaluation could add to the knowledge base.

7. Satisfaction data should be fed back into Patient Satisfaction and Patient Experience structures within trusts so that feedback can be actioned appropriately.

Midwifery and Obstetrics Services

1. All maternity staff should have perinatal trauma training, including prevention, recognition and management. Each member of staff has the opportunity to reduce the risk of PTSD following childbirth by ensuring women are treated with respect and dignity throughout pregnancy and postnatally; by ensuring women are included in decision-making; discussing

birth expectations and experiences; and by giving women ample opportunity to ask questions prior to discharge. Appropriate recognition of trauma is important to ensure timely referral for management.

2. A one-off session discussing a woman's childbirth experience, making use of clinical notes, should be provided by senior midwives who have had additional training, including training on perinatal trauma and detecting perinatal PTSD. It should be made clear that this one-off session is not a counselling session. There should be a clear outline of what to expect prior to the session, and this should focus on the individual's needs. The woman's expectations and hopes for the process should be ascertained prior to the session.

3. These sessions should be offered flexibly in hospital or community-settings, depending on what is most comfortable for the woman involved. Conducting sessions in women's homes is not recommended as this could mask symptoms of trauma. Being unable to attend a clinic or hospital due to the childbirth experience is a significant trauma marker.

4. Midwives require senior and peer support in this role. Midwives who have been involved with traumatic childbirths or incidences should be offered psychological support.

5. Women with markers of trauma or other maternity-specific anxieties should be referred to Obstetric Health Psychology for assessment and management. Psychological treatment for trauma symptoms or PTSD should not be provided by midwifery staff.

6. This pathway could also include input from Obstetricians for obstetrically complex cases, pre-conception planning and mode of delivery planning in future pregnancies.

<u>Health Psychology</u>

1. Health Psychology services is best placed within maternity services. This could be in the form of Maternity Outreach Clinics as outlined in the NHS Long Term Plan (NHS England and NHS Improvement, 2019).

2. Evidence-based psychological therapies should be offered by Obstetric Health Psychologists for those with specific pregnancy or childbirth-related anxieties such as PTSD or tokophobia.

3. Treatment for PTSD or PTSD-symptoms following childbirth should be provided by registered, trained practitioners. Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) are the evidence-based psychological therapies recommended by NICE for PTSD (NG116, 2018). NICE Guidance (CG192, 2020) states that one-off high intensity psychological interventions explicitly focusing on "re-living" the experience should not be offered. Treatment other than CBT and EMDR are not currently recommended.

Other staff

1. Primary care and Health Visiting staff would also benefit from training in perinatal trauma including prevention, recognition and management. This would aid in the recognising trauma markers during visits in the postnatal period including the six-week check with the GP. Community-based staff could be included in trust training sessions and information regarding the Birth Reflections Services should be shared.

Acknowledgements

With thanks to lead midwives from each of the seven trusts and to Lainey Fraser, Service Lead, Obstetrics and Gynaecology Health Psychology Service, Northumbria Healthcare NHS Foundation Trust, for their insights.

Bibliography and Reference List

Adams, S. & Allan, S. (2018) Muss' Rewind treatment for trauma: description and multi-site pilot study, *Journal of Mental Health,* 27:5, 468-474, DOI:10.1080/09638237.2018.1487539

Bastos, M.H., Furuta, M., Small, R., McKenzie-McHarg, K. & Bick, D. (2015) Debriefing interventions for the prevention of psychological trauma in women following childbirth. *Cochrane Database of Systematic Reviews 2015, Issue 4.* Art. No.: CD007194. DOI: 10.1002/14651858.CD007194.pub2.

De Graaff, L.F., Honig, A., Van Pamous, M.G. & Stamroom, C.A.I. (2018) Preventing post-traumatic stress disorder following childbirth and traumatic birth experiences: a systematic review. *Acta Obstetricia et Gynecologica Scandinavica,* 97, 648–656.

Fraser, L. (2018a) *Final Report To NHS England Maternity Experience Challenge Fund: Training for midwives on awareness, detection and prevention of perinatal post-traumatic stress disorder and birth trauma.* Northumbria Healthcare NHS Foundation Trust Obstetrics and Gynaecology Health Psychology Service.

Fraser, L. (2018b) *Training report For South Tees Hospital NHS Foundation Trust.* Northumbria Healthcare NHS Foundation Trust Obstetrics and Gynaecology Health Psychology Service.

Fraser, L. & Kearney, S. (2017) *Final Literature Report and Service Recommendations for the Birth Trauma/ Birth Reflection Maternity Project.* Northumbria Healthcare NHS Foundation Trust Obstetrics and Gynaecology Health Psychology Service.

Health Careers (no date) *Health Psychologist*. Available at: https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles/health-psychologist [accessed 26.3.20]

Health Service Journal (2018) *HSJ Awards 2018: Compassionate Patient Care.* Online. Available at: https://www.hsj.co.uk/the-hsj-awards/hsj-awards-2018-compassionate-patient-

care/7023828.article [Accessed 30/3/20]

National Collaborating Centre for Mental Health (2019) *The Improving Access to Psychological Therapies Manual.* Available at: https://www.england.nhs.uk/wp-content/uploads/2019/12/iapt-manual-v3.pdf

NHS England (2019) *NHS Mental Health Implementation Plan 2019/20-2023/24*. London: NHS England.

NHS England and NHS Improvement (2019) *Implementing the maternity & neonatal commitments of the NHS Long Term Plan: A resource pack for Local Maternity Systems.* London: NHS England.

NHS England, NHS Improvement & National Collaborating Centre for Mental Health (2018) *The Perinatal Mental Health Care Pathways*. London: NHS England.

