Title: Afterbirth support provision for women following a traumatic/distressing birth: Survey of NHS hospital trusts in England

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Abstract

Objective: Despite recommendations within postnatal care guidelines, many National Health Service (NHS) hospital trusts in the UK provide an afterbirth, debriefing type service for women who have had a traumatic/distressing birth. Currently there are a lack of insights into what, how, and when this support is provided. The aim of this study was to explore afterbirth provision for women who have had a traumatic/distressing birth in NHS hospital trusts in England.

Design: An online survey comprising forced choice and open text comments was disseminated via direct email and social media to NHS hospital trusts in England. Questions explored the types of support provided, when the support was offered, how and when the service was promoted to women, funding issues, and the role/training of service providers.

Participants: Fifty-nine respondents completed the survey, with responses from 54 different NHS hospital trusts from all geographic regions in England (40% of all trusts) included.

Findings: While the numbers of women accessing afterbirth services varied, this was often associated with a lack of dedicated funding (~52%), and poor recording mechanisms. Some 83.3% of services had evolved based on women's needs rather than wider research/literature. Midwives are commonly the sole provider of afterbirth services (59.3%) and in 40.7% of cases the professionals who provide afterbirth support had received no specific training. In only 51.9% of trusts were 'all' women routinely given information about the service, and women were more likely to self-refer (79.6%) rather than be referred via routine screening (11.1%) or obstetric criteria (27.8%). Almost all services offered flexible access (92.6%) and many offered multiple contacts (70.3%). While most services enabled women to discuss and review their birth, only 55.6% furnished women with information on birth trauma. Approximately 89% of services referred women to specialist provision (i.e. mental health) as needed, although directing support within personal (63%) or wider support (55.6%) networks was less evident.

Conclusions/Implications for Practice: While women want, and value opportunities to discuss the birth with a maternity professional following a traumatic/difficult birth, evidence suggests that resource provision is insufficient, hampered by a lack of funding, publicity, and recording systems. While further research is needed, funds to establish a well-resourced, evidence-based and well-promoted service should be prioritised.

Keywords: birth trauma, afterbirth support, debriefing, maternity, survey

Introduction

Childbirth is frequently viewed as a natural and positive event in a woman's life. However, for many women, their experience may be more mixed or, indeed, negative. Recent research reports that between 20-40% of women perceive their birth to have been a traumatic and/or distressing event (Alcorn et al, 2010; Ayers et al, 2009; Polachek et al, 2012; Thomson and Downe, 2016) and ~3% of women in general community samples develop Post-Traumatic Stress Disorder (PTSD) following childbirth (Ayers et al, 2017). Birth trauma/PTSD onset can occur irrespective of how the baby was delivered (i.e. vaginal, operative) and has significant negative impacts on women's emotional wellbeing, their relationship with their infant and family functioning (Elmir et al, 2010; Fenech and Thomson, 2014). The need to prevent and protect women from poor mental health is a national priority (Public Health England, 2016).

In the 1990's postnatal debriefing services were introduced in the UK as a means to reduce psychological morbidity following a traumatic/difficult birth. These services were introduced in the advent of key reforms, such as the *Changing Childbirth* report (Department of Health, 1993) whereby maternity services became accountable for care quality, and an associated consumer movement where women could demand services outlined in government charters (Smith and Mitchell, 1996). Therefore, while debriefing services offered the promise to help women resolve adverse responses associated with childbirth, they also signified an important risk management tool to resolve complaints and minimise litigation claims (Smith and Mitchell, 1996).

Postnatal debriefing was originally based on structured psychological interventions, i.e. Critical Incident Debriefing (CID: Mitchell, 1982; Parkinson, 1997), designed to ameliorate psychological adversity following other types of traumatic events (i.e. natural disasters, war veterans). However, it is important to reflect that there is a lack of clarity as to what constitutes postnatal 'debriefing' (Ayers et al, 2006; Gamble et al, 2004). Psychological (i.e. CID) debriefing is a highly structured intervention whereby facts, thoughts and feelings are processed to facilitate emotional processing and prevent PTSD onset (Ayers et al, 2006). By contrast, postnatal debriefing tends to be less structured in its delivery with less clarity around content. However, it typically involves a one-off meeting between the woman and a health

