Queensland Mental Health Commission

Consultation Paper:

Development of a whole-of-government Trauma Strategy for Queensland

Pregnancy and Early Parenting

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What is this research about

*For the purposes of this paper the term parents or perinatal parents is used to encompass all individuals who have experienced perinatal loss or identify as birthing or non-birthing parents from conception to two years post birth.

The perinatal period is the timeframe from conception to two years postpartum. This is a time of great hope, expectation and opportunity but brings additional biopsychosocial vulnerability for expecting and new parents. The functional impacts of untreated historical trauma and intergenerational, childhood and acute (environmental or event) trauma often present significant barriers for parents in accessing services to meet their family's needs. For perinatal parents, appropriate management of their experience of trauma and its impact is also critical, to enable them to meet the responsibilities of caring for a new infant and to establish a secure attachment relationship that will promote their infant's optimal development and wellbeing (Isobel 2019, Goddard 2021, Clark et.al 2022). Mediation of intergenerational trauma is important to this process (Isobel 2019, Clark 2022). A suite of two papers will contribute toward the development of a whole-of-government Trauma Strategy for Queensland. These are *Pregnancy and Early Parenting* and *Infants and Young Children.* These papers, while delivered separately, are inextricably linked through the relationship between parents and caregivers, and their infants, and young children. This relationship is a significant determinate of the impact of early adversity and trauma across the First 2000 Days of Life.

The context for this research

The perinatal period is life changing and complex for families due to the enormous physical, social, emotional, and psychological adjustments parents need to make to care for their infants. The ease of these adjustments is heavily influenced by parents' genetics, their experience of being parented, individual experience of trauma and its impacts, pregnancy and birth experience, as well as social determinants of health (WHO 2010). The impact of trauma in all its forms can increase parents' risk for developing physical and mental illness, exacerbate existing health difficulties, compromise the development of parenting skills, and building secure attachment relationships with their infant (Olander et.al 2016, Oral et.al 2016 & Ortiz et.al 2022). The cognitive and other functional impacts of trauma also result in many perinatal parents' experiencing isolation and difficulty advocating for their needs. Frequently perinatal parents affected by trauma, avoid engagement with health and other services that can help the family due to difficulties in navigating service systems, and out of fear of stigma, discrimination, and child removal (Berthelot 2015, Chamberlain 2019, & Delap 2021.)

In recent times the increase in frequency of natural disasters and disruptive events such as COVID-19 have created extra challenges for expecting and new parents, indicating the need for health and other services to be trauma-informed and develop trauma support, management, and treatment skills. Adopting and developing trauma-informed approaches and strategies will be critical, for the future prevention and reduction of intergenerational trauma and promoting early wellbeing and lifelong resilience for parents, infants, and their families. Early recognition of prior experiences of trauma and perpetuating factors allows for a timely, all of systems response to reduce the emotional, physical, and financial burden of trauma on parents and their communities (Lawrence et.al 2023).

Pregnancy and early parenthood can also be a time where parents affected by trauma are significantly motivated to change their lives, for the benefit of their children and families (Olander et.al 2016). Due to the number of services

parents are potentially engaged with across the perinatal period (general practice, fertility practitioners, maternity, obstetrics, allied health, child health, peer support, mental health, and other government or non-government services), there are many opportunities for identification and early management of trauma The perinatal period also presents many opportunities and options to coordinate and implement universal, targeted, and indicated trauma-informed responses to support parents and their families. Evidence identifies that upstream investment during the perinatal period, reduces the social and economic burden of lifelong disease and illness. (Heckman 2012)

The key findings

Several issues emerge in the literature that require consideration around the prevalence and impact of trauma for perinatal parents including:

Key finding 1. Trauma for women in the perinatal period is prolific resulting in co-morbid difficulties with mental illness, the experience of intimate violence, differing needs for pregnant and parenting young people and functional and parenting challenges. Trauma for new and expecting perinatal women is common. Approximately 25% of women have experienced childhood sexual abuse, 50–80% report childhood maltreatment and 15% of women have experienced rape or sexual assault in their lifetime (ABS 2021-22, AIHW), It has been reported that 4–8% of women experience intimate partner violence during pregnancy (ABS 2021-22, AIHW), and 70-90% of perinatal women who have engaged with mental health services at some point during their perinatal journey disclosed experiences of trauma (Delap 2021). Studies indicate up to 45% of women report having had a negative birthing experience (Creedy et.al 2000, Sachdeva 2022), 41% of women reported memories of trauma triggered during birth (ABTA 2023) and 58% experienced dissociation during birth because of prior intimate sexual assault (Ward 2020). Somatic memories of trauma can be easily triggered by physical health care examinations and medical procedures. This re-experiencing of traumatic memories can cause a flood of negative emotions (Reeves 2015). Another study reported up to 5% of perinatal women meet criteria for Post Traumatic Stress Disorder diagnosis (Ward 2020). 1 in 4 perinatal women and approximately 1 in 15 men will develop perinatal anxiety and depression during pregnancy and in the postnatal period requiring treatment (PANDA).

