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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, 30 OCTOBER 2024

The Committee met at 9.10 a.m.

Ms JOHNSTON - Welcome to the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you very much for your submission. If we can begin today by please stating your name and the capacity in which you're appearing before the committee.

Ms ISABELLE ODERBERG, VIA WEBEX, CO-FOUNDER AND CHAIR, EARLY PREGNANCY LOSS COALITION AND **Dr SARAH SIMONS,** VIA WEBEX, EARLY PREGNANCY LOSS COALITION, WERE CALLED AND EXAMINED.

Ms ODERBERG - I am an author, a journalist, a media professional. I am the cofounder and chair of the Early Pregnancy Loss Coalition which, to a large degree, acts as a peak body or representative body for other organisations offering miscarriage care across Australia.

Dr SIMONS - I am an emergency doctor in Victoria/Naarm, and I sit as a policy advisor for the Early Pregnancy Loss Coalition.

Ms ODERBERG - I should just add that we are on Yalukit Willam land and sovereignty was never ceded.

Ms JOHNSTON - Thank you very much. Can I confirm that you've received and read the guide sent to you by the committee secretary, please?

Witnesses - Yes.

Ms JOHNSTON - Fantastic. This hearing is covered by parliamentary privilege, allowing individuals to speak with freedom without fear of being sued or questioned in any court or place out of parliament. This protection is not accorded to you, however, if the statements that you make may be defamatory and repeated or referred to you outside the parliamentary proceedings. Anything you say within the parliamentary settings is protected, but if you repeat them outside of the parliamentary proceedings, whether it's to media or outside, then you're not protected.

This hearing is public. The public and media may be present and should you wish that any aspect of your evidence be heard in private, you may make this request to the committee at the time. The committee will have a short deliberative meeting and decide whether that's appropriate. Let us know if there is anything that you need to be heard in a private, in-camera session.

I'll introduce myself. I'm Kristie Johnston, and I'm in Hobart in the physical building here and I'll be facilitating the meeting today.

Online we have our chair, Ella Haddad, she's the member for Clark, another Hobart-based member. We also have Anita Dow, who is a member for Braddon in the north-west of our state.

We have Cecily Rosol, a member for Bass in the north of our state in Launceston, and Rob Fairs, another member for Bass. So you have all three parts of our state represented on the committee here today.

As you're interstate, you don't need to make the declaration, but I will. The committee has decided to read a sensitive content hearing script at the start of every hearing because of the nature of what we're talking about today.

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. I'd encourage anyone impacted by the content matter during this hearing to contact services and support such as Lifeline's Helpline on 13 11 14 or via text at 0477 131 114 for 24/7 mental health support, the Tresillian Tasmania Parent's Helpline on 1300 827 282, or the PANDA National Helpline on 1300 726 306.

They are the formalities out of the way.

I invite you to make an opening statement, if you wish, before we start.

Ms ODERBERG - I have two living children. I had seven early pregnancy losses, one of which was a termination for medical reasons. It was the reason that I wrote my book *Hard to Bear*. I've done much journalistic investigation on this particular topic. It's the reason that I co-founded the Early Pregnancy Loss Coalition.

Miscarriage and early pregnancy loss lives in a very quiet space at the intersection of grief and vaginal bleeding - two topics that tend to invoke huge amounts of silence and are not discussed or treated. It's not discussed to the extent that it should be. It's not treated as well as it should be, whether medically, clinically, or with psychosocial supports. Often, peers and family members just don't know what to say because we just don't talk about it and we don't give them the power to support the people they love when this grief happens.

We were responsible for the first ever federal government budget targeted spend on miscarriage, or untied spend on miscarriage. It was around $10 million, including psychosocial support grants and various research grants to further investigate this space. We have a lot of plans in this space to try to improve care across all 'variants of care', if I can put it like that.

In terms of the scope of your inquiry, I would also add that there is best practice generally. There's best practice that's going to apply to Tasmania taking in the specifics of the Tasmanian landscape and medical landscape. There's also best practice care more generally that just isn't being applied anywhere in Australia that is really important.

In addition to supplying support or providing support or best practice clinical care for those who experience miscarriage, we can never forget pregnancy after loss is incredibly difficult. It comes with its own challenges. We know that supporting those patients clinically and with psychosocial support actually results in better outcomes and live births. That's very important as well.

If anyone is struggling with any of the topics raised, I would also encourage - for specific miscarriage care - Miscarriage Australia is a great website to go to for support.

My colleague, Sarah Simons, assisted with the submission that we gave to you all, adding in some very important Tasmania-specific information and considerations. Did you want to offer anything in addition to what I've said?

Dr SIMONS - I would just say that in Tasmania there is a huge variation between rural, regional and metropolitan healthcare resources. There is a huge social gradient and socio-economic gradient in people seeking healthcare. With miscarriage particularly, the number of social considerations that affect health, such as intimate partner violence for one, have to be important points of consideration when providing care around pregnancy and pregnancy loss, and that more complicated with greater distance to travel to access definitive care. That is more relevant in the Tasmanian setting than in other metropolitan settings across Australia.

Ms ODERBERG - We are well aware that a vast array of minority groups are not able to access adequate healthcare across a number of touch points. It's no different in the miscarriage space, especially among groups who are LGBTIQ+ and gender diverse, as well as Aboriginal and Torres Strait Islander peoples who suffer from a range of barriers, in this case as well and sometimes even more so.

Ms JOHNSTON - Thank you very much to you both. This is going to be a free-flowing session. We're really keen to hear what you've got to say. Thank you very much for your detailed submission. I know that we're interested in the rural and regional aspects of your submission, given our breadth of committee membership.

I might go to our committee Chair, Ms Ella Haddad, to ask a question.

CHAIR - Thank you both for providing such a comprehensive written submission to the committee. It has provided essential and important information for us to consider as we continue to do our work: report writing, findings, and recommendations for the parliament. So much of it is very important.

I want to go first to one of the things that you raised, which is data. We have heard from several other witnesses about a lot of the issues around data being a problem in our health system generally. You touch on it in a couple of ways such as opportunities for Tasmania to be a leader in collecting early pregnancy loss data, which I think is a really important recommendation, but also around patient care with files not being updated and information not being adequately shared when people are experiencing pregnancy loss. That can add to the trauma that they're experiencing. I wondered if you could elaborate on both of those sides of data sharing and data collection.

Ms ODERBERG - If it pleases the committee, I'm going to start with the first question, which is the collection of data. Sorry, that was not your first question, but I'm going to make it the first question if that's okay. There is generally an issue with data collection in Australia for a number of reasons, but I'm going keep this specifically to the early pregnancy loss issue.

There are a number of things going on here. The first issue is that people who experience early pregnancy loss have a number of different touch points. They may be under the care of a GP, they may be under the care of an obstetrician, they may attend an emergency room, and they may, especially if it's not a first loss, actually miscarry at home and no one outside of their circle - as in no one in a medical setting - knows that they've miscarried especially in the case

of earlier losses like chemical pregnancies and things like that. That's the first issue with the collection of data.

The second issue is that there's been an obfuscation of miscarriage data because of its intertwining with abortion statistics. This is in no one's interest. I know that the pro-choice lobby wants that to be unwound as well. We see this in the lack of transparency in Medicare coding. For someone who attends, for instance, a hospital for an early pregnancy loss and is given a D&C [dilation and curettage], that'll just be recorded as a D&C. It won't be recorded whether that is a situation where that person has made a choice to end that pregnancy because they don't want to proceed with the pregnancy, as opposed to a miscarriage where the person really is doing it for surgical management of that pregnancy.

What we also see is that sometimes, where a hospital is unable to offer care, that patient may go to, say, an abortion clinic or something like that in order to receive adequate care - or the care of their choice, I should say. Again, in that situation, it's not necessarily defined as to why they are seeking the abortion in question or the D&C. Therefore, that's where the obfuscation happens where there's confusion over which is which and what is what.

In the federal budget funding that we received, there are two things happening. The first thing is that the AIHW is doing an investigation into how we can best collect miscarriage data, early pregnancy loss data, which we expect to be slow but thorough. Also, we're looking at an audit of Early Pregnancy Assessment Service (EPAS) clinics which will also give some indication.

Is that an adequate answer in terms of the collection of data, some of the challenges that we have? Do you want to add anything before I go to the second -

Dr SIMONS - I would just say that in the public healthcare system, one of the significant issues that we have with data tracking is this concept of, I suppose, the lowest common denominator. When you present seeking healthcare, regardless of pregnancy specifics, the data that's collected, the discharge plans that are made, have to fit this lowest common denominator of, 'Can it be done in an emergency setting at four o'clock on a Sunday morning? Can you facilitate a safe discharge plan? Can you ensure that somebody gets the definitive care that they need? Can you do that within the remits of varying, again, socio-economic statuses, access to private healthcare, access to go and drive 200 kilometres to a definitive surgical clinic?'.

All these considerations mean that, often, people will seek emergency healthcare because it's open 24/7. They have to wait four days to EPAS, but that might be a day that they're working or a day that they can't get existing childcare. The problem that we then have is that people may also not have a regular GP if they're just hopping onto HotDoc, for example, to access a primary care consultation in the absence of any regular GP.

So, whilst the introduction of processes like My Health Record have been significantly beneficial to try to track all these things, it won't ever capture outpatient ultrasound scans that may have been done publicly or privately. It won't access any of the psychology or psychiatric input that we know has a significant overlay with pregnancy loss. It doesn't often capture lots of these sporadic GP appointments and many of those will be within the public sphere, but also the private sphere.

To have, as Isy says, a touchpoint where you can collate all these contacts is really challenging and often the onus is then put back onto the person who presents to say, 'Hey, look, what can I do?'

Ms ODERBERG - And it doesn't mean that it can't be done. It just needs a bit of lateral thinking. It's been done overseas like in the Nordic countries.

The other issue is with separation data, which is when you leave hospital. That's the data collection at the time of being discharged. If someone attends an emergency room and they're never seen because the triage desk says, 'Oh, you're going to be eight hours waiting to be seen. We know that the pregnancy is not ectopic. Here's some information. Go home and wait to miscarry', there's no separation data because they were never admitted. That happens quite frequently as well.

So, second question regarding files being updated. There are various best practice methods being used overseas, for instance, when someone is pregnant after loss. There are a few hospitals in the UK that are involved with Tommy's National Centre for Miscarriage Research. They put a little sticker, a rainbow, on the person's chart so that whoever is treating that patient is aware that it's a pregnancy after loss, and is careful, understands that that patient may be experiencing higher levels of anxiety or stress, or those sorts of things.

One of the biggest problems we have in Australia is that, because the systems do not talk to each other, even if you have had a loss that is acknowledged by a file with one medical provider, another medical provider may not be aware of it. So, often what you have, especially in the public system, is someone will have a loss and then get a call two months later, 'Are you ready to come in for your next midwifery appointment' or whatever. There is just no consistency in communication across the different touchpoints, even when it is in the same hospital. I have had examples of case studies where people have miscarried, attended emergency, been diagnosed, had a D&C, everything, and the same hospital's maternity setting will contact them and say, 'Are you coming in for your appointment next week? We are just calling to confirm'. So, there is a real issue with communication as well.

Does that answer the question around files not being updated and that sort of thing?

