THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON REPRODUCTIVE, MATERNAL AND PAEDIATRIC HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE HOBART ON WEDNESDAY 23 OCTOBER 2024 AT 9. 05 A.M.

The Committee met at 9.05 a.m.

CHAIR (Ms Haddad) - Welcome to today's hearing. Thank you very much for flying from Brisbane to be here and being available to provide important insights to our committee's hearing. I am Ella Haddad, the Chair of the committee. We are joined at the table by my colleague, Kristie Johnston, and online by two of our committee members, Anita Dow, who is in Burnie in the northwest of Tasmania, and Cecily Rosol, who is in the north in Launceston.

Could you please state your name and the capacity in which you are appearing at today's hearing?

Ms DAWES - My name is Amy Dawes. I'm the co-founder, CEO and Director of the Australasian Birth Trauma Association. I'll be representing the association.

CHAIR - Thank you very much. Can I confirm that you have received and read the guide sent to you by the committee secretary?

Ms DAWES - Yes, I have.

CHAIR - Just to explain a little bit about the parliamentary hearing, you are covered today by what's called parliamentary privilege, which basically means you can speak freely, say anything that you want the committee to hear, and without fear of being sued or questioned in any court or any other place outside of parliament. That protection is not accorded to you if statements that you make could be considered defamatory and you repeat them or refer to them outside of this parliamentary hearing. That's how parliamentary privilege works in the Chamber and in a hearing like this, which is technically still part of the parliamentary proceedings.

That said, if during the course of our conversation there's information that you would like to share in private, you can request that. We'll then have a short deliberative meeting and we'll do what's called going in camera, which I'm sure is a term you've heard. It means then that the broadcast stops, the information is still transcribed by *Hansard*, but it's not a publicly available transcript. That is an option available to you if during the course of your evidence, there's something that you'd like to share with us that is more private.

I've introduced all my colleagues on the committee. Could I ask you, please, to make a statement that's in front of you on the card?

Ms AMY DAWES OAM, CO - FOUNDER, CEO and DIRECTOR, AUSTRALASIAN BIRTH TRAUMA ASSOCIATION, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - As a committee, we've also agreed to make a sensitive content statement at the beginning of each session. There are people watching from the public gallery today and we know that there are also many people watching online. Due to the seriousness of the evidence that we've been hearing at our public hearing so far, we've agreed to just provide that statement and I'll read that to the committee now.

As a committee, we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these hearings. The committee encourages anyone impacted by the content matter during this hearing to contact services and supports, including Lifeline helpline on 13 11 14, Tresillian Tasmania's Parent helpline on 1300 827 282 or PANDA National helpline 1300 726 306.

With those formalities completed, if you would like to, I will invite you to make an opening statement.

Ms DAWES - Thank you for this opportunity. I'm pleased that this committee continued with this inquiry that initially started last year. It's so important and I commend the work of the community as well for ensuring that this would happen.

Eight years ago, I was diagnosed with life altering injuries as a result of the forceps birth of my first child. My diagnosis occurred with an appointment with a pelvic health physiotherapist. When I got home from that appointment I googled 'physical birth trauma' and nothing came up. I tried 'birth trauma' and I came across a United Kingdom (UK) based charity that focused on PTSD as a result of birth trauma. With my particular symptoms and diagnosis, I felt like I was the only one. After this, I started researching and I found out how common birth-related trauma is. Despite this, there was no support available for women. It was for this reason that I co-founded the Australasian Birth Trauma Association so that other women like me would have somewhere to turn to for support.

Since starting the Australasian Birth Trauma Association, we've gone on to support thousands upon thousands of women in every state and territory. Those women have experienced psychological and or physical trauma as a result of their birth experience. We work collaboratively with both parents and the range of professionals involved in the care of birthing families to better prevent, diagnose and treat birth-related trauma. This includes midwives, obstetricians, nurses, pelvic physiotherapists, urogynaecologists, specialists, surgeons and mental health clinicians in our mission to increase understanding of birth related trauma and provide support and advocate for people impacted across communities.

We have developed a range of learning, health information and resources and launched our e-learning hub for maternity professionals earlier this year. Our models are endorsed by the Royal College of Obstetricians and Gynaecologists, and the Australian College of Midwives. Our work is done almost entirely by volunteers and everyone involved has some lived experience of birth related trauma. We receive little to no government funding. We rely almost solely on donations and the energy and passion of our volunteers, so, most of the work we do to raise awareness, and the education and support, is done by people like me living with birth-related trauma.

Throughout the history of medicine, there has been a flawed paradigm adopted by certain members of the medical community that women should just accept their fate; that medical intervention, research and conditions that primarily affect women don't require as much study or research as those that affect men. Suicide remains the leading cause of death of women, of mothers up to the first year postpartum, and the most likely time for women to suicide is between the ages of 45 and 55.

There seems to be a dysregulation between those who choose to promote the health of women through pregnancy, birth and the postnatal transition, and those who accept the status quo. Birth-related trauma is under reported, undervalued, and over represented in the community. This issue has wide-ranging ramifications across society, yet it is mainly women and families that must shoulder the burden of managing the impacts and seeking treatment.

From feedback within our community we see the health system care pathways are fractured and access to care can be a lottery depending on your postcode and your social economic status. This shouldn't be the case. We look forward to working with the Tasmanian government and the maternity health systems to prevent ongoing birth related trauma in Tasmania. Thank you.

CHAIR - Thank you very much. Thank you also for sharing your own deeply personal story and the history of why your organisation has come to be. That description of feeling like you're the only one and now you've supported thousands of women who have experienced psychological or physical birth trauma is very meaningful.

You've touched on it, also, in your written submission to the committee: the importance of trauma-informed care. I wondered if you can elaborate a bit more on the need for that kind of training, what kind of training is available, and the scope of health professionals who, in your view, need to make themselves available, or have that training made available to them?

Ms DAWES - I'm really grateful that I have been able to learn from our community. Trauma-informed care is something that was really highlighted through stories that I've heard, including, I think of one mum in Tasmania that that has submitted to this inquiry. We all have a trauma history in some way, shape, or form. One in five women are experiencing domestic violence. I think in Queensland, where I'm from, police are called to a domestic violence incident every five minutes. Then, in 2023, the child maltreatment study came out and it indicated that 28.5 per cent of Australian adults aged between 16 and 60 have experienced child sexual abuse. Women are predominantly those who are impacted by sexual abuse or emotional abuse.

That prior trauma history can influence the birth experience, but for me as a layperson, I don't think anyone's connecting the dots with that. So, as you have probably seen with the submissions, when there is a tick box that says, 'Have you experienced prior trauma?' it is literally that: a tick box. It doesn't have any bearing on the type of care that they get. Often when we look at women and the model of care that they receive, we're looking at her physical health and wellbeing, we're not necessarily delving into the trauma history that she may have and nor should she be at duty to have to necessarily provide that outline.

In an ideal scenario, everyone should be providing trauma-informed care. We recognise that there are barriers to doing that. We're effectively asking clinicians, potentially, to be exposed to trauma and taking into account that they may well have experienced it themselves. But, what I've seen is that if we think about the impact of trauma - and we're learning about the mind/body connection - to have a baby, physiologically, we've got to be relaxed and birth can be really impactful regardless of whether you have trauma or not. It's a huge experience to go through and we are just assuming that every woman can birth vaginally and pushing women to that mode of birth - assuming that that is the mode of birth best for them - without actually taking into account what she's carrying into the birth suite.

I don't know if I explained that well enough, but in my eyes I see that there is a great need to understand what women bring into the birth suite - women and people - and also acknowledge that there are unconscious bias assumptions that are made. I think that came up in the Australian Lawyers Alliance a lot talking about unconscious biases. It's really important and I think that there is a disconnect between recognising why trauma-informed care is important and that's where that gap in information is, I think.

CHAIR - Do you have examples of where trauma-informed practice is better than in other parts, or is it basically a nationwide issue that trauma-informed care is not practised deeply enough across the country?

Ms DAWES - I would say it's across the country, yes. In our submission into the New South Wales inquiry, they've got a trauma-informed care framework. Queensland is working on a trauma-informed Queensland [framework], but I don't think it's been put into practice and that's why, as an organisation we really advocate for a collaborative care model where women get wrap-around support. They need continuity of care, absolutely, and it's really important to have a known carer all through their pregnancy and birth, but also beyond that and in preparation, working with mental health clinicians when required, having that access to care.

Pelvic health physio is important because they can actually talk about what the body does physiologically, what the pelvic floor does. The pelvic floor needs to stretch to three times its size in order birth the baby vaginally, some of us just can't do that. That's why that wrap-around care of support, having a midwife through pregnancy and birth but, beyond those two weeks to six weeks, who are women more likely to connect to? Hopefully they've got access to a pelvic physio, a mental health clinician if required. So, yes, that's why we advocate so much for a collaborative care approach.

CHAIR - Continuity of care is something that's come through very strongly in this committee so far in the evidence that we are hearing, and also the fact that there are publicly available pelvic floor consultations available. Often clinicians don't know that and don't know that they can refer women to pelvic floor physio through the public system after birth. So, a lot of it's about better information sharing across the system.

Ms DAWES - It's absolute luck as well if people feel comfortable to talk about it. I really recognise the privilege that many in our community are Anglo-Celtic, have good health literacy, they're empowered to seek support, but how many women are suffering in silence?

CHAIR - That's right, and it's come through in some of the submissions, as well, that often the aim of the medical model is a healthy baby. If you've gone home with a healthy baby, it's very easy for women to neglect their own health needs.

I'll ask one more question before opening it up to the rest of the committee. Through some of the evidence that we've heard so far in our hearings, and also in the written submissions, it feels like often women might realise that they've undergone birth trauma quite some time after the fact. Sometimes not even until a second or subsequent pregnancy when they have a very different experience and reflect on their first and realise there was something pretty serious that happened at that time.

Do you find in the thousands of women that you've supported across Australia that that might be the case, that it takes some time to recognise that birth trauma, either physical or emotional, has been experienced?

Ms DAWES - Yes, that's such a brilliant question. If I reflect on it all, we've done many surveys over the years with our community and our biggest cohort is women up to 12 months postpartum. Our second biggest cohort is two to five years. We've actually got a survey running at the moment. It's our annual survey Your Birth, Your Voice: Survey for Better Care 2024. We've got an early analysis of findings - just amongst 174 women - but if I look at the breakdown, 24 per cent of those are up to 12 months postpartum, but 35 per cent are three to five years postpartum.

CHAIR - So, quite possibly after a second or subsequent pregnancy and birth.

Ms DAWES - They are either thinking about having another baby and then they're like, 'I can't do that', which is really common, or they're pregnant as well, which is really difficult because then they're realising 'I've got to navigate the system again'. Then the issue with that is, 'Where do they go for care?'. There are no perinatal mental health organisations that can provide access to service. We do have one in Queensland, Peach Tree Perinatal Wellness, and they look after women up to five years postpartum, which is important because in that first year you're focused on keeping the baby alive, looking after the baby, and you're not really thinking about how you feel.

We also encourage mental health clinicians, when women are presenting to them, to inquire about her physical wellbeing as well, because if no one asks, we just accept that perhaps urinary incontinence is our new normal.

CHAIR - That's exactly where my brain went as well. I think there is an assumption amongst women who have had babies that urinary incontinence through pelvic floor damage is just part of life. Actually, it isn't. It took me 40 years to realise that through talking to lots of women around their birth experience. If we don't know, we don't know.

Ms DAWES - Absolutely. For a long time, before kids were even on the horizon, it was like, you won't be able to jump on a trampoline again after having kids. When we did our birth injuries report back in 2022 and we had 800 people respond to that survey, that mattered to women: women feeling like they can't play with their children, they can't jump on the trampoline with their children. It really does matter and access to care is important because it's not always a guarantee that pelvic health physiotherapy will improve symptoms. Well, it will improve symptoms but you may need to see one for the rest of your life. In my circumstance, that's certainly the case, but conservative management very early could prevent the onset of exacerbating symptoms.

Also, getting access to mental health. It is women, and families, and people, that have to shoulder that burden and we don't prioritise that. Obviously, now we're in a cost-of-living crisis to actually be able to afford to see mental health clinicians is a huge barrier to care.

Ms JOHNSTON - Thank you for your submission with those comprehensive recommendations which is very useful for us in terms of hopefully doing a copy and paste maybe. I want to talk about - and following on from Ella - education and awareness. It has certainly been my experience when I had my two children that I had no idea about birth trauma, and one was very traumatic. In one of your recommendations you talk about education and awareness and particularly enhancing antenatal and postnatal education for women, birthing people, fathers, and families.

In previous evidence we heard on Monday, we talked about when is a good time to connect with people in terms of when there is the space that they can actually take in the information. I think the Australian Breastfeeding Association said that the second trimester is a really good time. The first trimester you are feeling a bit awful. The third trimester, you are busy preparing for a baby. Once you've had a baby, you're in a different space trying to keep a little one alive. The second trimester might be the ideal time.

Do you have a view about when's a good time to engage with women, birthing people, fathers, and families about what can happen and the supports that are there so that you're not dumping information on people immediately after they've given birth?

Ms DAWES - Firstly, I'm sorry to hear that you've had a traumatic birth experience. It's one in three. I think it's potentially more. That's the tip of the iceberg because, like you say, until you've experienced it, you hear the words but you don't necessarily know.

In terms of connecting in with women, I have to acknowledge that there is work now being done with the development of the LEAPP [Living Evidence in Australia Pregnancy and Postnatal Care] guidelines, that is national guidelines on antenatal education and postnatal support. That will hopefully guide more talking points in what we speak to women about. It's not only timing but it is also what do we talk to women and parents about? Because, for me working in this space, I did my first presentation back in 2017 and even then I was saying we need to talk about things that happen during birth. Always the pushback is, 'Well, you can't possibly inform women of all the risks associated with birth'. But, we can have conversations and we can guide to information because there are always going to be people who don't necessarily want to know the risks. Then, on the other end of the spectrum I want to know that one in four women may well end up with an instrumental delivery and what can I do to mitigate that risk.

In terms of checking in, if we look at obtaining consent and that process of consent and informed decision-making, it's not just one conversation. It's a constant flow of obtaining consent and providing information in a range of ways which could be written, or videos to watch. Very simple and obviously translated into multiple languages. But in terms of the time, I think it just depends on the individual. That's when it comes down to individualised care and having access to someone who can provide that information. But there needs to be a centralised source of reliable evidence-based information because we live in a world where people are potentially getting their birthing information on social media and, you know, is that evidence based? Is it up to date? Well, we don't see that because we see the fallout from that when women experience trauma, but they did all the right things and they still experience trauma. So, in terms of timeframe, it's not necessarily about that, but it's access to information and guiding them to the information so that they can kind of lead the way.

Also, in terms of antenatal information, again, I think it would be amazing for it to be a blue sky thinking that it would be delivered by a range of clinicians so they'd have their known carer and ideally midwifery-led care. They would also connect in with an obstetrician, so they can talk about, 'We do instrumental deliveries, emergency caesareans or elective caesareans', whatever that looks like, so that at the time of birth, people aren't forced into making decisions where they don't understand what they're consenting to. Because, I think the fear is, if we talk about, say, risks associated with vaginal birth, everyone would choose a caesarean - absolutely they wouldn't, but you know what, when there's an adverse outcome, they would emerge from the other side not being blindsided by their experience because they've prepared for it and they've made an informed decision about that process.

Ms JOHNSTON - That's really useful. The language that goes around, it's often medicalised. When you're actually in the moment and the language they use, if they can share that beforehand and there's some general knowledge and awareness, you absolutely have that ability to know what to expect. So, in the moment you can give informed consent because you've heard that term beforehand in a place where you've got the ability to actually think about things through rather than an emergency situation or a very stressful situation. I'm very keen to find out a bit more about that education component.

CHAIR - I think the difference between consent and informed consent is going to be something that we will need to focus on in our recommendations. We heard a story yesterday - sorry, Monday - from someone who gave a story about a woman based in a regional location. Can't remember where on the mainland, not Tassie, who was really excited to have her baby arrive in the bigger town a few weeks ahead and shared with the doctor that she couldn't wait to be a mum and was really excited. He said to her, 'Well, you could have it today at 37 weeks. We can induce you'. That's what she chose to do. No doubt she would have felt that she consented to that induction, but was it informed consent if she didn't have explained to her the risks of induction?

Ms DAWES - Yes, and the risks associated with the baby at 37 weeks.

CHAIR - And the risks of a 37-week delivery instead of going to full term. I do not think that story had a sad ending. I think that baby was born healthy. The reason it was shared with us was that it was illustrative of the difference between consent and informed consent and having the risks of whatever issues arising during labour and birth explained. So, as Kristie said, hearing it early and knowing in the back of your mind an emergency caesarean might be necessary, and knowing what that means before you're in the moment is really important.

Ms DAWES - Yes and it's also just women understanding because what we see as well when we ask about, 'How did you feel about birth preparation?', that's one of the surveys that we did way back in 2019. Women, post-traumatic birth experience, will say, 'I didn't realise how hard I had to advocate for myself', or 'I didn't realise I had choice', and it's really important to respect choice and that can go to like in all aspects.

But, if we to look at genuine, individualised choice, and that was a key recommendation that came out of the birth trauma inquiry, that one-size-fits-all approach to birth is not suitable, but yet that does still seem to be very much the approach. And that refusal, if a woman indicates that she wants to have an elective caesarean for example, that is a poor outcome for baby, there's still this really prevailing narrative that that's really harmful for the baby. But on what we see on the flip side to that, what's harmful for the baby? Well, the mum is so psychologically and physically traumatised that she cannot care for her baby. So let's just speak to individuals and give them true choice. Why is there a fear of providing choice in mode of birth, in model of care, when facilitating positive birth outcomes is about making sure the woman or person is at the front and centre of what she wants? Why is it so complicated?

Ms JOHNSTON - I think that the voice of lived experience is important there. I certainly remember at the time when I birthed my first child, nobody spoke about the range of different kind of births you can have. It was just assumed, and I had just assumed, it was going to be a normal vaginal delivery, everything was going to be fine. The importance of lived experience to talk about that, outside a medical eyes kind of environment, is important to allow women to feel informed about the process they're about to go into before they go into that process. Also, to acknowledge that things can go wrong and that's okay because there's a range of things we can do but that they're supported in that particular process.

Ms DAWES - I was reading one of the other submissions from the Health Consumers Tasmania. It was a brilliant submission and so detailed, and many of their recommendations talk about collaborating with consumers in providing information. That should always be at the forefront because, as I said in my opening statement, this is the medical profession assuming that they know better when what we're saying is women and people know their bodies and honour that experience. Of course that comes with challenges because there may be disagreements about what the best model of care should be for that person. Then that sort of flips into that litigation risk - I think that is probably the fear for many clinicians that if they think that there's a challenge with safety, but the mum or person is saying, 'I don't want to do that', how do we manage that and who is at risk? That's probably a challenge.

Ms DOW - Thank you very much for presenting to our committee today and for coming down to Tasmania to do so. The candid discussion we've had this morning has been really good, just talking about some of those issues around pre- and post-education.

In your submission to the committee you talk about the importance of data collection around birth trauma and the fact that we're not doing that well in Tasmania. Could you please elaborate on that for me and any other collaborative partnerships that you've seen, for example, with universities across the country where there is good data being collected around birth trauma to inform the delivery of services and future care needs?

Ms DAWES - Thanks for that question, Anita. I can say that in my understanding that there's no data on birth trauma being captured. This is why we talk about this so much. If we look at the mother and baby data that comes out, that is very much focused on the mode of delivery, whether pain relief was administered and what type of birth they had. We're not getting a picture of her or their psychological and physical outcomes. That's why we would really like to see an opportunity for data collection that is beyond that initial birth experience, something that looks and checks in again with women perhaps at three months, at six months, and a year postpartum. The reason that we really feel that is because, again, it ties into the fact that a lot of people don't identify as having trauma because they're very focused on the baby and so we can't really get a true measure of outcomes.

At the moment everyone's talking about the high caesarean rate in Australia and that is a really huge sort of issue. But why are we not asking how those women feel about their experience and how are they doing physically and psychologically? Let's check in with the women who have had instrumental deliveries, how are they doing? We just need to tell more of a story with the data and then that can help inform our services. My understanding is that instrumental delivery is on the rise, and we know that one in two women who have a forceps delivery will end up with pelvic floor muscle avulsion, but we don't capture avulsion anywhere.

We're left to shoulder the burden of who do we go for support. Avulsions are a really tricky one because it is very difficult to measure at the time of birth -

CHAIR - Could you just tell us a bit more about what that means?

Ms DAWES - Yes. A pelvic floor muscle avulsion is where the pelvic floor muscle is basically detached from the bone. You can have a bilateral avulsion on both sides, or a partial avulsion. Around 10 per cent to 15 per cent of women have a full avulsion and it's about 15 per cent to 25 per cent of women have a partial avulsion. In terms of lifestyle implications, it's a similar impact to, say, women who are suffering from endometriosis. Similar statistics as well.

So, again, the survey that we're running at the moment, if I look at the early data that we're capturing, women with avulsion, PTSD was the most commonly reported mental health condition, 40 per cent identifying that they have PTSD. That increases to 63 per cent of women with avulsion. The tricky thing is, because you can't identify at time of birth, it is often ignored. There are red flags. If a woman can't walk, she is potentially suffering from avulsion. As I said, one in two women with forceps delivery will experience full or partial avulsion, and one in 10 on a vacuum delivery. But, shockingly, one in 10 if you have a straightforward vaginal birth.

So, the way that you identify it, pelvic physios are really well placed. They can pulpate it, they can actually feel that the muscle is avulsed from the bone. You can also identify it through 3D, 4D ultrasound with a urogynaecologist. Now, my understanding at this stage is there is no surgery to repair pelvic floor muscle avulsion because there's no way to attach that muscle back to the pelvic bone. Avulsion is the leading risk for women to experience pelvic organ prolapse. And the pelvic organ prolapse is typically perceived as an older women's condition, but we see it across our cohort from as young as 20. That has a huge impact on wellbeing, as indicated with that PTSD.

We also reported, one of the questions that we asked in this survey that we're running at the moment is: have you ever experienced thoughts of ending your life since experiencing birth-related trauma? And 33 per cent of people indicate that they have suicide ideation. It increases to 51 per cent of women who have experienced pelvic floor muscle avulsion. But the condition is ignored and that is why we want to see some data capturing psychological outcomes.

Ms DOW - Are you aware of other countries where they do the longitudinal studies across women of childbearing age and following their story, and any subsequent consequences to their health status after birth?

Ms DAWES - I'm not aware of it, no. There is a longitudinal study being done in Australia, but I don't know if they're looking at, say, for example, pelvic floor function as an indicator. It has been interesting because ABTA (Australasian Birth Trauma Association) was probably one of the first organisations - well, we certainly were the first organisation in Australia talking about birth injuries and we remain one of only three globally, so there is still quite a lack of awareness around the impacts of birth injuries, for example.

Ms DOW - My last question before I hand over to Cecily is, some of the evidence that we're seeing being presented to this committee is indicating that in more regional and rural parts of Tasmania there are incidents of birth trauma. You've obviously met a lot of women from across the country. Is that a trend that you're seeing through your interactions across the country? Is there anything further that you'd like to put on the public record for the committee around that?

Ms DAWES - Yes, access to care, we know it's an issue. It's an issue if you are in a metropolitan area because, like I said, it's luck of are you able to speak about your experience, are you able to reach out for support? In regional and rural areas, it is across the country. We recently did a training in Tamworth and we were having a conversation about pelvic floor muscle injuries or anal sphincter tears, for example, and where women go to see specialists, travelling hundreds upon hundreds of kilometres to go and see a specialist therapist. You've got to take time either away from your child, away from your work. It just doesn't work. There's so many costs attached to that as well. That is echoed across the country.

I think Victoria is doing some really interesting work in the women's health space where they've created these women's health, like, not pop-ups but it's wrap-around support for a range of women's health conditions. They are doing really great in terms of creating access to care, and they're quite focused on women's pain, particularly women who are suffering endometriosis. But when we do surveys, like our current survey, the most commonly reported conditions that we're seeing women are suffering post-birth are ongoing pain management, incontinence, pelvic organ prolapse. Pelvic organ prolapse isn't recognised as a chronic condition - that needs to change. We put that in our submission into the Victorian Pain Inquiry to actually get levator avulsion recognised as a chronic condition so that women can access more support. So I think VIC, in terms of every state, is leading the charge in getting women's health the recognition and the investment into it. But it's early days in terms of that program.

Ms ROSOL -I'm interested in the preventative aspect. I know that we've talked about some of that already, talking about the importance of education and information, and the continuity of care and collaborative care. I'm wondering if you have any other specific preventative actions or protective factors that help reduce the rate, or the likelihood of birth trauma.