Studies also report that the impact of trauma in the perinatal period for women with pre-existing mental illness significantly increases their risk for chronic mental illness, longer recovery periods and needing more intensive support and specialist treatment (Nillina et.al 2018). Many women who have experienced complex trauma are often diagnosed with personality disorders (Iyengar et.al 2019, Recio-Barbero et.al 2019, Ainsworth 2014). Perinatal depression, and anxiety disorders are also commonly diagnosed mental illnesses for women and men with histories of complex trauma and a future predictor for psychopathology in offspring (Verbeek 2012). Complex trauma and the commonly resulting poor ante and postnatal care is reported as a key risk factor for the development of perinatal mental illness (Kim 2022). The **incidence of infanticide** is one of the most devastating outcomes of untreated trauma and mental illness for parents in the perinatal period. Most infanticides are committed by the natural mother, who in half of all cases is suffering from a severe health mental disorder (Porter & Gavin 2010, Oates 2000). Research suggests that personality disorder is a risk factor for infanticide and "very often there is a history of interpersonal trauma, which probably proceeded the personality disorder" (Klier 2019).

Unresolved trauma and early parenting can also be attributed to the **suicide rates of Queensland women** in the perinatal period, with suicide being the leading cause of maternal deaths in Queensland. The 2021 Queensland Maternity and Perinatal Quality Council (QMPQC Report 2021) report states that most Queensland women who died by suicide "faced significant psychosocial adversity, including low levels of social support, homelessness, domestic violence, comorbid mental health difficulties, often long standing and associated substance use disorders and were often subject to child protection concerns." Maternal death reviews highlighted that frequently these women experienced histories of multiple adversities over their lifetime, including complex trauma and adverse childhood events (ACE's), (ACE's cdc.gov, Modini et.al 2021, QMPQC Report 2021, Sullivan et.al 2003, Oates 2003). Recent research by the Perinatal Wellbeing Team Metro-North Hospital and Health Service revealed a high incidence of ACEs in an antenatal clinic population, indicating a significant percentage of parents who had experienced multiple childhood adversities (Mackle et.al 2023). In this study, sixty women (22.9%) reported four or more ACEs. "These women were almost four times more likely to endorse perinatal trauma, when compared with

those who either did not report ACEs or had less than four ACEs A 6–7fold increase in perinatal trauma was seen amongst women who reported having at least one ACE related to abuse or neglect". The severity of perinatal-PTSD symptoms for those with perinatal trauma in pregnancy was significantly higher in those women exposed to at least one ACE related to abuse (Mackle et.al 2023). Demographic data also reveals that many perinatal women who suicide live in isolated communities in rural, regional, and remote areas of Queensland. Out of a total of 17% of perinatal women who have completed suicide, 6% were First Nations women (QMPQC Report 2021). Aboriginal and Torres Strait Islander perinatal women make up a significant proportion of these statistics due to being particularly affected by complex intergenerational trauma, following the impacts of colonisation, and ongoing systemic racism and discrimination (National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017, Fiolet et.al 2023).

The Queensland Partners in Prevention study (Meurk et.al 2022) and recommendations from the QMPQC report (2021) highlight the need to improve mental health assessments and pathways to care for perinatal women experiencing suicidality. The Partners in Prevention research highlights that "there are opportunities for intervention, but that realising them requires awareness, skill and time among non-mental health professionals, and equitable pathways to suitable services" (Meurk et.al 2022). This suggests that there is a lack of awareness among health and other professionals in recognising trauma, and workforce training and skill development is required to improve identification of trauma and manage its impacts and refer to adequate pathways to care (Workforce Productivity Commission Report, Mental Health 2020). Previous and current Queensland mental health plans aim to address this through the development of specialist perinatal mental health services and positions across Queensland. These services develop localised pathways to care, however gaps still exist regarding:

- the integration of these with health and other services,
- consistencies in service delivery across the state
- service establishment in rural and remote areas and regions where there is high risk and small service populations and resources
- funding directed into community-led service provision
- young parents being able to access specialist perinatal mental health services.
- services that embed cultural safety using cultural healing frameworks and practices that offer options other than "westernised medical models of care" for Aboriginal and Torres Strait Islander parents (Working Together 2014, Fiolet et.al 2023)
- the provision of services to fathers and partners and access to evidence-based group models of care that treat women's and parents' trauma histories impacting on their mental health and attachment relationships
- inadequate funding to provide for a health promotion, prevention, and early intervention approach.
- workforce shortages, need a strategy to increase the number or people specializing in perinatal social and emotional wellbeing and mental health
- changes in University curriculum to include trauma-informed care.