professional (often a midwife) in the early postnatal period to help a woman understand what occurred during her labour and birth (Ayers et al, 2006; Baxter et al, 2014). Several experimental studies have been undertaken to assess the impact of postnatal debriefing interventions on postnatal morbidity. A recent Cochrane review identified seven randomised controlled trials undertaken between 1998-2005 in high-income settings (Bastos et al, 2015). While the review concluded there was no clear evidence of effectiveness, there was wide heterogeneity in the trial designs and the quality of the evidence was low (Bastos et al, 2015). Due to the lack of evidence in this area, current UK postnatal guidelines do not recommend formal debriefing, rather that women should be offered an opportunity to talk about the birth, and ask questions about their care (NICE, 2015).

Despite current recommendations, available research indicates that many National Health Service (NHS) hospital trusts in the UK provide an afterbirth service for women who have experienced a traumatic/difficult birth (Ayers et al, 2006). To date, two survey studies into UK based afterbirth provision have been undertaken. Steele and Beadle (2003) collected data from 43 maternity units in two health regions in England, with respondents asked to identify what elements of postnatal support were provided from a pre-defined list. The pre-defined elements were developed from professional guidelines to differentiate what would constitute normal postnatal care (i.e. women being able to describe their experience, discuss their feelings, provided with a rationale for the management/care and referred to more specialist provision as required) or additional elements that would constitute a debriefing service (e.g. discussion and information on normality of women's experiences and trauma-related responses). This study found that 88% of maternity units offered women the opportunity to discuss their experiences of maternity care - 14% provided a debriefing type service, 28% offered care commensurate with postnatal care, and 58% selected combinations that did not constitute a full debriefing service but included elements that went beyond postnatal care (Steele and Beadle, 2003). The study by Ayers et al (2006) used computer generated randomisation to select a quarter of UK hospitals with a 76% (n=71) response rate. Findings highlight that while 94% of hospitals provided support (formally or informally), 78% were debriefing-type services (by virtue of providing a formal service for women to discuss their birth experience) provided by midwives, counsellors and/or doctors. Psychotherapists (counsellors/clinical psychologists) were involved with 23% of services. In the majority of cases the service was available to all women who were informed about the service by a midwife post-birth (Ayers et al, 2006).

While the lack of evidence, or clarity as to what postnatal debriefing should comprise is disconcerting, it is important to note that such opportunities reflect what women want. A recent study identified that while ~46% of women did not seek out support following a distressing/traumatic birth, the most preferred support option was to discuss the birth with a maternity professional (Thomson and Downe, 2016). A recent critical meta-ethnographic review of women's experiences of postnatal debriefing reports that women valued opportunities to understand what happened and why during the birth, and to have their birth experience validated (Baxter et al, 2014). Debriefing helped women to resolve feelings of self-blame and guilt and to prepare them for future pregnancies (Baxter et al, 2014).

Given that women want, and find value in, opportunities to discuss their birth with a maternity professional, and that most recent insights into afterbirth debriefing services were published over 10 years ago, there is a need to update knowledge in this area. We undertook a survey study of NHS hospital trusts in England to elicit insights into the nature, content and format of afterbirth provision for women who have had a traumatic/distressing birth.

Methodology

Survey development

Survey questions were developed based on literature into women's support needs following a traumatic/distressing birth (Gamble et al, 2004; Thomson and Downe, 2016) and previous surveys in this area (Ayers et al, 2006; Steel et al, 2003). We obtained initial feedback on the survey design to assess for comprehension and completeness from three maternity professionals and a clinical psychologist with a background in this area. Due to the lack of clarity as to what constitutes postnatal debriefing, we adopted a broad approach to elicit the nature, format and content of afterbirth provision for women who had had a traumatic/distressing birth. The survey comprised forced-response and open questions to capture the types of support provided, when it was provided and how it was promoted to women. Additional questions explored when the service had been established, whether the staff who provided the service had received any specific/relevant training and how the service was funded.