CHAIR - Yes, you have given a good example of that Nordic experience, that is a simple and effective way to alert other medical professionals. You have also highlighted the complexities of data sharing. Obviously, it is not working if the same public hospital is also calling people - and you have touched on that in your written submission as well. That would be heartbreaking to get that call asking you to come in for an appointment. Equally, if the miscarriage has occurred outside of that public hospital setting, there are problems that we need to be aware of in terms of sharing information between healthcare providers. So, it is very comprehensive.

Ms ODERBERG - There is also pregnancy tracking apps, which people use a lot, which are very difficult to opt-out of - they deliberately make it difficult to opt-out. You are continually getting these 'your baby's as big as a watermelon' messages on your phone. They are very difficult to opt-out of because they want you to stick to the app so that they can mine your data for commercial reasons.

The other thing I would say, just very briefly is that, within that hospital setting and within all care settings really, the progress that we have made, whatever you want to call it, progress or just advancements in care, have meant that pregnancies are being personified at a younger and younger gestation and earlier and earlier gestation. I can do a high-sensitivity pregnancy test two days after my period is due and find out that I am pregnant, so that personification process happens earlier and earlier. For previous generations of healthcare providers, that process was different.

Often there is not the understanding that a miscarriage is a huge trauma for a number of patients. They do not understand that and they just go, 'You just had a miscarriage. What is the big deal? Move on'. However, as *The Lancet* said in 2021, the days of just dismissing that grief and relegating it to, 'Oh well, too bad, whatever', are over. They did not use those exact words, but that is paraphrasing.

CHAIR - That is great, thank you.

Dr SIMONS - I would say one of the biggest practical considerations is the divergence between paper written records that many regional and rural hospitals and facilities rely on, and the centralised, again, more metropolitan, electronic medical records. But, even in different hospitals, we use different programs, and that trajectory of data sharing is so poor that it can often take three months for a discharge summary from an emergency department or urgent care centre to actually hit a GP, if you have a GP registered. Again, that pushes the onus back onto the patient to be the person responsible for communicating their health needs and their health access.

The mental health space has some particularly interesting examples of use of tech in this area. I think that probably relies a lot more on the fact that mental health engagement is, again, across multiple different professionals of outpatient psychologists, but potentially inpatient stays, private care - so that is potentially an avenue where you can collect lots of stuff and you can pull things and, if you have an identifying health record number, then that is of some utility. But again, you end up marginalising people who potentially do not have permanent Medicare access, who do not speak English as their first language, who aren't particularly technologically competent. So, again, you have to have this catch-all common denominator for any of these interventions.

I think over time, I would hope, I would desperately hope as a clinician, that we move away from paper-based records. We know the evidence suggests that they are unsafe, that they lead to increased errors, poor communication, drug errors - there is a very comprehensive list of things we would rather avoid if we can. We know that that is a detriment to equitable care and that's a big consideration moving forward, to look at the use of safe technology.

Ms JOHNSTON - Thanks very much. I might jump in there. Your recommendations around communication are quite clear. You refer to the continued use of inappropriate terminology and, Isabelle, you were leading that way in your final comments. Are there any examples of guidelines on material that you suggest we look at, or recommend that we adopt in Tasmania, that have the appropriate terminology and some training and awareness for health professionals around what that might be in best practice?

Ms ODERsimoBERG - I know that Pink Elephants provide some workplace-based training. I should declare that they are an organisational member of ours, as is Red Nose. I

absolutely suggest that you look at Tommy Centre for Miscarriage Research, which is probably the world's leading provider of research in the early pregnancy loss space. The Early Pregnancy Loss Coalition has a lot of information on our website, and Miscarriage Australia also has information on its website around optimal terminology. We're also working with the Royal Australian College of Obstetricians and Gynaecologists, and the Nursing and Midwifery Federation and the College of Midwives.

We're all on the same page. None of these things are controversial but, as you know, often changing culture isn't just flipping a switch. It's a lot of work and the information is there. I'm more than happy to provide any additional information that you think would be helpful. But there is a number - we can - even if everyone was on the same page and decided to flip the switch tomorrow on some of this terminology - products of conception or spontaneous abortion being used in front of patients. There are also significant cultural issues that need to be embedded and that's where the work needs to happen and a shift needs to take place.

I'll give you an example. A patient that I was interviewing went to hospital, severe ectopic, needed emergency surgery. They were explaining to the patient what they were going to do and the male obstetrician was laughing and joking the whole time with a nurse in the room. He then said, 'What we do is inflate your abdomen like your 40-weeks pregnant to do the procedure'. This is someone who was losing a very, very much wanted pregnancy and was completely traumatised both by the demeanour of the treating clinician, which was totally inappropriate for the circumstance, but also by what was a terrible metaphor in the circumstances.

That's where it gets difficult, but as for the terminology, we are working on it. That's about all I can say at the moment. We're more than happy to provide that information to anyone who needs it. It is available on our website, on the Tommy's website and on Miscarriage Australia's website as well.

Ms JOHNSTON - Is undergraduate training for healthcare providers being delivered, in terms of being trauma informed and understanding the significance of early pregnancy loss? Is that happening? Is that something that needs to happen?

Dr SIMONS - There is a movement towards - shared gold standard of care has historically always been ideas around shared communication and decision making. Often with patients who present with pregnancy complications, the level of health literacy surrounding the pregnancy and expectations can be a lot higher than perhaps somebody who comes in with a foot that's sore. That's like another consideration.

So, often establishing someone's baseline understanding, but also their expectations, their understanding, their hopes, and the level of risk that they're willing to accept. Again, a lot of that does come down to what we were saying about the regional/rural/metropolitan split. If home is five minutes down the road and you're still near a tertiary centre, the risk that you might be willing to accept and talk through with your clinician is very different from if you were to live 200 km away on a farm.

There is a movement, back to your original question, with communication training. Lots of medical schools are now pushing towards placement-based experience. That was obviously impeded by COVID. We have a class and a cohort of medical students who unfortunately had to undertake a lot of their training time online and didn't sit in the same clinical spheres that we

would have done however many years ago. We're working on that, but that's a recognised limitation of a lot of the care for junior trainees at the moment.

Aside from that, different hospitals have different provisions. There are certain public hospitals that are religiously guided and therefore the access to pregnancy care is compounded by the restrictions of what the hospital can offer. There are different experiences that people will have in different hospitals and there isn't a standardised model of care. Every hospital has an EPAS; every hospital has an obstetrician or a gynaecologist. That does affect people's experiences of seeing these encounters earlier in their career. That's something that would need to go back to the universities to ensure that that practice is standardised. That's a very difficult thing to take from a population-level public-health approach.

Ms ODERBERG - I'd add - in addition to conscientious objectors when it comes to certain forms of treatment - the best practice for miscarriage, the best practice care, is that the patient is offered three options. Expectant management, where they, by whatever natural means, go home and pass the miscarriage naturally, or they do it in an ED, whatever. The second option is medical management, which is the administration of - we're trying to get this changed - mifepristone and misoprostol, or just misoprostol, which are your 486 or one component of, in order to bring the miscarriage on, in which case you pass it vaginally. The third is a D&C, which is the same procedure as an abortion in order to end that pregnancy. That is patient choice. There are different reasons different patients would choose different options.

What happens is, in addition to the conscientious objectors, these are not seen as in any way - for instance, if a patient opts for a D&C, often it's not seen as a priority in the context of a hospital setting, which is usually really under pressure, resource light, not fit for purpose to come in and do the procedure for a variety of reasons and, therefore, they say they are not willing to pay for an anaesthetist or that it will take two weeks, in order to deter the patient from seeking surgical management of the miscarriage. There are numerous reasons that care is not offered or provided in the way that it should be balanced with best practice.

In terms of the shift towards women's health, there is certainly a shift now to recognise, in part led by Ged Kearney at a federal level and her work in this space. The endometriosis lobby has done a really good job of highlighting the need to be refocused on women's health.

Dr SIMONS - And the Victorian Pain Inquiry.

Ms ODERBERG - And the Victorian Pain Inquiry and other inquiries that are seeking to put the spotlight, especially, on medical misogyny. Medical misogyny, I have to add, goes from everything from men being given more grant money than women's health issues, both in the sense of who's doing the research and what the research is looking into, all the way through to a woman presenting in an ED with pain and being told they are hysterical. There are lots of different ways that medical misogyny affects our system. There is a shift to address and change that. There are multiple ways in which culture affects this. I've had doctors say to me, 'I would never use the words 'spontaneous abortion' in front of a patient, I would never do that. That would never happen'. I could probably get the names of say 50 patients, including myself, who have all had the words 'spontaneous abortion' said in front of them. When I sat in on a medical lecture at a large university in Melbourne, guess what terminology they used all the way through the lecture around miscarriage? It was spontaneous abortion. Is it any surprise that that's the terminology that clinicians are using in the field when they aren't thinking about what is actually best for the patient's psychosocial health?

One other small point: not everyone who experiences a miscarriage experiences trauma. There are situations, often in a DV context or a patient who already has living children who hasn't connected with the pregnancy there are solutions, where people don't experience trauma from early pregnancy loss, and that is okay.

To a large extent, the treating practitioner must be aware of what language is being used by the patient and be led by the patient. That means if the patient uses the word 'baby', you use the word 'baby'. If the patient doesn't use the word 'baby' and uses the word 'foetus' because they haven't connected with that pregnancy in a personified way, you use the word 'foetus'. There are things that have to be led by the clinician as well, using the soft skills of clinicians that are sometimes not their strong suit, if I can say it like that.

Dr SIMONS - I would add also, just as another consideration, even with the best training and the best intent of the clinicians, if the system will not allow you to discharge a patient with their discharge paperwork until you put in the ICD code, which is a predetermined list from the World Health Organization, I know we are talking very high level, but you can have all of these conversations with the terminology at the patient's preference, but if you then have to put a big heading at the top of the discharge summary for a diagnosis code that still says 'spontaneous abortion' because that is the language and the terminology that are used by the system, there is only so far you can go.

Ms ODERBERG - And remember, these doctors are under huge pressure in a system that is not fit for purpose, I really want to emphasise that. It is important to understand that they are operating in less than ideal situations where they are under-resourced, stressed out and, post-COVID, even more so.

Ms JOHNSTON - Thanks very much. I might go to Anita or Cecily, if you have any questions?

Ms DOW - I just had one, thanks Kristie. Thank you very much for your comprehensive presentation and submission. I want to take you to the recommendations in your paper around respective care and the development of dedicated complication or pregnancy loss units across the country. You make reference to a dedicated unit in the ACT. I wondered if you could elaborate on that, on whether there were others, or whether that is actually the first in the country, and what that model of care looks like in more detail, please?

Ms ODERBERG - The unit in the ACT came about as a result of my special adviser to the EPLC board, Karen Schlage, who contributed to this submission, who is a phenomenal advocate, who pushed for a special unit where babies born sleeping, or as a result of early pregnancy loss, could be delivered away from a maternity setting. As you can imagine, if you are labouring a baby that you know is not going to live or is unlikely to live, it is pretty traumatic when you hear babies being born around you who are going to live, without any shade being thrown at that. We are very happy babies are born living, but it can be very traumatic when you are in the process of that grief yourself. That was an amazing achievement by Karen. It is, as far as I know, the first in the country of its type. There are other units that have been set up - they will put aside a bed, for instance - but this unit was created explicitly for this purpose.

Around the country, there are early pregnancy loss services which were created often as a result of the incident that we described with Jana Horska in Royal North Shore Hospital in

Sydney, where the patient birthed during early pregnancy in the emergency room toilets, a baby boy.