Prevalence of acute trauma in the perinatal period

Traumatic experiences around the time of pregnancy and birth result in physical and emotional impacts that parents take with them to future pregnancies, and affects the experience of becoming a parent, and their enjoyment of parenting. Events that are associated with trauma with lasting impacts include:

Termination of Pregnancy (ToP): It is generally accepted that somewhere between 10,000 and 14,000 pregnancy terminations take place each year in Queensland. It is estimated also that between one quarter and one third of Australian women will experience a termination of pregnancy in their lifetime. Trauma can be associated with the nature of conception, the decision to proceed with an unplanned pregnancy and unplanned or unwanted infant, medical procedural trauma and grief and loss of pregnancy for medical reasons. For women who experience complex trauma, these associations all negatively impact women, partners, and potential future pregnancies. Risk factors for post-termination psychological problems may include: previous or concurrent psychiatric illness, coercion, increasing length of gestation, ambivalence and lack of social support, poor relationships with others or religious affiliation (ToP Clinical Guideline, Queensland 2019). For the majority of mental health outcomes, there is

no statistically significant association between termination of pregnancy and mental health problems, however, unwanted pregnancy may lead to an increased risk of mental health problems. Termination of pregnancy may also exacerbate past history of mental health problems for women after an unplanned pregnancy (ToP Clinical Guideline, Queensland 2019). One linkage study reported that young women reported a suicide rate 6 times higher following a ToP and those under the age of 25 years were 12 times higher (Gissler 2005).

Miscarriage: Unfortunately, miscarriages are quite common, with up to 1 in 5 pregnancies ending before 12 weeks. Early pregnancy loss (EPL) is estimated to occur in approximately 15% of recognised pregnancies (AIHW, Queensland Clinical Guidelines; Early pregnancy loss). It can have negative consequences both physically and psychologically. Physical complications can include infection, haemorrhage, embolism, damage to uterus and associated structures, and anaesthetic complications. Psychological complications such as grief, depression and anxiety are common (Quenby et.al 2021).

Birth Trauma: Birth Trauma is a woman's experience of interactions and/or events related to childbirth that cause overwhelming distressing emotions and reactions, leading to short and/or long-term negative impacts on a woman's health and wellbeing (Leinweiber et al 2022, ABTA 2023) Research suggests that in Australia, between 30% and 48% of women identify their birth as traumatic. With 309,996 registered births in Australia in 2021, this equates to over 103,000 women and families potentially impacted by birth-related trauma every year in Australia and approximately 30,000 births in Queensland (ABTA 2023). Birth trauma is a very individual experience and associated with psychological expectations, birth procedural issues, and medical intervention needed for corrective procedures. One Queensland study reported 1 in 3 women experienced a traumatic birthing event with 5.6% meeting the criteria for PTSD, while others report that fear of subsequent pregnancies and future births result in significant anxiety and may even impact on whether a parent has more children (ABTA 2023). Research identifies a greater need for collaboration around birth planning, improved communication between parent and health professionals about parental expectations, medical interventions, and continuity of care in the immediate postpartum period (Vignato 2017, QMPQC 2021).

Stillbirth: Perinatal mortality is defined as all foetal deaths (stillbirths) and neonatal deaths – death within the first 28 day of life. The perinatal mortality rate in Queensland in 2018-19 was 9.8 per 1000 births. This included: **826 stillbirths** (6.8 per 1000 births), **361 neonatal deaths** (3.0 per 1000 live births), (QMPQC 2021). Grief, loss, clinical anxiety and depression are common outcomes for parents, and anxiety in subsequent pregnancies is a significant issue for parents who have experienced infant loss.

Infants needing Neonatal Intensive Care (NICU): The number of liveborn babies admitted to a special care or intensive care nursery in Queensland was approximately 16,950 or 26.9% births, which is higher than the national average in 2019, of 18%. This is often due to being born preterm or due to a congenital anomaly (and sometimes both). (QMPQC, 2021) Perinatal anxiety and depression are common for parents with infants in NICU care. Premature birth is also a risk factor for attachment difficulties between parents and infants.