National Institute for Health and Clinical Excellence (2020) *Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline CG192*. London: National Institute for Health and Clinical Excellence. https://www.nice.org.uk/guidance/cg192/

National Institute for Health and Clinical Excellence (2018) *Post-traumatic stress disorder. NICE guideline NG116.* London: National Institute for Health and Clinical Excellence. https://www.nice.org.uk/guidance/ng116

National Institute for Health and Clinical Excellence (2015) *Routine postnatal care of women and their babies. Clinical guideline CG37.* London: National Institute for Health and Clinical Excellence. https://www.nice.org.uk/guidance/cg37

Rowan, C., Bick, D., & Bastos, M.H. (2007) Postnatal debriefing interventions to prevent maternal mental health problems after birth: exploring the gap between the evidence and UK policy and practice. *Worldviews Evidence Based Nursing,* 4(2), 97–105. doi:10.1111/j.1741-6787.2007.00088.x

Appendices

Appendix 1: Definitions

Health Psychology: specially trained to help people deal with the psychological and emotional aspects of health and illness as well as supporting people who are chronically ill (Health Careers, n.d.).

Improving Access to Psychological Therapies (IAPT): provide evidence-based treatments for people with depression and anxiety disorders, and comorbid long-term physical health conditions or medically unexplained symptoms in the community (National Collaborating Centre for Mental Health, 2019, p 8)

Specialist Perinatal Mental Health Services: provide both community-based and inpatient care and support for women with complex or severe mental health difficulties, from pre-conception to 24

months post-partum (NHS England, 2019). This includes both psychiatric and psychological assessment and management with a multidisciplinary team approach (NHS England, NHS Improvement and National Collaborating Centre for Mental Health, 2018).

Maternity Outreach Clinics: "will provide integrated models of care between maternity, reproductive health and psychological therapy for women who experience mental health difficulties that arise within the maternity context such as tokophobia and PTSD following birth and perinatal loss. This will address current gaps, where women with these difficulties who do not meet thresholds, or would not benefit from the particular interventions in specialist services, but require more specialist care than that offered through IAPT, for example" (NHS England and NHS Improvement, 2019, p16)

Appendix 2: Diagnostic Criteria for Post-Traumatic Stress Disorder

From NICE Clinical Knowledge Summary of Post-Traumatic Stress Disorder, 2019. Available at: https://cks.nice.org.uk/post-traumatic-stress-disorder#!diagnosisSub

To meet the DSM-5 criteria for post-traumatic stress disorder (PTSD) the person must have:

- **Been exposed to actual or threatened death, serious injury, or sexual violence in one (or more) than of the following ways:**
  - Directly experiencing the traumatic event.
  - Witnessing, in person, the event as it occurred to others.
  - Learning that the traumatic event occurred to a close family member or friend. In cases of actual or threatened death of a family member or friend, the events must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
- **Persistently re-experience at least *one* of the following intrusive symptoms:**
  - Recurrent, involuntary, and intrusive memories.
  - Recurrent traumatic nightmares (children may have frightening dreams not related to the trauma).
  - Dissociative reactions (e.g. flashbacks) in which the person feels or acts as if the traumatic event is recurring. These reactions may occur as brief episodes or the person may lose consciousness (children may re-enact the traumatic event through play).
  - Intense or prolonged distress after exposure to traumatic reminders.
  - Marked physiologic reactivity after exposure to trauma-related stimuli.
- **Persistently avoid stimuli associated with the traumatic event such as:**
  - Trauma-related thoughts or feelings, or
  - Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

- **Experience at least *two* of the following negative changes in mood or thoughts that began or worsened after the traumatic event:**
  - Unable to recall key features of the traumatic event.
  - Persistent (usually distorted) negative beliefs and expectations about themselves or the world.
  - Persistent distorted blame of self or others for causing the traumatic event, or for resulting consequences.
  - Persistent negative emotional state (e.g. fear, horror, anger, guilt or shame).
  - Markedly diminished interest in (pre-traumatic) significant activities.
  - Feelings of detachment or estrangement from others.
  - Persistent inability to experience positive emotions (happiness, satisfaction, or love).
- **At least *two* of the following trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event:**
  - Irritable or aggressive behaviour (with little or no provocation).
  - Self-destructive or reckless behaviour.
  - Hypervigilance.
  - Exaggerated startle response.
  - Problems in concentration.
  - Sleep disturbance.
- **The above symptoms should:**
  - Cause significant distress or functional impairment (e.g. social, occupational).
  - Not be caused by medication, substance use, or other illness.
  - Be persistence for more than one month.
- **PTSD with delayed expression** is diagnosed when the full diagnostic criteria are not met until at least 6 months after the traumatic event (although the onset of some symptoms may be immediate).
- **PTSD with dissociative symptoms** is diagnosed if they meet the DSM 5 criteria and they experience high levels of either of the following in reaction to trauma-related stimuli:
  - Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
  - Derealization: experience of unreality, distance, or distortion (e.g. "things are not real").

To meet the ICD-10 criteria, the person must:

- Have been exposed to a traumatic event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

- Experience persistent remembering or 'reliving' the stressor in intrusive flashbacks, vivid memories, or recurring dreams; or experience distress when exposed to circumstances resembling or associated with the stressor.
- Exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.
- Experience either of the following:
  - Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
  - Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following: difficulty in falling or staying asleep, irritability or outbursts of anger, difficulty in concentrating, hypervigilance, exaggerated startle response.
- Symptoms should manifest within 6 months, although in some cases there may be a delayed onset.

Appendix 3: Northumbria Health Care Trust Birth Reflections Service Pathway Referrals Card

Northumbria BRS Pathway Referrals C

Appendix 4: Northumbria Health Care Trust Referral Pathway for Health Psychology and Mental Health Services for Obstetrics and Gynaecology

Northumbria Obs Gynae Health Psych