Now, the early pregnancy loss services are not overseen by any central place. What we have heard anecdotally from many, many clinicians across the country is that often they are operating in name only, in a context where resourcing is low. They have, say, moved the ultrasound to another department that they feel needs it more, or they are just putting very young, qualified doctors in there as a 'you can just do your EPAS morning and then it is done' sort of thing. We have up to 150,000 families experiencing pregnancy loss a year, every five minutes. That does not include recurrent families where they have had multiple miscarriages in the space of 12 months.

We are deeply concerned about the early pregnancy loss services, regarding the way that they are operating, whether they are operating in name only or in practice. This is the reason that we pushed the federal government to fund an audit of those services across the country. Deloitte Access Economics has been given that project after a competitive tender and they have started that process. We have no idea what that looks like yet. I am doing a scoping interview with them next week so we will have more information on that very shortly from Deloitte Access Economics. We are pushing very hard at the EPLC, not just for the number of EPAS clinics, but actually, are patients happy with the service they are provided with at those clinics, are they being operated for two hours a day? Are they operating for nine hours a day? We need to know actual qualitative data, not just quantitative data on those services.

I have one patient who has a kidney disorder who I was interviewing. She has a kidney disorder, is in a huge amount of pain, is located in the ACT, and contacted the EPAS clinic as she was bleeding profusely. She had a high pain threshold because of her kidney disorder and was bleeding so profusely that she thought she might die in her shower. She called the EPAS clinic and said, 'I'm bleeding, I'm in so much pain, I don't know what to do', and they said, and I quote: 'Just calm down, dear. It's only a miscarriage'. And this is someone who thought she might die in her shower. Qualitative information is just as important as quantitative information.

Did you want to add anything to that?

Dr SIMONS - I would just say that whilst we know that COVID has challenged our health service in many ways, we know that we are able to recognise certain things. Throughout COVID we were able to have a hot, red, COVID-suspicious waiting room and a waiting room area where you had no respiratory symptoms. We were able to completely redesign entire emergency departments in the space of weeks and to flex where we needed to flex.

It is not that challenging to have a waiting area in a hospital where you can place people who might be presenting with pregnancy concerns in the context of a potential pregnancy loss and people who are visibly pregnant presenting for outpatient tests and reviews. I think the simple things are the most important consideration that affect someone's mindset prior to a consultation and they can go in with the mentality of at least being able to compartmentalise - for a short period of time - what they're undertaking. We know that that was a big recommendation in our list as well to discern these waiting areas -

Ms ODERBERG - And also, understanding that just because someone's life is not at risk doesn't mean that they are not experiencing extreme trauma. We know that people who

experience early pregnancy loss actually have very similar psychological issues to stillbirth and to other traumatic things and they need pathways for support.

As I said, subsequent pregnancy can be very, very challenging and these are all things that need to be considered, as does the fear of any obstetrics or gynaecology on behalf of treating-male clinicians - vaginas, they are scared of vaginas.

Ms DOW - Just one more question was around research again, and your approach to a health economist at the University of Melbourne to understand the economic costs of miscarriage. Obviously, it's some time ago that you submitted this submission and I wondered how that's progressing and whether you've been able to engage that -

Ms ODERBERG - We've actually moved away from that. The Tommy's National Centre for Miscarriage Research has actually provided us with the framework and they produced that piece of research as, sort of, like an advocacy piece. We had intended to do the same thing, but we've had recognition from the federal government; they don't need convincing they want to do the work in this area. So we're seeing that as 'less urgent' - if I can put it like that - than we did.

Now we're shifting our focus at the EPLC towards a priority-setting partnership among key stakeholders in the area so that we can move towards, potentially, something like a stillbirth CRE in the miscarriage space - a Centre of Research Excellence - or some such thing, but that's more of a focus now, I would say. We do have the framework to do this research, but we do not see it as as high priority.

Ms DOW - Thank you.

Ms JOHNSTON - Any last questions?

Mr FAIRS - No, I was just going to touch on the data, but Ella covered that perfectly so, all good.

CHAIR - It's been a really useful conversation, thank you. I didn't have any other substantive questions except that you mentioned some AIHW research around best practise data collection. Is that something that you've commissioned or do you know a timeline when that work -

Ms ODERBERG - That was part of the federal government budget allocation that we requested in our pre-budget submission from last year, awarded in May of this, March or May, it started with M, I'm sorry, my memory. This year's federal budget. We requested a review of Medicare coding and the best way to collect miscarriage data. They are doing that and we expect it to take some time, but we are very very happy that it's underway. There are international examples of it that we can draw on. Even though it seems insurmountable, it's not.

CHAIR - Thanks very much for giving us your time today.

Ms ODERBERG - Thank you. Happy to come back if there are additional questions or to provide any guidance in writing that the committee would find useful.

Ms JOHNSTON - Thank you so much to both of you. It's been really good to have you here and your comprehensive submissions.

As we conclude, what you've said to us here today is protected by parliamentary privilege. I am reminding you of that and that once you leave the table today, or the virtual table, you need to be aware that the privilege doesn't attach to comments you might make outside to anyone, including the media and including what you've repeated to us today.

Thank you so much once again for sharing with us today. A very comprehensive submission and I'm sure we could talk for a very long time about this, but you've been really useful so thank you very much.

Ms ODERBERG - Thank you for your work in addressing these challenges. I know it feels large, but we have to do it. Thank you so much for your work in this space.

THE WITNESSES WITHDREW.

The committee suspended at 9.52 a.m.

The Committee resumed at 10 a.m.

Ms JOHNSTON - Welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you very much for your submission from the AMA. If you could both please state your name and the capacity in which you're appearing before the committee for us. Perhaps you first, Michael.

Ms JOHNSTON - Fantastic. Can I confirm that both of you received and read the guide sent to you by the committee secretary, please?

WITNESSES - Yes.

Ms JOHNSTON - Thank you. I know you've done this before, but obviously you know that this hearing is covered by parliamentary privilege, allowing individuals to speak with freedom without fear of being sued or questioned in any court or place out of parliament. This protection is not accorded to you if your statements that may be defamatory or repeated or referred to you by outside the parliamentary proceedings. This hearing is public and the public and media may be present. Should you wish any aspects of your evidence be heard in private, then we can do that. We need a short deliberative meeting to decide to do that in camera and you need to make that request at the time.

I'll introduce ourselves. I'm sure you know who we are, but in the room here in Parliament House, I'm Kristie Johnston. I'm facilitating the meeting today because we have our Chair, Ella Haddad online. We also have online Anita Dow, Cecily Rosol and Rob Fairs here with us as well.

Michael, because you are in Tasmania, I need to swear you in as a witness appearing via video link if you could just confirm after me:

Do you solemnly promise and declare that the evidence you shall give to the committee shall be the truth, the whole truth, and nothing but the truth?

Dr LUMSDEN-STEEL - I do.

Dr MICHAEL LUMSDEN-STEEL, VIA WEBEX, PRESIDENT, AMA, TASMANIA BRANCH, VIA WEBEX, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED. **Dr ANNETTE BARRATT**, VIA WEBEX, FORMER AMA TASMANIA VICE PRESIDENT, WAS CALLED AND EXAMINED.

Ms JOHNSTON - Thank you very much.

Today we have decided to read a sensitive content script at the start of each proceedings, given the nature of the things that we are talking about today. The committee makes this statement:

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. I'd encourage anyone impacted by the content matter during this hearing to contact services support such as Lifeline's Helpline on 131 114 or via

text at 0477 131 114, Tresillian Tasmanian Parent Helpline on 1300 827 282, or PANDA National Helpline on 1300 726 306.

Would you like to make a short opening statement before we begin with some questions? Michael and Annette, over to you.

Dr LUMSDEN-STEEL - Thank you very much. I think this is one of the most important submissions that the AMA has made recently and we'll take the report as read. I can say that the AMA recently had a meeting with our members, particularly our obstetricians, paediatricians, mental health, and also anaesthetists regarding this issue and there was overwhelming consensus and support for the fact that the state needs to refocus its efforts on really working out what the demand for these services is. We need to take the politics out of a service plan and funding for it because, to speak frankly, we're not doing enough for our women and for our children in Tasmania.

We know we're not delivering the care that we should be and that's primarily due to inadequate recognition of the demand and funding for the services to meet the demand. Our submission outlines several areas of concerns. There may be one or two areas or concerns that have subsequently been addressed or highlighted as there have been plans in place but, unfortunately, the funding to provide the outcomes that we need is either not available or has not yet been enacted. We're happy to work through our concerns but also, I believe importantly, we will take questions from everyone that's online today about areas.

Ms JOHNSTON - Thanks very much, Michael. Annette, did you have anything to add to start with?

Dr BARRATT - Only to highlight exactly what Michael has said. This concern is something that I have seen growing over my 40 plus years as a GP, primarily in Tasmania and at the moment it is reaching a crisis point. Women are losing confidence to be able to receive safe maternity care and we have generations of children falling behind by not being diagnosed with conditions and concerns in the vital first 1000 days, let alone the first 2000 days, when the care is essential.

We believe - and I strongly endorse what Michael said - that this needs to be apolitical. Everybody needs to get on the same team, be heading forward, and not having it done by election guidelines and then having another policy change with the new incoming government.

Ms JOHNSTON - Thank you very much, it's refreshing to hear that. Your submission was very comprehensive. We have a lot of questions, which we'll try to get through in the very short space of time that we have here today. I might go to our Chair, Ella Haddad, for some first questions.

CHAIR - Thank you. I'll start where you finished, and on that I agree. One of the things that I enjoy most about this job as an MP is committee work because it does feel apolitical, and it's where the parliament gets to hear evidence and make evidence-based recommendations. That's certainly how I believe all of us on this committee are intending to operate as we continue to move through this work.

I want to start by thanking the AMA for such a comprehensive submission. It touches on all our terms of reference as a committee and beyond, and it provides some extremely important

information for our committee to consider, and I want to recognise that a number of your members who you've named in the cover letter have contributed to this submission, it's been very helpful for us.

As Kristie said, we've all got lots of questions. I'm going to jump to one part in particular, on page 4, where you've talked about - well, actually, I want to kind of conflate two questions. One: the lack of publicly available IVF services, and if you're able to expand a little bit on the experiences of Tasmanians in not being able to access that and whether there are differences in other states or jurisdictions that you're aware of, where those services are provided publicly.

And, second: the recommendation that you've made around publicly available birthing centres, and that that would be a benefit to women and families birthing through the public system. We've heard similar recommendations from others who presented to the committee so far, and I'd really be grateful if you could expand on that as well.

Dr LUMSDEN-STEEL - Thank you. To start with, the provision of fertility services, effectively in Tasmania, is limited to those with either private health insurance or those that choose to self-fund. Critically - and this is feeding back from our most recent discussion, which actually was last night with our specialists - it's probably just as important, but there's so many things we think are probably a higher priority.

Having said that, fertility services are provided by fertility experts. These are obstetricians and gynaecologists with a fertility subspecialty interest. At the moment, the two services are private - and this is based in Hobart - and what that means is that patients around Tasmania have to have the funds to be able to self-fund or be covered by insurance, and/or the means to travel to Hobart for their care. Now, there's obviously a telehealth component, but then there's the travelling to Hobart, and it's complex.

The other thing too is, the critical part of fertility services is having the appropriate accredited labs and scientists, which process the collected ovums and store them before you then undergo the fertilisation process, which will either be basically the eggs being inserted by a specialist, and/or the sperm being deposited in egg and then implanted. That's the real scientific part of actually then implanting that back in the female patient to carry the embryo.