Survey distribution

We used an online, secure survey platform for the study (Bristol Online). Between October-December 2017, we sent an introductory email and link to the online survey to heads of service and key staff, e.g. Consultant Midwife, Supervisor of Midwives in all NHS hospital trusts in England. An NHS hospital trust is an organisation that provide acute and community services within a specific geographical area and can include one or more maternity units. A separate email/link to survey was also issued on two separate time points to a Consultant Midwife distribution list. We also regularly promoted the survey/study via Twitter in attempts to maximise completion rates.

Ethics

As the survey reflected an audit of existing survey delivery and did not involve participant information, full ethics approval was not required. The Chair of the Science, Technology, Engineering, Medicine and Health (STEMH) ethics committee at the lead author's institution, reviewed and provided approval for the study. Participants were informed (in the covering email and within the survey) that the information would be published, and anonymity would be assured.

Analysis

All completed surveys were uploaded into SPSS v.24 and quantitative data were analysed using descriptive statistics. All the narrative comments collected via open text boxes were extracted, combined with the descriptive statistics, and analysed using a basic thematic approach, similar to other survey-based studies (Downe et al, 2012; Redshaw and Henderson, 2012; Thomson and Downe, 2016). This involved an iterative process of line by line coding, with data mapped into sub-themes and then final themes. The first author undertook initial analysis, and both authors contributed to final interpretations.

Findings

Overall 59 responses were received, five of which were duplicates. Final data represents insights from 40% of all NHS hospital trusts in England (54/134); with responses received from all geographical regions (Table 1). All the trusts who responded had a formal (n=46, 85.2%) or informal (n=8, 14.8%) afterbirth/listening service (e.g. '*ad hoc based on the referrals to the Consultant Midwife clinic - no formal service yet* (P35)) for women who had a difficult/traumatic birth.

Insert Table 1

An overview of responses to the survey questions is provided in Table 2. In the following sections, we present four key themes that blend quantitative and qualitative survey responses to report on 'service development and operational issues', 'background and training of professionals', 'access and availability of afterbirth support' and 'types of support'.

Insert Table 2

Service development and operational issues

The majority of afterbirth services had been in operation for more than 3 years (70.3%), and ~30% for 10+ years. While the numbers of women who accessed afterbirth provision across the services varied, i.e. 30 to over 300 p.a., this was often an estimate due to attendance not being formally recorded:

> *Difficult as women may see consultant midwife or obstetrician and data not captured specifically for debrief.* (P51)

Some services were in receipt of trust funding and/or allocated hours (40.9%) to deliver the service. However, just over 50% of services received no specific funding, with delivery subsumed within substantive posts due to perceived need for the service:

> *Not funded. We started it as Supervisors of Midwives and now keep it going with a dedicated few midwives carrying on with the service as we see the benefits for women.* (P52)

The level of funding had an inevitable impact on service delivery. For instance, some unfunded services offered a reactive service due to resource limitations, *'due to capacity issue, it's not offered proactively'* (P1). Tensions in maintaining an additional service in the context of restricted resources was highlighted, *'it* [afterbirth service] *was beginning to look like a luxury 'we' couldn't afford'* (P21). One of the respondents referred to how they would operate *'under the radar'* in attempts to meet service demand:

> *This is difficult. We are only funded under tariff to see women up to 12 weeks but many women seek support after this in the postnatal period. Myself and my consultant midwife colleague will see* [women] *within our clinic, but somewhat 'under the radar' as this is not commissioned.* (P35)

However, from a more positive perspective, a few respondents referred to having strategic support with plans underway to expand current provision, i.e. *'our simple service is undergoing investment and development due to service demand'* (P12):

> *The Trust is committed to providing this service as a midwife is now being supported in undertaking the Diploma in Counselling to assist me and also take over the role once she is qualified.* (P44)

Approximately 83% of respondents indicated that their service had evolved in direct response to women's needs:

> *The birth afterthoughts service has developed in response to local women's needs, appointments are provided if a midwife or doctor feels a woman would benefit from discussing her birth experience with a senior midwife or if a women self refers to the hospital or via her GP/or health visitor.* (P26).