Ms DAWES - Yes, I think the biggest elephant in the room, particularly for Tasmania, is the lack of workforce investment. We cannot have clinicians provide optimal care if they're suffering from burnout, compassion fatigue, vicarious trauma. And all those conditions, I think, are probably quite interplayed with one another. The outcome is all the same: women are on the receiving end of really poor care.

When we're looking at big ticket items that can really help to prevent trauma, it's trauma-informed care, access to education - not just for women and birthing parents to have the information should they want to access it, but clinicians to understand those contributing factors to birth trauma and what they can do to help prevent it. The reason we say birth-related trauma is because it's events that can occur from conception through pregnancy, during the labour and birth, or that post-natal period. Typically, all those things are underpinned by how women, or people, are treated in the moment. So, what can we do to prevent poor treatment? And that is invest in workforce.

I think there was an article in the paper today about the midwifery shortage. We need to invest in midwives, but we also need to provide support for them. If they're witnessing trauma, what is the impact on that? And I think we see it for midwives and doctors. We expect our care providers to be superhuman, but we know the effect of witnessing trauma and what that has on the brain, yet there's no opportunity for reflective practice in there. Again, it's my understanding that there's no opportunity for reflective practice.

In fact, when I speak to other midwives - I was speaking to another midwife in regional New South Wales recently and flying the flag for providing support for caregivers because they can't provide optimal care if they're not supported. She gave me an example of something that had occurred. It wasn't really like the worst end of the scale of the outcome, but they were all sat round in a group and somebody shared what had happened. The midwife that was involved in that experience was there. And all the other people said, 'Well, I wouldn't have done that', and it really would have made that individual feel worse. That's not a great opportunity for learning and growth.

So, yes, providing that access to the caregivers, support, and really recognising that if we don't support them, how can they provide support? We see the end result of that of women being shouted at during the birth. Women being made to feel belittled during their birth experience is a big theme that sort of comes up for us. That's a huge one. Again, it's education because although the awareness and understanding of birth trauma is increasing, I still think a lot of people don't quite believe it. There's still a narrative of 'At least you have a healthy baby'. That still prevails so strongly today, doesn't it? Whereas, we really should be aiming to facilitate positive birth experiences for both the mother or person and the baby.

Also, let's not forget the father or non-birthing parent. We support dads within our service and they experience trauma too, and the ramifications of that on the family unit, and there's no access to care. It's hard enough for women to seek support, but the other parents just don't get to look in. I was speaking again to a clinician about this recently, talking about the carer's trauma with fathers and he was like - it's not vicarious, it's direct trauma and understanding what those red flags for fathers may be.

I was delivering one of our in-person support groups about a year and a half ago. There were seven individuals there and six of the seven women had to have further surgery after their birth experience. A few of them were in surgery for a couple of hours, a couple of them were in surgery for four hours, and one mum was having an emergency hysterectomy, A young mum, 27, was having an emergency hysterectomy. I asked, 'How were your partners in this?'. Only one of the six said that their partner was communicated to on the wellbeing of mum or baby. They're just kind of left and you can understand you're thinking about your loved one or your child and no one's checking in on you and -

CHAIR - A need that's being missed.

Ms DAWES - Yes, absolutely. We need to think of the family unit if that's the case and provide resources and support for both parents.

Ms JOHNSTON - Going back to the question about data collection and how important that is, do you have somewhere we can go to look for a definition of what trauma or injury might be in the context of collecting data around this and recognising, as you just said, it's not just the birthing person who's collecting the data for it; it could be birthing partners and things like that. Is there a definition that we should be looking to that we can try to suggest the government use in their data collection that not only looks, as you say, at the moment of birth, but looks at a longitudinal kind of impact as well? Is there a good definition that's used somewhere?

Ms DAWES - I think it's probably listing an option for symptoms really, you know, like on our website, and I think it was used in the Australian Lawyers Alliance where it lists typical psychological trauma symptoms. It's not an exhausted list, but 'Here's an example' and then, 'Are you experiencing any of these?' But you drill into the symptoms of PTSD. There are PTSD scales, there's a City Trauma Scale which was developed in the UK, but an Australian researcher actually validated it in an Australian context and it obviously crosses over. They have since also done a trauma scale for fathers and non-birthing parents as well. It is more around asking about symptoms because women or people may not realise, for example, that trying to avoid talking about the birth is a sign of trauma, not being hyper vigilant. They may not realise that they kind of need to be, you know, 'Are you constantly checking baby?'. It's how we frame it because they might not even realise themselves that they're experiencing trauma symptoms. Often symptoms of trauma as well, just on a tangent present similar to that of depression and anxiety, but people actually do need specialist trauma treatment and that's not always identified, although I think that that's coming.

Ms JOHNSTON - Yes. Is that data best collected as you said earlier, three months, six months survey, of families coming through our maternal services? Is that what you suggest would be a recommendation?

Ms DAWES - Yes.

Ms JOHNSTON - Have a formal structure of surveying, you know, three, six, 12 months, whatever it might be, to try to collect that data over a period of time.

Ms DAWES - That would be incredible.

CHAIR - Or even longer.

Ms JOHNSTON - Even longer.

CHAIR - Yes, one of the questions I asked earlier on. Sometimes people realise that their birth experience was traumatic after they've gone through a second or subsequent, yes,

Ms JOHNSTON – and said oh ‘that's not the same as the first one’.

Ms DAWES - Maybe a way that there's an opportunity for people to connect. In the other thing that we're seeing, which is really interesting in the trajectory of our organisation because one of our ways in which we support is peer-to-peer social, which is a Facebook community at this stage for women who identify as having birth-related trauma, and that started in 2017. You're seeing the trajectory of women as they age and now more women, I'm noticing increasing conversations around 'What are my surgical options?'. I know quite a few women in our cohort have opted to go for the surgery route, even though there may be quite a high risk of failure if they've got the presence of an avulsion as an example. They really want to share that with their community. But we have to be mindful of not getting people information because they're too early in their outcome.

Our responsibility is to get this information and ensure we can pass it on so people can learn from it, but it's got to be done the right way. We need to be connecting with our community. We say, rather than you talking about your outcome now, can we check and do a survey with you in six months, and then can we do another one again in six months so we can really see their surgical outcomes. That's on a really micro level with a small organisation like ours, but we need to tell a story, and we really need to understand how people are feeling. Even if it was only up to a year, I think we would still get -

CHAIR - Get some valuable data.

Ms DAWES - Yes, because they're not realising it. Nobody's checking in, nobody's asking. However, if there's an opportunity to reflect and say, 'Actually, I'm not feeling okay', or 'I am still having nightmares', or 'I can't walk past the hospital', that is a great opportunity for them to say, 'Oh, okay, this is a thing, I'm not the only one'. I think that is a prevailing feeling that I'm the only one or I'm a failure; there's lots of shame attached and we need to do a lot to destigmatise that shame.

CHAIR - Amy, our time together has raced by. We could happily speak to you all day, but we have our next witness ready to come to the table to provide information. Is there any closing information you'd like to share with us that's come to mind during our conversation that you feel we haven't heard?

Ms DAWES - No, I don't think so. I'd just say that whatever you do, do in collaboration with your community, with the consumers and the brave women who have put their voices out there and shared their stories. We can learn from the people who have experienced poor outcomes and they want to help with their experience. We see that again and again, the brave women who share their stories with us, they want to help be a catalyst for change. Bring consumers front and centre into everything. Thank you for having me.

THE WITNESS WITHDREW.

The Committee suspended at 9.51 a.m.

The Committee resumed at 10 a.m.

CHAIR - Welcome and thank you for attending today's Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania and for the written submission that you provided to the committee. My name is Ella Haddad. I'm the Chair of the committee. I'm joined at the table by my colleague, Kristie Johnston, who is a member of the committee. We have two committee members online, Cecily Rosol, who is based in Launceston and Anita Dow, who's based in Burnie. We're keen to hear about regional stories as well.

Can I ask you to please state your name and the capacity in which you are appearing before the committee.

Ms DAVIES - I'm Bernadette Davies and I'm representing the Australian Lawyers Alliance, the ALA.

CHAIR - Can I confirm that you have received and read the guide sent to you by our committee secretary?

Ms DAVIES - Yes.

CHAIR - Just to explain as well that this hearing is a parliamentary proceeding, which means you're covered by parliamentary privilege. That means that you can speak freely and with freedom, you can share whatever it is that you would like to share with the committee without any fear of being sued or questioned in a court or any place outside of parliament. That parliamentary privilege protection doesn't extend to statements that could be considered defamatory if you refer to them or repeat them outside of these parliamentary hearings. With that said, if there is a need for you to provide information in private or during the course of today's conversation, if something occurs to you that you would prefer to provide in a private setting, we can do what's called going into camera, I'm sure it's a term that you're familiar with. We will have a short deliberative meeting and the broadcast stops. There's still a *Hansard* transcript, but it will be private and not part of the public transcript, so if during the course of our conversation something occurs to you that you'd like to provide in camera, you can do that, just make the request at the time and we can deal with that at the time.

Can I ask you please to make the statement that's in front of you on the card there?

Ms BERNADETTE DAVIES, SOLICITOR, BLUMERS PERSONAL INJURY LAWYERS, AUSTRALIAN LAWYERS ALLIANCE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - We've decided as a committee as well to provide a sensitive content warning at the beginning of each hearing. We don't have any members of the public in the gallery today, but we know that there have been for other hearings for this committee and there are people watching online, so I'll just share that statement with the committee now.

We recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. As a committee, we encourage anyone impacted by the content matter during this hearing to contact services and supports such as Lifeline helpline on 13 11 14, Tresillian Tasmania's Parent helpline on 1300 827 282 or PANDA National helpline on 1300 726 306.

With those formalities out of the way, if you'd like, I invite you to make an opening statement.

Ms DAVIES - Thank you, Chair, and I would also like to thank all members of the select committee for inviting the Australian Lawyers Alliance, the ALA, to appear at today's public hearing.

I am Bernadette Davies, a member of the ALA's Tasmanian Branch. I work as a solicitor on birth trauma and medical negligence cases. I would like to acknowledge the traditional owners of the lands on which this public hearing is taking place today, the muwinina people. I pay my respects to their elders past and present, and to any Aboriginal and Torres Strait Islander peoples taking part in today's public hearing.

The ALA is a national association whose members are dedicated to protecting and promoting access to justice, human rights and equality before the law for all individuals, regardless of their position, wealth, gender, age, race or religious belief. The ALA is represented in every state and territory across Australia and we estimate that our 1500 members represent up to 200,000 people every year nationally.

Our submission to the select committee for this inquiry focuses on birth trauma. Based on the experiences of our clients, ALA members have concluded that the causes of, and factors underpinning, instances of birth trauma reflect systemic issues within Tasmania's health system. This affects women, their partners and support persons, their children and babies, who are some of the most vulnerable people in Tasmania and who deserve protection and safe access to healthcare services.

The six de-identified client case studies sourced from ALA members in Tasmania reflect the issues regarding birth trauma in Tasmania, including that the cultural and health needs of Aboriginal and Torres Strait Islander women are not being met before, during and after they give birth. A lack of communication, informed discussions and education are all compromising women being able to provide informed consent for certain procedures being done or instruments being used while they give birth. No continuity of care for pregnant women and women giving birth is putting women at risk of experiencing birth trauma and services, and resources in Tasmania's regional hospitals are inadequate. We have made a number of recommendations in our submission, which we contend should be implemented in order to avoid or reduce instances of birth trauma in Tasmania. The physical, psychological and cultural safety of pregnant women, women giving birth and their support people in Tasmania must urgently be prioritised.

Thank you again for the opportunity for the ALA to appear before this public hearing. I'm happy to answer questions from the committee.

CHAIR - Thank you as well for the written submission that you've provided to the committee. The case studies, while I understand they've been de-identified, are really harrowing. If it's appropriate and possible to pass on the thanks of the committee to the people who have had their de-identified story shared, we'd really appreciate that. It is very important informative information that will be pivotal to the recommendations that the committee makes.

Something that comes through many of those case studies that you've shared and through some of the other evidence that the committee has been provided from others submitters is the difference between providing consent and informed consent during an emergency situation or during labour pre or post emergency. One of the stories that we had shared with us on Monday was about a woman in a regional location on the mainland who had to go to a nearby bigger town to deliver her baby. She was there at 37 weeks, not to deliver, but because she needed to be there. In the weeks leading up to her expected delivery. She shared with the clinician that she was really excited to become a mum and she was really looking forward to giving birth. The clinician she was speaking to said, 'Oh, well, we can just induce you. You can have your baby today', and she tries to go down that pathway. I think the story didn't have a sad ending. I think that baby was born healthy. But that woman no doubt felt that she provided consent to that induction without having the risks of induction necessarily properly explained to her or the risks of having a delivery at 37 weeks versus full term.

I wondered if through the experience that you've had representing women who have had interventions during labour, if you can explain to us some of those experiences of what information is shared with women prenatally or during labour before those interventions are delivered or imposed, I suppose, and the experience of those women having the risks around different interventions during labour explained to them.

Ms DAVIES - What I'd say from the outset is that our experience is that the explanation is completely inadequate, that women are providing some level of consent, but it's not an informed consent and it's not reaching the standard that's required by the law, which is a meeting of the minds, so that the medical professional and the patient are on the same page if you like. We're seeing it's inadequate and then women, of course, are suffering various levels of trauma, physical and psychological trauma related directly to that lack of consent.

So we make recommendations in regard to that specific issue, in particular, how to provide - so we make submissions that there should be greater education and regulated education for medical providers, doctors, midwives, nurses beginning in their university or other training on how to assist a patient to provide consent, and how that can be provided in an ongoing manner from the beginning of the pregnancy, throughout the pregnancy, the labour, the birth and postpartum.

Some of the recommendations we make there are education, as I've said, but also the creation of a birth plan beginning in pregnancy, which can also be recorded in a written manner and that provides not only an opportunity for the woman to provide her specific preferences, but it's a written record of each time she's received advice as to instrumental deliveries, the risk-benefit of each potential intervention that she may undergo. If there's an emergency situation or an intervention that's required later in the pregnancy, she's been able to consider and write out her preferences along with her support people and family. That's one of the big recommendations we make there; the education and that written birth plan.

CHAIR - In the first case study that you shared, you told a story. I think it's this one. The mother sought to obtain medical records on six occasions and was denied that information by the hospital. Outside of this committee, I have heard stories of people having to put in right to information requests for their own medical information. I'm wondering, did that woman eventually have her medical information provided by the hospital and through what mechanism? Was it through an RTI or through persistence of asking? What is the hesitation?

Is it a fear of litigation that is driving hospitals or clinicians to not share medical information with their patients when requested?

Ms DAVIES - I can say that she did eventually get a copy through her GP and her GP had to ask a number of times. She was not able to get a full bundle of records until she sought legal advice.

CHAIR - Really?

Ms DAVIES - So that was through a lawyer acting on her behalf, through the RTI process but that specific example - sorry, what was the second part of that question?

CHAIR - How she obtained the information and also whether the resistance to provide information by hospitals' administration or by individual clinicians, is it a fear of litigation or is it just a policy setting that people are expecting not to have to provide medical records and information to their patients?

Ms DAVIES - It is difficult to know as I don't work in that setting. From our perspective, we do consider that there is a level of fear around litigation in the medical profession. One of our recommendations is that as part of that education that we've advocated for, medical professionals would receive specific training around medical litigation and what it actually means for an injured person so that they might then understand it's not a punitive measure. It's not punishment of the doctor or the medical professional. It is about putting that the person who's been injured back into a financial position that they would otherwise have been in but for their injury.

Yes, there's definitely fear and we've seen that in one of those cases - the one that we're talking about. There was certainly behaviours by medical professionals as soon as there was a mention of a link to the birth and any possibility of an error there was a shutdown and there were comments made by professionals that they did not want to say anything because they work in that system.

I think one of the other areas that we've made recommendations for is in the area of open disclosure. I know that in Victoria under their *Human Rights Act*, they actually have a legal obligation for public health services to discuss an adverse event. It's actually legislated and we make submissions that that should be explored in Tasmania. In Victoria, what then follows is there'll be an apology or an expression of regret, a factual explanation of what occurred, including the consequences. There will be an opportunity for the patient to relate their experience and then the steps taken to manage the event and prevent its recurrence. We know that if those things occur, the litigation often does not progress because the matter is resolved and not every error results in litigation.

CHAIR - One of the things that the committee heard on Monday is about the importance of good complaint handling systems to be in place across health settings, and the importance of those to be seen as opportunities for service improvement, not necessarily just opportunities for risk for those clinicians. I think what you have just described really does reinforce that.

I might ask one last question on a different topic before we open it up across the committee for more questions. One of the things that we heard from the previous presenter from Australian [Australasian] Birth Trauma Association is when somebody recognises that they have experienced birth trauma, and that it's not necessarily immediate, that it could be months or even years down the track. Are you finding that in your client cohort of women that you're representing? How do they come to know necessarily that they might have a legal avenue to pursue to the point where they reach out to a medical negligence specialist lawyer and on their kind of trajectory of birth to litigation when they might recognise that what they went through did represent birth trauma?

Ms DAVIES - Yes, I think for some women unfortunately it is the baby that has suffered a trauma. And so, often times the baby doesn't reveal or it doesn't show signs of a birth trauma until developmental milestones begin to be missed. At times that can be when they get to school and they're learning that becomes obvious because it may not always be a physical injury.

Often times, women may say, 'Look, there's a couple of times when I wondered …', but they might ask the doctor and the doctor might not come around that way. Sometimes school, for a child or a diagnosis at some point with a GP or a specialist and then yes, if it's a physical or psychological trauma, often it's through a diagnosis that they'll attend a psychologist and things will come up there or with a physical trauma, they'll begin to realise that this injury that they might have been told will get better or it will get better over time is not getting better.

There are instances where the incontinence and the severe injuries that can occur - nerve injuries. There are instances where women are told, 'This will get better and don't worry about it', and it will not and it cannot. Then they'll find out one year, two years and that's when they'll often consult a lawyer.

Ms JOHNSTON - Going back to the issue around informed consent and the difficulties accessing medical records, how does that difficulty in accessing medical records impact on a client's ability to advocate for themselves in a situation where they're being asked to give consent about a range of procedures that might happen to them or events that might happen to them? And then also post-birth in terms of their care post-birth, how does that impact on their ability to engage with a medical profession in an informed way if they've had difficulty accessing their medical records either from a prior birth or from prior medical procedures and things like that?

Ms DAVIES - Yes, well, I think they can't. They can't properly provide informed consent if they can't be involved and come to understand what happened to them medically. If we're talking about a previous birth, it may impact on the next birth. If they can't have that understanding and they're not given that opportunity to discuss the records, discuss what occurred with a medical professional, then they're just not able to, they can't have that meeting of the minds that I mentioned before. They're not able to properly understand what occurred and so then they can't make those decisions later.

Again, like you say, I think they're not then able to provide proper informed consent post-birth if there are other things that flow on. If there's further physical therapy that's required or psychological therapy and they are not able to understand completely what happened during the - and they haven't got those records, then I think it's a complete barrier to providing further informed consent.

Ms JOHNSTON - One of your recommendations looks at processes and service that should be standard for women giving birth and postpartum, and you talk about appropriate debriefing after birth. Would that include, in your view, full disclosure about everything that happened in that particular birth? It's quite a traumatic situation and a difficult, stressful situation. Women's ability to retain all the things that happen to them in the moment are often lost and to be able to debrief or document everything that happened at birth, whether or not there has been an issue or not, but to be able to use that to inform future medical issues.

Ms DAVIES - Absolutely, we make submissions in regard to open disclosure. As I mentioned, Victoria's legislated. We make the submission that legislation should be explored here to enable that to occur so that, exactly like you say, then women can come to understand what has occurred, but also the hospital or the medical professionals involved can then actually take part in indicating how they are going to make changes and how they are going to prevent that from happening again. There is a case study that you have read where the particular woman involved who lost her baby found out later that events had occurred at that particular place where she gave birth in regional Tasmania involving the same clinicians had happened multiple times and, if she had known, she would not have walked into the hospital. So change did not occur and a life was lost.

Ms JOHNSTON - In terms of the information that is provided, particularly postpartum and that debrief after birth, obviously women get a discharge report as they leave the hospital. It is very medicalised in terms of abbreviations and things like that. Do you have a view about the standard of information that needs to be provided about medication that might be given, procedures, interventions, all those kinds of things in a content that is accessible and digestible, I suppose.

Ms DAVIES - Yes, but we do make the recommendation for the birth plan and that includes postpartum. So I think yes, there needs to be great detail and proper written notes taken of each attendance and what is said to the woman and her family and then, like you say, her medications. It could be an ongoing thing. You have the little blue book for the baby, so you could have something very similar for women for their birth plan and their health. That is what we are advocating for there, yes.

Ms DOW - I have a couple of questions. Bernadette, thank you so much for presenting to us this morning. The case studies that you include in your submission are, as Ella said, absolutely harrowing, but unfortunately, they are quite common stories that you hear. I know that you have to keep them, that they are de-identified. But, obviously, there is only one public birthing service in the north-west. So those that are attributed to that, obviously, for a regional setting, are from the north-west, is that right?

Ms DAVIES - That is correct, yes.

Ms DOW - Would you in your experience, or your colleagues' experience, say that there are high instances of representation from women from rural and regional areas with birth trauma in Tasmania?

Ms DAVIES - Yes, we have included that in our submission and we have made recommendations in regard to greater funding, greater staffing levels. It is just essential. Also greater technology and you will recall one of our cases there just was not an ultrasound, which is basic.

Ms DOW - You talked about the need for the government to do a strategic review of regional and rural maternity services. You talked a little bit about that now around obviously the shortages around staffing and high dependence on locums and the like. Is there anything else that you want to put on the public record about what that strategic review should include?

Ms DAVIES - I would add to that, as I have said, resources are absolutely essential; they need to be prioritised, in terms of staffing levels, funding, technology. I would add to that in terms of something I learned at an obstetric conference that I was learning at, was having a consultant on site 24 hours because, as we know women, go into labour in the middle of the night generally if they are not induced. Having someone on call was essential for that hospital. We also have made a recommendation in regard to transporting women to Hobart or Melbourne if they are high risk and doing it early. If they are a high-risk pregnancy of any kind, they need to be in a place because if the proper equipment is not available, they have to be moved. So yes.

Ms DOW - Thank you. The other thing that you mentioned in your submission is around the economic impact of birth trauma. I wonder if you might elaborate on your thoughts and experiences of that to the committee, please.

Ms DAVIES - I think that there is an economic impact on Tasmania in general because if there's birth trauma that was avoidable and preventable by greater informed consent, greater staffing levels, funding and technology, et cetera, then we're not going to see the level of trauma requiring psychological and physical intervention for a long period following these birth traumas. As well on a personal level for women, you're looking at complete life changing situations where they cannot work. Their economic loss is huge on a state level, but also on a personal level and we're seeing many times that these injuries are avoidable or can be reduced.

Ms DOW - My last question is about that rural and regional model of care and through the work that you have done, whether there are examples of good models across the country or other countries that you could share some information this committee?

Ms DAVIES - One of the areas that we haven't touched on is the cultural and health needs of Aboriginal and Torres Strait Islander women. I am aware that in the Northern Territory their Health Service - obviously they've got a greater number of Aboriginal and Torres Strait Islander people - they're ahead in terms of how they are addressing ways to properly culturally address the needs of women and their families. I think they're leading the way. Tasmania could learn and an extension of that, of course, is other linguistic and cultural backgrounds. We could look interstate for those. I think Victoria, in terms of their open disclosure regime are leading the way in that manner. The example I gave in terms of having a consultant on site 24 hours, I think was from Victoria. We need to be looking interstate. In saying that Tasmania, just because we're a small state and small geographically, doesn't mean we need to be small in our funding or in our health services. That's very important for us. We can be leaders in this area. It's up to you guys.

CHAIR - We heard from the Tasmanian Aboriginal Centre on Monday who talked a lot about the needs of Aboriginal and First Nations women. They are advocating for a lot of really positive change. One of the things that really stuck with me from their presentation was they feel when women tick the box of yes, I identify as Aboriginal, it's then - through a medical model and the current medical mindset that we have around birth - described as a deficit mindset rather than recognising the unique and really positive needs and approaches to birth practice amongst First Nations people and families. I think we can learn a lot from that as well.

Ms DAVIES - We would agree with that.

CHAIR - Which would apply to rural and regional service delivery very much so.

I had a question. You've touched on it through some of the case studies, but also in the body of your submission, around continuity of care. It links to your recommendation around the written birth plan. Continuity of care and fragmentation of service provision has come through very strongly in the evidence that this committee has heard so far of people seeing multiple different professionals each visit and not being able to actually feel like they're having a holistic approach to their care because they're seeing somebody different at each different appointment. How important is continuity of care from the experience you've had with the women you've represented and how important is it to your recommendation around a birth plan, that if a birth plan is written with the same clinicians each time, how much more impactful could it be in terms of the experience of that woman through her pregnancy and birth and postnatally?