It's complex. I don't think there's particularly a strong push at the moment that these services should necessarily be replicated by a separate public service, but there needs to be a strategic discussion and decision made by the government as to how they're going to support that process that also, gives a fair and transparent access to both providers, or an open tendered process. If that's what the government chooses to provide - that the alternative model - and I believe that - and I apologise, I haven't seen the submission that was made by Dr Bill Watkins, who was a previous fertility expert in Hobart, but I believe in the last several years, he actually provided a paper that went to the department that talked about how you'd provide a public-access IVF service. Now, that paper, I believe, was within the last five years. Apologies; we can track that down to forward to you. That report did make some recommendations.

CHAIR - That would be great, thank you.

Dr LUMSDEN-STEEL - I would say, though, that there is enough capacity with the fertility experts that work in Tasmania to provide that service. The question is: could it be provided face-to-face around the state? Probably not. You do need to have a centralised

expertise process that does it well. The question is: how we remove barriers to patients travelling and accessing that? Even if you can do a lot of the components by telehealth, one of the other challenges facing this is that you have to have sonographers who can do the accurate and appropriate ultrasounding, which will help determine how patients undergoing IVF treatment are suitable for, for example, egg collection or ovum pickups. That's been one of the other critical challenges that's meant that, unfortunately, sometimes patients having ultrasounds at the north of the state, when they're subsequently rescanned in Hobart are found to have less favourable conditions than have been reported because it's a subspecialist's scan.

What I'm saying is, it's not just the doctors, it's the ultrasonographers. It's then having the scientific process to safely manage that very careful process and then the implementation phase, which can be done either with or without anaesthesia involved.

The final comment I'll make is that in Hobart, patients can go to that stage of implantation with or without anaesthetic. Some patients choose to have it done under anaesthetic, and that's currently provided at Hobart Specialist Day Hospital and/or, if patients don't meet the requirements having anaesthesia, at Hobart Private Hospital. I'm not aware of there being any implantations or collections occurring in public at this stage. Thank you.

Dr BARRATT - The other component is that these patients are not eligible for PTAS (Patient Transport Assistance Scheme), so there is no public transport support. That's the additional cost on top of the actual costing of the IVF. Coming from the north-west coast, all their expenses can't be subsidised by our government services either.

CHAIR - Thank you both. The other part of my question was around your comments on publicly available birthing centres. We have heard about that need from others who have submitted to the inquiry so far. I wonder if you would like to expand on your views on how that would benefit birthing families in Tassie?

Dr BARRATT - The idea of a birthing centre as compared to being born in an acute hospital goes back to when I did my diploma in obstetrics back in the 1980s, for godsakes.

CHAIR - Wow.

Dr BARRATT - They were brilliant. They were a family centre where it was a much more holistic, less traumatic, and much more family orientated system. They disappeared because there was not government funding, there was not government subsidies to keep them going. They are essential and they would certainly be working very well in other areas around the country.

Dr LUMSDEN-STEEL - The further comment I would make to that, though, would be, we have to temper the enthusiasm around that by also looking at how it's going to be co-located and bound by safe services. Let's be frank, we have a midwife crisis in Australia. Tasmania no longer trains midwives for our own program. Our midwives are trained through university joint placements. I'm sure you're aware of this. What that means is that we are struggling to actually maintain enough midwives to provide services.

We have a higher reliance for locums in the north-west, that's obstetricians and midwives. We have a model in Launceston, which actually - it's one location where it's performed seamlessly and that's at the Launceston General Hospital. At the North West, we heard reports

last night that bringing the services back to one location isn't functioning effectively. We have unsafe paperwork, bureaucratic processes, which is delaying urgent access to maternity services because they're trying to run a dual paperwork process in one hospital, which is unsafe. This has been escalated and discussed by the AMA at the North West and it has not been addressed.

If you're looking at having birthing suites and centres, at the moment we'd also have to acknowledge the challenges if it's not immediately co-located with an appropriate medical facility. If there is an emergency during that process, how do we get those patients transferred safely to a public hospital that can immediately deal with a birthing situation that is no longer progressing normally, needs to be rapidly assessed, and needs rapid access to specialist medical care that can mean going to theatre or vaginal assisted delivery. To be frank, we don't have the services to provide that at the moment.

We are struggling to provide safe obstetric care at the Royal Hobart Hospital. We've seen in the media recently that we have had extreme concerns raised by midwives around potential delays to labour through inadequate midwife resources. It literally is a case of trying to pick who is the most urgent delivery to start from induction time. That means we are starting inductions on patients at unsafe hours because that is when the next shift of midwives comes on. So a higher risk delivery, which would normally be started first thing in the morning, the induction process is started when the next midwife shift starts, which might be in the afternoon, which means that when it all goes to, unfortunately, needing a caesarean section or an urgent surgical intervention, that is happening after hours.

Now, the corollary is that Tasmania has not set up a proper obstetric service that has dedicated caesarean section theatres available 24/7. That means that even in hours, and I can speak from frank experience, when we have an emergency caesarean section called from the labour ward for someone who needs to have a baby right now because the baby or the mother is going to die, we do not have a theatre that we can push a patient straight into. We have to find one, we have to scramble to move resources to that theatre, and that can mean there are delays. We had that as recently as this week at the Royal Hobart Hospital where, literally, a lady in labour was booked as an E1 caesarean section, it was upgraded 10 minutes later to 'this must come out now' because the lady's uterus had ruptured and the baby was free in the abdominal cavity. We then had to madly rush to move that patient to another theatre. That is a reflection of the fact that we have not told the Hobart - we are not funded to provide a service of having a dedicated theatre that we can take a mother to immediately.

Because we have not built enough capacity in our hospitals, we have to find a theatre, or wait till a patient has finished. I have even been in a situation where I have had to stop a patient who has been asleep from starting surgery, to get that patient out, to get a patient into that theatre. That is a reflection of what we have accepted as risk in our hospitals for not having immediate access to care.

We get back to how we are designing our services. We can talk about having these birthing centres, which can provide another option. The critical thing is that those services must still have obstetric oversight. There must be a clear communication pathway. If there is a requirement to transfer, we need to do so. If we go back and look at all the previous papers published in the NHS, around the world, that looked at maternal deaths, they have highlighted all the issues. History has shown us why mothers and babies were dying and we have tried to make this the safest process as possible. Unfortunately, that does mean that things have become

a bit more medicalised in our public hospitals, but that is because that is a safe way of delivering it.

If we want to provide women with more choices for how they are going to deliver, that must be matched with a safe pathway that will facilitate rapid escalation of care. If you are at a birthing centre and you require transfer to a public hospital, that is going to require multiple other contingencies to get you there, notwithstanding an ambulance and some way of transferring you.

It is great to have these discussions, if those birthing centres are going to be within the public hospital in a great purpose-designed space, which leads me to the next thing I am going to say; for God's sake, why do we not have a women's and children's hospital in Hobart? We had one at the Queen Alex. It was a dedicated centre that did all the tertiary and complex stuff. That women's and children's hospital was closed. It is now a private hospital. We have now tried to make it work within the public system. We have seen the challenges we have for that. We have seen in Launceston that the private services were shut down and brought into the public. We have seen some of the challenges faced with that. We have seen up at the North West, running two locations in a facility that was in a town that was too small to provide sustainable services how we co-located.

I am sorry, I know I have sort of segued off there, Ella, but I am trying to highlight the concerns.

CHAIR - No thank you. I appreciate it.

Dr BARRATT - Like he was saying, the Queen Alex - we had two birthing centres as part of that wonderful Queen Alex Women's and Children's Hospital. That is what I would be very keen for us to go back to. As Michael was saying, we need the women's and children's hospital.

Ms JOHNSTON - Thank you. I think we might move to Anita. Michael, you touched on some regional issues and I know Anita is very keen to talk about those.

Ms DOW - Thank you very much for presenting to our committee today. I was really disheartened reading your submission around the status of regional maternity services. That's something I feel very strongly about improving across Tasmania. It wasn't that long ago that the AMA called - that there was a crisis situation in the North West. I think it was almost two years ago now that we had women being turned away due to staff shortages.

It's alarming to hear that just last night you even had a meeting where you are concerned that the current status of services continuing around obstetric shortages and paperwork is continuing to make it unsafe. What needs to change in the North West to ensure that we have a good model of maternity service care that caters well for our dispersed population?

Dr LUMSDEN-STEEL - Having spoken to the obstetricians again last night, maternity services have to be provided at one location, the public hospital, without any duplication or processes mixing up who is a public and private patient. One location, one provider, one clear pathway. This has to happen. The corollary is that if you wish to be treated as a private patient, you still can be treated as a private patient in that public hospital but there is one system looking after you.

The other problem we have up the North West is the locum reliance. Now we've heard recently that we're going to make a commitment to support how our GP obstetricians might be able to help provide that obstetric cover in in the North West. We heard last night that they've lost their accreditation for training registrars. That means that that site should not be providing medium- to high-risk deliveries because they do not have an obstetric registrar on there 24/7.

We need to go back to look at how we can safely start that model, which is special supervision, the potential use of GP obstetricians, and how we can focus on getting that site back up to being accredited for registrars. If you can do those things at one location, let's cut this nonsense out which is having to have and run separate paper and separate stickers and call on separate teams to operate on private patients.

The clear example is there was a private patient who had an urgent caesarean section because it was an emergency situation. It hadn't been planned, there were delays and, at the time, and hopefully this has been overcome, there was not the support for using a registrar public hospital doctor to assist the private obstetrician for doing that caesarean section. Now, it was only fortunate that there was another obstetrician who could go in and assist the surgeon operating. That resulted and minimised the likelihood of an adverse event happening, but that's an unnecessary delay.

When a patient needs to have a medical intervention done, the focus has to be on the doctor ensuring that the patient understands what's going to happen, that the team has mobilised, and that the procedure is done safely in the shortest possible timeframe to make it happen to avoid the adverse outcome for the mum and the baby. Anything else, to be honest, that delays that process is an administrative bureaucratic barrier that we put in place that is unsafe. We need to resolve those issues up in the North West.

Likewise, we hear time and time again that, because we're offering limited obstetric services in the North West and we'll probably also lose private services in the North West, that means that all patients at the North West will be through the public system. That does actually remove the choice for those options at the North West. What we're saying is, the obstetric services in the North West should all be in the public hospital and the theatre should be in the public hospital.

I'm afraid that when there were specialist people brought in on how to design it up the North West, the obstetricians were largely ignored. Their concerns were largely overridden by the other services put in place up there.

The final element as everyone in the room would be aware of is, it's not just the obstetricians, it's the anaesthetic cover. We know when there was private obstetrics that ladies could not access epidurals and they had to change that classification to being public. If you make it all one hospital very clearly, you're one patient, you'll get access to 24/7 pain relief, which is at least giving them an epidural. But also, it's very clear if there's a paediatric attendance required to support midwives at delivery, who is going to be providing that cover.

Particularly regional centres, it's impossible to try to run a private-public roster. You're all one team, you're all working together for safe outcomes.

Ms DOW - You've made mention of the need for a women and children's hospital in Tasmania. Given the inequities that you've highlighted in your submission to this committee and that we know exist across the state - you said that should be in Hobart, but what are your thoughts on that being based in the north of the state, so that it's more equitable for women and children right across Tasmania?