On occasion, the service had been initiated by motivated individual(s) rather than a management directive, and had developed overtime due to positive feedback:

> *Previously Supervisors of Midwives offered debrief service via monthly clinic. Due to capacity I then usually reviewed women who were pregnant, [I] now see all. Service evolved as word spread from the women how beneficial the service was.* (P8)

Other respondents reported that service initiation had been a Trust decision (9.3%) due to the number of complaints received from women:

> *Complaints also received from women about experiences of care so we developed a criteria and referral processes and pathways for the Birth Reflection clinic.* (P52)

In only 24.1% of cases had wider scientific or theoretical literature been used to inform service delivery. However, the majority of services used formal (i.e. audit, research) (33.3%) and/or informal (50.0%) evaluation methods to gauge the value of the service, and to inform future delivery:

> *Looking at developing the service further to incorporate women's feedback to influence future practice development in line with LMS* [local maternity systems]. (P53)

A few respondents also referred to how insights disclosed by women during afterbirth discussions were shared with their attendant midwives to influence individual and service change. One participant reported:

> *Our service also gives women the opportunity to feedback what went well with their care and also where we could improve our services for future users. We also give feedback both negative and positive to individual practitioners.* (P34)

Background and training of service providers

In all bar one service, midwives either solely (59.3%), or in conjunction with doctors and/or psychologists (37%) delivered the afterbirth service. Approximately 41% (n=22) of services were provided by professionals who had no specific training. Some respondents referred to how their skills had evolved on an experiential basis, rather than via formal education, and were fuelled by a belief in woman-centred care:

> *My own ' training' was on the job learning. If I were to start over I would consider psychotherapy. However I felt strongly that as a midwife I was carrying out my role according to the code, and my belief in partnership working with mothers.* (P21)

Overall, in only 22.2% of services had all the professionals who delivered the afterbirth service accessed any related training. Services who employed psychologists/specialists to co-deliver the post-birth service benefited from individuals trained in therapeutic approaches, i.e. psychodynamic therapy, psychotherapy. Multidisciplinary teams were considered to hold wider benefits through shared learning and mutual support:

> *The midwives who run the service have support from a trained psychologist and this takes place off site with midwives from two other hospitals so we can come together to share learning and support each other.* (P34)

The qualitative comments also indicated that the nature and extent of training received or provided to midwifery professionals varied. Some of the midwives had accessed counselling-related training, e.g. *'counselling techniques'*, *'coaching'*, *'motivational interviewing'*, *'debriefing'*, or specific trauma/PTSD sessions/courses. However, the depth of study ranged from *'a counselling study day'*, or an *'awareness course on PTSD and trauma'* to accredited training and qualifications, e.g. MSc in counselling and psychotherapy, Birth Trauma Resolution Practitioner Training (accredited by Royal College of Midwives).

Access and availability of afterbirth support

While afterbirth support was reported to be available for 'any' women in almost all services surveyed (96.3%), 'all' or 'some' of the women were routinely informed about afterbirth provision in 51.9% and 31.5% of services respectively. As indicated above, restricted promotion of the service could be strategic due to limited resources, '*not currently* [promoted to all] *as workload would be too much for my 15 hours available'* (P44), or potentially reflective of inadequate promotional methods, '*it is mentioned in notes but not all women are talked to about it'* (P27).

Overall, there appeared to be a reliance on midwives (90.7%) and/or other professionals such as health visitors (59.3%) or General Practitioners (family doctors) (48.1%) to inform women about the service. Other less utilised methods included leaflets provided on a routine (27.8%) or targeted (13.0%) basis, and posters (13.0%). Qualitative data also highlighted supplementary promotional methods such as information detailed in discharge booklets or a bookmark, and online methods, e.g. websites, social media. Some respondents also reported plans for new methods to advertise the service, such as via *'service user leaflets'* and posters in '*the local GP surgeries, children centres and hospital clinics, also via our Facebook page'* (P15).