Ms DAVIES - One of the things that we noted was, in particular again for Aboriginal and Torres Strait Islander women, their continuity of care. They often don't even get in to see someone until they're a fair way along, but that can be in rural and regional areas as well. I think what you lose with a lack of continuity of care is that relationship development between the clinicians and the woman, and again, it comes down to that informed consent. They're not going to be in a position to properly provide informed consent if the midwife last week told them one thing and the obstetrician this week told them another, and this week it's a registrar and they've all been doing the same thing over and over, but things can so easily be missed.

If it's the same person, I think that relationship and the meeting of the minds between the woman and her clinician, of course there would be a team and clear, clear detailed documentation of what was discussed, what worries she's got at that particular time, what was explained to her about where she's at and possible future interventions. All of that provides continuity of care and that birth plan provides a written record of that. It's absolutely important because, again, we've noted that informed consent - and it's a legal requirement, but it's a woman's right and it's basic, and it's not happening. Women are finding themselves making major life decisions for themself and their child in an emergency situation, having not been advised when they weren't in an emergency and in pain.

Ms JOHNSTON - Your submission refers a number of times to the trauma experienced by birthing partners and fathers, in particular. How is the law catching up with the impact around what that trauma might be on birthing partners and fathers in terms of their experience and how that is dealt with?

Ms DAVIES - Yes, in my practice, we certainly have fathers or partners who have been absolutely impacted psychologically by what they've witnessed and what has occurred. There is recourse for them in the law. Again, I think our recommendations cover this birth plan and includes fathers, partners, family members being involved in these discussions because they're going to be part of it. I think that's an important recommendation, that they're not left in the dark until the day of the birth as well. They need to be involved in the woman's decision-making, where appropriate. That, again, will reduce trauma.

Ms JOHNSTON - Would you say the current situation is that clinicians don't recognise the important role that birthing partners or families might play in the birthing process, and also don't recognise the impact of any trauma or stress in that particular role? Is that how you would see the current situation?

Ms DAVIES - I think that many clinicians would recognise the risk of trauma and that there's a need. But we consider that there's not enough staffing and funding, and there's not enough regulation and proper processes around this area to enable clinicians to involve the partner or to have that space to do that.

Ms JOHNSTON - And that would extend to getting informed consent in regards to something that might be happening in an emergency situation to their partner?

Ms DAVIES - Correct.

Ms JOHNSTON - And being able to understand the process. Again, I suppose it comes back to the birthing plan involving the birthing partner so that the wishes or preferences of people are clearly identified.

Ms DAVIES - Exactly, yes that's right.

Ms ROSOL - I have a question around accessibility to legal assistance. We've talked about the economic impact of birth trauma and about equity issues around people being in regional areas. I imagine that taking legal action is expensive. What is accessibility like for people who have less financial resources in terms of being able to get legal assistance in Tasmania for birth trauma issues?

Ms DAVIES - Most law firms that would engage in this type of litigation would always accept an inquiry based on without charge or at a very low charge to at least provide some advice around whether there's the possibility of a claim. You're absolutely right. They're very expensive and very time-consuming and can be very re-traumatising, so litigation often will only suit very, very serious injuries. There is the health complaints process which can be utilised and it does not cost. I would say that certainly there are plenty of law firms that will take on no-win no-fee in the appropriate circumstances to provide that access, because, like you say, otherwise there's just simply none.

CHAIR - You mentioned the Health Complaints Commissioner process. Have many of your clients who have gone on to formal litigation already been through the health complaints process, or through an Australian Health Practitioner Regulation Agency (AHPRA) process?

Ms DAVIES - Look, yes. We would have both at different times, and often times they reach a barrier in that process which then would lead them on to further inquiries from us.

CHAIR - Do you have any general comment - and don't share them if it's not appropriate, but through our day-to-day constituency work in our offices, I wouldn't be alone in hearing people comment on the adequacy of AHPRA complaint processes, and we know there are long wait times and backlog of work in the office of the Health Complaints Commissioner. Do you have any insights into either of those that you care to share with the committee?

Ms DAVIES - I would simply say that they are significantly important aspects of health care and they probably also need some staffing and funding increase so that they can properly provide what they've been given the power to do.

Ms DOW - In your submission, you talk about the experiences of young women across Tasmania and the high incidence of women having babies at a young age we have compared to other parts of the country. Could you elaborate to the committee or put some comments on the record about those experiences and some of the barriers for those women to accessing good pre- and postnatal maternal care?

Ms DAVIES - Certainly. I think for younger women who are pregnant and going through labour and postpartum, the informed consent process is even more - it can be difficult. But it is also equally important at any age. We make recommendations again around the birth plan, and I think that that is one way and a very specific way that younger women can be engaged in the process and be educated. Again, it goes back to the education of the medical professionals, that they are educated on the different vulnerable groups of people who are going to come to them. We've made those submissions in regard to proper education around these groups so that informed consent and the entire process can be properly provided.

Ms DOW - In relation to the model in New Zealand where there are legislative changes around birth trauma and a compensation scheme that the New Zealand parliament introduced, could you talk more about that, please?

Ms DAVIES - Really, I would say that I don't have a lot of specific knowledge on that specific model apart from what we've put in our submissions. However, we can certainly provide, after this committee hearing, a proper answer to that question, if you'd like, in writing.

Ms DOW - Thank you.

CHAIR - Thank you. If there are other things that come up for you or any other ALA members or practitioner colleagues after today's hearing that you think would benefit the committee to hear about, please feel free to reach out to any one of us or to our committee secretary because we'll be spending quite a bit of time report writing and making recommendations. If there's further information that comes to mind later that you'd like to share with us, please don't hesitate to do that.

Ms DAVIES - Yes, thank you.

CHAIR - Is there anything else that's not been covered that you'd like us to hear today?

Ms DAVIES - I think we've well covered it. All my list is covered. I'd probably just reiterate that we're urging the government to really take a stand and make a change in this area, and we're relying on you, so thank you for having us.

CHAIR - Thanks for appearing. We really appreciate it.

THE WITNESS WITHDREW.

The Committee suspended at 10.41 a.m.

The Committee resumed at 11 a.m.

CHAIR - Hello and welcome to the committee. Thank you for attending today and thank you for the very comprehensive written submission that you've provided to the committee as well. My name is Ella Haddad, I'm the Chair of the committee. I'm joined at the table by Kristie Johnston, my colleague who's a member of the committee. We have two members who are joining us remotely. Cecily Rosol who's on the screen now, is a member for Bass and is based in Launceston, and Anita Dow, who is online as well, is a member for Braddon based in Burnie. We're keen to hear about regional service delivery as well.

Could I ask each of you in turn to state your name and the capacity in which you are appearing before the committee?

Ms CRAWFORD - I'm Tanya Crawford. I'm the Clinical Director - Parent, Infant and Early Childhood Mental Health Services. I'm a clinical psychologist and I work for Tresillian.

Associate Professor SMIT - Jenny Smit. I'm the Executive Director of Clinical Services, responsible for all of the multidisciplinary services that Tresillian provides.

Dr DWYER - Hi, my name is Alice Dwyer. I'm the Medical Director of Parent, Infant and Early Childhood Mental Health. I'm trained as a psychiatrist so I work in partnership with Tanya and one of our other colleagues who is a clinical nurse consultant, to support the parent, infant, early childhood mental health delivery through Tresillian.

CHAIR - Can I confirm that each of you have received and read the guide sent to you by Mary, our committee secretary? Great, thank you.

This hearing is covered by what's called parliamentary privilege. So, technically we're in a session of the Tasmanian parliament. What that means is that you are protected by that privilege, meaning you can speak freely and honestly and share with the committee anything that you want to share. If you make statements that could be later considered defamatory, that protection doesn't extend to you if you refer to or repeat those statements outside of today's hearing.

That said, we are also able to hear information in camera, which means in a private hearing. So if during today's conversation something comes up that you feel you would like to share with the committee in private, please ask for that. We'll have a short deliberative meeting and we can move into an in camera session. What that means is that the broadcast would stop but we would still transcribe it but that transcribed evidence becomes private part of that hearing. That is something that's available to you if you wish to do that.

Can I ask each of you, please to make the statutory declaration that's on the cards in front of you?

ASSOCIATE PROFESSOR **JENNY SMIT**, EXECUTIVE DIRECTOR OF CLINICAL SERVICES, Dr **ALICE DWYER**, MEDICAL DIRECTOR PARENT INFANT EARLY CHILDHOOD MENTAL HEALTH (PIEC-MH) SERVICES, AND Ms **TANYA CRAWFORD**, CLINICAL DIRECTOR PIEC-MH SERVICES, TRESILLIAN, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I'm just going to share a short statement, we've decided as a committee to provide a sensitive content warning. We know that there are people very interested in this committee who may be watching online, and a lot of what we're discussing has been deeply personal, and we've just decided as a committee that that's appropriate. So we'll do that at the beginning of each session. So I'll just share that with the committee now.

We recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. The Committee encourages anyone impacted by the content matter during this hearing to contact services and supports, including Lifeline on 13 11 14, Tresillian Tasmania's Parenting Helpline on 1300 827 282 and thank you for providing that service to Tasmanians, and PANDAS National Helpline on 1300 726 306. That's all of the formalities dealt with.

I invite all or each of you, or whoever would like, to make an opening statement to go ahead with that.

Associate Professor SMIT - Not to rehash what's in the submission, but I used a but word and that was not the intention. I believe our superpower sits with multidisciplinary integrated care and our partnerships management. We are deeply experienced in creating, maintaining nurturing partnerships of various kinds. As we've expanded regionally in New South Wales, the ACT and Victoria, that has been an integral element of the success. So, working closely with CHaPS and the Health Department here in Launceston, as we commence services there next year is eagerly awaited. We are humble in our approach, never to take over, always to enhance and concatenate closely with services that are already there. I hold the relationship with CHaPS probably the most important one of all, for the success of Tresillian in Tasmania to the community.

CHAIR - Did either of you want to make an opening statement as well?

Ms CRAWFORD - I might just make a comment on the work that we do that really provides a service to people in that missing middle, which is just ever expanding. Many people don't meet criteria for acute services, particularly in New South Wales and the Australian Capital Territory where we do already provide a service. Many, many people can't afford a private service, or don't meet criteria or exclusion criteria for private services where they feel that people might be too complex or have moderate to severe issues. I think that's really an area we excel in, providing individualised services to those people who come with multiple complexities and difficulties, and that's something I feel like we do really well. Particularly not just birth trauma or mental health concerns, but also people experiencing domestic violence or parenting issues that lead to child protection concerns.

CHAIR - The missing middle is something that we'd really like to delve into in today's conversation. This is something that we hear coming through from Tasmanians, not just in a maternal health context, but across the board with mental health.

I'd like to open with a question that comes to that last part that you mentioned. The previous attendees that we've had at the committee table today have very much focused on birth trauma. We've heard from Australasian Birth Trauma Association and from the Australian Lawyers Alliance, who often are in the position of representing women and families legally around medical negligence and birth trauma legal matters.

I noticed that in your written submission you said that at Tresillian, each parent is screened for birth trauma as well as other mental health vulnerabilities. We're interested in delving into the lack of data collection in Tasmania around birth trauma and wondered if you have some advice for the committee around what that should look like, what definitions you use in your screening tools that we might be able to learn from in making recommendations around better data collection around birth trauma.

We recognise, as our previous conversations at the table today have, that sometimes a woman might not recognise that what she's experienced is birth trauma, perhaps until a second or subsequent pregnancy and birth experience. That might cause her to reflect on what happened first time round and recognise that there was trauma experienced. I wondered if you've got any advice for the committee on those things.

Dr DWYER - A fantastic question, such a hugely important area. The reason why I think Tanya's smiling and directing to me is that I'm sort of a bit of a data nut. I'm very keen and Tresillian is very keen and committed to collecting adequate data so we really understand who we are supporting and who we might need to do more work with. So not only on who we're getting in the door, but how they go and how they travel.

At Tresillian, we've committed to screening using the Centre for Perinatal Excellence guidelines, which is the national perinatal mental health guidelines that have been updated last year in 2023. They've trolled through all the literature and reviewed the ins and outs of how to screen, when to screen, what do we know works and what doesn't work.

The basic approach at the moment for perinatal mental health, and birth trauma comes into it, one of the instruments is to use the Edinburgh Post Natal Depression Scale and the Postnatal Risk Questionnaire. In the Postnatal Risk Questionnaire, there's a particular question that says, 'Did you find your birth experience disappointing or frightening?' We have obviously that data for every family or parent that comes in and is admitted to Tresillian. I recall it's about a third that endorsed that indeed they did find their birth experience frightening or disappointing. I quite like that question because it's wide. It's not asking, 'Did you find it traumatic' because, like you say, some people go, 'No, it was just hard'. But then as you start to ask them more questions and then they might say, 'Actually, I do have nightmares about it', or 'I never want to have a baby again, it was so awful'. Then you start to be able to develop that relationship with them and they can be more open.

That is a great first question. I think Amy Dawes probably went into this. You obviously need to form that trusting relationship with someone to get a better picture. I think even asking a screening question like that gives you that opening to explore in more detail.

CHAIR - That Edinburgh Scale and Questionnaire, at what point is that usually asked? Is it very soon postnatally? One of the things we did also hear from Amy is the importance of longitudinal data collection.

Dr DWYER - In New South Wales they've developed a Safe Start Programme, which is supposed to be rolled out throughout all the public hospital systems where anyone who books in is screened. Certainly, in postnatally, they're supposed to be screened, but not everyone is using the Postnatal Risk Questionnaire where they ask that particular question.

The EPDS is more around depression, anxiety and doesn't ask about the birth at all. So, we use both of those. At Tresillian everyone who's admitted will be offered these screening tools and asked to fill them in, and that's in the admission process, which would happen within an hour or two of arriving.

CHAIR - Okay. At what stage are you seeing people? Are people sometimes drawing on your services a long time after birth, or is it usually pretty soon after?

Dr DWYER - It is zero to three for admission, and the Mental Health Service Model is looking at stretching us to zero to five. So, looking at those first 2000 days and really intervening as early as you can for that next generation, as well as for the parents.

Ms CRAWFORD - They come back as many times as they like; there's no limit to that. Sometimes we have people come straight to us from the maternity ward, and they don't even go home yet, if they've got particular vulnerabilities, and it's been recognised in the hospital that they might benefit from a stay with us. They can come back again when the baby goes through different developmental stages, or they felt like they got part of the way there to reach their goals and they would benefit from another visit.

So, the Edinburgh Postnatal Depression Scale, you can screen every seven days. It's asking about the last seven days. We wouldn't recommend that, but that's possible. Whereas the Postnatal Risk Questionnaire has a lot more historical information. It doesn't change as much. It does have some questions about your last 12 months. Of course, that can change a bit. But it asks things about your experience of your parent. Whether your mother was supportive? Whether you've experienced any abuse, physical abuse or sexual abuse, in your lifetime? All those sorts of things. It's designed to understand: do you have risk factors that could mean that you might experience a mental health concern post-birth?

CHAIR - Okay, thank you.

Associate Professor SMIT - The great thing about both these scales, that it doesn't have to be administered by a counsellor or anybody with counsellor experience. It's a nurse. So, it's on admission to a res or on registration to a day service as an ambulatory client. The nurses administer it. Long before the guidelines were updated, Tresillian took the decision to give nurses greater granularity in their clinical judgment with regards to when do they introduce the clients to the likes of Tanya's and Alice's teams, and it gave them the satisfaction that the marriage of the two of them, were in the EPDS and PNRQ, the Postnatal Risk Questionnaire, gave them the granularity to say, 'Okay, this is the threshold in which we include the multidisciplinary team'.

Ms CRAWFORD - The Postnatal Risk Questionnaire really covers like ACEs [Adverse Childhood Experience Questionnaire] questions. So, there's adverse childhood experiences questions. I mean it's not exactly the same as just completing that ACE questionnaire, but it covers quite a bit of it. It just has more detail and it's more specific to that perinatal period.

On COPE, if you are looking for it on the Centre of Perinatal Excellence site and their guidelines, they actually call it the Antenatal Risk Questionnaire with post-natal items. We just call it the Postnatal, yes, if you are looking for it and there is a dad's version. So, you can screen dads with the EPDS and PNRQ as well. They said that dad's items just have a couple of different questions because they did not experience - they did not have the birth, but they can have experienced it, yes, and the EPDS has different scoring thresholds for dads too as to what is considered indicating clinical indicators of depression or anxiety.

CHAIR - So, for the work that you deliver in other states, and I know you are about to start delivering it in the north of the state, we're very glad about that. Are there dads involved in those inpatient stays or in the outreach services that you provide or other non-birthing parents and same-sex couples?

Associate Professor SMIT - Yes. Every time.

Ms CRAWFORD - But there is only one admitted parent as such. So in the residential centres, one parent is identified as the admitted parent but the other parent can board and stay as well. In day services, as many people as they like can come to visit but one parent is the admitted parent. We are very father inclusive, we are very interested in fathers being involved and we present particularly some groups for dads to join. So like, Circle of Security Parenting groups for fathers.

CHAIR - Yes, I have read about that program.

Ms CRAWFORD - Yes, and we run our own Postnatal Depression and Anxiety group as well that is targeting mums but we have a dad's night so that they can come along and hear about how to support a partner with postnatal depression and hearing from them what it is like and we run some dads' groups in the residential units as well.

Associate Professor SMIT - That one was quite informal, the dads' groups in the residence, whichever dad is present of an evening, and we make it evening, because it is it is more accessible for them.

Dr DWYER - Usually there is the barrier of work hours and so on; usually, not always.

Ms ROSOL - I am interested in how the parenting line is going because I think that started earlier this year, am I correct in that? How is it going in terms of how many calls are you getting and what kind of requests are you getting? Yes, you have an update on the parenting line.

Associate Professor SMIT - Thank you. It kicked off 1 July, three months later, it is actually really slow. I have regular catch ups with Trudi Steedman as Director of Nursing and Midwifery for Child Health and Parenting Services, CHaPS. We are discussing options because the Healthdirect line for the Tassie parents is picking up maybe 100 calls a month. TasBub is really slow. We have peaked at three and this is on a helpline. Our other parents' helpline, we averaged between 1500 to 1800 calls a month.

CHAIR - From mainland callers?

Associate Professor SMIT - From all over Australia but primarily New South Wales. We would like that to pick up. Until the word is more out with the Tasmanian community, we know that neither Trudi, nor I, want to terminate the Healthdirect line, but we are in a position to pick up that capacity overnight when it is ready. From there, the next level up is, if a caller wishes - if a caller takes on board the strategies that are advised on the first call and then calls again for additional support, we can make an appointment for them and they can have a virtual with us and we still have that one ready to go anytime. But until our calls increase, we are not going to be able to offer the level two services for that to happen.

We have all the services, the CHaPS services mapped so every caller is linked back into their CHaPS local service. Generally, they're already linked, but if they're not, we ensure that they have somewhere else to go once the call is over.

So, yes, we would love to be busier.

Ms ROSOL - Thank you. You've alluded a little bit to that communication and mapping the service out, but if a parent calls you and you provide them with support, what are the reporting processes back to CHaPS? Just thinking about an integrated service that you talked about before, how does that communication happen? What information do you share between you?

Associate Professor SMIT - Right now we are collecting certain demographics, but, as I say, I think nine is a stretch goal of the number of calls, but it's demographics and it is the presenting issue so far has been breastfeeding. But, we would like all of that information to come back to Tasmania.

I would like - and I've just been speaking with Trudi about this - we want to start the work as soon as our contract is signed to get IT services that link the [Tresillian] Tasmanian services into Tasmanian health digital platforms so that the data sovereignty remains here. We've got that model in New South Wales, where in northern New South Wales we've got access into their systems from Sydney, so it's possible. We just need to help craft that between us and Tasmania. I certainly hope it will be in place by the time Launceston is commissioned. It's looking like maybe June next year. We'll see. We don't have a contract signed yet though.

CHAIR - Okay, I didn't realise that. I thought a contract had been signed.

Associate Professor SMIT - No.

CHAIR - So, potentially service delivery for the inpatient beds and the outreach will be a mid-next year start date?

Associate Professor SMIT -Yes, that's right. Yes.

Ms ROSOL - To follow up, I think that the needs are huge, like we're hearing about the huge needs. What do you think the barriers are to people contacting you?

Associate Professor SMIT -It wasn't long, maybe six months into a research project where we heard from regional families, because they used to have to go to either their GP or their equivalent CHaPS to get a referral to us. We felt that that was the best use of our resources, then we knew that it was people with complexities that were coming to us resistant to the universal interventions.

We heard from the regional families that they couldn't afford to pay the gap to go and see a GP just for a referral for us. So, overnight we wiped the referral system and they can self refer. Interestingly, we haven't yet had a person who thinks they need our help, not need our help. They're in the clinical range. Parents know best.

CHAIR - So, self-referral works?

Associate Professor SMIT - Yes. We've redesigned our parent helpline, where, in fact, they phone the parent helpline - one of ours - who will then on their behalf make a referral using our health professional referral form so that they're coming through our system.

So, I think access to free health at community level is an important one for those living with poverty and undisclosed poverty. That was the other thing: we made all of our groups free. There used to be a small fee. Thinking that that was a nice surrogate, that if you've paid a little bit of money, you're going to come for the eight sessions. We've got three therapeutic groups going at the moment, postnatal depression, Circle of Security, and in the fullness of time, Alice will talk about her particular one that's a pilot at this point in time, but it's sequential, it's sessional. That if they paid a little bit of money, they'd stay the course and we would use that money to pay for childcare. But, in fact, those who really were living in poverty didn't ask to waive the fee. They just didn't come.

So, again, overnight we made our groups free for that reason. Without knowing, that has been our experience in the regional services.

Self referral is a good one. Flexible options. Some will travel far on the first but not on the second or the third. We would like our day services structured. We would like that centre-based because that's when we can do the full screening. That includes if they are without their partner, from domestic violence.

Then, we would like to pursue them into their homes, at their invitation, to see if the strategy that we've recommended for their particular circumstance is relevant in their home environment before they return to us. We can only go to their homes if it's within 30 minutes because the return trip is one hour of non-productive time out of the day. There are exceptional times where we do move to an hour and a half, but that means there are two visits, sometimes only one visit, in the day. That's quite an expensive option but we are flexible in that regard. Otherwise, we do virtual if it's too far away, but we've had families travel for two hours to a centre to access the services in the regions.

So, flexible options, free at the point of service delivery, and trust. I'm inspired by all the Tresillian frontline staff who can so quickly develop that trust. We've done a lot, thanks to Tanya and Alice, really looking at trauma. There is a program called My Early Relational Trauma Informed Learning (MERTIL) and all of Tanya's team have been trained in it at Tresillian's expense. We are making it more and more available because to come with a trauma lens means that a parent that you would view as oppositional is actually not. They're just defending the risk that they are not willing to share with us yet.

CHAIR - Because of the trauma.

Associate Professor SMIT - Because of the trauma, yes.

And, of course, we've got so much to learn from the Aboriginal and Torres Strait Islander communities. Our research project showed that we've got to take the time, we've got to have very big ears for the longest time before we jump in with options or wait to be invited in with options. I truly believe if we get it right with the Aboriginal and Torres Strait Islander communities, we actually get it right for every community after that. We have some experience in that regard as well. I don't know if there's anything that you would -

CHAIR - Anita, you had your hand up.

Associate Professor SMIT - Was there anything else?

Ms DOW - I wanted to ask you about the model of care for the northern beds and the outreach service that's proposed for north-west Tasmania and to other regional centres from Launceston by the baby bed unit. If you're saying that you don't travel - I think I heard you correctly when you said about the lost time in travel - how will you deliver that service to women, for example, on the west coast of Tasmania, or King Island, or up to the north-east around Scottsdale, Derby, those areas? How will that care be rolled out across the state?

Associate Professor SMIT - An option around virtual, but also we have established things called satellite clinics where we go for the day to a bricks and mortar place and offer services out of that place. The distances in Tasmania are quite far. Recruitment in the local area, who will be managed by the hub and the spoke, which is what we have now as well. We have mobile vans in regional New South Wales that could be the equivalent of a satellite. Say, Burnie, find a shopfront or a fit-for-purpose housing stock, whatever that looks like, and that one person would operate a service out of there under the supervision of, the managerial supervision, of a nursing unit manager. We have a very well-developed clinical supervision framework for nurses and midwives because the vicarious trauma, if not managed, can be quite debilitating. The idea that we would run satellites, and that's what I'm looking at certainly from Launceston and Burnie in the first instance, but working really closely with CHaPS to see how else we can work with them to provide services.