Dr LUMSDEN-STEEL - That's an excellent point. The reason I mentioned Hobart - the other reason for that is it's the tertiary subspecialty area where complex women's gynaecology surgery has to happen as well as complex deliveries do come to Hobart.

I fully support the fact that you need to have dedicated women's and children spaces in all the zones. In fact, we know that there's significant concerns about how some of the service delivery up in the north of the state. I guess they're having an overarching statewide framework. Particularly, we highlighted our concerns there that perinatal support for those mums having depression, trouble breastfeeding, trouble with newborn babies and those that need that sort of combined midwife breastfeeding support and dealing with mental health issues after a birthing experience, which you know can be quite traumatic, and the access to those services is even harder in the north and north-west.

At the moment, the service delivery, having lost the mother and baby unit, is not fit for purpose, to be frank. I agree, we're not saying that the north should be excluded from these services. I guess the reason why we talk about that being a particular hospital in Hobart I have made the point because that's where the subspecialist complex deliveries have to happen. Patients do travel to Hobart for that, where we've got the paediatric and NICU intensive care unit.

It would also allow us to actually set up proper accommodation of the support, because if you're aware, we've got the Ronald McDonald House, which can support families with children and there's some elements of support coming to Hobart. But I look at what's offered to women in Melbourne with the Royal Women's Hospital and the Royal Children's Hospital, the fundraising that we can actually build to support that process, the accommodation support that can be offered and we've got nothing like that in Tasmania. If we refocused in the state, under a statewide umbrella, but if you do have to travel from Burnie and Launceston through a complex, complicated or high-risk delivery in Hobart, we can support that better. We can support you and your family better too if we've got a dedicated facility.

We find that delivering at the Royal Hobart Hospital, we have a capacity limit because there's only one obstetric theatre and that's only for normally the morning session, Monday to Friday. If there are extra deliveries, it's very hard to organise additional deliveries because they're competing with all the other elective surgery. Women's and children's surgery is often not the priority. It's not seen to be the priority because they're competing with all the other urgent surgery that has to happen in a public hospital that's got the tertiary emergency surgery for neurosurgery, for vascular as well too. They're always competing. They don't have their dedicated control of their theatre and access.

The other example is we don't run an obstetric list over a long weekend. So if you have a four or five day long weekend period - for example, recently you've got Good Friday, Saturday, Sunday, Monday, Tuesday, public holidays. At the moment, we haven't resourced and staff to plan to have an elective caesarean sections over that period. We often find that it's very hard for those mums trying to have deliveries during that period, they become emergency

caesarean sections rather than elective caesarean sections. The focus needs to get back on 24/7 women's and children's health.

Ms DOW - My final question because I know others have burning questions as well. Obviously, there are lots of issues around recruitment and retention, what are your recommendations to this committee about how we can attract more obstetricians to regional Tasmania, or even to Tasmania full stop? You talked about the role that perhaps nurse practitioners could play providing more community-based care rather than hospital-based care for pre- and post-natal care for women and families. Is there anything specifically that you would like to put on the record for this committee around retention and recruitment?

Dr LUMSDEN-STEELE - For workforce, we have identified issues with there being a disconnect between GPs who used to help provide co-managed obstetric care, that's one issue. The second issue is obviously again, and this is really lobbying with the private health insurance and the federal government, is that women are excluded from access to private obstetric cover unless they've had that for 12 months at the time of delivery. That's actually a barrier. We know that not all pregnancies are planned, some are unplanned but you're very happy when you fall pregnant when you're trying but that then obviously forces you to take the public hospital pathway or self-fund. That's the discussion we need to have with the health insurers. The Medicare rebates certainly are putting pressures on patients so that can sometimes make a private pathway a challenge because we know that Medicare hasn't been indexed, again it is a federal government issue.

If we look locally at our public hospitals, we've got the capacity to train obstetric registrars in Tasmania, end-to-end training. They might go to the mainland for subspecialty training and we encourage that. We've now got competitive employment conditions for those doctors, but again, within Tasmania we don't tend to support the training rotation very well. At the moment you can't rotate to the North West because we've lost accreditation for training.

We need to again focus on supporting and rebuilding our sites to provide 24/7 cover. How can we get registrars back to North West? Part of that issue is going to be focusing on attracting retained specialists up in the north-west. We know is that if you work in an environment with a high locum turnover, that puts a lot of pressure and stress on you because you're having to supervise locums that are coming in. You actually don't know what the quality of the locums is going to be like: some are fantastic, some aren't fantastic. You're always carrying an additional mental load.

In the public hospital, looking at obstetrics, we need to look to make sure that we're providing an adequate interface for our private specialists to also work in the public hospital.

Vice versa, to be frank - and this is an issue that's Hobart-based because we're running three obstetric locations - it's the opinion of the specialist in Tasmania that running three obstetric locations in Hobart is not sustainable and probably not safe. The impact of losing a senior obstetrician in Calvary has halved their deliveries. Calvary Hospital now has gone from delivering between 30 and 40 deliveries a month and potentially being viable to now 15 deliveries a month. Specialists are not necessarily choosing not to work at Calvary because it's unsafe, but they're choosing to want to work at one location because it's more convenient and safe to know you've only got one person labouring at one hospital.

That's why we're seeing Hobart Private Hospital perform approximately 50 deliveries a month. Now if private obstetrics fell over in Hobart and Tasmania, that would be a disaster. Imagine if the public had to pick up an additional 1300 deliveries; it does not have the capacity to do so. I think it's really important that we understand the care and ensure we provide patients an option.

Unless we get together and talk about improving access to care and providing a better service, we're going to have this same conversation in 10, 15, 20 years' time. We need to get on with actually saying we can provide a better service, we've seen what they've done on the mainland. They've certainly provided a clear and very well working functioning model whereby you've got a dedicated women's hospital, and within that women's hospital you actually have a dedicated functioning private ward and theatres. Unlike this hybrid model, which has failed completely in the north-west, you literally have a private model that's running separately to the public model, but physically in the same building. If you suddenly need to surge and you need to push patients into the public ward or private to public or into other theatres, you can deliver that safe and immediate care and it's more cost effective.

You also find you get much better collaboration between public and private if you're working in one building and you know that if you've got a high-risk private delivery, you can have that patient stay out of the public system. They can be treated in that ward, which is the private ward, but the baby can be treated safely because you've got the Neonatal Intensive Care Unit (NICU) in the same building. It is literally one floor down. What that does is unload the public system too because you've got these high-risk pregnancies staying in private but using the NICU, which they have to use anyway. That allows you to have new resources to treat your public patients, because at the moment you're competing in a public space for both private and public patients at the same time.

That collaboration is better for the public system. If it's done well, it does help you attract and retain specialists because they can see you can offer both a good mix of public and private practice. We know that, generally, procedural specialists do often enjoy that mixture of public and private practice. That allows you to help attract and retain more specialists and it also allows you to attract and retain more registrars because it offers more training program options if you can be exposed to training in the public and private sector. Many training programs allow that but at the moment, to be frank, we're not that sophisticated in doing that at all because we haven't set it up well to do so.

The final thing I would say is we talk about how we improve and enhance women's surgery in the future. One of those other things is looking at how you bring in the use of robots. If you are clever and strategic and you had a proper women's and children's hospital, you'd be able to operate private robot to provide complex women's cancer and other surgery that can help with fertility and the treatment of endometriosis, et cetera. You can do that by having a proper, dedicated centre that can provide that for women's and children's complex surgery, including robot. That robot would also be used for other general and neurology surgery to provide major surgery. By thinking strategically, you get the best bang for buck, but you provide an absolutely fantastic service. That is what we are unable to do at the moment.

Ms ROSOL - Moving now to perinatal and infant mental health. We've heard quite a bit about how inadequate the services are in Tasmania, and how great the need is. I noticed in your submission that you were suggesting that those services be provided through CYMHS [Child and Youth Mental Health Service], and I understand that, in terms of, let's say, the child's

mental health and being able to progress through CYMHS. How do you see the maternal mental health fitting into that space? How would that work?

I understand parents' mental health is one of the biggest factors in a child's development and their own mental health. If we were providing that service in CYMHS, and that focuses on the child, where do you see the parents' needs fitting in that? Where would that service be provided?

Dr LUMSDEN-STEEL - Thanks, Cecily. That is an excellent question, and I don't know if I have an actual answer for you to what the framework is, but it's a massive area of need. Clearly, obviously, we need to look at the journey, which can be antenatal depression and postnatal depression, it can be breastfeeding difficulties and trouble establishing a routine, and in that first 1000 days - even in the first 30 days - it's about how you support the parents who are having a rough time.

At the moment, we don't have equitable, adequate access around the state. We lost the Mother Baby Unit in Hobart; the Royal is not fit for purpose. We need to get it out of where it is. It needs to have midwife support and mental health support, and it needs to be able to be assessed. I guess, how do you get access to that? That's one of the first things. At the moment, public patients pretty much never had clear access to the public Mother Baby Unit, because there weren't enough positions funded, so you only got access to that if you had money and you had private health insurance, which is appalling.

How does a screening occur? I'm not sure we do that well. How do you identify those people who are at risk? Again, if you went back to the older models, where you had more GP practices and your nurses working with them, you had that shared care. After you had delivered, you'd have the obstetrician, but pretty much once you leave hospital you're on your own. How do you actually tap back into that? That's where your community health nurses come in. You'd go to them for your baby assessments and measures and all the questionnaires. We need to make sure that they're functioning well, and they're able to then escalate the concerns that they find.

We need a combination of inpatient and outpatient care. When I say inpatient, it's purpose-built facilities. It's not in a mental health ward. That needs to be an overriding statewide umbrella, then, whether it's CYMHS or however the structure looks, it does need to be able to provide the appropriate service.

Where should it sit operationally? We've suggested it's under the PIMHS service or under CYMHS, and that's for consistency, but, certainly we can discuss that. The important point is that we actually make a decision where we provide a service in each of the three regions that support it. It's got to transition from being support at home to escalating to support to an appropriate inpatient facility. At the moment, there's no real clear public access to that.

We've obviously got, I think, Tresillian up the north-west, up at north sorry, which is providing a service which is being established. Again, we don't really have that down south at the moment, and to my knowledge, it is nothing like up the north-west. So, it's one of these situations where I think the Launceston area, the north, is leading the state recovering from this, but again, it needs to be funded, and there needs to be equity of access to that service, and we just don't have enough capacity.

Dr BARRATT - Can I also add that if you're talking about the prenatal, what you need is access to psychiatrists - psychiatric nursing - quickly. At the moment, if the GP identifies a pregnant lady with a mental health issue, it can take a long time for that doctor to be able to make a referral. So, if you're talking about the first 1000 days being under CYMHS, you need to be able to have that early access to a psychiatrist with an interest in women's health in the public sector being easily accessible in all regions. At the moment, that is not something that GPs are able to do.

Dr LUMSDEN-STEEL - Just to support Annette there further, we know we don't have enough GPs. I mean, the entry points for a lot of this is going to be by a community nurse, or when your child's having that community assessment. If the patient doesn't actually have a GP - it's quite possible they won't have a GP - how will they then get referred back to the service, and how do they get their quick assessment done by an appropriate training nurse, or midwife that could do that assessment and then escalate to CYMHS?

It ranges from helping to settle the crying baby through to the mother having full-on postnatal depression or the other elephant in the room is sometimes the father, that might not be actually coping very well too, not being very supportive for the mother. There's a lot of dynamics, as we all know, that change when you have children, and not all of us biologically are actually set to do it well at the start, and sometimes the baby just isn't going to feed well, and we all know it can spiral from there.