Women tended to be made aware of the service in the postnatal (90.7%) rather than the antenatal (53.7%) period. Referrals for support were also most commonly made via self-referrals (79.6%) or professional-based requests, rather than via routine screening (11.1%), or being based on certain obstetric criteria (27.8%) (i.e. birth complications, caesarean):

> *Generally we will offer follow up appointments at 6-8 weeks postnatal for any stillbirth/neonatal death, ICU admission, hysterectomy, eclampsia, major obstetric haemorrhage, or if a woman requests to meet with her consultant and/or midwife.* (P16)

The majority of respondents (92.6%) identified that women could access afterbirth support as and when required, which could, as indicated below, be sometime after the index event:

> *Women generally come a few months after birth or when they are next pregnant, but we have had a couple come 20-30 years after the event.* (P34)

Four services (7.4%) offered support during fixed postnatal periods (i.e. '*6 weeks - 1 year after delivery or in subsequent pregnancy'* (P31)). Seven of the respondents also indicated that while a specified timeframe for support was recommended, an earlier appointment could be accommodated if required:

> *Recommend 2 - 3 months however will see if woman wishes to be seen sooner.* (P8)

From the qualitative comments provided, the timeframe for an appointment to the afterbirth service was generally after four to six weeks post-natal. Some participants, as reflected in the quote below, justified this timeframe as a means to allow women to integrate their experiences and for post-traumatic stress symptoms to be easier to detect:

> *Due to experience we wait until 6-8 weeks when women are better able to assimilate the information and any signs of PTS would be clinically relevant* (P40)

In 18.5% of services women were able to access one session only, and others suggested a flexible approach with ongoing sessions agreed, or sought at a later point if needed (70.3%):

> *As many as they feel they need, but quite often they only need one and then possible referral to other services or departments* (P42)

Some respondents reported that repeat sessions, when they occurred, tended to be during a subsequent pregnancy and for recall purposes, rather than for additional/different forms of support:

> *Generally one session is enough, there are a few women when they may come back to go over the same birth again when they have a future pregnancy and cannot remember the details of the first meeting as it was done soon after the birth* (P34)

Types of support

The majority of respondents reported that the afterbirth support was either fully (31.5%) or partly (64.8%) based on women's needs. Some participants reported that while support was individually tailored and could *'vary widely'*, others considered that women's support needs generally followed a similar pattern - to resolve the past and envisage a more hopeful future:

> *I always took my lead from mothers, however that did seem to follow a pattern. She needed to talk through her most recent birth or the birth that had caused bad memories. After this and after helping her to explore why what happened, happened, she would then generally be ready to look towards the next birth.* (P21)

Most services surveyed provided women with an opportunity to describe details (92.6%) and disclose feelings (94.4%) associated with their birth - the women's maternity notes would be reviewed (92.6%) and reasons for care decisions (94.4%) provided. Service providers would discuss women's future responses (81.5%) and seek to normalise women's adverse emotions and behaviours (79.6%), although only 55.6% of afterbirth services provided women with information on birth trauma. While ~89% of services would refer women to receive more specialist support, e.g. psychology, psychiatry, as needed, information and encouragement to access wider support from personal networks (63%) or other trauma-related services, i.e. Birth Trauma Association (55.6%) was less evident. Some 83.3% of the afterbirth services surveyed also provided women with guidance and support for a future birth (either before or during conception):

> *The woman is able to make a plan for her next birth which includes a resume of what happened in the last birth to help carers see the whole picture to make another birth experience a better experience* (P34)

Moreover, while support for birth partners/family members was not a pre-defined question option, a few of the respondents specifically referred to offering this wider support, e.g. '*partners/family members often attend and their response/feelings are also discussed'* (P26).

Thirty-nine (72.2%) NHS trusts offered additional specialist in-hospital support that women could access. These included perinatal psychiatry, clinical psychology, specialist midwives (i.e. mental health), consultations with other clinicians (i.e. consultant midwife, anaesthetist, neonatologist, obstetrician), counselling, perinatal mental health and bereavement services. Some respondents highlighted a tiered, targeted pathway in operation, e.g.:

> *1. Consultant Midwife consultations in clinic setting or home. 2. Perinatal Mental Health Team has psychologists, if woman meets their referral criteria then offered appointment 3. Women offered IAPT* [Improving Access to Psychological Therapy] *appointment where appropriate.* (P2)

In one service a multi-professional team reviewed each case and then directed the woman into available support as appropriate:

> *It is still being developed. We have a referrals meeting where women are streamlined to a particular service i.e., Tocophobia/PTSD (consultant midwife) PNMH* [perinatal mental health] *clinics, safeguarding or women's health counsellor and pregnancy loss midwives.* (P17)

However, qualitative comments from a small number of respondents reported how access to wider, specialist support could be problematic, e.g. *'difficult to get access to clinical psychologists'* (P27).