They are already providing a Level 2-3 type with their extended home visiting program; these are clients that have multiple vulnerabilities. We've got something similar. We're not looking to duplicate or trounce any services that Tasmania is already offering. I'm in particular looking at staff training for the CHaPS extended home visiting program because our extended home visiting program provide mastery in certain tools for the nurses and midwives which we would be very keen to provide for the CHaP services.

So virtual, for areas where people cannot travel from, we already offer a virtual residential parenting service which mimics closely a face-to-face residential service. In our proposal for Launceston, we are looking to offer that in parallel with the face-to-face services out of the Launceston hub. That has been very successful and it's currently being evaluated in New South Wales. We're coming into the year of evaluation. It's not cheap: nobody saves any money because you still need the intensivity around the nurse clinician, the mental health clinician and the GP. You might save on night duty because the night duty for the face-to-face also provides a service to parents who are on the virtual program, if they need any services overnight.

Ms DOW - At the Launceston hub, will you have a multidisciplinary team or will that be mostly nursing based?

Associate Professor SMIT - Yes, we have a partnership with Gidget Foundation Australia, but also Tanya and Alice, and with Ann DeBelin and the clinical nurse consultant head up the PIEC-MH team where the criteria for their services is really very complex. Gidget is not that complex. We have experienced that if there's active domestic violence, if there's active substance use, for us active substance use -

Dr DWYER - Part of the territory.

Associate Professor SMIT - Provided they're not impaired -

Dr DWYER - Yes, as long as they can engage safely.

Associate Professor SMIT - Whatever impaired means. That's right, yes, some of those are at a very high tolerance for risk.

Ms CRAWFORD- Suicidality, a child over 12 months, Gidget only sees them up to that -

Associate Professor SMIT - Yes, so we'll pick up what Gidget doesn't. Definitely multidisciplinary -

Dr DWYER - Including psychiatry -

Associate Professor SMIT - Including psychiatry.

Dr DWYER - Social work, psychology, group, individual, we can review medications. We are actually in the middle of updating the service model, so when it's updated, more than happy to share. It's very much looking at that no wrong door approach. The wonderful thing about working at Tresillian, what I love, is the vision, which is every child has the best possible start in life. All the work we've done, Tanya, Ann DeBelin and I have done under Jenny's guidance and leadership has been very much around how can we meet the needs of those who are currently missing out. That goes to the missing middle, it goes to those who have those complexities that need multidisciplinary care. They do need a specialist mental health review and they do need often perhaps the GP to be aware as well as psychiatric review.

Unfortunately the sad reality is that the perinatal period is usually when something like DV actually becomes more common, rather than less. So we really try to capture when we can, when they're right there with us. They've called, they've said, 'I need help'. They often say, 'I need help for breastfeeding', or sleeping and then we start to ask questions and we find there's a bigger story.

And we really want to try and, rather than say, 'Oh, we'll go and see them' or 'We don't do that', we really want to say, right, they are right here. This is such an opportunity to intervene early, get in there early, give them that wraparound care. Happily, we're not saddled with the Medicare model because Tresillian has generously invested in providing the mental clinicians and psychiatric support. So we're able to be flexible and really respond individually.

Because sometimes people are like,' Well, I can't come every week', or, 'Unfortunately, I can't leave the house because my partner's here and he doesn't want me to', and we're able to work around that to try as much as we can - we are obviously never going to be perfect - to meet the person where they're at, always with that lens of what's happening in that relationship with the next generation.

So, the reason why I love this work is just you can do so much good, not only for the person sitting in front of you, but to shift that trajectory for the next generation. Which, not that it should all come down to economics, but that's a huge government saving as well. Rather than saying, 'Oh, why don't you go and see them?', and then they don't do it because they're frightened, they don't want to retell their story, particularly when there's trauma. They can't get to a GP to get a mental healthcare plan because there's no one available or it's too expensive, and it seems like a missed opportunity. So, we're really trying to build those principles in to say where -

CHAIR - To keep people engaged?

Dr DWYER - Yes. This is a real opportunity and it kind of kills me when sometimes, obviously, that can't happen or they've left early, and that's just how it is. But we're really trying to build that awareness and capture them when they've said, 'I'm not coping'. So yes, it's very exciting.

Associate Professor SMIT - The focus on the infant, infant mental health is a new term. I don't even think 10 years ago people were using it as freely as they are now. But to think that a child is so vulnerable, so responsive to the risks that it's exposed to at the parental level. Finally we are really understanding that no child is safe in an unsafe environment. It's all about infant mental health. Even perinatal mental health is about infant mental health.

Ms CRAWFORD- I think, and particularly in New South Wales, child and adolescent mental health services often fund the perinatal infant mental health arm of the work. That's where I came from before Tresillian. It's really an adolescent's mental health that starts in the perinatal period, it really does. We, in particular in the last 12 months, have invested a lot of training and supervision and expertise in our team in working in the infant mental health, which to some people sounds very strange. Like, what is an infant's mental health and how do you know when an infant's mental health isn't good? I suppose for some people you can say, well, it's when they're coming to a service like ours because they're not sleeping, they're not feeding, they're not settling, they've got what a parent might consider a difficult or challenging temperament. But it's very much a symbiotic relationship. The regulation of the child's emotion really comes from the parent and it's this co-regulating relationship.

So, that infant mental health starts with the nurses doing that work that they're doing around the parenting support, and we're all working together so well, really, to support that infant and early childhood mental health to give them the best start. I know it sounds like it's in our vision, but it's actually true. That's what we're working towards.

Dr DWYER - We just did some data collection around the people we're asked to assess in Tresillian. In terms of giving you a sense of what we're picking up, and this is obviously New South Wales-specific, but we've got only 50 baseline scores, but about 20 per cent of them reach criteria for complex post-traumatic stress disorder. That's not just birth trauma-informed. It's usually childhood trauma as well. Then another about 38 per cent report low self-esteem, poor emotion regulation and poor relationships, so it's about another 35 per cent or so. Then the rest probably have - and I don't mean to be dismissive when I say this, but probably standard anxiety or depression, which is a bit less complicated. Still deserving of attention and, obviously, we look after them as well.

But I think the data also showed that those with the more complex needs, their parenting, the scores were much lower, quite dramatically lower. We use a Me as a Parent scale on admission. If someone's around 60 or lower, things are a little bit in trouble. The average for all of them were 60s, which is what we expected. But those with complex trauma and disturbances of self-organisation, their average was 45, which is quite dramatically lower. The ones with the self-esteem issues, and so on, was about 52.

We see quite a range and, happily, we're supported to provide for all of those parents. We want to be as holistic and as integrated as possible. Again, that's the no wrong door approach. What's wonderful, because we have that multidisciplinary team, I have nurses coming up to me saying, 'Oh, you know that mum that I was chatting, something's just not quite right', or 'They weren't really attending to the infant', and we're able to get a lot of different sources of information and really have that sense of holding that family. That lifts our capacity to understand what's going on. We can share insights across our different professions. I have just had these fantastic conversations and I'm, like, 'Oh, that is so interesting because I didn't see that'. Then the next time I might see that person and it's like, 'Oh, yes, okay, and I might just ask a bit about this', and -

CHAIR - Through a demonstration of the non-failure of the multidisciplinary style of service delivery.

Dr DWYER - Yes, and it's a real feeling professionally, and the staff have also fed back, being able to share that load, too. Because sometimes some of these families can be quite confronting. Jenny has talked about vicarious trauma. To be able to say, 'It's okay, someone's got my back as well', we really try to build that culture of safety in the team and for the whole organisation.

Ms DOW - My question is in relation to what you just said about trauma for health professionals as solo practitioners. I didn't really get anything specifically around the model of care for the north-west. If it's one solo practitioner, I guess that sends alarm bells about the sustainability of that service and whether they will actually be supported by a multidisciplinary team. I want to clarify again that there won't be any face-to-face services provided across the north-west of the state by your service; they'll all be via telehealth. Is that correct, to more rural and remote areas?

Associate Professor SMIT - It comes down to funding. We've got these wonderful mobile vans. So, that's the dream, that we actually do have a mobile van that goes to these remote areas. We've got six of them in New South Wales. Our original one really took, we learnt so much from that original one about community engagement and where best for the route. That van now has a reliable, predictable, whether their clients booked in or not, route where they attend the same areas every week. Over time, they are pretty fully booked in those sites. The vision for the remote areas in north-west is to have a mobile van, if we do establish satellites. All of this is to be worked through. You've seen our proposal and you know what is possible. We are very aware of sole practitioner -

Ms DOW - During the election campaign, the state government announced that there was going to be a commitment to mother-baby beds in the north of the state and there would be an outreach service. I'm trying to understand - you said that you don't have an agreement with them. Does your agreement include servicing via the buses, or is the money that's on the table for the service not going to stretch that far? I'm trying to understand exactly what services being committed to by the state government will actually look like when it's delivered on the ground, particularly in rural and regional areas?

We have heard through this committee, we have only been having hearings for the last couple of days, but there is a dire need for additional support across rural and regional Tasmania. I find that concerning, as a rural and regional Tasmanian, that the model that's been proposed by the government doesn't really appear to be clear that it will in fact service this area. I guess that's the background to that and why I want to understand more clearly about what's actually proposed and possible for the north-west of the state.

Ms CRAWFORD - A van has already been gifted for that area.

Associate Professor SMIT - The work that's happening with Launceston hub now is for a face-to-face residential parenting, a virtual parenting residential program and a satellite to Burnie; I envisage that as phase one. In working with CHaPS to see how else we can extend ourselves, and them, in areas where the need is great because we totally are aware that regional and remote have vulnerabilities and needs. Nobody thinks the metro families are well resourced until you move into regional and remote and you realise how privileged the metro families are. I'm very aware of wanting to move out there.

Just to address, I understand about alarm bells for a sole practitioner. The satellite to Burnie, there is a fair amount of travel, but if we could recruit locally, it would be more than one clinician working with the families, we would need to understand what the demand was. The clinical supervision is a framework that we have developed, and in fact, it's run through the CNC-Perinatal and Infant Mental Health. It's based on a FAN [Facilitating Attuned Interactions], where it's an attuned program where you ground yourself and then check in with the other person. We have modified that for the Tresillian context, so that staff attend regular, at least weekly, supervision series that's made available throughout Tresillian.

Ms DOW - That's one of the issues that, particularly, in this part of the state, there are significant shortages of midwives in the first instance, and even the ability to recruit people and a high turnover due to burnouts. That was one of the things I wanted to understand, whether that person would be well supported in that role. The last thing you want to do is introduce a service and then it not be sustainable.

Ms CRAWFORD - Could I respond to your question about vicarious trauma?

On the ground we would have some nursing staff who provide the parenting specific side of the service. But we also have mental health clinicians who are dedicated to provide that support to the clients who meet the criteria for mental health service as well, in New South Wales. I suppose what we're saying is, what's happening in Launceston and then potentially the rest of Tasmania is yet to be determined but this is what we already do in New South Wales and the Australian Capital Territory. We would expect to have similar sorts of services depending on what happens with contracts but, a nurse is not left with those complex families that we talked about, all on her own. There are mental health clinicians to provide support.

The way we manage that in New South Wales is we just find them from somewhere. Even in the ACT where we only have a couple of mental health clinicians. The nursing manager from QEII [Queen Elizabeth II Family Centre] in the ACT called me up on Friday afternoon and said that they have a parent who's just admitted to some suicidal thoughts and our clinician isn't here today, what help can we get? I just worked with them myself, but we find someone. We just find our available resources. That's our clinicians on the ground. We've got 17 or 18 of those and we will find them to provide that kind, someone's at risk right now or has quite moderate or severe mental health concerns, we'll do that assessment, make sure they're safe, support the nurses as well. That's a big part of my job and Alice's job and the CNC [Clinical Nurse Consultant] who does perinatal and infant mental health is to make sure the services are there for the parents and support the nurses. We're just on call too. They ring us, we support them, and we follow up with case review and case conversations to make sure that we covered everything off, that everyone was safe, that the staff feel okay and then how can we do things better in the future?

We are doing that all the time. I guess it's partly because we are this nimble organisation where we don't have this big layer of managers who aren't clinicians. They're all doers. All of us are nurses, psychologists, doctors, social workers, and therefore they call their managers and we're all a clinician as well and can do what needs to be done. We'll never let someone go without getting a service.

Ms DOW - Can I just ask one last question? I want to understand when you think that you will have the contract finalised? You said that the beds should be available by mid next year but you know the contractual arrangements about what service delivery will look like. When do you expect that to be finalised?

Associate Professor SMIT - I know it is a top priority with the various ministers at the moment. I have that assurance, so what can I say?

CHAIR - Well, we've just had a ministerial reshuffle in the government. Hopefully it will be a higher priority, we are hoping.

Associate Professor SMIT - Minister Barnett made a commitment to that, that this was important to him. Even in the new portfolio, he'll keep an eye on things and certainly the handover to the new minister for Health.

CHAIR - She was a member of this committee until today, so we know that maternal health is something very important to her.

Ms JOHNSTON - The committee has heard loud and clear there is a really strong demand in Tasmania for the service that you provide recognising that limitations of government funding provided and four beds in the north in particular. How do you triage the demand that the community is probably going to bombard you the minute you open your doors? How do you triage that?

Associate Professor SMIT - We have our priorities already set out. We have well evidenced and established criteria for priority one, which is an admission within one week.

Ms JOHNSTON - Who decides that? Do you decide or the referring doctor?

Associate Professor SMIT - No, we decide based on history and the parents, given that they do not have to have a referral. That priority setting is made by a Tresillian nurse at the end of the phone because they will phone TASBUB hopefully. That will then set that criteria. We have KPIs that we have set ourselves about how to manage it. There is a smoothing of demand through Day and Residential. Day is at a level two, where the throughput through that course is much higher. You can have three families through a day for a day service as opposed to four families a week through the residential. There is an ebb and flow through the residential and the day. It hasn't been our experience that we are absolutely inundated from day one because the pathways and acceptance by the community is still to be established. I'd be happy to be proven wrong.

Let's remember also smoothing the demand through to the level 2 for the TASBUB to hold them while they wait for a face-to-face.

Ms JOHNSTON - With the services you'll be delivering in the north, and your triaging of that into priority 1 particularly for those residential beds, is there a requirement those people live in the north?

Associate Professor SMIT - No, it's statewide.

Ms JOHNSTON - Anywhere statewide, right.

Associate Professor SMIT -All our beds, all the time, have only ever been statewide.

Ms JOHNSTON - Okay.

Associate Professor SMIT -They're prepared to travel; the doors are open.

Ms JOHNSTON - My final question is - as I expect there will be significant amount of demand on you from day one - what's the mechanism for feedback to government about that demand? If you can't meet the demand on day one, or day five, or two months later, or six months later, what's the mechanism you give to government in terms of feedback about the level of demand in Tasmania for your services?

Associate Professor SMIT - We always have KPIs that we work to. Waiting times is an important one. Meeting our KPI for priority 1, 2 and 3 is another one. Presenting issues. In terms of flexible options, if our waiting time is blowing out, we can bring in a family. Through day services. We can bring in families with a similar, so-called, simple presenting issue. All breastfeeding, or all sleep and settling. We can run clinics and for some that'll work before the the more one-on-one intensive consultation starts. So, flexible options.

Regarding our feedback, we're tightening up quite good reporting mechanisms on those KPIs. However, the Tasmanian government, minister for Health, will establish - because we've got the same reporting mechanisms in NSW where we are accountable for the KPIs.

Ms JOHNSTON - Can I squeeze one more question here, sorry? For those accessing the residential services, is there a timeframe in which they have to depart, or are they there until they're ready to walk out that door and have all the wrap around support? Is there a timeframe around that?

Associate Professor SMIT - Generally, it's four nights, five days, but, if they need to return - and some do as Tanya and Alice's teams know, domestic violence - sometimes it takes a while to engineer a separation into safety for that parent and child. Tresillian services can be used for that, so, a repeat visit in between times and there's no limit on that.

Ms CRAWFORD - They can ask for an extended length of stay. That does happen quite a bit for families where, perhaps, it takes a little while to get into the swing of it and the goals that they're trying to achieve. On that first admission, they talk about what they want to achieve at the stay, whether that's day service, virtual, or residential. If there's extra complexity or risk issues so long as there's space.

But, we do have because of illness or other reasons, people sometimes cancel their admission the day before or even the day of at times, so, we do find that we'll have a space for whatever reason. There are people who we would identify to offer an extended length of stay, but that's usually still seven days, not -

Associate Professor SMIT - That's a seven-day service where it is just continuous, whereas this initially will be a five-day service. I think that would be the other option to additionally fund. When you go from a five-day service to a seven-day service, you actually increase your throughput by up to 90 per cent. It's not double, but it's surprisingly bigger. You wouldn't think in those extra three days, but, you know that last day, the Friday, it's effectively four nights, four days. With that continuous service, you increase your throughput by 90 per cent.

CHAIR - I hate to draw us to a close, but we have run little bit overtime and our next person is waiting online - the next one's online. Thank you very much, all of you, for attending. It's been really informative. We're all looking forward to that service beginning in the north of the state. If there's other things you'd like to share with us after today, you might think of things that didn't come up in the conversation, please feel free to get back in touch with us via Mary.

THE WITNESSES WITHDREW.

The Committee suspended at 12.03 p.m.

The Committee resumed at 12.07 p.m.

Ms **KELLY LANGFORD**, VIA WEVEX, MAMA FOUNDER AND MIDWIFERY WAS CALLED AND EXAMINED.

CHAIR - Thank you very much for joining us online. My name is Ella Haddad, I'm the Chair of this committee. I'm joined at the table by Kristie Johnston, a member of the committee, and online, along with you, we have two of our northern members, Cecily Rosol, who is a member for Bass and based in Launceston, and waving to you now, and Anita Dow, who is a member for Braddon and based on Tasmania's north-west coast in Burnie.

Could I ask you please to state your name and the capacity in which you are appearing before the committee?

Ms LANGFORD - My name is Kelly Langford and I'm an endorsed midwife and founding midwifery leader of Victoria's first private midwifery clinic, MAMA (Mothers and Midwives Australia).

CHAIR - Thank you. Can I confirm you have received and read the guide sent to you by the committee secretary?

Ms LANGFORD - I have, yes.

CHAIR - As you've heard, having watched some of the earlier hearings, you're protected through this hearing by what's called parliamentary privilege, which means you can speak freely and honestly with us without any fear of any legal ramifications. That protection doesn't extend if you did make statements that could be considered defamatory and you refer to them or repeat them outside of these hearings.

That said, if you would like to give any information to us in a private setting, you can ask for that and we can have a short deliberative meeting. We can go into a private session called in camera. The broadcast, in that instance, would stop and you can share information with us privately. If that comes up through the course of conversation, please feel free to ask for that.

We've also agreed, as a committee, to share a short sensitive content statement because of the sensitivity of a lot of evidence that's been shared with this committee. We're very grateful to the many people who have been generous to share their personal stories. We now know there's lots of people watching online and, from Monday's hearings, we did have members of the public in the gallery with us.

We recognise, as a committee, that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. The committee encourages anyone impacted by the content matter during this hearing to contact services and supports, including Lifeline on 13 11 14, Tresillian's Parent Helpline on 1300 827 282 and PANDAS National Helpline on 1300 726 306.

With those formalities completed, I invite you, if you would like, to make an opening statement.

Ms LANGFORD - Yes, sure. First, I wanted to thank the committee for asking me to speak because it's quite a privilege and honour to be able to speak on behalf of clients and colleagues of mine that birth trauma is such a big issue and it's something that we interact with on a daily basis in our profession. So, thank you, to start off with.

I wanted to give you a bit of context as to where I'm coming to the table from. I graduated myself 16 years ago and worked for a year in a major public maternity hospital in Melbourne. And by the end of the year, I was ready to leave midwifery due to moral distress. So, my midwifery journey started off being quite distressing. I suppose throughout the year I realised more and more that I wasn't able to provide the care that I had thought I would be able to give in the hospital setting. And just so many moments in my grad year that I remember that I did things that I was told to do or follow policies that just didn't feel right. I know that I'm not alone in this feeling, that there are many midwives that work in the system that also feel the same way, and that we lose so many incredible practitioners for this same reason.

But I was lucky enough that I was invited by privately practising midwife to mentor me into private practice the year after my grad year. It was an incredible opportunity for me. I had two mentors that had over 60 years of experience, and I felt very safe to step out of the public maternity system. Of note, both of my mentors themselves had had previous birth trauma and that's what spurred them into private practice themselves.

So, from the beginning of my career, it was really evident that this was something that made people both want to support people in a different way, but also was very inherent in the care that we were providing, or in the care that people were receiving.

In 2010, my mentor and I saw the maternity reform changes and went through the endorsement process. Then in 2011 we opened MAMA, Victoria's first private midwifery clinic. Since then, we've had over 2500 clients that were supported to birth. Over 50 per cent of these people had birthed before, so we've got probably a large proportion of clients who are coming to us in their second or consecutive births. A lot of them had had their first birth in the standard public or private obstetric system, so they are coming to the private midwifery setting through a previous birth experience in the public setting. A large proportion of these clients would have described their previous experiences as traumatic. I could tell you hundreds and hundreds of stories that I've personally heard that have been relayed to me through boxes of tissues and tears in our consulting suites. It's extremely distressing to hear but, of course, even more so to live through that. Also, many more distressing situations that I've supported women through in my role as a midwife, standing next to women in the hospital setting.

In my experience over the years, the trauma that people describe is not about the type of birth or the place of birth but, actually, just around the way that they were supported or the way that they felt they were able to make decisions, and whether they were getting consent for the decisions that they were being asked to make.

Some common themes I wanted to highlight: a lot of women are saying that they leave their dignity at the door when they step into a birthing suite or, 'thank God they did this, otherwise me and my baby would have died', which is a really common thing for women to come out of birth feeling like or saying. But in reality, the actual number of women or babies that would have faced death is much lower than what people believe. It's actually just a perceived idea of this life-or-death situation that they've just survived, coming out of that sort of trauma survival state. A lot of women describe out-of-body experiences, so dissociating through birth, which is a big PTSD flag, the people who dissociate.

In our practice, we support clients to birth at home where appropriate. But a large proportion of our clients choose to birth in hospital, and in that setting we are there as support people. We've proactively chosen not to go down the path of visiting access because we did go down that path a few years ago but came to realise that there were a lot of restrictions and policies that we would have to adhere to that would counteract the ability for us to provide the evidence-based trauma-informed care that we are currently providing. So, we currently don't have visiting access at our public hospitals.

But we do have a multidisciplinary care team. We currently have three clinics in Victoria and 10 midwives who provide continuity of care, a women's health physio, two counsellors who are birth trauma-specific, and all of our clients have access to a visit with them during their journey with us because our whole mission and the reason that we opened was off the back of my mentor, who's just retired this year, and her traumatic experience and she never wanted that to happen to anyone again.

CHAIR - Thank you for being so generous in sharing what's obviously a deeply personal story. It's similar to stories that have been shared with the committee both at our hearings on Monday and also in written submissions from private practising midwives who specialise in homebirth support in Tasmania. I think that often the pathway into delivering that kind of care can be personal experience, as you described from your mentor's experience.

I'm interested in where you finished off. You said you support women to birth at home and in hospital. I'm wondering whether there are birthing centres as well? There is really only one private birthing centre in Tasmania. Is that something that's a feature of Victorian maternity health?

Ms LANGFORD - No, all the birth centres have been absorbed into the labour wards.

CHAIR - Into hospitals?

Ms LANGFORD - Yes.

CHAIR - We heard on Monday from a retired privately practising midwife who talked about the challenges of not having admitting rights in Tasmanian public hospitals. You've described that almost in the opposite way to what we heard on Monday around the difference between being a support person versus having clinical capacity in that role. Can you talk us through the difference between those two roles in a bit more detail and what the experience of your organisation is in terms of supporting women to give birth in hospitals?

Ms LANGFORD - I can absolutely see the benefit of being credentialled in a hospital, but the way that the public hospitals that we were working with had the criteria and limitations, and also the financial limitations of the model that we were presented was not going to work for us. I'll talk, I suppose, to the hospital that we were working with, and I know that it can vary across different models.

When we were first wanting to access visiting access, we weren't able to get information around how much the hospital would be charging the client and what policies and procedures would be in place for the clients that came under our care. It was only once we got the contracts that we were given the information about how much the clients would be charged, which was three times the amount that another public hospital that had visiting access were charging. It was quite a surprise to us, and we quickly realised that clients wouldn't want to pay that substantial extra amount because we couldn't afford to reduce our fees to absorb the amount that the hospital was charging. So, that was quite a surprise. I think the hospital keeping their fees down is a key part to that model working.

But also there was criteria in the paperwork that was not going to allow us to visit the clients in their homes before they came into the hospital, which is a large part of the care that we provide at the moment. It is when clients are in early labour we visit them at home and provide some care and tuck them up in bed when they're in early labour and leave them again. That was something that was not going to be permitted in the credentialing model.