Exposure to intimate partner violence (IPV) in the perinatal period. Approximately 1 in 7 Australian women (15%, or 18,000) experienced intimate partner violence during their pregnancy (AIHW 2021-22). Intimate partner violence experienced during pregnancy may result in physical and psychological health problems for both the mother and foetus including maternal depression, anxiety, and post-traumatic stress disorder, low birth weight, premature labour, injuries, foetal stress, trauma, and miscarriage (WHO 2021). 17% per cent of the overall percentage of early pregnancy loss (miscarriage) was attributable to intimate partner violence (AIHW 2021-22). Women experiencing IPV during pregnancy are also more likely to engage in adverse health behaviours during pregnancy, including maternal smoking, alcohol, and substance use, and delayed prenatal care (Suparare et al. 2020, WHO 2011). Difficulties with the attachment between the mother and child and lower rates of breastfeeding may also be associated with intimate partner violence (WHO 2011). The context of IPV presents significant challenges in the management and treatment of trauma for parents and their families due to the perpetual cycle of violence that is present for women at a particular time of great physical and emotional vulnerability, and with risks to the infant (Gartland et.al 2014).

Pregnant and Parenting Young People: Younger people (under 20 years) who have experienced 4 or more ACE's and high rates of DFV, are 11 times more likely to attempt suicide (ACES cdc.gov). Young parents also report different needs due to often living with multi-generations or being homeless and rejected by their families, maintaining educational requirements, and establishing occupations and financial considerations (Mann 2022). Younger mothers are at increased risk of being underweight, smoking during pregnancy and having a preterm birth, compared to women aged 20–34 years (AIHW 2022). They are also less likely to receive the recommended minimum number of antenatal visits (AIHW 2022). Other differences for pregnant and parenting young people also include service system access. Differences in eligibility due to age across service systems and for health services clinical governance issues, often result in inequities in access to needed specialist assessment and treatment services. Models of antenatal care that promote continuity of care by the same provider have a very important role in reducing these risks for a range of socially disadvantaged women and young parents.

Functional impairments of untreated trauma in the perinatal period pose challenges for parents, are long lasting not only affecting themselves but their families and future generations. (Dachew 2030, Herzog & Schmahl 2018). Altered thoughts and emotions, concentration and memory difficulties, sensory issues and difficulty regulating emotions are results of untreated trauma (Madora & Vaughn2022). Trauma negatively impacts a mother's biochemistry increasing levels of cortisol in the placenta. This leads to differences and biological alterations in the foetal antenatal environment and development during pregnancy and epigenetic transmission of negative gene expressions to subsequent generations. Untreated trauma in the perinatal period may impact not only perinatal parents but also their families and future generations (Dachew 2030). Trauma impacts a mother's biochemistry, thoughts, emotions, and actions, leading to differences and biological alterations in the foetal antenatal environment and development during pregnancy, and epigenetic transmission of negative gene expressions to subsequent generations (needs reference). Trauma responses may be triggered by the intimate nature of experiences associated with pregnancy, birth, and breast feeding; and the attachment needs of the infant. The long-lasting relational effects can impede the capacity of parents to nurture and care for their children and may contribute to 'intergenerational cycles' of trauma.

There are currently no Queensland guidelines which comprehensively cover prevention care for trauma during the perinatal period.

Key Finding 2. Vicarious trauma negatively impacts on parent and infant wellbeing.
Vicarious trauma is also frequently experienced in the perinatal period. Fathers and partners can experience vicarious trauma through exposure to medical procedures, being witness to birth trauma, experiencing partner death, still-birth of their infant, or their infants having congenital issues, or being placed in neonatal intensive care (Fletcher et. al 2022). Research at Bond University (2023) also found that 47% of 151 non-offending parents unable to prevent childhood sexual abuse of their child experienced a traumatic "moral injury" and increased PTSD symptoms (McGillivray, 2023). This indicates that parents who have little control over events that occur can develop mental health issues as a result. Fathers and partners also find their own childhood adversity impacts on their parent-infant relationships, resulting in negative outcomes for their infants across developmental domains (Paulson & Bazemore 2010, Dachew 2023). These experiences place a huge burden of risk on parenting partners resulting in lost productivity, fractured family relationships, and can significantly impact on a parent's ability to form secure connections with their infant or those born following subsequent pregnancies (PWC 2019). Currently in Queensland there are no specialist screening, assessment or treatment services for expecting and new father's and partners to identify the impacts of trauma or perinatal mental health issues.