Discussion

The findings from this study highlight variations in afterbirth service provision for women who have experienced a traumatic/distressing birth. While most afterbirth services had been in operation for more than three years, just over half had no dedicated funding with inevitable consequences on the numbers of women supported. In most occasions, the afterbirth service had been established in direct response to women's needs, and while almost all used formal or

informal evaluation methods to inform service provision, less than a quarter of services had been developed based on wider scientific or theoretical literature. In almost 60% of cases, midwives were the sole provider of afterbirth support, with ~41% of services provided by professionals who had received no specific training. In only just over half of the services surveyed were all women routinely provided with information about the afterbirth service. Most services offered flexible, as and when needed access, with appointment frequency determined on an individual basis. The types of support provided were more likely to be 'partly' based on women's needs and the majority offered opportunities for women to describe and discuss birth events and emotion-based responses. While just over half of the afterbirth services provided women with information on birth trauma, most had referral pathways to direct women to more specialist support as needed.

This study offers up-to-date and detailed insights into afterbirth support provision in England. However, a key limitation relates to the low response rate. While a high survey response rate is perceived to legitimize the study findings, with response rates of 60% recommended, a steady downward trend in health professionals' completing surveys has been reported (Cook, Dickinson & Eccles, 2009). Some perinatal survey studies have yielded low response rates, such as 14% amongst family physicians/gynaecologists (Wiebe et al, 2012), and 32% amongst nurses and midwives (Cooper and Brown, 2017), despite different strategies to encourage completion rates being employed. Whilst our response rate of 40% is a potential concern, we were able to capture insights from all regions in England, thereby increasing the generalisability of our findings. It was also difficult to determine whether the low response reflected a lack of service provision, or time for survey completion. A further limitation is the amount of detail that can be captured within a survey design. Further research that involves direct contact with lead personnel and qualitative methods would generate a higher response rate and richer insights. Furthermore, as there is a lack of knowledge into service provision in other countries, research to explore afterbirth provision in different countries and contexts may well highlight important variations and areas of good practice.

The issue of funding had an inevitable impact on afterbirth provision, with services being offered on a reactive rather than proactive basis, restricted promotion of the service, and some staff referring to how they offered a 'discrete' rather than mandated service due to recognition of its value. These insights reflect other research that highlights that whilst women want opportunities to talk about the birth, they were not often aware that such services exist and/or

had lengthy waits to access the support (Priddis et al, 2017; Thomson and Downe, 2016). Our findings also indicate that promotion of the afterbirth service is most likely to be by professional discretion. However, wider research indicates that women can avoid professional contact following a distressing birth (Fenech and Thomson, 2015), lack insights into how to access help (Fonseca et al, 2015; Thomson and Downe, 2016) and are reticent in disclosing poor mental health for fear of repercussions (Bayrampour et al, 2017). The survey study by Thomson and Downe (2016) with women who had a distressing birth highlights that women want information on birth trauma and where to access help and support. Routine information on birth trauma, the afterbirth service and wider support networks (such as the Birth Trauma Association) through leaflets in discharge packs, posters in hospital and health facilities, or via digital solutions are important considerations. Current postnatal care guidance recommends that midwives enquire into baby blues, anxiety and depression, and for women to be screened for postnatal depression if symptoms persist (NICE, 2015). However, this is not the case for birth trauma, and reflected in our study by the low numbers of women who are referred to afterbirth support via routine screening. A potential solution could be use of the PTSD postpartum scale developed by Ayers et al (2018) to help identify women with PTS symptoms and to direct them to appropriate support.