So, yes, thank you for identifying that this is a massive undermet service and we need to look at the demand and then we need to fund a service that is structured and consistent across the state.

Ms ROSOL - Thank you. There was some comment in your submission around the Child Health and Parenting Service (CHaPS). Potentially 'empowering nurses to take on a broader role' is how it was described in the submission. Can I ask for your thoughts on that? Are you talking about scope of practice for CHaPS nurses increasing, or are you talking about policies changing so that they can do more? Did you have specific suggestions around how we could be better utilising CHaPS?

Dr LUMSDEN-STEEL - Thank you. Page 12 contains our commentary about that.

What we are saying here is that it is partly scope of practice, but it's medically integrated care. We know that the key thing is assessing in the community and if we assess things in the community and we provide support for the community then there's a pathway to escalate concerns, be that the mental health pathway and your combined paediatric pathway for that assessment. It is really a sub-speciality area of providing that postnatal early care and assessment. I think they are a bridge to accessing care.

The question is, I don't believe there are enough nurses in that space. If there are not enough nurses how do you actually meet the demand, particularly if things have been flagged or families have been flagged as being high risk or needing support? How do you get in there to provide that support early and then how do you continue that support and guidance?

We know that early intervention can sometimes stop you from progressing down to things getting more complicated or mental health evolving. It's not a good term, but you can

'nip things in the bud' early. You can help turn away the unsettling baby. You can get on top of the situation much earlier with support.

Education support is really important to support young mothers who are struggling and provide them with the tools to cope. Reducing hospitalisation is always important. We don't want people to deteriorate to the point where they get to need hospitalisation. We're hoping that the CHaPS nurses can provide their early intervention but also be a conduit and support for that person getting access to medical care if they don't have a GP or into CYMHS. I think that's certainly an area we can focus on.

The other point we want to make at the end of that is that there's a massive gap for the assistance to settle infants through the overnight service. That was obviously something we had through the Mother and Baby Unit which we lost in Hobart. Again, that would be an extension of identifying someone needing support: let's get into support early and let's try to get on top of things before things deteriorate.

Ms ROSOL - Thank you. To comment, I really appreciated you making that link between the importance of providing these services to families and children when they're young because it has such massive implications for their development and trajectory through their whole life. Thank you for highlighting that.

Ms JOHNSTON - Thanks so much, Cecily. I might just check in on Rob. Rob, do you have anything?

Mr FAIRS - One observation is that what you're talking about, obviously, is on a massive scale and it's not a quick fix at all. A lot of the things you're talking about like designated centres and all that, it's going to take a long, long time to implement, a lot of money to implement and all that sort of thing. My question is, how do you see it short-term so we help people now, while the future generations are considered down the track? As I said, things aren't built in one day, they take time. I wanted to get some clarification from you whether you believe current hospitals should have designated areas made available as quickly as possible for now?

Dr LUMSDEN-STEEL - I disagree. In COVID, China built a hospital in 10 days. If you decide you want to do something, you can actually do something. I'm actually getting a bit fed up and I can tell you now doctors are sick and tired of continually hearing that, 'Well, Tasmania can't afford to do that. We can't have a new hospital. We can't provide a service because we don't have the funds'. We're actually fed up with the politics now around healthcare and we have actually had enough.

What we are prepared to do is support you in the journey, where we go to the public in saying that the government is being expected and required to, increasingly, provide more services, but you have a revenue problem. Now, we are happy to talk to you about the stories and vignettes to get there, but it is up to you guys to actually start selling the story as to what it is that you want to do, but how we are going to fund it. What you are asking for is, again, a political solution which you can sell quickly, as a quick fix, but it is actually not going to fix the problem. We actually need to get back to the basics, which we started out with.

Mr FAIRS – I think you're misunderstood there -

Let us have a quick service plan. The service plan again is to look at what the demand is. I think we have highlighted the demand areas, but if we were to urgently convene and hear from the people, and you will hopefully pull it out of this submission, where the gaps are. We know roughly what the demand is. The good thing about paediatrics is that our birthing rates are relatively stable. Our actual paediatric population, which is obviously from newborn to 18, is actually pretty consistent. From that, we can extrapolate what the demand roughly is and then, from that, we can work out what the services are. Early intervention is critical because we have to start early intervention because that is going to have us see more benefits in three to five years time, but we have to start working on the back end of things as well too.

Let us look at actually integrating our obstetric services. Let us look at how people get access to paediatric clinics. We need to be honest and open about the trouble that Tasmanian patients are having accessing paediatric outpatient clinics. We need to look at how we can improve access to paediatric outpatient clinics. It gets worse than that because you have a paediatric outpatient clinic, where you see a specialist who wants to see you in six months time to adjust your ADHD medications if that is what you need, but then you cannot book an appointment because the system will not allow it. When you try to then book that appointment, someone else has taken that new appointment.

The outpatient referral time is six to 18 months. The only way we can fix that is by starting to recruit more paediatricians, but also starting to be innovative about how we have more registrars and how we provide services. What we cannot see is a bureaucracy that delays the approval for replacements and short-term contracts when you put in submissions for leave, which we have seen from time to time as vacancy control.

The other point is that our business models that support our healthcare are not sophisticated, they are not current, and we see that creative ways of funding solutions have taken little plots of money from everywhere to fund a position. That pot can suddenly disappear or be taken away and that position disappears because it has never been justified. I think we need to consolidate the services that we provide and the funding that is within that service, but we need to actually be funding the service going forward.

I have grave concerns that, effectively, the current budget projection has about $200 million a year coming out of healthcare, which is going to force the Department of Health to find those savings. We know that, if you look at the wage increases, just for our staff, that goes up at roughly 2.5 per cent to 3 per cent per year, plus staff rising up through increment levels. I cannot see how we can continue to actually provide innovation and improve services with a health budget that is effectively going backwards each year for the next three years.

I know that is not the answer you wanted to hear, Rob. I do not have the answer for you right now about what the quick fixes are, but we have to stop with a quick fix mentality. We actually need to come back and say, 'What is our service, what is our demand, what is our service plan to meet the demand?', and let us talk about how we are going to find the funding and that cannot come from, I don't believe, existing funding. It has to be new funding because I do not know where you can make cuts. I am sorry, that is not the good news you want to hear.

Mr FAIRS - No, I think you misunderstood my point to a certain degree. I am not looking to make it a political thing, so I am sorry if you took it that way. I am more concerned with people right now and making sure that they are covered. That is what I was trying to establish there.

Dr LUMSDEN-STEEL - The other key thing is, one of our biggest challenges is our locum workforce providing healthcare in Tasmania. When you look at the recent locum statistics, we have an unbelievably high reliance on midwife locums and nursing locums. It is very hard for services to provide continuity of care for patients when, every time they come back, they are seeing a different nurse who does not know their story.

Patients are not widgets, they are not numbers, and neither are healthcare providers. Patients form a relationship with their healthcare provider, their nurse, their GP, their midwife, their paediatric nursing community. Those relationships are really important. If we get back to focusing on, within our health system, identifying what we're not doing well looking after our staff, identifying why people are leaving the healthcare system, and how we can train our nurses and keep them in Tasmania for end-to-end training and our doctors as well too. We need to start that process at the same time to remove the locum reliance, the patients are seeing the same people all the time. Also those people in the healthcare system have ownership of the issues that they will implement new programs to have continuity of care and innovation as opposed to someone who rocks up, does a job for a day or a week and then leaves.

Ms JOHNSTON - Thank you very much, Michael. I think our time is just about up. I think we've actually gone over our time. Thank you so much for your comprehensive submission and your presentation here today. It's probably clear to all committee members the dire situation that women and children find themselves in Tasmania's health system. Thank you very much for providing that.

I'll just double check there's no further questions online from committee members before we wrap up?

Ms DOW - I wanted to ask, one of the recommendations that's been made to this committee is recommencing an undergraduate Bachelor of Midwifery or establishing an undergraduate Bachelor of Midwifery course in Tasmania, whether that's in partnership with the mainland university. I wanted to get the AMA's comments on that and whether you think there's merit in that.

Dr LUMSDEN-STEEL - Yes, we would support the capacity for Tasmania to provide end-to-end training for our healthcare workers. We can't provide everything in Tasmania, but we think we should be able to provide midwife training. Be that in collaboration with another university, but we need to provide a pathway that removes barriers so that people that want to become midwives can do in Tasmania and easily.

There's another subtle point and it's not necessarily my comment to necessary say how our nurses should be trained, but overwhelmingly I get the impression that we need to get back to training nurses in our hospitals. Sorry to speak frankly about this, but I think there's increasingly observations that, and a bit like medicine, we spend a lot of our time actually in the hospital with our training, but producing nurses who are actually having their training aligned to the role, which is not always what you get from a university-based process. I think we need to maybe look at how we're doing that within Tasmania.

Midwife training is a classic example, and you would all be aware that the midwives now don't have to do nursing before they become a midwife. The subtle little point about that is that occasionly, from time to time, particularly in a challenging situation, you need to make

sure you've got enough midwives who also have a nursing background because patients, when they deteriorate, can have other medical conditions and things that you need to treat. It's not just always about a safe, straightforward delivery. Increasingly, it's about managing patients with other comorbidities who are also having babies as well. You have to manage the patient with other medical conditions, which is important.

I did make a summary before, but are there any other questions? I want to summarise six quick points, which will take me 30 seconds in closing, if that's okay?

Ms JOHNSTON - Absolutely, Michael.

Dr LUMSDEN-STEEL - First of all, I think our number one priority is we actually need to fix the north-west maternity services. It is still unsafe. We have concerns about the viability of ongoing obstetric services up the north-west when effectively you're relying on the locums and the obstetricians that are up there actually still feel unsafe about work in that environment at the moment. That is an immediate priority. We think there are some simple fixes we can make there around bureaucratic nonsense, to be frank.

We do need to address the private maternity in the south. We need one private provider only. Unfortunately, the private hospitals are not going to engage in the discussions about giving that up easily, but it's becoming a bit of a futile exercise and that's going to put pressure back on the public.

We're again advocating for a tertiary statewide women's and children's hospital. We need to train our workforce that's needed and that includes medical nursing staff. I'm glad we've talked about midwives because we can provide that in Tasmania and we need to provide pathways for people who want to be midwives. It's end-to-end training where you don't need to leave Tasmania.

We need to ensure that prenatal mental health services are accessible statewide and that's again one of those things we should be looking to incorporate as a matter of urgency and don't ignore the needs of paediatricians. It is obviously not just about a birth but it's about health of the baby. It's about supporting the baby during the first 1000 days, but we know it's also about adolescence. We need to be situated to ensure that we've got public and private or community paediatricians. About 95 per cent of paediatric care should be delivered in the community, if not more, and that's GPs being able to then escalate concerns to paediatricians. We actually don't have enough paediatricians and we know that's reflected by our public hospital outpatient wait times, which can be between six months and two or three years for a paediatric appointment. That's just unacceptable.

Ms JOHNSTON - Thank you, Michael. That was an excellent summary of the evidence here today.

CHAIR - Thank you. I think we could talk to you guys for hours more if we had the chance.