Key Finding 3. Impact of intergenerational trauma in the perinatal period
The impacts of intergenerational trauma created through colonisation have negative effects on the mental health of Aboriginal and Torres Strait Islander perinatal parents, families, and communities. Data identifies that Aboriginal and Torres Strait Islander perinatal women are less likely to engage in maternity and child health services and therefore are at greater risk of having undetected perinatal mental illness (Working Together 2014, National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017, Chamberlain et.al 2019, Owais et.al 2020, Fiolet et.al 2023). Acknowledging and understanding the

impact of intergenerational trauma and the impacts that this has on parenting and family's willingness to engage with services, is fundamentally important in providing culturally safe and appropriate perinatal services (National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017). Other reasons why Aboriginal and Torres Strait Islander perinatal women may not engage in antenatal and postnatal service provision, include:

- Systemic racism and discrimination
- Deficit lens of culture and not recognising that culture is a protective factor.
- Lack of culturally safe and relevant place-based models of maternity and child health care
- Fear of child removal at birth - rates of first Nations child removal at birth increasing in the past 5 years in Queensland. (Australian Institute of Family Studies. Child protection and Aboriginal and Torres Strait Islander children 2020)
- Sigma and shame
- Lack of understanding of intergenerational trauma
- Assessment, diagnosis and treatment not being inclusive of a cultural healing framework
- Lack of early intervention and continuity
- Lack of family-centered practice (QMPQC 2021)

Families experiencing socio-economic disadvantage, CALD and other diverse groups are also at higher risk of having experienced intergenerational trauma and experience similar barriers as listed above, inclusive of the consequences of systemic prejudice resulting in fear and mistrust of government services. This also includes perinatal parents who previously or currently have statutory involvement with child protective services, are more reluctant to engage in perinatal services due to fear of having their child removed (Scott JG 2023). Professor Davis (2019), strongly resonates with our authorship team regarding the impact of child removal stating, "N*ewborn removals are highly traumatic for the birth parents, with birth mothers recounting feelings of shock, pain, sorrow, disbelief, anxiety, guilt, shame, and emptiness upon the removal of their babies. Birth mothers and fathers are left to live in an 'in-between state where their child is gone but did not die', and the complexity and depth of their grief can lead to serious and longstanding psychological damage. This may then have a significantly detrimental effect on their later experiences of pregnancy and parenthood. It is widely recognised in the literature relating to compulsory child removals that many women suffer 'a downturn in functioning' post removal. Anecdotal evidence indicates that women may 'seek comfort in a further pregnancy'. This may lead to successive removals of newborns from the woman's care*."

Key Finding 4. Social inequity exists for expecting and new parents identifying with diverse groups:
Few trauma-informed perinatal health services are available to specific groups of parents who identify as culturally and linguistically diverse or who are refugees, identify as gender diverse or LGBTIAQ+, or who live with a disability in Queensland. Many parents also report experiencing discrimination, stigma, and inappropriate perinatal care due to a lack of understanding about issues experienced by diverse populations in early parenthood, and isolation due to distance from families or well-known social structures and customs (Searle et.al 2017). The key social inequities that exist in diverse populations include affordable access to fertility treatment, access to trauma-informed and culturally safe pregnancy, birthing and postnatal care, which are underpinned by overt and covert discrimination by policy makers and systems stakeholders. The inability of families to engage in cultural practices and traditions, and community support and connections can cause significant distress (Croll et.al 2022, Searle et.al 2017).

Key Finding 5. Service accessibility and continuity of care for women and families, as well as peer support provides significant benefits in engagement and health outcomes of perinatal women, their partners and infant.
Service accessibility, lack of specialised services and integration across services, difficulties in sharing confidential consumer information across services, challenges with rural and remote service delivery, business hours for parents, and a lack of publicly funded, place-based and continuity care services, all impact on parents' ability to access the right support at the right time for the benefit of themselves, their infants and family. (QMPQC Report, 2021) The large geographical landscape of Queensland with a widely dispersed population presents service accessibility issues in relation to physical location and continuity of maternity care and access to specialist services. However, a variety of factors including socio-demographic, socio-economic, cultural capability and safety, and service availability, as "well as a lack of recognition of the complexity of some pregnancy conditions, appear to influence perinatal women's engagement with health care" (QMPQC 2021). For First Nations women and birthing parents who have