And also then having the policies and procedures as what we would be bound to in the practice. I understand that we can still talk to clients and give them the ability to make decisions but I think that having those policies and procedures as what we needed to talk to as the first line of, you know, recommendations for induction or whatever else the recommendations were, were going to change the way that we spoke to our clients about particular things.

So I think, at the end of the day, when we looked at the increased cost, the fact that we wouldn't be able to visit clients at home, which is a large benefit of our model at the moment. And also the restrictions that we felt the hospital policies and procedures would put on the information that we could give to clients, we just thought it will actually end up being a model of care that isn't as good as what we can currently provide, which is all those things at a reduced cost.

When we step into the hospital at the moment, we are there as, we become support people, so we're not officially recognised as midwives, which means that it's hard from a moral perspective as well that we walk in and then suddenly we're not health professionals any more. I understand that from a legal standpoint. But it does mean that we can continue to give the information that we have available to us, the best evidence that different hospitals practise different things, that we can still continue to practise in the way that we currently do and not feel restricted by policies and procedures.

CHAIR - Okay. Would you say the majority of women who come through your practice opt to give birth at home, and it is only if complications arise that you end up in the hospital setting? Or are there some who choose the hospital setting and your support from the beginning?

Ms LANGFORD - It's changed over the years. In the first nine years or so of opening, pre-COVID, we had about 70 per cent of our clients planning to birth within hospitals, so it was only about 30 per cent planning to birth at home. We have about 200 birthing clients a year. The majority were still planning to birth in hospital with us and we've formed really great relationships with the hospitals over the years because we have been there a lot. But since COVID, it's actually changed a lot. Since a lot more of the hospital homebirth programs have come in and the general perception of homebirth is starting to shift. We see about 50 to 60 per cent of our clients planning to birth at home at the start of pregnancy.

CHAIR - I might just ask one last question before opening it up to my colleagues. We're the only state in Tasmania that doesn't have publicly funded homebirth services. I wondered if you can share with us a little bit about how publicly funded homebirth works in Victoria, so that we can learn a little bit about what Tasmanian women are missing out on by not having those publicly funded services here.

Ms LANGFORD - Yes, it's incredible having publicly funded homebirth programs because there's such a large portion of the population where having a homebirth is a safer place for them to birth. We know that from evidence. So having the hospital offering this just, you know, brings it into the public eye and people can actually view it as a safe option. If the hospital is offering it, it must be a safe option. So it's wonderful in terms of cost savings for the public healthcare system because it is a much better, more cost effective model of care, but also for the women going or women and birthing people going through those services. It's free, compared to the private midwifery model, it's accessible, but also it's a very trauma informed, wonderful continuity model that has to exist for that home birthing service to exist. We have five hospitals currently providing public homebirth services.

There are quite strict criteria on the publicly funded homebirth models, which I understand why it exists and that differentiates the public models from the private midwifery models. There's still work that can be done. The oldest model in Victoria is Joan Kirner Sunshine Hospital. They have incredible statistics and they're slowly starting to increase or change the boundaries of care because they're seeing how safe it is and they're adding things to the program, so the longer the program runs, the better the model gets I think.

CHAIR - Thank you, I open it up to anyone else around there.

Ms JOHNSTON - Thank you very much, Kelly, for coming along today. Can I just get you to elaborate on that? I think I interpreted you right - the final point you made there, but the difference from those accessing a publicly funded homebirth and/or privately funded homebirth and the restrictions, I think it was a word you used around what the hospital allows those publicly funded people to access. I'm assuming it's a risk factor from the publicly funded hospital program that they're assessing. Is that how it works?

Ms LANGFORD - Yes, it is. There is certain criteria that are inclusion and exclusion criteria at the start of pregnancy. But, officially, no one is accepted into the homebirth program until they've had - well, they're accepted in, but they're not confirmed that they will be able to birth at home until they've had a 36-week obstetric visit. So it's quite a long journey for those people going through the publicly funded homebirth programs to have that confirmation at the 36-week visit. We quite often have clients coming to us at that point saying 'I thought I was in, but I'm out. What can I do now?' kind of thing.

So there's certain criteria that definitely risks people out of the public homebirth programs, but the criteria that don't allow much wiggle room for practitioners to look at the individual case and figure out if this individual is safe to have a homebirth rather than a criteria that just risks a population out. One example might be if they've had a previous postpartum haemorrhage. They would be risked out of a lot of the hospital models of homebirth. But if you look in the notes of people who have had a postpartum haemorrhage, sometimes it is very clearly stated that was from an episiotomy that was cut and so you could rationalise that if another episiotomy is not cut that that person maybe not at a high risk as someone who had a physiological birth that had no intervention, that also had a PPH [post partum hemorrhage]. So, I think the criteria is quite strict and does risk people in and out from the outset.

Ms JOHNSTON - That uncertainty that people might experience up until, I think you said 36 weeks, where they kind of ruled in or out of the program, do they still get continuity of care through your service up until that point of 36 weeks? And then, if for whatever reason they can't continue with a homebirth, are you able to then continue on in a supported role in a hospital birth?

Ms LANGFORD - Well, we're a private service so we don't have that same risk in and out criteria. We have guidelines from the Australian College of Midwives, we have evidence from all around Australia and around the world to guide our practice but we don't have the same policies and protocols as a public hospital setting. If a client is going through the public homebirth program, they're seeing the midwives for continuity throughout the pregnancy and then get confirmation or not at 36 weeks that they can stay in the program or that they have then the option to birth in hospital with those continuity midwives.

Some people find themselves in a situation where they can either birth in hospital with their continuity midwives or find another option. So it's these people that are sometimes coming to us at 36 weeks saying, 'I thought I was having a homebirth and this is where I would really like to birth, but I've been told I can't any longer'. So there for some people, they're either seeing their options as accessing a private midwife at 36 weeks or free birthing or birthing in a public hospital.

Ms JOHNSTON - So, it's the hospital providing the home birthing services, but the midwifery services rather than a private practice midwife providing those services for publicly funded.

Ms DOW - Thanks, Ella, and thank you, Kelly, for joining us today from Victoria. With the hospitals that do the public homebirths, are any of those situated in regional areas? Are they all metropolitan based hospitals?

Ms LANGFORD - Geelong Hospital is the most regional. The other four are in metropolitan Melbourne.

Ms DOW - The other thing I wanted to ask, obviously you'll be a fee-based service being private. What is the cost to utilise a service like yours? Obviously people with private health insurance - that's different, but the upfront cost?

Ms LANGFORD - Yes, it varies based on practitioner and service but for our homebirth client, anywhere from $5000 to $12,000 out of pocket. There are some Medicare rebates available or we mentioned private healthcare rebates available. That's an area that is really limiting and makes it not accessible to everybody.

Ms DOW - How many women and families would you have on your caseload at a given time?

Ms LANGFORD - We've fairly consistently since 2014 had 200 births per year. So yes, that's where we've sat, and we have 10 midwives now that are providing that care. Some of our midwives have smaller caseloads than others, work part time and full time and that's a new model of care that we've instigated in the last two years because burnout in the private midwifery space is, as you can imagine, fairly hefty and midwives find working seven days a week on call not sustainable.

We actually have an employed private midwifery practice model where the midwives work whatever EFT that they are able to.

CHAIR - Kelly, I wanted to ask if you could expand on something that you've mentioned at the end of your written submission, which is around the models that are used in Sweden and New Zealand. We can go away and do that research, but I wondered if there's any particular elements of the care that's provided in those jurisdictions that you see as best practice that you would like to share with the committee or point us to.

Ms LANGFORD - The main things that I see different in those countries to here is that the model is based on what the woman would like. I suppose the funding follows the birthing person and is also based on midwifery care being the standard model of care, and if any obstetrical medical care is needed then they're, the midwives, who are also consulting with those practitioners.

I think everybody is treated as a normal physiological pregnancy, and then, other practitioners are consulted and used as they are required. Also, that the system really does include and support birthing in different settings - homebirth, public hospital birth settings - and that midwifery continuity of care is just part of the normal care. So everyone has access to it, to a known midwife, in a setting that they feel most comfortable birthing in.

CHAIR - Is that in the public health system, do you know? I don't know much about Sweden's healthcare system, but I think New Zealand has a mix like we do.

Ms LANGFORD - Yes, I am pretty sure Sweden is; they have very high tax, but they all get good healthcare.

CHAIR - In New Zealand is that midwife-led model of care provided through the public health system?

Ms LANGFORD - It is, yes, the funding follows the birthing person. They get allocated a certain amount per birthing person, and that gets split up through the health professionals that she needs to see.

CHAIR - Continuity of care is something that has come through really strongly for us in the written submissions and the hearings that we have held so far as well. Particularly, in the public system here we have a real fragmentation of care and women seeing a different person each time they go for different prenatal checks, and that can obviously lead to the opposite of very woman-centred and patient-centred care.

We are keen to hear about jurisdictions that provide that continuity of care in a more successful way, that ultimately, probably, reduces things like birth trauma and uninformed consent procedures. If there is continuity of care from health professionals through the prenatal period, it is more likely, I think, that women's wishes are going to be known and understood by their healthcare professionals.

Is there anything else that has not come up in our conversation that you would like the committee to hear about?

Ms LANGFORD - I think starting the conversations right at the start of pregnancy is really crucial; it is really important for people to have informed decision-making. Having GPs understanding what the different models are and what is available to people, having people understand what the likely outcomes are of walking into different settings, is really important. A lot of what we hear is they are finding this information out at the end of pregnancy or after birth that they did not know beforehand and felt that they were not informed or empowered to make decisions, because they just assumed that they would get all of the information and choices.

I think, just having everybody understand what all of that is, it helps having the key health professionals who are providing the care understand that. Also, we are not aiming for enough in our maternity care system. That having a live mother and baby at the end of it is just not enough. We really have to support families and birthing people to come out of the experience feeling empowered, or at the very least, like they made choices. Because going into parenting after that huge transition, and arguably, one of the most important transitions in life feeling disempowered, really, just affects everything, all parenting and everything in life.

Ms DOW - I have had a look at the service that you provide and obviously it extends postpartum as well. You provide breastfeeding support. I invite you to put any comments around the importance of that extended midwifery service and support after the birth of a child, as well as for the mother and baby. Here in Tasmania, that is very limited. It really then transfers to the child health nurses. Could you provide some comment around that, that would be great?

Ms LANGFORD - Thank you. Yes, I think that's part of the beauty of the private midwifery model in that we do get to see our true scope of practice from early pregnancy. We get people calling us up as soon as they wee on a stick and have two lines, and we can take them right through all of their maternity care. Then, through to that six or seven week postnatal period, we are very closely connected to our clients in that period because such big things are changing and we have breastfeeding support services integrated into our care as well. All the midwives provide breastfeeding support, but we have a lactation team as well that comes in and has free breastfeeding drop-ins a couple of times a week. Also, if the ability to support the client is out of the midwife's scope and we need lactation consultants, we've got them there as well.

Our breastfeeding rates are close to 100 per cent because in those first few days, particularly that first couple of weeks, we're seeing our clients most days. As things are changing with breastfeeding and postpartum healing, we're really seeing them a lot. Thank you for pointing that out, that is key in that transition for the parents.

Ms DOW - Thank you.

CHAIR - Kelly, thank you so much for sharing your experience with the committee. It's been important for us to hear the experience from another state, and it's been very valuable for us to hear from you as a committee.

If there are other things that, after today's conversation, spring to mind that you wish that we'd heard, please do get in touch with us again through Mary, our secretariat representative.

Please feel free to stay in touch with us and we will keep you informed as well as we continue our work and release our report next year.

Ms LANGFORD - Amazing. Thank you so much for having me.

THE WITNESS WITHDREW.

The Committee suspended at 12.39 p.m.

The Committee resumed at 2.24 p.m.

Dr NISHA KHOT, VIA WEBEX, VICE-PRESIDENT, THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS (RANZCOG), WAS CALLED AND EXAMINED.

CHAIR - Welcome and thank you for joining us online and for providing a written submission to the committee as well. Could I please ask you to state your name and the capacity in which you are appearing before the committee?

Dr KHOT - I'm Dr Nisha Khot and I'm appearing as Vice President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

CHAIR - Can I confirm that you have received and read the guide sent to you by the committee secretary?

Dr KHOT - Yes, I have.

CHAIR - Thank you. This hearing is considered as part of the parliamentary proceedings of the Tasmanian parliament, which means that you are protected by what's called parliamentary privilege. That allows you to speak with freedom and confidence without fear of being sued or questioned in any court or place outside of parliament. However, the protection does not extend to any statements that you make that could be defamatory if you refer to them or repeat them outside of these parliamentary proceedings. That means you can still share them with the committee, but that protection only applies during these hearings. That said, we are able to also move into an in camera session. If during our conversation you reach the point where you feel there's information you would like to share with us in private, you can request that and we can move into an in camera session. The broadcast will stop. Our words will still be transcribed, but it won't be a public transcription.

We've decided as a committee, because of the sensitivity of a lot of the evidence that we've been provided, to provide a short sensitive content statement at the beginning of each session. I'll quickly just share that for any members of the public who are watching online. We recognise as a committee that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. The Committee encourages anyone impacted by the content matter during this hearing to contact services and supports such as Lifeline on 13 11 14, Tresillian's Parent Helpline on 1300 827 282 and PANDAS national helpline on 1300 726 306.

With those formalities completed, I invite you, if you would like, to make an opening statement to the committee.

Dr KHOT - Thanks very much for having me to present to the committee. Looking at the terms of reference, I thought I would address the ones that pertain to obstetrics and gynaecology.

The first one there is reproductive health services. I wanted to highlight the inequity of access to both abortion services as well as access to long acting reversible contraception across the state of Tasmania for women who are not based around the major city of Hobart, for example. Also, to highlight the inequity of access to ultrasound services, the two things are tied together because ultrasound services are usually the first port of call before a woman then goes on to access abortion services. If she's not able to access the ultrasound, that then delays access to abortion and has an effect on whether she can access medical versus surgical abortion. So that was the first bit of it.

The second is maternal health services. Of course, ultrasound services come in to maternal health services as well. Because access to good quality ultrasound is very important for pregnancy care and again, inequity of access and access to a good quality ultrasound is something that concerns members. The other thing to highlight is the fact that the entire state of Tasmania has only one maternal foetal medicine specialist. We know that pregnant women are entering pregnancy with more medical disorders with more issues, things like being older mums, being heavier in pregnancy - all have implications for pregnancy outcomes. Having only one maternal foetal medicine specialist who would be the specialist to see those more complex pregnancies has implications for the health of the mother and of course for her pregnancy outcomes. Inequity of access to pregnancy care across the state is something that also needs to be highlighted.

The third point is birth trauma. Birth trauma is a really important issue emerging increasingly amongst pregnant women. We know that what works to improve the rates of birth trauma is having informed consent before we get into the space where birth occurs. Trying to have care that is multidisciplinary, so it's not just one discipline but actually having midwives, doctors, allied health, all involved in the care at the same time; making sure that every healthcare provider that is providing pregnancy care actually has training in trauma-informed care so that they're able to provide the care that is right for the particular woman in front of them. Having evidence-based antenatal education classes available to all women so that they enter pregnancy and birth well informed about their choices and their rights; having some information for healthcare practitioners on how to manage situations where women decline recommended care. This is again something we are increasingly encountering and we should have a collective way of managing this situation, keeping the woman at the centre and making sure she has all the information she needs to make her decisions.

Also having access to training in informed consent. This is something that all providers of maternity care should have access to, to reduce the rates of birth trauma. When we talk about birth trauma, we are talking about a wide variety of things. One of those traumatic things is actually the physical trauma of birth and what women who encounter physical trauma - things like significant perennial tearing - third and fourth degree perennial tears - need is a urogynaecology service to look after them after they have had these injuries. Currently, Tasmania doesn't have a urogynaecology dedicated service. It is serviced either by people who visit or generalists who have a special interest in urogynaecology. I think investing in urogynaecology service is really important for Tasmanian women.

The fourth issue is that of workforce and workforce shortages. Again, workforce is something that is a challenge for everyone, not just Tasmania, across the country and across the world. But there are some real challenges to having accredited training sites in Tasmania. Currently, the North West Regional Hospital doesn't have accreditation for training, which means that we are not able to have as many trainees in Tasmania. People who train usually tend to stay and provide a service in that same place. If you don't have the number of trainees, then you don't have the number of doctors who will stay on and provide the service. That has implications for workforce as well.

We understand that there are wage disparities which may be contributing to these workforce shortages. Depending on how much people get paid may be a reason to make a choice to live and work in a particular state or a particular place versus another.

Those were the things that I wanted to highlight. I am very happy to answer any questions that you might have for me.

CHAIR - Thank you very much, Dr Khot. I just realised that at the beginning I failed to introduce ourselves as a committee - that was my omission, sorry. My name is Ella Haddad. I'm the Chair of the committee and I'm joined in Hobart by Kristie Johnston at the table with me, who's also a member for Clark. We're both based in the Hobart metropolitan area. Two of our committee members are joining us from online: Anita Dow, who's the member for Braddon, so based in the north-west. You mentioned the North West Regional Hospital just now, she's based in Burnie. Cecily Rosol, who is the member for Bass, is based in Launceston.

We are really interested in a lot of what you said around diversity of access across metropolitan and regional parts of Tasmania as well. I'll just open up to questions. Is there anyone who'd like to jump in first with a question? Anita?

Ms DOW - Thank you, Dr Khot. It's great to have you with us today presenting to our committee. As Ella said, I am based in the north-west, I live in Burnie where the North West Regional Hospital is, and you've spoken about the lack of accreditation at our local hospital. I want to understand what would need to happen for that - for the hospital to become accredited again to train doctors here locally? Could you explain that to me please?

Dr KHOT - It's a bit of a chicken and egg situation, literally, you know, with pregnancy. In order to train a new generation of specialists, we need to have the specialists with the skills already working in those hospitals who can then provide the training. When you don't have the specialists, the appropriately qualified and experienced specialists, working in the hospital they can't then provide training, which means that there are no trainees. Then it becomes this kind of cycle in which it's really difficult to break that connection. You know, if you don't have trainees, because you don't have trainees, you then don't get senior doctors and you don't have senior doctors, hence, you don't get trainees. I think investing in having the right number of senior doctors with the ability to provide training is really important because that is what will get the site accreditation for training.

Ms DOW - Some of the evidence that has been presented to us is around the high numbers of locums, particularly working in the north-west. That would, obviously, be attributed to that as well, that we haven't had people working permanently here, so they're coming and going and they're not -

Dr KHOT - Yes.

Ms DOW - Okay. I also want to ask you about the ultrasound services across the state. If you could elaborate more on that, talk about the importance of that and where you see the deficiencies in that across Tasmania.

Dr KHOT - Ultrasound has now really has become an extension of everything that we do in obstetrics, gynaecology and women's health. We wouldn't be able to do anything without ultrasound - and having access to good-quality ultrasound. First of all, having access to any ultrasound and then having access to good-quality ultrasound is really crucial to any decisions we make from a pregnancy point of view or from a women's health, gynaecology point of view.

From our members, we hear that the access to ultrasound is inequitable across Tasmania. There are parts where it's easier to access ultrasound, but in your part of Tasmania it is quite difficult to access ultrasound. There are long waitlists and when the ultrasound does happen, it may not be up to the same quality as we would want the ultrasound to be. Which means that the women then have to travel, perhaps to Hobart, to see a specialist who will do the second ultrasound to confirm the findings or refute the findings of the first ultrasound they've had.

That adds time, of course, to women's decision-making, but it also adds stress because here you have an ultrasound which shows perhaps that your baby has an abnormality, which may or may not be there, and then you have to wait till you can get an appointment to see the specialist, travel to Hobart, have a second ultrasound, and then you can make further decisions about what happens in your pregnancy. It certainly adds to the stress for women, not to mention financial addition stress as well.

CHAIR - I have a question about something you touched on in both your written submission and your opening statement. That's the need for training around informed consent for all health professionals that might be involved with somebody's pregnancy or labour. Some of the evidence given to the committee at previous hearings and in written submissions is around the best time to have conversations with women during pregnancy so that they understand all the likely or possible interventions that might come up during their labour in order for that woman to be aware of those risks. We've heard stories of women providing forms of consent, but not necessarily informed consent, during labour in a very fast-paced and rapid emergency-type situation.

Can you elaborate on your views on the difference between consent and informed consent for labouring women, how that training might look for health professionals, and when those conversations around possible interventions should happen in the pregnancy phase so that women go into labour very informed?

Dr KHOT - Thanks very much for that question. It's such an important question. There's two bits to it. First of all, when should women get information? Women should not be hearing about an intervention for the first time when they are in labour. That is not the time to be discussing interventions in the detail that they should be discussed. So, all these discussions should happen before we get into the labour room.

If they should happen during pregnancy, we are very fortunate that pregnancy lasts nine months and most women attend pregnancy appointments. They usually attend multiple pregnancy appointments, so we have many opportunities for the vast majority of women to have these discussions, and they should be happening during pregnancy. The best way to do that is during antenatal education. Again, most women, especially women having their first baby, will attend some form of antenatal education. If that antenatal education incorporates the possibility of intervention, what that intervention looks like, what the reason for that intervention might be, that would be the best time to have these discussions and allow women to then have questions. If we did it in the antenatal education bit of it, then it takes it out from the clinical role when you go to see a doctor or a midwife. That might then spark women to ask those questions of their healthcare provider when they go for their appointments. So, definitely the discussions need to happen prior to labour.

Of course, they should be revisited in labour. I'm definitely not saying that it's all been said and that's it, we don't need to ever talk about it again. Absolutely, when we are going to intervene in any form during labour, we must revisit that discussion and make sure that that consent is still valid. But definitely have it during pregnancy.

The second question is training for healthcare providers. We don't get trained as well as we should when we talk about informed consent. And we certainly don't usually get training in having those discussions very, very quickly. We learn it on the job and we learn it from our senior person who we follow around during the day. It is time for us to actually have a more robust way of teaching how to do consent, how to talk about informed consent and do it in a formal way.

So, absolutely, midwives, doctors, all should have a formal training program where we learn how to talk about informed consent, how we can make sure that we give people information without scaring them. Because sometimes when we give information, it can come across as being, you know, 'the doctor's telling me all these scary things might happen' to you. But it's how we put it across and how we make sure that we let the women know that this is not about scaring them, not about coercing them. It's about giving them information so that they can make the decision that works best for them.

More importantly, I think it is respecting those decisions. Once women make those decisions, actually respecting the decision a woman has made is another thing that we all need to be able to manage better.

CHAIR - Thank you. That's really interesting. We were told a story on our hearings on Monday around a woman who was living in a regional location outside Tasmania, a regional part of mainland Australia, who had to travel to a bigger town at 37 weeks. It wasn't a high-risk pregnancy. She was really excited about becoming a mum and shared that with the health professional who she spoke to when she got to the hospital, and was told, 'well, we could just induce you today and you can have your baby today'. I think that story had a happy ending. I don't think there were risks. But she no doubt felt she'd provided consent to induction, but hadn't had the risks of induction described to her, the risks of a 37-week delivery versus a full-term delivery described and explained to her.

It's not really a question but it points to the need for that training, I suppose. I'm interested to know whether you've heard similar kinds of stories across your profession, and what we might be able to learn from that as a committee in terms of the work that we do.

Dr KHOT - I do hear these discussions happen and one of the things that sometimes it's useful to have a framework and to give people a framework of how to have these discussions. For my purposes, I use what's called the BRAIN framework. So that's the Benefits, Risks, Alternatives, Interventions and what happens if I say No. That sort of framework is really useful for both the provider, the clinician, and also for the woman to ask those questions. My firm belief is that, yes, of course we should train ourselves and our professions to do this well. But we should also make sure that we let women know that these are the questions that they can and should ask their healthcare providers. When presented with an intervention, or a test or an option, they should also feel comfortable asking, 'Doctor what are the benefits of this, what are the risks, what if I say no, what are the alternatives?'.

CHAIR - I haven't heard about that framework, but that's very illustrative. Thank you.

Ms JOHNSTON - Interested in extending that to informing birthing partners too, in terms of being able to ensure that they are part of that journey. We've heard a lot from witnesses about community and the importance of community. We've heard from the Tasmanian Aboriginal Health Service around that in terms of what they believe is important to ensure that there's that wraparound support for the woman experiencing birth. Can you speak a bit more about how that can be enhanced in terms of providing information to birthing partners and other caregivers in that scenario?

Dr KHOT- I think including birthing partners and caregivers in all our discussions when we talk about whether it is antenatal education, whether it is talking to two people about intervention, including the family, the key people who are the support people is given. It should happen all the time.

Ms JOHNSTON - In your experience, is that what's happening? In terms of that particular antenatal appointments, I suppose it's often difficult to ensure that everyone's there at those appointments.