The types of support provided in the afterbirth services surveyed correspond with women's needs in relation to opportunities to talk, be listened to and receive answers on their birth experience (Baxter et al, 2014; Gamble et al, 2014; Sigurðardóttir et al, 2019; Thomson and Downe, 2016). However, it is important to reflect that while many women value afterbirth support (Baxter et al, 2014), a recent study undertaken in Australia highlighted dissatisfaction through women feeling blamed (Priddis et al, 2017). In many of the services we surveyed, the maternity staff had not received any specialist training, and service provision had evolved based on women's needs rather than any scientific or theoretical underpinnings. There was also wide variation in the type and extent of training amongst the service providers who had received specialist training. As our study did not collect satisfaction data, it is difficult to gauge the impact of afterbirth support provided by staff who are trained or untrained, and/or those who work as part of multidisciplinary team. One of the successful randomised controlled trials of postnatal debriefing interventions involved midwives being trained in a theoretically-informed counselling-based approach and providing support to at-risk women at 72 hours and six weeks postnatal (Gamble and Creedy, 2005). The trial found that women who received the intervention had reduced trauma and depression symptoms and reduced self-blame when

compared to controls (Gamble et al, 2005). It may be, as reported by Ayers et al (2006), that a midwifery-led debriefing focus on clinical events has a different impact than those that utilise psychological approaches, but currently there is little research in this area.

As women are often uninformed about PTS symptoms and tend to self-blame and internalise their responses following a traumatic/difficult birth (Fenech and Thomson, 2015) - with poor memory integration being a leading cause of PTSD onset (van der Kolk, 2014) - early information and support is essential. Perinatal mental health (PMH) is a burgeoning public health issue, with birth trauma/PTSD identified as a key cause (Bauer et al, 2014); the costs of poor maternal health estimated at 8.1 billion per one-year birth cohort (Bauer et al, 2014). The recent *Better Birth* report also highlights the need for significant investment in perinatal mental health (National Maternity Review, 2015). As afterbirth support offers an important and valued opportunity to aid women's cognitive processing and to direct/refer women to specialist support, further investment appears warranted. Afterbirth services should ideally be well-funded, evidence based, offered by trained providers and with routine evaluation undertaken, but currently there is no research or guidance into how such services should be operationalised. Further research to determine the costs and the essential ingredients of effective afterbirth provision should be prioritised.

Conclusion

This study captured insights into afterbirth service provision for women who had a traumatic/distressing birth in NHS hospital trusts in England. The findings highlight varied provision, with services limited in scope due to a lack of resources, restricted promotion, and insufficient recording systems. Many services were provided by midwives who had no specialist training, and had evolved based on women's needs, rather than scientific or theoretically-informed insights. Most services also referred and/or had referral pathways for women to access specialist support, rather than directing women to support within personal or wider trauma-related networks. While most services offered flexible access and opportunities for women to review/discuss the birth and their emotional responses, discussions on birth trauma was less evident. Afterbirth support offers an important and valued early opportunity to aid women's cognitive processing and to direct/refer women to specialist provision. Further research to identify the costs and essential ingredients of effective afterbirth support to inform service provision should be prioritised.

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Table 1: Geographical region of Hospital Trust

Area	Frequency	Percent
East Midlands	3	5.6
East of England	4	7.4
London	12	22.2
North East	3	5.6
North West	10	18.5
South East	9	16.7
South West	3	5.6
West Midlands	6	10.9
Yorkshire and the Humber	4	7.4

675 **Table 2: Survey questions and responses (n=54)**
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Survey questions	Frequency	Percent
Role of respondent		
• Director/Associate Director of Midwifery	2	3.7
• Head/Deputy Head of Midwifery	6	11.1
• Birth afterthoughts coordinator	1	1.8
• Matron/Sister	9	16.7
• Consultant Midwife	14	25.9
• Lead/Specialist Midwife/Professional Midwifery Advocate	16	29.6
• Midwife	4	7.4
• Other[1]	2	3.7
How long been in operation?		
• Less than 1 year	3	5.6
• 1-2 years	10	18.5
• 3-5 years	12	22.2
• 6-10 years	10	18.5
• More than 10 years	16	29.6
• Don't know	3	5.6
How many women access the service each year?		
• 0-50	13	24.1
• 51-100	17	31.5
• 101-150	7	13.0
• 151-200	8	14.8
• 300+ women	3	5.6
• Not recorded	5	9.3
Types of support provided?*		
• Woman is able to describe details of her labour/birth experience	50	92.6
• Woman is able to discuss her feelings about her labour/birth experience	51	94.4
• Information on birth trauma is given to the woman	30	55.6
• The maternity notes/details of the birth are provided/discussed with the woman	50	92.6
• Information on/reasons for the management/care (during labour/birth) is given to the woman	51	94.4
• There is a discussion about how the woman may feel in the future	44	81.5
• The woman is encouraged to talk to/access support from others in her personal network	34	63.0
• The woman is given reassurance that her responses (i.e. emotions about the birth) are normal	43	79.6
• The woman is referred to other supporting agencies/professionals (e.g. psychologist, mental health service) as appropriate	48	88.9
• The woman is given information on other available services, e.g. Birth Trauma Association	30	55.6
• The woman is able to discuss her birth choices for a future conception	45	83.3