experienced complex trauma, a broad range of factors contribute to this outcome including infrequent antenatal care, availability of Indigenous Liaison Workers, domestic and family violence intimate partner violence, socio-economic stress, homelessness, inadequate management of diabetes and delayed presentation for decreased foetal movements. The majority of babies born to First Nations families live in regional and remote areas (54% regional, 31% major cities and 14% remote), (Queensland Health Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019 – 2025). In a culture where connection to country and community is critical to wellbeing, many women in Queensland are forced to leave their communities to birth due to lack of culturally safe and supportive service availability. This can place additional financial and emotional stress on parents and their families. Women who receive their pregnancy care within a continuity model of care are more likely to be satisfied with their perinatal care and engage more readily with their known caregiver. Restricting access to the type or location of care a woman wants, can lead to distrust and disengagement. Models of care that enable continuity by the same healthcare provider, should be an overarching key component of trauma-informed quality maternity care (Queensland Health Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019 – 2025).

Social inclusion and the value of lived experience and peer supports: Peer support is a form of social and emotional support and involves an exchange of resources between individuals of equal or similar status. Positive peer support is founded on principles of respect and shared responsibility and can be delivered in various forms including face-to-face meetings, groups, online forums, text messaging and phone support lines (Jones et.al, 2014 & McLeish et.al, 2023). Benefits of peer and lived experience support includes emotional validation through the provision of a safe and non-judgmental environment for parents to share honestly about their thoughts, feelings and concerns (McLeish et.al 2023, Huang 2022, Rice 2022). A variety of mental health, alcohol and other drugs, birth trauma, early pregnancy loss and stillbirth services in Queensland currently utilise peer support models of care with significant success and positive outcomes for parents accessing these services. These services are not available locally to all expecting and new parents across Queensland with the existing specialist services residing mainly in southern metropolitan area of the State and those in rural and remote regions reliant on online information, internet forums and chat groups for support.

Key Finding 6. Cross sector workforce capacity – trauma informed knowledge and specialist skills to identify, manage and treat trauma in the perinatal period:
While service sectors are aware of the need to upskill in knowledge and acquire the skills to assess and treat trauma, education is fragmented, and often reliant on individuals and services to engage in training when time permits. Currently there is no consistent trauma-informed workforce approach that uses a common language and understanding of trauma and informed care and management of trauma for perinatal parents. Many sectors lack understanding of the impact of trauma, and necessary support for parents, the nuances of perinatal trauma-informed care, and specialist treatment. The Australian Commonwealth Workforce Productivity Commission report (2020) recommends trauma informed care provision at key points of service identification and care including pre-conception care, antenatal maternity care, birthing and medical interventions, postnatal care and breastfeeding, the development of parenting skills and parent-infant relationships.

Key Finding 7. Early prevention, intervention, and treatment - brings significant individual, societal and economic benefits, and reduction of lifelong burden of disease and subsequent intergenerational trauma:
Trauma-informed approaches and strategies can provide parents with alternative experiences that promote post-traumatic growth and the development of resilience. Recognition and treatment of trauma can allow individuals to potentially experience post-traumatic growth in their ability to identify personal strengths, experience improved relationships and have a greater appreciation for life (Tedeschi & Calhoun 2004).

What does this research mean for policymakers

Implementation of a consistent trauma-informed approach that is inclusive of a social-determinants of health framework is imperative. By acknowledging that many individuals may have experienced trauma in their lives, service stakeholders in the perinatal period can create safe and supportive environments that reduce isolation and promote healing, resilience, and in many cases post traumatic growth that transcend prior life events (Tedeschi &

Calhoun 2004). Perinatal trauma and co-morbid mental health issues or illness place an enormous burden on the Australian and Queensland economy. A 2019 study reported the medium and long-term health, economic and wellbeing costs in Australia of perinatal depression and anxiety, to be $1.5 billion three years after the birth of a baby. This is made up of $195 million in health costs, $1.3 billion in economic costs and $14 million in wellbeing costs (PWC 2019). Trauma-informed strategies integrated into care at the perinatal stage of life will contribute to economies by improving workforce productivity of partners and reducing absenteeism or turnover rates, and primary caregiving parents returning to work. Trauma-informed approaches also contribute to the reduction of stigma for people experiencing the ongoing impacts of untreated trauma, alleviating feelings of shame and barriers to engagement with health and other support services. The costs and benefits of trauma intervention during the perinatal period highlight the following priorities:

Upstream investment and strategies that:

- **Adopt a family-centred approach** as early as possible in a family's life, to prevent or mediate later problems and intervene in intergenerational cycles of disadvantage.
- **Universal culturally safe and trauma-informed** antenatal and postnatal wellbeing education and care
- **Awareness raising of what is trauma and the impacts this has across the lifespan** through universal health promotion, education, media campaigns and information dissemination at this time of life can create common understandings addressing impacts of trauma.
- **Prevention, early detection, and intervention** Early and sensitive management of risk and protective factors through education, screening, assessment and diagnosis, continuity of care and integrated care pathways will contribute to the reduction of the impact of trauma in the perinatal period and its intergenerational transmission. Early intervention and specialist treatment early in a family's journey is demonstrated in research as more achievable and cost-effective than remediation.
- **Secondary intervention** with at-risk perinatal parents and families experiencing impacts of complex trauma, optimises cost-benefit ratios.
- **Higher investment earlier** yields higher returns. (Heckman.org) Trauma-informed care can contribute to the overall well-being and social cohesion of communities.
- **Establishing Integrated service systems that address social and service inequities in** the perinatal period following birth, to support family's wellbeing and establish secure parent-infant relationships with the right service supports at the right time are critical for all perinatal families.
- **Co-designed lived experience and culturally relevant** social policies, service sectors and health and wellbeing services are also essential to meet family's needs, promote wellbeing and prevent and mediate adversity and its impact.

Options for reform

In consideration of the abovementioned issues and impact of trauma on the perinatal parenting population the following recommendations are made:

Trauma Workforce Education Initiatives – within and across sectors

- Trauma-informed care to be included into tertiary educational curriculums, and across workforce sectors from primary through to tertiary specialist intervention services to identify, manage and treat trauma for perinatal parents.
- Trauma-informed care guideline for the perinatal period to complement the perinatal and infant mental health clinical guideline to be published.
- Develop workforce options to service specialist and rural and remote areas.
- Workforce education supporting service collaboration and integrated pathways to care.

Universal - all of Perinatal Population Recommendations:

- **Lifecycle return on economic investment** –services, policies and programs that reduce stress, prevent toxic exposures, and provide support for pregnant mothers and families with infants and toddlers will result in better health outcomes across the lifespan and save billions in health care costs. This is the greatest

opportunity to build a stronger foundation for a healthier and more productive adult population (Heckman, Nobel Prize for Economics, 2000).

- Free and low-cost safe spaces to explore, play and develop are essential to parents and infants' wellbeing, E.g. Goodstart Program, First Five Forever Library Program, Nature Play Queensland Program
- Education and prevention campaigns and Web information around raising emotionally resilient children is needed (L'Hote et al, 2018). Other examples of effective low-cost parent support and education include parent websites such as Raising Children's Network, text messaging programs such as Connect2U, SMS4Dads and Ready to Cope parents app.
- Screening of Adverse Childhood Experiences (ACEs) and ongoing support for the Queensland Perinatal Mental Health Screening Initiative under the current Commonwealth Bi-Lateral agreement, during pregnancy and in the postnatal period.
- Antenatal education that includes Emotional preparation for parenthood classes e.g. EPP Program Redcliffe Hospital.
- Expansion of perinatal peer support services across Queensland e.g. Peach Tree
- Opt-out home visiting maternity and child health services e.g. Maternity Group Practices, Australian Nurse Family Partnership, Birthing in Our Community, Right at Home
- The embedding of cultural and lived experience in all workforce sectors e.g. Identified roles for Aboriginal and Torres Strait Islander peoples, CALD and lived experience positions.

Specific Recommendation: Development of a clinical guideline for Trauma-Informed Care in the perinatal period for health professionals, to complement the Perinatal and Infant Mental Health Clinical Guideline (in development).
Specific Recommendation: Development of a clinical guideline for Birth Trauma for healthcare professionals.

Targeted - Early Intervention Perinatal Population Recommendations:

- Rural and Remote service delivery and access to timely and local services - access to telehealth, digital platforms, home visiting, face to face specialist services, culturally relevant approaches including co-designed models of care, access to stepped care including hospital in the home, perinatal mental health services and local peer supports.
- Expansion of parent volunteer, parent aide and support services (several models of care currently operate in separate parts of metropolitan regions in Queensland).
- Considerations for further education of specialist services to support diverse parent groups with specific needs including LGBTIAQ+, Aboriginal and Torres Strait Islander Groups, CALD groups, parents with disabilities including physical and neurodiverse or cognitive disability.
- Fathers and non-birthing parents - screening for trauma and mental health issues, access to services that address their needs and support connection with partner and infant.
- Expand social inclusion, family and community support options for parents that don't have partners.
- Increase funding for counselling options for termination of pregnancy, early pregnancy loss, stillbirth, and birth trauma to process trauma, address complaints, reform social justice inequities and promote, ongoing healing from both a psychological and physical perspective. Increasing options for ongoing referral to other specialist health professionals needed to manage and treat ongoing psychological and physical issues that persist outside of the perinatal period.
- Parents with Pre-term infants' access to counselling and social supports.