Dr KHOT - Correct. Some of the things that we could do in that space is actually flagging key appointments. For those key appointments, the support people are there because it's not like we have all these discussions at all the appointments. There are certain key appointments where we would have these discussions and then flagging them and saying, this is the appointment at which we will be having this discussion. Make sure you've got whoever you want to be there in the room with you for this particular appointment.

Ms JOHNSTON - That leads on to my next question. We've also had a lot of evidence about the importance of continuity of care and building that relationship of trust with the clinicians in particular. It's been raised with us about concerns that often a woman will have an appointment with a midwife, with an obstetrician, with a registrar. Sometimes they are slightly different nuanced pieces of information that they receive. Is there any kind of guidelines in terms of what ought to be delivered at key points in time throughout a pregnancy? How would that information be provided to the pregnant woman, despite who is giving that particular advice?

Dr KHOT - There are certainly guidelines around what information should be given at key appointments, but every individual will have their own way of delivering that information and sometimes that is the key to providing the information. We are saying the same thing, but if we are not saying it in the same way and we are not making sure that the person in front of us actually understands what we're saying, then we are missing out on giving that information, and absolutely, continuity of care is the gold standard that we should be aiming for.

In my opinion, it doesn't really matter if that continuity of care is with a particular kind of provider, whether it's a doctor continuity of care, a midwife continuity care or GP continuity of care or a specialist continuity of care. The key is to make sure that there is some continuity of care provided there. We know that there are challenges in providing continuity of care across the full spectrum from pregnancy care, birth and care postpartum. Even if we can aim to provide continuity of care during pregnancy, then that will also achieve a degree of satisfaction for women.

Ms JOHNSTON - Leading from that, in your opinion, is there good information sharing between different kinds of clinicians and healthcare providers in terms of information provided to a woman, so that if they are seeing various specialists or doctors or midwives, that all those people have a full picture of what's been happening for that particular woman on that journey?

Dr KHOT - I think we do try to share the information, but we can do better.

Ms JOHNSTON - Is there anything that would be better done that you can think of, off the top of your head, that you would think would be helpful?

Dr KHOT - Having a common health record which can be accessed by everyone, the doctors, midwives, allied health, anyone else who needs to access it, in which we can document what the discussions we've had would help. Then there is a record that somebody else who's seeing the woman can go back to and look at and say, this is what was discussed, let's follow on from there. Having that sort of technology to help us would be good. We do have the technology, so we should use it to help us.

Ms ROSOL - I don't know if we're both going to the same place, but I was interested to hear from you about the women who decline parts of obstetric care and to hear what are some of the different approaches that are taken by obstetricians in those situations and how you might manage those situations?

Dr KHOT - Thanks very much, Cecily. It isn't just obstetric care. Some patients will decline midwifery care. They will decline other things as well so it has to be a team approach. Women do have the right to make choices about themselves, their pregnancy care and their journey. Ultimately, our role is that of providing the information that will help them best to make the decisions that are in their best interests. We do see increasingly women declining recommended care. Sometimes that declining may come from a place of not having enough knowledge. I think the first step is making sure there is enough knowledge. Again, I stress, it's knowledge; it's not about coercion or scaring people because it can sometimes come across as a doctor telling you scary things can happen to you and things can go wrong.

It's about information. It's about making sure that we do it in a safe place and we do it as a team. When women hear different things from different members of the team, that then creates confusion, it creates distrust. Whereas if we all said, you know, 'Here we are, we are a team, we are here to look after you. We all feel that these are the risks that are involved. We want you to have this information so that you can make a decision'. Then women are more likely to be receptive and more likely to trust us because we are speaking as a team. When we don't do it as a team, that's when it becomes more fraught. I can understand if I was at the receiving end and I got different information from different people, I would not want to trust them. So that is a really important thing of making sure we do it as a team and stay together as a team when we talk about these things.

Of course there is a medico-legal aspect to it as well because we have to make sure that we are providing the information and we are making sure that we are confirming that the woman has understood, her support people have understood, what we've been telling them and making sure that we have a good record of the discussions we've had. When women decline recommended care, by and large, pregnancy doesn't end in a terrible disaster. One out of many might end in disaster and in that situation that can be very challenging. Of course it's challenging for the family involved, but it's also challenging for the clinicians who were involved because there is this thing of, 'What could I have done more?', 'How could I have made sure that I prevented this from happening?'. In those situations, it's important to support both the people involved and people who are going through a really traumatic time and to support the clinicians who've probably tried their best to avoid this trauma.

CHAIR - You said in your answer just now that you've seen by and large an increase in people declining recommended care. What do you think may be leading to that increase?

Dr KHOT - I think partly at least, it is driven by the lack of good information and driven by misinformation, disinformation and a lot of it is driven by social media-based disinformation. There are a whole lot of non-experts out there who are providing misinformation to women, misleading them, making them feel like they should be declining recommended intervention. We haven't really got a way of managing this new phenomenon that exists out there. There was a time when we could say 'We are the experts, trust us', whereas now there is so much information out there that doesn't come from experts that women rely on, for whatever reason, and it is our duty to make sure that we inform women that that is not true and that they should go to more reliable sources of information, direct them to reliable sources of information so that they can get things that are based in research.

CHAIR - Do you think there's been a correlating increase in risks to either the pregnant woman or their unborn child? Is there a correlation between increases in adverse outcomes, I suppose, and refusal of care or refusal of different elements of care?

Dr KHOT - Yes, there is. There is definitely a link. When clinicians recommend an intervention or a particular test or whatever that might be, they recommend it because there is a concern. Declining that recommendation can lead to adverse outcomes for both mothers and babies. We have seen that happen in a few states. Usually when something traumatic and bad happens, it makes it to the newspapers, we hear about it. But behind that one really tragic case lies a whole other collection of cases where, yes, it wasn't a tragedy, but actually things could have been so much better in terms of outcome for mother and baby if women had followed the recommended action.

CHAIR - Okay. Anita, I see your hand. Thank you, doctor.

Ms DOW - The provision of maternity services in Tasmania has changed a lot over the last, say, 10 years really, where we've had reduction in services from where we even had - I think it would probably be longer than 10 years - but people are still having babies in more rural and remote areas. So, you've seen a significant reduction in the number of beds that are available for maternity services. Do you think that has impacted on the issues that you've outlined around retention, and recruitment, and workforce? Also has that attributed to higher incidences of birth trauma given that there is such a scant resource of staff and beds across certain parts of the state?

Dr KHOT - Absolutely.

Ms DOW - But still the same number of babies and women.

Dr KHOT - Absolutely. When we lose a rural maternity unit, we actually lose a whole lot more than just the doctors and midwives and the babies being born because a maternity unit is kind of like a litmus test. If there's a maternity unit, that usually means that that's a community where babies are being born and it's not just the doctors who are providing pregnancy care and midwives. It also means that there will be an anaesthetist there, so surgical procedures can carry on. Most people are obstetricians and gynaecologists, which means that they not only birth babies, they also provide other women's healthcare, gynaecological care, treat heavy periods, provide contraception, provide abortion services. So, when you lose a maternity unit, you actually lose a whole lot more than just the maternity unit and, of course, it has implications not just for birth trauma, but for women's healthcare in general.

Ms DOW - Thank you.

CHAIR - I'd like to go to that issue as well and it's where you opened in your opening statement, which is access to termination, abortion services, and to contraception. What is the experience of your members here in Tasmania? You described it as an inequity of access and a lack of access. Can you just expand on that for the committee a little?

Dr KHOT - It's tied up with the lack of having appropriate clinicians there to provide both medical and surgical abortions as well as to provide long-acting reversible contraception because all three procedures require specific qualifications. If you don't have the appropriately qualified people to be able to provide this service, then that creates a desert, if you like, of those services.

GPs are very crucial to the provision of all these services because they are qualified to provide medical abortion as well as contraceptive services. Utilising our GP colleagues to provide those services is something that we would definitely support and encourage. That's why the college runs specific programs to make sure GPs can have the extra knowledge and skills to be able to provide those services. That's where we come in, in trying to make sure that there is equitable access to abortion care.

CHAIR - Thank you. Would you say that overall there is a lack of knowledge around abortion service access in Tasmania? I know there was a period where there was very little availability - I think that's been remedied now - but there may still be a lack of public awareness of what's available.

Dr KHOT - Yes, there may be a lack of public awareness. There may be places where the doctors and healthcare providers are conscientious objectors and hence don't provide the service themselves, which means that women then have to travel and see someone else somewhere else for the service.

Pharmacies may not be providing the medication that's needed for abortion care and again, that's something to also address. So, even though you might have a local doctor who provides the service, the pharmacy actually that is local to you doesn't provide you with the drugs, so you have to go somewhere else, to another pharmacy somewhere else to get the medication.

CHAIR - Thank you. Any other questions down here or up north? Cecily, Anita?

Ms DOW - Yes, thank you, Ella. You spoke about the need for us to have more training available. I think it was either around urogynaecology services or the other medical specialty - I think it was foetal medical specialists that you mentioned. Could you expand on that for the committee, just to outline where you see the inadequacies in that and what the opportunity is for training to make sure that we can have better access to that service?

Dr KHOT - Starting with maternal-foetal medicine specialist, so these are subspecialists. They've done their basic training in obstetrics and gynaecology and then done specific training in maternal-foetal medicine (MFM). They deal with complicated pregnancies, especially in pregnancies where there is either an anomaly with the baby or there is a baby that's not growing well or a mother who has complex medical conditions like diabetes, blood pressure issues, things like that. As I said, there are more and more women coming into pregnancy at an older age with more chronic health conditions and so they would need a specialist maternal-foetal medicine person to be able to look after them.

Currently, in Tasmania, there's only one MFM specialist and this person is based in Hobart and provides a referral service for the entire state, which would be around 6000 women. Normally in any other situation you would have more than one MFM subspecialist providing this service.

The second one is urogynaecology. Urogynecology is gynaecologists who have done their basic obstetrics and gynaecology training and then had subspecialist training in managing urinary issues, usually urinary incontinence, things like that. Currently, Tasmania doesn't have a urogynaecology service as such. People from the mainland come and provide some service but there isn't anyone located in Tasmania. Women who have significant trauma after birth - third or fourth degree tears - may need further surgery and this surgery is usually performed by urogynaecologists. They certainly should be seeing someone with that kind of expertise to be able to manage any symptoms they have. As the population ages, women are more likely to have issues with urinary incontinence and so they would also need to see a urogynaecologist to get that treated.

Ms DOW - The final question that I have for you is, in years gone by, we have had standalone maternity hospitals in Tasmania. We don't have any now. Other major capital cities and other centres around the country have women's and children's dedicated hospitals. I wondered if your organisation had an opinion on that, or could provide some further information to the committee about whether or not there is a need for a dedicated women's and children's hospital in Tasmania?

Dr KHOT - We don't have a firm position because different things work in different places. Certainly, a standalone women's and children's hospital will have the problems that are associated with women being not just either pregnant or not pregnant, or men with breasts or however we seem to kind of consider them. Women will also have other complex health issues and for that they need a range of different specialists and having a hospital that provides all those specialists within one location is a good thing.

However, the advantage of having a standalone women's and children's hospital means that there is dedicated funding and dedicated space which is allocated to women's and children's health. Both have their advantages and disadvantages. We don't have a view one way or another. I think it has to be what works best for that place, that situation, that population of women.

Ms DOW - Thank you, it's good feedback.

CHAIR - I had one final question. You're speaking on behalf of a national body. Are there any specific things to Tasmania that stand out to you in your national role that you feel it would be beneficial for us to hear about as a committee? The big ticket items or things that are different here that could be handled better that we could learn from other states and territories?

Dr KHOT - I think I've already mentioned the things that I feel need better management - the inequity of access to ultrasound, subspecialty, those are the ones.

CHAIR - We haven't missed any in our discussions today, that's good to know. Thank you. If after today's conversation, other things do come to mind that you feel it would be beneficial for us to hear, please do reach out again, either to me as Chair or to Mary from the secretariat. You might reflect on the conversation and think, 'Oh, they should know about the xyz'. Please do reach out to us again if there's other information you'd like to share with us.

Dr KHOT - Thank you very much for leaving that opportunity open because I'm sure leaving here I will think oh, I should have said that.

CHAIR - Thank you very much for joining us and giving us your time today, I really appreciate it. On behalf of the committee, thank you again for joining us.

Dr KHOT - Thank you very much for having me and for addressing this really important work.

THE WITNESS WITHDREW.

The Committee suspended at 3.05 p.m.

The Committee resumed at 3.17 p.m.

CHAIR - Welcome and thank you for attending today's hearing of the Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you also for providing a very comprehensive written submission to the committee.

I'll introduce all the committee members. I'm Ella Haddad, the Chair of the committee, Kristie Johnston, my colleague here in the south is at the table, and two of our northern colleagues are joining us remotely. Anita Dow, on the screen right now, who you both know as the member for Braddon, based in Burnie, and Cecily Rosol is a member for Bass and based in Launceston.

Could I ask you to each state your name and the capacity in which you are appearing before the committee?

Dr M. JONES - I am Marita Jones. I am appearing as a GP and a representative for the RACGP.

Dr T. JONES - I'm Dr Tim Jones. I'm the current chair of Child and Young Persons Health for the RACGP, also appearing representing RACGP Tasmania.

CHAIR - Thank you. Can I confirm that you've both received and read the guide sent to you by the committee secretary?

Witnesses - Yes.

CHAIR - This hearing is formally a part of the Tasmanian parliament's proceedings, which means that you're covered by what's called parliamentary privilege while you are sharing information with us. What that means is that it allows you to speak freely and openly with no fear of repercussions, no fear of being sued or questioned in a court or any place outside of parliament. The only exception to that is that the protection doesn't extend to any statements that might be considered defamatory if you refer to them or repeat them outside of these proceedings. You can still say them here under the protection of parliamentary privilege.

That said, if during today's conversation things arise that you feel you would prefer to share with us in a private setting, we can move into what's called an in-camera session. Just ask for that and we'll have a short deliberative meeting and move into a private session. That just means the broadcast stops because we know there are members of the public joining us online today. The information is still transcribed, but it becomes a private part of the *Hansard* transcript.

Dr MARITA JONES, MEDICAL EDUCATOR, RACGP TASMANIA, AND **Dr TIM JONES,** NATIONAL CHAIR, CHILD AND YOUNG PERSONS' HEALTH SPECIFIC INTEREST GROUP RACGP, SENIOR MEDICAL EDUCATOR RACGP TASMANIA AND TASMANIA FACULTY REPRESENTATIVE CLARK DIVISION RACGP TASMANIA, THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS (RACGP) TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. We've also agreed, as a committee, to provide a short sensitive content warning at the beginning of each session, understanding that a lot of what the committee is hearing is sometimes very serious content. We recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. The committee encourages anyone impacted by the content matter during this hearing to contact services and support such as Lifeline on 13 11 14, Tresillian's Tasmanian Parents Helpline on 1300 827 282 and PANDAS National Helpline on 1300 726 306.

That's all the formalities completed. I invite each of you to make an opening statement.

Dr M. JONES - First, we want to thank you for allowing us the opportunity to represent RACGP to the committee. Tim and I are here as GPs who have an interest in family health, but we're also here wearing parenting hats. We have young children, we're very involved in local parenting communities and through the school association in our local public school. So, we feel like we see the issues from lots of different perspectives.

I'll start with a brief statement about mother and baby services and then Tim will make a statement about early childhood services. We're happy to discuss anything else that's in the submission today.

When I refer to mother and baby services, what I mean is parenting and infant services, recognising that families come in every form. Struggles in early parenthood are a common reason for people to present to their GP. Those struggles can range from feeding and growth problems, sleeping and settling issues, parental exhaustion, all the way up to mild to significant maternal or parental mental illness. What we know is when these families come in, if we are able to help them and support them early, things improve and they get set on a positive trajectory. If we don't give them the support they need, the wheels tend to fall off, things will snowball, problems will turn into diseases. It has a big impact on the whole family unit and we know that it has an impact on the development of the child for years to come.

Every child deserves that start in life that's safe and stable and loving and nurturing, but parents need support to provide that. Currently in Tasmania, in contrast to other states, we don't have any single point of call for families in need. We used to have the private St Helen's Hospital providing essential mother and baby services, noted mainly to private patients, but since the closure of that service over a year ago, we've been even more limited in what we can offer families. There are limited beds available at the Royal Hobart Hospital that provide and cater to only a small number.

What's needed is holistic, community based wraparound intervention that doesn't solely focus on mental health but on the whole parenting support journey. So, the partnership of the government with Tresillian to build a northern parenting hub is most welcome, but what about the people in the south where half the babies are born in Tasmania? The original Tresillian modelling suggested a northern and a southern hub would cater for our number of births and what we're seeing on the ground with patients on a day-to-day basis is that that is desperately needed.

From our point of view, it seems like a no-brainer; a vital cheap, early intervention that sets people on the right path but saves a lot of money to tertiary services down the track. It's also the least of what our babies deserve.

Dr T. JONES - I want to follow through into how early intervention for children in Tasmania is currently working and to share an example of where some of the gaps in our services are. There's a child I'm familiar with who, unfortunately, several years ago was the victim in a road rage MVA where the vehicle they were travelling in was repeatedly rammed. From that point on, that child started to experience high levels of stress, worry - they weren't sleeping very well. The concern that was raised was that, in the early school environment, they weren't concentrating and they weren't applying themselves. Now, this family was really trying with any resources they could cobble together to support their child, but there were no private child psychologists available in that area who could take them on. The only thing that their GP knew to do was to refer them into public paediatrics. Because the concern was around behaviour and learning in school, it went to our ADHD assessment clinic, which had a two-year wait time. It was two years of that child struggling before receiving a service that really wasn't targeted at what they needed anyway.

So, trying to ascertain that, when we talk about early intervention, we're talking about a whole spectrum. We do have, through NDIS and other services, very high level supports available to kids with significant disability. What we really lack are some of those focused early intervention supports to kids with milder spectrum presentations, where ideally you want something family focused and community-based, again just to make all the difference in the world and not let those problems snowball as well.

CHAIR - Thank you, I might open with a question that goes to that to an extent, but it's something you mentioned in your written submission and that's around information sharing and integration of services. That's something the committee has heard quite a bit in the hearings that we've had so far and in the written submissions around continuity of care, particularly for people going through pregnancy and birth in the public system. I think what you've shared, Tim, extends through until early childhood interventions and care as well.

Do you have any information or insights that you could share with the committee around the importance of information sharing between health professionals and multidisciplinary care that has that patient-at-the-centre approach? It feels like that case that you've shared with us, if more information was shared about the trauma that that young person had gone through perhaps he wouldn't have been diverted straight into the ADHD clinic, but maybe would have been provided a service more suitable to his needs.

What's information sharing like at the moment across the health system and how could we make recommendations around improving?

Dr T. JONES - The best example I can give is in the setting of breastfeeding rates in Tasmania, which I'm sure the committee will hear from others, have continued to fall. A lot of that starts day one of a new baby's life. The best example I can think of, as to where information transfer doesn't readily happen, is knowing what a family's birth experience was like. We receive as GPs a generic discharge summary with how much blood was lost, how long the labour was, what the weight of the baby was, but we know nothing about the subjective experience, so we're often waiting for that little bit of information to know that that's a family that needs early support.

As GPs, we're well placed because we know their background, we know what existing levels of stress they may be under, or what other supports are in place. Even that handover information of 'that's a family who had a difficult birth experience,' we don't always get that and that doesn't stop. It just translates through any further child interaction with our broader healthcare system. Fragmentation is a major challenge and individuals learn to get around it by having phone calls or sending little emails, but that's cribbed together, it's not built into our system

CHAIR - And it relies on a high level of self advocacy-

Dr T. JONES - It does.

CHAIR - I suppose as well that many members of our community might not have.

Dr T. JONES - Related to that, we have the fact that our child health nurses, who are doing good community work, and our GPs don't share databases and don't share shared information about what's happening with a child and family situation, even though generally we're both trying to provide a very similar level of care in similar areas.

Dr M. JONES - In addition to that, sometimes, particularly patients who are vulnerable and high-need, if their instruction from a child health nurse is to follow-up with their GP, we don't know that they've been given that instruction. Whereas, we might know those patients very well and know if we get a note saying 'so-and-so is not growing well' or 'so-and-so has a a problem with their hips' and we don't see them pop up on our books, we call them and we chase them up. There's an opportunity to advocate for vulnerable patients, particularly non-English-speaking Aboriginal and Torres Strait Islander families. The lack of communication between those two services is really impacting patient care.

CHAIR - Are there other barriers to sharing that information digitally around private practice versus public health information, or is it deeper than that?

Dr M. JONES - I believe it's probably because they don't have access to the same kind of software that the hospital does, but we still share information between private practices and the hospital quite freely.

Dr T. JONES - This problem seems to be at an IT level.

Dr M. JONES - You can hand write in the blue book and we communicate between the nurses and the GPs via comments written in the blue book, which is often left in the car, forgotten, left at school -

CHAIR - That was me every time.

Dr M. JONES - But also we don't get that that flag of 'I know this person needs medical care and I know that they need a bit of extra help following it up'. It's only if they physically bring the blue book do we know if the child health nurse had a concern.

CHAIR - I'll just ask one more question on this. It will probably be one for the Department of Health when we hear from them. There is a Department of Health and THS-wide IT project on foot. Do you happen to know whether or not that has within its scope this kind of information sharing that you're talking about?

Dr T. JONES - I'm not aware of that.

CHAIR - I'll ask that of the department that is a bit of an early warning on the *Hansard*. I guess that's one of the questions that we'll ask the department around information sharing here.

Dr M. JONES - Do you have a comment about the statewide referral criteria in paediatrics?

Dr T. JONES - I do, and this relates to that case I was sharing because services are precious and we want use them where they are. One of the projects that's been slowly happening through THS that we're aware of is the development of so-called statewide referral criteria, which are universally agreed flow patterns for what information needs to be gathered, what supports could potentially be offered, and which services would be appropriate to refer to within the public system for support. We know that the process in paediatrics is not progressing and, because that area has some of the most significant wait times for those services, as GPs we're particularly interested in advocating that that needs to happen as a priority.

CHAIR - Do you know why it's progressing more slowly than other areas?

Dr M. JONES - From my perspective as a GP, they're big, complicated issues and everybody in that department needs to agree on what those criteria are before they are translated into the new electronic referral pathways, which by the way, are very useful and excellent in general, if they're switched on.

CHAIR - That's good. We can ask questions about that, too, when we hear from those colleagues. I will open it up to the committee, if I may.

Ms JOHNSTON - Thank you both for coming along today. I heard very clearly in your opening statements, and it's a clear issue we've heard about throughout the evidence we've received over the last couple of days, about access to services and timely access to services. Waiting lists, whether it be for the mother baby unit or paediatric services, is critical. Can you give some evidence and speak to what the impact of a waitlist is on very young people? Maybe the newborns and infants when their developmental stage is important. So, a two-year waiting list during a child's development - I'm imagining - would have a significant impact long-term, as opposed to someone who's 40 like me and waiting two years for a service. Can you speak to that? I don't know if I've worded it quite right, but the impact-

Dr M. JONES - The impact is significant. We can describe it differently depending on what they're referred for. For example, if you're referred for early parenting support for a tiny baby where every day and every week is critical, what happens is that the mental health of the parents deteriorates. If the baby is not feeding well, is not growing well, they tend to start seeking alternative solutions. Maybe they're going to alternative health practitioners for solutions to why their baby won't sleep, or they're paying money for non-evidence-based treatments because they're desperate and really simple, safe, and supportive interventions aren't available to them. The other problem is that sometimes what might start out as a lack of a parenting skill, turns into a child who has a growth problem and it turns into a disease.

It's different with older children having to wait, say, for a behavioural clinic. It's impacted on by waiting in other clinics. For example, if the reason they have a behavioural problem is that they're not hearing very well, they're waiting a long time for an ear, nose, and throat appointment, they then need to be seen in the developmental behavioural clinic because their behaviour and development is hampered. You miss those windows of opportunity to develop and that child might be behind for the rest of their life.

Dr T. JONES - Another pertinent example around what happens is a child I came to as beyond a tertiary level of care and it was a good example of how the wheels can really fall off. This was a single parent doing a really good job for a very big personality toddler, but the sleep just wasn't working. The parent was spending four hours a night trying to help their toddler settle. They had managed to get into paediatric services and they'd received generic advice, but it wasn't tailored to their individual circumstance. It was impossible for that one parent to implement and that crushed the parent even more because they just felt like, 'well, if even the highest level supports aren't helping us, it's not going to work'. Whereas, fortunately, because of my areas of love as a general practitioner, I was able to put strategies in place that were family focused to that family and the situation resolved itself within two visits. It wasn't big interventions.

CHAIR - It was the right intervention.