• Other forms of support (i.e. support for birth partners, feedback is provided to individuals in the organisation on good or poor practice issues)	5	9.3
How structured is the support offered?		
• Partly structured (i.e. has some elements of structure, but generally based on woman's needs)	35	64.8
• Structured (i.e. generally follows a set format)	2	3.7
• Unstructured (i.e. completely based on women's needs)	17	31.5
Who is the Birth Afterthoughts/Listening service provided by?		
• Midwives & Doctors	12	22.2
• Midwives & Psychotherapist (counsellors/clinical psychology)	2	3.7
• Midwives only	32	59.3
• Midwives, Doctors & Psychotherapists (counsellors/clinical psychology)	6	11.1
• Other (i.e. counsellor)	1	1.9
How did the hospital/Trust decide on the types of support to be provided?*		
• Evolved in response to women's needs	45	83.3
• Trust decision	5	9.3
• Based on available research	13	24.1
• Don't know	7	13.0
Have the professionals who provide the service received any specific training?		
• Yes - all of them	10	18.6
• Yes - some of them	20	37.0
• No	22	40.7
• Don't know	2	3.7
At what time-point are women able to access the service?*		
• As/when referred/self-refer	50	92.6
• Fixed appointment provided/offered	11	20.4
How many times are women able to access the service?		
• One session (but woman is able to request/re-attend a further session as needed)	26	48.1
• One session only	10	18.5
• One session, with follow-up sessions discussed/agreed between the professional and woman during the meeting	12	22.2
• Other	5	9.3
• Don't know	1	1.9
Are all women informed of the service?		
• Yes – all of them	28	51.9
• Yes – some of them	17	31.5
• Other (i.e. not formally advertised)	6	11.1
• Don't know	2	3.7
How are women made aware of the service?*		
• Poster	7	13.0
• Leaflet (routinely provided)	15	27.8
• Leaflet (provided via discretion)	7	13.0
• By midwife	49	90.7

• By health visitor	32	59.3
• GP/Doctor	26	48.1
• Other (i.e. website, other hospital services)	10	18.5
When are women informed about the service?*		
• During pregnancy	29	53.7
• After birth	49	90.7
• Other (i.e. as/when requested, or due to attending postnatal clinic due to complications)	2	3.7
• Not recorded	1	1.9
How are women referred into the service?*		
• Routine screening	6	11.1
• Referred on certain obstetric criteria	15	27.8
• Requested by woman	43	79.6
• Via midwife	43	79.6
• Via health visitor	34	63.0
• Other (i.e. GPs, Obstetricians)	5	9.3
• Not recorded	1	1.9
Is the service available for all women?		
• Yes	52	96.3
• No	2	3.7
Has the Birth Afterthoughts/Listening service been evaluated?*		
• Yes – formal audit or research project	18	33.3
• Yes – informal feedback	27	50.0
• No	10	18.5
• Don't know	5	9.3
• Not recorded	1	1.9
How is the service funded?		
• Trust/within maternity budget/allocated hours	22	40.9
• Work undertaken as part of role/no specific funding	28	51.8
• Seconded post	1	1.9
• Grant funding	1	1.9
• Not recorded	2	3.7
Does the Trust offer any other postnatal services for women who have experienced distress/trauma due to childbirth?		
• Yes	39	72.2
• No	14	25.9
• Don't know	1	1.9

1 Post-natal support counsellor/Health in pregnancy worker

* Multiple options could be selected