Specific recommendation: Modify and adapt the Safer Baby Bundle initiative for Termination of Pregnancy and birth Trauma. (Safer Baby Bundle is a national initiative with 5 evidence-based interventions aimed at decreasing the number of preventable stillbirths that occur after 28 weeks. It has been implemented across Queensland facilities since 2020 with research continuing to inform future strategies.)

Specific recommendation: Fund and adopt SMS4Dads support message programs for parents who have experienced stillbirth and perinatal loss and SMS4Dads NICU, message support for parents with infants in Neonatal Intensive Care Units.

Peer and Lived Experience Support:
The expansion of lived experience workforce, including peer support models across perinatal cross-sectoral services to offer increased support and therapeutic interventions to families. A Statewide co-design framework will ensure that there is no confusion about the necessity of building systems and services with the people who will be using them. This will also ensure service and model of care relevance, reduces the power imbalance between individuals, enabling genuine connection and empowerment (Rice 2022). In Queensland, most of the peer supports are not available outside of metropolitan regions in Queensland. Investment in rural and remote peer support service options will reduce inequity across the state e.g. Peach Tree Perinatal wellness offer supportive and inclusive models of peer support for all parents in Southeast Queensland that is scalable to other regions.

Young Parents:

- Ensure that consistent Child and Youth Mental Health Service and perinatal models of care are used across Queensland that ensure that young parents can receive perinatal mental health support.
- Create a suite of fact sheets and resources specific to the journey of young parents.
- Fund the creation of a cross sectoral network (including professionals, consumers, and carers) to advocate, plan and effect creation of policy, strategy, and service design across the state.
- Proactively support seamless transition of children and young people along the care continuum.

Specific recommendation: Improve mental health outcomes for young people who are pregnant and parenting and their infants through offering wider knowledge of service options, and expansion of service offerings due to increased advocacy. e.g. Caboolture Young Mothers for Young Women Program – Micah Projects and Young. Pregnant. In Control. Website: ypic.org.au

Aboriginal and Torres Strait Islander Families:

- Culturally competency training to be standard practice across service sectors.
- Co-design culturally safe and community-led perinatal mental health services and resources with local First Nations peoples[42]
- Strengthen partnerships between Queensland Hospital and Health Services and ATSICCHO's.

Specific recommendation: Provide and fund trauma-informed maternity and perinatal care in the context of cultural healing practices and First Nations ways of "being, knowing and doing" frameworks e.g. culturally relevant continuity of maternity care models such as Birthing in Our Community (BiOC) models of care in both Aboriginal and Torres Strait Islander community controlled (ATSICCHOs) and Government Hospital and Health services (HHS) e.g. Waijungbah Jarjums, Gold Coast University Hospital.

Indicated – Specialist Treatment Perinatal Population Recommendations:

Specialised Services providing early specialist treatment – early in a family's life:

- 0-4 family inpatient units to address parent-infant attachment difficulties.
- Increased access to longer term free and low-cost intensive psychological therapies for parents with experiences of trauma due to Adverse Childhood Experience's or other complex traumas. Increased specialised services for those presenting with personality vulnerabilities e.g. eye movement desensitisation and reprocessing therapy, trauma focused therapies, parent-infant psychotherapy, specialist group programs for dialectic behavioural therapy intervention, South Australian Borderline Personality Disorder Perinatal and Infant Mental Health Day Group Program.
- Hospital in the home programs for perinatal parents with mental illness at risk of requiring inpatient treatment – Metro North HHS Hospital in the Home and Western Australia Perinatal Hospital in the Home.
- Funded perinatal mental health community and outpatient education-social inclusion groups for parents.
- Expand capability of the PANDA intensive care coordination service.
- Development of perinatal nuanced trauma-informed framework for suicide risk assessment, crisis management and intervention pathways to care for perinatal parents.
- Education and support groups for Parents with cognitive and other disabilities.

Specific recommendation: Specialist substance use and treatment facilities for pregnant women (including young parents) and those with young infants, e.g. Cape York Family Centre, and Uniting Care Regen's Mother-Baby Alcohol and Other Drug Withdrawal Service in Ivanhoe, and The Salvation Army Bridgehaven Mother-baby Drug and Alcohol Program, Victoria.

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