Dr T. JONES - Yes, and tailored to an individual circumstance, which, when you have that relationship - and it's why we keep talking about community-based services - it is so important. Also, because it removes the stigma. You know, this parent was talking about their child needing to be assessed for NDIS-level supports and possible autism, when really the problem was that the child wasn't sleeping.

Ms JOHNSTON - I'm hearing clearly that not only - unlike I suppose other health issues with particularly babies and paediatrics - there's potentially two patients that are impacted by waitlists, the caregiver and the patient itself, the child. So, the impact of waitlists can have adverse health outcomes on multiple parties unlike, perhaps, other conditions and things like that.

Dr T. JONES - Could I make one more comment, too. The thing that we lose in all of this is parental confidence, that ability to feel like they actually can be an effective parent to their child. If that isn't supported early that relationship is very vulnerable from that point on and when that child moves through their next set of challenges, it's almost like a re-traumatisation, in a way, for that parent.Whereas, if they learn very early on that they've got this and that the system supports them, we see long-term thriving and the impact that has on our communities is tremendous.

Ms JOHNSTON - Their relationships, too, and it's generational.

Dr T. JONES - Absolutely. You know, it's not beyond the scope to talk about these being intergenerational challenges.

Ms ROSOL - Could you expand on the impact of four-year old's missing out on assessments, I noticed in your submission Medicare rebates have changed so they're not covered, but Child Health and Parenting Services don't have the capacity to assess them. What I'm hearing is most four-year old's are missing out on that assessment. What's the impact of that?

Dr T. JONES - What I'm hearing from my patients is that almost all four-year olds are missing out on those checks around our state. The impact of that is we're not identifying early those kids who are going to struggle in a school environment, it may be missed opportunities, for early support. We're also not picking up the kids with hearing impairment before they start school. As much as our education system is trying to do some things, they're trying to do some basic in-school screening with the school nurses now. That's not a system designed to do that, they've had to crib it to make it work.

The last factor that's really hurting, is we know a lot of our funded early intervention supports expire by age six. Given the lag times to access them, if we're not identifying kids at four, by the time they get through the system, they're already moving out of the window where supports can be available to them through early intervention. Which means they just miss out and there's nothing after that point really that we can access for them.

Ms ROSOL - Their whole life trajectory is impacted by that?

Dr T. JONES - Yes.

Dr M. JONES - For private and independent schools, it's variable as to whether or not they'll have a school nurse doing those kinder checks. The public schools at least have a kinder check opportunity, but again, it's not creating consistent and equal access to every child in the state.

Ms DOW - Thank you, Tim and Marita, for presenting to us. You referred in your opening statement, Marita, about the inadequacy of the current mother-baby beds at the Royal Hobart Hospital and how there is the need for more community-based beds. You referred to the northern model which we've had some discussion with Tresillian about. Could you elaborate on some of the current issues being experienced with the beds currently available and the need for more beds in Hobart.

Dr M. JONES - One problem is what the design of those beds were for. Initially, it was to cover the public psychiatry beds that were at the St Helen's Hospital, which could have been up to three beds. To use those beds, you need to be admitted underneath the Perinatal Infant Mental Health Service, which is a psychiatric service. That process requires seeing your GP, being referred to the service, and having two to three assessments, prior to having admission. There's a reasonable wait list of several weeks for that and telling your story over and over again to different people. Then we have a hospital-based system that's only in the south, so accessibility geographically is limited.

Having treatment in a tertiary hospital which has stigma attached, it's not an easy place for people. Just the basics of parking and having your family come to visit you and access you in that hospital limits a family's comfort in being admitted there and staying there for the time they need. It also has limitations in terms of that the hospital is susceptible to infectious disease outbreaks, et cetera. For some families, their trauma began there and going back to have treatment there may not be helpful -

CHAIR - Or impossible for some families.

Dr M. JONES - or impossible, exactly. The nursing staff can only be commended for their skills in this area and there is no criticism over their focus from parenting support.

However, the medical model that exists there is mostly mental health based, which is only a small number of the people who need help. Seeing as we no longer have other early interventions, potentially private patients, people with non-mental health-based struggles in parenting, maybe taking the beds from people who need them. There are multiple problems with the structure as well as the limited number.

Tim, you could probably explain from your own experiences on what the actual patient experience is like in there.

Dr T. JONES - By nature of the work I do, I have a fair number of patients who access the beds at the Royal and the biggest thing they tell me is they were there for the nursing care. They needed the support with hands on, knowing what their baby's signals were, how to feed their baby, how to settle their baby. They could take or leave the medical stuff. That wasn't the support they were really needing. The thing that they found really hard is that hands-on support, the moment they were discharged, they were just back out into the community where there wasn’t any of that step-down care. There wasn't the ability to access a day program. There wasn't even the ability to follow up with anyone other than the medical team, who as we mentioned, the vast majority of my patients would say that's not the needed service. That's why we really look to the hub in the north as delivering more of that holistic wraparound approach. That's very much the feedback from the community I live and work in is that’s what they need.

Dr M. JONES - We do think we have always had a problem for our PIMHs team to have an appropriate place for parents who are really acutely psychiatric in need to have a place to go with their babies. There is an importance to separate that acute mental health need and the rest of parenting supports. They need to keep those beds, but they're not the same thing. It's a different service and it would be a shame for the psychiatric service to lose the ability to admit their tertiary patients if they need to.

CHAIR - I've had midwife friends explain the difference of the model of care that can be provided in a mother and baby unit in the style that St Helen's did and hopefully, Tresillian will be able to compared to the style of service delivery and model of care that can be delivered in a tertiary hospital. Can you elaborate more on that? I hear and appreciate what you said about the importance of keeping those two acute clinical beds for those that need it, but perhaps be a bit more information for the committee about practically on the ground, the difference of model of care that can be provided in an acute setting versus a mother and baby unit in its true sense would be helpful for us to hear.

Dr M. JONES - I think you could answer that better, having physically worked in the other unit.

Dr T. JONES - It begins with the structure of what a unit looks like. A hospital looks like a hospital. It feels like a hospital. There're ward rounds, emergency alarms going off, code blue's for arrests being called.

What we're talking about in a parent-baby model is a residential space that feels like a quiet, private home-like environment where you feel comfortable to be yourself and where your baby is part of the design of the place. The difference is in not just that, but the communication. It's normalising the parental experience, not pathologising it. It's around getting to know parents and their babies and not delivering just a one-size-fits all strategy but really working with people on their own innate knowledge of their baby and supporting that.

Rather than having people either in hospital or not, it's having the ability for people to access some day programs or a follow up phone or video call or even the ability to have someone video in at 2 a.m. and see how it's going. The ethos is very different.

CHAIR - That's really illustrative, thank you. Anita, I feel like I cut you off. You started that line of questioning. Can we come back to you?

Ms DOW - That is okay. I think you've answered that very well and will be of assistance to the committee's work. The other point was access to assisted reproductive therapies and was something you mentioned regarding the access to IVF in your submission. It's not something that has been raised with us yet as a committee, but I was hoping you'd be able to put some more remarks on the record and provide the committee with some more of your experience on this issue and how it's a barrier to families and women.

Dr M. JONES - Assisted fertility and IVF therapies are very specialised therapies and we can't necessarily speak to the medical side of how specialised that is. From an access point of view of, those therapies are only accessible privately. Therefore, patients who are struggling to conceive, we can refer them to a private fertility specialist and they can embark on a very well supported, but extremely expensive journey, to hopefully end up starting a family of their own. If you don't have financial means, that's not an option for you.

As far as we understand it, those fees can be set by the private practitioners or their companies. Recently, one of Tasmania's independent IVF companies has been bought out by a mainland company and so they can set the fees. They're not specific to our Tasmanian community or the practitioners aren't independent in the fees. So it's just highlighting that again, it's an inequity.

Dr T. JONES - Could I also highlight that, across Australia, 30 per cent of pregnancies experience some issue with sub-fertility. This is a very large percentage of our population that we're talking about may need some degree of support. That inequity is only going to be more important into the future as we talk about our ageing population.

CHAIR - Are there states that offer publicly available IVF services?

Dr T. JONES - I'm afraid I don't know the answer to that question.

Dr M. JONES - I don't know about IVF services, but there are some more clear pathways in terms of other sub-fertility assessments. Some people can receive help with injections to boost their fertility, that type of thing, which I think potentially could be done in our hospital if that person was there. But we don't have a pathway or a clinic set up to assess sub-fertility even to diagnose what the problem is.

Ms DOW - The only other question I was going to ask, Ella, was in relation to access to terminations, which you also mentioned in your submission in the inequities around that. One of the issues that's been raised with us through the evidence presented has been the limited knowledge that Tasmanians have about accessing terminations across their community. Is there any further information that you'd like to leave with the committee about that issue?

Dr T. JONES - Certainly what we've put in our submission about health literacy being key to accessing termination of pregnancy services as it currently stands, is important. There are some small-scale services providing advocacy support for people who need that sort of care to navigate our system, but there isn't a lot of community education about what services are available. Termination of pregnancy services can generally be accessed either through the public system or at reduced cost through primary care, but it requires awareness of how to navigate the system to get that.

Dr M. JONES - The other thing is that structured support post-termination is very ad hoc. So whether that is a person who is actually requiring contraceptive support and it's go and see your GP or sometimes after surgical terminations that will be organised in the hospital but that would, again, be an ad hoc service. Mental health support following a termination of pregnancy can be very limited because there is a lot of stigma associated with it. The same actually goes for pregnancy loss at any point. That may have been brought up by some of your other groups.

I recently had a patient who had an unexpected ectopic pregnancy loss after trying to fall pregnant for some time and was devastated. She had her emergency surgery in the hospital and was given a bag that had various pamphlets, the PANDA pamphlet and other 'you can call this number if you need support'. She came to see me and said, 'I haven't even been brave enough to open the bag but I need help when I don't know where to go'. We phoned around private psychologists and weren't able to find anyone with less than an eight-week wait, plus you would have to pay, through the mental health care plan. We organised for her to have a referral to Gidget House which has opened recently. I saw her only a week or two ago at about the eight or nine week mark and she still hadn't been given an appointment. The support for pregnancy loss, whether it be a planned pregnancy termination, or whether it be an unexpected pregnancy loss, is very poor.

CHAIR - That's really very sad to hear and very important information for the committee to know. Thank you for sharing it. Are there any other questions in the north?

Ms JOHNSTON - Back to mother baby unit. I'm particularly passionate about this issue, having been a patient of the baby unit 18 years ago now. I'm very concerned about the limited numbers that we will eventually have, recognising numbers now aren't great either. In terms of the triaging of who needs to access those services and the length of time of those services are offered for us, we've heard earlier this morning, I think I'm correct, five to seven days is the length of stay in the residential program. From my experience, it was three weeks in the mother-baby unit 18 years ago. Recognising that some of the issues we are dealing with are not quick issues and you mentioned, Tim, the need for step-down support in exiting residential services, whether it be a phone call or at night when your baby's not settling for the first night at home, all those kinds of things. Do you have a view about the length of service provision in some of those services, particularly those residential services? Perhaps you can elaborate on what those step-down services might look like. For me it was very important. I can only imagine what it must be like for others.

Dr T. JONES - One of the key points to make in all of this is that we need both step-up and step-down services. Families often don't know what they need until the support is there working with them. It's quite okay for a family that's struggling in the community to be taken into one of these community-based services like the Tresillian model in the north will deliver, and potentially even there, integrate with the psychiatric beds provided at the Royal Hobart Hospital with the proviso that the teams talk to each other and that a family-centric handover of care that delivers the same goals and the same model of care is continued.

Similarly, those patients needing those psychiatric beds may well be able to step-down into those community based residential services, if again those strong links of communication are happening, but service fragmentation at that point of care, mixed messages, changes of opinion in the mother/baby model. As GPs we were only allowed to admit for five to seven nights maximum. We frequently encountered that challenge where our only option was to hand over care to a paediatrician or a psychiatrist who may not necessarily always be aligned with the work that was already being done as we were ringing around to find them. Making sure that is baked into the design of a system, that pyramid approach, it could still use those services, but it would need to be absolutely enshrined to deliver the care of the community needs.

Dr M. JONES - Some of the step-down models would involve being potentially discharged from the residential program but maybe being admitted to a virtual program so that you can then continue your work once you get home. In the ideal picture in the Tresillian model the nurse can then visit you at home. That could help support an earlier discharge, which might be helpful for people who are either distant from the community setting, or people who have got other children and need to get home and that kind of thing. The other, hopefully, ideal factor is that the earlier we get in, sometimes a shorter admission will work, but sometimes it won't. That's why we do need to have a long-term option available as well as repeated admissions available too. Provided that the service is not inundated and then there's a six-week wait for you to get readmitted if the wheels fall off that weekend.

CHAIR - I did wonder about that because they did explain that they have a readmission model, but I wondered about what the wait might be.

Ms JOHNSTON - Obviously if you're discharged and things don't quite go as planned when you get home, that parental confidence you're talking about can take a massive hit: 'Oh, it worked when I was in the residential setting, now I am at home and by myself, it's not working'. The time lag to re-enter residential services might be

CHAIR - detrimental.

Ms JOHNSTON - The exacerbation of the issues might be greater at that point in time than it was initially.

Dr T. JONES - It's worth the attention of the committee that interstate we have seen models of care almost entirely relying on hubs that only provide day services for intensive support coupled with virtual after-hours models of care still deliver excellent outcome and see less than 3 per cent of families accessing that level of care needing to progress to more formal residential mother-baby style models. Given our dispersed population, considering that from the beginning as to how we design these services is also very important.

Ms JOHNSTON - Whereabouts are those services?

Dr T. JONES - Mostly in rural New South Wales, which has the similar challenges with dispersed communities and large amounts of distance between them.

Dr M. JONES - Karitane, who I know has also made a submission to the committee, has quite a lot of research about virtual models of care that they put out and started, I believe, during COVID or just before COVID. There are some models out there that we could explore.

CHAIR - Yes, they have submitted. I don't think at this stage they're presenting in person, but we've got a written submission from them.

Dr M. JONES - They're very good with data. Their research papers are very good to look at.

CHAIR - Is there anything else that hasn't come up in our discussion that you'd like to share?

Dr T. JONES - Just one.

Dr M. JONES - Is that early childhood intervention services?

Dr T. JONES - I really wanted to speak to the Early Childhood Intervention Service which, for the purposes of the record, is the state government's funded early supports for families of kids experiencing developmental differences through the Department of Education. This service covers zero to age 5 under the current system.

What we have seen progressively over my time as a GP, which is seven years now is with the rise of NDIS, there's been a progressive defunding of that service. Now it does still exist, but in a very limited capacity. As a GP I speak on behalf of our profession. We are not getting good results out of early intervention like we used to because the difference I believe, again, was that this service was localised. It was aware of everything that was in the community and it had direct links through the Department of Education to all the school systems. A child who is deviating from normal development - maybe they had a visual or hearing loss, or maybe they had autism, all sorts of things could access this service receive both therapeutic supports but also, really importantly, a navigator role in making sure that child's journey through accessing care was much smoother and their transitioning to the school system was well supported.

What we've seen now is that early intervention supports are largely being promoted through NDIS which has an extended wait time, which is a national model that has very limited local links and none of that continuity or navigator stuff is happening for our families anymore and the abrupt handover into education systems is very, very jarring as a point for those families.

CHAIR - I imagine there'd also be a lot of young people with developmental issues who wouldn't necessarily be eligible for an NDIS package.

Dr T. JONES - Yes.

CHAIR - They could very much be falling through the cracks.

Dr T. JONES - You read my mind. A lot of the kids I'm seeing have very mild challenges. They may be mildly delayed in their development in one or more areas. They may have some significant speech concerns. They don't need enormous five figure NDIS support packages that will take two years to get access to.

CHAIR - No, they probably wouldn't be approved for one, realistically.

Dr T. JONES - No, but, again, having that very timely, very focused individual circumstance, okay, well, these services can all support you and we're going to keep popping up through your journey until you're well established in school-based systems.

I think it's very much within the scope of our submission that we need to re-examine the role of state level early childhood intervention, because it was delivering better outcomes at far reduced cost compared to what NDIS is delivering as a nationwide strategy.

Dr M. JONES - It is worth highlighting that we call it ECIS or the Early Childhood Intervention Service. It didn't need to be a diagnosis to access help and it could be allied health driven. We absolutely know that a speech pathologist is very well placed, qualified to assess and make a management plan without any intervention from a medical person. That's being limited and the same going for physiotherapy for a child with a gross motor delay or something like that.

These interventions were put in place, therapy was started and then the allied health professional would refer to us and say, we've started these things and we're concerned this child has this condition or that condition and can you start the medical process, so things were happening in a dual way, whereas now you can't necessarily access.

I want to give two examples of the system working well and not well. One example from our personal life is that our child had a speech delay and had his child health nurse assessment in the first week, because we knew he had a speech delay and accessed an ECIS speech pathologist who came to the school half an hour once a fortnight for two terms and voilà, his speech is beautiful - an early intervention that works really well.

The other example is a child who was in the private system who is from a family where one child has an NDIS package for a severe disability and the other child is in an independent school, at kinder age, has multiple symptoms of autism and is developmentally struggling and at the moment doesn't quite meet the threshold for ECIS, doesn't have a diagnosis and so it cannot meet the NDIS threshold eligibility. Their only option is to join the extremely long wait list at the Royal to have a diagnosis or through the Tasmanian Autism Diagnostic Service. However, this child will actually just thrive with an occupational therapist and a psychologist. When they came to see me, I couldn't offer them anything except my support and a long waiting list.

CHAIR - And that has changed over time, that availability of the ECIS supports? Previously, you would have been able to refer that family to receive that allied health support. Over what period of time have you seen that reduction in funding and availability?

Dr T. JONES - To me, that is the last five years that we have really seen that progress. The other thing really good about ECIS is we get letters back from them, saying we have seen the family, we have met with the concern, we have seen the child, we are activating these programs of support. Now, more than likely, we may get a letter back from ECIS saying they can no longer meet our eligibility criteria. We are having to prioritise the services.

The best example of where this model works is our premature babies, who we know are high-risk for all sorts of developmental concerns. They automatically enter what is called Premature Baby Playgroup at ECIS where, on a regular basis, the families are all meeting, they are playing together and they are being observed by trained allied health professionals, OTs, speech pathologists. Concerns, they do not even have to wait for the family to start advocating, there is a collaborative environment right to the start to say hey, they are not walking quite early enough, their speech is not coming along, they are not seeming as brave with the other kids. Again, there is not necessarily any labelling or diagnosis happening, it is just we will get some supports running and see how we go.

CHAIR - How premature do they need to be to be eligible?

Dr T. JONES - I think you have to be born before 30 weeks is my understanding to meet the eligibility for ECIS Premature Baby Playgroup.

CHAIR - I did not know that existed.

After today's conversation, if there are other things that spring to mind for you both, please feel free to remain in contact with the committee, either through any of us, you know all of us, or through Mary, through the secretariat. There might be other things you will think of afterwards that would be beneficial for the committee to hear as we continue our work. We would really welcome hearing from you again.

Dr T. JONES - Thank you.

CHAIR - Our time together has raced by, we would love to keep picking your brains, but thank you very much again, both of you individually, and also thanks to the Royal Australian College of General Practitioners for participating in this inquiry and providing your time, insights and expertise has been invaluable to the committee, so thank you very much.

Dr T. JONES - Thank you again.

Dr M. JONES - Thank you so much for all your work.

The Committee suspended at 4.04 p.m.

The Committee resumed at 4.15 p.m.

CHAIR - Welcome and thank you to all three of you for appearing before this Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you also for providing a comprehensive written submission for the committee's knowledge and information.

I'll introduce the committee. My name is Ella Haddad, I'm the Chair of the committee; Kristie Johnston is my colleague joining us at the table here, and we have two of our committee members joining us remotely from the north and the north-west. Cecily Rosol is the member for Bass and is based in Launceston; and Anita Dow is a member for Braddon and based in Burnie on the north-west coast. We're interested in talking about access to regional services as well.

Could I ask each of you to state your name and the capacity in which you are appearing today?

Ms SHAKES - My name is Rowena Shakes, I'm an endorsed midwife and I'm currently the secretary of the Tasmanian branch of the Australian College of Midwives.

Ms WILKINSON - My name is Maya Wilkinson. I was previously the Chair of the Tasmanian branch of the Australian College of Midwives and currently an ACM member, an interested person, and parenting two young toddlers.

Ms WEATHERSTONE - I'm Alison Weatherstone, the chief midwife at the Australian College of Midwives.

CHAIR - Can I confirm that each of you have received and read the guide sent to you by Mary, our committee secretary?

WITNESSES - Yes.

CHAIR - All three of you are covered by what's called parliamentary privilege. This is a hearing of the Tasmanian parliament, so the privilege that extends to politicians when we're speaking inside the Chamber extends to all three of you here. What that means is you can speak freely and honestly, and say whatever you would like to say without fear of repercussions or being sued or questioned in a court or a place outside of parliament. The exception to that is if you did make any statements that could be considered defamatory and you repeat them or refer to them outside of this parliamentary proceeding that parliamentary privilege doesn't extend.

That said, you can provide information to us in camera. This is a public hearing and we know there are people joining us online watching the hearing. If during our conversation today there's something that you decide you would like to be able to share to us in a private setting, you can ask for an in-camera hearing. We can facilitate that. The broadcast stops, it's still transcribed, but it doesn't become a public transcript. That's an option if, during our conversation, there's something specific that you'd like to share that you're worried about that parliamentary privilege.

Ms <u>ROWENA SHAKES</u>, ACM TASMANIA BRANCH SECRETARY AND CLINICIAL MIDWIFE, **Ms <u>MAYA WILKINSON</u>,** ACM BRANCH COMMITTEE MEMBER, WERE

CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

Ms ALISON WEATHERSTONE, VIA WEBEX, CHIEF MIDWIFE, AUSTRALIAN COLLEGE OF MIDWIVES WAS CALLED AND EXAMINED.

CHAIR - I don't need to repeat that for you, Alison, because you're interstate, but thanks for being here.

We've also agreed as a committee to provide a short, sensitive content warning at the beginning of each session, understanding that a lot of what we're hearing is serious content. I'll share that for all of us here and those joining us online. The committee recognises that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. The committee encourages anybody impacted by the content matter during this hearing to contact services and supports, including Lifeline on 13 11 14, Tresillian's Parent Helpline on 1300 827 282 or PANDA's national helpline on 1300 726 306.

That's all the formalities dealt with. I would like to start by thanking you again for appearing and asking you for each or one or all of you would like to make an opening statement.

Ms SHAKES - I'm happy to read the opening statement, if that's okay. I'd like to acknowledge that we stand on the unceded lands of the muwinina people of lutruwita and the Yidinji lands in Cairns, which we're presenting from today. We pay our respects to First Nations people, past, present and emerging, and acknowledge all First Nations people here today.

On behalf of the Australian College of Midwives, ACM, we would like to thank the committee for the opportunity to appear today. ACM is the peak professional body representing midwives in Australia.

Midwives are primary care providers and provide women and family support, care, and education and advice from preconception during all stages of pregnancy and labour, birth and the postnatal period through to influencing the best start to life for a child in their first 2000 days. Midwives are the experts in sexual and reproductive health and our scope of practice is well positioned to holistically encompass the needs of childbearing women and their families across the pregnancy continuum.

Midwives are both autonomous clinicians and integral to multidisciplinary maternity care teams. ACM recognise the importance of collaboration for women and newborns experiencing complexities and also highlights the importance of the woman remaining at the centre of their care, and not having their care or maternity experience defined by any complexity.

Universal access to reproductive healthcare is a priority to improve outcomes for women and children, particularly those in rural and remote areas of Australia. Midwives working to full scope of practice, scaling up access to midwifery continuity of care, including birthing on country models, and the recognition and promotion of endorsed midwives, play a key role in improving access and thus outcomes for women in pregnancy, regardless of the geographical location.

ACM's submission to the select committee provides a practical and solutions-focused approach to addressing some of the current issues impacting reproductive, maternal, and paediatric health services in Tasmania. These align with national strategic objectives, such as the woman-centred care Strategic Directions for Australian Maternity Services and the National Agreement on Closing the Gap.

Some key areas we wish to highlight from our submission include that -

ACM recommends greater support for midwives and policy changes to enable all midwives to work to their full scope of practice.

Implementation of publicly funded homebirth, as Tasmania is now the only state in Australia not to have access to this model of care.

Endorse midwives' work in both public and private settings. This endorsement qualifies midwives to prescribe medications, pathology, and diagnostics within their scope of practice. In Tasmania this is currently limited in both the public sector and by the Poisons (Midwifery Substances) Order 2011, which details a limited medications formulary. Tasmania is now the only state that retains a formulary for midwives. An example of a known barrier is the inability of midwives in Tasmania to be able to prescribe the MS-2 step for early termination of pregnancy.