Ms JOHNSTON - Thank you very much for your appearance here today, both Michael and Annette. What you've said to us here today is protected, as you know, by parliamentary privilege. Once you leave the table, you need to be aware that the privilege does not attach to the comments you may make to anyone, including the media, outside of this place, even if you

are repeating what you've told us today. Thank you very much for your time, we really appreciate it and we will talk to you soon.

THE WITNESSES WITHDREW.

The Committee suspended at 10.58 a.m.

The Committee resumed at 11.35 a.m.

Ms KAREN EDWARDS, VIA WEBEX, CLINICAL DIRECTOR, GIDGET FOUNDATION AUSTRALIA, WAS CALLED AND EXAMINED.

Ms JOHNSTON - Welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you very much for your submission, Karen. If you could please state your name and the capacity in which you're appearing before the committee?

Ms EDWARDS - My name is Karen Edwards and I am the Clinical Director of Gidget Foundation Australia.

Ms JOHNSTON - Thank you very much, Karen. Can I confirm that you've received and read the guide sent to you by the committee secretary please?

Ms EDWARDS - Yes, I have. Thank you.

Ms JOHNSTON - As you may be aware, Karen, this hearing is covered by parliamentary privilege, allowing individuals to speak with freedom without fear of being sued or questioned in any court or place out of parliament. This protection is not accorded to you if statements that may be defamatory are repeated or referred to by you outside of this place and parliamentary proceedings.

This is a public hearing, and the public and media may be present. Should you wish any aspects of your evidence be heard in private, you can make this request to the committee at any time, and we'd have a short deliberative meeting and then decide to move to what we call an in-camera session. Just let us know if that's something you'd like us to do.

I know you are interstate, so we don't need to make a statutory declaration.

I'll introduce you to the members in the committee here today. I am Kristie Johnston; I'm here in Hobart, and member for Clark. Online, we have our committee Chair, also a member for Clark, Ella Haddad. We also have Rob Fairs and Cecily Rosol; they are both members for Bass, which is in the north of our state. We have Anita Dow, who is a member for Braddon, who is in the north-west of our state. We've got all three parts of our state represented on this committee.

Ms EDWARDS - Pleased to meet you all.

Ms JOHNSTON - We would like to make a sensitive content statement at the beginning of this hearing, given the nature of what we're talking about today so I'll read that out.

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. I'd encourage anyone impacted by the content matter during this hearing to contact services and supports, such as Lifeline's helpline on 13 11 14, or via text at 0477 13 11 14, Tresillian Tasmania's Parent helpline on 1300 827 282, or the PANDA national helpline on 1300 726 306.

Thank you very much for joining us, Karen. If you'd like to begin the hearing today by making a short opening statement?

Ms EDWARDS - Good morning, and thank you for inviting me to attend today. My name is Karen Edwards, and I'm the Clinical Director of Gidget Foundation Australia.

Gidget Foundation is a not-for-profit organisation that exists to support the emotional wellbeing of potential, expectant, and new parents, through advocacy, education, and service delivery, to prevent and treat mental health issues.

Ensuring equitable access to perinatal mental health services is essential for the provision of effective and appropriate perinatal care, and plays a critical role in improving the mental health of Tasmanian parents and infants. As a national provider of perinatal mental health services, Gidget Foundation Australia sees firsthand the importance of prevention, screening, and early intervention, in reducing the impact of perinatal mental health disorders. Effective care during the perinatal period not only improves immediate health outcomes for mothers and babies, but it also fosters improved long-term developmental, emotional, and physical health for the entire family. Investing in perinatal care creates a positive impact on the family's immediate and future wellbeing.

How parents adjust to pregnancy and the birth of their baby is an incredibly individual experience, which may take some time to process. But, for many expectant new parents, stereotypes and stigma around perinatal depression and anxiety can be a barrier to acknowledging their challenges. This can contribute to delays in accessing support and early intervention. However, routine assessment of mental health and wellbeing during antenatal and postnatal consultations can support improved recognition and response to perinatal mental health presentations.

Without treatment, perinatal mental health issues can significantly impact parents, their infants, and the wider family. Affecting parent-infant attachment, family relationships, and feelings of self-worth as a parent and partner. Appropriate physical and psychological care is critical in reducing disruption to early attachment, and building parenting confidence and wellbeing.

The provision of trauma-informed care is also essential in helping women feel safe, heard, and supported at all stages in their perinatal journey, and should sit at the centre of all maternity care. Women should be provided with a range of clinical care options aligned to their physical, emotional, and cultural needs, and care should be decided collaboratively and without judgement. Access to sustained relationships with a single primary care provider should also be improved.

Effectively supporting maternal and paediatric health requires a skilled and capable workforce. Working in reproductive and maternal health can be a rewarding role, but it can also place significant demands on healthcare workers. Healthcare practitioners who are exposed to trauma, loss, emotionally challenging work and demanding rosters are vulnerable to burnout. This can lead to a loss of confidence in professional practice, a decreasing job satisfaction and an increased desire to leave the profession prematurely. Supporting the health workforce through education, training and adequate resourcing is critical to the delivery of accessible, high-quality care.

Finally, in seeking to improve the perinatal mental health of Tasmanian women and their families, Gidget Foundation Australia acknowledges the importance of providing education and training in the delivery of trauma informed care for all healthcare workers delivering maternal and paediatric health services. Ensuring clinical services are client centred, culturally safe and consider both the physical and psychological wellbeing of women and their infants. Developing models of care which focus on universal antenatal and postnatal screening, improved access to early intervention, a wraparound service provision and continuing to work on innovative strategies to address disparities in access and continuity of care through the establishment of integrated community based paediatric and maternal care and improved referral pathways.

Ms JOHNSTON - Thank you very much for your submission. I might go to our Chair, Ella Haddad, to start the questions.

CHAIR - Thank you, Karen, and thank you in particular for providing your written submission as well, which has provided some valuable insights that I know the committee's been very grateful to be able to read in our work. I know you'll be supporting the work of the committee when we move to hearing from individual members of the public who have submitted to the committee. Thank you in advance for providing that support to our work.

Ms EDWARDS - It's a privilege to be able to contribute.

CHAIR - I hope I can encapsulate this question, but it goes to where you finished about the importance of training and education, specifically around trauma informed practice and recognition of birth trauma.

We've heard from some other submitters to the committee, you've touched on it as well, that it can sometimes be over a year of diagnosis of birth injuries and birth trauma. We've heard from other submitters that it can sometimes not be until a second or subsequent pregnancy that somebody might recognise that their former experience or their first experience did actually lead to birth trauma.

I wondered if you could share some insights about how that training can best be delivered to families and health professionals, also the importance of those referral pathways that you've referred to in that part of your written submission, recognising that the recognition of birth trauma might be some way down the track for some families.

Ms EDWARDS - When we're talking about the education piece, there are a number of elements to that. The first thing is making sure that we embed that educational piece into the earliest level of training of healthcare providers. That needs to be in the tertiary education programs of our midwives, psychologists, doctors, et cetera. I think that's a really important piece, that the messaging starts really early in healthcare provider training. I also think it is something that needs to be continuous and ongoing. It needs to look at not only recognition of the signs and symptoms, but how to have the conversations that health professionals need to be having to help women understand their own experiences. We've just spoken about the delay for some women in recognising that perhaps they have been traumatised by their birth experience. The training for health professionals needs to help create the space and the appropriate conversations to elicit that information.

It also needs to happen in a way that happens through the development of a trusted relationship. That education really needs to talk to the rapport building and the significant investment in the healthcare relationship. That is such an important part of understanding where women truly find themselves emotionally, psychologically and physically in their birth trauma experience.

I know you asked me some other questions but you're going to have to refresh my memory.

CHAIR - Thank you, no, that's really informative. The other part was just about referral pathways. One of the things that we know, not just in this area of health, but across the board in Tasmania, is long wait times. The referral pathway might exist, but the service that the patient needs to be referred into has an unacceptably long wait time. I wonder if you have any comments about your early experiences in Tasmania around wait times for programs that need to be resourced for people to be referred into or, equally, what your experience is in other jurisdictions that Gidget operates in?

Ms EDWARDS - Wait times are certainly one of the barriers that parents face in accessing onward referral and continuity of care. Wait times are not only about the length of time that it might be associated with waiting periods to enter a service, but the entire referral process can add significantly to the wait time.

I regularly speak with health providers, particularly hospital-based midwives, who talk about the challenges that they find in referring to not-for-profit providers and other service providers outside the state-based health system because, for many of the funding models, those referrals have to go back via a GP. So we're experiencing delays in getting that referral from the primary healthcare provider back to the GP, engaging with the GP, then getting the GP to make that onward referral. So, we've got a double wait happening there because we know, particularly in rural and regional areas, GPs are really, really time pressed and there can be significant waits to see a GP.

Streamlining some of those referral processes is an important part of the conversation and allowing - I guess facilitating - warm handovers. What we also get with warm handovers is a really, really critical transfer of information that helps the incoming service provider understand the urgency of care, the complexity of care and the support services required. Sometimes that enables them to put in place mechanisms that can begin immediate support even before they might be able to access the primary reason for referral. For example, they might be able to access some lower intensity interventions while they await their primary care intervention, or they may be provided with some wraparound support services that address some of their psychosocial stresses and improve their readiness to engage in care when they enter the service.

The other thing, is that there are a number of issues that impact the waiting lists and one of them is around workforce generally. There is a very, very significant shortage of skilled perinatal mental health clinicians, and there is a skilled shortage of mental health clinicians in the workforce generally. That's something that some of our peak bodies have been talking to government about for an extended period of time. That shortage adds to waiting periods, particularly in more isolated regional and remote areas and Tasmania, which has some of those more challenging workforce issues around isolation and the lack of large-city resources experiences that at a heightened level.

I think that's about looking at where some of those infill services, in particular access to services like telehealth that aren't geographically constrained in the same way that place-based services are, can help create some continuity of care for women who need timely access.

CHAIR - That's been informative, thanks very much. I hand over to my colleagues. I know we all have lots of questions.

Ms ROSOL - I was interested to ask about the workforce development program that you mentioned in the submission. We've heard quite a lot and we've talked about it with you today, but we've also heard from others about the need for training and skilling-up the workforce. I'm curious how that operates within Gidget. Is that in-house only? Is it an accredited course, or are you looking for accreditation for it? Is it something that could be opened up to others if it isn't open already?

Ms EDWARDS - Our workforce development program, which has grown even in the time since we provided submissions to the committee on this, looks at training already qualified mental health clinicians to deliver perinatal specific services. It is an area that's quite nuanced in terms of identifying and treating the presentations that are unique in the perinatal period. The workforce program is now run in conjunction with Federation University. We are now offering it as a graduate diploma in perinatal mental health. What the training provides is a 12-month program and the placements are completed through Gidget Foundation Australia, with supervision provided by experienced perinatal mental health clinicians at Gidget Foundation. Those clinicians help support the perinatal mental health trainees to deliver direct clinical services. There's an immediate uptake, as people enrol in the program, in the workforce capacity to meet the demands for perinatal mental health services, but with the support of experienced supervisors to ensure that the care is safe, appropriate, efficacious.

That's a 12-month program and the academic component is completed through Federation University. At the end of the 12-month program, the majority of clinicians continue to work with Gidget Foundation Australia as perinatal mental health clinicians. We take two intakes a year and that's advertised nationally. Remote placements are an option and all the training is online and the supervision can be provided online as well. There are no barriers to that. These are paid placements because one of the things that's a real barrier, particularly for women working in the mental health sector, is the ability to undertake further training when those are unpaid placements. So, these are paid placements; people receive a fee for the services that they provide throughout their training program.

We also have a supervisor development program that looks to train our experienced clinicians to be supervisors. With a workforce development program that needs intensive supervision, we need to generate a pipeline of appropriately qualified supervisors to provide that supervision. We also provide a supervisor development program that ensures that some of our most experienced clinicians become skilled in providing that education, training, and mentoring piece that we've spoken about already in these hearings.

The final element is that we are currently looking at piloting a broader student placement program for undergraduate students. We are hoping to be able to roll that out with a couple of universities in the hope that we can support that very early interest in perinatal mental health service delivery and that we can also support students to begin their careers in that specialist area, whilst also developing a workforce that continues to grow to meet the demand.

Ms ROSOL - What I'm hearing is that someone doesn't have to be working in Gidget to join the program and they don't have to work in Gidget after they've done it. It's open beyond -

Ms EDWARDS - They have to apply for the program through Gidget and they must work in Gidget throughout their placement period. They can't do a placement elsewhere because of the nature of the supervision requirements. We do ask that people continue to support perinatal health service provision. We do ask for 12 months of service afterwards, but that is something that, whilst we're very hopeful for, we recognise that there are always circumstances where people may or may not be able to manage that commitment.

Ms ROSOL - I did have a question about universal screening and the importance of that for identifying perinatal mental health disorders. We've heard in Tasmania that universal screening isn't being done particularly well, if it's happening. Are you able to share any insights of what's happening in other states, and whether there are systems or processes being used in places where it's working well?

Ms EDWARDS - There are some states where it is working well and some of that depends on the policies and processes within the local health districts, or the health services that are providing public services. But, one of the things Gidget does is work towards also encouraging universal screening in private maternity hospitals and facilities.

I guess the thing that really makes the difference between whether a program works significantly or not, is helping health professionals understand the importance and the value of universal screening, in creating opportunities and space to identify women who are at risk of or may have developed a perinatal mental health disorder - because without that clinician buy-in, you struggle to succeed to get the consistency with the screening.

The other element of that is making sure that the training that clinicians need to have these conversations, is available. Clinicians tend not to want to work in areas where they don't feel confident and comfortable to manage the presentations that might emerge. So, we want clinicians working at the top of their scope. To do that and to achieve that, they need the knowledge, skills, and understanding around how to screen, how to respond to what might come up in screening, and where to refer when that screening identifies issues.

Ms JOHNSTON - I might jump in there, if I may.

One of your additional recommendations you made, Karen, in your submission, was around the delivery of informed choices, and healthcare workers working collaboratively with women right throughout their care - both in emergency situations and after care - and supported choices around feeding, discharge, and follow-up care in the community. We've heard a lot from submissions and witnesses to the committee around the lack of informed consent that's been provided, and the difference between consent and informed consent, and how that can contribute to birth trauma.

I wonder if you could elaborate on that, particularly in the after-birth situation, where that ongoing care is provided, and continuity, and the importance of informed consent at that point in time?

Ms EDWARDS - The issue of informed consent should be seen as a sort of a continuum, rather than a sort of a discrete activity that happens at point A, B and C. Informed consent is about starting to have early conversations with women, particularly in the antenatal period, where you understand what they're looking for in their care; what emotional and physical supports they need, and what they're hoping their birthing experience might look like. It then translates into the actual delivery period, where informed consent is about checking in throughout the delivery process - because it's not a static process, and what starts as a Plan A may well end up as a Plan E or F as the delivery progresses.

It's about having those regular check-in points. It's about clear communication in plain English, so that people understand what they're consenting to. It's about making sure that they fully understand the options that are available to them and the risks associated with those options. It's not informed consent if you're only presented with a couple of alternatives or you're not really apprised of the risks that sit with each of those alternatives, and the likelihood of those alternatives eventuating.

The other point that's really important is that women also need to be respected to be able to make choices that carry an acceptable level of risk and to factor that into their care. So, risk management cannot sit entirely with the health professional. It should be a consultative process between the health professional and the woman receiving care.

In the postnatal period, informed consent is then about all that follow-up care around whether people feel that they're being given options and choices around when they might be discharged from hospital, for example, around whether they choose to breastfeed or bottle feed, around how they might access support services, what support services they might be referred to and what options are available for that. It is really important that those conversations happen in an ongoing way before a woman is discharged from hospital because that is the time where some of those care planning decisions are made. Women who are discharged prematurely often are not given an adequate opportunity to understand what their needs might be and to make appropriate decisions around what care might best support them moving into that next phase of their parenting journey.

Ms JOHNSTON - Thank you for that. I am also interested in another recommendation you made around development and delivery of comprehensive cultural competency training for perinatal mental health conditions and prioritising improved access and safe care pathways for the First Nations called on and the LGBTQIA+ communities.

Can you give an example of where that is done particularly well in another jurisdiction perhaps? It has been highlighted in a number of our submissions that there is that lack of cultural competency and awareness and has it been done well elsewhere that we can perhaps draw on?

Ms EDWARDS - I cannot provide you with an example that springs to mind about where it has been done well. What we do know is that when we look at the care that is provided to say, for example, women in First Nations communities who access care with an Aboriginal health worker, they access care through an Aboriginal medical service or similar organisation, that they do report higher levels of safety and security around the care that they receive. They do report accommodations that better suit their experience of parenting, pregnancy, childbirth and feel much more contained and much safer as a result of those supportive experiences.

Ms JOHNSTON - Thank you. I will go back online. Anita, anything?

Ms DOW - I was going to ask about the culturally sensitive approach as well, but one of the things that you also mentioned in your submission is around telehealth models of care and having a combination of face-to-face and remote. I wondered if you could elaborate on that, where you have seen that work well across regional areas, please?

Ms EDWARDS - Yes, one of the things that we can look to do in regional areas, where there is not someone with specialist qualifications located in the service centre, is to really be able to look at how we collaborate between existing health professionals who might be located within the town or nearby, and health professionals elsewhere who might have the specialist knowledge and skills. It is a hub and spoke model where the wraparound care is provided by the local healthcare service provider, so they are able to provide that face-to-face interaction, they are able to be on the ground evaluating risk, they are able to provide wrap around psychosocial support, and the expertise for the healthcare provider comes in from outside.

In addition to providing direct support to clinicians, that telehealth model also facilitates a consultation liaison facility where, in fact, the health professional who is located in the centre is able to talk to a specialist about ways that they might better support the client in their local environment and may provide the care that they need in consultation and in conjunction with the specialist service provider.

Ms DOW - Thank you for that.

Ms EDWARDS - I guess the key benefit is about trying to assist people to receive the care they need close to home. We know that improves the likelihood that they will benefit from the care, that they will persist with treatment that is required, and that they will feel safe and contained by the care that they receive and that it is culturally appropriate and safe for them.

Ms DOW - I was going to add to that, if you would not mind, just around the Gidget Centre, which has been established in Hobart, whether you had any feedback about how that is going and whether you see that there is an opportunity for that type of centre to be rolled out in other locations across our state?

Ms EDWARDS - The Gidget centre in Hobart is going really well and we certainly have some really experienced clinicians working there who are quite well connected with some of the local community agencies as well, quite connected with some of the local health teams.

We are looking at this stage at rolling out another Gidget House in Launceston and that will be co-located with the Tresillian facility that's coming to Launceston. So, we are looking to expand face-to-face service delivery in Tasmania, looking for opportunities to co-locate with other healthcare service providers so that we're able to provide that integrated care to people across that perinatal spectrum.

Mr FAIRS - Just one question, Karen, sorry my camera's not working, but I am here.

You were talking about patients. I wanted to get your experience and knowledge on this issue about patients having a better say on their own care. Do you find that in your experience patients are intimidated or scared to speak up about their own health and what's best for them, in their opinion, especially if there's greater risk?

Ms EDWARDS - So, Rob, that's a really interesting and complex question in that there's probably not a single answer. Some people will feel very capable of speaking up and advocating for themselves and others not at all. What we do know from the research is that access to a primary care provider really increases the likelihood that people will communicate openly and honestly with their healthcare provider; that they will have conversations that involve mutual trust and that they are less likely to be distressed or traumatised by the decisions that are made because there is an understanding that they're having a conversation with someone that they trust, someone who knows and understands them, and someone who they feel confident and safe with.

What's really important in improving the ability of, particularly, anyone from a marginalised community group, improving the ability of people in those circumstances to speak up, is to make sure that we're not changing their care providers constantly, we're not moving them from one person to the next so that every encounter with a health professional is a new and challenging experience.

We need to provide stability in that care, continuity in that care and we need to build meaningful and trusting relationships if people are going to feel confident to contribute to, and collaborate in, decision-making.

Mr FAIRS - Thank you.

CHAIR - Going back to your comments about workforce, I know you've touched on the importance of a peer workforce, and I wondered if you would care to elaborate a bit on the value of peer workers in the work that Gidget Foundation does?

Ms EDWARDS - One of the important things with peer workers is that they have an enormous capacity to add to the scope and the strength of the work that is being done by health professionals. Apart from bolstering the size and scale of the workforce, they bring unique perspectives and insights that healthcare workers alone can't bring and we know that parents really benefit from hearing about the experience of other parents and knowing that some of what they're noticing, feeling, experiencing is not unique to them, that they're not alone and that other parents have felt, and experienced, and navigated their way through similar challenges.

I think, particularly with some of the stereotyping that appears on social media, it is really really valuable for parents to have exposure to some of the real and the hard that goes with parenting and to hear that from supportive peer workers who are going to provide that, I guess, more holistic 'whole-of -parent' kind of support is really, really important. That's an area of the workforce that we need to be harnessing.

The peer workforce is a complementary workforce to the health professional workforce, and the two workforces have an enormous potential to reach and support parents in a way that either workforce alone will find more challenging.

CHAIR - Thanks, Karen.

Ms JOHNSTON - Are there any further questions online? No?

It brings us almost to the time we had allocated for that. Karen, is there anything else you'd like to add for the committee to hear whilst we have you here?

Ms EDWARDS - When we're talking about all the various approaches, the one thing that really stands out to me is the importance of ensuring that we have a suite of care options available. Parents have different needs at different times in their parenting journey. There is a need for low-intensity, moderate-intensity and high-intensity services and for parents to be able to step-up and step-down through those services. They need to be able to self-refer for low-intensity services and receive clinician-led care when their support needs are more intense.

It's really important that we make sure that we're not looking for any one-size-fits-all solution, that the solution lies in a range of supports, but, that is only effective when there are smooth transitions between those services so that people feel they can step their care up and down according to their clinical need rather than accessibility or availability.

Ms JOHNSTON - Excellent, thank you so much. I should have mentioned it to previous witnesses, but if there's anything you think of after today that you think the committee needs to hear, or you've forgotten to mention today or you want to elaborate on, please feel free to contact and you can contact through Mary.

Thank you very much for your time with us today. We appreciate your submission and your evidence today.

This is a little reminder that what you've said here with us today is protected by parliamentary privilege but once you do leave the broadcast today, you need to be aware that the privilege does not attach to the comments you may make to anyone - including the media - outside of these proceedings, even if you're just repeating what you've said to us today.

Thank you so much for your time today. We appreciate it and you take care.

Ms EDWARDS - Thank you all for your time and for your incredible investment in understanding the needs of Tasmanian families.

Ms JOHNSTON - Thanks so much, Karen.

THE WITNESS WITHDREW.

The Committee adjourned at 12.14 p.m.