Endorsed private practice midwives do not have visiting rights access in any Tasmanian hospitals. This limitation means that women and families employing a privately practicing midwife do not benefit from continuity of care during labour, the cost savings associated with Medicare rebates when care is provided in the hospital, and women may be restricted in their choice of birthplace and care provider.

ACM acknowledges that there are midwifery workforce shortages across Australia and indeed internationally, and that strategies to address these shortages needs to reflect both the unique local needs within Tasmania and broader national commitment by all stakeholders to valuing sustaining the midwifery profession, through dedicated midwifery workforce supply and demand models, recruitment and retention strategies, career pathways, support for midwives and leadership.

ACM recommends prioritising a local Bachelor of Midwifery undergraduate course, with education and clinical placement being exclusively within Tasmania. This will enable Tasmanian residents to fulfil their midwifery aspirations on the island without having to complete a nursing degree first. This would represent a significant investment in our future midwifery workforce and current Tasmanian residents, many of whom have very deep connections to the state.

Implementation of strategies to sustain and retain midwives across all stages, from students to late career. This requires incentives, developing innovative approaches to meeting staff needs, and exploring barriers to midwives remaining in the industry.

Addressing workforce shortages and investigating barriers to midwives working in continuity of care models, and implementation of count the babies in midwifery ratios, to ensure safe staffing levels for midwives and families.

In closing, there are two further priority areas for Tasmania to highlight from ACM submission, which the GP's spoke about very well, which is improving access to mother-baby units across Tasmania for women experiencing mental health challenges, and implementing birthing on country initiatives to support dedicated, culturally safe continuity of care maternity models for First Nations women and families. Thank you.

CHAIR - Thank you. It is very important content and we also heard some birthing on country evidence from the TAC yesterday. I would like to get to some questions about those things and about different locations for birthing. We heard from HomeBirth Australia yesterday, around the need for variations in diversity of where women choose to labour.

I wanted to go first to the workforce challenges that you mentioned. One of the things that we're hearing a lot through our roles as MPs, but also the current AMF campaigns around workforce shortages, are concerning and they go to the issues that we're hearing around continuity of care. Particularly through the public system, hearing of the need for more of a continuity of care approach.

I wonder if you can expand a little bit more on, from the ACM's view, what those workforce challenges are and how Tasmania is best placed to become an employer of choice for midwives. We want to see a strong, stable, and continuous workforce of people wanting to work in our health system and stay here. Could you expand a little bit more about those workforce challenges, in terms of how they might be unique to Tasmania, because I know there are workforce challenges elsewhere as well?

I have a question about count the babies as well, but I might stick with workforce for a second.

Ms SHAKES - Did you want to start with that broadly, Alison, then I can link it back into Tasmania?

Ms WEATHERSTONE - I'm happy to do that. Thank you for the question. The Australian College of Midwives is very keenly watching and actively advocating for changes in workplace conditions for midwives, and we always promote continuity of midwifery care; that's where you have a known care provider throughout the whole pregnancy. There are variations across Australia. There are antenatal and post-natal models where the woman and her family receive continuity in antenatal and post-natal, but then present to a hospital for birthing, and they don't receive the same midwife in that model.

What we're seeing today is, the launch of the Midwifery Futures Report in Canberra. That report has now been released from embargo and that has created some very real recommendations that ACM supports to actually support the future of the midwifery workforce. A lot of that is around midwifery designated leadership, because we know that many midwifery models of care are led by nursing. And the nursing profession, very respectfully to our nursing colleagues - it's important to understand the models of care to midwifery are quite unique and, in that sense, require midwifery leadership at all levels, right from middle management up to executive levels.

Growing a midwifery workforce with a pipeline, as we spoke about in the opening statement, is having access to undergraduate then postgraduate study, and having that local, is demonstrated to support attrition.

Also, there's a number of students who don't wish to hold a dual qualification, so having a double degree is a barrier for some students. In other states the Bachelor of Midwifery is often oversubscribed, and then we are losing those future workforce because they're not re-enrolling the next year if they're not successful.

CHAIR - Okay, thank you.

Ms SHAKES - We have heard from quite a lot of women who would like to study midwifery and delaying it and delaying it because there aren't local opportunities for them. So, that is a key area to make a difference, to grow them here, because then they have a commitment to stay here.

Ms WILKINSON - To speak from my own experience, I grew up in Hobart but travelled to Melbourne to do a Bachelor of Midwifery. I was young, I wasn't really sure what I wanted to do - I had midwifery or linguistics as my top two. I definitely wasn't going to do nursing. If Melbourne hadn't been an opportunity for me, I would have done something entirely different. I saw them as completely different professions, which they are.

Ms SHAKES - Until recently we have had some of the lowest pay in Australia for midwives, which I think has been a disincentive. We don't currently have the same kinds of incentives that you see in New South Wales and Queensland, for example, where there are significant financial incentives for midwives to come for set contracts or permanency.

Ms WILKINSON - Again to interject, I went from Melbourne to Canberra, which at the time had some of the best pay rates for midwives and continuity midwives, in terms of the on-call loading. It was a real pay cut to then come back to Hobart MGP. It was no question for me, I'm Tasmanian to the core, but if I wasn't desperate to live in Hobart and in Tasmania, then that might have been a different decision.

CHAIR - This question might be one that you're well placed to answer, Alison. For the states and territories that do have separate midwifery degrees, do you know what proportion of people are taking that degree after having done a nursing degree versus what you've described, Maya? I have friends who've done both, definitely friends who have wanted just to study midwifery and have gone interstate to do that versus people who've done a nursing qualification first. Do you collect that kind of information at the ACM?

Ms WEATHERSTONE - We don't actually collect that data, but I'm very happy to take that on notice and to provide some statistics to you. What we do see is each state and territory does do it slightly differently and there are variations of that. Most states and territories will have the option to do the employed model or they could have a Bachelor of Midwifery or you can go on and do a dual degree. Not all midwives actually study nursing as their second degree. Some do paramedicine or psychology and so there are variations of that.

There is also the Postgraduate Diploma of Midwifery once you've got your nursing qualification. You can go back and do 12 to 18 months of midwifery, so it does vary across states and territories. There are different contributing factors to that as in the entry requirements for each of those courses and there are slight nuances in each state and territory. What we do see is that the majority of people wanting to study midwifery want to do midwifery alone because they also have the consolidation side of that and the continued professional development. If you have two degrees, you need to maintain your recency of practice in both.

CHAIR - In both? That's a challenge as well.

Ms SHAKES - In one of my other roles, I work with student midwives in Tasmania and I polled them. There were probably 15 in total and they were all nurses, already doing midwifery. I asked them all what their preference was. All but one wanted to be midwives and they had done nursing first. For some of them it has taken 18 years to get to where they want to be, doing midwifery, and some of them have just got their nursing qualification and straight into midwifery.

What that tells us, and what we know from our own clinical practice, is that for midwives in Tasmania to have to do nursing first if they're doing it within the state, we're effectively poaching from the nursing workforce, which has its own shortages. The opportunity for student midwives to really specialise in the field as well is enhanced when you're doing a Bachelor of Midwifery so that's three years of specialising within all the nuances of midwifery, which is a very diverse field, doing one year or 18 months on top of it is absolutely right for some people, but for others, being immersed in it will be more helpful to them.

One other thing that we also know from the research is that a higher percentage of midwives who choose to work in continuity of care models have done a Bachelor of Midwifery, so that's quite telling. It's a national objective to have more continuity of care models. We know that it's the gold standard. We know there are issues to attracting people to these models of care, but midwives, as we have done, BMid, we are very well placed to prioritise that. It's our preferred model of care.

Ms WILKINSON - That philosophy aligns really well with the basic midwifery philosophy which is really embedded in a direct Bachelor of Midwifery.

CHAIR - Okay, that makes sense. Thank you.

You said you practiced previously in the MGP. Can you just tell us a little bit more about that? We heard yesterday there's often people who aren't eligible for the MGP for various reasons: it might be complexity or geographical location of where their home address is. I'd like the committee to be able to hear what the benefits might be of expanding the MGP or trying to move to a model where more women are seen through a continuity of care model like the MGP.

Ms WILKINSON - I have worked in it and spent some time as co-ordinator, but less recently than Rowena.

CHAIR - Okay, you're in there too. Please share; I would love to hear.

Ms SHAKES - Midwifery Group Practice is a continuity of care model. You meet your midwife early on. Your primary midwife ideally provides the majority of your antenatal appointments, be on-call for your birth and postnatal care down here, up to two weeks. In our proposal we have suggested a six-week postnatal care period but I guess a lot of MGPs around the country, to my knowledge, have started out as being low risk and over time, as they have developed - this is my experience in Tasmania and one that I've been part of is that there's an expansion of the complexities that women may experience in their pregnancies that are supported within it, but there are still criteria where women are not eligible for it. We have suggested that women from minority backgrounds or who are experiencing a lot of complexities, would be some of the best to receive continuity of care throughout their pregnancies. So, we would definitely advocate for changes to the model to enhance that.

Ms WILKINSON - The Hobart model, and I can't speak to the north or north-west, was set up with a goal to be more inclusive. Also bearing in mind that there's more socio-economic disadvantage in Tasmania. It's not solely a self-referral model, in that it's not only women that hear about it through their friends and ring up. Sometimes people are referred, through triage, through their GP or by recommendation from a care provider, which is a positive. It also tries to be more flexible and more open, in terms of medical risk for Aboriginal and Torres Strait Islander clients.

I would say that probably some of the barriers come in, in terms of complexity, not so much in willingness, but more in just how to have those really robust systems of consultation with the obstetric team and with the other teams. That's probably where it's been a bit more restricted, would you say? Historically, I think sometimes some of those Aboriginal clients have been bouncing back between, you know - they've needed to see an obstetrician or see a social worker, and then it just gets a bit much going to the MGP appointments as well. The more complex care and complex medical care as well as social care, needs to be a bit better integrated with MGP.

Ms SHAKES - Or, there be different models for it within the system.

Ms WILKINSON - There could be like a combined model for those with higher medical risk or higher social risk.

Ms SHAKES - Or one for young people having babies would be a fantastic idea.

Ms WEATHERSTONE -Yes. It's definitely the position of the college that all women have access to Midwifery Group Practice or continuity of midwifery care, regardless of risk.

There's a lot of evidence, research and data to demonstrate the improved outcomes for women and babies, such as reduced intervention, and less likely to have birth trauma. Our caesarean section rate nationally is rising and our induction of labour rates are rising. These sorts of models have protective factors for mums and babies. I think what we need to see is looking even at continuity of medical care, in alignment with midwifery and continuity that they received. Also it is strengthening the midwifery leadership, because where the Midwifery Group Practice becomes challenging, in terms of accessing, is because of workforce usually, and that's because annual leave isn't backfilled, and there is not combined leadership in governance over that model of care, and so it's less attractive to midwives to want to work in.

We see out of the New South Wales Birth Trauma Inquiry that there's overwhelming evidence that Midwifery Group Practice is what women want, and there's wait lists across Australia. So it's more looking at what are the barriers to scaling it up. But really the position of the college is there should be universal access to continuity of midwifery care, and one of those models would be MGP.

Ms SHAKES - In the local context around the distances that you said there, workforce is probably the most significant contributing factor to that, because it's around, okay, do we have the midwife to be able to drive one hour to that person's house for the post-natal care? That's where the geographical aspects of it come into it. It's not about where the woman lives. Do we have a satellite clinic that the woman can attend for her appointments -

Ms WILKINSON - Because the MGP model utilises more post-natal care in the home and less in the hospital, compared to other models of care.

Ms SHAKES - And that's why it's cost saving, significant cost saving with midwifery group practise, partly through reduced intervention rates and then also through reduced hospital stays, which are very expensive. That means we can put that money towards longer postnatal care, which hopefully supports better breastfeeding, a better start to life. Some of the things the GPs were just talking about then wove in very well with what our position is or why it is our preferred model of care.

Ms WILKINSON - The Hobart MGP has recently offered a more part-time model because they have found a lot of the workforce, due to family demands and things, are not able to commit to being on-call and working 0.8 or full-time, and from what I have heard that is going very positively. That might be an option. I am not sure about Launceston.

Ms JOHNSTON - Thank you for coming and presenting. You and your list of recommendations in your submission are great. The recommendation you have made on reopening rural and remote birthing centres and establishing new services in underserviced areas and prioritising, as we have spoken to, about continuity of care models. We have heard in other evidence the lack of birthing centres in Tasmania and the options around home birthing, birthing centres, hospital birth. Can you perhaps speak to what providing greater access to birthing centres would mean to women in Tasmania, in particular to those from Aboriginal communities, for instance, who might want to have that community care model more?

Ms WEATHERSTONE - Thank you. Australian College of Midwives has done a lot of work over the last 18 months with the Rural Doctors Association of Australia and the Office of the National Rural Health Commissioner on refreshing the National Maternity Consensus Framework and that is a document that should be launched towards the end of this year that enables rural and remote places in particular, to look at their local needs-based assessment of how they can provide birthing surfaces closer to home for women and families. It is really important not to look at the number of closures over the years and look at how we can substitute services. Women travelling long distances to birth increases the number of roadside births, it displaces families which has a social, financial and emotional impact on the family for many weeks before and even after the baby is born. This is also a national challenge, but we need to look at innovative models of care where we are utilising Telehealth, we are utilising midwives in community.

Because of the scope of practice and autonomy of a midwife and their ability to consult and refer, then they can often sometimes be the only health provider in community to provide those services and then the outreach happens in a different way. There is an opportunity here just to change our ways of thinking and working so we can provide services locally for women. Thanks.

Ms JOHNSTON - In terms of birthing services, and we have heard a lot about birth trauma and, particularly, some negative experiences in hospitals and the reluctance to go to hospitals and all the baggage that goes with entering a hospital system. Do you have any data on the experiences of birthing centres as opposed to hospitals in addressing some of those risk factors of birth trauma?

Ms SHAKES - We could take that on notice in that specific example, but what we do know is that birth outcomes for women from satisfaction and clinical outcomes in freestanding birth centres as opposed to birth centres that are alongside birth centres co-located within the hospital grounds, they might be the same hallway or it could be right beside it, freestanding birth centres have better outcomes.

When I was listening to the GP talk, it reminded me of what he is suggesting for the mother baby unit, that it is homelike, women are comfortable there, you are not pathologising the person's experience. We have very clear referral pathways available to us to transfer, very clear, just like homebirth. We have very clear pathways, should transfer be indicated, so yes.

Ms JOHNSTON - There is value in having those birthing centres, not only in rural and remote areas, but also along in urban areas too, where you get better outcomes across the board no matter who is accessing it regionally.

Ms WILKINSON - The Launceston Birth Centre is a great example and Jamie does have some really great stats on the outcomes there. Then there is a lot of new building research on the birthing on country, particularly in Waminda.

Ms SHAKES -They're in New South Wales, a First Nations' specific birthing centre. Very exciting to see that come to the front.

Ms WILKINSON - Looking to those successful pre-existing models as well as with any First Nations changes that would be consulting with the community. For instance, like a publicly funded homebirth program could also utilise a birth centre.

Ms SHAKES - The difference for the Launceston Birth Centre, it's a privately funded space. We would very much advocate for publicly funded freestanding birth centres, as well as those privately funded birth houses or birth centres, because women want choice. We hear that overwhelmingly in the feedback they provide.

CHAIR - The Hobart Birth House, do either of you have experience in that?

Ms SHAKES - There has been a committee looking at that for a number of years. It's stalled and hasn't progressed at the moment, but it's not off the cards if there's some public funding for it.

CHAIR - That might be something we can lean to in recommendations.

Ms SHAKES - It would be fantastic.

Ms WILKINSON - A lot of this is on the endorsed midwives also. The Launceston Centre is run by an endorsed midwife. Changes to the opportunities for midwives to seek endorsement and changes to the potential ways of working and improved scope for endorsed midwives could then lead to further opportunities in the private space as well as them working in the public system.

CHAIR - Cecily and Anita, would either of you like to jump in? I feel like we're hogging the time down south. Anita, your hand is up.

Ms DOW - Thank you very much for presenting to our committee. You have provided advocacy on the undergraduate Bachelor of Midwifery in Tasmania. What is the reason given for why it isn't currently offered in Tasmania? Do you have any insight into that?

Ms SHAKES - From informal discussions with people I have insight into it, which is that it is not considered financially viable. The Tasmanian University has said perhaps it would be something that would be viable if they co-badged with a mainland university.

Ms DOW - The other recommendation you make in your submission is distinguishing between the role of the chief nurse and the chief midwife in Tasmania. Currently, that's a dual role. I was quite interested in that proposal and having a separate stand-alone chief midwife. I'm from the north-west and there's been a lot of changes and issues around maternity services up here of late. You make mention of the closure of the Mersey Community Hospital birthing services and consolidation at the North West Private Hospital. Could you please elaborate on the advantages you see in having a chief midwife at a government level across the THS. Then secondary to that some of your thoughts on the consolidation of services in the north-west and the impact that's had for staff and for north-west Tasmanians accessing that service, please.

Ms SHAKES - Thank you. I'll get Alison to speak on the chief midwife.

Ms WEATHERSTONE - Thanks, Rowena, and thanks, Anita. I would firstly like to acknowledge that the Chief Nursing and Midwifery Officer in Tasmania does hold dual qualification and she is one of two who does have that in Australia currently.

While we strongly advocate for a designated chief midwife role, we also acknowledge the size of Tasmania and that currently the incumbent has both. What we would seek to still progress towards having separate leadership roles at executive level. I'll give you those reasons in a moment. But in terms of the progress towards that, a secondary recommendation would be in the event that role became vacant, that could then also become the opportunity to split the two roles, so you wouldn't necessarily actively seek to do that immediately.

Based on that, midwives should be leading midwives. What we've seen is with midwifery being a distinct and separate profession that where there is midwifery leadership across all levels from middle-management all the way up to those decision-making roles, that you are more likely to have increased midwifery continuity of care and a stronger workforce.

What we've seen recently with the appointment of the Chief Midwife Officer in Queensland is a commitment from the state, as well, to increasing access and also looking at from a woman-centred perspective, but also from a midwives' and sustainability of the profession. I'm very happy to provide some recommendations specific to that, on notice, but we have also a position statement on Midwifery Leadership, and it is a priority in almost all our submissions, especially the scope of practice submission recently, as well, for Primary Maternity Care Reform.

Ms DOW - Thank you. That would be great. I do appreciate that.

Ms SHAKES - On the topic of the north-west, we acknowledge that it's been a very difficult few years for midwives and families in the north-west. I personally am not well positioned to make further comment on the specifics of it. We hope that the changes that are emerging are positive and are rebuilding.

Ms WILKINSON - We did see some of the north-west midwives at the recent national conference and heard about some of the staff that have been lost through the process, and hope that it's coming back on track, in terms of being all back within the same health service.

I'm not sure about your perspective of how it's travelling now, but -

Ms DOW - We will just have to wait and see, won't we? It's been a pretty challenging time. In part, the representation made from different parties has really prompted this inquiry through the Tasmanian parliament as well. This is a good opportunity to get some things on the record about it, so thank you.

Ms JOHNSTON - Another one of your recommendations is to provide pathways and support for midwives to work in dedicated bereavement midwife roles. What's happening in those roles at the moment? Is it ad hoc in terms of who can provide, or special training?

Ms SHAKES - What I would probably say it is within the scope of practice of all midwives to offer bereavement care, but in acknowledging that it's such a profound time for families, there are opportunities for that to be further specialised to just really enhance families experience through such a difficult time.

Ms JOHNSTON - Is that in both training but also in supporting you in practice, in terms of time allocated for those families in particular? Is it two kind of things that can be done?

Ms SHAKES - Yes, definitely. Alison, would you have input on that?

Ms WEATHERSTONE - Thank you. Bereavement care is such an important aspect of midwifery care, and it's also has a huge impact on the women and their families when they undergo perinatal loss. We see that midwives require support and education on going to work in that model because when that's solely their role or task - a lot of facilities will have a bereavement midwife or a perinatal loss midwife - it's important that they have the right supports when they're supporting families through their grieving process as their sole role.

The other aspect in terms of maybe rural and remoteness or when perinatal loss is not something that's often experienced at a service is often midwives can feel a little, not so much unsupported, but just have some pressures around how they provide that service because it's not something that they're routinely doing.

It's important to have access to a really clear perinatal loss service, as well as education and then supports for both families and midwives. I think what you'll see is out of the Birth Trauma Inquiry again in New South Wales, and I'm sure your submissions in Tasmania, that the care that a woman and her family receive during this time will stay with them for their lifetime and will really impact on how they will see future pregnancies or just even their lifestyles after that. It is such an important and underrepresented aspect of midwifery care. Like

Rowena said, it is core business for all midwives but we can't cram everything into an undergraduate degree.

We're seeing so many challenges with what's actually part of the curriculum, especially coming out of what's culturally-safe and trauma-informed care. Just providing support will also retain midwives in the profession as well. It's definitely an area that should be a priority.

Ms JOHNSTON - Thank you.

CHAIR – There's something that you've written about in your written submission that I'd like to explore a little bit more. It's a federal issue and I know that there's been a slight reprieve, but it's around the insurance issue for private practicing midwives with homebirths. Is there anything that you would like to share with the committee for our knowledge about that issue that we could perhaps build into our recommendations to then advocate on behalf of Tasmanian women to the federal government? I understand some of the complexities we heard from the HomeBirth Australia yesterday, who shared some of their explanations around the current insurance issue, but is that's something that you'd like to add ACM's views on as well?

Ms SHAKES - Alison, do you want to start with that and I can see if there's anything to add?

Ms WEATHERSTONE - Yes, Thank you. In my role as Chief Midwife, with the CEO of the college and our board and our president and on behalf of all members, we are in close communication with the Commonwealth around the progress towards an insurance solution for professional indemnity insurance for midwives.

We understand that the exemption will be extended to the end of December 2026 while this insurance solution is finalised. We do understand that this is a final extension. Obviously, we do know that the removal of collaborative arrangements comes into effect from 1 November also. We are fairly confident as a college that the consultation is in train and that our number one thing would be communication for midwives because it's really important that all midwives, whether they're working in private practice or not, understand what's happening in terms of communications for this professional indemnity insurance because that also translates to communication for consumers as well.

Ms SHAKES - We acknowledge that it's been a stressful time for midwives and families, but I guess sometimes through adversity you do get more voices coming out. I think it's been very positive to see the uprising of people having their input around it. The voices are coming from where they need to, so HomeBirth Australia, and I think just more advocacy from all avenues, I think, is very positive.

CHAIR - I think so too. I share your positive feeling that that extension has been made by the federal government because I think what a terrible situation would be if we end up with an insurance product that diminishes the capability of PPMs to be able to practice. That is one of the risks with one of the proposed models of insurance, as I understand it. It's a very layperson's understanding. I wouldn't profess to be expert in it, but there was a risk with one of the proposals I think that it could actually reduce the capability of people to be able to access homebirth services.

Ms WILKINSON - It is about not defining risk as solely related to medical or physical risk. Sometimes even women with higher risk in an obstetric sense, pregnancies, home can be the safest place for them and that we know that sometimes past trauma or birth trauma can lead people to that choice. We're not wanting to restrict those clients from that option or drive people into freebirth or unsafe situations.

Ms SHAKES - That is one of the genuine risks of an unsuitable or not fit-for-purpose insurance product is that people will opt out and we will have to respect that's their right to make that choice, but it would be a shame to see freebirth rates on the rise for this reason.

Ms WEATHERSTONE - In terms of advocacy from Tasmania, it would be really great to ensure there is ongoing communication because as you mentioned, unintended consequences are what we want to avoid. By having subject matter experts at the table, we are able to arrive at that decision appropriately from the outset.

CHAIR - Yes, that's really important. Are there any other issues that you were hoping to raise with the committee that haven't come up in our conversation. Any of you?

Ms SHAKES - I think we've had a good cover of it. Alison, is there anything?

Ms WEATHERSTONE - No, I think our submission and our opening statement and your questions are very comprehensive. I would like to thank you for having the opportunity to bring these voices out. Inquiries like this see really meaningful recommendations that do ultimately improve outcomes for women, babies and midwives. Thank you.

CHAIR - Thank you. That work isn't possible without hearing the expertise of people in positions like yours. We're very grateful as committee members for you sharing your experience, giving up your time today and your very comprehensive written submission. It's very meaningful and we are very grateful for it as a committee.

If after today other things come to mind that you think of later, that you think I wish I'd mentioned that or the committee would benefit from hearing it, please don't hesitate to stay in touch with us through Mary or with any one of us as committee members. We'd welcome hearing from you again as we continue our work and move into the report writing phase of the committee's work, and we'll keep you updated when that report's ready as well.

Ms SHAKES - Thank you. We will look forward to it.

THE WITNESSES WITHDREW.

The Committee suspended at 5.00 p.m.